Periodontists

The Focal Point of the Link Between Oral Health and Systemic Health

Bone Grafting and Implants:
Always the Best Treatment?

Phosphor Plate Radiography:
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The coming years may be a time for "getting back to basics" for periodontists. And the "basics" – preventing, diagnosing and treating gum diseases – are more important than ever.

That's because of growing evidence linking periodontal disease with other systemic diseases, including cardiovascular disease, kidney disease and diabetes. Though the connection between periodontal and systemic health has been known to dentists and medical doctors for some time, the word may be filtering out to the public at large. If so, periodontal services may be more in demand than ever in the coming years.

To a certain extent, periodontics has – as other dental specialties – been a victim of a “blurring of the specialties,” says Susan Karabin, DDS, a practicing periodontist in New York City, assistant clinical professor at Columbia University College of Dental Medicine, and past president of the American Academy of Periodontology. Procedures that used to be the domain of, say, surgical specialists, are now being performed by generalists. Similarly, some of the things that periodontists used to do exclusively, such as soft tissue grafting, are now being done by oral surgeons. And endodontists are now doing implants and oral procedures. "There's an identity crisis among the specialties," she says. What's needed is for each one to find its niche.

"The periodontal/systemic link has made what we do more important," says Karabin. "Finding ways to make the mouth healthy and the body healthy will be the way we will keep our specialty alive and well."

The American Academy of Periodontology (AAP) reports that it has about 3,700 active members, a number that has stayed fairly consistent over the past 10 years. About 2 percent of dental students opt to specialize in periodontics, again, a number that has stayed consistent for the past decade.

Consensus Paper
The most recent link between periodontal disease and cardiovascular disease was a recently published consensus paper on the subject by the American Journal of Cardiology, a publication circulated to 30,000 cardiologists; and the Journal of Peridontology, the official publication of the AAP.

Cardiovascular disease, the leading killer of men and women in the United States, contributes to 2,400 deaths each day. Periodontal disease, a chronic inflammatory disease that destroys bone and gum tissues that support the teeth, affects nearly 75 percent of Americans and is the major cause of adult tooth loss. The common link between them is inflammation.
While inflammation initially intends to have a protective effect, untreated chronic inflammation can lead to dysfunction of the affected tissues, and therefore to more severe health complications, according to the AAP.

"Both periodontal disease and cardiovascular disease are inflammatory diseases, and inflammation is the common mechanism that connects them," said Dr. David Cochran, DDS, Ph.D., president of the AAP and chair of the Department of Periodontics at the University of Texas Health Science Center at San Antonio, when the consensus paper was published. "The clinical recommendations included in the consensus paper will help periodontists and cardiologists control the inflammatory burden in the body as a result of gum disease or heart disease, thereby helping to reduce further disease progression, and ultimately to improve our patients' overall health."

"Periodontal disease used to be thought of as an infectious disease, whereas now it's considered an inflammatory disease," adds Karabin. "[It] contributes to the inflammatory burden of the body. So it makes control of this disease much more important than we thought in the past."

In years past, the loss of a tooth or two was regarded as unfortunate, but not potentially life-threatening. But considering the link between gum disease and other diseases, tooth loss becomes much more significant, says Karabin. "So instead of tolerating a low level of inflammation in the mouth, now [we know] we need to control it better. How that changes the way we treat it clinically is probably something that will evolve over the next few years." More antimicrobials, and more local delivery, are two ways periodontists might attempt to keep inflammation under tighter control.

Cardiovascular disease isn't the only condition linked to periodontal disease. A 2008 study, conducted at Case Western Reserve University and reported on in the Journal of Periodontology, suggested that edentulous, or toothless, adults may be more likely to have chronic kidney disease than others. The study examined the kidney function and periodontal health indicators, including dentate status, of 4,053 U.S. adults 40 years of age and older, according to the AAP. After adjusting for recognized risk factors of chronic kidney disease such as age, race/ethnicity and smoking status, the results revealed that participants who lost all their teeth were more likely to have chronic kidney disease than patients who had maintained their natural dentition.

