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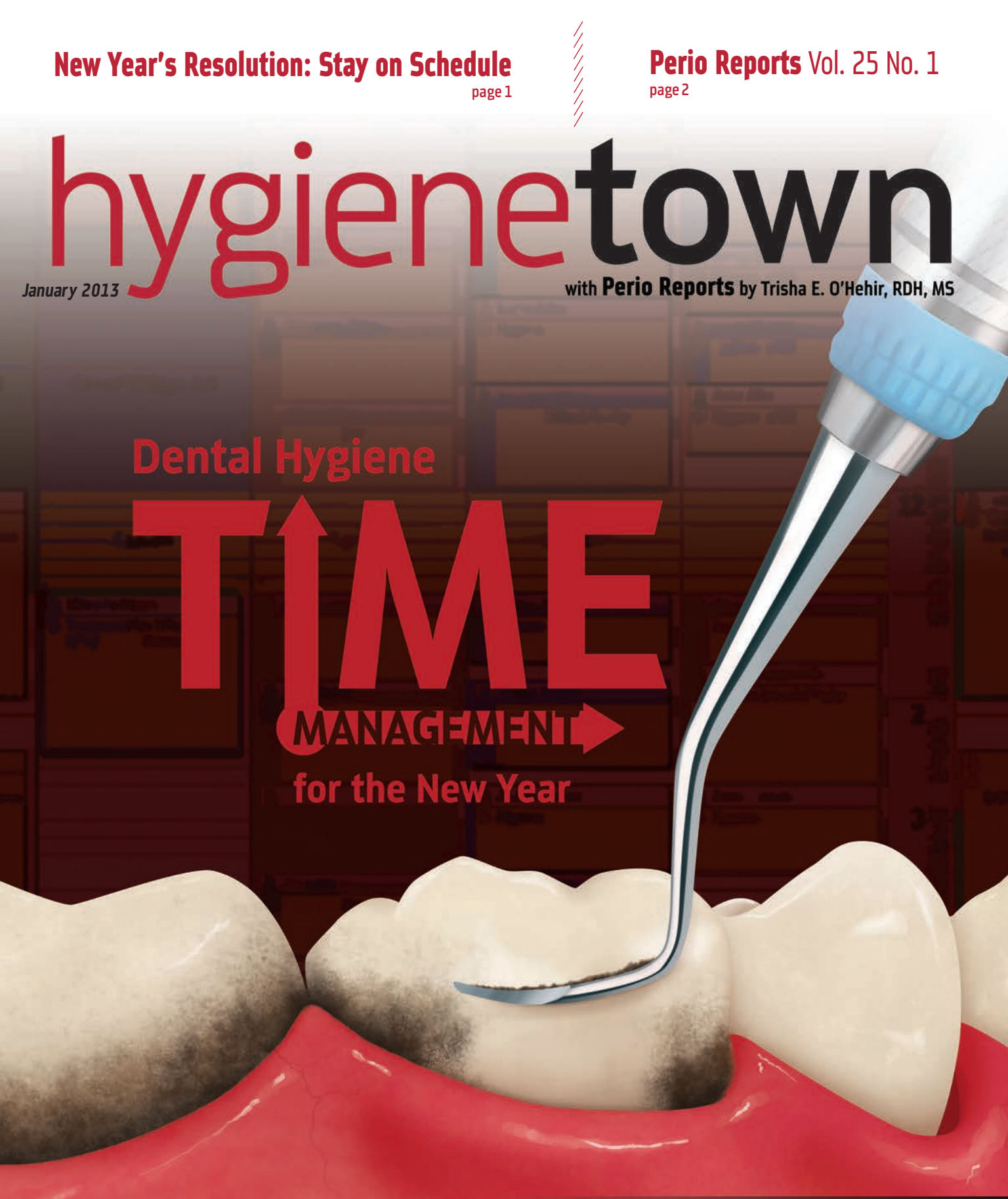
hygienetown

January 2013

with **Perio Reports** by Trisha E. O'Hehir, RDH, MS

Dental Hygiene TIME MANAGEMENT for the New Year



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A Division of Farran Media, L L C

New Year's Resolution: Stay on Schedule

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

It's the time of year for reflecting back at the past year and looking forward to the new year. New Year's resolutions confirm the desire to improve, do better or generally change. Popular resolutions include eating healthier, getting into shape, saving money, helping others and getting organized, but let's face it, most resolutions are just wishful thinking with no hope of being accomplished. They're dreams that seem unattainable. By the end of January, gym attendance is back down to pre-holiday levels and pizza is again on the menu. To accomplish New Year's resolutions, they must be measurable and attainable. They need to be small changes that when added up make a big difference over time.

