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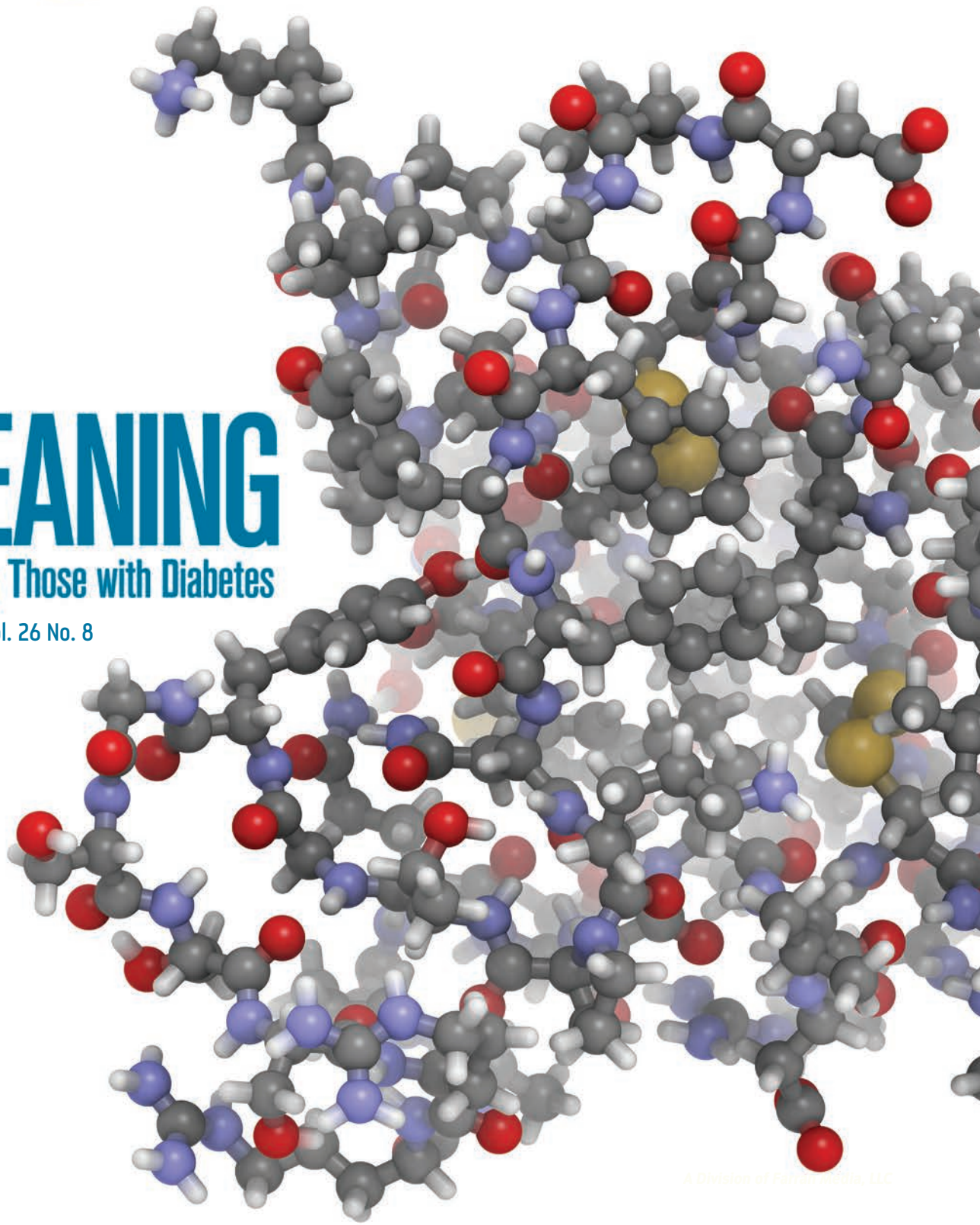

