ISP GUIDELINES ON PERIODONTAL CARE
The lack of awareness and motivation amongst general dental practitioners in the management of periodontal patients is known to all of us. They often stumble at every step leading to a lot of untreated or worse, mistreated patients.

In order to tackle this situation, ISP gathered most of the Key Opinion Leaders in Periodontics at a specially organized workshop. After a lot of brainstorming and intense deliberations we were able to arrive at a consensus on most facets of periodontal care culminating in the formulation of the "ISP Guidelines on Periodontal Care".

This project was the brain child of our past-president Dr. Ashish Jain, and I congratulate him and his entire team for a marvelous work they have done. I also congratulate Colgate-Palmolive (India) Limited, especially Dr. Sunil & team, for their unconditional scientific contribution.

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It is my immense pleasure to introduce ISP Guidelines on Periodontal Care - a brand new endeavor from Indian Society of Periodontology for raising the standard of overall oral health care. The society has recognized the need for a systematic document to cater to the quest and knowledge update of the subject of Periodontology for everyday clinical practice of the general dental practitioners. An elaborate advisory board including Periodontists, general dentists and medical physicians has been consulted to carefully update the art and science of Periodontology support for holistic oral health maintenance. The support document has been shaped by Standards of Practice, Clinical Guidelines, and Interdisciplinary Support competencies, which shall serve as the hallmark of success of these set of guidelines. Each section contains evidence-based background information emphasizing core science, intended for clinical implementation by the professionals.

I sincerely wish and hope, ISP-GPC shall provide a useful interface for enhancing the quality and success of treatment by all dental professionals caring for patients suffering from oral disease.
Dear Professional Colleagues,

It is a moment of pride that for the first time in the profession of Dentistry in our country the Indian Society of Periodontology is coming up with the "ISP Guidelines on Periodontal Care" (ISP-GPC) for the general dental practitioners. It is our endeavor that the dental practitioners are suitably equipped with knowledge and guided in the diagnosis and the management of periodontal diseases as they happen to be the first persons to encounter the patients in most of the cases.

You all would agree to the fact that periodontal diseases have assumed alarming proportions and have afflicted our population to such an extent that it is being considered as one of the most common chronic infections. Such situations need to be handled with caution as there has been a proven positive link between periodontal diseases and the systemic diseases.

The ISP-GPC committee members which included renowned professionals from various specialties of Dentistry, clinicians, general dental practitioners and medical professionals deliberated exhaustively on the different aspects of periodontal diseases and have enlisted these guidelines which will definitely be beneficial to the general dental practitioners in serving the patient population and the society in a more meaningful way.

ISP Guidelines on Periodontal Care: A Resourceful Reference.

I am delighted to pen down the foreword for the first Indian evidence-based "Guidelines on Periodontal Care" particularly for general dentists with endorsement by the Indian Society of Periodontology. As the holistic dental treatment aims at the complete restoration of oral health, function and esthetics for the patient, so it essentially involves many collaborative interdisciplinary decisions and interventions as well. ISP Guidelines on Periodontal Care (ISP-GPC) are intended to provide a systematic aid to making such complex treatment decisions and enhance healthcare quality and outcomes.

The initiative for the first draft of ISP-GPC has been taken by Indian Society of Periodontology and is based on scientific evidence, clinician experiential knowledge of the periodontists, other specialty dental practitioners, general dentists, medical colleagues and patient values. The proposed standards cover a number of elements essential to developing sound practice guidelines, including transparency; conflict of interest; guideline development group composition; establishing evidence foundations for and strength of recommendations; articulation of recommendations; rigorous review. The advisory board discussions highlighted the significance of leaning on contemporary evidence and expert clinical consensus; both aspects complimented each other for best clinical practice guidelines development. In addition to providing a practical resource containing the core science of Periodontology principles, it is designed to serve as a valuable clinical resource for the general practitioners and an interdisciplinary document that recognizes both the common body of knowledge and the unique skills that each member of the multidisciplinary team possesses.