It's usually bad habits like smoking, drinking or overeating that trigger New Year's resolutions. There are even bad habits in the hygiene department that could lead to New Year's resolutions. Running behind schedule can be a chronic bad habit founded on good intentions that actually makes for the foundation of measurable and attainable resolutions. Small changes made within each visit can impact the entire day's schedule and the overall health of the patients.

This month's feature lays out two steps to take during routine dental hygiene visits to avoid spending unnecessary time providing subgingival instrumentation. Two more suggestions for patients to follow will help them take control of their own oral hygiene and return with less calculus and less bleeding. Incorporating these simple steps into routine dental hygiene visits will make it easy to keep that hygiene department resolution to stay on schedule. ■

Inside This Section

Health Patterns in First-Year University Students

Self-efficacy is a measure of a person's confidence. The person has the ability to complete tasks and reach goals. Self-efficacy plays an important role in many health issues, but few studies have evaluated the relationship between self-efficacy and oral health.

Researchers at Okayama University in Okayama, Japan, evaluated oral health self-efficacy responses from a written questionnaire and compared it to gingivitis indices. The study subjects were 2,111 first-year university students. Due to the presence of a large engineering department in this university that attracts more males than females, more men participated in the study: 1,197 men and 914 women.

Gingivitis was determined by calculating the total percentage of bleeding upon probing sites. In addition to the self-efficacy scale, questions were also asked about daily toothbrushing, flossing and visits to the dentist.

Similar to studies in other populations, the females had less bleeding and plaque than the males. Twice-daily brushing or more was reported by 80 percent of the group. Regular dental floss usage was reported by five percent and regular dental visits were reported by 14 percent. The percentage of bleeding upon probing sites was 29 percent for the entire group, 28 percent for women and 30 percent for men. Higher self-efficacy scores corresponded to better oral hygiene practices and fewer bleeding upon probing sites.

Clinical Implications: Interacting with young university students to boost their confidence might help them realize they have the skills to prevent dental disease and can improve oral health. ■

Mizutani, S., Ekuni, Furuta, Tomofuji, T.m, Irie, K., Azuma, T., Kojima, A., Nagase, J., Iwasaki, Y., Morita, M.: Effects of Self-Efficacy on Oral Health Behaviours and Gingival Health in University Students Ages 18-19-Years-Old. J Clin Perio 39: 844-849, 2012.

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Honey Mouthrinse Shows Promising Results

Mouthrinses have been used for centuries for both medicinal and cosmetic reasons. Today's gold-standard antibacterial mouthrinse ingredient is chlorhexidine. Within the past decade more products that claim to have antiplaque, anticalculus and anticaries properties have been introduced.

Complementary and alternative medicine includes a diverse group of practitioners, disciplines and treatments. The area of apitherapy offers treatments for many diseases using honey and bee products. The good taste, availability and antibacterial properties make honey a potentially valuable ingredient in various oral health products.

This two-part *in vitro* and *in vivo* study was conducted by researchers at the College of Dental Sciences in Bangalore, India. The *in vitro* or laboratory portion of the study tested the bacterial inhibition of chlorhexidine, saline and a honey mouthrinse on six oral bacterial species. These tests were done in duplicate. Chlorhexidine was the most effective, followed by the honey mouthrinse. No effects on the six species were observed for the saline solution.

The *in vivo* or clinical portion of the study measured four-day plaque regrowth in a group of 66 volunteers aged 20-24 years. Both the chlorhexidine and the honey mouthrinses inhibited plaque regrowth better than the saline rinse. There was no statistical difference between the chlorhexidine and honey groups. The honey mixture was a 1:1 dilution of honey and distilled water.

Clinical Implications: Honey has the potential to be an effective antigingivitis/antiplaque ingredient in oral mouthrinse. ■

Aparna,, S., Srirangarajan, S., Malgi, V., Setlur, K., Shashidhar, R., Setty, S., Thakkur, S.: A Comparative Evaluation of the Antibacterial Efficacy of Honey In Vitro and Antiplaque Efficacy in a 4-Day Plaque Regrowth Model In Vivo: Preliminary Results. J Perio 83: 1116-1121, 2012.

