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July 2011 – Volume 7, Issue 7

hygienetown®

with Perio Reports

by Trishie E. O'Hehir, RDH, BS

Finding Creativity in Clinical Practice

Discussions from Hygienetown.com

**The Occlusal Factor
When Treating Perio**

Gloving Too Much





Take the Gum Disease Toothpick Test

by Trisha E. O'Hehir, RDH, MS, Hygienetown Editorial Director

The number of medical self-tests is increasing rapidly. In the comfort of their homes, people now check their blood pressure, blood sugar levels, prothrombin times, pregnancy and answer questionnaires to measure stress levels. In dentistry we now have a periodontal self-test in the form of a toothpick test or Eastman Interdental Bleeding Index (EIBI). The toothpick test can also be used in the office for a quick periodontal screening. If full-mouth probing is done once a year in your practice, the toothpick test can be used at visits in between.

Here's how it works. Simply insert a triangular-shaped wooden toothpick between the teeth from the facial and push it in so it's tight between the teeth and rub in and out four times. Move from one interproximal to another and then look back to check for bleeding on both facial and lingual surfaces. It's quick, easy to do and easy to teach patients.

Periodontal disease begins between the teeth, where tissue in the col area is not keratinized and thus, more susceptible to bacterial endotoxins. Bleeding is a good indication of periodontal infection, but bleeding upon probing scores are time-consuming and can only be done by the dentist or hygienist. The toothpick test can be done easily by patients at home.

The EIBI is named for the research center where it was developed: Eastman Dental Center in Rochester, New York. Researchers microscopically evaluated papilla to determine the correlation between gingival bleeding and cell level infiltrate. Patients scheduled for periodontal surgery donated papilla for this evaluation. Before removing the papilla, a triangular wooden toothpick was placed into the interdental area from the facial aspect. While keeping the toothpick perpendicular to the long axis of the tooth and depressing the papilla one to two millimeters, it was rubbed in and out four times. Bleeding within 15 seconds was recorded.

Microscopic evaluation of the tissue samples confirmed a correlation between bleeding and inflammation. The sites that bled with the toothpick test had significant inflammatory infiltrate visible microscopically. Those that didn't bleed appeared histologically healthy. Although both facial and lingual sections of the bleeding papilla demonstrated some inflammatory infiltrate, the greatest break-

down of collagen was noted in the mid-interproximal section – the col area, right under the contact.

This study not only provided the first histological correlation between interproximal bleeding and the mid-interproximal location of the inflammation, but also introduced a convenient bleeding index which can be used by both clinician and patient.

The uniform pressure exerted across the col area by the triangular toothpick seems to be more reliable than the traditional bleeding on probing method. Use of the probe can be influenced by probe size, location and pressure. Where the toothpick fits, the EIBI has fewer variables to influence results and reports a low frequency of false positives. This is in contrast to an evaluation of bleeding on probing where pressure was repeatedly increased until bleeding was achieved. The harder the probing pressure, the more likely you are to elicit bleeding. Based on several studies, the EIBI is a reliable index for clinical evaluation of interproximal inflammation. Teaching patients to monitor their own gingival health has a side effect. Rubbing the triangular wooden stick between the teeth also removes plaque, leading to lower bleeding scores over time. The easy toothpick test provides valuable periodontal information in just minutes.

On a completely unrelated but very important note, it's time for Townie Choice Awards again! This is the sixth annual opportunity for Hygienetown Townies to vote for their favorite products and services. Even if you don't post in the discussions online, your vote is important. Click the Townie Choice Awards icon on the home page to access your personal ballot. From there, simply select your favorite product in each section. You can complete the entire ballot in one sitting or over several days. Thank you and remember, your vote matters! n

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Perio Reports Vol. 23 No. 7

Perio Reports provides easy-to-read research summaries on topics of specific interest to clinicians.

Perio Reports research summaries will be included in each issue to keep you on the cutting edge of dental hygiene science.

Saliva Test for Oral Health

There are three critical phases of periodontal disease with biomarkers released first into gingival crevicular fluid and then into saliva. The three biological phases are inflammation, connective tissue degradation and alveolar bone turnover. Six protein biomarkers can be measured in saliva: interleukin 1beta (IL-1 β), interleukin-8 (IL-8), macrophyage inflammatory protein (MIP), matrix metalloproteinase-8, (MMP-8), osteoprotegerin (OPG) and tumor necrosis factor alpha (TNF- α).

Researchers at the University of Kentucky in Lexington monitored these six biomarkers in a group of 68 subjects with chronic periodontitis. Half the group received oral hygiene instruction (OHI) alone and the other half received oral hygiene instructions and scaling and root planing (SRP). Saliva samples and clinical exams were done at baseline, 16 weeks and 28 weeks.

Both groups showed improved periodontal health, with greater clinical healing in the SRP group. Both groups showed reductions in OPG and TNF- α . IL-1 β and MMP-8 levels were significantly reduced only in the SRP group. IL-1 β was reduced at both time points for the SRP group and only at 28 weeks in the control group.

Those who responded well to OHI (27 percent) or SRP (63 percent) were evaluated separately, showing significant reductions in OPG, MMP-8 and MIP-1 α at both 16 and 28 weeks. Based on these findings, salivary biomarker levels could provide valuable information for the assessment of periodontal health both in dental and non-dental settings.