Economics Favor Periodontics

There's no doubt that periodontists, as other dental specialists, are facing lean times, reflecting the state of the economy at large. "Everyone's having a hard time," says Karabin. "We depend on referrals from general dentists, and they're having a hard time. But I think there's a segment of the population who understand that in this economy, you need to stay healthy. They recognize that doing the normal maintenance and preventive procedures are still a good bang for your buck."

Involvement by insurers could stimulate the profession. Indeed, a 2007 study in Japan of 4,285 patients over three and a half years found that cumulative healthcare costs were 21 percent higher for patients with severe periodontal disease (involve
bone loss and diminished attachment around the teeth) than those with no periodontal disease.

"I think insurers will be very interested in this information [linking oral and systemic health]," says Karabin. In fact, after lecturing recently to a group of payers, she found widespread interest in providing preventive dental care to pregnant women and others. "I think they're looking at risks, and they see periodontal disease as one of the risk factors for systemic disease," she says. By paying for preventive dental care, insurers may help their patients avoid complicated - and expensive - medical issues down the line.

Sales Rep’s Role

From a technological point of view, Karabin says she is excited by research into and development of growth factors, which can stimulate bone production faster than was previously possible. "I can regenerate tissues that were lost, something I couldn’t do 10 years ago."

And she says distributor sales reps can be a potentially key part of the future of her profession, "not only by providing good service and good products at reasonable prices - that's the baseline," she says. Rather, reps can be a link between general dentists and specialists, and among specialists themselves. They are bearers of news of what other professionals are doing successfully. Furthermore, they are born networkers. Having heard of an opening in one practice, they may have become aware of someone who recently lost their job in another. Calling on so many customers, "they are in a unique position to assess practices and connect people," says Karabin. ~ITK

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Your practice is our inspiration.
When reading the most prestigious dental implant publications, it appears that the solution to most of the difficult partial and completely edentulous situations with inadequate bone lies in grafting the defective sites, waiting for healing, placing dental implants, and restoring the defects. In such cases, significant amounts of autogenous bone (the patient’s own bone), allograft (human cadaver bone), alloplast (synthetic graft materials), or xenograft (animal bone) are placed into the defective site.

There is no question that these procedures are desirable, and sometimes successful. However, the process can be extremely expensive. If the grafting material is autogenous, it is often painful at both the site from which the graft was taken and the site into which it was placed. Grafting large defects can be time consuming, often unpredictable overall, and can sometimes result in a less than perfect aesthetic result. We, as educated dentists, are the most knowledgeable clinicians concerning these situations. Are we providing adequate information to patients to allow them to make an educated and informed decision about their complex therapy? Is informed consent education providing all of the alternatives for such difficult situations being delivered to them? Often, patients see restorative dentists and prosthodontists after the grafting and implant placement has already been accomplished by a surgical specialist. At that late time, there are no alternatives except to proceed with whatever the surgical clinician accomplishing the grafting and implant placement envisioned. The clinical result may range from adequate to disastrous.

In recent months, we have seen clinical examples that have caused concern about apparent overtreatment or mistreatment. In the following cases, more conservative plans would have been possible and potentially better than those planned:

- Older teenagers with partial anodontia and stable remaining primary teeth treatment planned for removal of all functional and stable primary teeth, extensive iliac crest bone grafting in to all 4 quadrants, placement of many implants into the edentulous jaws, and fixed restorations on both jaws. Each of the jaw restorative rehabilitations had the planned cost of a new automobile. The cost of an entire oral rehabilitation such as this often equals...
The characteristics of informed consent should be well known to each of us. From both moral and legal standpoints we, the dental professionals, must thoroughly inform patients about the following 6 points:

1. Alternatives for care for their clinical situation
2. The advantages of each treatment option
3. The disadvantages of each treatment option
4. The costs of each option
5. The risks of each option
6. The result of doing nothing at all.

