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Aesthetic Crown Lengthening of the Maxillary Anterior Teeth Due to a “Gummy Smile”

Establishing a Perio Program/ Hygiene Department

Discussion from Hygienetown.com
There’s a lot of talk about evidence-based health care these days and we have Dr. Archie Cochrane (1909-1988), a Scottish medical researcher to thank for that (hence the Cochrane Collaboration). He believed in the importance of using sound judgment together with evidence to make the best possible clinical decisions.

Dr. Cochrane’s experience as a prisoner of war in German hands gave him reason to question the value of medicine. He was assigned to provide medical care to 20,000 prisoners living on 600 calories a day and suffering from diarrhea, typhoid, diphtheria, infections, jaundice and sand-fly fever. From a ramshackle hospital, all he had to offer was aspirin, antacid and skin antiseptic. Without medical tests and medications, he expected hundreds to die of diphtheria alone. Instead, three of the four deaths experienced during his stay were from gunshot wounds, not disease. He understood that the excellent results had nothing to do with his clinical skills as a doctor, but clearly demonstrated the recuperative power of the human body.

Returning to Britain, Dr. Cochrane found the lack of evidence supporting treatments of his day frustrating. He spoke and wrote of the importance of systematically reviewing randomized controlled trials (RCTs). His words were recognized and valued by lay people, as well as health professionals as medical care at that time was often a matter of life and death. While some interventions appeared to treat the problem, they actually resulted in increased patient death. Doctors needed to know which treatments were both effective and free from serious side effects like death.

The first Cochrane Center opened in Oxford, UK in 1992 and now oral health-care reviews are part of the Cochrane Collaboration. There are many reviews directly related to oral health. Looking for research to support dental hygiene care found two reviews. The first review included one study on recall intervals since no other studies were found that fit inclusion criteria for evaluation. The conclusion: “There is insufficient evidence to support or refute the practice of encouraging patients to attend for dental check-ups at six monthly intervals.”

The review of routine scale and polish for periodontal health included nine studies and came to this conclusion: “The research evidence is of insufficient quality to reach any conclusions regarding the beneficial and adverse effects of routine scaling and polishing for periodontal health and regarding the effects of providing this intervention at different time intervals.” Since the studies evaluated were performed by periodontists or periodontal graduate students, this comment was included in the review: “There were no studies comparing the effects of scaling and polishing provided by dentists or professionals complementary to dentistry.”

The scientific evidence for dental hygiene care is currently based on tradition and research performed by periodontists, not dental hygienists. This lack of evidence holds true for dentistry as well as dental hygiene. Performing research to prove that what is currently being done works is not always interesting to researchers who want to “discover” something new and exciting. However, as a profession we do need to identify scientific evidence for the care we provide. It’s not enough to say “But I know it works.” Scientific evidence is only one part of the equation. Clinicians must bear the responsibility of considering the nature of the condition, one’s experience in treating a particular condition, and the preferences of individual patients.
Perio Reports Vol. 23 No. 2

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Piezoelectric Scaler More Comfortable

The two most commonly used power scalers are the magnetostrictive and the piezoelectric. These power scalers use different technology to convert power to vibration and each has a different tip stroke – elliptical for the magnetostrictive and linear for the piezoelectric. Both are cooled with water lavage, but the piezoelectric produces less heat than the magnetostrictive. Power scalers remove less root surface structure compared to hand instruments. Research is lacking comparing these two power scalers for effectiveness and patient comfort.

Researchers at Baylor College of Dentistry compared the magnetostrictive (Cavitron) and the piezoelectric (EMS) in a group of 75 patients with early to severe periodontal disease to determine patient perceptions of pain, vibration and noise. The first 37 patients were treated with the Cavitron on the right side and the EMS on the left side. The remaining study subjects were treated with the power scalers on opposite sides of the mouth. The dental hygiene clinician began treatment on the right side for all patients and each side was treated for approximately 30 minutes.

After each half-mouth treatment, subjects were asked to rate pain, vibration and noise experience using a visual analog scale. They put a mark on a line from zero to 100 to reflect their experience. Zero being no pain and 100 being the worst pain ever.