Clinical Implications: In the not-too-distant future, consumers will buy over-the-counter saliva tests to measure and monitor their periodontal health.

Sexton, W., Lin, Y., Kryscio, R., Dawson III, D., Ebersole, J., Miller, C.: *Salivary Biomarkers of Periodontal Disease in Response to Treatment.* *J Clin Perio* 38: 434-441, 2011. n



Salivary Occult Blood Test for Perio

Perioscreen is a new salivary occult blood test developed by Sunstar International in Japan. The paper strips detect human hemoglobin in saliva using a colloidal gold-labeled antibody. After swishing with three milliliters of distilled water for 10 seconds, the mixture is spit into a cup and the Perioscreen test strip is dipped into the saliva sample. The colloidal gold-labeled antibody dissolves in the saliva sample and if blood is present, an immune complex is formed and moves up the test strip by capillary action, resulting in a magenta line.

Researchers in Japan compared findings of the Perioscreen test to clinical examination in a group of 2,861 residents of the town of Hisayama in southern Japan. The clinical exam consisted of probing and bleeding scores on mesial-facial and mid-facial surfaces of all teeth. This screening method is known for underestimating periodontal disease, but is used for speed and convenience. Subjects also completed a questionnaire about dental history, medications and general health.

In 52 percent of subjects, no probing depths of 4mm or deeper were found and in 60 percent of subjects, bleeding upon probing was less than 15 percent of sites.

Based on bleeding and probing depths, subjects were divided into two groups – poor periodontal health and healthy. A total of 1,197 were diagnosed with poor periodontal health, while only 861 had a positive Perioscreen test and 336 had false negative scores. Of the 801 periodontally healthy subjects, 384 had positive Perioscreen tests and 417 had negative tests.

Clinical Implications: The Perioscreen test from Sunstar might be a screening option in the U.S. in the near future.

Shimazaki, Y., Akifusa, S., et al: *Effectiveness of the Salivary Occult Blood Test as a Screening Method for Periodontal Status.* *J Perio* 82: 581-587, 2011. n

Mothers Share Caries Risk with Their Children

The relationship between parents' oral health and the oral health of their children was reported in 1946 among 3,000 offspring in 1,150 families. Caries levels in 15-19 year olds was twice as high when parents had high caries rates compared to children of parents with low caries rates. Several studies show that both parents influence the caries rates of children, but the influence of the mother's oral health is greater.

Researchers at the University of California, San Francisco evaluated agricultural workers in Mendota, California, 160 miles southeast of San Francisco. A total of 179 mothers and their 387 children were evaluated clinically. Most mothers (80 percent) reported their oral health to be fair or poor and only 33 percent had ever received professional dental hygiene care. Six percent of mothers and 19 percent of children had never had a dental visit. One-third of the mothers and 85 percent of the children had Medicaid dental insurance.



Untreated caries were found in 46 percent of mothers with a mean decayed-filled-surfaces score (DFS) of 13.5, affecting half their teeth. Untreated caries were found in 27 percent of children (average age of the children was nine years, ranging from one to 17 years). The DFS rate for permanent teeth was 4.3 and the rate for deciduous teeth was 13.5.

The adjusted odds ratio for this group was similar to that reported in 1946. The children of mothers with untreated caries were twice as likely to have untreated caries themselves.

Clinical Implications: **Caries prevention for children begins with the mothers. Mothers should be encouraged to get their oral health in order before their children's teeth erupt to reduce the child's caries risk.**

Weintraub, J., Prakash, P., Shain, S., Laccabue, M., Gansky, S.: *Mothers' Caries Increases Odds of Children's Caries.* *J Dent Research* 89: 954-958, 2010. n

Gingivitis Causes Endotoxemia

Gingivitis is a reversible inflammation of the gingival tissues, triggered by endotoxin. Endotoxin is part of gram-negative bacterial cell walls. Endotoxins pass through altered sulcular epithelium, triggering an inflammatory response from the body that includes activation and recruitment of white blood cells, specifically neutrophils. Endotoxins also find their way into the bloodstream and move to other parts of the body.

Researchers at Indiana University, School of Dentistry monitored endotoxin levels in the blood of 50 healthy black and white men and women who participated in an experimental gingivitis study.

For three weeks, study subjects refrained from all oral hygiene to induce experimental gingivitis. At the three-week point, subjects received a prophylaxis and resumed daily oral hygiene with two more weeks of monitoring. Blood samples were taken at baseline, following three weeks without oral hygiene and again two weeks after resuming daily oral hygiene.

Endotoxemia was evident in 56 percent of serum samples after three weeks of experimental gingivitis. Two weeks later, endotoxemia levels were back to baseline levels. Neutrophil activity was also measured in the blood, with levels elevated at three weeks and returning to baseline levels after two weeks of oral hygiene. In identifying endotoxin positive and negative subjects, it was evident that of the endotoxin negative subjects, more neutrophil activity was seen in black subjects. In endotoxin positive subjects, more neutrophil activity was seen in women. Persistent neutrophil activity over time plays a role in tissue destruction. Periodontitis is more destructive, but gingivitis presents an early problem that needs to be addressed.

