

Is Soft-Tissue Therapy a Rip-Off?

dwright | David M. Wright, DDS | Total Posts: 12 | Member Since: 7/13/2005 | Posted: 7/30/2005 11:06:22 AM | Post 1 of 55

I am an orthodontist who visited one of my referring dentists recently. He uses the soft-tissue therapy that was advocated in the '90s for a lot of his patients. By this, I mean, he has a whole program where his hygienist irrigates every tooth with chlorhexidine, root planes and scales, and then the patient gets a Rota-dent. The whole process takes four appointments. I talked to a periodontist I use and he said that there is no scientific evidence that supports the irrigation or use of the electric toothbrush. They don't use it. If the evidence isn't there, is this fair to the patient? The fees are very high.

thisisit | Total Posts: 1,655 | Member Since: 3/1/2002 | Location: Chicago, IL | Posted: 7/30/2005 11:52:33 AM | Post 2 of 55

He is ripping patients off if he is charging for irrigation. He is ripping patients off (and committing fraud) if he charges for scaling when the patient is healthy (absence of BOP [bleeding on probing] and more than 5 mm pockets).

gregholm | Total Posts: 8,743 | Member Since: 4/28/2001 | Location: Wichita, KS | Posted: 7/30/2005 11:56:56 AM | Post 3 of 55



There are many offices that jumped on this STP [soft-tissue program] bandwagon. I had one young pt with perfect teeth and soft-tissues that was told she needed a full-mouth program to the tune of \$800+ bucks. Absolute rip-off! I am sorry, a lot of this is just pure bull@!\$*.

Yes, I've been to a few of these programs, but I guess I am just not quite "with it."

This is not to say there are not plenty of people who truly do need periodontal help.

drtique | Tom Schoen DDS | Total Posts: 3,662 | Member Since: 5/15/2001 | Location: Wabasha, MN | Posted: 7/30/2005 12:14:07 PM | Post 4 of 55



There is a lot of both under-treatment and over-treatment with regard to perio therapy. STM [soft-tissue management] is an attempt to prevent under-treatment, and it does just that. The problem, as I see it, lies in the increase in over-treatment that these programs push; overuse of root planing and medicament therapy with no data to prove a significant positive effect for the patient. There is an answer to this over-treatment/under-treatment issue. It is called PreViser, a computer data program that takes into account the patient's risk factors (age, smoking, diabetes, dental history, oral hygiene, etc.) and recommends treatment for each individual patient based on that data. It is entirely science-based. Go to PreViser.com to read up on it. Having used it for over a year now, it truly works.

Randy Nolf | Total Posts: 567 | Member Since: 11/5/2001 | Location: Stroudsburg, PA | Posted: 7/30/2005 3:16:49 PM | Post 9 of 55



Soft-tissue management, [is] AKA hard-tissue mis-management. Even when done in appropriate circumstances, one of the most difficult treatments in dentistry is to scale and root plane. Typically, the patient with pockets is placed in the recall system afterwards because treatment is over; "four quads" are done. Dr. Tique hit it on the head, risk assessment should guide treatment. If the post SRP PreViser score has reduced to 336 or less, maintenance is the next phase. 336 is three on the risk and 36 on the disease score. If it's over 336, surgical intervention for the pockets should be considered, or the case referred.

More specific guidelines will be forthcoming in the next six months on referral and surgery guidelines.

I do all my own SRP, so I know how well it's being done, with sharp instruments. When pockets remain and we go to surgery, there's sometimes smooth calculus and calculus at the CEJ that remains. If the case was done in a STM program outside my office, and held for a while, the subgingival picture is usually pretty nasty. Non-surgical treatment, no matter the case, is usually a formula for under-treated and slowly progressive cases. Low-risk cases with pockets are not indicated for surgery in most circumstances. Risk assessment is essential to appropriate treatment.

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serikson | Total Posts: 275 | Member Since: 1/11/2005 | Posted: 7/30/2005 6:45:56 PM | Post 10 of 55



There is no clinical data that supports the use of irrigation and in fact, the AAP [American Academy of Periodontology] reported in one of their position papers that it serves no useful clinical function. The reason is that the GCF [gingival crevicular fluid] washes the material out as soon as it is placed, and even with good substantivity (PerioGard), the liquid is washed out. These patients would be better served by being placed on Periostat (20 mg. doxycycline bid) during their treatment, which has some clinical data to support the anti-collagenase role of bone catabolism.

A Rota-dent is a terrible brush, as it is too aggressive and causes gingival trauma in most patients, with a small surface area. This brush is simply a marketing tool for profit. Place the patients on an Oral-B sonic, Sonicare, Spinbrush, or soft-brush, which have larger surface areas, and are better in terms of plaque removal and less soft-tissue trauma.

Most GPs don't know how to root plane, as they can't remember what a furcation or root fluting looks like. The same reason that most periodontists don't know how to prep for a veneer, as they are not doing these on a regular basis.

hygienehms | Diane Sharp, RDH | Total Posts: 253 | Member Since: 9/29/2004 | Location: Indianapolis, IN | Posted: 7/30/2005 9:06:14 PM | Post 15 of 55

Wow! Lots of sweeping generalizations here. By "STM" are you guys specifically referring to the Pro-Dentec program? Or are you against all general practices providing non-surgical therapy? What is wrong with a skilled hygienist or doctor providing SRP on patients with BOP and 5+ mm pockets? Four to six week re-eval, and then continuing care, if pockets are improved and patient is maintaining good OH. There are certainly cases where the patient should be referred out immediately, if they will see a specialist, or if the SRP and homecare regimen fails to elicit improvement that can be maintained.

