An interview with Maha Yakob, PhD, RDH, Global Director, Professional Relations and Scientific Affairs, Philips Oral Healthcare

By Dental Tribune MEA/CAPPmea

Maha is a scientific guru for Philips Sonicare. She started as a dental hygienist many years ago in Sweden while also lecturing at the Karolinska Institute. Karolinska is well known in the world of dentistry as it has housed many Nobel Laureates, both in physiology and medicine. Dental Tribune MEA had a chance to hear from Maha on her evidence based approach on Sonicare, the electronic toothbrush.

I was completely on the academic side when Philips approached me, and I joined them three years ago. What I implemented in the company was this whole evidence-based approach. Before I joined Philips, they had all these great studies that they had done, but they didn’t really focus as much on getting the publications to the professionals. We just assumed that once people tried Sonicare, they would love it. But then my focus shifted and I thought, let’s publish these papers and show our peers and colleagues why they should recommend Sonicare based on evidence.

In that case, they are not just recommending Sonicare because they like the product. Often we would hear dentists or dental hygienists say, I know it is working because when my patients come back they have fewer splitting gingivae. They could all see the clinical results, but our approach needed to be evidence based. Patients loved the product, it was just that the scientific part was missing, which is what we see now with the Journal of Clinical Dentistry, launched at the International Dental Show, with five papers that were published in this peer-reviewed journal.

In this special issue, you will find five papers. The first two are randomised control trials looking at Sonicare versus manual toothbrushes. Two randomly assigned groups are compared after one group receives a manual toothbrush and the other, a Diamond Clean. Not surprisingly, of course, Sonicare performed significantly better in the areas of plaque removal and gingival health.

In the first study, we saw that the Philips Sonicare FlexCare Platinum power toothbrush was statistically significantly more effective than a manual toothbrush in reducing supragingival plaque, gingival inflammation and gingival bleeding.

The second study showed that the Philips Sonicare Diamond Clean versus the Premium Plaque Control brush head significantly reduced gingival inflammation, gingival bleeding and plaque following two and six weeks of home use, compared with manual toothbrushing alone. This is how we substantiated the claim, “Up to ten times more plaque removal.”

The Sonicare toothbrush has flexible sides, allowing it more coverage of a larger surface area.

The objective of the third study was to evaluate the short-term clinical efficacy of high-frequency, high-amplitude sonic-powered toothbrushes compared with manual toothbrushes on plaque removal and gingivitis reduction in everyday use, through a meta-analysis of randomised controlled trials. The combined results of 18 studies with a total of 1,870 subjects showed that sonic-powered toothbrushes had significantly greater plaque removal. In conclusion, high-frequency, high-amplitude sonic-powered toothbrushes decreased plaque and gingivitis more effectively than manual toothbrushes in everyday use, in studies lasting up to three months.

Of course, studies one, two and three confirm that Sonic technology is superior to the manual toothbrush.

Study four is a head-to-head study done by an independent research organisation to compare the effect of the Philips Sonicare Diamond Clean toothbrush, used with the Premium Plaque Control brush head to the Oral-B Pro 12 used with the CrossAction brush head on gingivitis and supragingival plaque reduction. In the results, we can see that the numbers were significantly better than with the other technology.

The fifth study is moving away from simply brushing your teeth to using AirFloss as an additional toothbrushing as well. The addition of interproximal cleaning to manual toothbrushing is statistically proven to significantly reduce gingivitis and plaque compared with manual toothbrushing alone. Among the adjacent interproximal cleaning regimens, AirFlossPro provides a similar reduction in gingivitis and plaque to string floss.

For me, working for a company like Philips feels like the perfect fit. It is not just a technology company, but also a health tech. Forget the lights and anything else that people associate with Philips, it is a health tech company that has everything from diagnosis to home treatment to prevention, and we are really focusing on the holistic approach so that the FDI World Oral Health Day is about increasing awareness of the oral systemic link. That’s why a partnership with the FDI is perfect — it increases public awareness and helps you make the smart decision about what you are using in daily care. Many people are still unaware of good oral health care, especially in this region.

This is something we have shared with the community. We do trade shows, events and different kinds of summates of the studies. In the US, we aired a TV commercial that talks about the studies, and of course, the different conclusions.

Together with the FDI World Dental Federation, we are trying to educate and raise awareness. Partnership with the FDI World Oral Health Day is something of which we are very proud and it is our way of spreading the message.

