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Periodontal Implant Center
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Periodontal News

A Recurring Publication from the Periodontal Implant Center ♦ No. 6, February 2011
Jacob Hager, DDS, MS ♦ Board Certified by the American Board of Periodontology

Our goal is to function as an extension of your office, offering your patients the highest level of periodontal and implant services.

In doing so, we are committed to the highest level of inter–office communication and promise that you will always know what treatments your patients are receiving in our clinic.

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- Journal Watch - Featured Article

El-Sharkawy, et al. **Adjunctive Treatment of Chronic Periodontitis with Daily Dietary Supplementation with Omega-3 Fatty Acids and Low-Dose Aspirin.** *Journal of Periodontology. Vol. 8, No 11, 2010.*

Although periodontal diseases are associated with specific pathogenic bacteria, research over the last two decades has revealed that most of the tissue damage caused by periodontal disease is a result of the host's inflammatory response to the infection and not by the infectious agents directly.

Intuitively, any treatment that can reduce the destructive effects of the host inflammatory response should improve the outcomes of periodontal therapy.

Periostat (20mg doxycycline) was developed in 1992 for adjunctive use with root planing. The main function of Periostat is to decrease the activity of host MMP-8, an enzyme that breaks down collagen. Research estimates additional attachment gains of 0.3 to 0.5mm with the use of Periostat vs. root planing alone. Periostat cost per month is $60-$90 and requires a prescription. The FDA recommends treatment with Periostat be limited to 9 months.

The current study, evaluated the adjunctive benefit of 900mg Fish Oil *(omega-3 polyunsaturated fatty acids)* and 81mg aspirin with root planing.

80 severe periodontitis patients were randomly split into two groups: one receiving daily fish oil and aspirin with root planing and one with root planing alone. Results were assessed at 3 and 6 months post root planing.

The test group had statistically significant improvements in probing depth reduction and clinical attachment gains compared to the *(continued on page 3)*

Patient Selection for Root Coverage Grafting

There are many questions that must be answered prior to making the decision to treat an exposed root with a tissue graft. As I tell patients referred for grafting - recession alone is not a sufficient indication for treatment. Below are simple guidelines to use in considering patients for root coverage grafting.

- **Esthetic complaint:** Particularly across the anterior maxilla, if a patient is complaining of a "long tooth" due to recession, a root coverage graft may be esthetically preferable to a class V composite.
- **Thermal complaint:** For areas without interproximal bone loss, root coverage grafting can predictably reduce thermal sensitivity.
- **More than 4mm of recession:** This amount of recession would indicate a facial bone level 6mm from the CEJ – an amount of bone loss equal to severe periodontal disease. Mobility now becomes a serious concern if the area suffers additional attachment loss and tissue grafting should therefore be considered.

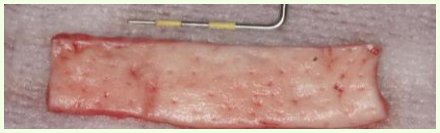
Genetically thin biotype with generalized recession: A small number of patients have attached gingiva that is so thin and friable that facial attachment levels will not hold up to normal wear and tear from mastication and tooth brushing.

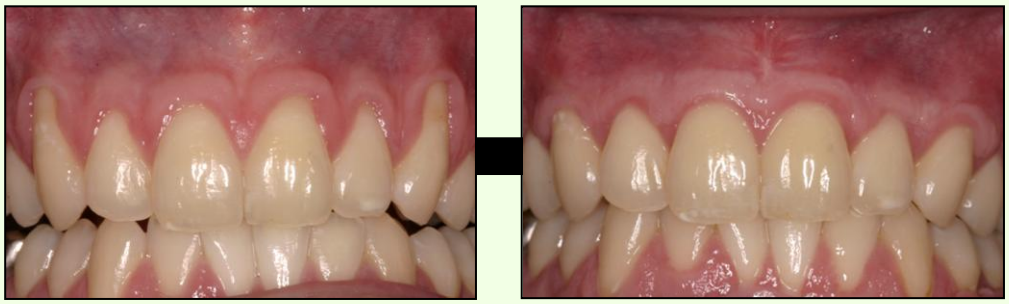
- **Shallow root caries:** As an option to a composite restoration, tissue grafting can sometimes offer a better esthetic result and better long term stability for esthetic sites with shallow class V caries.

