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June 24-25, 2011, marked the first Annual Scientific Session for the newly formed American Academy for Oral Systemic Health. There are academies for periodontics, general dentistry, dental hygiene, cosmetic dentistry, sleep medicine and others, so it’s only fitting and timely to now have an academy for the oral systemic connection. This organization was founded by Townie Dr. Chris Kammer and a core group dedicated to “Making the Connection,” as this first meeting aptly illustrated.

The two-day conference effectively made the connection between medicine and oral health with a line-up of speakers demonstrating significant links between oral health and cardiovascular disease, high blood pressure, stroke and diabetes. While this year’s audience was primarily dental professionals, with a few physicians, future meetings are predicted to show an increase in the number of medical colleagues attending.

Cardiovascular topics were covered by a physician-nurse practitioner team who developed the Bale-Dooneen Method of personalized risk assessment and disease management. Dr. Bradley Bale and Amy Dooneen created the Heart Attack and Stroke Prevention Center in Spokane, Washington, to find the root cause of inflamed blood vessels that could ignite future heart attacks and strokes. Their goal is to prevent heart attacks and they seem to be quite successful. Since beginning the center in 2003, they have treated 3,500 patients using the Bale-Dooneen Method and only one of those patients suffered a heart attack and has since made a complete recovery. Many of the patients are physicians with cardiovascular disease.

Audience participants were familiar with dental and periodontal research supporting a link between oral disease and many systemic conditions. How refreshing to be introduced to the vast array of similar research being published in medical journals. Several studies presented confirm a strong link between periodontal disease and high blood pressure. It’s all about inflammation, similar to periodontitis, so it makes sense that one would be linked to the other. The subgingival extent of the periodontal open wound is about the size of the palm of your hand. Picture this: the entire endothelial system is the size of five tennis courts! Oral bacteria, endotoxins and cytokines all enter the blood stream and travel to other parts of the body. Before getting to the heart, fetus, pancreas or other organs, these toxic waste products travel through the blood vessels, often penetrating endothelial cells, the lining of the blood vessels. This is where changes occur, causing inflammation of the cells, allowing cholesterol to seep in and eventually breaking and leaking, leading to a coronary event.

Casey Hein, RDH, MBA, is currently working at the University of Manitoba producing a vast array of sophisticated yet easy-to-follow multimedia modules to educate non-dental/medical professionals on the latest understanding and research linking oral disease and diabetes. Understanding the inflammatory process of one disease helps one understand the inflammatory process of the other and how they are linked.

After a day and a half of scientific research building a strong case for the oral systemic link, dentist and inventor of PerioProtect, Dr. Duane Keller, provided practical information and scientific research to support a novel approach to lowering the bioburden of bacterial biofilm prior to invasive periodontal therapy. Hydrogen peroxide and antibiotics used in the PerioProtect trays direct and hold the antimicrobial/antibiotic substance in the subgingival area, significantly reducing biofilm prior to instrumentation that would otherwise dump millions of colony-forming units and toxic substances into the blood stream. This is an interesting local delivery alternative to systemic antibiotics.

You’ll want to attend next year’s AAOSH Annual Session as the research in this area is ever increasing! See you there!
Unimpressive Results

Although the plaque control looks okay, these women in their 50s still have bleeding gums. What would you suggest?

newbie10
Posted: 2/2/2011
Post: 1 of 17

I have a couple of patients who came back for their first three-month recall with gingival bleeding and moderate pocketing. Their oral hygiene seemed really great, no plaque and regular flossers. Still the gingiva was red and bleeding. I cannot feel any calculus either. Both are women in their 50s, so I’m thinking hormones make them extra sensitive to the bacterial flora in their mouths. So what else can they do for oral hygiene other than Waterpik WaterFlosser?

JERSEY DEVIL
Posted: 2/2/2011
Post: 2 of 17

It could be hormones, medications, mouth breathing, smoking, sinuses or a systemic factor like diabetes. Ask them more questions about their health and habits.