Despite an extensive and rigorous review progress, I envision these standards to be applied in clinical practice, analyzed for effectiveness, assessed for reliability and validity and evolve as science and experience dictate. We have targeted this guidance for practice in India keeping in view the social, demographic and cultural factors in evidence base and therefore their clinical implications may be similarly applied in India.

I want to thank the excellent team of advisory board members who conducted this quite rigorous work with extreme care and diligence. The committee was very dedicatedly supported and assisted by Colgate-Palmolive (India) Ltd. I acknowledge and appreciate whole heartedly their participation. Future additions and revisions time to time shall set out standards for further editions of the clinical practice guidelines as per the emerging evidence in Periodontology.

It is my sincere hope and expectation that these guidelines will provide an enriching learning experience and referenced resource for all health professionals caring for dental patients, leading to improved patient care.

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Guidelines for Periodontal Care

Advisory Board Meeting on Good Clinical Practice Recommendation formulation held on 10th & 11th March, 2018 at Mumbai, Maharashtra

The word periodontium originates from the Greek terms peri-, which means “around,” and - odons, which means “tooth.” Literally, it means that ‘which is around the tooth.’ Periodontium includes the tissues that surround and support the teeth viz. gingiva, cementum, periodontal ligament, and alveolar bone. Recently the global epidemiological data survey revealed that periodontal diseases are one of the major contributors to the overall burden of oral diseases and are rated as the 6th most prevalent disease afflicting mankind. According to the latest prevalence data from the UK Adult Dental Health Survey, 37% of the adult population suffers from moderate levels of chronic periodontitis while in the United States of America, one out of every two adults above the age of 30 suffers from periodontal disease. The Indian burden of periodontal disease seems to be much higher than the global burden, with prevalence across states averaging to about 95%. The disease is not restricted to adults only. Epidemiological studies have found that a significantly higher number of Indian children (50%) and adolescents (61%) are afflicted with periodontal diseases, as compared to the global standards which range from 0.2 to 0.5% of children in USA to 31% to 56% in the Latin American countries.

The high prevalence rates have earned periodontal diseases the moniker of being a ‘silent epidemic.’ However, it is mainly because of this ‘silent nature’, the disease often remains undiagnosed or under diagnosed which adds on to its increased prevalence. Diagnosis of periodontal disease is based on its classification and/or causative factors. The 1999 American Academy of Periodontology (AAP) classifies periodontal diseases into 8 different categories depending on the presenting symptoms. An updated classification is recently suggested at the joint workshop conducted by the European Federation of Periodontology (EFP) and AAP in 2017 which would help standardize the definition of the disease. The recently updated periodontitis classification builds on a notable change from the 1999 classification. The disease is now defined as one of 3 distinct forms viz; periodontitis (formerly aggressive and chronic), necrotizing periodontitis and periodontitis that manifests based on systemic conditions. Each condition in addition features a multi-dimensional staging and grading framework. It specifies 4 staging levels that are determined based on severity of disease at presentation and 3 grading levels that provides supplemental information about the biological features of the disease. The new staging and grading system provides a structure for making treatment decisions and to monitor the patients response to therapy.

The pathogenic organisms responsible for various oral problems harbors at various sites in oral cavity such as dentition, dorsum of tongue, buccal mucosa & saliva and this microbiology provides an understanding on the Whole Mouth Health Model which aims to address the tooth-related, gingival and periodontal diseases. Although periodontal disease is multi-factorial, the oral microbiota is implicated as the main causative factor. It is hypothesized that complex interaction of bacterial infection and host response, modified by behavioral factors such as smoking etc, can result in periodontal disease. Considerable evidence also points to the fact that the effects of periodontitis go beyond the oral cavity. An individual as a whole is affected by the haematogenous dissemination of both bacteria and bacterial products originating in the oral biofilms and inflammatory mediators in the inflamed periodontium. These mechanisms allow the inflammatory periodontal disease to impact the various chronic inflammatory general body diseases notably diabetes, rheumatoid arthritis and pulmonary infections.