Patients reported no difference between the Cavitron and the EMS for noise. Scores for pain and vibration were lower in the EMS group compared to the Cavitron group.

Clinical Implications: When you have both a magnetostrictive and a piezoelectric power scaler in your operatory, patients might find the piezoelectric more comfortable.


Nurse Practitioners Screening for Perio

Research confirms an oral-systemic link, as stated in 2000, by Surgeon General David Satcher, “Oral health and general health are inseparable... the mouth is a portal of entry for infections that can affect local tissues and may spread to other parts of the body.” Despite growing evidence in medical and dental journals of the oral-systemic link, medical professionals lack information and actions reflecting that link. A study of internal medicine trainees found them unprepared to screen or discuss periodontal health as it related to general health. Only two percent reported screening their patients for periodontal disease.

Researchers at the University of Missouri-Kansas City assessed the willingness to screen patients for periodontal disease among a group of medical-care providers, the majority being nurse practitioners (NP), since they are likely to engage patients in a discussion of oral-systemic health. Written questionnaires were given to 200 medical-care providers attending a women’s health conference, with 137 returned. Some questions focused on knowledge of periodontal disease and the link with general health and others evaluated attitudes, opinions, practice behaviors and perceived competency to screen and refer for periodontal disease.

Ninety percent of the respondents were NP with an average of 15 years of experience. Twenty-two percent reported routinely screening their patients for periodontal disease.

Researchers at the University of Missouri-Kansas City assessed the willingness to screen patients for periodontal disease among a group of medical-care providers, the majority being nurse practitioners (NP), since they are likely to engage patients in a discussion of oral-systemic health. Written questionnaires were given to 200 medical-care providers attending a women’s health conference, with 137 returned. Some questions focused on knowledge of periodontal disease and the link with general health and others evaluated attitudes, opinions, practice behaviors and perceived competency to screen and refer for periodontal disease.

Clinical Implications: Medical and dental educational institutions are in a unique position to work together creating interdisciplinary opportunities to bring the latest research and knowledge about the oral-systemic connection to students pursuing various medical and dental careers.

**Treatment Safe for Pregnant Women**

Many studies have evaluated the association between periodontal disease and premature, low birth-weight babies, but none have demonstrated a direct cause and effect. Such a study would be lengthy, expensive and difficult to complete. One barrier to undertaking this study is the random assignment of pregnant women with periodontal disease to the no-treatment control group. Ethics committees find this unacceptable.

Researchers at Feira de Santana State University, in Bahia, Brazil devised a study design to avoid assigning a control group. The group of pregnant women with untreated periodontal disease was identified after giving birth. Seven days after giving birth, a periodontal examination was provided and those with periodontal disease were recruited as controls. Birth weights of their babies were recorded.

A group of periodontally healthy pregnant mothers and a group of pregnant mothers with periodontal disease were the test groups. Those with periodontal disease were treated with SRP and seen monthly during their pregnancy for follow-up care. The healthy subjects were also seen monthly for prophylaxis to maintain oral health.

The rate of low birth-weight was 11 percent in both the treated periodontal group and the healthy group. It was twice as high in the untreated periodontal group, although this group also had more risk factors for preterm, low birth-weight deliveries.

Although this study does not show benefit from periodontal therapy in preventing preterm, low birth-weight babies, it does confirm that periodontal therapy is safe for pregnant women.

**Clinical Implications:** This is additional evidence that treating pregnant women for periodontal disease during pregnancy is safe.


**Dental Hygiene Care Prevents Disease**

Early intervention during pregnancy and as the first teeth develop is the best time to provide oral health education and preventive dental care.

Researchers at the Hannover Medical School in Hannover, Germany designed a four-phase study over 14 years to provide oral health education and dental care to pregnant mothers and their children. Phase one included education of pregnant mothers. Phases two and three provided preventive care for mothers and children until age three and age six. This report is of phase four, evaluation of the children at 13-14 years of age whose dental care was provided by their family dentist since age six. An age-matched control group was randomly selected from a nearby high school.

At age three, all of the children were caries-free and without fillings and with no detectable *Strep mutans*, compared to 82 percent caries- and filling-free in the control group. At age six, 75 percent of the test group was still caries- and filling-free, compared to 50 percent in the control group.

