What’s the Protocol for Perio Disease in Your Office?

Townies weigh in on how to proceed when patients present with pockets … and what to do if they won’t agree to treatment

This question is directed mainly toward general dentists. Thank you.

New patient, 4–6mm pocket depth: Gross debride prophy, then SRP as needed. Allow six weeks to heal, then decide on future care.

So you schedule the patient for perio maintenance after six weeks, right? Or just to check on pockets?

Six weeks for review, then decide on supportive therapy.

For the ones who debride first: Isn’t this neglectful, watching periodontal bone loss for six weeks, then treating? Why not treat the irreversible ongoing bone loss more aggressively? Same can be said of supportive therapy such as Arestin, perhaps?

SRP ––> 4/6 weeks ––> re-evaluation to determine if surgical consults may be indicated to your favorite neighborhood gum jockey.

For me, it is mostly about overcoming objections. Have had multiple patients leave the practice because we did not just “clean their teeth,” which of course their insurance “covers at 100 percent.” People are training us the hard way. It is very disheartening and not motivational to try to do the right thing for people and realize that no amount of talking can persuade them. Yep, I am frustrated!

Generalized 4–6mm pockets with BOP? SRP ––> 4week re-eval ––> surgical consult if anything still 6+.

You can get over a lot of the complaints from patients if you treat them same day. Most patients come in for a cleaning of some kind. Also, many of them understand that if they went years between visits, it will take longer to clean. If you don’t have enough time for the whole mouth, just do one or two quads and reschedule for the rest. If you can PX, you have time for at least one quad.

Of course, this does mean scheduling 1.5 hours for a new patient. You are far more productive overall booking a little more time for a new patient!
Debridement if new patient and refer to perio for SRP. I’m done trying to persuade people and insurances it needs to be done. I let them know they have perio and give them a referral.

Just in the presentation, that’s all. …

“I am seeing gum and bone loss in several areas that has progressed over time—this means that you can lose your teeth if this is not treated. Is that something you would be interested in preventing?” (Of course you will get a yes.)

“We want to make sure we can offer you the most appropriate treatment that will ensure your gums and bone stay healthy and are maintainable in the future. We will start with an initial cleaning and re-evaluate in a month. For any areas that do not completely heal, we do have additional treatment that can help problem areas—this treatment will prevent you from having more gum and bone loss in the near future so that you can keep your teeth as long as possible.”

Once I ended the same-day PX-exam issue, patients did much better at accepting any kind of perio treatment that I felt was necessary.

Schedule the patient for X-rays, exam and treatment plan. This allows you to skip the problems that come with trying to change what the patient thought they were going to have done at that first appointment.

If pockets are deeper than 6mm, do you refer directly to periodontist?

At gross debrid appointment, if hygienist says there’s lots of sub-g calc then we go to SRP immediately. If not too much, then re-eval in six weeks.

For over 6mm, it depends on how generalized it is. These are some of the toughest clinical judgments I make. Gut feeling certainly comes into play, like how much compliance do I expect to get from the patient. In my location we see patients from many different cultures, and some are not amenable to accepting American dentistry.

IMO, there’s a vast difference between 4mm and 6mm pockets and you can’t treat them the same. I have lots of young patients who come in with generalized 4mm pockets with no bone loss. You can do a gingival scaling cleaning on them, they come back in after a few months of flossing and they look great. On the other side, there are patients that come in with generalized 5–6mm pockets who need scaling ASAP, and even after scaling them they come back after 6–8 weeks with little to improvement. Then you need a new treatment avenue (possibly more time, LANAP, perio referral). So it’s really a case-to-case basis. I don’t think you can treat all perio patients the same—look at occlusal factors, existing restorative work, etc. It’s a tailored treatment plan to each individual patient.

Oh, and I don’t get the gross debridement thing. Just get in there and scale. I’ve never seen a gross debridement patient come back who didn’t need scaling.

Gross debridement has nothing to do with treating disease, and everything with getting supragingival calculus off that prevents the examination.
Do you want to help patients, or are you more interested in covering yourself? If you have a new patient with 4–6mm pockets, most likely they have had this for a while. If you go slowly and educate them, there is a better chance they will follow through. I probe, take X-rays and sit with the patient and explain the problem. Then I do a gross debridement. Next I have them return to do a more thorough cleaning with localized deep scaling. I charge the debridement and PX fees. I have them come back in a month to see if there has been improvement and to make sure they are doing their home care.

Most times, I will start to see improvement because people really do not want to lose their teeth or have to go to the periodontist. “My mom went to a periodontist and she had a lot of pain and spent a lot of money.” Over time I have seen patients with 6mm pockets heal to 3–4mm. When I do not see significant healing in 6 to 12 months, I then refer for perio. As long as you inform the patient, you should be covered legally. The problems develop when you allow 5–6mm pockets to fester and have no plan. The most difficult thing is getting people to go for perio treatment. If you document and they don’t go, you have done your due diligence. ■

I can count on one hand the number of patients I’ve seen in 10 years that couldn’t have an exam without supragingival scaling of calculus. ■

If you’ve made an honest attempt to educate a perio patient on their disease condition and they still are not onboard with treatment, let them walk and don’t look back. I have no desire to treat those patients further or deal with their BS down the road. I’m very sure these are not patients you want; let’s quit letting these types dictate treatment.

Having your front desk filter the new patients on the phone helps a lot. We either put the patient into HYG for a 80–90-minute new patient exam/prophy if it’s been up to 1 year since they’ve had preventive care, or we put them for just the comp exam, X-rays, photos in my column (doctor schedule) first for 40 minutes, then reschedule their perio/hygiene. We’ve found that treatment acceptance goes up when we start with just the exam appointment first.

Any patients who call and it’s been more than 1 year since they’ve had any preventive care and say, “Well I just want a cleaning!” tend to be the ones who have perio (duh), don’t accept treatment and are consistently a pain when it comes to scheduling, compliance, etc. Sometimes they tend to go somewhere else before they come see us. These are the “insurance only” patients; I have no problem telling them this isn’t the practice for them.

However, not all practices are at a point in their evolution/growth where they can be selective about this. If you are new and need rapid growth, filtering them can limit your growth a bit. Sometimes you have to take what you receive, initially. Get them in your door. If you filter new patients, your growth will be slower but you’ll have a more ideal practice when you evolve. We had rapid growth in my first few years because we treated everybody; now we are scaling that back a lot and filtering people out, and it’s a good place to be.

Also, one thing I’ve found works very well with people is to just be honest with them regarding their disease, and don’t pushy with getting them to accept treatment. If you force them to do something they aren’t comfortable with, then you’ll get backlash and negative reviews. When they are ready, they’ll do treatment. And not everyone is ready right away. ■
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