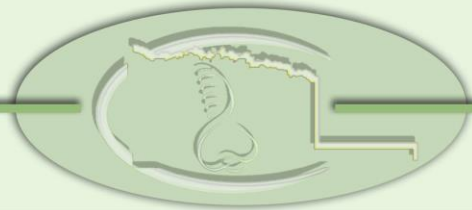


If you plan to attend and would like to request a reminder phone call or email the day prior to the reception, please call our office at 405-636-1411 to be placed on the reminder list - or email us at okperioimplantcenter@yahoo.com

Please join us on May 29th, between 4:30 and 6:30pm, for wine and hors d'oeuvres as we welcome Dr. Bowers to our south office with an open house reception.

Introducing Our New Associate, Dr. Blaire Bowers

Save the Date
May 29th



Periodontal Implant Center

Jacob D. Hager, DDS, MS

8203 S. Walker

Oklahoma City, OK 73139

Periodontal News



A Recurring Publication from the Periodontal Implant Center ♦ No. 12, April 2014

Jacob Hager, DDS, MS ♦ Board Certified by the American Board of Periodontology



Meet Our New Associate – Dr. Blaire Bowers

The Periodontal Implant Center is pleased to announce the arrival of a new periodontist to our south Oklahoma City practice – Dr. Blaire Bowers.

Dr. Bowers grew up in Shawnee, Oklahoma. She attended the University of Oklahoma for both undergraduate and dental school. After graduating dental school, she completed a General Practice Residency at the University of Colorado in Denver, Colorado. She then returned to her “Sooner born and Sooner bred roots” to seek a Master of Science in Periodontics from the OU College of Dentistry, where she graduated in May of 2014. Blaire attends Crossings Community Church in Edmond, OK. In her spare, she enjoys gardening, cooking, fitness and spending time with her family.

Please join us in welcoming Dr. Bowers to our practice at a come-and-go reception on May 29th from 4:30 to 6:30 pm at our south OKC location, 8203 S. Walker – just south of I-240 on Walker.

Managing Lichen Planus

Lichen Planus is a relatively common autoimmune disorder that can affect both the gingiva and mucosal surfaces of the mouth. It is characterized by an inflammatory cell infiltrate of the spinous epithelial layer and requires biopsy and microscopic interpretation for formal diagnosis. Lichen Planus is a chronic disease that cannot be cured – symptoms can be managed with topical steroids and analgesics (*see below*). The demographic most affected is middle to late-aged females. Severity of the lesions can be exacerbated by poor plaque control, lack of adequate marginal gingiva and acidic/spicy foods.

Topical Steroid Options for Lichen Planus

Dexamethasone Elixir (sugar free), dispense 500ml, use 5ml 5 times daily for 3 weeks, repeat as needed

Lidex ointment, dispense 15 grams, apply to ulcerations 5 times daily for three weeks, repeat as needed

Tacrolimus ointment 0.1% (*immunosuppressant*), dispense 15 grams, apply to ulcerations 2 times daily for two weeks, repeat as needed

Topical Analgesic Option for Lichen Planus

Viscous lidocaine 2%, dispense 250ml, rinse orally with 5ml for 30 seconds and spit out, use as-needed



Our office is located in OKC just south of I-240 on Walker in the Willow Brook Gardens Condominiums.

Offering your patients the highest level of periodontal and implant services

Contact Us

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Managing Peri-Implant Infections

The Key is Prevention

Below are simple guidelines to help reduce the occurrence of peri-implant infections in your office.

1) Limit implant placement to patients that smoke less than 10 cigarettes a day (*implant complications increase greatly in patients that smoke more than a half-pack per day – as much as 50%*).

2) Avoid implant placement in poorly controlled diabetics (*check to make sure that a diabetic patient's last A1c level was less than 7.5 – an indicator of glycemic control over the last 4-6 months*).

3) Avoid implant placement in a deficient alveolus. Exposed threads at the time of placement are a significant risk for later complications. Three-dimensional imaging with a CT scan is recommended for any planned implant site that is suspected of a lateral bone deficiency.

4) Prevent cement extrusion onto the abutment / implant collar (*best accomplished by keeping cement lines no more than 2mm subgingival – custom abutments are usually needed to accomplish this in anterior sites. Also important to use minimal cement at the time of prosthetic delivery and take post-delivery radiographs to check for cement extrusion.*)

5) Work with an experienced implant lab that will prevent poorly contoured or over-contoured implant restorations that are prone to increasing plaque accumulation.

6) Minimize off-axis occlusal contacts on final implant restorations.