A correct diagnosis is the first and a very fundamental step in effective treatment, minimizing complications and preventing recurrence. Diagnosis of periodontal disease involves taking an accurate history and determining the pattern, type and extent of the disease based on a careful clinical examination. A timely and precise diagnosis of periodontal disease is specifically critical in children and adolescents, since periodontitis that affects them generally progresses rapidly and can cause irreversible damage if not accurately diagnosed and treated.

The treatment protocol involves both non-surgical and surgical therapies, followed by regular clinical or in office monitoring and follow-up. Oral hygiene instructions (OHI) forms a very vital part of the treatment regimen. Scaling and root planing is the gold standard and is often the most recommended protocol for treatment of gingival and periodontal disease. Lasers and other modalities are also being increasingly used in the treatment.
Burden, barrier, and challenges

Diagnosis and referrals

Recommendations (GCPR) for Periodontal disease

2 Methodology

An expert committee consisting of dental practitioners, including the honorable members of the Indian Society of Periodontology, representatives from the Indian Society of Prosthodontics, Indian Orthodontic Society, General Dentists and experts from the field of Endocrinology, reviewed the current available data regarding various aspects of periodontal diseases. A thorough discussion and review of current evidence in addition to their own clinical experience formed the basis of these consensus recommendations to formulate a India specific GCPR.

These expert consensus recommendations cover the following aspects of periodontal diseases:

- Burden, barrier, and challenges
- Etiology and classification
- Initial screening and charting
- Diagnosis and referrals
- Treatment strategy
- Halitosis and dentine hypersensitivity
- Peri-implant diseases

The consensus was made with an aim to provide right direction to develop and support overarching guidelines for the appropriate screening, diagnosis, management and prevention of periodontal diseases. The recommendation proceedings from this committee are not a substitute for clinical judgment and are primarily aimed at enhancing the decision-making skills of a non-periodontist dental practitioner to create an effective treatment plan for the patient.

The ultimate judgment regarding the effectiveness of any specific therapy/measure must be made by the clinician and the patient in light of all the circumstances presented by the individual patient and the competencies of the practitioner.
3 Expert consensus recommendations

For each of the topics deliberated upon in the meeting, we present the consensus recommendations that were proposed by the expert committee.

3.1 Burden, Barriers and Challenges

The expert panel unanimously agreed that the burden of periodontal diseases in India is very high with scattered data putting the burden prevalence as high as 80 – 90%. The expert panel highlighted two main reasons for high disease burden among urban Indians:

- Under diagnosis of the disease in a general dental practice which can be attributed to lack of awareness or willingness of general dentists to identify signs and symptoms of early disease, different treatment modalities, inability to define treatment outcomes and their need thereof.
- The tendency of the masses to prefer need-based treatment rather than a prophylactic strategy which could be attributed to patient related factors viz. Lack of awareness, no symptoms of the disease, economic constraints and inaccessibility to dentists.

The committee further opined that even in the cases diagnosed for specific advanced treatment procedures, there is a limitation either in the availability of access to the specialist or the lack of confidence of the general practitioner in the referral procedure.

Thus, there exists a big lacuna in the implementation of the right management strategies. In view of the above-mentioned reasons and keeping in mind varied demographics and logistics in India, the experts felt the need to create a simple, concise guideline, named, ‘ISP-Guidelines for Periodontal Care’ (ISP-GPC) which could act as a tool to enable the general dental practitioner towards better identification and management of periodontal disease and more importantly to extend the domain of the treatment skills of his clinic by proper referrals or consultations from a specialist.

