SLDA News

SRI LANKA DENTAL ASSOCIATION

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SLDA/2021/2022/08/02 | Monthly News & Events Bulletin of SLDA | August 2021- For circulation among SLDA members

REFRESHER/GAP FILLING COURSE FOR DENTAL SURGERY NURSE ASSISTANTS NVQ LEVEL-3 (3RD PHASE)

Private Health Services Regulatory Commission (PHSRC) together with Sri Lanka Dental Association, has successfully completed two phases of the above program in collaboration with National Apprentice and Industrial Training Authority (NAITA), where candidates from Private Dental Surgeries established in every part of the country and even Dental Surgeries established at Private Hospitals were assessed by conducting refresher courses and examinations.

The successful candidates have been listed in the Private Health Services Regulatory Council as "Private Sector Dental Surgery Nurse Assistants". There would be many more candidates eligible to follow the course according to the guidelines set by the council. We intend continuing the same program in collaboration with NAITA, Provincial Directorates of Health Services, and SLDA with the view of developing the quality of services rendered by the Private Dental Surgeries.

Since the 3rd phase of the program is about to commence, we request that all eligible candidates in your institute to be enrolled by using the application form downloaded from following link and submitting to the PHSRC on or before **20th September 2021**.

Please note that, your institute should be registered at PHSRC for the year 2021 in order to participate in the program.

Downloads: https://tinyurl.com/SLDA-News-August

SLDA MEMBERS CONTACT DETAILS UPDATE

The following link can be used to send data to update your contact details at SLDA database.

https://tinyurl.com/SLDA-Contact-Update

Members also can text SLMC Reg. No, Email and Name to 076 563 9899 to update your contact details.

SLDA MEMBERSHIP APPLICATION FORM

SLDA membership application can be downloaded from the below link for new members.

https://tinyurl.com/SLDA-Membership-Application

ESTHETIC SUMMIT 2021

This was organized By Indian Academy of Aesthetic and Cosmetic Dentistry (IAACD), held from 27th to 29th August, 2021, in an online platform. SLDA members were invited complimentary registration for this Summit. About 85 members of SLDA were registered and joined this online conference. SLDA wishes to send sincere gratitude to IAACD for the cooperation extended in this regard.

VACCINATION PROGRAMME FOR DSAs AND DENTAL TECHNICIANS IN THE GENERAL DENTAL PRACTICE

A vaccination programme for COVID 19, organized by SLDA was held at National Dental (Teaching) Hospital, Colombo 7 on 3rd of September 2021. DSAs and Dental Technicians above 18 years of age received vaccination there.

NATIONAL APEX AWARDS

The deadline for the closing date of applications for the National Apex Awards 2021 has been extended till the 21st of September 2021. Applications should be reached at this office on or before 16th of September to be forwarded to OPA.

More Information: https://tinyurl.com/SLDA-News-August

SLDA - CDA CONTINUING EDUCATION PROGRAMME

Continuing Education, Publication and Web Development Committee of SLDA together with Commonwealth Dental Association (CDA) is organizing the next Virtual Clinical Meeting on 10th September 2021, at 8.00 pm SLST / 2.30 pm GMT on the Zoom link. https://tinyurl.com/SLDA-CDA Meeting ID: 627 4386 9476

VIRTUAL CLINICAL MEETING HELD ON 29TH SEPTEMBER 2021

The second SLDA - CDA clinical meeting for the month of September was held on 29th Sunday on 'Endodontic Retreatment - A Path Less Travelled'. Dr. Viresh Chopra BDS, MDS, Specialist in Endodontology, Lead for Endodontology and Senior Lecturer in adult restorative dentistry at Oman Dental College Muscat, Oman was the speaker.

NOTICES

A notice from Association of Specialists in Restorative Dentistry - Sri Lanka

A Notice from Peradeniya Dental Faculty Alumni Association (PEDFAA)

A Notice from College of General Dental Practitioners of Sri Lanka

College of General Dental Practitioners of Sri Lanka informs that, SLMC recognized MCGDP course which was slated to be operational by September 2021 and postponed due to the pandemic situation in the country, will be starting in the near future.