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Biofilm Redevelopment is Rapid and Complex on Natural Teeth

Biofilm is composed of many bacterial species held together in a polysaccharide slime. Biofilm formation is influenced by three things, the surface it attaches to, the fluid environment and the available bacterial species. Supragingival plaque regrowth samples are similar between people with good oral health and those with periodontitis. Subgingival regrowth differs between these two groups.

Researchers at the Forsyth Institute in Cambridge, Massachusetts, compared supragingival plaque samples from pre-prophylaxis samples collected from individuals with teeth and individuals with dentures. Following the prophylaxis, plaque samples were collected from randomly selected quadrants on days one, two, four and seven from both groups. Subjects were instructed to refrain from all oral hygiene during this seven-day period. Counts and proportions were calculated for 41 bacterial species.

Baseline bacterial counts in supragingival plaque from natural teeth and denture teeth were similar prior to the oral prophylaxis. On each of the subsequent days without oral hygiene, more bacterial biofilm formed on natural teeth compared to denture teeth. Of the 41 species tested, 28 had higher counts on the natural teeth compared to denture teeth. Biofilm redevelopment was significantly faster on natural teeth compared to denture teeth. From day one to day two on natural teeth, *S. mitis* and *S. oralis* increased significantly. *S. gordonii* increased significantly over the seven days on denture teeth but on natural teeth. The biofilm forming on the natural teeth was more complex than on the denture teeth.

Clinical Implications: Gingival crevicular fluid likely influenced biofilm reformation on natural teeth. ■

Teles, F., Teles, R., Sachdeo, A., Uzel, N., Song, Z., Torresyap, G., Sigh, M., Papas, A., Haffajee, A., Socransky, S.: Comparison of Microbial Changes in Early Redeveloping Biofilms on Natural Teeth and Dentures. J Perio 83: 1139-1148, 2012.

Individualized Spoken Instructions Better than Written

There is a difference between toothbrushing frequency and effectiveness. Just because someone brushes his teeth, doesn't mean he actually removed the plaque. Previously published studies reveal that more than 70 percent of Germans age 35 to 44 years report that they brush their teeth twice daily yet 98 percent have some plaque on their teeth and 24 percent have high levels of plaque. In this sample, 99 percent had gingivitis and 53 percent had periodontitis. Frequency of toothbrushing is not the problem while lack of toothbrushing skill is the apparent problem.

Researchers at Heinrich-Heine University in Duesselforf, Germany, compared three methods of teaching toothbrushing skill development: standardized instruction, written instructions and individualized instruction. A fourth group was given written instructions on sun protection, to be the control group.

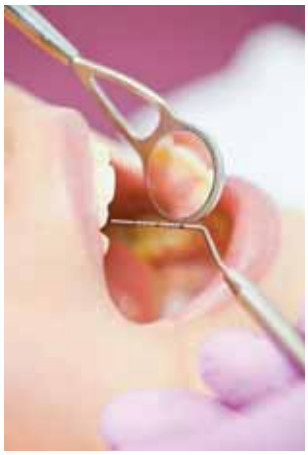
The written instructions included a brochure on how to floss and the Bass toothbrushing technique. Subjects were left alone to read this information. The group receiving standardized instructions was provided the same information as presented in the written pamphlet but demonstrated on a model. Those receiving individualized instruction received the same information demonstrated in their mouth with attention paid to skill deficits and ways to overcome these deficits.

Four weeks later, plaque and bleeding scores were recorded after subjects were allowed to clean their teeth. All four groups showed reduction in plaque and bleeding after four weeks. The control group did not show as great a reduction in plaque and bleeding as the three test groups.

Clinical Implications: Individualized skill development instruction showed slight, but not significantly better clinical outcome. ■

Harnacke, D., Beldoch, M., Bohn, G., Seghaoui, O., Hegel, N., Deinzer, R.: Oral and Written Instruction of Oral Hygiene: A Randomized Trial. J Perio 83: 1206-1212, 2012.

