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# *When to refer to a periodontist*

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by Brian S. Gurinsky, DDS, MS

Sometimes one of our toughest calls as clinicians is knowing when to bring in a specialist. Do you have a medically complex patient?

One who has failed to respond to previous perio treatment?

Or perhaps your patient has unresolved gingival inflammation?

A periodontist can help.

as a practicing periodontist, one of the most frequent questions I get is: "How do I know when I should refer this to you?" Well, my initial answer is, refer to me any patient who probes more than 3mm and bleeds. However, there are some specific guidelines based on science.

An immediate red flag is if you struggle to diagnose and/or treat a periodontal condition, whatever it may be. Some patients have a genetic predisposition to gum disease or do not respond readily to treatment.

Also, never hesitate to refer a patient—adult or a child—who has aggressive periodontitis.

In my practice, pocket depths of 4mm–6mm are prime candidates for definitive scaling and root planing, unless there is an absence of subgingival accretions and bleeding. Where this starts to

get tricky are in the areas where surgery may not be ideal (anterior teeth) or in areas where root anatomy and access become challenging.

Pocket depths greater than 6mm are almost impossible to reach predictably and effectively. Because single-rooted teeth will be easier to treat than multi-rooted teeth, I may try and scale and root plane anterior teeth if probings are deeper than 6mm.

That said, I inform the patient that we are probably making a compromise in the effectiveness of treatment in order to preserve esthetics.

I am more reticent to perform periodontal surgery in the maxillary anterior teeth in the smile zone, or on patients with a lot of gingival display. Traditional periodontal surgery inherently

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*The bottom line is that we are basically mediocre at best when it comes to effectively cleaning subgingivally.*

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creates recession. We must be conscious of esthetics any time we put a scalpel in someone's mouth.

Another aspect of this question centers around the skill set and comfort level of the person doing the hygiene, usually a hygienist. Certainly a more experienced hygienist will be more skilled with instrumentation. Most hygienists have a good feel for when and where they are going to be successful in pocket reduction during non-surgical therapy.

But don't take my word for it. Let's look at some of the research.

## Research

Studies from Stambaugh, et al, showed some pretty alarming and concerning statistics: The average curette efficiency was to a pocket depth of 3.73mm.<sup>1</sup> This efficiency was defined as the depth at which the root surface was hard, smooth and completely free of plaque, calculus, gouges and scratches from instrumentation. The maximum pocket depth in which instrumentation was observed was 6.21mm.

I know what you are thinking. "I am probably better at instrumentation than those people in that study." That may be true, but the average time the clinician

spent on a maxillary posterior tooth was 39 minutes, and for a mandibular posterior tooth, it was 25 minutes. Let's admit we're all probably not spending that much time cleaning one tooth.

Clinicians showed better calculus removal on the mesial and distal surfaces as compared to the buccal and linguals. A later study by Dragoo wanted to test these numbers and determine if using ultrasonics would be any better.

He found that the depth of efficiency with ultrasonics was 4.65mm.<sup>2</sup> While this is definitely an improvement over hand instruments alone, it isn't good enough. We also have learned that complete calculus removal is extremely rare. Fortunately, we have also learned that it is not mandatory for success. Phew!

So knowing that we are limited in cleaning subgingivally past 4mm–5mm, the next logical question would be, "At what point do we look to perform surgery?"

Brayer, et al, confirmed that for pockets greater than 4mm, open flap debridement (periodontal surgery) was more effective in removal of calculus than nonsurgical treatment.<sup>3</sup> In molar sites, the difference was noted at 3mm (Caffesse, et al).<sup>4</sup> So if we know we're not super effective at scaling and root planing, now we know that in molar sites, it is worse! What we have learned is that cleaning furcations is almost impossible without ultrasonics. In fact, the width of most curettes is wider than the top of the furcation entrance.

## Other factors

What these studies haven't addressed is whether the addition of other modalities will help our nonsurgical outcomes.

Those may include local delivery chemotherapeutics (e.g. Arestin, Atridox), laser treatment, subantimicrobial systemic antibiotics (e.g., 20mg doxycycline). The addition of these auxiliary treatments may enhance the outcome if definitive nonsurgical treatment is our goal and a realistic possibility.

The bottom line is that we are basically mediocre at best when it comes to

effectively cleaning subgingivally. I generally recommend scaling and root planing for pockets under 6mm and surgery for pockets greater than 6mm.

However, anterior teeth—or any area where I am worried about the esthetic appearance if and when I create recession—tend to get a little more leeway in terms of root planing to a deeper than 6mm pocket. Mobility, bleeding on probing, furcation involvement, generalized pocketing vs. localized pocketing, smoking status, and the patient's age and health also will play a role in which direction I go.

## A final analysis

Here are some factors to consider when deciding whether or not to refer a patient.

- If the patient has unresolved inflammation or has lost bone or attachment, even with careful treatment.
- If a patient needs a bone regeneration procedure to support teeth or a bridge.
- If a patient has pathological lesions in the esthetic zone that require excision and grafting.
- If a patient needs a graft.
- If a patient has peri-implantitis or a mucocutaneous disease.
- If a patient who has received treatment for gingival overgrowth still struggles with the condition.
- If you simply are not comfortable treating a patient, for whatever reason.

None of these rules is hard and fast, but is instead a basis for starting a consultation. Each patient is different; each doctor is different. Understanding our limitations and expectations can only help guide us in treating the patient most effectively and realistically. Your periodontist is here to work with you to create the best possible outcome for the patient. ■

### References

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### Author Bio



**Dr. Brian Gurinsky** was born in Dallas, Texas and attended college at the University of Texas at Austin. He continued his education at Baylor College of Dentistry in Dallas where he attained his doctorate of dental surgery. Following graduation, Dr. Gurinsky began a three-year residency in periodontics and dental implants. On completion he earned his certificate in periodontics from the University of Texas Health Science Center in San Antonio. He has private practices in Denver and Centennial, Colorado.



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