PERIODONTAL REPORT

DATE:

Thank you for coming to see me for your periodontal consultation, via a referral from . I have pleasure in enclosing the following report:

Reason for attendance

Periodontal assessment and provision of periodontal treatment.

Diagnosis

• Generalized/localized mild/moderate/advanced chronic periodontitis,

• primary occlusal trauma-secondary occlusal trauma

• gingival recession

• peri-implantitis

Periodontal Disease:

This is a type of periodontitis, which is inflammation of the supporting tissues of the teeth is resulting in loss of supporting bone. It is the major cause of tooth loss in adults and unfortunately can only get worse without appropriate treatment (periodontitis is a progressive disease). The bacteria that accumulate on the teeth in the form of plaque and the body’s immune reaction to it are considered the main causative factors. Of course susceptibility of the individual is an important factor in disease initiation and progression. You should also be aware that there is a potential association between periodontal disease and heart disease, although it has not yet proven to be causative. However, periodontal disease treatment tends to improve inflammation markers related to heart disease. Please note that a major risk factor for periodontal disease is smoking. Smokers tend to have deeper pockets than non smokers. Smoking may change the type of bacteria in dental plaque, increasing the number of bacteria that are more harmful. It also reduces the blood flow in the gums and supporting tissues of the tooth and makes them more likely to become inflamed. Smokers' gum disease will get worse more quickly than in people who do not smoke. Because of the reduced blood flow smokers may not get the warning symptoms of bleeding gums as much as non-smokers. Regarding periodontal disease and diabetes, people with diabetes are more likely to have periodontal disease than people without diabetes, probably because people with diabetes are more susceptible to contracting infections. In fact, periodontal disease is often considered a complication of diabetes. Those people who don't have their diabetes under control are especially at risk. Research has suggested that the relationship between diabetes and periodontal disease goes both ways - periodontal disease may make it more difficult for people who have diabetes to control their blood sugar. Severe periodontal disease can increase blood sugar, contributing to increased periods of time when the body functions with a high blood sugar. This puts people with diabetes at increased risk for diabetic complications.

Periodontal disease often tends to progress almost silently without giving much cause for concern, until it has reached an advanced stage and the supporting tissues around the teeth are seriously compromised.

TREATMENT OF PERIODONTAL DISEASE

Oral hygiene instruction and advice

The aim of the oral hygiene phase of treatment is to reduce the number of bacteria in the mouth and therefore reduce the level of inflammation. You will be given iadvice on how to use the various cleaning aids most effectively; for example, the most appropriate tooth brushing technique and the correct use of dental floss and interdental brushes.

Professional cleaning

All soft deposits will be removed from accessible areas of the teeth and the teeth polished and treated with fluoride polishing paste. Depending on the improvement seen in plaque control and gum health, further instruction and cleaning may be carried out in subsequent visits. The next step would be to remove all bacterial deposits and tartar from the root surfaces and gingival pockets (sub-gingival root debridement).

Antibiotic therapy

In some cases, with or without microbiological evaluation, antibiotics are prescribed to deal with active or persistent gum infections, which have not responded to oral hygiene measures.

Reassessment

After 6-8 weeks, I will make a full assessment of your gums to check the progress of your treatment. A special instrument called a periodontal probe is used to record the depth of any periodontal pockets and check for bleeding from the gums. If periodontal pockets are still present, further treatment options may be suggested, including surgical corrective therapy.

Corrective (surgical) treatment

Sometimes, a surgical procedure may be indicated to clean away plaque bacteria and deposits that are under the gum within periodontal pockets and on the root surfaces at the furcations (where the roots diverge). These areas are inaccessible to brushes and floss and inflammation will persist in these sites as long as bacteria are allowed to colonize them. Under local anaesthesia, the gum is lifted away and the root surfaces are cleaned under direct vision to ensure that all bacteria are removed. Sometimes, it is possible to treat bone loss at the same time using a special regenerative treatment. At the end of the procedure, the gums are sutured back into place around the teeth.

