What I implemented in the company approach on Sonicare, the electronic toothbrush.

I was completely on the academic side when Philips approached me, and I joined them three years ago. What I implemented in the company was this whole evidence-based approach. Before I joined Philips, they had all these great studies that they had done, but they didn’t really focus as much on getting the publications to the professionals. We just assumed that once people tried Sonicare, they would love it. But then my focus shifted and thought, let’s publish these papers and show our peers and colleagues why they should recommend Sonicare based on evidence.

In that case, they are not just recommending Sonicare because they like the product. Often, we would hear dentists or dental hygienists say, I know it is working because when my patients come back they have fewer splitting gingivae. They could all see the clinical results, but our approach needed to be evidence-based. Patients loved the product, it was just that the scientific part was missing, which is what we see now with the Journal of Clinical Dentistry, launched at the International Dental Show, with five studies that were published in this peer-reviewed journal.

In this special issue, you will find five papers. The first two are randomised control trials looking at Sonicare versus manual toothbrushes. Two randomly assigned groups are compared after one group receives a manual toothbrush and the other, a Diamond Clean. Not surprisingly, of course, Sonicare performed significantly better in the areas of plaque removal and gingival health.

In the first study, we saw that the Philips Sonicare FlexCare power toothbrush was statistically significantly more effective than a manual toothbrush in reducing supragingival plaque, gingival inflammation and gingival bleeding.

The second study showed that the Philips Sonicare AirFloss with the Premium Plaque Control brush head significantly reduced gingival inflammation, gingival bleeding and plaque following only six weeks of home use, compared with manual toothbrushing alone. This is how we substantiated the claim, “Up to ten times more plaque removal.”

The Sonicare toothbrush has flexible sides, allowing it more coverage of a larger surface area.

The objective of the third study was to evaluate the short-term clinical efficacy of high-frequency, high-amplitude sonic-powered toothbrushes compared with manual toothbrushes in plaque removal and gingivitis reduction in everyday use, through a meta-analysis of randomised controlled trials. The combined results of 18 studies with a total of 1,179 subjects showed that sonic-powered toothbrushes had significantly greater plaque removal. In conclusion, high-frequency, high-amplitude sonic-powered toothbrushes decreased plaque and gingivitis more effectively than manual toothbrushes in everyday use, in studies lasting up to three months.

Of course, studies one, two and three confirm that Sonic technology is superior to the manual toothbrush.

Study four is a head-to-head study done by an independent research organisation to compare the effect of the Philips Sonicare Diamond Clean toothbrush used with the Premium Plaque Control brush head to the Oral-B Pro 4000 used with the CrossAction brush head on gingivitis and supragingival plaque reduction. In the results, we can see that the numbers were significantly better than with the other technology.

The fifth study is moving away from simply brushing your teeth to using AirFloss in between your teeth as well. The addition of interproximal cleaning to manual toothbrushing is statistically proven to significantly reduce gingivitis and plaque compared with manual toothbrushing alone. Among the adjacent interproximal cleaning regimens, AirFlossPro provides a similar reduction in gingivitis and plaque to string floss.

The question now is: shall I change from a manual toothbrush to an electric one? Of course, it is a health tech and everything else that people associate with Philips, it is a tech company that has everything from diagnosis to home treatment to prevention, and we are really focusing on the holistic approach so that the FDI’s World Oral Health Day is about increasing awareness of the oral systemic link. That’s why a partnership with the FDI is perfect because it increases public awareness and helps you make the smart decision about what you are using in daily care. Many people are still unaware of good oral health care, especially in this region. They still use manual toothbrushes, which means we still have plenty of work, but I think we have more to do in education.
Pregnant women are hardly informed about the importance of oral health

By DTI

A new mother herself, pregnancy gingivitis has become a subject close to Dr Anja Carina Borer’s heart. She set up a joint campaign between Oral-B and the European Federation of Periodontology (EFP), which promotes oral health during pregnancy and educates health professionals and the wider public on the issue. Originally trained as a dentist in Mainz in Germany, Anja now serves as Professional and Scientific Relations Manager Europe at Procter & Gamble in Geneva in Switzerland, where we met with her for some questions and answers on the subject. Fittingly, she brought along her four-month-old daughter, who cooed quietly in her pram throughout the interview.