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They still use manual toothbrushes, strands. Evidence suggests that AirFloss is as good as floss when you use it with a manual toothbrush and strands.
Pregnant women are hardly informed about the importance of oral health

By DTI

A new mother herself, pregnancy gingivitis has become a subject close to Dr Anja Carina Borier’s heart. She set up a joint campaign between Oral-B and the European Federation of Periodontology (EFP), which promotes oral health during pregnancy and educates health professionals and the wider public on the issue. Originally trained as a dentist in Mainz in Germany, Anja now serves as Professional and Scientific Relations Manager Europe at Procter & Gamble in Geneva in Switzerland, where we met with her for some questions and answers on the subject. Fittingly, she brought along her 4-month-old daughter, who cooed quietly in her pram throughout the interview.

Oral-B and the EFP have touched upon a very important and personal topic, in that periodontal disease could affect the developing baby.

Dr Anja Carina Borier: Yes. Gingivitis is a well-known side-effect during pregnancy and the latest data shows that practically every pregnant woman suffers from it. The number of bleeding sites is about three times higher in pregnant women than in the average adult. Even I, a dentist equipped with more than enough scientifically sound Oral-B products, experienced some gingival bleeding for the first time in my life!

As we know, untreated gingivitis can lead to periodontitis, the inflammatory burden of which can negatively impact pregnancy. Although more consistent in-depth studies are necessary, periodontitis during pregnancy has already been linked with premature birth, low birthweight and pre-eclampsia. This topic is important as most pregnant women are not aware of this problem and therefore often do not recognize the warning signs of gum problems such as bleeding or sensitive gums. With our campaign, we want to inform women and make sure they take good care of their oral health and see a dental professional in order to prevent possible oral health problems and pregnancy complications.

How can periodontitis lead to these complications?

Clinical studies suggest that bacteria from the oral cavity — specific microbiomes associated with periodontitis—colonize the foetus and the placenta, with blood as the most likely vehicle of transmission. As a consequence, the presence of periodontal bacteria in the foeto-placental unit may activate a local immune or inflammatory response that might negatively affect the pregnancy.

Biologically, that makes perfect sense, but how widely accepted is this point of view?

Although clinical research on the matter has existed for years, it is still a fairly neglected topic. Not only does it not receive enough attention from dental professionals, it is also largely overseen by healthcare professionals such as gynaecologists and midwives. When I was pregnant, I was warned about many potential risks, ranging from flying to eating sushi or dying my hair. I did enough research on the aforementioned “risks” to conclude that there is no scientific data to support these. However, no one—or my gynaecologist included—told me to go and see a dental professional or take care of my oral health.

To me, this really was a very personal matter, as I felt pregnant while establishing the cooperation concerning pregnancy gingivitis with the EFP. I find it worrying that pregnant women are hardly ever informed about the importance of good oral health during pregnancy. Therefore, I was passionate about establishing the Oral-B/EFP cooperation and lead the joint campaign. Our aim is to better educate dental professionals and medical professionals in general, as well as the wider public, on the importance of good oral health during pregnancy.

Could you explain the changes in the bodies of pregnant women that cause pregnancy gingivitis?

The biggest hormonal changes in a woman’s life take place during pregnancy. It is a period of great change and obviously the mouth is one of the main areas affected by such changes, which in itself can lead to gingivitis.

It is not for nothing that people used to say that women gain a child and lose a tooth. During pregnancy, there is a 50 times increase in oestrogen compared with the amount during a normal menstrual cycle. This and the increase of progesterone and other hormones lead to an increased vascular permeability of gingival tissues, which promotes gingival inflammation in the presence of dental plaque. For women who have already developed periodontitis, the situation usually gets worse because of the changed hormonal situation.

Apart from cardiovascular disease, periodontal disease is known complication of diabetes. What is the risk of pregnant women with diabetes developing periodontitis?

For women who already have diabetes, the biggest challenge is to keep their blood sugar under control. Independent from this, a small percentage of women develop diabetes during pregnancy. Although this type of diabetes disappears after pregnancy, these women need treatment in order to avoid serious complications. Both groups, however, have a higher risk of developing periodontal disease. It is important to note that treatment is more likely to succeed if a person’s blood sugar levels are under control. Vice versa, periodontal disease also negatively impacts diabetes. Overall, it is important that women with diabetes take care of their oral health before and during pregnancy.