Two key points to remember when managing and referring patients with recession defects: 1) **root coverage grafting is only an option if interproximal bone levels are ideal**, and 2) long term stability of these areas requires correction of any factors that initially contributed to the recession defect (such as aggressive tooth brushing)

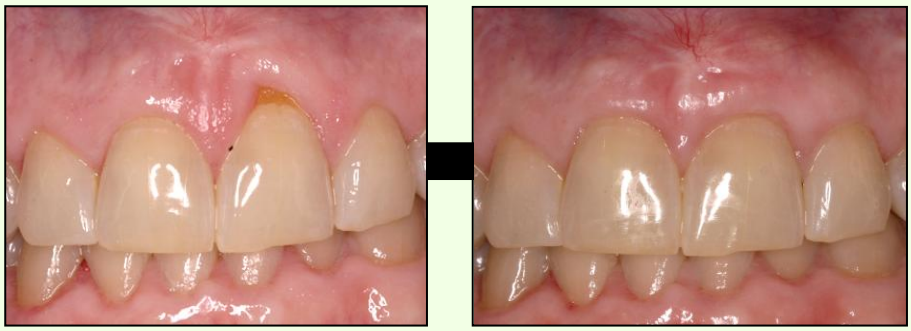
Tissue Grafting for Root Coverage

27 year old male with an esthetic complaint of recession involving maxillary anterior teeth. Treatment was rendered with a single procedure utilizing a donor tissue allograft.

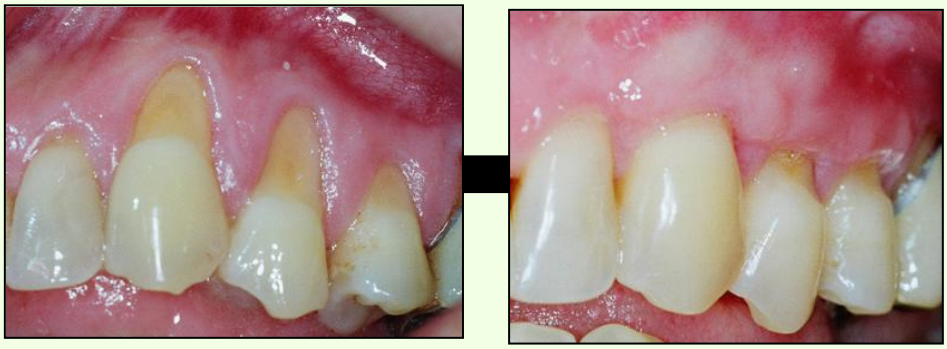




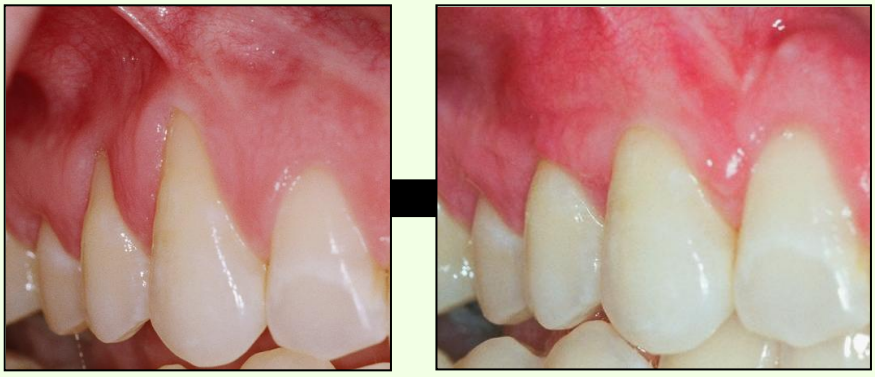
50 year old female with esthetically compromising gingival defect involving tooth #9. Shallow root caries is also noted. Treatment options include a class V composite that would not address the gingival asymmetry, or a connective tissue graft that can cover the root after caries removal and also establish proper gingival esthetics. A palatal graft was utilized for this case.



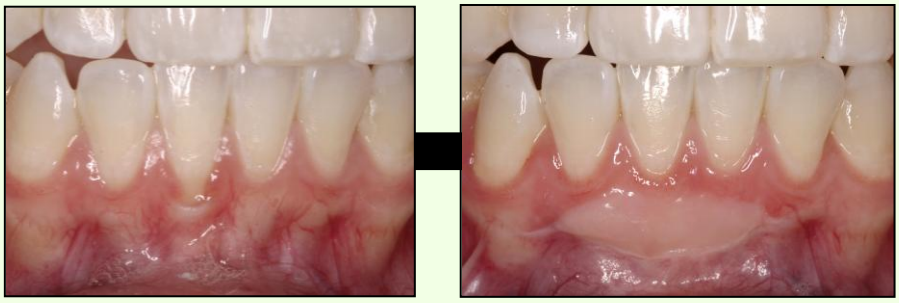
54 year old female with a chief concern of progressive gingival recession. Traumatic toothbrushing was suspected and addressed with oral hygiene counseling. A tissue allograft was utilized for this case placed under a coronally advanced flap. *Note the full interproximal papillas and lack of interproximal bone loss. Note also the residual cervical defects #12 & #13 represent enamel lost from cervical abfraction.*