The study began with 86 mother-child pairs, but due to relocation, 29 adolescents were available for phase four. Sixty-six percent were caries- and filling-free, 24 percent were caries-free with fillings and three teenagers had active caries. In the control group, 30 percent were caries- and filling-free, 27 percent caries-free with fillings and 13 had active caries. The test group visited the dentist more often than the controls.

**Clinical Implications:** Oral health education and dental care during pregnancy and early childhood will influence the future oral health of the children.

Although needle breakage is an infrequent complication of local anesthesia today, when it does happen, it carries potentially serious complications. Since the 1960s, disposable stainless steel needles have been regulated by the International Organization for Standardization. The use of disposable needles, advances in metallurgy and better anesthesia training are responsible for fewer broken needles. Needle breakage now is due to using inappropriate injection techniques or choosing the wrong needle. In 1955, Monoject, the first disposable plastic needle was introduced, followed in 1956 by a plastic, disposable syringe, replacing glass syringes.

Researchers at the University of Zurich in Switzerland reviewed the literature from 1900 until today for needle breakage. They focused on disposable needle breakages from 1966 to the present, realizing that most needle breaks go unreported. Of the cases reported, 23 patients were under 16 years old and 40 patients were older than 16 years old, with an average age for all of 28 years old, and a range from three to 71 years.

The majority (70 percent) of needles broke during inferior alveolar nerve block injections. Other needle fractures occurred in buccal areas and a few occurred during intraosseous injections. Reasons for needle breakage include unexpected patient movement, use of 30-gauge, short needles for block injections and needle bending, especially at the hub.

Clinical Implications: A few rules to follow to avoid needle breakage – use a needle of sufficient dimension (25-27 gauge) and at least 35mm in length for the inferior alveolar injections, leave at least 5mm of the needle outside the tissue and avoid bending needles at the hub.


Traditionally, periodontal diagnosis has included probing depths, bleeding on probing, attachment loss and radiographic findings. The future will bring chairside diagnostics using either saliva or crevicular fluid. Saliva is the most likely for several reasons: collection is rapid, non-invasive and it is readily abundant. Saliva testing would be the easiest for both dental office and home testing. Biomarkers being evaluated currently are associated with inflammation, collagen breakdown and bone remodeling. Biomarkers of periodontal disease might be elevated due to the presence of systemic inflammation from rheumatoid arthritis.

Researchers at the University of Kentucky in Lexington compared clinical examinations and salivary samples from three age- and sex-matched groups. Each group consisted of 35 adults: 1) periodontally healthy, 2) chronic periodontal disease and 3) rheumatoid arthritis. The goal was to determine the influence of rheumatoid arthritis on three salivary biomarkers for periodontitis: interleukin-1 (IL-1), tumor necrosis factor (TNF) and matrix metalloproteinase-8 (MMP-8).

The arthritis and healthy groups had less periodontal disease than the perio group, however the arthritis group had more bleeding than the healthy group. MMP-8 and IL-1 were higher in saliva for those with periodontitis. IL-1 was higher for those with arthritis than the healthy controls. Periodontal disease is associated with higher levels of IL-1 and MMP-8. Increased IL-1 levels in arthritis patients compared to healthy controls indicates that systemic inflammatory disease markers are detected in saliva.

Clinical Implications: The future will bring chairside saliva tests. With more research, the extent to which rheumatoid arthritis influences biomarkers for periodontitis will be determined.

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Dr. Jeffrey Hillman is a quiet, thoughtful man who is curious about science and has the innate ability to objectively assess a situation or a scientific accident. He says it’s because he doesn’t study it in depth, but rather sees things from a global perspective. Take opera for instance. He enjoys the music, lyrics and acting for pure enjoyment. Taking it all apart, understanding the theory, separating each instrument and voice to study it in detail changes the focus and also takes the enjoyment and pleasure out of the experience. In science, Dr. Hillman focuses on the possibilities of what can be learned from experiments gone wrong, not simply on following the steps of an experiment to an expected outcome. He values each experiment gone wrong as the opportunity to raise or answer another question, perhaps not the question he was asking at that moment. The accidents that Dr. Hillman has pursued in his career have led to some amazing discoveries that have the potential to eliminate caries and periodontal disease and replace antibiotics for treating serious infections.