Oral-B and the EFP have touched upon a very important and personal topic, in that periodontal disease could affect the developing baby. Dr Anja Carina Borer: Yes. Gingivitis is a well-known side-effect during pregnancy and the latest data shows that practically every pregnant woman suffers from it. The number of bleeding sites is about three times higher in pregnant women than in the average adult. Even I, a dentist equipped with more than enough scientifically sound Oral-B products, experienced some gingival bleeding for the first time in my life. As we know, untreated gingivitis can lead to periodontitis, the inflammatory burden of which can negatively impact pregnancy. Although more consistent in-depth studies are necessary, periodontitis during pregnancy has already been linked with premature birth, low birthweight and pre-eclampsia. This topic is important as most pregnant women are not aware of this problem and therefore often do not recognize the warning signs of gum problems such as bleeding or sensitive gums. With our campaign, we want to inform women and make sure they take good care of their oral health and see a dental professional in order to prevent possible oral health problems and pregnancy complications.

How can periodontitis lead to these complications?

Clinical studies suggest that bacteria from the oral cavity — specific microorganisms associated with periodontitis — colonize the foetus and the placenta, with blood as the most likely vehicle of transmission. As a consequence, the presence of periodontal bacteria in the feto-placental unit may activate a local immune or inflammatory response that might negatively affect the pregnancy.

Biologically, that makes perfect sense, but how widely accepted is this point of view? Although clinical research on the matter has existed for years, it is still a fairly neglected topic. Not only does it not receive enough attention from dental professionals, it is also largely overseen by healthcare professionals such as gynaecologists and midwives. When I was pregnant, I was warned about many potential risks, ranging from flying to eating sushi or dying my hair. I did enough research on the aforementioned “risks” to conclude that there is no scientific data to support these. However, no one — my gynaecologist included — told me to go and see a dental professional or take care of my oral health.

To me, this really is a very personal matter, as I fell pregnant while establishing the cooperation concerning pregnancy gingivitis with the EFP. I find it worrying that pregnant women are hardly ever informed about the importance of good oral health during pregnancy. Therefore, I was passionate about establishing the Oral-B/EFP cooperation and lead the joint campaign. Our aim is to better educate dental professionals and medical professionals in general, as well as the wider public, on the importance of good oral health during pregnancy.

Could you explain the changes in the bodies of pregnant women that cause pregnancy gingivitis?

The biggest hormonal changes in a woman’s life take place during pregnancy. It is a period of great change and obviously the mouth is one of the main areas affected by such changes, which in itself can lead to gingivitis.

It is not for nothing that people used to say that women gain a child and lose a tooth. During pregnancy, there is a 150 times increase in oestrogen compared with the amount during a normal menstrual cycle. This and the increase of progesterone and other hormones lead to an increased vascular permeability of gingival tissue, which promotes gingival inflammation in the presence of dental plaque. For women who have already developed periodontitis, the situation usually gets worse because of the changed hormonal situation.

Apart from cardiovascular disease, periodontal disease is known complication of diabetes. What is the risk of pregnant women with diabetes developing periodontitis?

For women who already have diabetes, the biggest challenge is to keep their blood sugar under control. Independent from this, a small percentage of women develop diabetes during pregnancy. Although this type of diabetes disappears after pregnancy, these women need treatment in order to avoid serious complications. Both groups, however, have a higher risk of developing periodontal disease. It is important to note that treatment is more likely to succeed if a person’s blood sugar levels are under control. Vice versa, periodontal disease also negatively impacts diabetes. Overall, it is important that women with diabetes take care of their oral health before and during pregnancy.

How do you integrate all of your findings in your Oral-B seminars?

Oral-B’s mission is to promote oral health and work closely with dental professionals to ensure optimal home care. Our collaboration with the EFP serves as a way to raise awareness about all matters concerning oral health during pregnancy. Our educational activities such as the Up-to-Date events are a way to communicate this and support dental professionals in their objective to improve oral health. We believe a healthy mouth is part of a healthy body and promoting good oral health during pregnancy is one way to help to achieve this.

Finally, what would your tips be for pregnant women?