Most medications that people in their 50s take cause dry mouth. Dry mouth causes the plaque to stick to the teeth quicker, even if they have great hygiene. Using Biotene products and xylitol products can help with the dry mouth. But if it is systemic it needs to be identified by their MD and treated!

rdh1982
Posted: 2/3/2011
Post: 4 of 17

Are you familiar with Sunstar Americas’ Soft Picks? My patients who have been using this simple yet very effective interdental gum-friendly device have less bleeding. My only complaint about this particular product is that local stores can’t re-stock them fast enough for my patients; it is that good!

shazammer1
Posted: 2/3/2011
Post: 5 of 17

I would ask you to do two things. During your spiel to them, hand them the floss and ask them to show you their technique. You might be astounded. Don’t help them until you see how it is being done, probably very wrong. Secondly, before you pick up a scaler drop five drops of Butler GUM disclosing solution under their tongue and ask them to swish it around for 30 seconds front and back. Rinse and then show them what is missed every day. You might be astounded again. It could be a health issue or it could be loosey goosey home care that we tend to take for granted and shouldn’t.

One time I dispensed a power brush to an older guy and told him to brush with it instead of his regular brush and I had him back in a week to see how he was doing. Disclosing showed plaque all over. I asked him to bring his brush in with him the next day and when he showed me his brushing technique he never turned the brush on. I took too much for granted. He was using it like a manual.

newbie10
Posted: 2/4/2011
Post: 6 of 17

That sounds so much like my young lady patient who asked me which teeth she should be flossing! I showed them on their first visit how to do sulcular brushing and spool flossing. Review of technique seems OK. I just received a boxful of disclosing tabs to give away so I
will use that too next time she comes in. I will try to see the health issue angle; kind of awkward too since this one works in the hospital taking care of sick people. But then again...

I used to have a poster which said, “Just floss the teeth you want to keep.”

Great suggestions everyone. Many people do not go to regular doctor visits. Therefore, we have to be the ones to nudge them toward regular medical checkups – just as important as regular dental checkups. Does your office have a wrist blood pressure cuff (BP) (available at Walgreens) so you can easily and quickly take a BP on every patient? I could tell you stories from my chiropractic practice that would curl your hair, including one 42-year-old guy who had a BP of 220/110. I refused to treat him and told him he had to get to his MD as soon as possible and get his BP under control. Instead he called his doctor for a refill on his BP meds and he was dead in two weeks of a heart attack and stroke.

I sometimes explain easy bleeding during a prophy as “fair complexion.” If a patient has freckles, light complexion, fair or reddish hair, you will many times find that despite their good home care, their gingiva will bleed easily. Many well-experienced RNs would tell you similar stories. I have never read a study or article about it, but having worked in the U.K. for many years, I found that more red-haired folks had “bleedy” gums than others.

To soothe this kind of gingival problem I would get the patient to put a teaspoon of granular xylitol in a glass of water and sip this as a drink. One glass during the morning and then repeat this again after lunch. The benefits of xylitol will help establish a healthy biofilm and a healthy mouth, usually in a very short time. If this is a yeast infection, xylitol is very effective on that also.

As already suggested, evaluate their floss and tooth-brushing technique to ensure it is truly effective. Evaluate their diet, especially vitamin Bs and protein for tissue repair. Evaluate the gingival tissue by spraying air upon them; do they lack stippling and appear to have a shiny appearance? Also is the pocketing more prominent in the bicuspid region than the classic molar area?

Have you considered aggressive periodontitis?

If so, have them dip their toothbrush in baking soda at night and use Spry mints, not the gum (any time during the day, but no rinsing until at least 30 minutes), it is more about the time the bacteria are exposed to the xylitol, not the amount. Have your clients dissolve the mint and swish it between their teeth. One a day is plenty. This will stabilize the tissue and prevent further bone loss.

I personally feel this is because the immune system is out of balance.
I feel it could only be four different reasons:
1. Plaque present, not being removed every 24 hours at least 90 percent
2. Poor nutrition... especially vitamin C, B complex, calcium and magnesium
3. Heavy stress
4. Oral myofunctional disorder leading to mouth breathing, tongue thrusting or oral habits leading to traumatic occlusion.

