The recent Dentistry Show held in Birmingham featured a number of symposia presenting the latest thoughts in patient management and treatment modalities. A session reviewing the latest trends in evidence-based prevention and management of periodontal disease was presented by Dr Anousheh Alavi, Colgate Scientific Affairs. This session provided an overall perspective for an integrated team-based approach, with particular reference to dental hygienists and therapists, discussed the evidence base and highlighted gaps in our clinical practice which could impact on the delivery of optimised prevention and care.

Dr Alavi began by revisiting subgingival plaque and the characteristics of biofilms, highlighting it is the particular composition of subgingival plaque biofilm in a susceptible patient which determines whether gingivitis progresses to periodontitis. Dr Alavi went on to briefly discuss a patient based approach to the management of periodontitis, and reviewed the skills and abilities each registerant group would bring to benefit the patient. In addition, the GDC ‘Principles of Dental Team Working’ document includes a section on working effectively as a team.

She then summarised the evidence for what we advise patients to do. Evidence based dentistry includes the integration of best evidence, clinical judgement and patient values and circumstance. There are varying levels of filtered and unfiltered information which determine the quality and strength of evidence. Dr Alavi outlined the different degrees of strength of evidence as stated in the Department of Health guidance document Delivering Better Oral Health – An evidence-based tool Kit for prevention. Delivering Better Oral Health provides advice and support that should be given to patients presenting with or at risk of periodontal disease, and includes a list of conditions that predispose patients to periodontal disease. We need to ensure we provide patients with evidence-based advice, which requires us to be up to date on latest evidence in effective mechanical plaque removal, effectiveness of chemotherapeutic agents in toothpastes and mouthrinses, and evidence for therapeutic dosage of active ingredients.

It is also important to remember, in light of recent emerging evidence, patients with periodontal disease may be at risk of diabetes, cardiovascular diseases, adverse pregnancy outcomes and pulmonary diseases.

Dr Alavi concluded that as clinicians, we are as responsible for the periodontal health of our patients and its maintenance, as we are in diagnosing and managing periodontal diseases. The prevention and management of periodontitis requires consideration of the patient as a whole, and should be seen as a life-long process, shared between us and the patient. It is our responsibility and duty of care to assess the evidence for the advice we give and the efficacy of the products we recommend on behalf of, and for patients. There are key areas on mechanical plaque removal which need more robust research into patient home care regimes to optimise periodontal health, and this is a genuine opportunity for our current generation of clinicians.

References:
1 Scope of Practice, General Dental Council, 2009.