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New Probing Approach

by Trisha E. O’Hehir, RDH, MS
Hygienetown Editorial Director

Telling patients they have periodontal disease when they are expecting a routine prophylaxis can be a challenge, especially if they have been patients of record for many years. The reasons for finding yourself in this situation and a plan of action to follow when this happens are covered in this month’s CE course, “No Longer Just a Prophy.”

Dr. Howard Farran came up with an idea years ago that makes this transition fun and easy for the clinician and more importantly, directly involves the patient. It’s called Probing According to Dr. Howard Farran and changes the pattern of probing to educate the patient. Instead of probing around the teeth as we traditionally do, probing is done in two passes around the mouth, separating facial and lingual surfaces from interproximal. Howard’s goal for the patient is to separate brushing surfaces from flossing surfaces.

At the start, tell patients you are doing a new test for gum disease and you will call the measurements out loud so they can hear them. The numbers should be 1 to 3, anything 4 or higher is disease and any bleeding points are a sign of infection.

Start by probing all the brushing surfaces, facials and linguals. When that’s complete, tell patients you are going to check for infection on their flossing surfaces. Hearing the probing scores separated between brushing and flossing surfaces immediately draws patients into the diagnosis. After you finish this process, patients will know their periodontal status and where they need to focus their attention before you say another word. The stage is set to inform them of their periodontal status.

With this new probing approach, you’ll be doing more non-surgical periodontal therapy (SRP) followed up with periodontal maintenance. This month’s Perio Reports covers new approaches to periodontal maintenance, the quality of life after SRP and new products to improve oral health.
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**Effectiveness of Subgingival Air Polishing**

Air polishing is generally done supragingivally due to the abrasiveness of the sodium bicarbonate powder on root surfaces and general tissue trauma. The EMS company introduced a fine-grain glycine powder that can be used on root surfaces, restorative materials and soft tissue without noticeable damage. This new glycine powder allows air polishing to now reach subgingival areas, making it an alternative to hand instruments for biofilm removal at periodontal maintenance visits.

Researchers at the University of Washington compared subgingival plaque biofilm removal on 30 patients using either hand instruments or air polishing with EMS Air-Flow glycine powder. Patients had probing depths of 4-9mm on at least two teeth and detectable levels of Pg and Tf. Subgingival and oral bacterial samples were measured at baseline, day 10 and day 90.

Subgingival air polishing was done with a newly designed nozzle with three openings to effectively reach the entire subgingival area. Each tooth surface was treated for five seconds. Hand instrumentation was done with curettes and scalers following no time limit. Both groups rinsed with chlorhexidine twice daily for two weeks.

Clinically, there were no differences between the test and control groups at 90 days. Microbiologically, at 90 days, fewer patients in the air polishing group (73 percent) were positive for Pg compared to the hand instrumentation group (93 percent). Air polishing might provide a shift in subgingival bacterial population. With calculus removal it might be the entire group.

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**Laser Used for Periodontal Maintenance**

Supportive periodontal care (SPC) is an integral part of managing periodontal health. The goals of SPC are to stop progression of periodontal disease, prevent or reduce tooth loss and provide early screening for oral cancer and other oral conditions. Mechanical instrumentation during SPC is done with hand or power instruments or a combination of both. The Er:YAG laser has been designed as an alternative or adjunct to mechanical instrumentation.

Researchers in Germany conducted a multi-center research study including four German university research sites. The study began with 78 non-smoking patients, and 58 finished the 26-week study. Clinical and microbiological outcomes were measured comparing mechanical instrumentation and Er:YAG laser during SPC appointments. Subjects each had two single rooted teeth in the same arch with probing depths 5mm or deeper and bleeding upon probing. Baseline clinical and microbial measures were repeated at 13 weeks and 26 weeks.

Patients presented after complete periodontal debridement. One test tooth was treated with the KaVo Key Laser and the other was treated with the KaVo Sonicflex Sonic Scaler to remove plaque biofilm. Treatment time was set at 20 seconds per diseased surface for a maximum of two minutes per test tooth.

No significant differences were observed between the two groups at 13 or 26 weeks for probing depths, attachment levels or bleeding upon probing. Baseline attachment levels were 9mm average for both groups and at 26 weeks were 7.5mm for the laser and 8mm for the sonic scaler.