I agree with Joy on all the above points; however I have found that mouth breathing is the most common cause for spontaneous bleeding on the maxillary facial and lingual tissue aspects with patients who have great oral hygiene! Be sure to ask your patients if they have (1) allergies, (2) wake up with dry mouth or (3) can’t breathe through their nose. It is amazing to me how many patients suffer from these three common breathing problems. Hope this helps!

Do they have a soda, juice or sport drink habit? The acid crossing over the anterior tissue causes irritation and bleeding similar in look to a mouth breather.

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

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Perio Patients Seen in Emergency Rooms

Periodontal disease is best controlled with regular maintenance visits and adequate daily oral hygiene. When regular dental visits are not followed, serious problems occur and patients seek treatment at hospital emergency rooms. Those without dental insurance also seek care in hospital emergency rooms. Data is collected each year from emergency rooms across the U.S. and published in a Nationwide Emergency Department Sample (NEDS).

Researchers at Harvard University in Boston, Massachusetts analyzed data from 2006 NEDS to determine how many visits were because of periodontal problems and if these emergency visits led to hospitalization.

During 2006, there were 120,033,750 emergency room visits with 85,039 of these visits being categorized with a primary diagnosis of periodontal disease. More patients were seen on weekend days than on weekdays. Some of these cases also had other medical problems including diabetes, heart disease, lung disease, liver disease, thyroid problems, alcohol abuse or HIV. A total of 1,167 of these emergency room visits required inpatient hospitalization.

The financial implications of these emergency room visits were close to $33.3 million with an average charge per visit of $456. For those who were also hospitalized, the charges escalated to $15,248 per visit.

Inpatient hospitalization occurred more often for those with multiple medical problems and for those with a primary diagnosis of acute or aggressive periodontitis rather than chronic periodontitis.

Clinical Implications: Prevention of periodontal disease with effective daily oral hygiene and regular dental and dental hygiene visits is important to treat and prevent serious periodontal conditions that might otherwise lead patients to seek treatment at a hospital emergency room.


Dental Treatment and Vascular Events

Treatment and control of periodontal disease might reduce the risk of cardiovascular disease. Other research suggests a transient risk associated with invasive dental procedures and the likelihood of a heart attack or stroke in the first few weeks following treatment. Low grade chronic inflammation is linked to cardiovascular disease. Acute inflammation after surgery or a bacterial infection is associated with a short-term increased risk of changes in blood vessels leading to stroke or heart attack.

Researchers at the Eastman Dental Institute in London, England analyzed the United States Medicaid claims database to determine if invasive dental treatment led to heart attack or stroke immediately after treatment. A total of nearly 10 million patient records over a five-year period were analyzed to find 20,000 who had been hospitalized for either stroke or heart attack. Of these patients, 1,152 underwent invasive dental procedures prior to hospitalization.

Invasive dental procedures included all treatment codes related to periodontal therapy and tooth extractions, with 89 percent of these procedures relating to extractions.

No vascular event occurred on the same day as the dental visit, but the majority happened within four weeks of treatment. Although invasive dental treatment might be linked to vascular events in the month after treatment, the long-term benefit of treating dental disease far outweighs this risk. These findings do provide evidence of the link between acute inflammation and the risk of vascular events.

Clinical Implications: Within this targeted population of Medicaid patients, invasive dental treatment might present a transient risk for heart attack or stroke in the first four weeks following treatment, but this risk is outweighed by long-term benefits from dental treatment.

Bacterial biofilm is the trigger which starts the periodontal disease cascade. Researchers have identified hundreds of bacterial species within biofilm and grouped them according to pathogenicity by color groups. Red and orange are the most pathogenic; green and yellow less so; and purple and blue the least pathogenic.

Researchers at the Forsyth Institute in Boston, Massachusetts wanted to know if there were differences in plaque recolonization and species after instrumentation in both periodontally healthy and diseased patients. A group of 38 patients participated in the study; 17 had chronic periodontitis with at least eight teeth probing over 4mm and the rest, considered healthy, had less than 20 percent of sites with gingivitis, redness or bleeding.