The aims of ‘ISP-GPC’ have been envisioned to be:

- Identification of the various risk factors that can increase risk of periodontal disease
- Early identification of high-risk population
- Prompting early diagnosis
- Implementing a step wise, evidence-based treatment approach
- Driving appropriate referrals
- Instituting and monitoring an appropriate and effective maintenance regimen

3.2 Etiology and Classification

The members of the expert panel were of the opinion that the present classification as proposed in the literature is quite complex and at times difficult to comprehend and follow, more so to incorporate into the general practice. Due to the complexities of such a classification, it is quite obvious that a general dentist may overlap the diagnosis, hence compromising the results. The members felt that there is a need to highlight those components of the big classification table of gingival and periodontal diseases, which are most commonly encountered in routine dental practices. Moreover, the risk factors including the systemic risk factors which have an impact on the periodontal disease and treatment should also be highlighted in a simple conceptual form. For simplified comprehensible purposes only, the members suggested that the periodontal diseases be better understood in two main categories:

- **Gingivitis:**
  Gingivitis or gingival disease is the reversible inflammation of the gingivae. The main features of gingivitis are: Erythema, edema and bleeding on brushing or probing. Persistent gingivitis can lead to periodontitis.

- **Periodontitis:**
  Periodontitis is an irreversible disease, sometimes difficult to treat and is characterized by increased probing pocket depth, increased clinical attachment loss (CAL) i.e. the base of the pocket moves apically to the cementoenamel joint (CEJ), gingival recession, increased mobility and furcation involvement.

Periodontitis can be further considered into 3 categories based on clinical features: Mild, moderate and severe (Figure 1, Table 1).

![Figure 1: Stages in Periodontal Disease](image)

<table>
<thead>
<tr>
<th>Table 1: Expert consensus on guidelines for determining severity of periodontitis based on clinical examination</th>
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<tbody>
<tr>
<td>Probing depths</td>
</tr>
<tr>
<td>Bleeding on probing</td>
</tr>
<tr>
<td>Radiographic bone loss</td>
</tr>
<tr>
<td>Clinical attachment loss</td>
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</tbody>
</table>

PD: Pocket depth, BoP: Bleeding on probing, CAL: Clinical attachment loss

*Localized disease is defined as ≥30% of sites are involved; Generalized disease infers <30% of sites are involved

*referral to specialist may be indicated for additional treatment after initial therapy** referral to specialist should be considered
**PD (Pocket Depth):** This is to be recorded with William's graduated Probe. It is the recording of the distance between the gingival margin and base of pocket. The probe should be walked around the tooth (Figure 2) and the deepest recording should be noted.

**CAL (Clinical attachment loss):** It is to be measured as the vertical distance from cementoenamel junction (a fixed reference point) to base of the periodontal pocket, with the help of UNC-15 probe. Because the bone level in health is approximately 2 mm apical to the cementoenamel junction, clinical attachment levels provide a more reliable indication of the extent of bone support for a tooth.

**Significance of CAL:** The clinical attachment loss reveals the approximate extent of root surface that is devoid of periodontal ligament.

A clear distinction should be made of the ‘true pocket (apical deepening of the sulcus)’ and ‘false pocket (caused by enlargement of the gingiva)’ since the treatment plan for both are quite distinct (Figure 3).

**Bone Loss:** An overall impression of the bone loss can be evaluated with the help of an OPG and/or IOPA X-Rays (Figure 5).

**Mobility:** Mobility of tooth should be recorded with the back ends of mouth mirror. The fingers should not be used to evaluate the mobility (Figure 6).

**Other Conditions of Interest for a Practitioner**

*Gingival recession*

All gingival recessions may not be connected to periodontal disease. Clinicians should look for validated symptoms of periodontal disease rather than considering standalone gingival recession as a sign and symptom of existing periodontal disease. A note of other conditions like ‘Dentinal Hypersensitivity,’ ‘Malodor’ should also be made at the time of diagnosing the case.

### 3.3 Initial screening and charting

The experts firmly agreed that objective screening protocols in dental clinics are currently non-existent in India and that there is an urgent need to develop a simple and consistent means of screening and consequent charting for patients which should be user friendly.