Interdental CLEANING Low Among Those with Diabetes

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Soft Picks for Interdental Cleaning Reduce Bleeding

Gingivitis is a widespread infection with interdental bleeding and most patients ignore suggestions to floss daily. Other options need to be found that make cleaning the interdental spaces easier and faster than using dental floss. A few years ago Soft Picks were introduced by the Sunstar Butler company as an alternative to dental floss. The soft, rubbery tip is flexible and easy to insert into interdental areas. The Soft Pick is used with one hand instead of two that are needed to floss. An in-and-out rubbing motion from the facial surface will disrupt the bacterial biofilm from above and just below the gingival margin.

Ten patients with no daily interdental oral hygiene were selected for this study. Baseline risk assessment and screenings were done for all the patients. They were seen for regular dental hygiene care and offered the Soft Picks as an alternative to dental floss. All agreed to participate in the study and provide feedback as to their Soft Pick usage and experience.

The group ranged in age from 20 years to 65 years, with seven women and three men. Subjects were instructed in the use of the Soft Picks and asked to record the presence or absence of bleeding after use. The dental hygienist followed-up with emails and phone calls. After two weeks of use, nine of the 10 subjects reported no more bleeding with Soft Pick use. One patient still reported bleeding. This showed a 90 percent rate of success with using Soft Picks to reduce interdental bleeding.

Clinical Implications: Recommend Soft Picks as an alternative to dental floss for those who can't or won't floss daily. ■

Przybos, A.: Is Reduction of Bleeding Possible When Using Soft Picks? OHU Action Research 12A-13, 2014.

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Xylitol Beneficial for Oncology Patients

Oncology patients undergoing chemotherapy and radiation suffer salivary gland damage leading to reduced salivary flow and problems with dry mouth. In addition to increased caries rates, lack of saliva makes it difficult to wear dentures and partials, and difficult to chew and swallow.

Research focuses on caries rates associated with dry mouth, but more needs to be done to find solutions to the quality of life issues faced by patients undergoing oncology treatments. A two-week trial involved two support groups for survivors of head and neck cancer in the Dallas, Texas area. A total of 11 volunteers participated. They completed a pre-test survey about dry mouth symptoms. They were provided with a variety of Xlear/Spry 100 percent xylitol sweetened products to test. Products included Spry chewing gum, SparX Candies, Spry Moisturizing Tooth Gel, XyloSweet granulated sweetener and Rain Moisturizing Spray. At the end of two weeks, participants mailed in a post-test survey about product use, product preference and impact on dry mouth symptoms.

At baseline, the majority of patients reported a feeling of dry mouth, difficulty swallowing and the need to sip liquids frequently. After using the products, all of the participants reported they experienced relief from using the 100 percent xylitol-sweetened products. Spry Tooth Gel and SparX Candies provided 10-20 minutes of relief, while the RAIN Spray consistently provided the longest lasting relief, from 20-40 minutes. Product preference was influenced by effectiveness and personal preference. Some of the products were not liked as much as others. However, everyone liked the Rain Spry.

Clinical Implications: Oncology patients with reduced saliva will benefit from 100 percent xylitol-sweetened products, especially Rain Spray. ■

Potts, K.: 100% Xylitol, Salivary Flow and Quality of Life in Oncology Patients. OHU Action Research 3A-13, 2013.

Straight Interdental Brushes More Effective than Angled Brushes

Daily biofilm control is an essential part of preventing caries and periodontal disease. Toothbrushing removes 40 percent of plaque biofilm. For periodontal maintenance, interdental brushes are twice as effective as dental floss. Interdental brushes are also more effective than floss for reducing inflammation and probing depths. Standard interdental brushes are straight. A new angled brush with a handle grip was recently introduced with the goal of making interdental cleaning easier and more effective.