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They reviewed 31 abstracts on the subject and narrowed it down to 13 full articles, of which nine were relevant to their question. The two host modulation drugs tested were low-dose doxycycline and low-dose flurbiprofen. Overwhelmingly, the data demonstrated improved periodontal healing following scaling and root planing when host modulation therapy was provided for smokers. Differences were more pronounced in moderate and deep pockets compared to shallow pockets. When these low-dose drugs are given to smokers in conjunction with treatment or maintenance, bacterial counts are reduced for the most pathogenic species.

Since smoking causes an increase in inflammation, providing a host modulation drug that reduces the level of cytokines released will enhance healing.

**Clinical Implications:** Based on the research, it makes sense to offer a host modulation drug to smokers being treated for periodontal disease and smokers receiving periodontal maintenance.

Ketorolac (Toradol) is a non-steroidal anti-inflammatory drug used to control pain and inflammation. It is delivered by injections or in oral tablets often causing gastrointestinal (GI) problems. To avoid GI problems, other delivery systems have been investigated, including transdermal delivery, ophthalmic solutions and an oral rinse. The newest delivery system is an intra-oral patch made of two bioadhesive polymers: hydroxypropyl methylcellulose and polyacrylic acid.

Researchers at King Saud University in Riyadh, Saudia Arabia tested the new adhesive patch containing 30mg of ketorolac. Test and placebo patches were tested on free-gingival graft sites in 68 patients in a double-blind study. The test group received the ketorolac patches immediately after surgery and the control group received the placebo patches. Pain levels were recorded by patients using a visual analog scale from zero to 10 with mild pain equaling zero to four, moderate pain equaling four to seven and severe pain equaling seven or higher.

Pain scores immediately after surgery were 7.7 for both groups. Test group scores were 5.2 at one hour, 3.4 at two and three hours, 2.0 at four hours and negligible after that. Pain in the control group was 7.8 at one hour and 5.63 at two hours. At this point, control patches were replaced with the ketorolac patches. One hour later, pain scores dropped to 3.4, then 2.5 at four hours, 1.3 at five hours and negligible after that up to 48 hours.

Clinical Implications: Oral pain relief patches might be available in the future for use after surgical procedures.


Listerine Used for Ultrasonic Lavage

The goal of non-surgical periodontal therapy is to reduce probing depths and bleeding and return all pockets to health. Providing scaling and root planing in chronic periodontitis cases does not always return all pockets to probing depths less than 5mm. Remaining pockets present a risk for further disease.

Researchers at the University of Sao Paulo in Brazil compared ultrasonic instrumentation using Listerine Cool Mint as the lavage to an identical tasting and colored placebo. A group of 64 patients were treated with traditional scaling and root planing using power and hand instruments in four to six sessions each. Four weeks later, these patients were again examined and all still had four to 10 sites measuring 5mm or more. This was baseline for the study.

Subjects received five minutes of ultrasonic scaling in each remaining diseased site using the randomly assigned lavage, either Listerine or control rinse. The Listerine and control rinse containers were identical, marked either Group A or Group B. No one knew the group assignments until the six-month study was completed. Periodontal exams were repeated at four, six and 24 weeks.

When comparing all data, no differences were seen between test and control groups for probing depths, clinical attachment levels, recession or bleeding on probing. A small difference was observed for pockets initially measuring 7mm or more. The Listerine group showed 0.65mm greater probing depth reduction and 0.77mm greater gain in clinical attachment. Not reported were reductions in the total number of sites 5mm or more.

Clinical Implications: For initially deep pockets, using Listerine Cool Mint in the ultrasonic scaler might enhance healing slightly.

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What’s colorless, tasteless and smells like money? The answer – according to an article by Shankar Vedantam in the Washington Post, June 30, 2008 – water! Think about it. Americans spend $60 billion each year on bottled water, when tap water costs only pennies.

Hundreds of companies are now selling bottled water to Americans in a country with the science and technology to provide safe, great tasting water to the entire population at very little cost to the consumer. Our water purification technology rivals the discoveries needed to take astronauts to the moon! However, the bottled water industry is successfully using marketing to convince Americans there is a substantial difference between what’s in the bottle and what comes out of the tap. Consumers are willing to pay markups of 1,000 to 10,000 times the cost of tap water. This is marketing magic!