Efforts should be made to disseminate the importance of an early and objective assessment during screening for proper diagnosis and treatment plan of the patient.

Based on this the following tools are suggested:

- A toolkit of minimum essential instruments required for a proper periodontal screening and diagnosis. *(Box 1)*
- An initial screening tool (created by combining basic periodontal examination (BPE) and periodontal screening and recording (PSR) and its interpretation). *(Table 2)*
- A guidance tool on interpretation of the codes and special investigations and treatment guidance. *(Table 3)*
Box 1: Minimum armamentarium for screening and charting

1. Mouth Mirror
2. Tweezer
3. Williams Graduated Probe
4. Naber’s Probe
5. WHO Probe
6. Autoclave pouches

Table 2: Expert consensus on initial screening for adults

<table>
<thead>
<tr>
<th>Code</th>
<th>Probing depth (By WHO Probe)</th>
<th>Observations</th>
</tr>
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</table>
| 0    | Pockets < 3.5mm             | First black band completely visible  
Healthy periodontal tissues  
No calculus/overhangs  
No bleeding on probing |
| 1    | Pockets < 3.5mm             | First black band completely visible  
Bleeding on probing  
No calculus/overhangs |
| 2    | Pockets < 3.5mm             | First black band completely visible  
Supra or subgingival calculus or plaque retention factor  
(overhangs etc) |
| 3    | Probing depth (3.5 - 5.5mm) | First black band partially visible, indicating pocket of 4-5mm |
| 4    | Probing depth > 5.5mm       | First black band entirely within the pocket, indicating pocket of 6 mm or more |
| *    |                             | Furcation involvement, ability,  
mucogingival problems or recession  
(indicating 3.5 mm or greater)*  
Detection of a furcation, mobility, recession and any  
mucogingival problem |

Table 3: Guidance tool on interpretation of codes

<table>
<thead>
<tr>
<th>Interpretation of codes</th>
<th>Guidance</th>
<th>Special investigations</th>
<th>Periodontal reassessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No need for periodontal treatment</td>
<td>None indicated</td>
<td>Repeat coding at next appointment</td>
</tr>
<tr>
<td>1</td>
<td>Oral hygiene instruction (OHI)</td>
<td>Plaque and bleeding charts</td>
<td>Repeat coding at next check up appointment</td>
</tr>
<tr>
<td>2</td>
<td>As for code 1, plus removal of plaque retentive factors, including all supra and subgingival calculus</td>
<td>Plaque and bleeding charts</td>
<td>Repeat coding at next check up appointment</td>
</tr>
<tr>
<td>3</td>
<td>As for code 2 and OHI, root surface debridement (RSD) if required</td>
<td>Plaque and bleeding charts</td>
<td>Periodontal charting of sextants scoring 3, after initial therapy</td>
</tr>
<tr>
<td>4</td>
<td>OHI, RSD. Assess the need for more complex treatment; referral to a specialist may be indicated</td>
<td>Plaque and bleeding charts</td>
<td>Full periodontal charting before and after treatment</td>
</tr>
<tr>
<td>*</td>
<td>Treat according to codes (0-4). Assess the need for more complex treatment; referral to a specialist may be indicated</td>
<td>Plaque and bleeding charts</td>
<td>Full periodontal charting before and after treatment</td>
</tr>
</tbody>
</table>

For the patients with score of 3-4 and/or *, a detailed charting is recommended.

*Migration to be added in the * category in future editions based on clinical validation.
**Box 2: Expert consensus on charting (For each sextant)**

(Representative for one sextant)

**Probing depth**

<table>
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**Bleeding on Probing**

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**Radiographic Bone loss**

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Once the probing depth, bleeding on probing and radiographic bone loss is charted, clinical attachment loss can be calculated and charted.

**Recording of *”**

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The experts were of the opinion that the general dental practitioner should take cognizance of key clinical features, which along with proper screening and charting (wherever required) should help him reach a proper diagnosis and subsequently a viable treatment plan as well.