Researchers at Witten/Herdecke University in Witten, Germany, wanted to know if the angled interdental brush was more effective than the standard straight brush. With newspaper ads they recruited 128 volunteers to participate in this two-week trial. The group was divided in half, each group receiving either the straight or the angled interdental brushes. Interdental brushes were of the same bristle stiffness and both were made by TePe. Patients were instructed to use their assigned brushes and returned after 12 days for a complete dental hygiene visit. After the prophylaxis, they were instructed to refrain from all oral hygiene for 48 hours. At that time plaque was illuminated with a fluorescent dye and an LED curing light and recorded. Subjects were then given two minutes to use their assigned interdental brush and plaque scores were again recorded.

Both interdental brushes reduced plaque scores, a mean difference of 1.0 for the angled brush compared to 1.6 for the straight brush. Comparing posterior difficult areas to reach and easy to reach anterior areas, the straight brush was significantly more effective.

Clinical Implications: Recommend straight rather than angled interdental brushes. ■

Jordan, R., Hong, H., Lucaciu, A., Zimmer, S.: Efficacy of Straight Versus Angled Interdental Brushes on Interproximal Tooth Cleaning: A Randomized Controlled Trial. Int J Dent Hygiene 12: 152-157, 2014.

Tongue Coating Relates to Bad Breath

The foul smell of halitosis is due to volatile sulphur compounds (VSCs) of hydrogen sulphide, methyl mercaptan and dimethyl sulphide. It is estimated that 60 percent of VSCs come from tongue coating. The amount of tongue coating may be a good indicator for bad breath.

Researchers at the University of Tokushima, Japan, evaluated 94 subjects who complained of bad breath and sought treatment at the Clinic for Breath Odor at the university. A subgroup of 40 subjects agreed to undergo a periodontal examination. Of this group, 13 had signs of periodontitis while 27 did not.

The full group was asked about tongue cleaning and underwent both organoleptic and gas chromatography to determine their level of bad breath. Subjects blew mouth air into plastic bags that were then given to the five dentists who smelled the air to measure the bad breath level. After keeping the mouth shut for 60 seconds, a syringe was inserted between the lips and an air sample was extracted and expelled into the gas chromatography machine to measure levels of three VSCs. Tongue coating samples were also taken to measure the bacterial content.

Subjects who cleaned their tongues daily had significantly lower tongue coating scores and also had significantly lower organoleptic and VSC scores compared to those who did not clean their tongues. Periodontal pathogens counts were much higher in the group that did not clean their tongues.

Those with and without periodontitis had similar tongue coating scores while those without perio had lower organoleptic scores and those with perio had higher VSC scores.

Clinical Implications: Encourage patients to clean their tongue daily. ■

Amou, T., Hinode, D., Yoshioka, M., Grenier, D.: Relationship Between Halitosis and Periodontal Disease - Associated Oral Bacteria in Tongue Coatings. Int J Dent Hygiene 12: 145-151, 2014.

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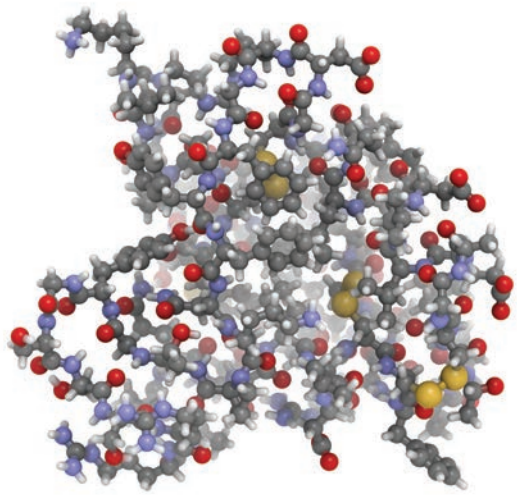
Interdental Cleaning Low Among Those with Diabetes

It is estimated that 371 million people worldwide have diabetes with 19 million in the U.S. These figures are growing each year. People with diabetes are at greater risk of periodontal disease. Failing to clean between the teeth on a daily basis contributes to periodontitis in adults with diabetes.