Periodontal Therapy Improves Quality of Life



Probing depths and clinical attachment levels have traditionally been the surrogate outcomes used to determine success or failure of periodontal therapy. In 2003 the World Workshop on Emerging Science in Periodontology recommended using patient-based outcomes as well, taking into account the patient's opinions before and after treatment.

Researchers at Queen Mary University in London, England systematically reviewed the literature to determine if periodontal therapy actually improved the quality of life for the patients. Eleven studies met the criteria for inclusion in the review. All of these studies reported that periodontal disease negatively impacted the person's quality of life. Post-treatment evaluations of quality of life were measured at various intervals from one week to one year post-treatment. The majority of studies provided non-surgical periodontal therapy and some provided surgical therapy. Study subjects ranged in age from 20 to 75 years.

The greatest improvement in quality of life was reported following non-surgical therapy. All non-surgical periodontal therapy studies reported a post-treatment improvement in the quality of life. The better the treatment outcome was, the higher the improvement in quality of life. Poor clinical outcomes led to low levels of change in quality of life outcomes. Surgical studies reported no change in quality of life after treatment. From a patient-centered perspective, non-surgical therapy is viewed as beneficial.

Clinical Implications: In addition to controlling periodontal infection, reducing probing depths, reducing bleeding upon probing and controlling attachment loss, non-surgical therapy can also improve the quality of life for the patient. ■

Shanbhag, S., Dahiya, M., Coucher, R.: The Impact of Periodontal Therapy on Oral Health -Related Quality of Life in Adults: A Systematic Review. J Clin Perio 39: 725-735, 2012.

Effectiveness of Manual Toothbrushing

Toothbrushing is generally accepted as the most common practice to reduce oral plaque biofilm. Despite the introduction of a variety of toothbrush designs and bristle configurations, no single toothbrush design has been found to be superior for plaque removal. Personal preference for one brush over another is how people decide which brush to use. Enthusiastic brushing is not however synonymous with effective plaque removal. Most people are able to remove approximately 50 percent of plaque with a one-minute brushing. This means people are generally not very good toothbrushers and live their lives with considerable plaque on their teeth. A systematic review was needed to determine the effectiveness of manual toothbrushing.

Researchers at University of Amsterdam in the Netherlands evaluated all available studies to determine the effect of manual toothbrushing on plaque removal. A total of 59 papers with 212 brushing experiments were evaluated. A total of 10,806 subjects participated in these studies. The outcome analyzed from each of these studies was the percentage of reduction in plaque from before to after the brushing exercise.