Dr. Hillman’s work didn’t start with oral probiotics. The foundation was laid with 25 years of research on genetically altered Streptococcus mutans to create a one-time replacement technology, SMaRT, to replace the oral bacteria responsible for dental caries with bacteria that don’t produce lactic acid. Along the way, other discoveries were made. With the SMaRT replacement technology came the discovery of a novel lantibiotic produced by bacteria to destroy other bacteria. Discovering a platform to synthetically create lantibiotics might in fact replace the antibiotics that are currently failing. Oral probiotics are far from the end of Dr. Hillman’s discoveries. Several new technologies are being investigated in the Oragenics lab today. He’s pursuing a new direction in disease diagnosis based on rapidly identifying protein targets released from cells undergoing change. His team is also working on an exciting discovery that will impact one of the most serious medical problems we face today – obesity. They’ve discovered a natural molecule that can be taken orally to induce programmed cell death in fat cells.

Having read Dr. Hillman’s research for many years, it was a pleasure to personally talk with him about his many discoveries, and the accidents leading to some of those discoveries.
Dr. Hillman, where did your research start?

Hillman: Prior to dental school, I worked in the lab of my first mentor, microbiologist Rob Gibbons, studying bacterial attachment to surfaces. At the time, no one could explain why you find certain types of bacteria on the teeth but not on the mucosa, and other types of bacteria that behaved in the opposite fashion. Gibbons thought there might be an enzyme in saliva that was responsible for the selective attachment. Without knowing much about bacteria, I discovered instead that the selectivity of attachment was a feature that is intrinsic to the bacteria. My work indicated that bacteria have surface molecules that interact very specifically with molecules on the enamel pellicle or on the surfaces of mucosal cells, a sort of lock-and-key-type mechanism. The specificity of bacterial attachment has provoked a lot of research over the subsequent years, since the prospect of preventing diseases by preventing initial attachment of bacterial pathogens to surfaces seems so appealing. Unfortunately, it appears that bacteria typically have multiple attachment mechanisms, so there haven't been any landmark successes using this approach to date.

How did you get started with replacement technology?

Hillman: It was an accidental discovery two weeks after beginning work in molecular genetics at Forsyth in the 1970s. I had a grant to study attachment of bacteria to tooth surfaces. I was repeating a protocol on a strain of Strep. Mutans that I used as a graduate student to chemically alter the genes of E. coli. For an indication of mutagenesis, I was looking for unusual appearing colonies on a particular type of cultivation medium, which happened to contain a pH indicator. Among the many small, white acid-producing colonies, I noticed several large red colonies, and wondered what they were. I determined that they did not produce lactic acid. At the time, most people working in the area of dental caries believed that lactic acid production by Strep. mutans was directly responsible for dental caries, the so-called Acidogenic Theory of decay. It occurred to me that a lactic acid-deficient mutant of Strep. mutans offered the perfect opportunity to test this theory. Once I showed that these mutants did not cause decay, and thus proved the Acidogenic Theory, the idea of using them to prevent tooth decay through replacement therapy dawned on me. This dramatically changed the focus of my research from bacterial attachment to finding a replacement bacteria for the oral cavity, but not without some resistance from my grant supervisor. Luckily, he agreed to allow my grant to take a new direction that started the journey to these exciting new discoveries we have today.

Your work on SMaRT took 25 years. What kept you going for so long is this direction?

Hillman: The process was never boring; it was challenging and exciting. My focus was on answering questions about how to achieve the potential for what I saw as possible in my early research, that of eliminating dental disease by replacing the disease-causing bacteria in the mouth with genetically altered bacteria. There were several quantum leaps in the process that were very exciting. First, finding a starting strain of Strep. mutans for this work, which had a selective advantage over all other strains of this species, took several wrong turns and four or five years to achieve. Next, it took several years to figure out how to eliminate the ability of these cells to produce lactic acid. The problem here was the discovery that elimination of lactic acid production killed our strain because it created metabolic problems for the cells. This problem was overcome using recombinant DNA methods, which we developed specifically for this problem, but which are now in widespread use for a variety of applications. The result is the SMaRT strain that is genetically modified to produce no lactic acid, and it also produces an antibiotic that kills all lactic acid producing strains of Strep. mutans. Each step of the process led to our goal, but there were also interesting observations that we selectively pursued. These led to other exciting discoveries, like our lead antibiotic, MU1140. Although it took many years to achieve the SMaRT strain, the process along the way was interesting and rewarding.