Date	Event	More Information
To be rescheduled	Organization of Professional Associations - Annual Scientific Sessions	www.opasrilanka.org
26-29 Sept 2021	FDI World Dental Federation - World Dental Congress (Special Edition) - Sydney	https://2021.world-dental-congress.org/
03-06 Nov 2021	DenTech 2021 - China International Exhibition & Symposium on Dental Equipment, Technology & Products - Shanghai	https://en.dentech.com.cn
22-23 Jan 2022	Annual scientific Sessions of the Nutrition Society of Sri Lanka 2022	NSSL link for details: http://nutritionsocietyofsrilanka.org/annual-scientific-sessions-2022/ Link for session registration: https://forms.gle/KWHBdrX5Gjp1XJBt8
01-03 Feb 2022	AEEDC - International Dental Conference & Dental Exhibition - Dubai	https://aeedc.com/

Dr Chandima Weerasinghe
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Seeing the unseen; from periodontal health to disease

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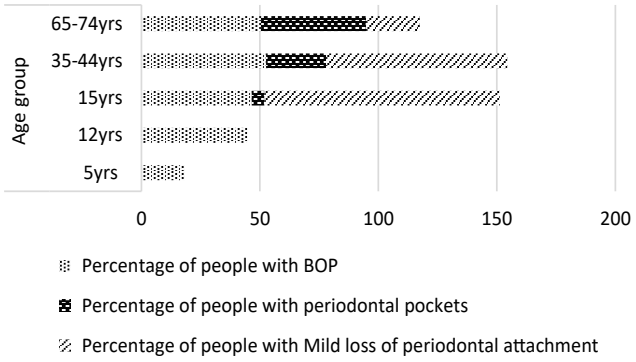
According to the Global Burden of Disease Study (2016), severe periodontal disease is the 11th most prevalent condition in the world affecting 20% to 50% of the population around the world.(1,2)

Do we see a comparable presentation in the Sri Lankan context?
2002/2003 National Oral health Survey presented that about 90% of the population is affected with some form of periodontal disease. Similar circumstances were reported in the latest oral health survey in 2015/2016 as well (Figure 1). Therefore, it is highly likely that the patient attends to your clinic has undiagnosed periodontal pathology awaiting the proper attention of the clinician.

Figure 1: Data from 2015/2016 NOHS



Periodontitis is an inflammatory disorder which initiates with gingivitis; inflammation of the gingiva. (3) If left untreated, the disease will surpass this reversible stage and will progressively evolve causing development of deep periodontal lesions, loss of periodontal attachment and ultimately tooth loss which could compromise the quality of life of an individual.(4)

Thus, early diagnosis is important to prevent further irreversible damages to the periodontium. Moreover, there are different forms of periodontal diseases and conditions which could mimic plaque induced gingivitis/periodontitis (Figure 2). Therefore, correct identification of the associated factors and the characteristics of the disease/condition, will pave the way to the best possible care that could be delivered to the patient.

Figure 2: A patient presented with desquamative gingivitis due to lichen planus

"Glance through" Vs Assessment of the periodontal health

Healthy gingiva is normally pale pink and is affected by racial pigmentation. Visual inspection of the gingival tissues for inflammatory changes such as redness, change in gingival contour and soft in consistency could give some information on the gingival health to the clinician.

The photograph shown in Figure 3 is from an otherwise healthy, 29-yr-old male, who complaint of bleeding from gums.

Figure 3: Clinical photograph of the patient

Due to the visible inflammatory changes in the gingiva, one might decide the condition in the patient as plaque induced gingivitis. However, it is difficult to assess the exact disease presentation alone with the visual inspection. Moreover, it would not warrant to differentiate plaque induced periodontal disease from other diseases/conditions that could affect the periodontium and to decide a severity level. Therefore, proper assessment of periodontal health

should be an essential component of routine patient evaluation.

What is the most efficient way to assess the periodontal health?

The assessment of periodontal health could be commenced by carrying out "Periodontal screening". Periodontal screening is a simple, easy way of evaluating the periodontal health which assigns a code according to the findings and provides guidance for further assessments as well as possible treatments. It is indicated for all patients at the initial visit.

There are two main screening techniques:

i) Periodontal Screening Record (PSR) introduced by American Dental Association and American Academy of Periodontology
ii) Basic Periodontal Examination (BPE) introduced by British Society of Periodontology

The coding system is based on mainly three parameters:

a) Gingival bleeding on probing
b) Detection of calculi
c) Probing depth

In both techniques, the mouth is divided into 6 divisions; sextants (Figure 4) and a similar coding system is used, though there are slight differences in additional parameters denoted by the code '*'. As additional features, the latest guidelines for BPE considers only furcation involvement (Code denoted by '*'). In contrast, PSR considers tooth mobility and recession apart from furcation involvement.

