Guest Editorial — Hard Tissue Management?

With the understanding that the vast majority of teeth lost after the age of 35 is due to the destructive influence of periodontal disease, it only follows that we as a profession would be called upon to accept a higher level of responsibility for the prevention, early detection, and management of periodontal disease. I believe that as this emphasis is incorporated into the regular program of services offered in the general practice that there is an enormous and shared benefit among the patients, the practices, and the specialty of periodontics. As with all "new" services, it is important to be sure that the quality of care in that area is consistent with the quality of care demanded of all other services in the practice, and that a satisfactory end point of treatment can be established that is definable, achievable, and maintainable.

Clearly, managing periodontal disease in our practice is simply the right thing to do, but, frankly, the enthusiasm has risen in large part due to the need to be more productive. With caries destruction dramatically reduced after generations of fluoride protection and the "downsizing" of our practices as patients try their luck in managed-care type programs, a number of "profit center" supplements or alternatives have been introduced and promoted. Among the more popular are temporomandibular joint therapy, bonding, bleaching and a myriad of cosmetic improvements, the treatment of halitosis, and, of course, the comprehensive Soft Tissue Management Programs. Each one of these "centers" can provide a valuable service for the appropriate patient in need.

With rare exception the need or desire to be more productive is very real throughout our profession. I believe that the need to supplement one's practice with one or more of these "services" arises from the misconception that there is not enough legitimate restorative care to support the practice. On the contrary, in my 24 years of practice I have seen hundreds of thousands of dollars of dental care sidelined in what I would like to refer to as Hard Tissue Management Programs.

In an effort to be kinder, gentler (less expensive), and more understanding, the practitioner frequently will elect to forego comprehensive evaluation and treatment planning in favor of adopting the "wait and see" attitude. We simply do not want to run the risk that our patient will leave our practice. However, when we fall into that trap, no one benefits! Were the patient's true dental needs evaluated? Was the patient given an opportunity to decide his or her own long-term dental future? Was the practitioner given the opportunity to provide that level of care that instills pride and profitability as well? Has the practitioner truly distinguished himself from the managed care experience or has he just become an unwitting competitor providing piecemeal service identifiable on a list of "allowable services"?

Those of us who practice periodontics often see the misuse of Soft Tissue Management by the general practitioner in the same light. Dental disease and periodontal disease have a number of characteristics that they share in common. Perhaps the most significant is that clinical symptoms often lag way behind the initial observation, whether it be a large, slowly expanding alloy in a maxillary bicuspid that is destined to lead to a palatal cusp fracture, or a 5 mm pocket on the distal of a maxillary first molar that is only first beginning to erode the bone in the bifurcation area. More often than not, appropriate and definitive interceptive decisions are put off and are not addressed until meaningful care becomes more complex, more expensive, and may carry a reduced prognosis. If one extends this line of thinking to more complex problems, such as those identified under the category of "occlusal disease," then the complications of waiting grow in a geometric fashion. The identifiable concerns in this area include: premature wear of the anterior teeth leading to a loss of posterior protection; significant fremitus patterns in centric and lateral contacts; hypermobility of individual or segments of teeth; significant deflection of the dentition between centric

occlusion and centric relation; cracked teeth and abfraction; and a myriad of subtle and not so subtle TMJ symptoms. I know that most of our patients present with these maladies and seem to get along okay, but we must recognize them for what consequences they may bring and share this with the patient so that together we can elect an appropriate level of care. This represents the true essence of our profession. This presupposes that you have sharpened your diagnostic skills in that area and that you are more than acquainted with a number of treatment alternatives and, when necessary, are willing to consult with a specialist who may be able to expand the process even further.

Additionally, we see patients enrolled in Soft Tissue Management Programs who present with deepened sulci on the distal of their second molars and are invited for multiple sessions of full-mouth scaling and root planing with local anesthetic, where a myriad of colorful solutions are irrigated to kill off the offending organism. As we well know, far greater attachment loss is created when trying to instrument the 2 to 3 mm sulci in the rest of the dentition of that patient than if we left the plaque there altogether. The commonly encountered hyperplastic retromolar pads and tuberosity areas can easily be reduced surgically and provide a definitive solution to those isolated problems and probably for the same cost of the "more comprehensive approach."

Though the value of pocket elimination has been open to question, nothing we know of today has greater long-term impact on reducing the bacterial challenge of subgingival debris and enhancing host resistance. Even the regenerative technologies (GTR) are focused squarely on pocket closure, for it would be a rare instance, indeed, if enough new attachment could be rebuilt to stabilize a loose tooth.

Attempting to manage a patient within the context of "the program" who presents with advancing disease far in excess of what one might have anticipated as a function of the patient's age, social status, and local factors represents poor judgment! These patients have a level of Rapidly Progressive Periodontitis and should be treated very aggressively. Trying to "control" these patients' conditions for as little as 1 year can often result in an even more unmanageable situation. These patients may even be refractory to any level of care and should be seen by a specialist.