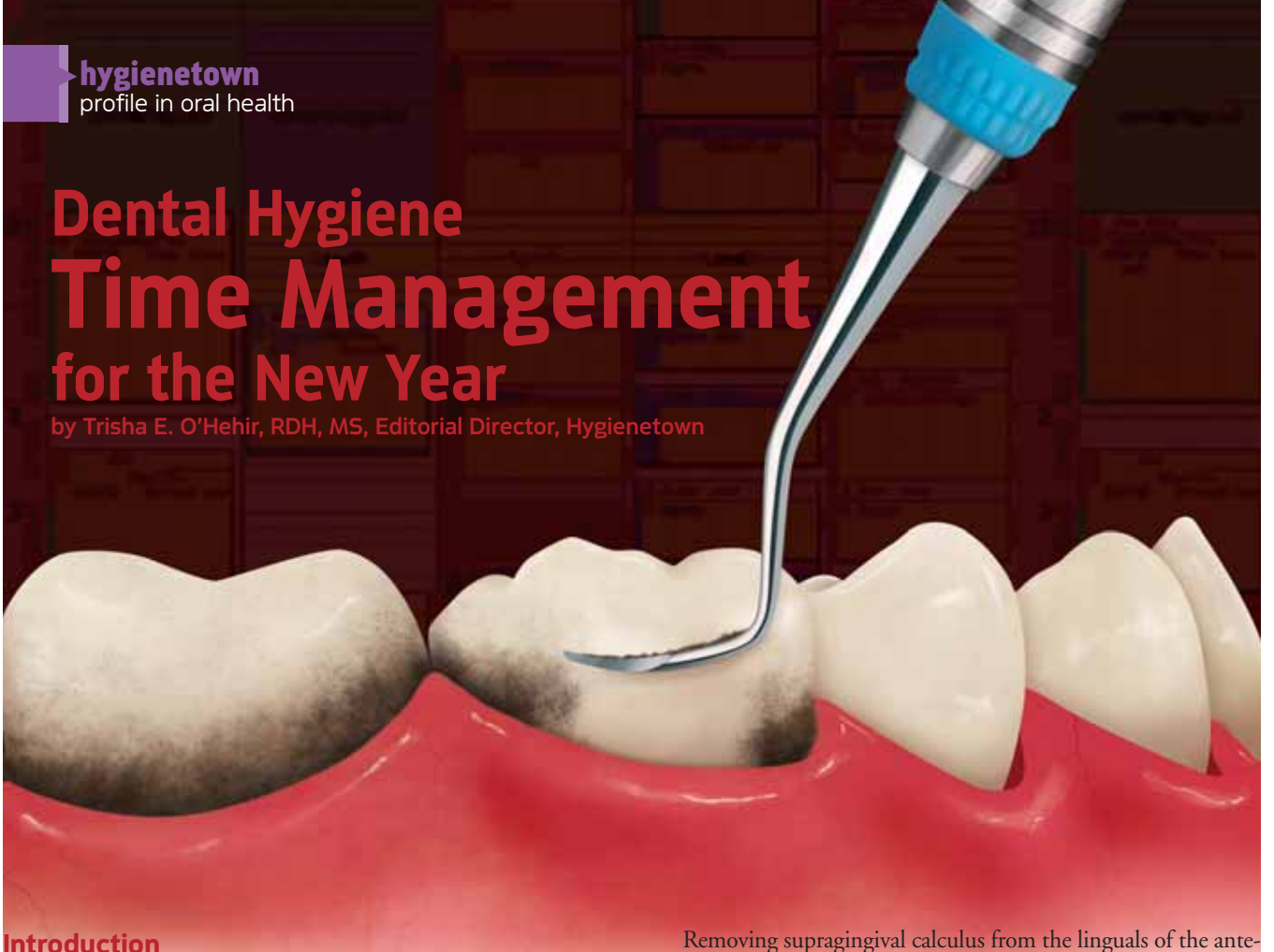
Overall, the manual toothbrush provides a 42 percent reduction in plaque scores. The reduction is 30 percent when the Quigley and Hein plaque index is used and 50 percent when the Navy plaque index is used. Sub-analysis revealed that various bristle designs reduced plaque scores 24 to 61 percent. Toothbrushing time also impacted plaque removal. For studies brushing for one minute, the mean plaque reduction was 27 percent and increased to 41 percent with two minutes of brushing.

Clinical Implications: Toothbrushing doesn't remove as much plaque as you might expect. ■

Slot, D., Wiggelinkhuizen, L., Rosema, N., Van der Weijden, G.: The Efficacy of Manual Toothbrush Following a Brushing Exercise: A Systematic Review. Int J Dent Hygiene 10: 187-197, 2012.

Dental Hygiene Time Management for the New Year

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



Introduction

No more bloody prophies in 2013! How many bloody prophies did you see last week? One is too many, but chances are, you struggle with several each day. Despite repeated toothbrushing and flossing instructions, subgingival instrumentation finds calculus and bleeding on many patients. If this is the case in your dental hygiene department, it's time for a change that will positively impact your time management of bloody prophy appointments.

A "prophylaxis" is a procedure performed on periodontally healthy patients to keep them healthy. Gingivitis and periodontitis are specific infections, like dental caries, to be diagnosed and treated differently than a prophylaxis. Removing subgingival calculus from interproximal areas where the tissue is puffy, swollen and bleeds easily is actually providing periodontal therapy. It is no longer a prophylaxis. Just because it frequently happens doesn't make it right. A prophylaxis appointment doesn't allow time for periodontal therapy so taking the time to treat localized periodontitis is bound to put you behind schedule. Patients don't appreciate the "free skilled therapy" you're providing, as evidenced by their comments suggesting you may be the "rough" hygienist. The patient's perception and that of the insurance companies is that a prophylaxis consists of polishing the clinical crowns of the teeth. Removing subgingival calculus from infected interproximal surfaces constitutes scaling and root planing for which you are not charging. It adds time to your appointment and the patients don't like it. Yes, they need it, but they don't like it and it's not technically part of a prophylaxis. Besides, it's what stresses you out, takes more time and often puts you behind schedule.