Qualified staff can educate patients to these 6 points, thus allowing the dentist to have only to confirm that the education has taken place and the patient is knowledgeable in all 6 areas. Use of videos, models, pamphlets, and other media help to simplify this process.

the cost of an average house in the United States.

- Partially edentulous patients with inadequate bone for standard-diameter implants (3 mm or larger in diameter), who were planned for extensive ridge augmentation using chin or ramus grafts; followed by implants, abutments, and crowns; when a simple, predictable fixed or removable prosthesis would satisfy the clinical situation from both a functional and aesthetic standpoint.

- Edentulous senior patients with inadequate bone for standard-diameter implants who were planned for major autogenous bone grafting into the anterior mandible and maxilla, before rehabilitation with removable overdentures; when placement of small, up to 3 mm in diameter, implants would have been ideal in the resorbed, mostly cortical bone that was present.

- Planning for the removal of functional and aesthetically acceptable 3-unit fixed prostheses; grafting of the single tooth edentulous site; and placement of an implant, abutment, and crown; under the guise that an implant in the edentulous single tooth areas would serve the patient better than the currently functional 3-unit fixed prosthesis.

- Planning for an active chemotherapy/radiation therapy patient to remove all remaining teeth, graft defective sites, place 4 implants on each arch; followed by a fixed prosthesis on each arch.

- Planning for placement of single implants between treated, previously periodontally involved mobile
teeth. These patients are often in a maintenance stage, but the long-term prognosis for the teeth is questionable. These patients often have several remaining teeth on each arch, several implants between the teeth, and a full-mouth rehabilitation is planned. Removal of the remaining teeth and placing conventional complete dentures or implant supported dentures often satisfies such situations more adequately, less expensively, and with more predictability.

- Planning for 4 or more implants with flattening of the bone on the crest of the ridge, and placing several over 3 mm diameter implants and a fixed prosthesis, when numerous other more conservative treatment plans could be considered.
- The many more examples witnessed over our cumulative years in practice would only add to the anxiety that we have stimulated in you already. The questions related to this article are clear. Should grafting and placement of implants be planned for everybody? Or, should more conventional therapy be accomplished occasionally?

This article is a call for each of us to ensure that our patients are:

- Honestly informed of the numerous alternatives for their complex oral rehabilitation needs;
- Encouraged to consult with other practitioners for their clinical opinions in addition to our own suggestions;
- Convinced that the “best” treatment for their specific situation is eventually chosen in light of their health, aesthetic needs and concerns, financial ability, age, temperament, and psychological well being. They should know that their treatment plan is not based on the highest revenue-producing procedure or whatever may be the most technologically advanced procedure at the time.

It appears that the previously described patients did not have the opportunity to make educated decisions about their therapy, since many of the planned treatments were neither logical nor in the patients best interest. For some dentists, the excitement of treating a “big” case and the obvious financial rewards cast a shadow over the patient’s true needs.

Both of the authors of this article are prosthodontists. And both of us graft defective bone sites and place implants. We agree that in many situations, grafting, healing, implant placement, and restoration constitute the best treatment. However, we also see many cases in which the treatment was excessive; ill-timed; too expensive for the patient or family, causing financial distress; or placed in situations where conventional oral therapy would have actually been better.
Treatment Planning Factors: Grafting and/or Implant Placement
We will use an actual patient to encourage you to think about treatment planning for difficult cases.

Figures 1 and 2 show the radiographs of a patient who came to us for a “second opinion.” According to the patient, a surgical dentist in our geographic area had removed a single upper anterior tooth, which led to removal of another apparently defective anterior tooth, an autogenous bone graft, and the eventual failure of the bone graft.

