Maintenance care for treated periodontitis patients


Abstract. This paper is a review of current literature combined with clinical observations. Well-controlled maintenance care is a key consideration in the long-term prognosis of treated periodontitis patients. Periodic professional tooth cleaning every 3 to 4 months often is recommended. Furthermore, recent studies indicate a potential need for selected retreatment in problem areas, since minute residual accretions may be left behind during active therapy—even with “open” surgery. While efficient plaque control is essential for optimal results during the healing phase of periodontal therapy, periodic prophylaxis may prevent loss of clinical attachment over long periods of time even for patients with less than perfect oral hygiene.

If a person once has developed periodontitis, it has to be assumed that he/she is at risk for future loss of periodontal attachment if bacterial action is not contained in some way (Loe et al. 1978). There is at present no “definitive periodontal treatment” that will cure all periodontal infections in the same sense as an infection in a finger or a toe may be cured with antibiotics without residual predisposition to a recurrent infection. Periodontal disease is the result of opportunistic infection (Lang et al. 1985) by infective organisms which cannot be eliminated from the mouth over prolonged time, and so far we have no way to boost the patient’s immunoresponses to the extent that these organisms would be innocuous. Complete periodontal health will exist only with perfect plaque control, which usually is an elusive goal over a long period of time for patients who have had periodontitis (Ramfjord et al. 1982). Obviously, the closer we come to maintenance of a plaque-free dentition, the lesser is the risk for return of any periodontal disease. However, the facts of life are that in spite of extensive attempts, we have not been able to maintain complete plaque control in periodontitis patients over years, even when unrealistic amounts of time and effort were spent towards that goal (Ramfjord et al. 1982). Fortunately, a great number of individuals may harbour some plaque without even developing gingivitis, and a good % of adults have plaque and gingivitis without developing periodontitis. Thus, dentists may function in comfort and without measurable loss of support for the teeth over many years, in spite of less than perfect plaque control. Gingivitis has to be characterized as a form of periodontal disease with a potential over time to develop into periodontitis. From a practical public health standpoint, it has been suggested that it would be very important to determine who can tolerate a certain amount of plaque and gingivitis over time without developing periodontitis, and only in susceptible individuals to intercept the infective process before periodontal attachment is lost (Posson & Goodson 1985).

To ignore gingivitis and treat only pockets which show indications of continuous breakdown would endorse a very questionable principle of only treating “fatal disease” (fatal to the teeth), and leave bleeding infected gums alone untreated. One may imagine how that principle could affect the practice of medicine if the physicians were to treat only diseases with fatal prognosis. Quality of life and elimination of disease are after all the main concerns in all health care, although by tradition length of life may be given the primary attention.

Both length of life and quality (comfort) of the human dentition is best served by the lowest possible attack rate of pathogenic organisms, and all our efforts should be directed toward a disease-free mouth. The fact that this goal may not be completely attained should not be used as an excuse to ignore some form of periodontal disease (gingivitis) and treat periodontitis only, especially since what is good for gingivitis (plaque control) also is good for control of periodontitis. Some confusion has crept into the discussion of effective maintenance programs for gingivitis and periodontitis, since it appears to take a longer time after treatment to re-establish destructive periodontitis than gingivitis with adequate oral hygiene by the patient. Thus, periodic professional tooth cleaning every 3 months may serve predictably well for prevention of clinical loss of attachment, but it may not be adequate for prevention of gingivitis if the plaque control is poor (Ramfjord et al. 1982).

Although plaque control is the alpha and omega of prevention, healing, and maintenance of periodontal health, it should be understood that adequate (1) prevention programs, (2) treatment and healing programs, (3) maintenance programs may differ both in execution and time frames and still give similar results, with regards to maintenance of attachment levels.