Women who have periodontists must seek treatment before pregnancy, whereas women who enjoy good oral health should go and see a dentist or a dental hygienist in the second trimester for a dental cleaning. Of course, they should brush their teeth twice a day with a fluoride-containing toothpaste — even better is a antibacterial toothpaste containing stannous fluoride — and clean their teeth interdentally. It is scientifically proven that electric brushes such as our Genius toothbrush are particularly good for reducing plaque and gingival bleeding. Moreover, they are a practical solution for women who have less time to brush their teeth. There is no question that all mothers with a baby will know exactly what I am talking about...
**Preservation of root cementum: A comparative evaluation of power-driven versus hand instruments**

By Bozbay E, Dominici F, Golboget AF, Cintan S, Guida L, Aydin MS, Mariotti A, Piloni A, Italy

**Background**

Grenvik et al suggested that cementum plays an important regulatory role in periodontal regeneration. One of the major goals of periodontal treatment is the removal of pathogenic micro-organisms by scaling and root planing. In the past the misconception was to obtain a root surface with smooth and hard surface characteristics that was free of endotoxins which resulted in the removal of the subgingival plaque and calculus deposits, and the removal of all or most of the cementum. Recent studies have reported that endotoxins were not located within cementum and removal of ‘diseased’ cementum was not necessary for a successful periodontal treatment. Saygin et al concluded that preservation of cementum on the root surface was necessary for new attachment and as a source of growth factor. Hence non-aggressive removal of cementum is essential for optimal periodontal health and regeneration.

**Material and Methods**

- 48 caries free, single rooted teeth in 27 patients diagnosed with severe chronic periodontitis with periodontal probing depth (P.D.) 5 mm in at least two sites per tooth with radiographic loss of more than half of the thirds of root length and scheduled for extraction were included in the study
- Teeth were randomly divided into four treatment groups: Instrumentation as well as the surface remaining following in vivo root instrumentation was evaluated along with scratches, gouges, cracks, and any other changes in the cementum that was present.

**Results**

- Percentage of coronal cementum remaining following subgingival instrumentation was 84% for U, 80% for U + AP, 94% for AP and 65% for HC.
- The amount of retained cementum with AP was significantly greater than with HC + SEM.
- Smoothest root surfaces were produced by the HC followed by the AP.
- Control and apical sections showed that AP produced the least amount of cementum loss and therefore the greatest retention of residual cementum.
- Root surfaces instrumented by U or U + AP presented grooves and scratches.
- Time taken to complete root instrumentation:
  - Shortest time taken was using AP and the longest time was with U + AP.
  - AP required 31% less time for root preparation in comparison to HC, whereas U + AP needed 30% more time.

**Conclusions**

Air polishing was significantly more effective and superior in preserving cementum.

- Hand instrumentation using curettes was most effective in removing cementum in comparison to ultrasonics or hand instruments.

**Aim**

To assess the amount of cementum remaining following in vivo root instrumentation as well as the surface characteristics of the retained cementum.

**Background**

Ultrasonics with new shaped tips and subgingival air polishing devices has been developed for removal of root accretions with minimal root damage. Air polishing has been suggested as a treatment modality for root debridement resulting in probing depth reductions and removal of subgingival biofilm. No scientific evidence exists today showing the loss of root substance or surface roughness produced by either ultrasonics or Air polishing.

**Material and Methods**

- 48 caries free, single rooted teeth in 27 patients diagnosed with severe chronic periodontitis with periodontal probing depth (P.D.) 5 mm in at least two sites per tooth with radiographic loss of more than half of the thirds of root length and scheduled for extraction were included in this study.
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**Conclusions**

Air polishing was significantly more effective and superior in preserving cementum.

- Hand instrumentation using curettes was most effective in removing cementum in comparison to ultrasonics or hand instruments.
The study found that the prevalence of periodontal disease was increased in patients with RA and could be a key initiator of RA-related autoimmunity. This is because autoimmunity in RA is characterised by an antibody response to citrullinated proteins in which the amino acid arginine has been converted into citrulline, altering the proteins’ structure. The oral bacteria Porphyromonas gingivalis is the only human pathogen known to express an enzyme that can generate citrullinated proteins.

The study included 48 at-risk individuals (positive test for anti-citrullinated protein antibodies), 26 patients with RA and 52 healthy controls. The three groups were balanced regarding age, sex and smoking.