Removing supragingival calculus from the linguals of the anterior teeth is also time consuming and not the most comfortable for patients either. This also adds unnecessary time to the dental hygiene visit. Believe me; patients would love to come in just for polishing and no scraping with sharp pointed instruments.

By changing two things you do at each dental hygiene visit you will avoid providing unpaid periodontal therapy and easily stay on schedule. Add two simple requests of your patients and forever change their future DH visits, making them easier and more pleasant for both of you.

A prophylaxis is a procedure done on a healthy patient to keep them healthy. The exact definition: "A dental prophylaxis performed on transitional or permanent dentition, which includes scaling and polishing procedures to remove coronal plaque, calculus and stains." No pockets. No bleeding. No subgingival calculus to remove, only coronal instrumentation, no subgingival instrumentation. Since there is no code for treating gingivitis or early periodontitis, D1110 is often used, inaccurately, for bloody prophies.

Providing periodontal therapy, subgingival calculus removal from interproximal areas, during a prophylaxis visit leads to a bloody prophy. We laugh about these visits, but the truth is, a bloody prophy doesn't help the patient or the hygienist. The patients continue to ignore their responsibility to daily clean the interproximal areas and the next visit is the same as the last. The periodontal instrumentation at each visit adds extra time and stress, often pushing the limits of the schedule. Bloody prophies need to be a thing of the past.

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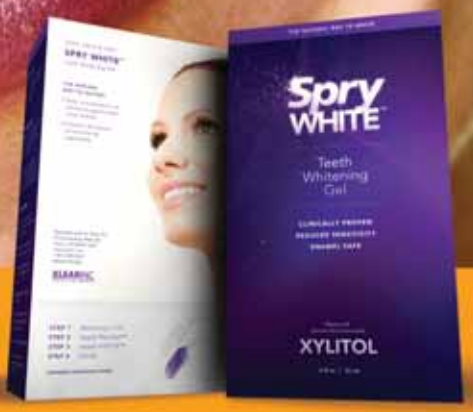

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Change just two things in a routine dental hygiene visit and the bloody prophy will be eliminated and the periodontal disease will be diagnosed. First, change your probing technique and second, change when you polish the teeth. These two changes will convert a bloody prophy into a diagnostic visit followed by polishing. After all, patients think a "cleaning" is the polishing! Give them what they want before giving away valuable periodontal scaling and root planing.

First Change – Recognize Interproximal Disease

Periodontal disease often goes undiagnosed due to faulty probing technique introduced by researchers and followed by dental hygiene educators. To be fair, not all educators follow the researchers. Instructors with clinical practice experience realize the importance of probing the mid-interproximal surfaces. Basic probing instructions suggest holding the tip of the probe in constant contact with the root surface, holding the probe parallel to the long axis of the tooth and walking the probe around the surface from line angle to line angle. Researchers wanted their probing to be reproducible, so rather than angling the probe to reach the mid-interproximal surface and find any crater development, they kept the probe parallel to the long axis of the tooth for all measurements. While being easily reproducible, this technique will not detect any mid-interproximal pockets and therefore significantly underestimates periodontal disease. When probing an interproximal site, hold the side of the probe against the contact area and aim the tip of the probe to the midpoint of the interproximal surface. This will ensure more accurate probing.

To focus more acutely on the interproximal surfaces, try probing according to Dr. Howard Farran. He suggests separating the brushing surfaces from the flossing surfaces as a way to educate patients while probing. It's really very simple and so much fun. Simply separate facial and lingual surfaces from interproximal surfaces, making two passes with the probe. First, probe all the brushing surfaces – facials and linguals. Tell patients you are doing a new test for gum disease and you will say the measurements out loud so they can hear them. The numbers should be one to three, anything four or higher is disease and any bleeding points are a sign of infection. After probing the brushing surfaces, tell patients you are now going to check for infection on their flossing surfaces. The same rules apply regarding the numbers one to three being healthy, anything four or higher is disease. After you finish probing according to Dr. Howard Farran, sit patients up and ask them what they think. They will know exactly which surfaces they are missing and where the disease is.

The bloody prophy patients are the ones who do no interproximal oral hygiene. They profess to brush like crazy, but they do nothing to clean between their teeth. The message these patients need to hear is "skip brushing and start cleaning in between." If they have time for only one thing, it has to be to clean between the teeth.