Researchers at New York University analyzed the National Health and Nutrition Examination Survey (NHANES) data to determine estimates of how many people with diabetes over the age of 30 clean between their teeth daily. They also wanted to identify characteristics of this population that would predict interdental cleaning behavior.

A group of 573 adults self-reported having diabetes was included in the data analysis. Of this group, 41 percent reported never cleaning between their teeth. This is compared to 25 percent who claimed to clean between their teeth on a daily basis. Specific to the daily interdental cleaning group were these characteristics: female, history of periodontal treatment and daily use of a mouthrinse. These findings are similar to what is known for interdental cleaning among adults without diabetes. Women are generally more likely to take better care of their oral health then men. Those who have been treated for periodontal disease have invested both time and money, which



explains why this group is more likely to clean between their teeth on a daily basis.

Many people with diabetes don't know the connection between oral health and general health. Hygienists play a key role in education and inspiring those with diabetes to do what is needed each day to protect their oral health.

Clinical Implications: Encourage those with diabetes to clean between their teeth every day. ■

Strauss, S., Stefanou, L.: Interdental Cleaning Among Persons with Diabetes: Relationships with Individual Characteristics. Int J Dent Hygiene 12: 127-132.

How Much Do You Believe Your Patients Already Know?

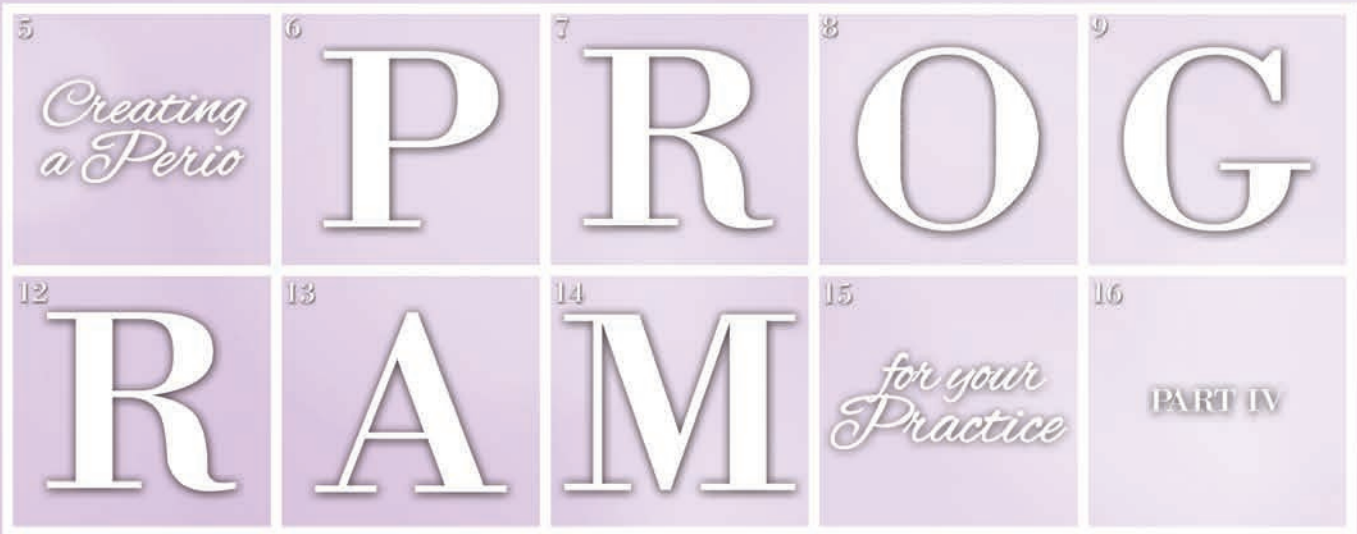
One of the important roles of oral health professionals is to educate, motivate and inspire patients to participate in effective daily oral hygiene. The traditional approach to oral health includes brushing flossing and fluoride, despite research showing that brushing and flossing are difficult to accomplish correctly.