**Risk Assessment:**

Patient care is evolving from a restorative approach to a more preventive and long-standing maintenance therapy. It is based on, observations of important clinical features, including risk assessment. Screening and charting forms make an integral part of the disease management paradigm.

A note should be made of local risk factors which are generally modifiable like plaque, calculus, improper contoured restorations, malpositioned teeth etc.

The presence or absence of **systemic risk factors** should also be noted. Some of these risk factors fall under modifiable category like smoking and some are under non-modifiable category like diabetes, genetics, aging etc. Visual inspection of gingival soft tissues for signs of inflammation, redness or change in contour of the gingival margins or presence of interdental papillae should be noted.

The experts felt that the following points should be kept in mind while assessing a patient’s risk to periodontal disease:

- An updated medical history of the patient
- Smoking History
- Relevant questions to understand current dental health status
  - Bleeding gums
  - Loose teeth
  - Ability to chew
  - Bad taste or smell from the mouth
  - Pain
  - Presence or frequency of occurrence of blisters or boils
- Visual inspection at every visit
- Appropriate charting and recording using standardized formats

### 3.4 Diagnosis and Referrals

The experts opined that major clinical features which distinguish periodontal diseases should be the key to diagnosis after the initial screening and charting is performed. Based on this an age group specific clinical feature list was agreed on, which should be known to the general dental practitioner at a basic level since they may be indicative of either an existent or impending periodontal disease. **(Table 4)**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Important C/F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &lt;15 years</td>
<td>BOP</td>
</tr>
<tr>
<td>Young Adults (15-30 years)</td>
<td>BOP, Mobility, Deep Pockets</td>
</tr>
<tr>
<td>Older Adults (&gt;30 years)</td>
<td>BOP, Mobility, Unexplained tooth loss, Increased space between teeth, Thermal sensitivity in absence of caries, Interdental itching, Pain on chewing, Food lodgment</td>
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</table>

BOP: Bleeding on probing
Referrals
Evidence suggests that an increasing number of patients would benefit from periodontal specialty care. Clearly, there has been some confusion regarding periodontal treatment, continued re-evaluation of its effectiveness and at what point a periodontist should be consulted as a member of the patient's treatment team. Guidelines can help the entire dental team in the timely identification of patients with periodontal diseases and those most appropriate for specialty care.\(^{21}\)

The experts strongly felt that expert interventions at the right time can greatly improve patient outcomes. However, there is a dearth of protocols on referrals in the Indian scenario. The panel discussed and suggested the best time for referrals and follow ups during the treatment process.

Time for specialist interventions
- At the time of screening and diagnosis for complicated cases
- At the time of treatment planning
- At the time of management of advanced periodontitis cases

Since a referral mechanism at the time of diagnosis is important, another tool, which helps the general dentist decide on referrals, on the basis of clinical features, was also suggested (Box 3).

Box 3: Clinical Features at the time of diagnosis ‘for a ‘YES’ ‘NO’ or ‘MAY BE’ Referral Decision

<table>
<thead>
<tr>
<th>YES referral decision</th>
<th>Advanced destruction cases, mobility, &gt;5mm pocket depth</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO referral decision</td>
<td>Bleeding without mobility or no deep pockets or no bone loss</td>
</tr>
<tr>
<td>MAYBE referral decision</td>
<td>&lt;5mm depth, other indications (aesthetics) depending on skill of the general practitioner</td>
</tr>
</tbody>
</table>

Post treatment ‘follow-up’ protocol to be decided by the periodontist especially in the surgical treatment cases based on systemic factors or other disease complications.

3.5 Treatment strategy

Literature review shows that treatment of periodontal disease can be broadly divided into two, viz non-surgical and surgical treatment. The expert panel confirmed the validity and application of various surgical procedures in the treatment of periodontal diseases. However, the committee felt that the surgical procedures should be referred to and performed by periodontists.