How do you integrate all of your findings in your Oral-B seminars?

Oral-B’s mission is to promote oral health and work closely with dental professionals to ensure optimal home care. Our collaboration with the EFP serves as a way to raise awareness about all matters concerning oral health during pregnancy. Our educational activities such as the Up-to-Date events are a way to communicate this and support dental professionals in their objective to improve oral health. We believe a healthy mouth is part of a healthy body and promoting good oral health during pregnancy is one way to help to achieve this.

How can general dental practitioners, periodontists and dental hygienists integrate this last thought into their daily practice?

It is important that they understand the connection between oral and general health, be it the link between periodontitis and diabetes, as well as cardiovascular disease, or complications during pregnancy. Gynaecologists, cardiologists and endocrinologists too should be aware of this connection. That being said, many women avoid professional dental care during pregnancy and, conversely, many dental professionals are insecure about treating pregnant patients. However, female patients of childbearing age should be informed about the importance of oral health during pregnancy.

This is especially important for patients who suffer from periodontitis. These patients should be encouraged by dental professionals to undergo treatment before pregnancy. During pregnancy, non-surgical periodontal therapy has been considered safe in the second trimester.

Finally, what would your tips be for pregnant women?

Women who have periodontists must seek treatment before pregnancy, whereas women who enjoy good oral health should go and see a dentist or a dental hygienist in the second trimester for a dental clean-up. Of course, they should brush their teeth twice a day with a fluoride-containing toothpaste—even better is an antibacterial toothpaste containing stannous fluoride—and clean their teeth interdentally. It is scientifically proven that electric brushes such as our Genius toothbrush are particularly good for eradicating plaque and gingival bleeding. Moreover, they are a practical solution for women who have less time to brush their teeth. There is no question that all mothers with a baby will know exactly what I am talking about.
Preservation of root cementum: A comparative evaluation of power-driven versus hand instruments

By Bozbay E, Dominoi F, Gokbuget AY, Cintan S, Guida L, Aydin MS, Mariotti A, Pilloni A, Italy

Background

Griensik et al suggested that cementum plays an important regulatory role in periodontal regeneration. One of the major goals of periodontal treatment is the removal of pathogenic micro-organisms by scaling and root planning. In the past the misconception was to obtain a root surface with smooth and hard surface characteristics that was free of endotoxins which resulted in the removal of the subgingival plaque and calculus deposits, and the removal of all or most of the cementum. Recent studies have reported that endotoxins were not located within cementum and removal of ‘diseased’ cementum was not necessary for a successful periodontal treatment. Saygin et al concluded that preservation of cementum on the root surface was necessary for new attachment and as a source of growth factor. Hence non-aggressive removal of cementum is essential for optimal periodontal health and regeneration.

Ultrasonics with new shaped tips and subgingival air polishing devices has been developed for removal of root accretions with minimal root damage. Air polishing has been suggested as a treatment modality for root debridement resulting in probing depth reductions and removal of subgingival biofilm. No scientific evidence exists today showing the loss of root substance or surface roughness produced by either ultrasonics or Air polishing.

Aim

To assess the amount of cementum remaining following in vivo root instrumentation as well as the surface characteristics of the retained cementum.

Material and Methods

48 caries free, single-rooted teeth in 27 patients diagnosed with severe chronic periodontitis with periodontal probing depth (P0D) ≥5 mm in at least two sites per tooth with radiographic loss of more than two-thirds of root length and scheduled for extraction were included in this study.

- Teeth were randomly divided into four treatment groups: instrumentation was performed with medium power settings
- Piezoelectric ultrasonic scaler - (Air-Flow Master Piezon, Instrument Tip PS, EMS SA)-U
- Piezoelectric ultrasonic scaler - (Air-Flow Master Piezon, Instrument Tip PS, EMS SA)-AP
- Hand instruments (Gracey curettes Flow Nozzles; EMS SA) - AP;
- Hand instruments (Gracey curettes Flow Nozzles; EMS SA) - U + AP

Remained cementum:
- Percentage of coronal cementum remaining following subgingival instrumentation was 84% for U, 86% for U + AP, 96% for AP and 65% for HC.
- The amount of retained cementum with AP was significantly greater than with HC SEM.
- Smoothest root surfaces were produced by the HC followed by the AP.
- Conical and apical sections showed that AP produced the least amount of cementum loss and therefore the greatest retention of residual cementum.
- Root surfaces instrumented by U or U + AP presented grooves and scratches.