On the other hand, efforts by the dental profession to convince Americans to prevent dental disease just aren’t working. In 2000, the U.S. Surgeon General released a report on oral health in America calling dental disease the “silent epidemic.” Estimates vary, depending on criteria used, but it is fair to say that at least 80 percent of our population will experience dental disease to some extent during their lifetime from caries to gingivitis. Caries and periodontal disease are preventable, but getting that message to consumers is nearly impossible and getting them to take appropriate action rarely happens. The complex cases presented on Dentaltown and Hygienetown are a testament to the enormity of the problem. We don’t see message boards complaining about too little disease as many lament the fact that people with serious dental problems are not willing to spend the money needed to treat the disease.

Despite the many benefits of preventing dental disease, consumers aren’t buying that message. In fact, most don’t even believe dental disease is preventable, they think tooth decay and gum disease are inevitable, no matter what their socioeconomic status. Just ask your patients, “Is dental disease preventable or inevitable?” The answers will surprise you. While flying from Dallas to Boston I chatted with the man sitting next to me prior to take off. He was a 40-year-old banker, married to an attorney with a seven-year-old son and a baby on the way. He and his wife were doing well financially, highly educated, and yet did not know that dental disease was preventable. We talked about his son and as a hygienist, I couldn’t resist asking if his child had any cavities. The father’s answer saddened me, as he replied, “He doesn’t have any cavities yet.” Yet? I questioned, wondering why
he anticipates his young son will eventually have tooth decay. His reply “I have fillings and so does my wife, so it’s just natural that he’ll have them too.” That’s the message being marketed to consumers – dental disease is inevitable and the damage can be repaired. Adding insult to injury, consumers feel that someone else should pay for their dental care, not them.

How can bottled water companies convince Americans to buy water in a bottle when they have perfectly good tap water and yet the dental and dental hygiene professions can’t convince people to do just a few inexpensive things each day that will save them money, prevent pain and avoid an ugly smile? The answer is marketing! A comparison of bottled water marketing and oral health marketing reveals significant differences that explain water’s success, and our lack thereof.

**Bottled Water**

**How It’s Marketed:** There are currently more than 1,000 brands of bottled water selling from 69 cents to thousands of dollars a bottle. Grocery store brands, which may in fact be just tap water, are sold for less than a dollar, while BlingH2O sells Swarovski crystal-studded bottles for more than a million times the price of tap water. Since tap water is the primary competitor for bottled water, selling water itself is difficult. They need to convince consumers that bottled water is safer, cleaner and better tasting than tap water. Look closely at the marketing for bottled water. They are selling emotion, not water. They are selling how you will “feel” when you drink this water, rather than the water itself. You’ll feel safer and feel healthier drinking their water.

**Why It’s Successful:** People first purchased bottle water to be “chic” and then marketing went from fashion to fear of tap water quality. Successful marketing triggers emotions. People respond emotionally, not logically when they purchase. Logically you’d drink tap water, based on cost, safety and taste. But people buy bottled water to feel safer than if they drank tap water (not true, but emotion nonetheless). They buy bottled water to feel healthier, to enjoy the taste more than tap water (proven in blind taste tests to be indistinguishable from tap water). They buy bottled water to feel chic and fashionable. Success comes from marketing emotions associated with drinking bottled water and not the water itself. This level of successful marketing makes selling snow to Eskimos seem like a reasonable proposition.

**What Harm it Causes:** The harm comes on several levels, from pollution to undermining the nation’s public water infrastructure. High levels of carbon dioxide are emitted into the atmosphere to produce and transport bottled water across the globe, when in fact the water here is cheaper and might even be safer, plus millions of plastic bottles now need to be disposed of.
in landfills. The pH of bottled water is lower, in many cases, than tap water and additional filtration might take out valuable minerals and also remove fluoride.