Non-surgical procedures are the cornerstone and the very first fundamental step in periodontal therapy and can be well performed by the general practitioner. These would mainly include oral hygiene instructions (OHI) and scaling and root planing (SRP).

OHI:
OHI, the panel felt, was an important part of periodontal therapy as it brings about a certain degree of behavioral changes in the lifestyle of patients and positively influences periodontal health. The TIPPS method as elaborated in the BSP ‘The Good Practitioners Guide to Periodontology’ found favor with the panel also. It comprises of 5 elements viz. Talk, Instruct, ask the patient to Practice, agree on a Plan and provide Support. It is an effective medium of communicating all aspects of OHI to the patient and can be easily incorporated by the general practitioner in his practice domain.

SRP:
SRP is a procedure that can be easily performed by the general practitioner and is considered the ‘gold standard’ for initial treatment of periodontal disease. The panel consented that if effectively done, SRP can produce effective plaque control and reduce progression of periodontitis.

The panel felt that although SRP looks easy, it is a difficult skill to master due to the complexities of access to the root anatomy, furcations and the grooves. There are also differences where use of hand instruments or powered scalers are concerned. It is important that the practitioner uses the equipment which he is most comfortable and can obtain best results with. Referring patients to a periodontist in case of inability to perform a proper SRP or in cases of complications is recommended by the panel.

Laser:
The panel agreed to the effectiveness of laser use as an adjunct to surgical or non-surgical procedures. However, it was pointed out that there is a lack of evidence concerning the efficacy of laser treatment alone for the treatment of periodontal diseases.

Surgical Periodontal treatment:
After completion of non-surgical treatment in cases of moderate to advanced disease, and despite good oral hygiene maintenance, there may still be residual pocket depths and bleeding on probing. Such patients require additional treatment care as periodontal surgical therapy for controlling or eliminating periodontal disease. Periodontal surgical procedures aim at restoration of lost periodontal tissues by bone and gum grafting procedures. Further, correction of anatomic conditions that may favor periodontal disease, impair esthetics, or impede the placement of correct prosthetics, including oral implant placements, is also achieved by surgical techniques. Periodontal surgery should only be considered in well-motivated patients and the presence of optimal plaque and risk factor control and essentially specialist care may be availed considering the relevant expertise, skill and experience of the general dentist.

Supportive periodontal treatment (SPT):
Supportive periodontal treatment is needed for all patients who have been treated for periodontal disease. It is initiated after completion of active periodontal therapy. Though usually scheduled every three months, this phase should continue at varying intervals based on the individual risk profile of the patient. Supportive periodontal treatment should include an update of medical and dental histories, radiographic review, extraoral and intraoral soft tissue examination, dental examination, periodontal evaluation, removal of bacterial plaque from the supragingival and subgingival regions, scaling and root planing where indicated, polishing of the teeth and a review of the patient’s plaque control efficacy and other appropriate behavior modification. The patients may move back into active care if the disease undergoes a period of exacerbation. It is vital for the long term health full functioning of the treated dentition by assisting the patient in oral hygiene maintenance and a very early diagnosis and management of recurrent episode of periodontal disease. The committee was of the opinion that a routine SPT case falls very much in the realm of the general practitioner. However, cases of exacerbation or non-resolving clinical situations should best be handled with the intervention of the specialist.
Basic tool kit for general dental practitioners

The expert panel suggested a basic tool kit for every dental clinic for procedures to be performed by the general dental practitioner. (Box 4)

Box 4: Contents of a ‘Basic Tool Kit’ for SRP

1. WHO probe
2. 15/30 scaler
3. Ultrasonic scaler with multiple tips
4. Universal curette
5. Universal scaler
6. Disclosing agent

3.6 Halitosis and Dentine Hypersensitivity

The expert panel confirmed the need to add halitosis and DHS as a part of the periodontal disease spectrum. Both these diseases are highly underdiagnosed in the Indian scenario and the general dentists need to understand the etiology and risk factors of these diseases and their association with periodontal diseases.