Time taken to complete root instrumentation

Shortest time taken was using AP and the longest time was with U + AP.
- AP required 35% less time for root preparation in comparison to HC, whereas U + AP needed 30% more time.

Conclusions

Air polishing was significantly more effective and superior in preserving cementum.
- Hand instrumentation using cutters was most effective in removing cementum in comparison to ultrasonics or hand instruments.

Editorial Note: The article was originally published in International Journal of Dental Hygiene.

08 September 2016, page 1-8
Periodontal disease may be key initiator of rheumatoid arthritis

By Curaden

For effective oral care, it is very important to use a toothbrush with soft bristles. The reason for this is that hard bristles can often damage teeth and gums. This is a negative side-effect that occurs if too much pressure is used while brushing.

Curaden's toothbrushes have one special feature in particular: they are incredibly soft. The 5460 CURÆN® filaments of the CS 5460 ultra soft form an extraordinarily dense and efficient cleaning surface. The bristles are stiffer than nylon and remain just as main in the mouth as they are when dry. These properties make it possible to manufacture toothbrushes with very fine bristles. Soft on the gums and teeth, the CURÆN® filaments are extremely tough on plaque. Anyone who has tested the cleaning power of a CS toothbrush will never want any other brushing experience.

An ideal toothbrush head is small and slightly angled to make it easy to reach those crucial areas. The bristles should be fine enough to clean the teeth and gums softly and thoroughly. The handle should make it possible to properly position the toothbrush at about a 45-degree angle, always half on the gums and half on the teeth. The gumline is just as important as the teeth.

The CS 5460 ultra soft combines these exact standards of design and function. The small, but efficient head at the proper angle ensures that your patients reach those crucial areas. An eight-sided bristle head ensures the perfect angle on the teeth and gums for optimal cleaning. The large cleaning surface with incredibly fine, rounded filaments ensures soft and efficient brushing of the teeth and gums.

The cleaning efficiency of the bristles is tightly packed into 39 holes. Combined with the lovely colours of the CS 5460 ultra soft, it makes for one of the most popular CURÆN® products. The toothbrush is also available with the CPS Prime interdental inserts. The CS 5460 ultra soft offers patients an individual at-risk of inflammatory arthritis.

Visit the website to learn more about our products: www.curaden.com/en

Patient motivation techniques

By DTI

When it comes to motivating pa-
tients to maintain good oral hygiene practices, a clear plan is essential in view of the time constraints of most den-
tal appointments. What this plan en-
tails, however, depends on what the most pressing issues to the patient are. Prevention magazine spoke with Sandy Basheda, a dental hygienist at the M & N Dental Practice in Bedford in the UK, about how she structures her oral hygiene appointments and the Ms Basheda, how did you first get started as a dental hygienist at M & N Dental Practice?

Sandy Basheda: I’ve been working at M & N Dental Practice for three years now. I started basically straight after I graduated from the University of Liverpool with a degree in dental hy-
giene and therapy. Prior to that, I had a background in dental nursing, but I wanted more of an instrument role with dental patients, which led me to hygiene and therapy.

What does your average day at work involve, and what is the structure of your oral hygiene appointments?

I see many patients with periodontal problems and so conduct a lot more hygiene right now than therapy. I also deal with a lot of children that, unfortunately, have dental caries due to a poor diet, lack of oral hy-
giene and likely a lack of education on how to prevent it. It’s not a good start for children if they have to have fillings put in or even have their teeth pulled if it’s particularly bad— it doesn’t give them a good first impression of the dentist.

Each oral hygiene appointment is scheduled for half an hour and be-
gins with a discussion about the patient’s existing problems and current oral hygiene routine. I then explain to the patient the what pur-
pose of the appointment is and what it will entail and conduct an assess-
ment of his or her oral health. Every patient is different, and depends on what he or she needs ad-

dressed as to how the appointment will proceed from there.

How can you get patients to continue with good oral hygiene practices after an appointment?

I think one has to build up from there that sort of instructional conversa-
tion. It’s very important to re-educate the patient to take charge of his or her oral health and seeing the dentist is a clear and un-
derstandable way why taking care of their teeth is important not just for their oral health but their overall health too.