Tell me about lantibiotics.

Hillman: Lantibiotics are potent antibiotics produced naturally by bacteria. The first lantibiotic was discovered in 1927, Nisin, and 50 others have been discovered since then.

Today we have many health-care associated infections and many are antibiotic resistant; for example methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococcus faecalis (VRE), and Clostridium difficile (C. Diff). This is a serious problem that continues to require newer and more powerful antibiotics.

In our work with the SMaRT strain, we discovered it naturally produces a potent antibiotic, which we call MU1140, that is active against all gram-positive bacteria. We developed a new organic chemistry technology to produce a synthetic lantibiotic, MU1140-S. This lantibiotic will potentially replace Vancomycin and Daptomycin, the current drugs of last resort for serious health-care associated infections, which are currently failing.

Are other synthetic lantibiotics being produced?

Hillman: No, we’re the first to figure out how to make these unusual molecules. Until now, standard fermentation methods have been unable to produce even enough material to test any of the 50 known lantibiotics as therapeutic agents for use in fighting infections and diseases. The unique chemical structure of lantibiotics prevents the necessary purification needed for clinical testing.

In order to produce large amounts of MU1140-S, we developed a novel organic chemistry synthesis platform known as DPOLT. This new technology will make it possible to synthetically produce any of the 50 known lantibiotics.

continued on page 8
How did you move from your work on SMaRT replacement technology to oral probiotics?

Hillman: In the early 1980s I attended a lecture given by Dr. Sig Socransky. I was intrigued by what he said about bacteria and periodontal disease. He said everyone has bacteria in their mouths that can cause periodontal diseases, but not everyone experiences the disease, at least not to the extent that they theoretically could. That made me wonder if perhaps there were bacteria normally present in plaque that inhibit the growth of the bacteria that cause disease. I talked with him about this after the lecture and asked him for plaque samples from healthy and diseased periodontal sites. Within two weeks, I had the answer – good bacteria were missing in the mouths of those with periodontal disease. We had other evidence that the good bacteria would disappear from a site before it started to break down, possibly because certain pathogens are known to produce an antibiotic-like molecule that specifically kills them.

Unfortunately, the idea of simply recolonizing a host with periodontal disease with the good bacteria proved to be ineffective: the good bacteria would disappear very quickly following their introduction, and we couldn't figure out what we needed to do to help them persistently colonize. This work was put on the back burner until I attended a meeting in Amsterdam in the late 1990s. It wasn’t a lecture this time that caught my attention, it was the attendees lining up for the lunch buffet. Each person took a little bottle of something and drank it after lunch. It was a probiotic to promote GI health. The fact that an entire population was willing to take a probiotic daily changed my thinking from a one-time treatment, such as we plan for SMaRT, to the potential for a daily oral probiotic that would deliver good bacteria to the mouth. Probiotics have been around for centuries for balancing the microflora in the lower alimentary canal to favor health. I simply moved this centuries-old concept up to the mouth. The result is ProBiora3.

What is ProBiora3 and how does it work?

Hillman: ProBiora3 contains three naturally occurring strains of beneficial bacteria, including *Streptococcus oralis*, *Streptococcus uberis* and *Streptococcus rattus*. When taken daily, these good bacteria change the balance of bacteria in the mouth to favor health. We focused on bacteria to promote dental and periodontal health, but found a few beneficial side effects – fresher breath and whiter teeth. The good bacteria inhibit the growth of bacteria that produce volatile sulfur-containing compounds and they release hydrogen peroxide that whitens the teeth. ProBiora3 is found in EvoraPro, EvoraPlus and EvoraKids. These flavored probiotic tablets are dissolved in the mouth twice daily after regular brushing. EvoraPro is taken for ten days after seeing the hygienist, followed by regular use of EvoraPlus. We also have an oral probiotic for pets, Teddy’s Pride, a powder that’s sprinkled on a pet’s food once per day.