Researchers at the University of Gothenburg in Sweden interviewed five focus groups with a total of 23 oral-health professionals. Their goal was to learn what these professionals thought about patient education. The full group consisted of nine dentists, four hygienists and 10 assistants. One focus group provided oral health promotion within the school system, two groups worked in public health, one group was dental directors of public health centers and one group was from private practice. They were asked questions about what they said and did for patients to prevent dental caries, with a focus on toothbrushing and toothpaste. They especially wanted to know the groups' attitude toward questions about proper toothpaste use. The group interviews were recorded and later transcribed.

The oral-health professionals expressed their interest in providing information in the patient's best interest. Their primary focus was on effective plaque removal with toothbrushing. The investigators were more interested in explaining the proper use of fluoride toothpaste. The oral-health professional considered instruction in toothpaste use to be something patients already knew and didn't need advice on how to use a toothpaste.

Clinical Implications: Patients know how to use toothpaste, but they do need advice on how to effectively remove plaque biofilm with toothbrushing. ■

Jensen, O., Gabre, P., Skold, U., Birkhed, D., Povlsen, L.: 'I Take For Granted That Patients Know' - Oral Health Professionals' Strategies, Considerations and Methods when Teaching Patients How to Use Fluoride Toothpaste. Int J Dent Hygiene 12: 81-88, 2014.



Diane Brucato-Thomas, RDH, EF, BS, FAADH, OMT, BBP:

In the last article of this five-part series, I mentioned educating the client and facilitating their decision to choose from several treatment plan options, based on information and their own desired level of health and commitment to achieve it. Between gathering a plethora of information and spending time on education and facilitation, by now you will have created an impression of thoroughness and caring, and planted the seeds of trust.

Once a treatment plan is decided upon, the fee must be determined and the case presented. Whether the dentist, the hygienist, the receptionist or the financial assistant does this, the first rule of thumb is that the presenting team member must see the value in the fee for service. If he or she feels at all uncomfortable with the fee, the patient will pick up on it and feel like they are being ripped off.

The patient should be sitting up and the clinician should sit facing the patient at eye level. I like to present a complete case fee that is inclusive of every appointment necessary for treatment and follow-up, as well as every possible charge. That way, there are no surprises and I do not come across as "nickel and diming" the patient. If final billing is less for some reason (for instance, if a certain product I thought I would use is not needed), I can always charge less and the client is happy, happy, happy!

So how do we determine a case fee? Some offices are contracted with insurance companies, so that the total case fee will be reflective of the restrictions of that contract. The more familiar and creative you are with insurance codes, the more you can help your patients with their benefits. Other offices do not participate in all insurance programs and charge fee for service. This allows for less of a cookie-cutter approach to treatment and fees. After all, periodontal disease is not periodontal disease is not periodontal disease.

With that in mind, one can determine the case fee by first determining the total amount of time that will be required and multiplying that by an hourly fee that varies with degree of difficulty. Supply or product costs are added to that to come up with a total case fee. The case fee can then be divided by the number of treatment appointments and the client is informed how much they will be expected to pay at each visit.

When delivering that all-inclusive case fee, always refrain from blinking. This confirms confidence and value in your treatment and the belief that the fee is reasonable and worth every penny. If your delivery is done in this confident manner, whether a fee is $5 or $5,000, your case acceptance should be in the 90th percentile.

Once the client confirms their commitment to care, it is time to schedule the treatment. In some practices, the clinician does their own scheduling. I have done that, however I find it works better to walk up to the front desk with my client and engage the scheduling expert with a verbal explanation of our treatment plan, the total cost and a breakdown of when fees are expected to be paid. This allows the client to hear the plan and the fees again and ensures we are all on the same page.

