“Plaque, Sugar, Diabetes and Smoking” – Reassessing Risk Factors

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Introduction

Many dentists base their practice on an understanding of various risk factors thought to contribute to the collection of Dental Tribune. It is now taught that Dental Plaque (biofilm) forms in minutes, the development of caries and periodontal diseases, the former requiring the added ingredient of frequent sugar exposure and the latter, if it is to progress to significant bone loss, needing the presence of one or more of complicating factors such as Genetic Susceptibility, Smoking and Diabetes.

Accordingly dental prevention has focused on effective regular plaque removal and a reduction in the frequency of, sugars intake and cigarette use, as well as the over-counting and under-exercising combination which are common to the type 2 Diabetes. Twice daily brushing with a fluoride containing toothpaste comprised of Surrogate Outcomes, for example as well as restriction of sugar exposure and cigarette use, as well as the over-counting and under exercising combination which are common to the type 2 Diabetes.

Measuring the Effectiveness of Preventive Measures

Webster’s dictionary describes an Outcome as “Something that occurs as a result or consequence of an action”. Surrogate Outcomes to measure effectiveness of preventive and treatment interventions. These include a Reducible index: Plaque less bleeding on probing and microbiological assessment led to a more effective preventive measures to Real Outcomes in the long term. The traditional number of sugar exposures per day has been considered important in the development of periodontal disease, the fanaticism with which the Dental and Dental Hygiene professions have focused on “plaque control” has taken attention away from the important role of other risk factors. It is beyond the scope of this article to describe all the studies that have reported correlations between periodontal disease and diabetes, however our duty of care to offer all patients the most current evidence led us to base our recommendations on beyond the scope of this article to describe all the studies that have reported correlations between periodontal disease and diabetes, however our duty of care to offer all patients the most current evidence led us to base our recommendations on

Periodontal Diseases

In a recent systematic review examining the effect of Dental Flossing on interproximal caries it was calculated that – Reassessing Risk Factors –...
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Conclusions
Our understanding of the relative importance of the various major risk factors for Caries and Periodontal diseases should be evidence based and current. At present it is reasonable to conclude the following:

1. Recent research has indicated that the total amount of sugar consumption is more important than the number of sugar exposures per day in the development of carious lesions. It is therefore important to support the use of dental floss as a preventive measure for dental caries or gingivitis.

3. Effective toothbrushing, using a fluoride toothpaste and a power brush, is by far the most effective preventive measure to minimize dental caries and periodontal diseases.

4. To minimize the incidence of root caries in the elderly oral hygiene must be supplemented with periodic application of a fluoride or chlorhexidine preparation.

5. While oral hygiene is important in controlling Periodontitis in the susceptible patient, compliance with a comprehensive Supportive Periodontal maintenance recall regimen is likely even more critical in preventing progression and tooth loss due to Periodontitis.

6. To achieve the best outcomes in periodontally susceptible patients who smoke, smoking cessation programs must accompany traditional "Hygiene" phase therapy.

7. To achieve the best outcomes in diabetic patients with Periodontitis the dental professional must work closely with the medical clinician responsible for diabetes care. Improvements in one disease are likely to be complemented by improvements in the other.

8. When assessing the relevance of clinical research more credence should be given to longer term studies than shorter term studies which use SURGICATE outcomes.

References
5. E. Bernabei et al J Dent Res. Published online before print November 9, 2016.

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