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**Clinical Implications:** After calculus removal, the laser and the sonic scaler provide comparable outcomes. ■

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**Clinical Implications: Subgingival air polishing with glycine powder might become the treatment of choice for perio maintenance visits. ■**


VSCs Linked to Periodontal Progression

Volatile Sulfur Compounds (VSCs) are gases released with the breakdown of proteins that can also be detected by their distinctive smells. VSCs associated with both bad breath and periodontal disease include hydrogen sulfide, methyl mercaptan and dimethyl sulfide. Tongue coating and periodontal disease release significant amounts of VSCs.

Researchers at Nigata University in Nagita, Japan followed a group of non-smoking, elderly Japanese over three years to determine if VSC scores were predictive of periodontal disease progression. Subjects were part of a larger study of 70-year-old Japanese examining the relationship between oral health and general health.

Dental examinations were completed at baseline and yearly for three years. Clinical attachment levels and bleeding upon probing were the key clinical indices monitored. VSC scores were also recorded. An interview was conducted to determine oral health and eating and drinking habits.

Subjects were divided into two groups, those examined before meals and those examined after meals. After meals VSC scores were lower than before meal scores. Those who showed evidence of greater than 3mm of attachment loss from baseline also showed higher VSC scores.

Those with the highest number of periodontal pockets measuring 6mm or more also had the highest VSC scores. The higher the number of teeth with periodontal disease, the higher the VSC scores. Reports of flossing, regular dental visits, alcohol consumption and frequency of toothbrushing did not impact VSC readings.

Clinical Implications: VSC levels might now be considered a risk factor for periodontal disease and become part of clinical records regularly collected to monitor periodontal disease progression.


Adding Patient-centered Outcomes to Periodontal Therapy

The concept of patient-centered approaches to health care began in 1948 when the World Health Organization changed their focus from the absence of disease to the wellbeing of the patient. Clinical research focuses on measurable changes in probing depths, attachment levels and bleeding upon probing. More recently researchers have begun evaluating the impact of periodontal therapy from the patients’ perspective.

Researchers at the University of Hong Kong evaluated both clinical outcomes and patients’ perceptions immediately following non-surgical therapy and at three-month intervals for a year. A total of 60 non-smoking Chinese adults between the ages of 35 and 65 with moderate to severe periodontal disease participated. In addition to the usual clinical indices, patients completed a 14-question oral health-related quality of life survey. Questions asked about chewing difficulty, trouble pronouncing words, eating comfort, having sore spots, feeling embarrassed, avoiding going out, unable to go to work, etc.

Experienced dental hygienists using local anesthesia provided non-surgical therapy over four to six visits completed within one month. Bleeding scores reduced from 86 percent to 32 percent. The overall mean probing depth reduced from 3.3mm to 1.8mm. The percentage of pockets 4mm or deeper was reduced from 31 percent to three percent.

The median quality of life scores began at 17, reducing gradually to 13 at the end of the year. The average score for a periodontally healthy person is 4.4.

Clinical Implications: The non-surgical periodontal therapy you provide your patients results in better oral health and also improvements in the quality of life they experience.

**XyliMelts Keep Mouth Moist Over Night**

Xerostomia is caused by medications, CPAP use, radiation treatment and a variety of diseases. Lozenges, gels and sprays can manage daytime oral dryness, but not overnight dryness. XyliMelts are bi-layer tables with a vegetable gum adhesive on one side to allow the disc to adhere to either tooth surface or tissue. All the ingredients, including xylitol, will dissolve, providing oral lubrication.

Researchers at the University of Washington evaluated the effectiveness of XyliMelts in a group of 15 subjects with xerostomia. Subjects were instructed to apply one disc to the buccal surface of a maxillary first molar or gingiva, either right or left side after breakfast, lunch and dinner. Before bed, they were instructed to apply two discs, one on each side either on the buccal of the maxillary first molar of the adjacent gingiva. Subjects were asked to determine how long the XyliMelt disc lasted during the day and how their mouth felt each morning for one week.

Baseline stimulated salivary flow was measured and repeated after one week. No changes were evident for any of the subjects in their stimulated salivary flow. Secretory rates ranged from 0.004 to 0.074 ml/minute. Average stimulated salivary flow rates equal 1 ml/minute, so these scores are very low.

Oral wetness was measured using a visual analog scale of zero to 100. Baseline oral wetness scores recorded upon waking ranged from zero to 50. After one week, scores ranged from 32 to 92. Discomfort upon waking scores were reduced from 22-92 to 6-55. Discs lasted one hour during the day.