Figures 3 and 4 show the resultant significant bone and soft-tissue defects. A surgical dentist had suggested another extensive bone graft into the defect, some implants and crowns. The patient, an educated and intelligent person, was concerned about more surgery, its expected success, the aesthetic result, and the time involved for the overall procedure. After considerable dentist and staff time expended for “informed consent” (Table), and evaluation of the potential for functional and aesthetic success, the patient decided to have a conventional fixed prosthesis. We agreed with the patient’s decision, feeling that grafting and the other procedures were not in the patient’s best interest, although we could have easily accomplished the other route with more grafting and restoration with implants.

We agreed to do the therapy. A defective canine was removed and the socket of the extracted canine was grafted with an Alloplast (Bioplant by Kerr) to provide long-term socket and ridge stability for the soon-to-be-made pontic. The other remaining teeth were built up and prepared for the fixed prosthesis (Figure 5). The prosthesis was made in a one-unit casting using high palladium noble metal, with both tooth-colored and gingival-colored ceramic placed on the metal. It was fabricated as shown in Figures 6 and 7.

The clinical result is shown in a lip-retracted view in Figure 8 and the patient’s highest natural smile is shown in Figure 9. Only the upper teeth including the premolars were included in the fixed prosthesis. The mandibular teeth and the maxillary molars were not restored due to their stability, their lack of aesthetic needs, and to control expense for the patient. Obviously, the gingival-colored ceramic as shown in Figure 8 will never show unless the lips are forcefully retracted, in spite of a relatively good aesthetic result. The patient was highly satisfied with the result.
The following factors were considered and discussed in detail with the preceding patient before he decided to accept conventional dentistry instead of another large bone graft, a long healing period, significantly more expense, and an unknown clinical outcome.

Example Informed Consent Procedure
Alternatives for treatment:

- Leave his maxillary anterior teeth “as is,” repair the defective crown margins, and make an all-resin or metal-supported removable partial prosthesis;
- Place a fixed prosthesis, including the maxillary premolars and the remaining anterior teeth;
- Extensive grafting, implant placement, abutments, and crowns;
- The ultimate failure – remove all of the maxillary teeth and place a removable complete denture, with or without implants.

Advantages of each treatment: After discussing the advantages of each alternative, the patient rapidly elected to accept the fixed prosthesis. The advantages of the fixed prosthesis were:

- Three appointments only spread throughout a period of several weeks;
- After removal of the defective canine tooth and
analysis of the other remaining teeth, the cost of the rehabilitation will be known;
• Significantly lower cost than grafting and implants;
• Known predictability for aesthetics and function;
• Relative lack of discomfort compared to the surgical approach.

Disadvantages and risks related to the fixed prosthesis:

• Higher cost than the removable prostheses options;
• Possibility for endodontic therapy need for some of the remaining vital teeth. However, some restorative dentistry would have also been needed if grafting and implants had been done;
• Unknown longevity of the fixed prosthesis, as with any restorative dentistry.
• Relative cost of the respective therapy: In this case, the grafting, implants, abutments, and crowns would have been at least 3 times the cost of the fixed prosthesis as shown.

In Closing
Numerous treatment plans are present for most extensive, difficult cases, including missing teeth and significant bone loss. In light of the observed frustration of many patients, concerning how to best treat their complex oral conditions, it appears that many patients need more information before agreeing to their treatment plans. The treatment team (consisting of general dentist, dental specialist, and dental laboratory technician) needs to communicate better before committing patients with complex needs to extensive/expensive treatment plans. Although dental implants are highly desirable treatment when indicated, all possible treatments should be considered and explained to patients before proceeding with oral rehabilitation. Usually grafting and implant placement are the most adequate therapy. However, conventional treatment that doesn't include implant placement and complex bone grafting may often be the best treatment choice. ~ITK