Clinical Implications: **Gingivitis triggers systemic changes that might have significant implications on general health.**

Wahaidi, V., Kowolik, M., Eckert, G., Galli, D.: *Endotoxemia and the Host Systemic Response During Experiment Gingivitis.* *J Clin Perio* 38:412-417, 2011. n

continued on page 5

No Brain Benefit from Chewing Gum

Chewing gum is considered beneficial for oral hygiene, to help cope with air-sickness and as an alternative to smoking. Researchers have suggested, anecdotally, that chewing gum enhances brain function.

Researchers at the University of Vienna in Austria wondered whether chewing gum would improve spatial task performance by healthy young adults. The Endless Loop Test (ELT) was used to measure spatial task performance. Individually, in a quiet room, seated before a computer, subjects were instructed to look at two images of an endless loop. The second image was rotated and the subject was asked to identify the direction of the rotation. A total of 23 image pairs were evaluated, with some used only for warm-up that were not included in the final analysis.

In the first experiment, three groups were tested: 117 subjects chewed sugared gum, 115 chewed sugar-less gum and 117 did not chew gum during the test. The test took approximately 10 minutes.

The second experiment involved the same ELT with different images. A group of 50 subjects were given sugar-free gum and instructed to chew during the test. The control group of 50 did not chew gum during the test.

Chewing gum did not enhance spatial task performance in either test. Those chewing gum did slightly worse than controls, but the difference was not statistically significant. The addition of sugar for the group chewing sugared gum did not provide any benefit over sugar-free gum or not chewing gum at all.

Clinical Implications: Neither chewing gum nor the presence of sugar in chewing gums enhanced the performance of spatial tasks.

Nader, I., Gittler, G., Waldherr, K., Pietschnig, J.: *Chew on this: No Support for Facilitating Effects of Gum on Spatial Task Performance.* Arch Oral Biol 55:712-717, 2010. n



Adolescent Smoking and Toothbrushing

Smoking is a significant risk factor for periodontal disease as well as other systemic diseases. Another risk factor is poor oral hygiene. These two risk behaviors, when started early, might become life-long habits.

Researchers at the University of Tampere in Finland used a 12-page survey with 85 questions to gather data from teens about smoking and daily toothbrushing. Demographic questions were also included. These teens were all part of a larger ongoing health study in Finland.

The survey was sent to 9,853 teens ages 14, 16 and 18, with 5,643 surveys returned for an overall response rate of 65 percent. The response rate for girls was 73 percent compared to 57 percent for boys.

Daily smoking was reported by nearly 10 percent of 14 year olds, 25 percent of 16 year olds and 33 percent of 18 year olds. A higher percentage of girls smoked at age 14 and 16 compared to boys. At age 18, daily smoking was similar for both boys and girls.

A higher percentage of girls in all age groups reported toothbrushing more than once per day compared to boys. Daily smoking and brushing less than twice a day were reported by seven percent of 14 year olds, 18 percent of 16 year olds and 22 percent of 18 year olds. This combination of two unhealthy habits suggests an increased risk of periodontal disease for these teens in Finland.

Clinical Implications: Tobacco cessation advice as well as oral hygiene coaching during routine dental visits for teens is advised. Research suggests that teens are more likely to listen to dental professionals about smoking risks than their parents.

Honkala, S., Honkala, E., Newton, T., Rimpelä, A.: *Toothbrushing and Smoking Among Adolescents - Aggregation of Health Damaging Behaviours.* J Clin Perio 38: 442-448, 2011. n