But is it possible to achieve this all within half an hour? Well, it’s not a lot of time, but we can always schedule an hour-long appointment if it is necessary. I see many anxious patients, patients who might not have been to the dentist in ten to 15 years. With these patients, a shorter appointment is often good in the beginning, because it means that they’re not overwhelmed and that one can build it up from there over the ensuing sessions. By the sec-
ond or third appointment, they’re a bit more relaxed and eager for treat-
ment.

How do you motivate your patients to take charge of their own oral hygiene?

I think it’s mostly about re-educating patients on what the correct and most effective cleaning methods are, what products are best for them. It’s about finding something that works for the patient, something that will get him or her excited about taking care of his or her teeth and seeing the benefits. Dentistry, it can be difficult to engage in a cooperative relationship with one’s patients—of-
ten, it’s a one-way conversation with the professional giving the patient instructions or advice on how to take care of his mouth. I like to leave that sort of instructional conversa-
tion to the beginning or the end of the appointment, as this allows the patient to think, while in the chair, whether he or she has any questions about oral care. For many, these future appointments will entail be-
ing able to answer those questions in a clear and understandable way is es-
tential to motivating patients.

Thank you very much for the inter-
view.
A soft approach for tough areas.

Enamel is hard. Harder than steel, even. And it should stay that way. Enamel-friendly brushing means: pampering your teeth and gums with tender loving care. Like with the gentle CS 5460 ultra soft. Mmmm, let’s do that again.
Oral hygiene instructions and patient motivation with and without dental hygienists

An interview with Dr Eric Thevissern, periodontist and pioneer of Belgian prophylaxis

By DTI

Dr Thevissern, I wanted to talk to a dental hygienist in Belgium. Why is that not yet possible?

Dr Eric Thevissern: Well, the good news is that, from June 2019 on, it will be possible to visit and talk to a dental hygienist in Flanders. Why Flanders has waited such a long time to start the education and training of dental hygienists is politically motivated and due, in large part, to the representative dental associations. Belgium has a long tradition of one- dentist clinics, often working without dental assistants. Since the introduction of a quite different admission exam for dentistry in 1997, the discipline has attracted fewer students. As a consequence, the number of graduating students has dramatically decreased, while the demand for dental care is continually increasing. Slowly, but surely, more and more group practices have emerged, hiring dental assistants. Back in 2006, the first meetings were organized between universities and dental societies about the qualifications needed to become a dental hygienist and the tasks that could be delegated to them. As always, there were proponents and opponents, and it took a very long time before all stakeholders agreed on the conditions and criteria needed to start dental hygiene training in Leuven and Ghent.

Let’s talk about your study “The provision of oral hygiene instructions and patient motivation in a dental care system without dental hygienists”.

Please tell us more about it.

Thirty years ago, I started working as a periododontist in Hasselt with another colleague. Since we were the first periododontists in this province, we had a flying start. After a few years, I noticed that dentists were always referring patients to our clinic with the same complaints, such as bleeding gums or bad oral hygiene. In my opinion, treating bleeding gums or giving oral hygiene instructions is the duty of every dentist and belongs in the sphere of primary dental care rather than in secondary or specialist care. Although we organized courses where a general dental practitioner (GDP) could learn patient instruction and guidance, I realized that we were considered by a large number of GDPs to be dental hygienists rather than periododontists. The truth was that we were both, periododontists and dental hygienists. This annoyed me because I knew that in neighbouring countries periododontists could spend their precious time on the work they were trained for.

In 2004, I took the initiative to set up a pilot study in Limburg with 65 referring dentists. We used the Dutch Periodontal Screening Index, a screening test for periodontal status that had been introduced in the Netherlands a few years earlier. We collected data from 814 patients. The results clearly showed: the screened age groups had, on the whole, periodontal problems and that doing so was a high need for treatment.

Around the same time, Prof. Hugo De Bruyn joined the teaching staff of Ghent University’s Department of Dental Sciences. Probably thanks to my publication, he asked me to become one of his staff members. Working with Prof. De Bruyn, one is quickly involved in clinical research and able to start investigating, in depth, the questions that had bothered me ever since I started my career. One of these questions was the kind of oral hygiene instructions GDPs provide to their patients.