“it has been shown that RA-associated antibodies, such as anti-citrullinated protein antibodies, are present well before any evidence of joint disease. This suggests they originate from a site outside of the joints,” said study author Dr Kulfveer Mankia, clinical research fellow at the university’s Institute of Rheumatic and Musculoskeletal Medicine. “Our study is the first to describe clinical periodontal disease and the relative abundance of periodontal bacteria in these at-risk individuals. Our results support the hypothesis that local inflammation at mucosal surfaces, such as the gums in this case, may provide the primary trigger for the systemic autoimmunity seen in RA.”

“We welcome these data in presenting concepts that may enhance clinical understanding of the key initiators of rheumatoid arthritis,” said Prof Robert Landewé, Chairperson of the EULAR 2018 Scientific Programme Committee. “This is an essential step towards the ultimate goal of disease prevention.”

The study abstract is titled “An increased prevalence of periodontal disease, Porphyromonas gingivalis and Aggregatibacter actinomycetemcomitans in anti-CCP positive individuals at risk of inflammatory arthritis.”

Patient motivation techniques

By DTI
When it comes to motivating pa- tients to maintain good oral hygiene practices, a clear plan is essential given the time constraints of most den- tal appointments. What this plan en- tails, however, depends on what the most pressing issues to the patient are. Prevention magazine spoke with Sandy Basheda, a dental hygienist at M & N Dental Practice in Bedford in the UK, about how she structures her oral hygiene appointments and the importance of building relationships with patients.

Ms Basheda, how did you first get started as a dental hygienist at M & N Dental Practice?
Sandy Basheda: I’ve been working at M & N Dental Practice for three years now. I started basically straight after I graduated from the University of Liverpool with a degree in dental hygiene and therapy. Prior to that, I had a background in dental nursing, but I wanted more of an instrumental role with dental patients, which led me to hygiene and therapy.

What does your average day at work involve, and what is the structure of your oral hygiene appointments?
I see many patients with periodontal problems and so conduct a lot more hygiene right now than therapy. I also deal with a lot of children that, unfortunately, have dental caries due to a poor diet, lack of oral hy- genes and likely a lack of education on how to prevent it. It’s not a good start for children if they have to have fillings put in or even have their teeth pulled if it’s particularly bad – it doesn’t give them a good first im- pression of the dentist.

Each oral hygiene appointment is scheduled for half an hour and be- gins with a discussion about the patient’s existing problems and current oral hygiene routine. I then explain to the patient what the pur- pose of the appointment is and what it will entail and conduct an assess- ment of his or her oral health. Every patient is different and I will depend on what he or she needs ad- dedressed as to how the appointment will proceed from there.

How can you get patients to continue with good oral hygiene practices after an appointment?
I think one has to build a relationship with them. They have to trust one and understand what the benefits of oral hygiene are, as they might not be aware that they have any prob- lems in the first place. For example, if smokers aren’t experiencing any breathing difficulties they might not think that there’s anything to worry about. One needs to be able to explain to them in a clear and un- standable way why taking care of their teeth is important not just for their oral health but their overall health too.

But is it possible to achieve this all within half an hour? Well, it’s not a lot of time, but we can always schedule an hour-long appointment if it is necessary. I see many anxious patients who might not have been to the dentist in ten to 15 years. With these patients, a shorter appointment is often good in the beginning, because it means they’re not overwhelmed and that one can build up from those over the ensuing sessions. By the sec- ond or third appointment, they’re a bit more relaxed and eager for treat- ment.

How do you motivate your patients to take charge of their own oral hygiene?
I think it’s mostly about re-educating patients on what the correct and most effective cleaning methods are, what products are best for them. It’s about finding something that works for the patient, something that will get him or her excited about taking care of his or her teeth and seeing the benefits. Dentistry, it can be difficult to engage in a cooperative relationship with one’s patients—of- ten, it’s a one-way conversation with the professional giving the patient instructions or advice on how to take care of him or herself. I like to leave that sort of instructional conversa- tion to the beginning or the end of the appointment, as this allows the patient to think, while in the chair, whether he or she has any questions there. I’ve found that our future appointments will entail re- being able to answer those questions in a clear and understandable way is es- sential to motivating patients.