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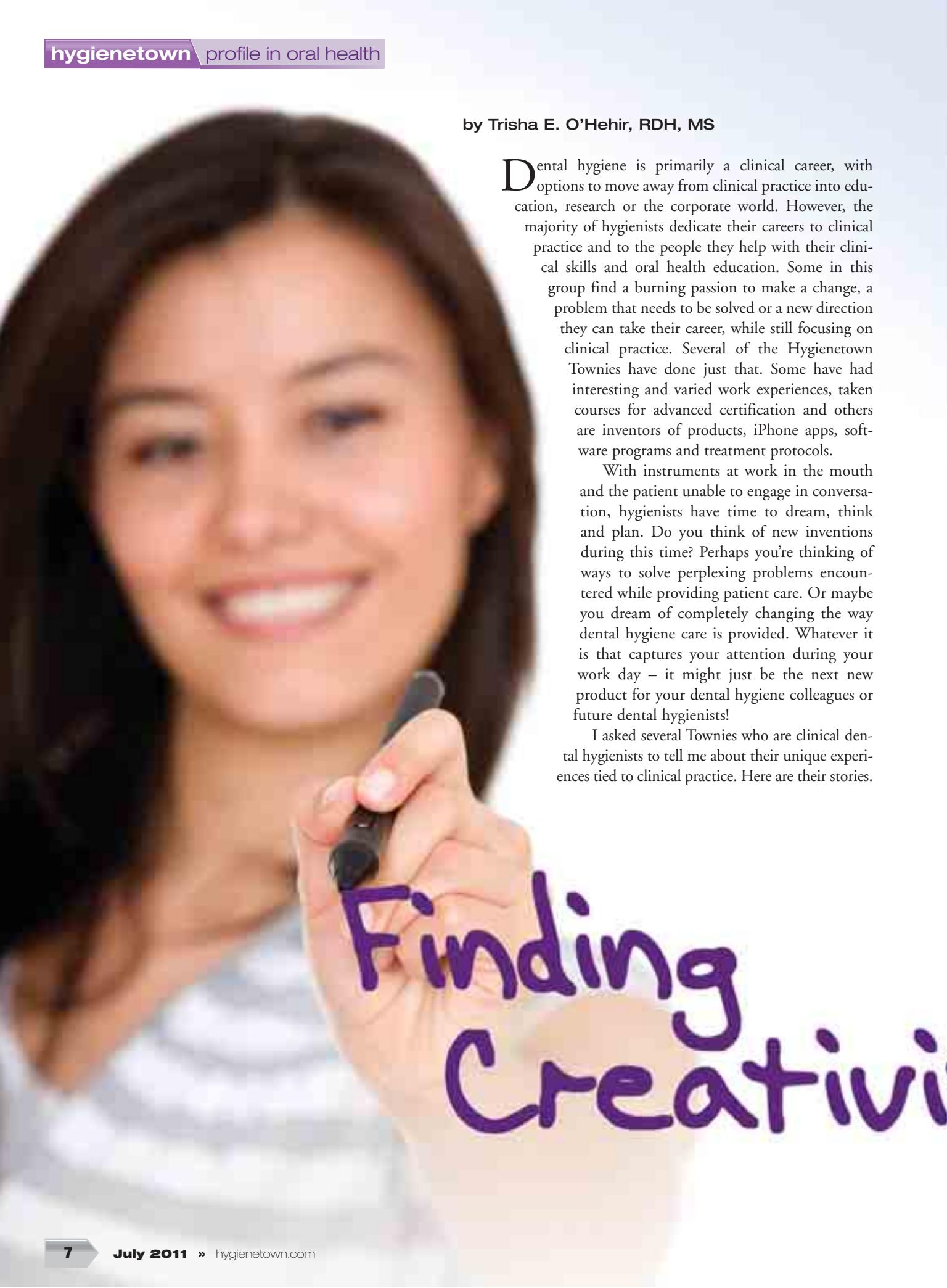


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by Trisha E. O'Hehir, RDH, MS

A close-up photograph of a woman with dark hair, smiling and holding a black marker. She is writing the words "Finding Creativity" in purple marker on a transparent surface in front of her. The background is blurred.

Dental hygiene is primarily a clinical career, with options to move away from clinical practice into education, research or the corporate world. However, the majority of hygienists dedicate their careers to clinical practice and to the people they help with their clinical skills and oral health education. Some in this group find a burning passion to make a change, a problem that needs to be solved or a new direction they can take their career, while still focusing on clinical practice. Several of the Hygienetown Townies have done just that. Some have had interesting and varied work experiences, taken courses for advanced certification and others are inventors of products, iPhone apps, software programs and treatment protocols.

With instruments at work in the mouth and the patient unable to engage in conversation, hygienists have time to dream, think and plan. Do you think of new inventions during this time? Perhaps you're thinking of ways to solve perplexing problems encountered while providing patient care. Or maybe you dream of completely changing the way dental hygiene care is provided. Whatever it is that captures your attention during your work day – it might just be the next new product for your dental hygiene colleagues or future dental hygienists!

I asked several Townies who are clinical dental hygienists to tell me about their unique experiences tied to clinical practice. Here are their stories.

Finding Creativity

Tim Ives, RDHPractice Appraiser • England • www.dentalvillage.co.uk

I'm a firm believer in setting goals for both personal and professional life, and a great promoter of life-long learning. However, experience has taught me that sometimes it's beneficial to undertake a course or qualification that might not immediately be of benefit and doesn't fit in with my immediate plans or career path, but can be put away in a bottom drawer to be used at a later date.

The Royal College of Surgeons (RCS) of England have a qualification called the Certificate of Appraisal in Dental Practices. A few years back they made this course available to hygienists and dentists. The one-year course qualifies clinicians to appraise all aspects of the dental office and the clinicians to ensure they are compliant in all aspects of dental care. In 2007 I was the first U.K. hygienist to gain this qualification.

Three years passed without ever using the qualification. But last year the government changed the way U.K. dental practices were legislated and many of the policies changed as well. This created a state of confusion and much anxiety amongst all members of the dental team.

An independent company established to assist dental offices through these compliance changes was looking for certified clinicians and offered me a position. I now spend one day a week out of the clinic as a practice advisor.

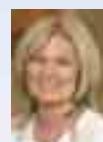
Suzanne Mann, RDHTemp Hygienist • Illinois • www.hygienetown.com

Twenty years ago my help was needed managing the family seasonal restaurant in Wisconsin. That ended my full-time employment in a single dental office. Thereafter I worked as a temp and one winter had the opportunity to fill in for a friend in Boulder, Colorado, an adventure that opened a Pandora's Box of excitement and learning.

I decided that combining work and vacation was the only way to fly, so from then on I found jobs in underserved areas of Colorado and it became my way to combine work and play. There is nothing like living in an area for four- to six-months stretches to let you know how the locals live.

I never felt new or isolated in any area as I was making friends with eight patients a day. They took an interest in the out-of-state hygienist and wanted to go to lunch or fill me in on social doings in the area.