Aftercare – supportive periodontal therapy

The long-term success of periodontal treatment depends both on your own efforts with oral hygiene and those of the practice team who provide your regular care and ongoing assessment. After the first phase of treatment has been completed, your dentist will need to review the condition of your gums at regular intervals to check that the inflammation has been halted. The frequency of your follow-up appointments will depend on the severity of disease and your individual risk of disease progression. Usually, follow-up visits are scheduled for every three to six months.

Regular follow-up appointments are vitally important to ensure that the disease process does not recur, causing further destruction of the gums and supporting bone. If there are signs of continuing disease, your dentist will be able to identify new or recurring sites of inflammation and treat them at an early stage. You will also be given advice on how to modify your oral hygiene practices to tackle the inflammation.

Successful periodontal treatment requires your full co-operation in regard to daily oral hygiene practices and attendance at regular follow-up appointments.

• Gum recession,

Gingival recession, or gum recession, is what happens when gum tissue is recessed and lowers its position on the tooth, exposing the roots of the teeth. This can be caused by any number of life habits, and your course of treatment is often dependent on the cause of the problem.

The following are some of the most common causes of gum recession:

o Overly aggressive brushing or flossing. Be gentle on your teeth, and remember that taking care of them isn't supposed to hurt.

o Genetics. Your gums' characteristics are determined by your genetics, just as the rest of your body is. If one or both of your parents have gum recession, you're at a higher risk for receding gums.

o Abnormal tooth positioning. If your teeth are not in alignment to one another, gum recession can occur in this situation.

o Grinding your teeth, or bruxism. Do you often wake up with a headache? Does your spouse or partner complain that you grind your teeth? This habit can be the cause of many dental maladies, not just gum recession.Teeth grinding can be treated easily and painlessly with a mouth guard and several other options.

o Trauma to gum tissue. The gum tissue may recede when a traumatic injury has occurred on a tooth or teeth.

o Poor oral health. If your oral health habits are questionable, gum recession may be a result of periodontitis.

When gum recession occurs, the root structure of the tooth becomes exposed. This means that tooth decay and other problems can affect the teeth along the gumline and beneath it. Since healthy gums are essential for a healthy mouth, getting gum recession treated is important for lasting dental wellness.

• Primary-secondary occlusal trauma,

Occlusal trauma has been defined as 'injury to the tooth surrounding tissues resulting from occlusal forces which exceed the reparative capacity of the attachment apparatus': ie the tissue injury occurs because the supporting tissues of the tooth are unable to cope with the increased stresses they experience.

When the maxillary and mandibular dental arches approach each together, as they do, for example, during chewing or at rest, the relationship between the opposing teeth is referred to as occlusion. If this occlusal relationship is not balanced properly it may result in pain, tenderness and even mobility of the affected teeth and gum recession.

When a patient exerts abnormally heavy biting forces on the teeth, stress cracks, chips and wear (attrition) may result. This is known as primary occlusal trauma. Primary occlusal trauma implies there has been no loss of the periodontal attachment (gingival attachment fibers, periodontal ligament, or bone), and the teeth themselves are damaged by the excessive forces on them.

This condition is related to secondary occlusal trauma, in that both produce changes in the patient's bite relationship (occlusion). However, secondary occlusal trauma occurs when there has been some degree of periodontal attachment loss, and even normal biting forces that were once tolerated by the gums, periodontal ligaments and bone are now too excessive for those structures to withstand. The result is loosening, tipping and movement of the teeth.

Peri-implant disease:

One of the long-term risks associated with dental implants is a condition called Peri-implantitis. Peri-implantitis

Definition: Infectious disease that causes inflammation of the surrounding gum and bone of an already integrated dental implant, leading to the loss of supporting bone. An overall picture of some clinical improvement emerges with the use of anti-infective therapies, in terms of resolution of inflammation and bone healing. Non- surgical or surgical peri-implant treatment or extraction of the implants may be considered depending on the degree of bone loss affecting the implants.