**Clinical Implications: XyliMelts offer an overnight as well as daytime remedy for xerostomia.**


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**Probiotics Might be Helpful in Preventing Oral Disease**

An estimated 100 trillion micro-organisms call the human body home. We ingest bacteria in the food we eat and the water we drink. Fermented foods also provide a source of micro-organisms: sausages, miso, tempeh, soy beverages, cheese, yogurt and other fermented milk products.

Probiotics are living microorganisms that provide beneficial functions in the digestive tract and also in the mouth. The term probiotic was introduced in 1965 in an article in Science Magazine, despite having been advocated for several centuries before. Probiotic is the antonym or opposite of antibiotic.

Probiotics are live microbial food ingredients beneficial to health. Prebiotics are non-digestible food ingredients that selectively stimulate the growth of specific bacteria beneficial to health. A beneficial mixture of probiotics and prebiotics is called a synbiotic. Hydrogen peroxide is produced by some oral probiotics to eliminate the undesirable bacteria and as a side effect, whiten the teeth. The bacteria used in oral probiotics are not acid-producing species. Changing the balance of bacteria in the mouth with specific oral probiotics will also eliminate the bacteria releasing the volatile sulfur compounds associated with halitosis.

In the mouth, oral probiotics change the balance of the microflora to one favoring health and enamel mineralization, rather than disease and demineralization. There are four key properties of oral probiotics: 1) binding to dental surfaces, 2) production of antimicrobial substances against oral pathogens, 3) reduction of inflammatory response and 4) alteration of environmental conditions of the mouth. Oral probiotics are delivered to the mouth in gums and mints.

**Clinical Implications: Oral probiotics can be an important part of oral health, prevention and fresh breath programs offered to patients.**

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No Longer Just a Prophy
by Debra Seidel-Bittke, RDH, BS

Continuing Education Course
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A prophylaxis is reserved for healthy patients with no signs of periodontal disease. The need for more than 20 minutes of subgingival instrumentation during a prophylaxis appointment shifts the focus from health to periodontal disease. Periodontal disease might be overlooked during a prophylaxis because of four reasons: improper probing technique, insurance roadblocks, unclear practice philosophy and financial profiling. To avoid providing periodontal therapy during a prophylaxis, a three-step plan of action should be followed. This plan includes periodontal assessments, discussing the findings with the patient and taking the time to explain to the patient the treatment that is needed. Understanding the reasons periodontal disease might be overlooked and following a plan of action when periodontal disease is present will assure that prophylaxis appointments do not include unplanned periodontal instrumentation.

Objectives
At the end of this program, participants will be able to:
1. Describe the difference between health and periodontal disease
2. List four reasons periodontal disease diagnosis is overlooked
3. Explain the three critical elements of successful periodontal therapy
4. Discuss how periodontal probing can underestimate periodontal disease
5. Understand the definition of CDT Code D1110

Are you scaling more than 20 minutes during a regular dental hygiene appointment? If you are, this is more than just a “prophylaxis” appointment. Your good intentions are actually leading you to provide subgingival instrumentation and periodontal therapy as part of a prophylaxis, which is a treatment reserved for healthy patients with no signs of periodontal disease.

You must have an accurate diagnosis and you must make the distinction between health and disease before providing the appropriate treatment. If the patient is periodontally healthy, the appropriate treatment is a prophylaxis, which should not take longer than 20 minutes for scaling and polishing. If probing depths, however, exceed 4mm and there is bleeding upon probing, the patient has periodontal disease, and you should provide the appropriate treatment and use accurate treatment codes. The purpose of the CDT codes is to achieve uniformity, consistency and specificity in accurately reporting dental treatment. The CDT code for a prophylaxis is D1110 and is defined as “the removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors.”

CDT Code D1110 is, thus, a preventive procedure for patients who don’t yet have periodontal disease and you should use it only with patients who have a healthy periodontium.

Here’s an example of a prophylaxis visit no longer fitting the definition of health. Every six months Mr. Goodtooth comes in for his “cleaning” appointment, and it always ends up becoming more than just scaling and polishing. There is bloody gauge on the patient tray, evidence of disease rather than health. Mr. Goodtooth needs topical anesthetic applied to alleviate the pain of subgingival instrumentation. His hygienist, Bethany, is stressed out and continually runs behind when he is on her schedule. Bethany finds herself scaling and polishing at least 40 minutes every six months, and she finds it difficult to do anything more than scale, polish, take X-rays and have the doctor complete an exam when she sees Mr. Goodtooth. She has no time for important assessments to evaluate for xerostomia, inquire for a smile analysis, provide an oral cancer screening exam, a caries assessment, an evaluation of implants, check for defective restorations, open contacts, malocclusion, etc.¹

Do you find yourself in this situation all too often? Do you turn the treadmill up to a much faster pace just to stay on schedule and complete the “cleaning” appointment your
patient anticipated? We have all been there, and it is a frustrating feeling! There are several reasons that might explain why this was no longer just a prophylaxis appointment to be unusually complex.