In the various practices, I introduced new ways of doing things: polishing first, disclosing everyone, ultrasonic scaling and my own personally evolved spiel. Most importantly I viewed each office as a continuing education treasure trove as each did things differently than the previous office. There would be no other way to gain this hands-on experience of new equipment, new products and new management philosophies. I brought a lot of experience to each practice, but I honestly left with more.

Judy Carroll, RDH, DirectorPerioPeak Innovations • Washington
www.peripeak.com

Periodontal endoscope technology caught my attention in the periodontal office where I was employed in 2000. I was forever changed from the moment I picked up the endoscope. It changed the focus and direction of my career from an employee, where I felt like a "cleaning lady," to an entrepreneur with my own practice within a dental practice: PerioPeak Innovations. I could see the path clearly and felt I could finally make a tremendous difference in the lives of my patients in a more definitive and measurable way. I knew intuitively that hygienists like me could restore "hopeless" cases, as well as provide unparalleled preventive care through more definitive diagnosis of all conditions.

Since 2000 my focus has been exploring clinical possibilities with advanced endoscope protocols, carefully documenting hundreds of cases. Restorative Periodontal Endoscopy (RPE), became the "fruit of my labors." Clients travel to our clinic from all over the world to undergo our advanced treatment. Clinically I am very fulfilled as I continue to explore and document the clinical significance of RPE for combined endodontic/periodontal lesions, root resorption cases, cemental tears, root fractures and furcation defects (teeth all deemed hopeless). I feel the door is wide open for RPE to become an evidence-based treatment option.

Currently I'm developing a business plan for the next-generation periodontal endoscope. Innovative clinical education with more advanced protocols and techniques will be a big part of this plan, as well as publishing research on RPE.

continued on page 9

+y in Clinical Practice

Victoria DaCosta, RDH, BSDH, SHC

Systemic Hygiene Consultant • California

www.holisticdentalhygiene.com

Early in my career, with just two years of experience in a periodontal practice, I realized the connection between the mouth and the body. This happened in 1990 and it forever changed my approach to clinical dental hygiene. Research was just emerging about the potential link between periodontal disease and systemic health. My interest was piqued and my studies began. Despite my excitement and enthusiasm about this, I was fired from four different general dental practices for talking to my patients about the mouth-body connection.

A friend of mine, a successful businessman, encouraged me to develop a mouth-body connection screening software program so that all dental hygiene patients could know and understand why their gums were bleeding. Never in a million years did I realize that this project would eventually affect the career options of thousands of my fellow dental hygienists. After much research and years in development, the StrawBerrySafeKiss Wellness Screening software evolved – a program that calculates a mouth and body wellness score.

My weekly schedule now includes clinical dental hygiene days and non-clinical days as a certified systemic hygiene consultant, offering "SafeKiss" screening appointments. As research accumulates confirming the link between oral health and general health, it is my goal to help other hygienists become systemic hygiene consultants to then go on to help their patients achieve optimum oral and systemic health.

Along the way, I developed an all-natural, organic, fluoride-free prophy paste for use in the dental office. This provides an alternative for dental hygiene patients looking for holistic dental hygiene services.

Andy Codding, RDH

Board Review Study App Developer • Georgia

www.andyrdh.com

I remember how stressful and time consuming studying was for the board exams. I remember feeling a huge void when seeking mentorship and encouragement as a student. Students and new grads don't have a support system to help them adjust to their career. I had an epiphany that not all students have to go through this... my goal became to help dental hygiene students succeed as students and as hygienists.

Since graduating from dental hygiene in 2002, I've been mentoring dental hygiene students and recent graduates. Mentoring ranges from applying to dental hygiene school through the educational process and finally to finding and adjusting to clinical practice. I help with the transition into the real world of clinical dental hygiene; how to improve speed without compromising effectiveness or ethics, handling objections to needed treatment and how to be an extraordinary employee. This process motivated me to create several products, one for clinicians, the RDH Data Tracking Program, and for students, the Dental Hygiene Board Review CD and a new Board Review Study app for smartphones and the iPad.

The Board Review Study app allows students to take their study material wherever they go and to take practice mock board exams at any moment of the day, and at any location.

Mark Frias, RDHInventor of the Kona Adaptor • Massachusetts • www.facebook.com/konaadapter

Since starting hygiene school in 2005, I've been obsessed with oral isolation products. I tried many isolation products on the market, but was not impressed by any of them until I tried the Isolite System. In 2008, I decided to buy my own Isolite System with the hope that my corporate employer would embrace the technology after seeing it in action. To make a long story short, that didn't happen. I work out of eight chairs doing assisted hygiene, so having only one Isolite System was not enough. Purchasing eight Isolite Systems was beyond my personal budget and constantly moving the one Isolite System from chair to chair just wasn't practical.

One day in the summer of 2010, I decided to tinker around with the Isolite mouthpieces. I created a simple connector made from modified saliva ejectors. It wasn't perfect, but it worked and it got me excited about using my Isolite mouthpieces again. Prior to that time, it had never crossed my mind that I could design, manufacture and sell a simple high volume evacuation adapter for the Isolite mouthpiece myself. By August 2010, I decided to do it. The process of bringing the Kona Adapter to market has been very exciting and it has sparked a drive within me to create more products for the dental hygienist. I would encourage all dental hygienists who have a desire to do something beyond clinical practice to do it! Don't be afraid to make mistakes or fail. If you have a passion for something, keep pursuing it until you succeed. [n](#)

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The Occlusal Factor When Treating Perio

Some treatment protocols suggest occlusal adjustments on all perio patients, but do all patients need it?