Thank you very much for the inter- view.

By DTI
AMSTERDAM, Netherlands: In re- cent years, increasing attention has been given to aspects of oral health in patients with rheumatoid arthri- tis (RA), especially related to associ- ations with periodontal disease. The results of a study conducted at the University of Leiden in the UK, and recently presented at the Annual Eu- ropean Congress of Rheumatology (EULAR 2018) in Amsterdam, dem- onstrated increased levels of peri- odontal disease and disease-causing bacteria in individuals at risk of RA.

The study included 48 at-risk individ- uals (positive test for anti-citrullinated protein antibodies), 26 patients with RA and 52 healthy controls. The three groups were balanced regarding age, sex and smoking.

“It has been shown that RA-assoc- iated antibodies, such as anti-citrulli- nated protein antibodies, are present well before any evidence of joint disease. This suggests they originate from a site outside of the joints,” said study author Dr Kulfveer Mankia, clinical research fellow at the univer- sity’s Institute of Rheumatic and Musculoskeletal Medicine. “Our study is the first to describe clinical periodontal disease and the relative abundance of periodontal bacteria in these at-risk individuals. Our results support the hypothesis that local inflammation at mucosal surfaces, such as the gums in this case, may provide the primary trigger for the systemic autoimmunity seen in RA.”

“We welcome these data in present- ing concepts that may enhance clinical understanding of the key initiators of rheumatoid arthritis,” said Prof Robert Landewé, Chairperson of the EULAR 2018 Scientific Programme Committee. “This is an essential step towards the ultimate goal of disease prevention.”

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Periodontal disease may be key initiator of rheumatoid arthritis

By Curaden
For effective oral care, it is very im- portant to use a toothbrush with soft bristles. The reason for this is that hard bristles can often damage teeth and gums. This is a negative side- effect that occurs if too much pressure is used while brushing.

Curaden’s toothbrushes have one special feature in particular: they are incredibly soft. The 5460 CURÉN® filaments of the CS 5460 ultra soft form an extraordinarily dense and efficient cleaning surface. The bris- tles are stiffer than Nylon and re- main just as stable in the mouth as they are when dry. These properties make it possible to manufacture toothbrushes with many very fine bristles. Soft on the gums and teeth, the CURÉN® filaments are extremely tough on plaque. Anyone who has tested the cleaning power of a CS toothbrush will never want any oth- er brushing experience.

An ideal toothbrush head is small and slightly angled to make it easy to reach those crucial areas. The bris- tles should be fine enough to clean the teeth and gums softly and thor- oughly. The handle should make it possible to properly position the toothbrush at about a 45-degree an- gle, always half on the gums and half on the teeth. The gumline is just as important as the teeth.

The CS 5460 ultra soft combines these exact standards of design and function. The small but efficient head at the proper angle ensures that your patients reach those crucial areas. An eight-sided handle optimizes the per- fect angle on the teeth and gums for optimal cleaning. The large cleaning surface with incredibly fine, rounded filaments ensures soft and efficient brushing of the teeth and gums.

The cleaning efficiency of the bristles is tightly packed into 99 holes. Com- bined with the lively colours of the CS 5460 ultra soft, it makes for one of the most popular CURAPROX prod- ucts. The toothbrush is also avail- able with the CPS Prime interdental products. The toothbrush is also avail- able with the CPS Prime interdental products that sort of instructional conversa- tion to the beginning or the end of the appointment, as this allows the patient to think, while in the chair, whether he or she has any questions there. I’ve found that our future appointments will entail re- being able to answer those questions in a clear and understandable way is es- sential to motivating patients.

Thank you very much for the inter- view.
A soft approach for tough areas.

Enamel is hard. Harder than steel, even. And it should stay that way. Enamel-friendly brushing means: pampering your teeth and gums with tender loving care. Like with the gentle CS 5460 ultra soft. Mmmm, let’s do that again.

curaprox.com
An interview with Dr Eric Thevissen, periodontist and pioneer of Belgian prophylaxis

Oral hygiene instructions and patient motivation with and without dental hygienists

By DT

Dr Thevissen, I wanted to talk to a dental hygienist in Belgium. Why is that not yet possible?