1. Improper Probing Technique

If you complete a periodontal screening exam and find no disease, yet still find yourself in the same situation as Bethany, it might be due to how you insert the periodontal probe into the sulcus during the screening exam. Some dental hygiene programs teach a reproducible probing technique, requiring the probe to be positioned parallel with the long axis of the tooth. While this might be a reproducible technique for researchers, it misses the mid-interproximal surface. To accurately probe the mid-interproximal surface, the probe needs to be angled into the interdental space. This is one reason periodontal disease is greatly underestimated.2 What might appear healthy at first glance with the probe held parallel to the long axis of a tooth at the line angle is in fact an interproximal periodontal pocket. It goes without saying that missing a periodontal disease diagnosis can cause your prophylaxis appointment to be unusually complex.

2. Insurance Roadblocks

Many dental offices today are insurance-driven. Patients are subconsciously educated to believe their insurance company will cover all the treatment they receive. Rarely if ever does the patient’s insurance plan pay 100 percent of the treatment needed. In 1970 many insurance companies had a maximum annual patient benefit of $1,000, and this value is still the same today. Never begin a conversation about treatment with this sentence: “Your insurance will pay X percent, and your anticipated portion will be Z dollars.” The conversation needs to begin with a discussion about the patient’s oral health status, disease diagnosis if applicable, necessary treatment and the benefits of undergoing the recommended treatment. This discussion works best with open-ended questions to determine the patient’s openness and willingness to accept and undergo treatment.

3. Unclear Practice Philosophy

The lack of a detailed practice philosophy on periodontal treatment is another reason patients are scheduled for a prophylaxis when in fact they need periodontal therapy. Defining the diagnostic criteria distinguishing the difference between health and disease will provide the foundation for a practice philosophy on periodontal treatment. This philosophy should include specific diagnostic criteria, treatment plans for early, moderate and severe periodontitis, periodontal maintenance intervals, appointment details and specifics of oral hygiene for periodontal patients. This philosophy should also include criteria for referral to a specialist. Daily interproximal plaque control is critical to controlling and preventing further infection and attachment loss, so the entire team should understand and provide patients with effective tools and instructions. This is an essential part of the practice philosophy on periodontal treatment. The primary role of health care providers is to prevent dental disease and secondarily, to treat it. An important aspect of this role is communication. Effective communication can create a change in patients’ values and the treatment choices they make.

4. Financial Profiling

Dental professionals subconsciously pre-determine exactly what treatment they think their patients are willing to accept financially. It is our role as dental professionals to communicate the truth and all the treatment options available and not necessarily what we think our patients want to hear. It is important from an ethical and legal perspective to provide patients with all the options available to them for their particular condition. Financial profiling is not done on a conscious level. Many times, subconsciously, a decision is made as to what the patient can afford. This might explain why a patient with periodontal disease is treated with a prophylaxis rather than scaling and root planing. Rather than discussing periodontal disease with Mr. Goodtooth, Bethany assumes he can’t afford scaling and root planing. Instead, she removes what calculus she can during his prophylaxis appointment, cutting short the time needed to educate him about his true periodontal condition, the treatment he needs and the necessary preventive actions he needs to take each day to prevent ongoing disease.

These four reasons explain why some prophylaxis appointments should actually be periodontal treatment appointments instead. Based on this information, it’s time to formulate a plan of action that will accurately diagnose periodontal disease before instrumentation begins. Ideally, a 60-minute prophylaxis appointment can be divided into three 20-minute segments. The first segment is for data gathering, assessment, diagnosis, treatment planning, case presentation and oral hygiene instructions. The second segment is for scaling and polishing, and the third segment is for the doctor’s exam, completing chart notes, scheduling of future appointments and turning the room around for the next patient.