JGonzalesRDH

Posted: 5/2/2010

Post: 1 of 25



The new hype in treating perio is to evaluate the occlusal forces. Some programs, like Millennium Dental (Perio-Lase), have a protocol that adjusts the entire occlusion while treating active periodontal disease.

I'm interested in learning more from my fellow clinicians. As of now, I am not convinced that there should be a blanket statement (i.e., if you have perio we must change your occlusion). However, I also recognize certain patients present with obvious signs of occlusal disease. For example, my 58-year-old patient... when I look at these images and compare them to my periodontal exam there's a strong suggestion of periodontal disease exacerbated by occlusal forces.

We start with Class I-II furcation involvement but note insignificant interproximal bone loss.



Fig. 1



Fig. 2



Fig. 3



Fig. 4



Fig. 5

Figs. 2-3: We see V abfractions.

Fig. 4: We see moderate occlusal wear.

Fig. 5: We see porcelain fracturing (#2, 13). Bulk fractures of alloys (#5), wear facets. What would your treatment plan be for this patient? ■

periopeak

Posted: 5/2/2010

Post: 2 of 25



Great case, Julia. Ah, where to begin? Wonder if you could give more info on the host and history. Is this patient a smoker?

Yes, I would definitely address bruxism with this case, in addition to full mouth diagnostic endoscopy to check for probable root fractures on those endo teeth. Any and all endo teeth with pockets and evidence of

bruxism need to be checked very carefully subgingivally for root fractures. I see them all the time! And yikes, what about the obvious decay on #3 distal.

I do like the idea of occlusal adjustment whenever you see obvious problems. I have seen pockets reduce just from occlusal adjustment and nothing else, as I am sure all of you have. Healing cannot occur as it should if there are constant forces preventing it.

Perio diseases are very complex; we need to address all factors. ■

Our office has the T-Scan which is a computerized method of measuring occlusal forces. This would eliminate the need for an occlusal splint like the NTI (supposedly). We have not implemented the system yet, but it would be very interesting to see what type of results we would get with SRP alone followed with subsequent occlusal equilibration after perio treatment.

Patient claims not to be a smoker and on no medications, aspirin, vitamins or herbal supplements. His blood pressure was moderately high (something like 150/80) and might have been exacerbated by stress and anxiety.

Interestingly, this patient is a world traveler and his last cleaning was a year ago in New Zealand. He claims no one has ever talked to him about gum disease. Difficult to believe, but hey, check out all the sub-gingival calculus that grew in a year. ■

**JGonzalesRDH**

Posted: 5/2/2010

Post: 3 of 25

I ran across an interesting thread on Dentaltown about a periodontist down South whose theory is that clenching is the root of most dental and perio problems. He has written many articles, not sure if they are peer reviewed, but they draw upon other occlusal theories like those of Dr. Henry Tanner. He says that there has not been enough emphasis on the effect of clenching and unbalanced bite when looking into perio disease.

For recession, he hardly even mentions bacteria and self-care. He claims the key ingredient is the presence of unhealthy clenching combined with too much toothpaste. It does bother me that most perio experts insist that it is fundamentally the "itis" that allows recession to occur, and it is the "itis" we must focus our treatment, but on premolars I see very little inflammation yet always and without exception see recession.

For what it's worth, I have not made my mind up about this issue yet, but here is some food for thought. ■

**skr RDH**

Posted: 5/16/2010

Post: 4 of 25

My philosophy is that perio disease is a multi-factorial process. Occlusion can definitely exacerbate a weakened area; perhaps even create the weak link. ■

**JGonzalesRDH**

Posted: 5/16/2010

Post: 5 of 25

I agree with you J... multi-factorial for sure! I can see doing occlusal adjustments when necessary, and I'm sure that could make a big difference in the overall outcome of treatment in some people. We all know that there are so many more issues that make up the big picture. Hard to believe it was only a year ago that he had his teeth cleaned (although I always double those estimates if I haven't seen the patient before!) and obviously there wasn't much sub-gingival cleaning going on. I have to say, you do get some interesting patients! ■

**Msimon**

Posted: 5/22/2010

Post: 8 of 25

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continued from page 12

needardh
Posted: 5/23/2010
Post: 10 of 25

Maybe we could get an online course here on Hygienetown to cover occlusion issues! ■

JGonzalesRDH
Posted: 5/24/2010
Post: 15 of 25

I guess I need to clarify what I meant by occlusion having a significant role in this specific perio case. His recession isn't horrific; it's the furcations that get me.

With this case, note that he does not have significant interproximal bone loss, rather his furcation involvement is Class II-III. So why is that? I don't have a confident answer.

When I look at this patient, I automatically think this isn't just your generic perio case. I look at the pathway of destruction and I just wonder even if you did treat this case and eradicated all the bacteria, bone loss would still be occurring due to natural forces at work in an unbalanced environment.