24 year old female with thin attached gingiva across #6 causing thermal sensitivity and esthetic compromise. The lack of interproximal bone loss and full papillas enables complete coverage with a traditional connective tissue graft taken from a palatal donor site. Long term stability will depend greatly on the patient's ability to perform atraumatic oral hygiene.



When attached gingiva is completely absent, a traditional gingival graft is still the treatment of choice to prevent further attachment loss. In some cases, such as the one shown here, root coverage can be achieved with a gingival grafting procedure. Other times, root coverage is not possible.



- Featured Article-

(continued from page 1)

control groups at both 3 and 6 months *(nearly 1mm additional improvement in clinical attachment gain and pocket depth reduction for the test group after 6 months).* Salivary markers of inflammation and bone resorption were also significantly reduced for the test group after 6 months compared to the control group.

The interactive relationship of omega 3 fatty acids and aspirin on reducing the destructive effects of inflammation remain an area of intense research. The two drugs are believed to potentiate the effects of one another.

The monthly cost of supplementation with 900mg fish oil and 81mg aspirin is $15-20 without the need for a prescription. Apart from a very low risk of increased bleeding time, there are no significant risks with long term use of these supplements. Additional systemic benefits, such as decreasing a patient's risk for stroke and/or heart attack, have been shown by multiple other studies with the use of low dose aspirin and omega 3 fatty acids.

Our office is currently implementing supplemental dietary recommendations that can reduce the effects of inflammation in the progression of periodontal disease. These recommendations will definitely include 900mg of daily fish oil and low-dose 81mg aspirin for all patients undergoing initial therapy / root planing and for patients who remain on periodontal maintenance with a history of moderate to severe periodontal disease. Similar recommendations are suggested for the periodontal patients of any general dental practice.

Please contact our office with any questions regarding this article or for a full text copy of the article.

Free Lunch CE

Call or email us to set up a short continuing education course for you and your staff over the lunch hour. Food is on us and signed CE cards will be provided. Pick your topic:

1) Dental Implants - General Principles and Case Planning.

2) Implants in the Esthetic Zone – A Simplified Approach to Custom Abutments.

3) Utilizing implant locator attachments to retain dentures and partial dentures.

To reserve a date, ask for Amanda at 405-636-1411, or email at okperioimplantcenter@yahoo.com

Service Highlight

With many respects, the productivity and efficiency of a dental practice is greatly influenced by the various companies chosen to assist with daily operations, equipment integration, management and/or repairs. Choosing the best support team can have dramatic effects on practice success.

Randy Draper, Elite Dental LLC, has proved to be an invaluable asset to my practice for over 3 years. As a locally owned equipment repair and service specialist, I highly recommend you consider making Elite Dental a part of your dental team.

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Randy Draper, Owner
Business phone: 405-222-8499
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Locator Attachment Tips

Locator attachments require less vertical space (3mm) than any other means of retaining a dental prosthesis with implants *(ERA or ball clasp)*

Two implants minimum to retain a lower denture. Four implants minimum for maxillary denture.

Locator attachments are meant to retain a dental prosthesis – *not support it*. The denture should rest fully on the edentulous ridge.

Only 1-2mm of abutment sleeve should be visible above the tissue level. Any longer and the risk of locking the denture in the patient's mouth during processing increases significantly.

Order of strength for locator inserts:
(Least) Black - Blue - Pink - Clear *(Most)*

Locator housings can be processed into the denture in two ways: 1) by your lab after a simple transfer impression, or 2) with a chair-side technique using an autopolymerizing acrylic resin such as *Mucohard* made by Parkell.

When processing the locator housings into the denture with a chair-side technique, the white gasket should always be used to prevent locking the denture onto the implants.

Transfer marking pencils made by *Great Plains Dental Products, 1-800-962-7612* are a great way to transfer the position of the locator abutments to the underside of the denture for very accurate relief adjustments.

Insurance codes for locator overdentures
Locator Denture: 6053
Locator Partial: 6054
Locator Abutment Placement: 6056
Replacement of retentive insert: 6091
Overdenture Repair: 6090

After seating the final locator abutments, we provide all the necessary components *(retentive housings, impression copings, and analogs)* to complete the case in your office.