Using questionnaire responses of 776 dental professionals gathered for various postgraduate courses in Flanders, we were able to determine that, given the absence of dental hygienists in Belgium, oral health instructions and patient motivation appeared to be non-compliant with international guidelines. Though dental professionals were concerned with prevention, there were several mitigating factors working against them delivering this adequately.

The study mentioned lack of time, remuneration and patient interest as complicating factors for the provision of preventative care. However, qualifications, speaking duration and time are crucial for providing oral hygiene instructions and patient motivation. Can dental hygienists be seen as a solution to these problems?

It is my conviction that dental hygienists are the solution to these complicating factors. Prophylactic care will be the main target of their work, since dentists are primarily trained for restorative care. Owing to factors such as the decreasing number of graduating dental students, the increasing number of retiring dentists in the next ten years, an ageing population and a higher demand for preventative care, the stress of work increases and forces dentists to manage their work time more strictly. Of course, GDPs prefer restorative and other more rewarding treatments. We all know how time-consuming patient motivation techniques for behaviour change can be. There is no time prepared to spend that time on preventative care. Generally speaking, dentists are used to giving a basic package of information on oral hygiene to every patient and, depending on compliance, they may want to spend more time on patient guidance. Here, dental hygienists can make the difference. They will be trained to insist on the importance of behavioural change and will take the time to explain and show how to perform proper home oral care.

You have also published studies on implants, such as an implant design. What made you publish your study titled “Attitude of dental hygienists, general practitioners and periodontists towards preventive oral care: An exploratory study”? You could have just continued with your research on implant systems.

Indeed, the team around Prof. De Bruyn is very driven by and focused on the outcomes of dental hygiene. To my knowledge, the Department of Dental Sciences at Ghent University published around 40 scientific articles in 2016, the majority of which are related to implant therapy. The subject of my PhD is not implant-related, but deals with different relationships in dentistry: between the patient and the dental professional, and between primary and secondary dental care, that is between GDPs and specialists.

What were the objectives and results of this study?

This second study was a step further than the first one. In the first study, we looked for an explanation for the differences in patient motivation techniques between Flemish GDPs and periodontists. In this second one, we compared our rather unique Belgian system with the Dutch system, a completely differently structured healthcare system including dental hygienists. We wanted to know whether the Dutch system represented the gold standard and how we were situated in Flanders.

The results showed that periodontists and dental hygienists shared more common viewpoints than GDPs and periodontists did. What was remarkable was the fact that more than 80 per cent of periodontists and dental hygienists were satisfied with their efforts in informing patients, compared with 38 per cent of GDPs. Secondly, whereas GDPs indicated nurture as the factor most contributing to the oral hygiene level of the patient, periodontists and dental hygienists focused on the influence of the dental practitioner and a patient-centred approach. In our multivariate analysis, the presence of hygienist assistants seemed to be of major importance.

But, as always in questionnaire-based studies, the results can be biased by socially desirable answers and by the inevitable structural differences between Flanders and the Netherlands. One of these differences, for example, is the fact that providing oral hygiene instructions is not reimbursed in the Belgian dental care system, whereas it is considered an autonomous activity.

What should the role of the dental practitioner in the successful treatment of peridontal disease be? What does the patient need to do?

The role of the dental practitioner, in particular the GDP, usually remains to keep a panoramic overview of everything that has to do with the dental and oral health of the patient. Especially considering the interaction of dental hygienists in the near future in Belgium, the dental role as a supervising manager is hygiene medication, age, nutrition and different systemic factors have been shown to accelerate the development of periodontal disease in the presence of biofilm, activated by a hyperactive or even a hypo-active immune system response. It is a fact that this sort of risk analysis has become part of the graduate curricular, including counselling on healthy food habits or how to quit smoking. The near future includes thorough assessment, using caries detection, and so on.

Finally, the patient should demonstrate his or her home care habits using his or her own toothbrush. We distinguish four levels of patient information needs: the lowest level is the patient who is almost totally ignorant about proper home care; in the next level, the patient thoroughly brushes his or her teeth on autopilot without paying attention to any technique, time duration or interdental cleaning; the third level is the patient who performs regular brushing, even complaints surface. A trigger then leads to the loss of tooth instead of its repair.

Why then does this appreciation not apply to oral health?

What are some of the oral hygiene instructions and patient motivational actions that you use in your daily practice?