Lucky for me, the scheduling experts in our office are also insurance coding experts. Here, any questions about insurance can be answered. They are familiar with every insured client's policy, maximizing clients' benefits to reduce out of pocket costs and pre-authorizing treatment where required. These team members are essential to the success of our periodontal therapy program, making sure the client is scheduled and confirmed, following up on prescription or premedication needs, and receiving payment due at the time of treatment. From the beginning, they set the stage for the success of our periodontal program by telling clients

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they are in good hands with the dentist and hygienist. Because these team members are the ones who hear the majority of clients' comments, they are the ones who can convey every confidence in the clinicians they represent. Through their words and body language they inspire the clients to "want some of that!"

Rachel Wall, RDH, BS, Founder of Inspired Hygiene, Inc.:

The first step in implementing your perio plan is to present treatment in a way that helps patients say "yes" to the care that will move them toward health. We have a simple system we teach for enrollment. It's called The 3 P's. Some of the steps are so simple that you may shrug them off as common sense, but they are extremely powerful.

Prep

Before doing the periodontal exam, it's important for your patient to know what it is you're doing and what the indicators are for health and disease. It might sound something like this: "Mr. Jones, now I am going to evaluate the health of your gums and the bone surrounding your teeth. I'm going to be taking some measurements and calling out some numbers. The numbers one through three are normal, and healthy gums don't bleed."

Now Mr. Jones knows that if he hears numbers over three or areas of bleeding then something is not normal. Trust me, patients really do listen when you tell them what to listen for.

Perio Exam

Now it's time to perform the periodontal exam. Of course you'll be assessing much more than just pocket depths. You'll also be evaluating:

- Bleeding
- Tissue appearance
- Furcation involvement
- Mobility
- Recession
- Radiographic bone loss

Calling out the information so the patient can hear you allows them to participate in the diagnostic process. Whether you use an automated system like Florida Probe, you have a teammate to record or you're working alone, always call out the data in the perio exam. Let patients know where there is bleeding and show them with a hand mirror or an intra-oral photo. Get them involved.

Present

Now you'll want to share with your patient your observations and the data you collected that will point to whether they are periodontally healthy or if there is active infection. Instead of scripts, key words are very effective at conveying the importance of moving forward with treatment. When the patient presents with active infection and you recommend treatment, be sure to:

1. Sit the patient up—When patients are lying on their back, they are in a very vulnerable position. Help them feel in control by sitting them up.

2. Sit knee-to-knee—When doctors come in to do the exam, I encourage them to immediately sit down so they are on the same eye level as the patient.

3. Use key words—Some hygienists were offended by the suggestion to change their words, but the truth is, whether it's at home with our families or with our patients and co-workers, we can *all* continuously refine our verbal and non-verbal communication. A few key words and phrases to use:

- Infection
- Significant bleeding
- You have (instead of I found)
- Disinfection therapy

4. Make it personal—Patients don't want to be the victim of the latest new technique or protocol you've learned. They want personalized service and treatment recommendations based on their current dental condition. This requires time spent with the patient on the front end of the visit to discover their medical and dental risk factors and asking some questions to point you toward their dental goals. Making treatment personal means making it relevant and connecting your recommendation to something the patient wants. Do they want to better control their diabetes? Treating their active gum infection will help them get what they want. Do they want to avoid losing teeth or wearing dentures like their parents did? Long-term periodontal maintenance will help them achieve these goals.

But what about my long-term patients?

This is the most common question we get from our coaching clients when they are preparing to implement an improved perio plan. RDHs, in particular, are sensitive to what patients think about them and the care they have delivered over the years. "What will my patients think? Will they think I've neglected them all these years? Will they wonder why I haven't said anything about this infection before?"

Here's the thing. We work with human beings. Our bodies are in a constant state of change. I have never met a hygienist or dentist that has intentionally neglected to tell a patient they have periodontal disease. Even if today is the first time you are presenting a definitive perio treatment plan, this isn't the first time you've mentioned it to your patient.