Dr Eric Thevissen: Well, the good news is that, from June 2019 on, it will be possible to visit and talk to a dental hygienist in Flanders. Why Flanders has waited such a long time to start the education and training of dental hygienists is politically moti-
tivated and due, in large part, to the representative dental associations. Belgium has a long tradition of one-
dentist clinics, often working with-
out dental assistants. Since the intro-
duction of a quite difficult admission
examination for dentists in 1997, the dis-
plinate has attracted fewer students. As a consequence, the number of graduating students has dramati-
cally decreased, while the demand for
dental care is continuing increase.
Slowly, but sure, more and more group practices have emerged, hur-
ing dental assistants. Back in 2006, the first meetings were organised be-
tween universities and dental socie-
ties about the qualifications needed to
become a dental hygienist and the tasks that could be delegated to
them. As always, there were propo-
nents and opponents, and it took a very long time before all stakehold-
ers agreed on the conditions and cri-
teria needed to start dental hygiene
training in Leuven and Ghent.

Let’s talk about your study

“The provision of oral hygiene
instructions and patient moti-
vation in a dental care system
without dental hygienists”.

Please tell us more about it.

Thirty years ago, I started working as
a periodontist in Hasselt with anoth-
er colleague. Since we were the first
periodontists in this province, we had
a flying start. A few years ago, I noticed that dentists were always re-
ferring patients to our clinic with the
same complaints, such as bleeding
gingivae or bad oral hygiene. In my
opinion, treating bleeding gingivae or
giving oral hygiene instructions is
the duty of every dentist and belongs
in the sphere of primary dental care
rather than in secondary or specialist
care. Although we organised courses
where a general dental practitioner (GDP) could learn about patient in-
struction and guidance. I realised
that we were considered by a large
number of GDPs to be dental hygien-
ists rather than periodontists. The
truth was that we were both, peri-
odontists and dental hygienists. This
annoyed me because I knew that in
neighbouring countries periodon-
tists could spend their precious
time on the work they were trained for.

In 2004, I took the initiative to set
up a pilot study in Limburg with 65
participants using the Dutch Periodontal Screening Index, a screening test for periodontal sta-
tus that had been introduced in the
Netherlands a few years earlier. We
collected data from 814 patients. The
results clearly showed:
The screened age groups had, on the
whole, periodontal problems and that
only a high need for treat-
mant. Around the same time, Prof.
Hugo De Bruyn joined the teaching
staff of Ghent University’s Department of Dental Sciences. Probably thanks
to my publication, he asked me to
become one of his staff members.
Working with Prof. De Bruyn, one is
quickly involved in clinical research
and unable to ignore in investiga-
ting, in depth, the questions that
had bothered me ever since I
started my career. One of these ques-
tions was the kind of oral hygiene
instructions GDPs provide to their
patients.

Using questionnaire responses of
776 dental professionals gathered
for various postgraduate courses in
Flanders, we were able to determine
that, given the absence of dental
hygienists in Belgium, oral health
instructions and patient motivation
appeared to be non-compliant with
international guidelines. Though
dental professionals were concerned
with prevention, there were several
mitigating factors working against
them delivering this adequately.

The study mentioned lack
of time, remuneration and patient interest as complicat-
ing factors for the provision of
preventive care. However, qualitative research shows that time and
clinical and medical time are crucial for provid-
ing oral hygiene instructions and patient motivation. Can
dental hygienists be seen as a solution to these problems?

It is my conviction that dental hy-
giennists are the solution to these
complicating factors. Prophylactic
practice will be the main target of
their work, since dentists are primarily
trained for restorative care. Owing
to factors such as the decreasing num-
ber of graduating dental students, the
increasing number of retiring
dentists in the next ten years, an age-
ing population and a higher demand
for preventive care, the stress of
work increases and forces dentists
to manage their work time more
strictly. Of course, GDPs prefer
restorative and other more rewarding
work, since dentists are primarily
educated with 38 per cent of GDPs.
Secondly, whereas GDPs indicated
in their factor contributing to the
oral hygiene level of the patient,
periodontists and dental hygienists
focused on the influence of the den-
tal practitioner and a patient-centred
approach. In our multivariate analy-
sis, the presence of childcare assis-
tants seemed to be of major impor-
tance.