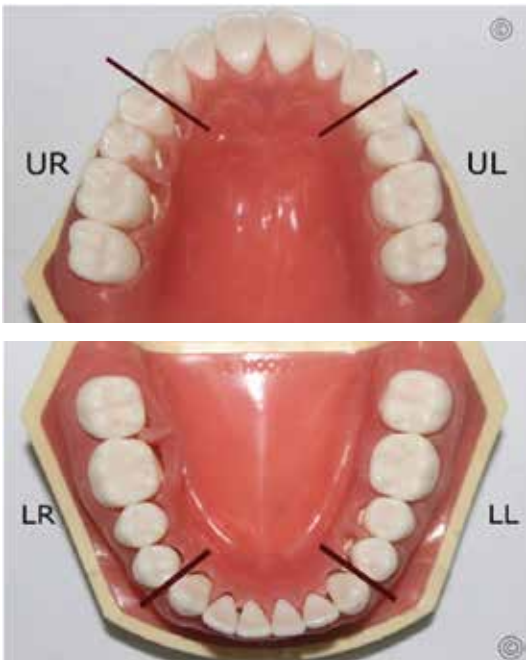


Figure 4: Divisions into sextants; UR-Upper right, UL-Upper left, LR-Lower right, LL-Lower left

How to perform BPE?

World Health Organization (WHO) periodontal probe/CPI probe (Community Periodontal Index) is the recommended instrument for periodontal screening (Figure 5 & Table 1).

Figure 5: WHO/CPI probe used for periodontal screening

Table 1: The advantages of features of WHO/CPI probe	
i) 0.5mm diameter ball tip	• Distributes the force applied during probing over a larger surface area. Therefore, reduce risk of injury during the procedure and increase patient's comfort • Keep the shank of the probe away from the tooth, enabling detection of subgingival calculi and overhanging restorations
ii) Coloured band/s a) from 3.5-5.5mm from the tip b) from 8.5-11.5mm	• Allows quick estimate on pocket depths

Usually, a probing force of approximately 20–25 g is recommended. Alternatively, in order to give an understanding of the required force to the clinician, the pressure required to depress the skin on the pad of the thumb by 1 mm or when the probe is placed underneath the thumbnail, the pressure required to blanch the tissues, is described.

A quick assessment is done by 'walking' the probe around the tooth, exploring the extent of any pocketing, presence of calculi and bleeding on probing.

Charting the BPE findings (Figure 6):

For the charting simple box chart is used reflecting the sextants in the same systematic order.

Sextants with less than two teeth are indicated with an 'X' and are not considered in the overall evaluation.

However, if the sextant has only one functional tooth, it is included in the preceding sextant. Following probing all the teeth, each tooth is scored from Code 0 to Code 4, but only the highest score of the sextant is recorded (Table 2). If the furcation is detected, the score should be recorded with '*'. Thus, the periodontal health of a sextant corresponds to the most important clinical sign observed within the sextant. This technique is recommended for patients 18-yr-old and above. For those who receive code 0/1/2, BPE should be repeated at all follow-up examination visits.

For the Periodontal screening of children from 7yrs of age and adolescents, British Society of Periodontology and British Society of Paediatric Dentistry have proposed a simplified version of BPE which considers only six index teeth (UR6, UR1, UL6, LL6, LL1 and LR6). As the children between 7-11yrs could present with false pocketing during the mixed dentition stage, only the BPE codes from 0-2 are applied while the full range of codes could be adopted for the aged 12-17yrs.

Moreover, due to the nature of the attachment around an implant, instead of these techniques, a 4/6-point pocket chart should be carried out around implants and should collectively assess the outcome with presence of bleeding on probing as a sign of inflammation of peri-implant mucosa.

Figure 6: Example of a BPE recording using a simple box chart

4*	3	4
X	2	3

What more the periodontium would express..

Depending on the readings of the BPE/periodontal screening, further periodontal assessments if indicated, should be carried out. There are several key parameters that would reflect the periodontal health.