Follow this plan of action when periodontal disease is present:

Step 1: Assessments

Gather the data necessary to accurately distinguish between health and periodontal disease. Have your prophylaxis and periodontal therapy definitions clear in your mind. Data gathering

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should include: full-mouth, six-point periodontal probing, bleeding upon probing, recession, mobility and all attachment levels, etc. Patient history of periodontal treatment and daily oral hygiene practices should be determined. Use this time of data gathering to discuss occlusal issues, and explain the relationship between occlusion and periodontal disease, treatment recommendations, benefits of treatment and prevention. The dentist and dental hygienist should regularly calibrate their probing technique to be sure measurements are consistent.

**Step 2: Discuss Findings**

After gathering the necessary data, sit the patients upright in the chair, and discuss the findings. Tell them the truth! The best thing you can do for your patients is to explain what is present in their oral cavity, why they need to return for non-surgical periodontal treatment and how this will benefit their overall health.

Always give patients the disease facts. Explain the process of periodontal disease. Periodontal disease is an inflammatory disease that affects the soft and hard tissues that support the teeth. The early stage of this disease is gingivitis. In later stages the teeth might become loose and the bone surrounding the teeth can degenerate. For example, Bethany might say, “Mr. Goodtooth, today we found bleeding and many of the probe measurements were more than 4mm. This indicates the start of periodontal disease.”

(Wait for the patient to respond. When he does respond, acknowledge any concerns.)

Bethany continues: “If these areas are left untreated, tooth loss can occur, in addition to bad breath and bleeding gums. Also, research shows that periodontal disease affects the whole body. It is associated with many diseases such as diabetes, Parkinson’s disease and even Alzheimer’s disease. All this said, we recommend scaling and root planing all four quadrants of your mouth and a re-evaluation six weeks afterward. Then, we will need to see you at least every three months for periodontal maintenance because this disease can return at various times during your life due to stress, diet and other risk factors like smoking, and those systemic diseases as I mentioned before, diabetes, rheumatoid arthritis, Crohn’s disease and more.”

**Step 3: Explain the Necessary Therapy**

The patient must accept three important aspects of periodontal therapy before treatment can begin. Two are professional care provided by the dentist or hygienist: scaling and root planing and regular maintenance visits. The third is daily plaque biofilm control by the patient. He or she must agree to all three in order to achieve treatment success. Depending on the practice philosophy of periodontal treatment, you might spend the bulk of that appointment going over facts about periodontal disease and daily plaque biofilm control by the patient. If time permits, you may then begin scaling and root planing or your patient might need to schedule one long or several one-hour appointments for Phase I periodontal therapy (scaling/root planing, chemotherapeutics). Tell your patients that from here on out, they need to return every 12 weeks, or at frequent, appropriate intervals, for supportive periodontal maintenance.

**Integrating Change**

When integrating a change like this into your practice, meet as a team to get everyone on the same page. This is a perfect time for the team to discuss the practice philosophy on periodontal treatment and to clearly define periodontal health and periodontal disease.

Keep up-to-date with all the evidence-based research. Research is constantly changing, and more evidence to support your findings is available. When we understand the research regarding periodontal pathogens, we can better communicate to our patients why they need to return in 12 weeks – and maybe sooner in some cases.

**Conclusion**

As dental professionals we are concerned about our patients’ oral, as well as overall health, and we want the very best for them. Educating patients on the difference between health and disease and providing appropriate treatment is the best way to achieve good oral health. To avoid spending more than 20 minutes scaling during a prophylactic appointment, accurate assessments are needed at the start of the visit. Probing into the mid-interproximal areas will establish accurate baseline data upon which a treatment plan can be made. Before beginning instrumentation, discuss the clinical findings and necessary treatment with the patient. Avoid making judgments about what you think your patient wants or is willing to accept financially. By distinguishing between health and disease, and prevention and treatment you will no longer find yourself on the “more than just a prophy” treadmill.

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**Author’s Bio**

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1. According to the CDT Codes, D1110…  
   a. is a preventive procedure.  
   b. includes scaling and root planing.  
   c. includes periodontal data collection.  
   d. should be provided every 12 weeks.

2. A patient may receive a prophylaxis when, in fact, he or she needs periodontal therapy. This treatment mistake is often due to:  
   a. improper probing technique.  
   b. insurance coverage.  
   c. financial profiling.  
   d. practice philosophy.  
   e. All of the above

3. An appropriate amount of time to spend scaling during a prophylaxis appointment is:  
   a. 10 minutes.  
   b. 20 minutes.  
   c. 30 minutes.  
   d. 40 minutes.

