Editorial

What Would I Do If It Were My Problem?

Since the introduction of implants into the armamentarium of the dental profession, periodontal disease is often overlooked or not treated appropriately. Patients with early or moderate disease that could be successfully treated with a positive long-term prognosis are allowed to smolder until they are virtually hopeless.

Most patients prefer to preserve their own dentition as opposed to extractions and implants even if it requires periodontal surgery. This is especially true when we consider the regenerative possibilities that periodontists have to offer. Do not lose sight that our primary objective is to achieve optimum periodontal health using the most conservative measures, which may mean proper oral hygiene, subgingival scaling, and pocket elimination where possible, so that ancillary personnel can maintain this health with routine maintenance visits.

The periodontal pocket is likely the most frequently encountered dental malady, but the treatment regimes run the course of paradox. Recently, an auditorium audience filled to the brim with clinicians expressing a keen interest in periodontology was asked if they would prefer to have significant pocket depth in their own dentitions. "Of course not," the incredulous audience proclaimed. Yet, how many practices have a double standard when contrasting their personal dental health with that of their patients?

If one accepts the bacteriologic roles in the etiology of periodontal disease and is aware of the investigations conducted by Socransky and associates as to the presence or absence of periodontal pathogens (the red complex) located in the pocket, it would appear that the conclusions would be self-evident.

The endpoint goal of all periodontal treatment should be the creation of an environment that the patient and hygienist can maintain. Dentitions exhibiting deep pocketing with compromised alveolar support are evidence of the patient's susceptibility to disease. Accepting the results of "soft tissue" therapies that do not result in a cleansable environment but provide pink, nonbleeding gingiva is only the first plateau of treatment. If the patient can't floss the depth of the probing and the hygienist cannot remove the accretions, the problem is not solved. All probing depths greater than 5 mm require more sophisticated analysis and treatment.

The naysayers proclaim that this is an impossible goal or not lucrative, but are health care goals really impossible or beyond the knowledge of our therapies? W. Somerset Maughan wrote: "It's a funny thing about life; if you refuse to accept anything but the best, you very often get it."

The obstacles to be encountered are predictable: the third parties will be aghast and patients wish to avoid surgery. Those who wait for statistical evidence will obviate the need to reach the previously stated endpoint goals. The manufacturers of products designed as alternatives to surgery would double their efforts to influence the clinical decisions of the less educated practitioners.

Dentistry has come a long way in the last two decades. Let us maintain the momentum for the continued benefit of our patients.

Thus, the litmus test is: What would I do if this were my own dentition?

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