Much of the bottled water purchased in this country is in fact, tap water. Some brands feature mountain peaks and waterfalls and the word “pure” when in fact the bottle contains tap water put through additional filtration and purification to make already clean water clean! Marketing that bottled water is “safer” than tap water undermines confidence in public drinking water. This thinking reduces support for repairs and upgrades to the nation’s public water infrastructure.

**Oral Health**

**How It’s Marketed:** Oral health is marketed as a medical issue, linked in some cases, to overall systemic health. Marketing is based on logic and scientific evidence. People are told what they should do, what they need to do, why they should do it, how to treat disease, how to repair the damage from dental disease and how to prevent future disease. This type of marketing doesn’t rely on emotion, but rather on efforts to gain “compliance.” Motivational interviewing focuses on listening to what patients want and what they are willing to do to prevent dental disease. This approach creates a foundation of trust to build a plan of action to achieve the necessary actions to prevent disease. This is a logical approach, but this is not successful marketing. Successful marketing is linked to emotion rather than logic, to feelings rather than science.

**Why It’s Not Successful:** What consumers pay for oral health falls into the “discretionary” category of purchases, just as bottled water does. The primary competition for oral health expenditures are things people purchase for fun, leisure and travel like electronics, cars, vacations, hair and nail salon visits, eating out, bottled water and Starbucks coffee, to name a few. These are emotional purchases, not logical purchases. Logic is used later to justify the emotional decision to buy. Positive emotions like confidence, self-esteem, belonging, pride, power, safety and enjoyment trigger purchases.

Unintentional marketing of the dental message happens in movies where negative emotions are associated with dental visits. Rarely is a dentist or dental hygienist portrayed as providing services that make you feel safer and healthier. Rather, the emotions triggered are extreme fear, pain and discomfort. Add to this the feeling of paying for these services is adding insult to injury.

One aspect of dentistry – cosmetic and aesthetic dentistry – has experienced successful marketing because it markets to the emotions. Pictures of bright, white, straight teeth paint a picture of confidence, fun and enjoyment. There’s no logic here; no link to the science of oral health, yet people are willing to buy cosmetic dentistry more readily than prevention or treatment of disease.

**What Harm it Causes:** Marketing oral health using logic rather than emotion falls flat. We already know that marketing the importance of flossing to prevent dental disease doesn’t work. We’ve been preaching that for decades and the research shows that more than 85 percent of the population doesn’t floss daily and those who do are not necessarily effective at removing biofilm. The only reason we continue to market this way is tradition.

Marketing toothbrushing as the primary means of plaque removal also masks the fact that most dental disease begins between the teeth, not on the facial and lingual surfaces. Toothpaste companies have marketed the feeling of clean teeth using their products, when in fact most people brush for only 30 seconds and do not remove adequate plaque to prevent dental disease. Good use of an emotion to sell a product, but this isn’t marketing prevention of dental disease; it’s marketing a clean feeling from toothpaste.

Marketing oral health as part of the medical model doesn’t tap into an emotion, therefore the desired action isn’t taken. If providing information and logic worked to market health, no one would smoke and no one would be overweight. The emotional marketing of smoking cigarettes to be chic, macho or sophisticated and the marketing of convenience foods to reward yourself and enjoy life with the time you saved have worked against health.

**Conclusion**

Appealing to consumers’ emotions rather than logic makes the difference. These emotions can be used to market oral health, with the science and logic used later to support the emotional decision. Research published several years ago by the Assistant Surgeon General of the United States Army Dental Corps General Bernier showed that military recruits bought into basic oral hygiene, not with brochures, scientific lectures or demonstration, but when oral hygiene was linked to kissability. The old adage “sex sells” might be something to consider when marketing oral health. Fresh breath sells not because it’s a sign of good health, but because people with fresh breath feel confident and it boosts their self-esteem. Marketing to the emotions rather than with logic is a challenge for our science-based profession, yet the scientific research in the marketing field confirms people make choices first from their emotions, and then support that decision with logic. Link oral health to feelings of confidence, security and the enjoyment of life rather than to the avoidance of future painful disease. A beautiful smile lasts a lifetime.