4. Dental insurance companies…  
   a. have not increased maximum annual benefit for many decades.  
   b. pay for most scaling and root planing procedures.  
   c. increase patient benefit maximum in line with cost of living.  
   d. None of the above

5. The primary role of dental professionals is to:  
   a. increase production from periodontal therapy.  
   b. prevent dental disease.  
   c. provide professional whitening.  
   d. None of the above

6. Current research suggests that patients return for supportive periodontal maintenance…  
   a. every twelve weeks, or at frequent, appropriate intervals.  
   b. when patients notice bleeding during home care.  
   c. as often as they would for a regular prophylaxis.  
   d. once a month.

7. Periodontal data collection should include:  
   a. full-mouth, six-point probing.  
   b. recession.  
   c. mobility.  
   d. All of the above

8. A plan of action when periodontal disease is present includes:  
   a. assessments.  
   b. discussing findings with the patient.  
   c. explaining necessary treatment.  
   d. All of the above

9. Three important aspects of periodontal therapy include:  
   a. treatment, periodontal maintenance and daily plaque control.  
   b. treatment codes, financial arrangements and payment.  
   c. scaling, root planing and curettage.  
   d. diagnosis, treatment planning and follow-up.

10. When integrating change in the practice…  
    a. just do it.  
    b. discuss the changes in a team meeting.  
    c. start with new patients, not existing patients.  
    d. explain the changes in a letter to patients.

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No Longer Just a Prophy by Debra Seidel-Bittke, RDH, BS

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For questions, contact Director of Continuing Education Howard Goldstein at hogo@dentaltown.com
I have a patient in my office who refuses to have periodontal probing done. I have made thorough notes, but do I also need him to sign an informed refusal form? Does anyone have a form for refusal of periodontal probing?

Many would say it is time to dismiss this patient. They won’t let you look under the hood, so you can’t fix the car. Without probings, you have no clue where to start, what to prescribe, etc. I agree with dismissing him, but I know clinicians who will just document and continue to treat them. I wish my wife (the dentist) would dismiss patients who do this kind of thing – mostly X-ray refusals. I can’t recall anyone refusing probing.

Start at the beginning. Have the patient share with you why he refuses to have an evaluation to diagnose perio or gingivitis. His concerns/fears should be addressed. Maybe it was painful once, maybe he is very sensitive, maybe he doesn’t want to hear the truth, maybe he thinks it costs more, maybe he has a fatal illness he hasn’t disclosed? By understanding his challenge, it will enable you to comfort or assure the patient of the importance of the procedure.

The only time I have surrendered to that request was from a patient who had terminal cancer and only three to six months life expectancy. She still valued having her teeth cleaned but felt that the perio probing would be unnecessary and preferred to avoid any unpleasant sensations. Based on her previous history and current medical condition I was more than happy to provide her palliative treatment until the end of her life, which was taken too soon at her young age.

As a former educator in radiography, one of the things you tell students is that refusal of radiographs is asking the dentist or hygienist to treat you without all the necessary information. Radiographs and periodontal probe depths are considered standard of care procedures and as thus cannot be done without. Legally, a patient cannot consent to negligent care and it would not stand up in court – this is what an “informed refusal” form is. A lawyer would laugh at that should he come back at some point and try to sue because you missed a diagnosis due to not using “standard of care” diagnostic tools. Since he is asking you to perform your job without all the necessary information and asking you to be negligent in your practice, I would kindly dismiss him. Why would or should we practice negligence? Can you imagine a physician treating a patient for diabetes without lab work? Or doing surgery without radiographs? No... they would not treat the patient and neither should we. Until a patient realizes he can’t dictate treatment, he will continue to ask us to compromise, and I see it done in dentistry all the time when it should not be. Stand up for your rights. Tell them that your conscience does not allow you to be negligent in his treatment.
I guess it depends why they decline probing. I have been told by some that it hurts more than the scaling. Has the patient given a reason? I remember hearing that during sales training, students are told to find out why someone objects to something, and once you know, you can overcome those objections.

I have never really asked a patient if I could do perio probing. I do it as a standard part of my exam. On regular patients I use a plastic ivory-colored PSR probe, probing with the traditional probe if the PSR probe goes into the red line. Green for go and red for stop. There are ballpoint probes available that might be less painful.

Maybe the probing is painful. I empathize with patients telling them that I know it sometimes feels like needles and this is one of the worst procedures we do. Then I continue to tell them why it is necessary as I am probing. You might try some topical anesthesia. Maybe have them hold a hand mirror to watch?
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