It makes no sense to talk flossing to patients qualifying as a bloody prophy. It's been done before and you've probably gone over flossing with them at least a half dozen times already. Tell them they no longer have to floss. It won't hurt to say this as it's clear they aren't flossing now. These patients need other options. Let go of your allegiance to floss. That was something they brainwashed us with in school. The scientific evidence shows that despite the dental profession's commitment to floss, very few people floss and those who do are not very effective at removing plaque from the proximal surface embrasures. It's time for alternatives: picks, sticks and flossing with water. These are easy to do and people like using them. If they clean between their teeth every day, there will no longer be bloody prophies in your schedule in the future. It makes no sense to remove the subgingival interproximal calculus at a prophylaxis appointment when there is no commitment to daily interproximal cleaning.

Patients have three options at this point. Based on the diagnostic probing, they have periodontal disease between their teeth. First, you can schedule them for four sextants/quadrants of periodontal instrumentation with anesthesia. The second option gives them a chance to control the infection themselves with daily cleaning between the teeth with sticks, picks or flossing with water. Find a convenient alternative to dental floss that works for patients. At the next visit it will be clear from the probing if they are cleaning between their teeth. If they are, it will be easy to remove the remaining calculus because the tissue will be much healthier. Wait until cleaning between the teeth becomes a daily habit before removing the subgingival interproximal calculus. It will be much more valuable at that time. The third option is to do nothing. In this case, they will return for their next dental hygiene visit with more subgingival calculus, biofilm and bleeding. The choice is theirs to make. Changing the probing technique to measure brushing surfaces separate from flossing surfaces clearly lets patients know what is missing in their daily oral hygiene.

Second Change – Give Patients What They Want

Probing according to Dr. Howard Farran has identified disease on the "flossing" surfaces of the teeth, giving patients the information they need to realize the value of cleaning between the teeth on a daily basis. Next identify alternatives to floss that will work into their daily schedule. The next step should be to polish. Given a choice, patients likely prefer polishing over instrumentation with sharp instruments. To them, the "prophy" is the polishing. Since that's what people expect, why not give it to them before instrumentation? Polishing first is a strategy to avoid doing subgingival instrumentation during a prophylaxis appointment. Many polish with a rubber cup while some are lucky enough to have an air polisher. With new softer powders, subgingival polishing can be accomplished, blasting out the plaque biofilm.

Polishing provides an opportunity to teach patients what a clean tooth feels like. Have patients feel the plaque biofilm on linguals of the mandibular posterior teeth or the facial surfaces of the maxillary molars before polishing. Before polishing have them remove it with a toothbrush and feel the difference. With this comparison, they will learn how a clean tooth feels to their tongue.

Following polishing and flossing between the teeth, instrumentation should be restricted to supragingival areas. The area with the greatest accumulation of supragingival calculus will be the lingual of the lower anterior teeth. Power scalers and hand instruments will effectively remove these deposits. Time will not allow for full-mouth subgingival instrumentation, which is wrongly included in a prophylaxis visit. Subgingival instrumentation constitutes periodontal therapy and should be scheduled at another visit.

Teaching patients a simple toothbrushing technique will prevent the future accumulation of mandibular lingual calculus. Reducing future lingual calculus will reduce the amount of time needed for supragingival instrumentation.

Toothbrushing instructions and pamphlets teaching toothbrushing most often suggest starting on the facial surfaces of the maxillary anterior teeth. According to the research, the area with the greatest calculus accumulation is the lingual of the lower anterior teeth. The area with the greatest plaque biofilm and bleeding is the lingual of the mandibular right (for right handed brushers, left for left-handed brushers). Based on this scientific information, toothbrushing should begin on the mandibular lingual to prevent calculus formation. Preventing calculus formation will reduce instrumentation time at future dental hygiene visits.

To feel the difference between plaque-covered surfaces and clean tooth surfaces after brushing, toothbrushing is best done without toothpaste. Without toothpaste, toothbrushing will take two minutes instead of 30 seconds, cover all areas of the mouth and most importantly, without the strong flavor of toothpaste the tongue will feel the difference between plaque biofilm covered surfaces and clean tooth surfaces.