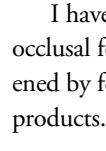
So then it leads me to wonder how he got here in the first place. What is it that I need to be looking at in my current patients that could be a potential red flag? As I've said before, I don't believe that if you are a bruxer/clencher you will have periodontal disease, but there's definitely a strong correlation that we are not well educated in and should be. Yes, let's get a CE course on occlusion. ■

lindadouglas
Posted: 5/25/2010
Post: 16 of 25

How is his diet as it regards intake of calcium, etc.? I was thinking that the appearance of the bone on the X-rays might suggest less than optimal bone density (i.e., the trabecular pattern). How does the cortical bone at the angle of the mandible look? The alveolar bone interproximally and distal of the max molars looks kind of ragged also. ■

dr-tique
Posted: 5/27/2010
Post: 21 of 25

Removing balancing and working interferences and controlling parafunction to limit mobility through the healing phase is part of the Millennium Protocol, which could amount to zero adjustments and no splint. You could be Class III end to end occlusion with a CR to CO slide and if there are no interferences and no parafunction, you don't touch a tooth. ■

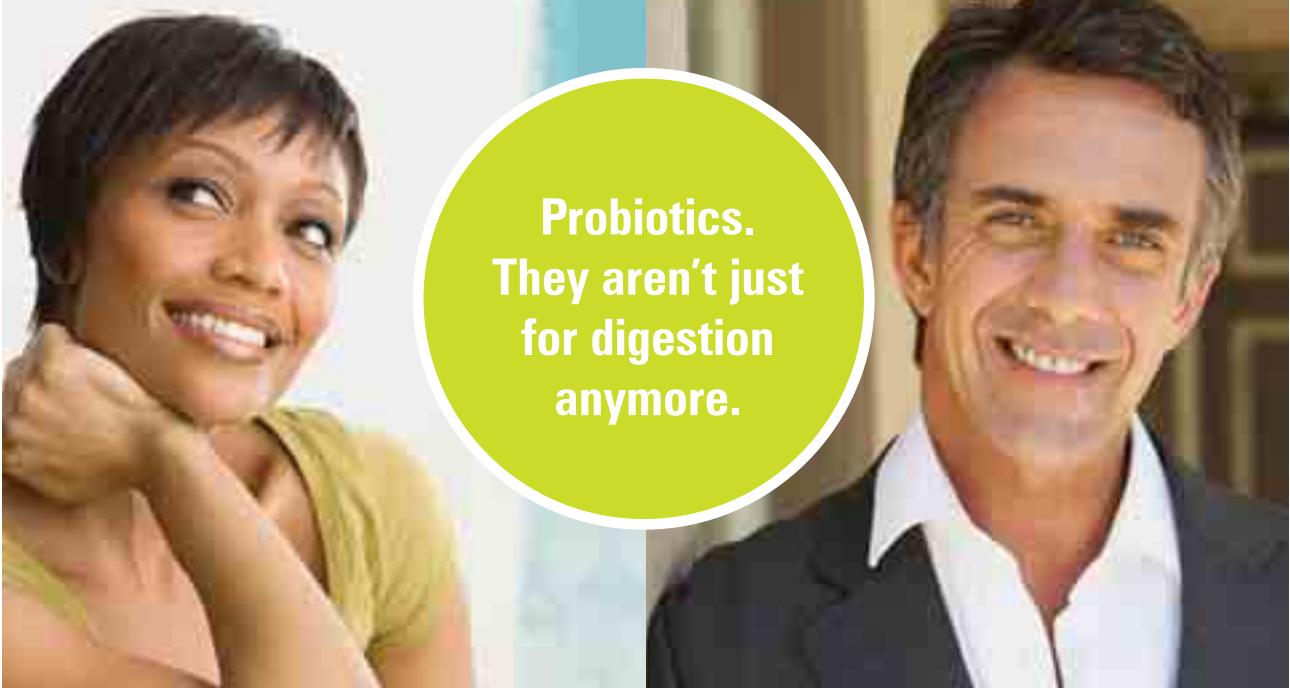
SandySqRDH
Posted: 1/29/2011
Post: 24 of 25

I have been practicing for 34 years as a hygienist. I definitely think that improper occlusal forces only makes the perio destruction go faster. If the gum fibers are weakened by force applied all the time, they can be destroyed faster by bacteria and its by-products. This idea is not scientific, only formed from years of observation. ■

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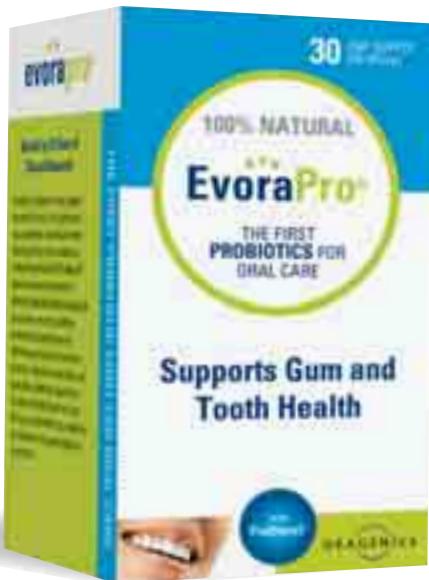
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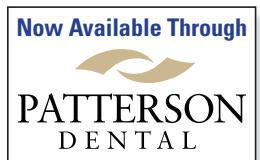


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Gloving Too Much

Gloving is standard and has been for several decades now. The number of pairs of gloves per patient has gone up as the price of gloves has gone down.

hygienemary

Posted: 11/13/2010

Post: 1 of 21

I am going through four to five pairs of gloves per patient. Is that too much?