Now that ProBiora3 is available commercially, what other things are you working on besides bringing SMaRT through all the complex FDA regulations?

Hillman: There are several other technologies we’re working on, including two of particular interest – diagnostics and weight loss. While searching for protein targets associated with periodontal disease diagnosis we discovered a way to identify proteins that are released into body fluids when a cell undergoes any sort of change. These so-called shed proteins are excellent targets for medical diagnostics and for developing therapeutic strategies. Using blood, saliva or urine, the technology we developed is able to identify proteins shed from diseased tissues and cancers. This technology has already proven its ability to identify protein targets for *Vibrio cholera*, *Escherichia coli* and *Pseudomonas aeruginosa* and now we’re working on *Mycobacterium tuberculosis* and bowel cancer.

Obesity has increased significantly in recent years and is responsible for serious medical problems in our country with large public health costs, so the potential for the work we are doing on weight loss is exciting. We have identified LPT3-04, a natural substance, which, when taken orally, targets fat cells to undergo programmed cell death.

The new technologies we’ve discovered are not all the result of experiments working out just as we expect. Accidents happen every day. Remaining open to those accidents and selecting which of the failed experiments are the right ones to pursue is the challenge. In dentistry, I see my work as part of a change from “sick care” to “health care,” providing people with easy, safe and reliable ways to prevent oral diseases.

Conclusion:

A lot goes into the development of a product like the oral probiotic, Evora, or soon the SMaRT replacement technology. Many years, many experiments and a few lucky accidents are needed to transform the idea to eliminate dental disease into exciting new technologies to do just that.
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Aesthetic Crown Lengthening of the Maxillary Anterior Teeth Due to a “Gummy Smile”

This surgical procedure reduced the “gummy smile” and enhanced aesthetics for an 18-year-old female patient who recently completed orthodontic therapy.

This case illustrates the surgical procedures involved in reducing the “gummy smile” and enhancing the aesthetics of an 18-year-old female patient. The patient had recently completed orthodontic therapy and wished to explore the possibility of a crown lengthening procedure.

**Fig. 1:** This photo illustrates the excessive gingival display which is apparent when the patient smiles. The patient’s smile is framed from the D of tooth 6 to the D of tooth 9. The crown lengthening procedure will include those teeth. The gingival margins of the all the teeth will be scalloped to create a harmonious smile.

**Fig. 2:** Pre-op photo of the maxillary anterior teeth gingival margins.

**Fig. 3:** The maxillary incisor gingival margins have been scalloped. An osteoplasty and ostocectomy has been done with a piezo surgical instrument to create a 3mm biologic width on each of the teeth.

**Fig. 4:** Photo right side surgery and sutures.
Fig. 5: Left side view of surgery and sutures. The gingival margin position of the lateral incisor should ideally be inferior to the cuspid and central incisor positions. The central and cuspid gingival margins should ideally be created with an even position.

Fig. 6: This is a two-month post-op. Note the increased clinical length of the incisors and improved aesthetics.

Fig. 7: Two-month post-op right side healing.

Fig. 8: Two months, left side healing.

Fig. 9: Two-month post-op anterior view.

The aesthetic crown lengthening procedure is one of the most gratifying surgical procedures done in my practice. It is indeed one of the few times that a patient requests a periodontal surgical procedure! It is always so exciting to show the patient the new smile and see them smile after this type of surgical procedure.

I had one of our local periodontists do that for me, with great results. He didn't take any before or after pictures. He said he wished he had. I love my smile now and I have to laugh really hard to see gums! Good job, I'm sure she is pleased!

I have found that if you really want to see the most amazing results, don't take any initial photos.

That is beautiful! It is wonderful when you can give a patient a smile to be proud of.

jersey devil
Posted: 12/4/2010
Post: 3 of 19

periosupport
Posted: 12/4/2010
Post: 4 of 19

ASB-RDH
Posted: 12/13/2010 Post: 15 of 19
Establishing Perio Program/
Hygiene Department

Working in a practice with no previous perio protocol presents business challenges with fees, codes and appointment scheduling, and also with patients who have been led to believe they are just fine.