Often the well-meaning enthusiasm of the hygienist leads to the unnecessary and prolonged attempts to keep a tooth which would be better handled by prosthetic replacement. Consider the cost-benefit ratio in time, effort, dollars, and restored sense of well-being between multiple visits of irrigation, pocket probing, subgingival debridement, bacterial culturing, and antibiotic therapy, and that of seeking a treatment that has shown predictable, long-term benefits that can be effectively monitored by a reasonably compliant patient. Patients have spent hours and hours and thousands of dollars to avoid the all-to-often threat... "otherwise, we will have to send you to the periodontist." No wonder when it finally becomes imperative, they simply won't go. And so, patients are flushing deep pockets with this month's "mystery fluid" or having high concentration antibiotic fibers shoved into the pockets and sealed off with Super Glue, while at the same time we in periodontics are coming closer and closer to being able to regenerate the lost periodontium on a predictable level. Which would you choose for your own mouth?

The overall goal of most Soft Tissue Management Programs is to reduce the supragingival and subgingival debris below a critical mass level to allow the natural defenses of the patient to regain control over a disease process that has created some level of destruction of the periodontal tissues. Treating moderate to advanced disease states to an effective conclusion within the customary framework of these programs is, at best, optimistic, given our knowledge of the limits of subgingival instrumentation, irrigation, microbial specificity, and patient compliance. Even those most opposed to treatment aimed at pocket elimination would have to agree that a shallow sulcus is not nearly as conducive to the maturation of a pathogenic flora as one beyond 5 mm. Soft tissue response as a barometer of treatment effectiveness is deceiving at best.

At least for today, there is a shrinking population of patients willing to take responsibility for their own dental needs who also have sufficient discretionary income to allow us to provide for them the finest that dentistry has to offer. I believe that within that group there is an enormous amount of undiagnosed and uncompleted dental care, both restorative and periodontal. Because we have been chosen to take responsibility for the dental needs of these people, we must avoid the condescending attitude that drove the physicians' patients into the claws of managed care. We must be prepared first to listen and then to support them with the most carefully thought out and expertly delivered treatment in an environment that bespeaks our commitment to quality. The general practitioner must be willing to take a more active role in the interoffice management of patient care when specialists become part of the team. All too often, the GPs manage their valuable asset (the patient) with either no or inadequate communication before, during, and after treatment. It is no wonder they feel that the specialist has commandeered the patient. Communication must become a two-way street.

Too many of our colleagues are frozen on the fence with fears of practicing in the Hard Tissue Management Programs. To break out of that rut and to become included in that small clique of fee-for-service practices, one must pay a great price. For generations, one needed only a diploma and shingle to establish a successful practice, the character of which was only a reflection of the vision and integrity of the doctor. Although this may still be enough in the most rural of settings, the present reality forces us to challenge ourselves to "seek the higher ground."

The occasional student in us must graduate to become the perpetual student. Managing the technological advances that allow us to provide a superior service demands constant study and the courage to change; the courage to continue to invest in ourselves, our staff, and our facility.

The general practitioners that I know presently included in that small "winner's circle" have extraordinarily high overheads. They use only the finest of material, employ only the most talented people to participate as team members of their staff, and work with the finest laboratories. They may or may not be included among the most successful dentists in terms of annual income. If that is your singular goal, the price may be too great! The one gift that these talented individuals share is the joy of going to work each day, achieving enormous personal satisfaction on an almost daily basis, developing the respect of their colleagues, their staff, and their community, and, more often than not, being surrounded by a family of motivated and appreciative patients. If that sounds like the direction in which you would like to grow, then what's holding you back?

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Erratum

Please note the following additions to the article "Soft Tissue Ridge Augmentation Utilizing a Combination Onlay-Interpositional Graft Procedure: A Case Report" by Seibert and Louis (Int J Periodont Rest Dent 1996;16:311–321). Figures 13 and 14 were inadvertently omitted in the original version of the article. The publisher regrets this error.

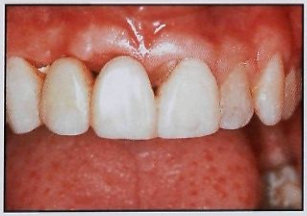

Fig 13 *At 6 weeks postsurgery (May 4, 1995), further augmentation is required to gain soft tissue in both the vertical and horizontal planes. The first-stage graft was successful in eliminating many of the irregularities in the surface of the ridge as well as gaining soft tissue bulk in both planes of space.*

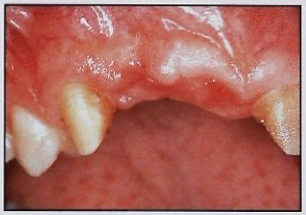

Fig 14 *Surface contours of the ridge with the provisional prosthesis removed at 6 weeks postsurgery. It was elected to perform a second-stage onlay–interpositional graft that day (May 4, 1995).*