But, as always in questionnaire-
based studies, the results can be bi-
ased by socially desirable answers
and by the inevitable structural dif-
fences between Flanders and the
Netherlands. One of these differ-
ences, for example, is the fact that
providing oral hygiene instructions
is not reimbursed in the Belgian den-
tal care system, whereas this is consid-
ered an autonomous activity.

What should the role of the
dental practitioner in the
successful treatment of
periodontal disease be?

What does the patient need to do?

The role of the dental practitioner, in particular the GDP, undoubt-
edly remains to keep a panoramic over-
sight over everything that has to do
with the dental and oral health of the
patient. Especially considering the introduction of dental hygienists
in the near future in Belgium, the den-
tists’ role as a supervising manager is
hygiene, medication, age, nutrition
and different systemic factors have
been shown to accelerate the devel-
oment of periodontal disease.

Thanks to research and clinical find-
ings, lifestyle habits, genetics, stress,
smoking and different systemic factors have
been shown to accelerate the devel-
oment of periodontal disease. It
is my experience that
some of them insist
on being treated for things they
do not complain about, as they see
these treatments as unnecessary.

If I personally have to undergo an annual medical check-up, I would
hope that all the exams needed are performed, but I would not be
very strict about it. Why then does this appreciation not
apply to oral health?

What are some of the oral
hygiene instructions and
patient motivational actions
that you would recommend?

In accordance with the technique
of motivational interviewing, we
build up a conversation with the
patient while giving instructions,
waiting for approval, repeating
and

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counselling. One needs two or three control sessions to check his or her dexterity and oral cleaning performance. Plaque disclosure remains a daunting but very effective tool to show the results of the patient’s cleaning habits.

Finally, the dental professional should show enthusiasm and keep on repeating until there are visible improvements.

From your point of view, does the dentist spend enough time on the diagnosis of a disease? Of course, dentists are duteful people who are concerned with their jobs. Spending time in certain forensic situations is their core business. Examining patients means exploring and looking for mostly hidden troubles or discomforts.

The next question is the most important one: is this problem acute enough that it should be treated immediately, in the very near future, or can we wait and see how it develops? This is risk management and it is dependent on multiple factors.

Often, prevention is neglected in dental practices in favour of diagnosis and restorative treatment. How can dental professionals implement prophylaxis in their daily practice, especially primary prophylaxis?

I would say, rather, that prevention is not neglected. Sixty-five per cent of GDPs provide information about oral hygiene as a standard procedure. Depending on compliance, the GDP may decide to spend more time on patient guidance. This requires dental professionals to be trained and informed, and to be able to write down in a few words how to improve home care and his or her personal hygiene. It is not necessary to wait for the patient’s face how motivated he or she is, or what he or she is interested in. This is not only asked of the patient, so one could rather say there is not enough time spent on communication.

I invite practitioners to do an experiment in their waiting rooms. While the patient is waiting for his or her appointment, ask whether he or she can be given a short questionnaire asking him or her to write down in a few words what he or she would like to do with dentistry. Let’s hope that in the near future, dental hygienists will be trained to communicate with patients about their oral health. Many patients prefer seeking dental care because of, for example, fracture or one of more of the front teeth owing to biking and other kinds of accidents, sometimes under the influence of alcohol or drugs. These students don’t want to wear removable dentures for life.

With respect to the first part of the question, of course the addition of dental hygienists makes financial sense. The purpose is to relieve dentists of those tasks that can be delegated to auxiliary staff. Secondly, GDPs will be available to give these people the necessary preventative care.

Professional bachelor degree programme in dental hygiene. Is that a breakthrough?

I remember Prof. Jan Lindhe saying that, nowadays, too many treatable teeth are extracted or replaced by dental implants. As a periodontist I agree with Prof. Lindhe; a dental implant is an effective instrument to rehabilitate edentulous areas, but only after all other options have been considered. But often life decides differently, and at Ghent University, I see practitioners who are using dental implants to a great extent.

Dental hygienists are trained to communicate with patients about their oral health. Many patients prefer seeking dental care because of, for example, fracture or one of more of the front teeth owing to biking and other kinds of accidents, sometimes under the influence of alcohol or drugs. These students don’t want to wear removable dentures for life.

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