St George's University Hospitals NHS
NHS Foundation Trust

Department of Restorative Dentistry
Maxillofacial Unit
St George's University Hospitals
NHS Foundation Trust
London

Periodontitis Treatment Protocol

Periodontal Assessment

Signs of periodontal disease: - Gingivae become red/purple
- Gingivae loses stippled texture
- Oedematous, swollen, spongy, friable gingivae
- Gingival margins can become thick, blunted, rolled
- Suppuration
- Disease may be present in the absence of these signs

BPE should be carried out at every examination visit. Use of WHO probe (diameter of 0.5mm and coloured band from 3.5-5.5mm) and probing force of 20-25g is recommended

BPE Scoring codes:

0	No pockets >3.5 mm, no calculus/overhangs, no bleeding after probing (black band completely visible)
1	No pockets >3.5 mm, no calculus/overhangs, but bleeding after probing (black band completely visible)
2	No pockets >3.5 mm, but supra- or subgingival calculus/overhangs (black band completely visible)
3	Probing depth 3.5-5.5 mm (black band partially visible, indicating pocket of 4-5 mm)
4	Probing depth >5.5 mm (black band entirely within the pocket, indicating pocket of 6 mm or more)
*	Furcation involvement

Pre and post-treatment full periodontal indices should be completed where there are BPE scores of 3 or 4

Plaque scores can be good motivation for patients, however please note the appearance of the gingival tissues as this is a better indication of inflammation than the patients plaque score on the day.

Diagnosis: 2018 Classification (https://www.efp.org/newsupdate/world-workshop-on-classification/)

1	Health is <10% of sites bleeding on probing, no pockets >4mm, no bone loss (on a healthy or reduced periodontium) Gingivitis – Localised (10-30% BoP) or generalised (>30% BoP) in healthy periodontium (no bone loss) or reduced periodontium (stabilised periodontal disease with no pockets 4mm or above with BoP) Gingival diseases
2	**Periodontitis -** Staging takes into account severity and complexity of management. Grading gives an opportunity to describe biological features Necrotising periodontal diseases – NUG / NUP
3	Perio-Endo lesions Abscesses of the periodontium Periodontal disease associated with systemic illness Mucogingival deformities and conditions – Recession types 1 (no loss of interproximal attachment), 2 (loss of interproximal attachment) and 3 (interproximal attachment loss is greater than the buccal attachment loss) Traumatic and prosthesis related gingival or periodontal diseases
4	Peri-implant disease - Peri-implant health, Peri-implant mucositis, Peri-implantitis, Per-implant soft and hard tissue defects

Treatment:

Mild to moderate periodontitis		Severe/very severe periodontitis	
Stage I	Stage II	Stage III	Stage IV
Grade A, B or C			
Standard periodontal treatment		Complex and/or multidisciplinary treatment	

1. Non-Surgical Treatment

a. OHI – the use of snug fitting Tepe brushes, floss and single tufted brushes (+ smoking cessation, advice on diabetes control as appropriate)
b. Full Periodontal indices (see attached)
c. RSD pockets 4mm or deeper under LA (2mins per site using ultrasonic) + OHI
d. Oral hygiene review at one month post RSD (assess inflamed soft tissues, remove calculus, reassess Tepe brushes and demonstrate snug fitting Tepe brushes)

Tepe Brushes: Snug fit, change in size as inflammation subsides, use them in furcations, use a single tufted brush or small Tepe brushes vertically in deep pockets

Expected outcomes from non-surgical treatment (Cobb CM. J of C Periodontol. 2002;29(Suppl 2):6-16):

Pocket depth (Cobb 1996)	Reduction in pocket depth	Attachment change
1-3mm pockets	0.03mm	- 0.34mm (loss)
4-6mm pockets	1.29mm	+ 0.55mm (gain)
7mm + pockets	2.16mm	+ 1.19mm (gain)

2. Reassessment & Further Treatment

- Minimum of 3 months post RSD before reassessment to allow gingival healing
- Full periodontal indices (which should include at least pocket depths and bleeding on probing)
- Assess reasons for the presence of residual pockets
- Plan either a further cycle of non-surgical RSD or surgical treatment – pockets that are 6mm or deeper would be considered incomplete treatment and would need further treatment

3. Supportive Periodontal Treatment / Periodontal Maintenance

Frequency depends on the compliance of the patient, may vary between 2 – 4 months and should include the following:

a. Review and reinforce OH – i.e. show the patient which areas are being missed and show them in how to clean these areas in the patients own mouth
b. Full periodontal indices (which should include at least pocket depths and bleeding on probing)
c. Scaling pockets that are 4mm or deeper and maintaining them - may need LA and RSD (may even need to consider other treatment such as surgery, root amputation, hemisection – this can be provided in secondary care)

Date:

Patient Name:

Date of birth:

Mobility															
Furcation															
Suppuration															
BoP															
CAL															
Recession															
6PPC															
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
6PPC															
Recession															
CAL															
BoP															
Suppuration															
Furcation															
Mobility															

Excellence in specialist and community healthcare

St George's University Hospitals NHS Foundation Trust