Think of all the times you've:

- Told them about their bleeding gums
- Educated them on home care

- Shortened their recare interval
- Mentioned the observed inflammation
- Shown them plaque and calculus with a hand mirror
- Documented all of the above in the clinical notes

Every one of those conversations is about periodontal inflammation. Here's the language that we've found works very well when enrolling existing patients into periodontal therapy. "Mr. Jones, we've talked about your bleeding gums for years. We've tried lots of different approaches and your body has not responded the way we had hoped. You still have active infection. It's time to do something different."

And that's really the key to implementing your perio plan. It likely will not all come together over night. You won't suddenly be 100 percent comfortable using new words and new distinctions for when to recommend additional treatment. Committing to taking one small step every day will make a huge impact in your career satisfaction and your patients' health.

Sarah Cottingham, RDH, CEO BCS Leadership, LLC:

When implementing an "optimal oral health program" (periodontal program) into your practice, it is important to verify the level of comprehension of health versus disease with all team members. This should be established by having training or educational meetings with the dental team to discuss and test the level of understanding.

What we find in many practices is that this step is routinely overlooked based on many factors (time, schedules and the money that it costs to set up a team meeting). However, it will cost your practice exponentially more money in the long run if you don't adequately train the team to discuss health versus disease, because this will result in patients not accepting treatment plans. Not adequately training the team to have these conversations has not only a high cost to your practice; it also has a high cost to the patient in the level of health that they will not achieve when they leave your practice in search of a prophy.

This conversation revolves around the team member who will be presenting the case; they have to have a remarkably clear understanding of conservative periodontal treatment and how it can impact a patient's overall health when treatment is performed effectively and in a timely manner.

We have previously discussed the team's role in developing their periodontal philosophy and discussing level of disease tolerance, diagnostic data collection, and most recently, the ADA codes that are available for use. Now is the time to discuss why there is no cookie-cutter approach to treating periodontal disease. Each and every patient who walks through the doors has their own unique situation, including: immune system, level of oral hygiene routine dedication, bacteria levels and so on. This precipitates the need for the hygienist to be a dental disease detective and master of intervention with their tool box of effective intervention treatment options. The tool box that the hygienist is equipped with is determined by the periodontal philosophy of the practice and can include conventional scaling and root planning, use of the endoscope, laser, salivary diagnostics, systemic antibiotics, locally delivered agents, oral irrigating, pH monitoring, probiotics, oral hygiene training appointments and nutritional counseling—to name a few. The contents of your hygiene department's tool box will allow hygienist to become the master of intervention when it comes to promoting oral and periodontal health. With a variety of tools to choose from, the hygienist is better equipped to plan the care for each patient taking into account the level of disease presentation, the patient's immune system, family history and dental IQ.

We work with many practices that have outlined perio programs for patients, which is a step in the right direction. We caution clinicians about having "programs" for patients. This type of training is great as a guideline but should only be used as a guideline. Each patient's particular situation should be taken into consideration and then the plan of care that is developed should revolve around getting the best result for that patient with the tools that the hygienist deems appropriate.

Hygienists must begin to look at themselves as a frontline oral health-care provider and begin presenting a plan of care based on the patient's needs and not a cookie-cutter periodontal program. When the patient's unique circumstances (systemic health, family history and so on) are included in the development of the plan of care, the results are always remarkable in comparison to the ones that apply the same recipe to every situation. If you were a master baker with a basic recipe, you are likely to get a really good result over and over—yet when outside factors like temperature, humidity and elevation vary, the recipe must be adjusted to account for these factors in order to get the same predictable result. The same is true with individualized care plans.

A team trained to be oral-health detectives and given a variety of tools will far exceed your expectations, both in patient health and revenues that can be generated by an optimal oral health program. ■

Have you implemented a perio program yet? Leave your comments at Hygienetown.com

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