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Editorial

Asymptomatic

A patient presents with fibrous tissues, no bleeding upon brushing or flossing, and probing depths of 6 to 7 mm. Radiographically, approximately 25% of the bony support around the teeth is missing. The patient has no complaints regarding discomfort, swelling, etc.

Another patient presents with significant wear on all occlusal surfaces of his dentition. Cusp tips and cusp inclines have essentially been obliterated. No tooth mobility is noted greater than degree I. No joint symptoms or pain during function are elicited.

A third patient demonstrates a lack of keratinized tissue, a buccolingual soft tissue thickness of approximately 1 mm on the facial aspects of the mandibular anterior teeth, and a thin, highly scalloped biotype. No soft tissue recession has occurred. The soft tissue margins are 1 mm coronal to the cementoenamel junctions of the teeth. The patient has no complaints, but is planned to receive orthodontic therapy, which will include buccal tooth movement and arch expansion in the anterior region.

Should any of these patients undergo active therapy? Does the first patient require periodontal treatment to eliminate pocketing and create a milieu more conducive to plaque control measures? Would the second patient benefit from replacement of lost tooth structure and reestablishment of anterior guidance, etc? Should the third patient have soft tissue augmentation therapy performed on the buccal aspects of the mandibular anterior teeth prior to initiation of arch expansion? The practitioners performing the initial examinations on each of these patients stated that the patients were "asymptomatic."

The challenge is not to decide whether to perform therapy for any of these patients or which treatment modality to employ. Rather, a decision must be made as to whether these patients are truly asymptomatic.

Upon entering periodontal clinical practice in 1981, I often heard that periodontal disease was a "silent disease." This was analogous to the "silent killer" label given to heart disease. We now know that behavior modification and interceptive medicine significantly reduce the incidence of heart disease. Tests are available to predict patient susceptibility to developing heart disease, as well as to detect the early stages of heart disease and treat the problem before more serious sequelae develop. When clinicians speak about periodontal pathologies being a "silent disease," is this characteristic innate to periodontal pathologies, or is it a result of a lack of diagnostic tests, a failure to perform a thorough diagnosis, or both?

A patient presents to his primary care physician for an annual checkup. The patient has no complaints and states that he "feels normal." Thorough examination by the primary care physician reveals polyps. The patient is sent for a colonoscopy and a diagnosis comes back of rectal cancer. Does the fact that the patient did not complain of symptomatology render him asymptomatic? Or is the patient symptomatic once appropriate examination and testing are carried out?

All too often, our profession speaks of symptoms as something that must be elicited verbally from the patient. However, advances in diagnostic testing and a more thorough understanding of disease processes mandates that a true definition of "asymptomatic" be one that results from no patient complaints, no possible signs of disease discovered by the clinician, and no abnormal test results.

A patient requiring crown-lengthening osseous surgery to expose adequate tooth structure for appropriate restoration in a milieu that will be cleansable for the patient does not present

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with a "chief complaint." This patient's symptomology is a direct result of a thorough examination and diagnosis.

Clinical judgment may also work in the opposite manner, overriding diagnostic "symptoms" in determining that specific therapies are overly aggressive. A patient in her 70s who demonstrates a Class I buccal furcation involvement at the mandibular left first molar, no tooth mobility, and no need for restorative intervention in the area should not be subjected to periodontal resective surgery to eliminate the aforementioned furcation. In such a situation, the severity of the symptoms taken in the context of actuarial realities does not warrant intervention.

Analogies may be drawn to the inclusion of continuing education, evolution of practice philosophy and patient treatment, and management of a clinical practice. Is a clinician who has not been trained in developing concepts and techniques over the last 10 years appropriately trained? Is the therapy he or she is performing within a reasonable definition of the standard of care? The answers must be no. Regardless of the clinician's innate talents, failure to keep abreast of developing concepts, materials, and therapies and their integration into everyday clinical practice represents a significant compromise in the treatment delivered to the patient.

Attending continuing education courses that do nothing more than review well-established therapies without discussing newer treatment possibilities and challenging attendees to think critically merely serve the purpose of accumulating regulatory board-mandated continuing education credits. Our patients deserve to be treated by clinicians who understand the potentials of available therapies and how best to integrate these treatment approaches into daily clinical practice.

It is for this reason, among many others, that symposia such as Quintessence's International Symposium of Periodontics and Restorative Dentistry are invaluable to our profession, ourselves, and our patients.

Clinicians must also perform appropriate examination, diagnosis, and testing when considering the health of their practices from a management point of view. A clinical practice that has devolved into nothing more than piece work, treating problems reactively as they become acute and having treatment philosophy and therapeutic end points dictated by insurance corporations, is diseased. Appropriate diagnosis demonstrates the expected symptoms. The challenge is for the clinician to formulate a comprehensive treatment plan and restore the practice to a state of health. A clinical practice that is "standing still" is a failing practice. While the decline is more subtle than an overt collapse, appropriate diagnosis and testing easily reveals the problem and the need to intervene.

While patients should never be overtreated, therapy must be delivered in an interceptive manner so as to treat problems at their most incipient stages. Comprehensive care, defined as the totality of therapy required to restore the patient to health, must be rendered independent of corporate mandates.

To quote a song lyric that was popular decades ago, "We see what we want to see and disregard the rest."[1] We must expand our scope of vision.

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Reference

[1]Paul Simon, "The Boxer."