Some of my friends never do free gingival grafts [FGG]. Everything is treated with a CT [connective tissue] graft and an overlying flap. I'm a fan of free grafts.

Here is a case where I think a free graft is indicated. Notice that there is not a tremendous amount of keratinized gingiva [KG] at the adjacent teeth for a lateral pedicle. And there is a lack of marginal KG for an envelope flap or CRF [coronally repositioned flap].

I was just looking for interesting cases to post and thought this was a good, simple one.

John, I love free grafts, but got away from them for a while. I thought they were less elegant and looked like tire patches in some of my cases. Worked great, patients didn't mind and the referring dentist could see I really did something. I lost my head and thought it violated my perio esthetic sense. I found the trouble of a CT graft is not worth it many times because the blended graft looks like it was original equipment and the referring doc doesn't always realize I did a procedure. You're right and I'm doing them regularly again.

One of the things that got me doing them more was attending Tom Wilcko's Wilckodontic's Program in Erie, PA. He seems to do a lot of grafting and talks about the rationale.

Upnperio, if I want root coverage, then I always do a connective tissue graft. If I just want to have nice thick tissue that is resistant to further recession, then I might want to use a FGG. What was your goal for this patient? I see that you got some good root coverage, but not 100%. Do you think you could have gotten 100% with a CT graft?
Dbear, not to answer for my buddy John, but the result couldn’t be better. No mucosa at the neck of the tooth, all dense connective avascular tissue! I pretty much have never had a marginal or submarginal graft fail, but do not get 100% root coverage when doing SECTGs [sub-epithelial connective tissue grafts] all the time. You will usually get root coverage even when doing a marginal graft because of the BW [biological width] regenerating. Only my opinion, but I love the choice John chose for this patient. Pat Allen loves the simplest procedure whenever it can be done. Have a nice day!

I’m not a periodontist, but it looks like there is adequate attached tissue on the mesial of # 26 to do a lateral pedicle. Why am I wrong? Second question if I may, if the patient didn’t like the bulk of the free graft, would a plasty solve the problem long term?

In this case, if I remember correctly, the patient had no chief complaint. The problem was pointed out by the dentist to the patient. All she wanted was the best long-term solution. If the patient has specific concerns about the way the tissue looks in the lower anterior (they rarely do) that will help to drive the choice of Tx. I oftentimes do lateral pedicles with EMD [enamel matrix derivative] or a CT graft underlying the pedicle. In this case, I must have decided that the adjacent tissue was too thin. Photos oftentimes do not tell the whole story. Some of the other advantages to this treatment is Tx time. It takes me nine to 15 minutes to do a FGG, I schedule one and a quarter hours for a CT graft. This is a real difference in my opinion. It’s all about the suturing.

Just a thought about lateral sliding flap from # 26. # 26 already has incipient recession and not the best tissue to do a sliding flap. If you did, the root surface present is greater than the tissue being moved. So, actually it is a contra-indication. Good thought however.

…I have found in the absence of mobility, that placing dense tissue on the facial has saved teeth for years. If you control the potential parafunction on the tooth and have a graft, you are likely to keep it a long time. Even if it was a mobile tooth, the unfashionable lingual wire or fiber splint would have taken care of it...if the mobility was a perceived clinical problem. As we know mobility is not a reason alone to splint teeth.

Anyway, great case and I love that you brought up that the bone loss is worse than the recession, so graft sooner than later. There has been discussion on DT [Dentaltown] about the need for grafting. As I understand the perio lit, it can’t be proven in the lit but have you found grafted cases have a better outcome? What are the downsides to grafting?

Howard, I’m a little curious about “saving” these teeth. Are you implying that attached gingiva is what has kept them viable? If so, have you then seen the converse; i.e. teeth lost due to lack of keratinized tissue? Personally, I haven’t. I’m not aware of literature to show loss of teeth to recession or lack of keratinization.

Howard, there was a Grade I mobility that I didn’t feel required splinting at the time, although, I did perform a limited occlusal adjustment to eliminate protrusive contacts. The case is two years old now with no
changes in attachment levels. I don’t know if these teeth would be necessarily lost without the graft procedure, but without question, it does improve the patient’s ability to care for the area, so indirectly I suppose the mortality of the tooth is improved. You are correct that in the perio literature the issue of grafting is still debatable. My clinical impression (IMHO [in my humble/honest opinion]) is that these areas do better than when not treated, meaning that further attachment loss does not seem to occur as readily and the tissues look healthier and less inflamed. But unfortunately, we still cannot accurately predict which sites get worse and which will not, which compromises our ability to make definitive treatment recommendations for these situations.

>In response to a post by Gumslinger on 1/9/2006 at 11:40:24 AM

Joey: Don’t mean to interfere with your question to Howard, but in my practice, I have had to remove plenty of teeth with severe facial bone loss leading to chronic gingival irritation, abscess formation or uncomfortable mobility. In my mind, there is little difference between an 8 mm facial pocket with no recession and a 2 mm facial pocket with 6 mm recession. Both sites have 8 mm attachment loss that compromise tooth stability; and therefore, require some form of intervention. The presence or absence of recession is often related to the periodontal biotype.