Please see the photo below as a guide for the teeth numbering

Examination Findings

Medical History:

Dental History:

Major concern:

Risk factors: Smoking is a major risk factor for the progression of gum disease

Genetics: Genetics are involved in the progression of periodontal disease

Extra-oral examination: On examination I did not notice anything of significance during the extra-oral examination.

Intra-oral examination: The soft tissues of your mouth have been examined (tongue, cheeks, roof and floor of the mouth and lips) and happily no pathology was detected.

The teeth have been examined and the dentition is mildly/moderately/heavily restored.

Generalised occlusal wear is present/not present

Mild mobility is affecting the following teeth:

Advanced mobility is affecting the :

The gingival appear with gingiva mild/moderate/advanced recession and generalized/localized loss of the inteproximal papilla

The plaque score on examination was and we discussed that to improve the prognosis for the future the plaque score which we would ideally be looking to achieve is below 10%.

The periodontal pocket depths range from 4 to mm and more advanced appear towards the molar teeth which presented with the mm pocket

Furcation involvements affect the teeth (bone loss in between the roots of the individual molar teeth) A furcation involvement, also called a furcation invasion, is defined as an area of bone loss at this branching point of a tooth root. The bone loss results from periodontal (gum) disease. Early detection and treatment with coverage of the furcation entrance may prevent further gum and consequently bone and tooth loss.

The following categories of gingival recession which represent different degrees gum recession were noted:

Miller 1: UR2, UR3, UR4, UR6, UR7, UL2, UL4, UL6, UL7, LR2, LR4, LR6, LR7, LL4, LL6, LL7,

Miller 2: UL3

Miller 3: UR1, UL1, LR1, LL1, LL2, LL3

On teeth with Class 1 and 2 gingival recessions we can expect full root coverage and recreation of a thick strong band of attached gum which acts a physical barrier around the teeth preventing from further gum,bone and eventual tooth loss.

Teeth with Miller Class 3 gum deformities are missing the pointy interproximal gum papilla and this is due to bone loss already present in between the teeth. With gum grafting procedures on this particular teeth we are looking into covering most but not all the exposed root and also we aim at recreating the strong thick gum barrier.

On teeth with Miller Class 4 root coverage cannot be achieved.

The teeth present with complete loss of attached gum, which means they lack a strong physical gum barrier to prevent from further gingival recession.

 Peri-apical Radiographs were taken for the periodontal assessment of the bone levels and exclusion of peri-apical pathology and I observed

Case Discussion and Periodontal Treatment goals:

With your susceptibility to, and extent of, periodontal inflammation currently present in your mouth, the way you clean your teeth needs to improve further. I believe we can achieve that by assessing your overall cleaning technique and concentrating on certain areas, in particular at the back of the mouth, near the gum line and in between the teeth.

The aim of treatment is to control the existing infection of the gums arrest disease progression and prevent further damage to the supporting tissues of the teeth. In other words, improve the health of your mouth and prolong the life of your teeth. The tooth mobility and the teeth positioning cannot be reversed with periodontal treatment. The orthodontic treatment may be initiated once the periodontal disease is stabilized and the periodontal pockets present up to 4mm and not bleeding

The overall prognosis of your gum with comprehensive periodontal treatment is questionable if the plaque score will not improve and due to the risk factor of smoking negatively affecting the progression of the disease.

With regard to the individual teeth prognosis the teeth unfortunately present with a questionable/poor prognosis for the future due to the mild/moderate/advanced bone loss and mild/moderate/advanced mobility.