To my knowledge, the Department of Dental Sciences at Ghent University published around 40 scientific articles in 2016, the majority of which are related to implant therapy. The subject of my PhD is not implant-related, but deals with different relationships in dentistry: between the patient and the dental professional, and between primary and secondary dental care, that is between GDPs and specialists.

By DTI

Dr Thevissern

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counselling. One needs two or three control sessions to check his or her dexterity and oral cleaning performance. Plaque disclosure remains a confronting but very effective tool to show the results of the patient’s cleaning habits.

Finally, the dental professional should show enthusiasm and keep on repeating until there are visible improvements.

From your point of view, does the dentist spend enough time on the diagnosis of a disease? Of course, dentists are dutiful people who are concerned with their jobs. Spending time in correct patients’ a-pi-nosis is their core business. Examining patients means exploring and knowing their usually hidden troubles or discomforts.

The next question is the most important one: is this problem acute enough that it should be treated immediately, in the very near future, or can we wait and see how it develops? This is risk management and it is de-pendent on multiple factors.

Often, prevention is neglected in dental practices in favour of diagnosis and restorative treat-ment. How can dental profes-sionals implement prophylaxis in their daily practice, especially primary prophylaxis? I would say, rather, that prevention is not neglected. Sixty-five per cent of GDPs provide information about oral hygiene as a standard proce-dure. Depending on compliance, the GDP may decide to spend more time on patient guidance. This requires patience and understanding on the patient’s face how motivated he or she is, or not what he or she is interested in. This is not often asked of the patient, so one could rather say there is not enough time spent on communica-tion.

I insist practitioners to do an experi-ment in their waiting rooms. While the patient is waiting for his or her appointment or has been given a short questionnaire asking him or her to write down in a few words his or her opinion of proper home care and his or her personal routine. The patient can then be asked if he or she would be interested to know more about it. We use this method in our clinic. In the waiting room, patients have time to reflect and one might be surprised at how interested patients really are if one gives them the opportunity to com-municate and to prepare their ques-tions.

To be honest, I think that primary prophylaxis is impossible to achieve because we do not control all the influencing factors, of which some can be health- or patient-related. It means that we need to try to pre-vent people from developing caries or periodontal disease. This is some-thing futile, since caries and peri-dontal disease are the most wide-spread infectious diseases present in almost every patient. Twenty-five per cent of 5-year-old children have bleeding gingivae, and this figure rises to 55 per cent for 15-year-olds. Primary prevention is like plac-ing speed cameras on highways: it works all the time and for speed cameras, it is highly effective and noninvasively justified. Today, I heard in the news that, thanks to these speed cameras and other regulations, the number of persons killed by traffic every year is diminishing. This is primary preven-tion. However, I strongly believe in secondary prevention, it is the dentist’s duty to examine and to inter-vene, preferentially before detrimental clinical signs occur.

What kind of prophylaxis does the Belgian dentist perform in the Netherlands, up to ten differ-ent kinds of procedures? Does the addition of dental hygienists make financial sense or does prophylaxis make financial sense for the dental practice if the practice already makes good money with implants?

I have read some articles in which GDPs may decide to spend more time on patient guidance. This requires patience and understanding on the patient’s face how motivated he or she is, or not what he or she is interested in. This is not often asked of the patient, so one could rather say there is not enough time spent on communica-tion.

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To be honest, I think that primary prophylaxis is impossible to achieve because we do not control all the influencing factors, of which some can be health- or patient-related. It means that we need to try to pre-vent people from developing caries or periodontal disease. This is some-thing futile, since caries and peri-dontal disease are the most wide-spread infectious diseases present in almost every patient. Twenty-five per cent of 5-year-old children have bleeding gingivae, and this figure rises to 55 per cent for 15-year-olds. Primary prevention is like plac-ing speed cameras on highways: it works all the time and for speed cameras, it is highly effective and noninvasively justified. Today, I heard in the news that, thanks to these speed cameras and other regulations, the number of persons killed by traffic every year is diminishing. This is primary preven-tion. However, I strongly believe in secondary prevention, it is the dentist’s duty to examine and to inter-vene, preferentially before detrimental clinical signs occur.

What kind of prophylaxis does the Belgian dentist perform in the Netherlands, up to ten differ-ent kinds of procedures? Does the addition of dental hygienists make financial sense or does prophylaxis make financial sense for the dental practice if the practice already makes good money with implants?

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