I struggle to automatically refer to the periodontists in my area for specific reasons. Most notably the fact that, having worked in a few of their offices, I can tell you that the level of care that the patients received in the initial, non-surgical SRP stage is not necessarily better than what I am providing in my GP practice.

In fact, they hire "newbie" hygienists straight out of school to do the SRP, or temps that they know nothing about. It is not necessarily true that the SRP at the specialist's office is superior, especially if multiple clinicians are involved.

At one well-respected perio office the patients weren't being probed more than once annually. Oftentimes, by the time I probed there were SIGNIFICANT changes, and not for the better, after this amount of time. And the referring general practices usually didn't probe the patients at the alternating three-month visit because they assumed it was being done regularly at the perio office. This surprised me because I always probe my three-month perio maintenance patients.

I could go on. Like the periodontist who, upon having the referring Dr. call and question why the initial report that they received indicated no deep pockets were found, had to call the patient back in to reprobe and then apologize for missing 6+ mm pockets. (BTW, this happened three times in two months)

I'm not dissing periodontists. I'm just saying we shouldn't generalize. There are excellent periodontists providing non-surgical therapy, and there are excellent general offices doing the same. Just my observations after 23 years.

doc4smile | Total Posts: 191 | Member Since: 11/29/2002 | Location: California | Posted: 7/30/2005 11:56:31 PM | Post 19 of 55

...I just attended a STM seminar this weekend. Honestly, I wasn't impressed with what they are selling. But, I was wondering how many of you out there believe in the use of ultrasonic scalers and/or peizos over the use of hand instruments? As I recalled, I have heard the lecture from CDA (I believed her last name is Fong from San Francisco) claiming sonics and peizos are now more effective and better for access to the deep pockets, than conventional instruments. What do you guys think of this?

Secondly, if the electric scaler is a good adjunct, is there a "superior" difference between ultrasonic vs. peizo?

Lastly, is there a doc out there who truly practices the Pro-Dentec STM honestly, ethically, and can vow to see improvement with their patients under the therapy?

hygienehms | Diane Sharp, RDH | Total Posts: 253 | Member Since: 9/29/2004 | Location: Indianapolis, IN | Posted: 8/1/2005 7:27:51 AM | Post 27 of 55

My typical SRP appointment looks like this:

Dr. gives anesthetic, because I can't in my state (yet). On first appointment, it's usually half-mouth at a time (unless the calculus is extremely tenacious, then maybe only one quad). I schedule extra time on the first visit for OHI [oral hygiene instruction]. Usually, close to two hours for this visit. While they are getting numb, I sit them up and do a face-to-face OHI with two-tone disclosing solution. Usually takes close to 15 minutes for this education part. Use a hand mirror and actually show them how to use the proxibrush, floss, Waterpik, or whatever I'm recommending.

Then I use ultrasonics (usually universal tip and then switch to piezo fine perio slim tips) and hand instruments (very sharp Gracey After Fives). I actually keep a sharpening stone in my instrument pack and stop to sharpen a couple of times. I do irrigate with chlorhexidine afterwards, just to flush debris out of the pocket. I don't charge for it.

I do a quick polish of the ENTIRE mouth to knock down plaque and bacteria on the side we haven't root planed yet.

The patient gets written take home post root planing instructions and a written oral hygiene instruction sheet.

Second half-mouth visit is scheduled as close to the first as possible. This is usually around 90 minutes or so for this one.

Four to six week follow-up to reprobe and check scaling. Depending on what we find, either two to four month perio maintenance, or referral for surgical evaluation. I do a full probe at every perio maintenance. If we can't continue to see improvement in pockets that didn't respond or if they are losing any ground, I recommend a referral. As I said before, sometimes it may take a few PM [perio maintenance] visits of me talking about non-responsive sites before they agree to go for the evaluation at the specialist. I just had the periodontist I met with tell me that actually this works to his advantage, because when they do see him, they are expecting the "surgery talk" and go ahead and schedule the work.

BTW, my patients all get a "folder" at the diagnosis appointment with information about periodontal disease, SRP (pamphlets and handouts from the ADA and AAP) and what to expect. That way, even though I've explained it all, they still have something to look over when they get home. I tell them I won't quiz them on the info, but please read it over so they can ask me questions about their condition, if there is something I didn't cover.

I try to be very thorough and help the patient understand the disease. If they don't get the bacterial component and their responsibility in the process, SRP is a waste of time! I'm still always trying to learn. One thing we don't do enough of in my practice is systemic antibiotics, I know. I do use Arestin moderately. My doc hates writing script for metronidazole because he's had a few patients get very sick on it.

N8RV | Don McNamara, DDS | Total Posts: 1,846 | Member Since: 1/13/2004 | Location: Indiana | Posted: 8/3/2005 6:28:07 PM | Post 44 of 55

I'd like to jump in here with a quick comment about the term "STM."

As someone who referred out all perio for over two decades (my periodontists love me!), I had no "program" at all in my practice.

Things have changed. Like many, I went to a Rota-dent seminar once and was introduced to the concept and the term Soft-Tissue Management. That was the first I'd heard that term.

Fast forward to today. Thanks to Diane, I have finally begun seeing and treating my own patients' perio needs. I still have the periodontists available when needed, but I know that we can properly attend to most of my patients' needs. My patients are happier and so are we.

However, if the term Soft-tissue Management (STM) connotes something bad, what should we call our hygiene programs designed to treat moderate perio? Is there a better term to use that adequately describes SRP and all of the adjunctive procedures? The last thing I would want is for my colleagues—or worse, with the availability of misinformation on the Internet, my patients—to latch onto the term "STM" as charlatanism.

I no more wish to rip-off my patients than I would rip-off my own mother!

Find it online

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