Dr. Christensen is currently a practicing prosthodontist in Provo, Utah. His degrees include DDS, University of Southern California; MSD, University of Washington; and PhD, University of Denver. He is a Diplomate of the American Board of Prosthodontics, a Fellow and Diplomate in the International Congress of Oral Implantologists, a Fellow in the Academy of Osseointegration, American College of Dentists, International College of Dentists, American College of Prosthodontists, AGD (Hon), Royal College of Surgeons of England, and an Associate Fellow in the American Academy of Implant Dentistry. Drs. Gordon and Rella Christensen are co-founders of the nonprofit CR Foundation (previously CRA) and the Gordon J. Christensen CLINICIANS REPORT. He has presented more than 45,000 hours of continuing education throughout the world and has published many articles and books. He can be reached at (801) 226-6569 or at info@pccdental.com This e-mail address is being protected from spambots. You need JavaScript enabled to view it.

Disclosure: Dr. Christensen reports no conflicts of interest.

Dr. Child is the CEO of CR Foundation, a nonprofit educational and research institute (formerly CRA). He conducts extensive research in all areas of dentistry and directs the publication of the Gordon J. Christensen CLINICIANS REPORT, and other publications. Dr. Child graduated from Case Western Reserve University School of Dentistry, completed a prosthodontic residency at Louisiana State University, and maintains a private practice at the CR Dental Health Clinic in Provo, Utah. He is also a certified dental technician through National Board of Certification in Dental Lab Technology. Dr. Child lectures nationally and copresents the “Dentistry Update” course with Drs. Gordon and Rella Christensen. He lectures on all areas of dentistry, with an emphasis on new and emerging technologies. He maintains membership in many professional associations and academies. He can be reached at (801) 226-2121 or via e-mail at toni@cliniciansreport.org This e-mail address is being protected from spambots. You need JavaScript enabled to view it.

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Phosphor Plate Radiography: An Integral Component of the Filmless Practice

by Scott Benjamin, DDS

Although there is surprisingly little talk about it within the dental community, the federal government’s National Health Information Infrastructure (NHII) initiative will require all dental and medical practices to store and share all patient data digitally starting January 1, 2014. One of the main consequences of this initiative for dentistry is that dental practices using film radiography will by definition not be able to comply with these requirements for electronic dental records.

Even if the NHII initiative were not coming, however, it would behoove any practice still using film radiography to switch to digital. Of course, many practices have already made the switch, in many cases to direct digital radiography using a CCD or CMOS sensor. However, a solution worth exploring for practices that continue to use film exclusively as well as those that use a combination of film and digital sensors is to replace film with digital phosphor plate, or PSP, radiography.

PSP Versus Film
PSP radiography has existed for about 10 years, but during most of that time, it has been overshadowed by the surge in popularity of sensors. And while sensors clearly offer many important advantages, there is a place in most practices for PSP as well. Whether a practice is currently using film exclusively or in conjunction with sensors, replacing film with PSP makes sense for numerous reasons.

1. Speed of image development. While it can take 6 to 8 minutes to complete a full-mouth series with film, this can be done in less than 2 minutes with PSP. In addition, panoramic images can be available in 25 to 30 seconds and cephalometric images in only a few seconds more.

2. Identical sizes to film. PSP plates are available in all of the sizes that practices are accustomed to with film. All of the intraoral and extraoral plates are identical in size to that of film.

3. PSP positioning and placement are identical to film. As with film, the smaller, thinner, more flexible phosphor plates (Figure 1) are easy to accurately position within the oral cavity, minimizing the chance of image elongation, foreshortening, or retakes. This permits the capturing of images in the few areas that the thicker, nonflexible sensor plates are not able to access.
4. Same workflow as film. Perhaps the most pleasant surprise for film users contemplating a switch from film to PSP is that the workflow is essentially unchanged, meaning that there will be no time spent teaching a new protocol to your staff.

5. Patient comfort. The smaller, thinner size and softer edges of the flexible PSP plates make for a very pleasant patient experience, as does the fact that patients spend less time in your chair.