I discussed with you that all the dental conditions with regard to caries, root canal treatments, fabrication of mouthguard, prosthetic restorations and all other suggested dental treatment will be performed by your referring dentist <<…..>>

Suggested Periodontal Treatment Plan

The initial periodontal treatment I suggest involve:

• Intensive oral hygiene instructions monitoring and reinforcement where needed. Please see <practice website> for detailed instructions and videos on oral hygiene advice. I suggested that you brush 2xdaily with a soft electric toothbrush, use the Tepe brushes 2xdaily and rinse your gum with the Listerine Gum Treatment or the Corsodyl Daily mouthwash for the long term and use the Curasept 0.2% mouthwash for the duration of the active treatment.

• Referral to your dentist for investigation and treatment of

a)

b)

c)

• Referral to the hygienist to review with you the aforementioned oral hygiene techniques, monitor the plaque score and to perform full mouth scale and polish (cleaning the teeth above the gum line) with particular attention at the 4-5mm bleeding pockets.

• Laser assisted non surgical periodontal treatment with subgingival root debridement (cleaning the teeth below the gum line) with laser sulcular debridement and subgingival placement of chlorhexidine(antibacterial) gel under local anaesthetic on all the deep bleeding periodontal pockets over x appointment with me

I stressed the importance of meticulous oral hygiene. For the long term success of treatment I would strongly suggest daily removal of bacterial deposits (plaque) from your teeth with brushing twice a day with a soft electric toothbrush, rinse with Corsodyl or Curasept 0.2% while you are being treated for the periodontal disease and then switch to the Listerine Gum Treatment or Corsodyl Daily Mouthwash. Also equally important is the use of the Tepe brushes and floss, as well as periodic periodontal maintenance therapy with the hygienist (every 3 months) after the proposed treatment at a dental office, since bacteria tend to return in a 3 month period. An annual review visit with the periodontist to ensure stability of the periodontium and exclude any oral pathology is indicated.

Also, please be aware of the side effects of subgingival debridement which are gum recession (teeth will look longer), possible increased tooth sensitivity and increase in the size of interdental spaces.

I also explained that periodontal health is achieved only when periodontal pockets present up to 4mm with no bleeding on probing and plaque free. During the periodontal re-assessment I will investigate the periodontal healing. In the unfortunate event that there are very deep periodontal pockets still present and are persistently bleeding, further treatment may be required.

• Reassessment 6 weeks postoperatively, evaluation and discussion if further treatment is required. Upon healing of the periodontal pockets healed then we can proceed with the gum recession treatment

• Reconstruction of gingival recession

Traditional gum recession treatments involve the use of donor tissue from your roof of the mouth or soft tissue grafts (such as donated human tissue-Alloderm)) in order to rebuild the gumline. The areas of gum recession will be prepared to receive the graft with a blade. This soft tissue graft would be sutured in place and would join with existing gum tissue as it healed. While this traditional grafting treatment is effective, comparable results with better patient experience can be achieved through the Chao Pinhole® Surgical Technique.

During the Chao Pinhole® Surgical Technique, a needle is used to make a small hole in the patient's existing gum tissue. Through this pinhole, special instruments are used to gently loosen the gum tissue. These tools help expand and slide the gumline to cover the exposed root structure. There are no grafts, no sutures, and no incisions needed with the Chao Pinhole® Surgical Technique. It simply involves the adjustment of the existing tissue. For more information please visit my website at www.pinholesurgicaltechnique.london

Additionally once you have had your treatment completed it is essential for you to have regular maintenance therapy with the hygienist. This involves regular 3-4 monthly checks on your oral hygiene and gum status as well as the condition of your teeth together with scaling and polish. This part of the treatment is also important since is a life time commitment. If plaque is prevented from building on the teeth on a regular basis, then the gums should remain healthy without any deposits building below the gum line.

Please note that is practice policy that the estimates are only valid for up to 3 months. In particular with periodontal disease as it is a progressive disease, if a long period elapses between initial assessment and start of treatment, the baseline records may no longer be valid, in which case the measurements that we took initially, may have to be updated.

I am looking forward to the commencement of your treatment. Please do not hesitate to contact me prior to your next scheduled appointment if you have any further questions.

Yours sincerely,