

Periodontal Health Policy



Background

Not all patients are susceptible to periodontal disease and only 15-20% are at high risk of losing their teeth. If we can determine a patient's risk we can base our management more on their needs. If risk is low, then treatment may not be required, as disease is not expected to progress. Periodontal status is a combination of severity and extent of disease and the risk of further disease

- The severity and extent of disease is used to determine how much and what type of treatment is needed
- Risk is used to determine how conservative or aggressive treatment should be
- e.g. High risk but low severity may require rigorous OHI and intensive maintenance.

Recording

BPE for every patient at least every 12 months.

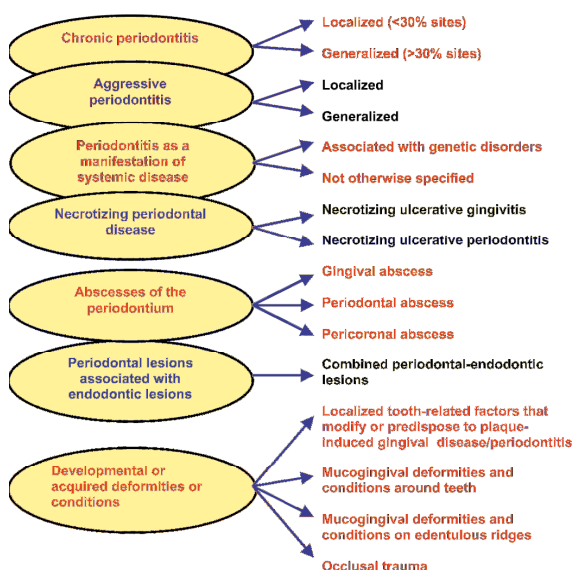
Grade 3 need bitewing radiographs

Grade 4 or * need further investigation, a full pocket depth chart and periapical radiographs

Recording risk of disease by use of a validated online risk calculator (Previser)

Recording of disease state to convey to patient (PreViser)

Provision of diagnosis



Can be classified as Mild, Moderate or Severe

Re-occurring disease is classified as recurrent

'Aggressive disease' is defined as disease in patients who are systemically healthy, with rapid loss of attachment and alveolar bone, and a high incidence of a familial link.

Disease can also be "historical" when it has been treated but is not active at present.

Resources

Patients with BPE ≥ 3 or Previser risk ≥ 3 or above to be treated by Hygienist
New patients to be seen as prescribed - eg a diagnosis of Generalised mild chronic periodontitis may take 90mins. Possibly 2 x 45 min appointments
30 min maintenance adult appointments 15 min OHI for children
All staff to be capable of giving oral health advice
Aim to reduce dentist time spent treating periodontal disease

Treatment Regimes

Low risk or BPE Code 1&2 – OHI supragingival (& sub if necessary) scaling and polishing

Medium risk -Previser 3 or BPE 3. As above plus Root Surface Debridement to reduce the sub-gingival bacterial load to a level where health can be maintained. Bleeding Score and re-measurement at completion of active phase treatment.
NB. For BPE code 3 a detailed chart is needed at the end of treatment for those sextants (but not at baseline)

Average pocket depth reductions across the mouth should be a 1mm reduction in 4-6mm pockets and a 2mm reduction in pockets of 7mm. Ideally there is no BOP (Bleeding on Probing) at review (<10% of sites).

In certain cases eg generalised aggressive periodontitis systemic antibiotics will be considered as an adjunct to debridement.

In localised residual pocketing of 5mm with BOP after debridement a locally delivered antibiotic eg Periochip can be considered.

Active phase is considered to be over when there has been a reduction of pocket depth with no BOP and no sub-gingival deposits.

High risk –Previser 4/5 or BPE 4 As above plus consider referral

After active phase recall intervals can be decided

Maintenance

Patients should be aware that they need to have regular maintenance visits to maintain their periodontal health and prevent recurrence of the disease. These visits should include a review of baseline findings, re-motivation and removal of all supra-gingival plaque and calculus.

Sub-gingival scaling is confined to areas which are difficult for the patient to access such as pockets >4mm with BOP.

The recall interval is important to ensure the correct level of treatment is provided.

This could be assessed by use of Previser

Risk 3 or more should be recalled every 3 -4 months.

Risk 2 – Every 6 months if stable with absence of BOP and good plaque control

Risk 1 – Annually if stable with absence of BOP and good plaque control

Treatment Stratification Matrix

	Health	Gingivitis	Beginning Periodontitis	Moderate Periodontitis	Severe Periodontitis
Very high risk	Cannot be currently measured		Risk = 5 Disease = 4-10	Risk = 5 Disease = 11-36	Risk = 5 Disease = 37-100
High risk	Risk = 4 Disease = 1	Risk = 4 Disease = 2-3	Risk = 4 Disease = 4-10	Risk = 4 Disease = 11-36	Risk = 4 Disease = 37-100
Moderate risk	Risk = 3 Disease = 1	Risk = 3 Disease = 2-3	Risk = 3 Disease = 4-10	Risk = 3 Disease = 11-36	Risk = 3 Disease = 37-100
Low risk	Risk = 2 Disease = 1	Risk = 2 Disease = 2-3	Risk = 2 Disease = 4-10	Risk = 2 Disease = 11-36	Risk = 2 Disease = 37-100
Very low risk	Risk = 1 Disease = 1	Risk = 1 Disease = 2-3	Risk = 1 Disease = 4-10	Risk = 1 Disease = 11-36	Cannot occur

Patients in these categories have the most complex needs generally requiring advanced clinical skills and experience

Patients in these categories are borderline for treatment complexity

It is possible but unlikely to observe patients with these disease and risk profiles

Patients in these categories have routine needs generally requiring basic clinical skills and experience

From Previser

Referral Policy

This can be assessed by use of Previser. Referral to a specialized should be discussed with new patient if they fall into the red zone of the above chart. New patients with a risk level 4 but with gingivitis should have OH measures aggressively taught and reinforced.

Existing patients could be considered for referral if there is a change in their risk level (increase of 1) or a change in their disease state (increase of 10)

The Royal College of Surgeons in collaboration with the BSP also provides guidelines for referral based on BPE and modifying factors such as smoking or medical conditions.

BPE Code 1-3 – Treated in Practice Complexity 1

BPE Code 4 with no modifying factors- Complexity 2 - Consider Referral

BPE Code 4 with modifying factors – Complexity 3 - Refer

It is recognized that not all patients will want to undergo specialist treatment however the consequences of no treatment must be discussed and noted.