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Posted: 4/9/2011
Post: 1 of 15

Our patient is in the process of having an implant placed #15. I noticed that he had a small parulis on the buccal aspect #15 where the implant was placed six months ago. Patient was unaware of the lesion.

Long story short, the patient went to a periodontist based on his insurance coverage (not our recommendation). He had a terrible experience and does not want to go back. However, legally, we cannot place a crown until we get the “green light” from the perio office.

Note the open gap between the implant and abutment. What should be the next move?

I would not place any permanent restoration until the infection is resolved. Do you know what implant system was used? The gap you see on the radiograph might be a platform switch. The concept is to internalize the micro-gap between the abutment and the implant platform to help maintain crestal bone. What are the probing depths around the implant? Seems like another surgical procedure to explore the facial area of the implant is in order. Once the area is visualized a decision can be made to graft the area or remove the implant. If a graft is planned to reconstruct the area, I like to use Emdogain and Bio-Oss with a Bio-Gide collagen membrane. The abutment should be removed and the tissue coronally advanced for primary closure. Tough situation for everyone involved.

Periosupport
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Albert, Wouldn't this area require a sinus lift? Couldn't this be why it's infected? The implant looks like it's in the sinus. Yikes! I am clueless, please teach me.

Legally you don't need a green light from that perio office. Write a written consent where the patient affirms you have advised him to return and he has elected not to. Then handle as you would a patient locating from out of town.

Send the patient to your usual surgeon or if you want to handle it yourself, remove the healing abutment, determine if it is soft tissue or bone. If soft tissue, resect the soft-tissue wall to eliminate the fistula (crown lengthening) or get a CBCT scan image at your referral surgeon's office. It will likely give you some answers. We have an i-CAT in the office, and though I have placed more than 12,000 implants in the last 25 years, I find it indispensable. Having looked at thousands of scans I can tell you 2D radiographs are plagued by misinterpretation, not only for implant site selection, but for

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periodontal defect evaluation, endo diagnosis, etc. The CBCT will let you know if it’s likely a bone issue, and the true relation to the sinus. ■

I just had a situation like this three days ago. A new patient came in and upon probing I found 6-7mm pocketing around an implant in the #7 space, also absolutely no bone present on the facial aspect. I could literally see my yellow plastic probe under the tissue as I probed, plus copious amounts of exudate. This man just had the implant placed last year. He stated he was never told that he had to floss the implant, just brush. Of course, I don’t know the whole story so we just referred him back to the oral surgeon who placed the implant. ■

Periopeak, You nailed it! I am a hygienist in a periodontal practice and we have had several patients in our office who had implants placed elsewhere and they are now having problems because the implant was placed into the sinus. A sinus lift should have been done! Do not place a crown on this implant as this will only cost the patient more money. Unfortunately, this implant will likely have to be removed. ■

Rudebaga, I agree with you wholeheartedly. I use an endoscope daily, many times to look and debride around failing/infected implants. It’s ridiculous how much cement is left behind on implants. It’s also frightening how little cement is needed to cause an implant to fail. We also use regular ultrasonic tips and scalers to clean. First though, we take our fingers and press on either side of the implant to see if we can get anything expressed out of the sulcus. It gives us our first clue on what we might find. If nothing can be expressed, we gently probe and debride around the implant. The other day I scoped around a series of anterior implants and so much residual cement came out that I had to put down my instruments and gently pry out the cement from under the crowns with cotton pliers. When I called the referring dentist to tell him what I found, he wanted to know why I didn’t use “something” to smooth off the exposed threads of the implants since no bone was going to regrow around them. Speechless is what I was. ■

Great posts from everyone, and an interesting case! Last year at the IFDH symposium in Scotland I attended a lecture on management of ailing implants given by a Swedish doctor. As you know, in Sweden, implants were covered by health services so they have placed many implants since about 1965. The most memorable thing to me about this lecture was effective scaling of the implant is more significant than preventing scratches on the surface. She says it is not really crucial to use plastic instruments on implants. I have not used regular scalers on implants so far (I guess I have not yet let go of what I learned years ago). However, I like titanium scalers.

Once again, I’ve grown more brain cells by reading great posts on Hygienetown. ■
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