Summary

These two changes in your approach to the bloody prophy appointments will focus your efforts and prevent the temptation to provide periodontal instrumentation. Focusing the probing and subsequently the oral hygiene on interproximal areas is bound to create healthier patients and shorter regular dental hygiene visits. Polishing first and teaching patients to dry brush inside bottom teeth first will reduce calculus buildup and cut down on the need for future instrumentation. Start out 2013 with these ideas to streamline your appointments and increase patient health. ■

Is It Okay to Leave Sub-gingival Calculus After a Prophy?

What are the legal ramifications of performing only a prophy when you know the patient needs SRP, but refuses the treatment?

Konarocky
Member Since: 10/08/05
Post: 1 of 22

If a patient needs SRP, can you still perform an actual prophy? To me, a prophy involves removing all plaque, all supra- and sub-gingival calculus (usually very little in the lower anteriors) to prevent disease in a healthy mouth. A prophy cannot treat or prevent a disease that already exists. The SRP and prophy procedures imply completing something. When you do a true prophy you complete something. When you do SRP you complete something (e.g., quadrant). The only procedure that implies leaving something incomplete is a full-mouth debridement (D4355), but that only applies if you can't complete an exam. Can you legally perform and bill a prophy when SRP is indicated? ■

MAY 17 2010

Trisha O'Hehir
Member Since: 05/22/03
Post: 2 of 22

Great question, Mark! As I understand it from the insurance gurus, performing a prophy and charging for a prophy implies a diagnosis of health. In a court of law, the clinician doing a prophy on someone with periodontal disease would be charged with failure to diagnose periodontal disease. This points out an important aspect of the insurance code business that is missing in dentistry. In medicine, treatment codes must be accompanied by diagnostic codes. When we have to submit both a diagnostic code with a treatment code, this problem will be addressed head-on! Wonder what will happen then! ■

MAY 17 2010

JGonzalesRDH
Member Since: 06/17/07
Post: 3 of 22

Oh, but there's a loophole you see! Consider a case that has localized periodontal disease with generalized gingivitis. Legally, you can still complete a prophy to address the areas of gingivitis and then at the same or separate appointment complete the localized SRP. True? ■

MAY 17 2010

Trisha O'Hehir
Member Since: 05/22/03
Post: 4 of 22

I don't see the loophole. Gingivitis is periodontal disease and should be treated with periodontal therapy. A prophylaxis is a preventive procedure to keep a healthy mouth healthy. It is not the treatment for gingivitis.

The problem: a bloody prophy (be careful saying this in Australia, New Zealand or the UK). But you know what I mean. So many patients with gingivitis are seen for a prophy when in fact they have periodontal disease, from gingivitis to moderate periodontitis. These cases are truly not a "prophy" by definition. Just because hygienists give away periodontal therapy and call it a "prophy" doesn't make it right. (I was guilty of this myself for many years.)

Diagnosis is the key. Is the person periodontally healthy or not? If he isn't healthy, he needs more than a "prophy" in order to stop the disease process and prevent further progression. ■

MAY 17 2010

Konarocky
Member Since: 10/08/05
Post: 5 of 22

I agree with Trisha on this one. I think a prophy is, or at least should be, a dental procedure that is utilized to prevent all periodontal disease. Unfortunately, from the legal point of view, there is nothing that I'm aware of that clearly states a prophy is the correct procedure for a patient with gingivitis. I was wondering more about the patient who clearly needs four

quads of SRP, but only wants a prophy. Even if you clearly document that the patient is refusing the needed treatment, how do you perform an actual prophy when a prophy implies completing a procedure that helps prevent gingivitis and/or periodontitis? You can't prevent something that already exists. It seems equivalent to charging a patient or insurance company for a vaccine that prevents a disease that the patient already has. ■

MAY 17 2010

Ahh, the age-old debate: The patient needs more than a prophy but only wants to do what his insurance covers or only wants to pay for a prophy when he really needs more. Would that same patient only want to do half the heart surgery or would he do whatever it takes to get the right treatment? ■

MAY 18 2010

JERSEY DEVIL
Member Since: 11/04/05
Post: 7 of 22

I do not give my patients the option of just doing a prophy. If they do not wish to have SRP, I try to educate them more and as we all know, there are still patients who just won't do it or do not get it. I figure that if this situation were to go to court I would be responsible because I did something that implies that patient has a healthy mouth and I am not willing to risk my license or his health just because of insurance. ■

MAY 18 2010

RDH3589
Member Since: 03/03/06
Post: 8 of 22

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