You are correct that there is no literature proving tooth loss due to lack of keratinized tissue. But there is literature that has shown further attachment loss when mucogingival defects are not treated and even when oral hygiene is adequate. You are also correct that there isn’t literature specifically attributing recession to tooth loss. But since recession is a result of bone loss (in my example, associated with limited anatomy and orthodontic therapy) you can cite a number of studies that show uncontrolled attachment loss can lead to tooth loss to support the rationale for tissue graft surgery. …

Spoken like the gentleman that you are, Howard. Why do I get wound up? Read my comment to Nick. I’ve seen that patient’s chart. I’ve seen other cases that developed resorption 5+ years post-graft. I’m not trying to beat a dead horse either, but stuff like that tempers my desire to graft sometimes. Look at John’s case pre-op. Do you see much inflammation? When we know that sites like that can be maintained in the presence of adequate hygiene (you have the references) and it appears that hygiene is indeed adequate around a virgin tooth not planned for restoration, then I have a problem thinking that the graft “saves” this tooth. Is it an improvement? Of course. Would I treat it? Sure. Where I practice, a lot of patients would demand treatment for esthetics alone. But if the patient asked me point-blank if the tooth would be lost without a graft, I couldn’t honestly say, “yes.”

Hey Slinger: I agree with you 100%. I actually explain to all my graft patients that they probably would never lose the tooth if they decide NOT to have the graft. BUT, I also explain that since we cannot predict which ones will get worse, AND, since we are currently unable to really regenerate the area (bone, cementum), then it’s a crap shoot with the negative of waiting to treat when additional attachment loss occurs is that we are now guilty of some supervised neglect. I came from a REALLY conservative perio program and it has taken me years to really grasp this issue and change my treatment philosophy…. I had a referral send me a case to graft about 5 years ago that I decided didn’t need it. The patient was lost to follow up by me and his GP and later wound up having the tooth extracted because it got worse. Would the graft have helped….I don’t know,
maybe. But in the end, I felt like $*%@, the patient was @#$$%& and the referral stopped referring. So, I changed my philosophy on this issue, with the added understanding that literature can often be deceiving. (I wonder if this is why he didn’t want me to do his implant?)

Dan Melker | Periodontist | Total Posts: 2621 | Member Since: 07/26/03 | Posted: 1/10/2006 4:34:22 AM | Post: 41 of 54

The key to both John’s outcome and Nick’s is that now there is a piece of dense avascular connective tissue protecting the bone from bacteria. My opinion, hell, they are only grafts which have been around for 40 years (SECTGs only 20) but the key is the benefit they serve the tooth. PROTECTION. Argue all day how important or not important grafts are, but I tell you what, don’t have adequate AG when doing restorative and see [how] quickly the tissue recedes. Funny too the attitude of patients in Florida – they don’t like long teeth and love when they get them covered up. Great job John and Nick!

Howard M. Chasolen | Prosthodontist | Total Posts: 2755 | Member Since: 11/15/02 | Location: Sarasota, FL | Posted: 1/10/2006 5:05:43 AM | Post: 42 of 54

I think Danny has hit the important point. We all do procedures that carry risk. Implants fail ALL THE TIME. I make a good part of my living re-doing failed cases. But my perceived benefit of the grafting outweighs the potential risks. JMO [just my opinion]. I also see a great benefit in grafting prior to implant placement. So, we all make decisions based on our biases. These biases are formed from training, experience, mentors, residency philosophy and other factors. My biases lead me to endorse the grafts because I have seen such a nice result with them over the years. Would my reconstructions and implant cases look as good without the grafts? I can’t really say for certain, but I firmly believe the answer is yes.

Dan Melker | Periodontist | Total Posts: 2621 | Member Since: 07/26/03 | Posted: 1/10/2006 6:31:39 AM | Post: 43 and 46 of 54

Howard Answer: I can say for certain as Howard and others have seen 100s of cases that without AG the cases look far less healthy and long term change quite a bit for the worse. Clinically, this is an absolute as I have seen cases in my own practice. My belief backed up by 1,000s of documented teeth, AG is critical to the long-term maintenance of perio-rest cases.

[Posted: 1/10/2006 8:49:05 AM]

Hey may as well watch?
We’re not going to lose the tooth over this, right?
Abscesses never occur, right?
I’m gonna’ watch this one.
RRRRRRIIIIGGGGGGHHHHHHTTTTTT!

upperio | John Hall | Periodontist | Total Posts: 611 | Member Since: 01/14/04 | Location: Michigan | Posted: 1/10/2006 5:56:31 PM | Post: 47 of 54

This is a good example, Danny. All of the literature would say that this lower molar does not need a graft. No inflammation, good oral hygiene, no plan for a restoration (sub-g or otherwise), but clinical experience will tell a different story.

Find it online

This is an excerpt from the Dentaltown.com message boards. To read the complete thread or join in the conversation got to: http://www.docere.com/MessageBoard/thread.aspx?ss=2&f=137&t=60417