JJW, RDH
Posted: 5/20/2010
Post: 1 of 29

This is my first post so be patient with me. I work in Indiana and graduated in 2007. I now work full-time in a general practice. The dentist I work for purchased the practice at the end of 2008. Prior to this, perio was not diagnosed for the most part and patients were given whatever treatment plan was satisfactory to them. I am trying to establish the hygiene department and perio program. I would love to incorporate xylitol and possibly others products into the program. We do offer Sonicare and hydroflossers at this point, as well as PreviDent. I am looking for any and all information that you can give me.

Mbonanno
Posted: 5/21/2010
Post: 2 of 29

Sounds like your dentist needs to be whipped into shape. You need to create a system for diagnosing and treating disease. I'd recommend partnering with a coaching company to help get this set up and give you the support you need to co-create the environment where patients will flourish and accept treatment for their disease.

suziesun
Posted: 6/1/2010
Post: 17 of 29

I feel for you... you have your work cut out for you. The biggest thing I can suggest is educating the patient! This is going to be new to them, so you will need to spend time educating. First, I think you need more time with new patients (90 minutes). You will need to spend time educating especially if they have perio disease. I don't agree with doing a prophy on every new patient. If there is gum disease I feel that it is best to get them back for scaling.

campbelk
Posted: 6/4/2010
Post: 18 of 29

I really appreciate your post; I, too, have had difficulty in establishing a perio program at my office. Unfortunately, I came into an office without a perio protocol and a lot of perio disease either went undiagnosed or was treated, but was coded as a 1110. I butt heads with the dentist too often. I have diagnosed perio and recommend four quads when there are greater than 5mm and moderate to heavy BOP (bleeding in probing), but no radiographic calculus. The doctor then recommends to the patient that I just ultrasonic and code as an 1110 and just have the patient come in more often than every six months. Have any of you had to deal with this?

lindadouglas
Posted: 6/5/2010
Post: 19 of 29

This makes no sense to me. I have heard about so many dentists saying that hygiene is a loss leader, yet a perio program will address the health needs of the patients, and a healthier bottom line too. Why the resistance?
Thanks for all the great replies and information! I wish I knew why there is so much resistance with the docs and setting up a perio program. In my office, we have six hygienists and two docs. They are so fixated on production and having us take pictures of cracked teeth, etc. to sell dentistry that perio disease often goes “undiagnosed.” I recently had a patient with 4-6mm pockets in the molars and spent about 15 minutes discussing SRP (scaling and root planning), perio disease and maintenance and he was ready to schedule. When I brought the doc in to confirm my diagnosis, he basically downgraded the patient’s condition and told him I would do a 1110 prophy and have him back in four months for re-evaluation. Everything I told the patient was completely disregarded. Very frustrating.

For old movie lovers out there who’ve seen Cool Hand Luke, it sounds to me like what you have is a “failure to communicate.”

Is there a specific reason why your doctor only wants you to ultrasonic and bill as a prophy? I can only think of a couple of reasons:

1. He is afraid that if he tells patients that they have a disease they will get upset and leave his practice.
2. The doctor has no understanding of what periodontal disease is or how to present treatment for it.

Neither of the above scenarios are sound rationale and would not be excusable in a court of law should the dentist and hygienist find themselves sued for periodontal negligence. Instead of butting heads, I would suggest a discussion. Find out why your boss is resistant to offering periodontal therapy. Once you know the answer you can proceed from there. Good luck.


I completely understand why the doctors want the hygienists to discuss restorative treatment options and take photos, but if you have perio issues that are going undiagnosed, then the docs might be restoring teeth that do not have a strong foundation. By addressing the perio issues first, the patient will enjoy a healthier outcome and the practice will benefit from the higher production.

Since your office is “so fixated on production,” why not present the doctor with the monetary loss of doing an 1110 prophy versus periodontal treatment. Perhaps seeing it on paper will change your situation.