1. Bleeding on probing (BOP):

BOP denotes the inflammation of the gingival tissues provoked by applying the probe to the bottom of the sulcus/periodontal pocket. It is also considered as an early sign of gingivitis than other visual signs of inflammation. However, be cautious when interpreting BOP in smokers, as smoking is found to exert a strong suppressive effect on BOP. [5]

2. Periodontal probing depth

Probing depth is measured from the base of the sulcus/pocket to the gingival margin. Depth of 4mm or below dictates the patient's ability to maintain periodontal health by optimal plaque control

Table 2: BPE guidelines *(2019/BSP)*

Scoring Code	Parameters	Follow-up action
0	Pockets <3.5mm No calculus/overhangs, no bleeding on probing (black band entirely visible)	No need for periodontal treatment. Repeat at next check-up visit
1	Pockets <3.5mm No calculus/overhangs, **bleeding on probing** (black band entirely visible)	Record plaque & bleeding chart Oral hygiene instruction (OHI) Repeat at next check-up visit
2	Pockets <3.5mm **Supra or subgingival calculus/overhangs** (black band entirely visible)	Record plaque & bleeding chart As for Code 1, plus removal of plaque retentive factors, including all supra and subgingival calculus Repeat at next check-up visit
3	**Probing depth 3.5-5.5mm** (**Black band partially visible**, indicating pocket of 4-5mm)	- Require radiographs to visualize crestal bone levels. - As for Code 2 including risk factor control. Following initial therapy, in a reassessment stage, record a 6-point pocket chart (6-PPC) only in that sextant. Carryout root surface debridement (RSD) if required.
4	**Probing depth >5.5mm** (**Black band disappears**, indicating a pocket of 6mm or more)	- Carryout full mouth 6-PPC for pockets ≥4mm. Record bleeding on probing on the same chart. -Tooth mobility, presence of recession, furcation involvements also could be recorded. - Require radiographs. - OHI, RSD. - Assess the need for more complex treatment; referral to a specialist may be indicated
*	Furcation involvement	Same as codes 0-4. Assess need for more complex treatment; referral to a specialist may be indicated

measures. Therefore, recording the periodontal pockets with ≥4mm, guides the clinician on the sites that need to be monitored. However, any deep pockets found in a patient who has undergone periodontal non-surgical treatments, will not always signifies disease as they could be uninflamed and stable.

For patients currently in the maintenance phase of treatment (supportive periodontal care), full periodontal charting would be required to assess at least annually for evidence of disease progression.

3. Tooth mobility:

Tooth mobility would not be always considered as sign of disease. For e.g., a tooth with widened periodontal ligament space due to occlusal trauma could manifest as increased mobility. Moreover, a tooth with a reduced but healthy periodontium could also manifest tooth mobility due to the reduced support. Therefore, mobility due to active periodontal attachment loss should be carefully assessed and determined.

4. Gingival recession:

It is defined as apical migration of the gingival margin beyond the cemento-enamel junction (CEJ). The presence of recession could be associated with clinical attachment loss (CAL) including loss of gingiva, periodontal ligament, root cementum, and alveolar bone. However, it is important to note that due to the multifactorial aetiology, the full depth of CAL that is evident as recession may not reflect the true attachment loss that has been taken place due to plaque induced disease. Therefore, the other associated factors should be assessed and possibly excluded. The recession is measured from deepest point on the gingival margin to the CEJ by using a periodontal probe. It is worth recording the side of the recession defect; buccal/labial or lingual/palatal for monitoring purpose. If the 6-PPC is indicated, same chart could be used to record the recession defects.

5. Radiological assessments:

According to the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions, the diagnosis of periodontitis is based on clinical attachment loss detected with reference to the CEJ.[6] The usual distance from the CEJ to interdental bone crest (IDBC) in healthy individuals could vary between 1.5-2mm. However, it is important to note that factors such as patient age, tooth type, angulation of teeth, and severe attrition can influence the CEJ-IDBC height, thus caution must be exercised when assessing this parameter as a measure of periodontal health. [7]

The other radiographic features of a normal, anatomically intact periodontium would include an intact lamina dura (both laterally and at the alveolar crest) and no evidence of bone loss in furcation areas. In presence of bone loss; degree of bone loss (in percentage), the bone loss pattern that could observe, presence of local risk factors and other pathologies such as endo-periodontal lesions should be assessed.

The multi-model pathogenesis of periodontal diseases involves interplay between the plaque biofilms and the host's immune-inflammatory responses, which could be influenced by genetics, lifestyle and environmental modifying factors.[8] Therefore, identifying the modifiable risk factors such as sub optimally controlled diabetes mellitus and smoking or non-modifiable risk factors such as genetic predisposition, would help the clinician to further categorize the susceptibility of the patient to periodontal disease. Furthermore, it guides the clinician to incorporate approaches to reduce the risk factors, deciding the recall intervals and plan the maintenance care.

For the successful management of a patient with periodontal disease, adequate evaluation of the periodontium is mandatory. As discussed, the patient assessment should expand beyond the visual inspection, with aids of the necessary procedures that would reveal the accurate status of the periodontal health.

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