One pair for setup, one pair for X-rays, one pair for treatment, one pair during doc visit and one pair for clean-up. ■

lorilovebug

Posted: 11/13/2010 • Post: 3 of 21

I wouldn't worry. I change gloves when I need to. It isn't worth contamination to save a few cents. ■

JGonzalesRDH

Posted: 11/13/2010

Post: 4 of 21



Wow! I'm glad you posted this because we really don't realize how many pairs of gloves we use on one patient. Five pairs of gloves sounds like a ridiculous amount, but makes sense when you explain it. We are a latex-free office so our gloves are expensive! I try to be conservative with my glove use, not only from a financial perspective, but also to reduce unnecessary accumulated waste. In general, I wear a medium, which is easy for me to remove. So if I need to remove my gloves during treatment, I simply lay them in a clear area of my instrument tray so I can reuse them. Although I was taught to wear gloves during the setup, it's not something I do in practice, mainly because I'm not contaminating anything that goes in their mouth. I just use the plastic barriers to attach suction or air/water syringe and then that gets covered by another barrier. My total glove use for a patient needing radiographs: three pairs (four if you include the doctor's pair he uses for an exam). Check this math; assuming each box contains 100 gloves, I use one box in four days; you are using two boxes in four days (double). If you can reduce your glove use to three pairs, that means you would be saving 50 boxes a year! ■

skr RDH

Posted: 11/13/2010

Post: 5 of 21



I thought I was using too many at three to four pairs per patient. I don't think five pairs is unreasonable either. I sometimes take them off just to give my hands a "breather" during downtime (e.g. waiting for the doc after doing my treatment). There is no way I can reuse gloves. It is impossible for me to get them off without them going inside-out. ■

amydhd

Posted: 12/31/2010

Post: 6 of 21

Nope, not too much. I do about the same. Although I have found it easier on my hands to wear nitrile gloves (Kimberly Clark Lavender or Purple gloves) for setup and radiographs, and latex gloves (Dash Aloepro – great gloves coated with aloe and slightly thicker and longer for putting over my gown cuffs) for exams and cleanings. ■

newbie10

Posted: 1/3/2011

Post: 8 of 21

Hu-Friedy sells purple utility gloves. I used these in school and asked the clinic I now work in to buy them for me. That's one pair, if not more gloves saved when cleaning up and helping around the sterilization area. By the way, they are chemical-resistant so your hands never feel weird after a day of using those chemicals. They cost about \$5 a pair. ■

Seems excessive to me. You should set up the room with clean hands. You should clean the room with nitrile utility gloves. Right there, you are saving two pairs per patient. ■

I use about three pairs per patient. I also try to use overgloves if something comes up and I need to leave the room quickly or grab something not sterile. ■

I'm glad you brought up this issue. Made me think for a minute. I set up my room with washed hands; use one pair if I take X-rays, one pair during the appointment and one pair for clean-up. If the patient has substantial bleeding I will remove my gloves midway through the appointment and re-glove. I worry about my impact on the environment more than the cost of the gloves. Our bigger concern is our patient's well-being and not causing cross-contamination. Bottom line, do what is necessary to provide universal precaution. ■

We need to remember that patient perception is important. If we leave the operating room, we need to make sure the patient sees us re-glove when we return. They have no idea what we did when we left the room. Do unto others as you would want them to do unto you.

The nitrile glove prices have come down to about the same price as latex. All we use are nitrile and my hands love them much better than latex. ■

I set up the room with freshly scrubbed hands. I use one pair of gloves for my procedure. If I need to "break scrub" at any time, I remove my right hand glove so that it turns inside out, put it on my left hand (contaminated side to contaminated side) leaving me with my scrubbed right hand and an inside out, non-contaminated gloved left hand. To return to my procedure, I remove the glove from my left hand so that it turns inside out and put it back on my right hand. With a little practice you can do this quite quickly and without contaminating the cuffs of the gloves. At the end of the appointment, I break down the room with contaminated gloves, then repeat the de-gloving of my right hand donning it on my left and use a new glove on my right hand to wipe down my room. I then discard those gloves and scrub my hands to set up for the next patient. So unless I touch a contaminated surface while in "scrubbed hands" mode or if my hands get too sweaty to re-glove, this works quite well. Not counting the doctor's gloves, that means three gloves or one and a half pair per patient.

My biggest problem is finding gloves with a broad enough palm and wide enough fingers without having those fingers be inches longer than I need! My hands have changed quite a bit in 37 years of practice! ■

AnnieB25

Posted: 1/3/2011

Post: 9 of 21

Nancyd

Posted: 1/7/2011 ■ Post: 10 of 21

flossy007

Posted: 1/7/2011

Post: 11 of 21

Carmelia

Posted: 1/7/2011

Post: 13 of 21



Greetings

Posted: 1/8/2011

Post: 14 of 21

Gloving Too Much

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