Sometimes it takes an outside source to show the dentists the value of a solid periodontal program! With a solid periodontal program, hygienists can many times produce more than the doctor! It has to be scheduled for success and planned for! Just as the doctor should be using block scheduling, so should the hygienist!
BOOK REVIEW:
“No More Allergies, Asthma or Sinus Infections”

Author: Dr. Lon Jones, Review: Tim Ives, RDH

Dr. Lon Jones is an osteopathic physician. He is a qualified DO for readers in the U.S. or a GP for readers in the UK and considers himself a “country doctor” as he practices in rural Texas. Robert C. Martin, DC, DACBN in the Advance Praise section considers this book to be light years ahead of its time and suggests that Dr. Jones is the modern day “Father of Functional Nasology.”

Osteopathic physicians attend four years of medical school followed by at least three years of residency and they use all conventional methods of diagnosis and treatment. Osteopathic medicine tends to focus more on the person, while traditional medicine tends to focus more on the symptoms. A founding principle of osteopathic medicine is that the body is able to heal itself if it has what it needs and everything is working well.

Osteopathic medicine has an ally: xylitol, a five-carbon chain sugar.

Most of the research for xylitol throughout the last 40 years has been based on its effects on teeth and it is now well established that xylitol prevents tooth decay.

One such study on the effects of xylitol chewing gum was published in 1996 in The British Medical Journal, also had other interesting observations in that the participants of the study had 42 percent fewer ear infections in a group who had recurrent problems.

At the same time, Dr. Jones was treating his eight-month-old granddaughter for recurrent ear infections. As chewing gum is not possible for babies, Dr. Jones mixed some xylitol into a saline nasal spray and ensured she received it at every diaper change. The ear infections went away. This was the beginning of his journey.

Dr. Jones also discusses other similar cases and explains the connection between the various upper respiratory areas and associated diseases. The reader fully understands his motivation when he explains the link between ear infections and special education, the long-term effect on children and the problems and lack of success with the conventional treatment for this problem.

He discusses the importance of our nasal defenses and breathing through the nose. The statistics on how allergies and asthma are increasing is overwhelming and very disturbing to read how conventional drugs designed to help with these issues might be having a detrimental effect.

Dr. Jones explains how squirting xylitol up the nose every day works in eliminating upper respiratory infections (URIs), asthma and allergies. His very logical and straightforward answers are contained in the book, and might be your answer to remaining illness-free.

The reader begins to understand that the conventional approach to treating and preventing URIs isn’t working and
there are complex reasons involving the companies that hold the purse strings, education and change management. Since xylitol is generally available, it can’t be protected, making it more complicated for pharmaceutical companies.

The continuing theme throughout the book is the approach of defending our bodies against disease rather than attacking invading organisms or allergens. He uses a great analogy with fighting wars and the arms race with the continuing use of antibiotics. He explains how a war with bacteria is unwinnable. When challenged they mutate and develop more resistant strains. He feels the best approach is to develop contextual pressure (such as condoms to prevent sexually transmitted diseases) and to prevent bacterial and viral infections, washing our hands and noses regularly.

There is a chapter on dental health and on how to best use xylitol to protect our teeth. Even if you already know all about xylitol, this is a very succinct and up-to-date section not to be missed.

At the end of the book, Dr. Jones gives more good news regarding xylitol and its many side benefits. Is xylitol one of the most important health discoveries of recent times?

At the very end of the book, Dr. Jones has written a chapter entitled “Putting It All Together,” which concludes the book from a holistic and harmonious standpoint. There is a mention of dental hygienists as one of the only professions who are willing to work with doctors and patients when it comes to fulfilling the best role in education and information on disease prevention.

Dr. Jones has illuminated me on a subject I knew very little about. I would urge all health-care professionals to read this book and pass on the information to everyone. Very few people die of tooth-related issues nowadays compared to the millions that die every year of pneumonia, asthma and other respiratory diseases. If something as simple as a xylitol nasal wash could impact that, then we are ethically bound to spread the word.

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**Author’s Bio**

Tim Ives, RDH, is a UK dental hygienist who worked in the Royal Air Force, in Hong Kong, Cyprus, New Zealand, Germany and Holland. He is the first RDH in the UK to qualify as a practice appraiser. Besides clinical practice in Rutland, UK, Ives is a writer, mentor, speaker and consultant.
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* vs a standard manual toothbrush and anticavity toothpaste.
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