7) Provide detailed oral hygiene instruction for patients with implant restorations and encourage the use of floss and an interdental proxabrush that can remove plaque at the level of the implant collar / cement margin

Initial Non-Surgical Therapy for Peri-Implantitis

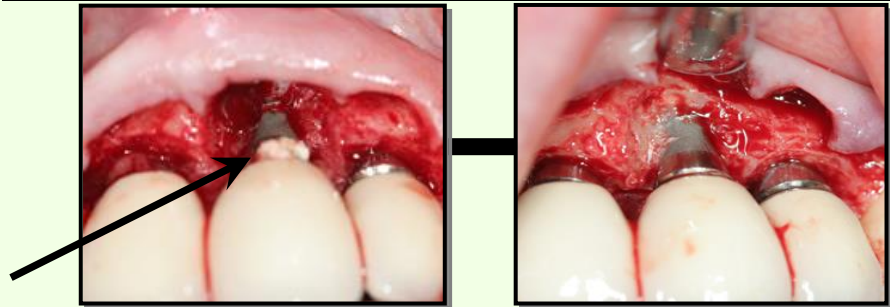
Determining the primary etiology and addressing modifiable risk factors are the keys to non-surgical management of peri-implantitis.

- Heavy smoking / diabetic control?
- Adequate plaque control?
- Subgingival calculus / bacterial biofilm?
- Retained cement?
- Lateral / off-axis occlusal contacts?
- Poor restoration contours contributing to plaque accumulation?
- Inadequate peri-implant attached gingiva?

**If the peri-implant infection occurs shortly after delivery of the final restoration, retained cement should be suspected.*

Non-surgical debridement with curettes (*plastic, titanium, gold*) or specifically designed Cavitron tips is recommended. Supplementation with local antibiotics (*Arestin*) is also an advisable adjunct. Surgical intervention or referral should be considered if peri-implant infection does not respond to initial non-surgical therapy, bone loss extends beyond the second thread radiographically or clinical pocketing exceeds 6mm.

Surgical Therapy for Peri-Implantitis



Implants placed 7 years prior to examination in our office. Longstanding history of peri-implant inflammation with recent acute abscess formation facial to #9. Flap debridement recommended due to 10mm pocketing and severe infection – surgical entry revealed a large accumulation of cement on the implant collar. Site treated with debridement, decontamination and grafting with particulate bone graft.



Implants placed 6 years prior to examination in our office. Longstanding history of peri-implant inflammation with recent acute abscess formation facial to #6 and pocketing 7mm. Surgical debridement revealed ledged, overhanging crown contours that were corrected by the addition of composite resin to create a convex shape from the crown ledge to the implant collar.

Gingival Overgrowth Associated with Calcium Channel Blockers

Overview

Gingival overgrowth associated with a certain class of anti-hypertensive medications / calcium channel blockers can be a significant complicating factor in the periodontal disease process. Medication-induced gingival overgrowth from calcium channel blockers is well documented in the periodontal literature. In the susceptible individual, the medication increases the proliferative potential of the oral gingiva – especially in the presence of active inflammation.

It should be noted, that patients taking a calcium channel blocker who have a naturally thin tissue type and excellent daily plaque control will rarely be affected by gingival overgrowth. Conversely, the patient with poor plaque control, thicker baseline gingival biotype and subgingival inflammatory etiology (i.e. calculus accumulations or subgingival restorative margins) is at much higher risk for gingival overgrowth associated with calcium channel blockers.

Treatment goals for this class of patients are early recognition, removal of subgingival inflammatory etiologies and ideal plaque control. For those patients with advanced overgrowth, surgical resection of excess gingiva is usually the only option for treatment. It is important to understand that discontinuing the medication will not result in a decrease of tissue mass – once the hypertrophy has occurred it is only reversible with surgical excision. Medical consultation to discontinue / switch blood pressure medications should be considered for those individuals that are most severely affected.

Common Calcium Channel Blockers

- Nifedipine
- Amlodipine
- Verapamil
- Diltiazem
- Caduet (Amlodipine and ‘-statin’ drug)

*Please email our office at okperioimplantcenter@yahoo.com if you would like a copy of the medical consultation letter we send to a patient’s physician / cardiologist requesting a possible change in blood pressure medications if gingival overgrowth associated with the use of a calcium channel blocker is suspected.



Classic appearance of gingival overgrowth associated with the use of calcium channel blockers. Note the edematous papillae, pebbled surface texture and tissue position well above the CEJ’s.



Before and after surgical resection of the excess hypertrophied gingiva. Note the many subgingival restorative margins that were initially present and contributing to plaque retention and chronic inflammation.