6. Image resolution. While resolution is not necessarily a problem with film, most clinicians who have used both systems believe the resolution with PSP is slightly better.

7. Less maintenance. Your staff will tell you that one of their most dreaded tasks is having to clean and maintain the chemical processor. The PSP digital processor requires no routine cleaning or maintenance. Eliminating the chemical processor will save staff time as well as improve morale.

8. Multiple-operatory usage. Units like the ScanX model I use allow simultaneous usage by 2 or more operators in 2 or more operatories.

9. Office space efficiency. Going filmless means there is no longer a need to devote a room or significant counter space to a chemical processor or other precious space to store the chemicals and other supplies. Many of the PSP processors (such as the ScanX Duo, shown in Figure 2) have a significantly smaller footprint than their chemical processor counterparts. This is to say nothing about freeing up the space currently required for the storage of the acquired film images.

10. Easier image access. Accessing, retrieving, and managing images is significantly faster and easier with all digital systems, including PSP, than with film.

11. Practice profitability. Most film users will find that PSP might as well stand for “Profitably Smart Practices,” for 2 reasons. First, there will be no more paying for the costly chemicals associated with film radiography. Second, you can literally get thousands of uses out of a PSP plate, and when it is time to replace one, the cost of an intraoral PSP plate is less than 30 dollars.

Sensor Users
PSP doesn’t just make sense for practices that use film exclusively for their radiography. Many practices that
Currently, there are 3 ways a practice can go completely digital: (1) a combination of direct digital sensors and film that is scanned into a digital format; (2) a combination of direct digital sensors and PSP; or (3) exclusively PSP. Our practice uses the combination of direct digital sensors and PSP, and while it requires a larger upfront investment, we feel it gives us maximum flexibility in meeting our patients’ needs. Moreover, if our sensor system should ever go down, we can still easily use an all-PSP protocol until the direct sensor situation is corrected.

Summary
The federal government has mandated that all dental and medical patient records be electronic in 3 years. Practices using film radiography will be unable to comply with this mandate. PSP radiography is not only a surprisingly convenient way to transition from film to digital imaging, it can also greatly enhance the practice’s productivity, profitability, and patient satisfaction. Modern, forward-thinking practices will want to take full advantage of PSP’s superiority by making this transition now rather than waiting until they are forced to. ~ITK

General practice dentists seem to be leading the way with social media. They are grasping the concept and using it more often in their practice. Although many specialists have jumped into the game, many are still hesitant to use social media.

Any small business or dental practice (specialty or not) can benefit from increased exposure. Here are three reasons dental specialists should use social media.

1. Social media sites like Twitter are some of the highest referral sites for links to blogs and websites. Even though they are a specialty, they should still be concerned with web traffic. I took a look at their website and there is little optimization. Google will have a hard time finding them.

2. Referrals to specialists are also tied to patients preference. Many times potential patients have no idea of who the oral surgeons are in town. A social media presence could put a face on the practice and actually increase referrals. I would much rather go to an oral surgeon that I was familiar with.

3. Social media can allow the practice to help other GPs in the area. Many oral surgeons and periodontists can post helpful tips and articles that GPs can then share with their patients. This builds a rapport between thegps and the os leading to more referrals. It will also build more links to the specialist’s blog or website helping web ranking.

Some social media platforms like Foursquare turn “checking in” into a game. This may be good for specialists dealing with younger patients. They could have a contest to see who can check-in the most.

Females and Moms make up a huge majority on social media sites. Always keep in mind who is making the dental decisions in the household. They are also the most likely to interact with a product or deal on social media.

Please email any questions to jason@socialmediadentist.com.

Jason Lipscomb is a dentist in Richmond, VA and coauthor of the book Social Media for Dentists.

Check out the book, Social Media for Dentists 2.0, and Jason’s blog at socialmediadentist.com.
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