The under-diagnosis of DHS was attributed to the following factors:

- Easy availability of medicated dentifrices as over-the-counter products.
- Marketing of products which influences the decision of the practitioner. The scientific nature of the product should form the basis for prescription e.g. A meta-analysis conducted by Bae et al. published in The Journal of Periodontology in 2015 concluded that “there is sufficient evidence to support the use of Arginine-, Potassium-, stannous fluoride- & calcium sodium phosphosilicate- containing desensitizing toothpaste for dentin hypersensitivity, but not the use of strontium-containing desensitizing toothpaste”

Control of advertisements of OTC desensitizing products

The panel stressed the need to place a degree of control on advertisements of desensitizing products which are being sold over the counter. The following points were suggested to bring about the control on advertising of OTC desensitizing products:

- Wrong or exaggerated product advertisements leading to under diagnosis and masking of underlying condition
- Suggestion to the policy makers to remove over-the-counter (OTC) label. Desensitizing products that have an active ingredient to treat DHS should be prescription based, as in other countries
- Measured use of OTC products containing medicated pharmaceutical agents should be advocated

3.7 Peri-implant disease

The experts concurred with the current evidence on the increasing number of dental implants taking place in clinical practice. Currently there are no clear-cut guidelines for preventive implant care and patients are not being adequately informed about performing oral hygiene procedures post the implant restoration, which could lead to peri-implant diseases and subsequently implant loss.

Suggested basic maintenance protocols for patients with implants:

- The patient needs to be aware that peri-implant tissue is likely to wear off earlier, faster than the tissue around a natural tooth and needs to be taken care of in a more pro-active manner
- Oral hygiene instructions (brushing, inter dental brushes, floss, & irrigations) should be provided to the patient

Post-surgical patient handling

The panel agreed that post-surgical patient handling should be an integrated effort of both the periodontist and a prosthodontist.
Conclusion

Periodontal diseases remain very common. Whilst early stages may be symptom-free, the impact on peoples’ lives at later stages of the disease is quite significant. With almost 90% of the Indian population being affected by periodontal disease, it is now the need of the hour that an India specific ‘Best Practice Guideline’ is formulated that will improve the quality of care.

This report developed by a committee of experts (Honorable members of the Indian Society of Periodontology, representatives from the Indian Society of Prosthodontics and Orthodontics, Endocrinologist and general dentists) is to our knowledge the first of its kind held with an aim to formulate a Good Practice Guideline to better address the issue of patient care with periodontal disease in general dental practice.

These key consensus recommendations combine scientific evidence and clinical experience. The objective is to create a ‘Good Practice Recommendation’ that will help general dentists and other medical practitioners reduce the overall burden and correctly treat periodontal diseases in the Indian population.

Future Directions

A few suggestions that could be incorporated in the subsequent versions of the guidelines were put forward by the committee.

- ‘Conjoined Recommendations’ to overcome the definite lack of awareness among other medical colleagues with respect to systemic disease as a risk factor to periodontal disease and vice versa. Diabetes associations do recommend annual oral health check-up as a part of the protocol, but it is rarely followed in clinical practice. ISP together with other medical associations should endeavor setting out a ‘conjoined recommendations’ collaboratively.

- ‘Pull-Outs’ in the guidelines explaining probing depth & attachment loss, morning breath & malodor, explorer and probe, OPG or IOPAs, SPT and maintenance, screening and charting, pocket reduction surgery and regenerative surgery were suggested.

- Preparation of a referral form: The experts also felt the need to prepare a template for referral forms to ensure uniform flow of relevant information and seamless delegation of responsibilities in the treatment protocol of periodontal patients.

- A channel to initiate ‘hand-holding’ of non-periodontist colleagues which could impart training via webinars, Training of Practitioners (TOP) workshops or master programs.
References:


