Plan de tratamiento periodontal

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Gingivitis

Lesión inflamatoria que resulta de la interacción entre el biofilm dental y la respuesta del huésped.

1) La placa es factor necesario y suficiente para causarla
2) Es reversible
3) No hay pérdida de inserción
4) No hay pérdida ósea
5) Presencia de bolsa falsa

Periodontitis

Enfermedad inflamatoria crónica, caracterizada por la destrucción progresiva del aparato de inserción del diente.

1) La placa es factor necesario pero NO suficiente para causarla, necesitamos del medio y que haya predisposición genética en el huesped
2) Es irreversible
3) Hay pérdida de inserción
4) Hay pérdida osea
5) Presencia de bolsa verdadera

¿Cómo clasificamos la enfermedad periodontal?

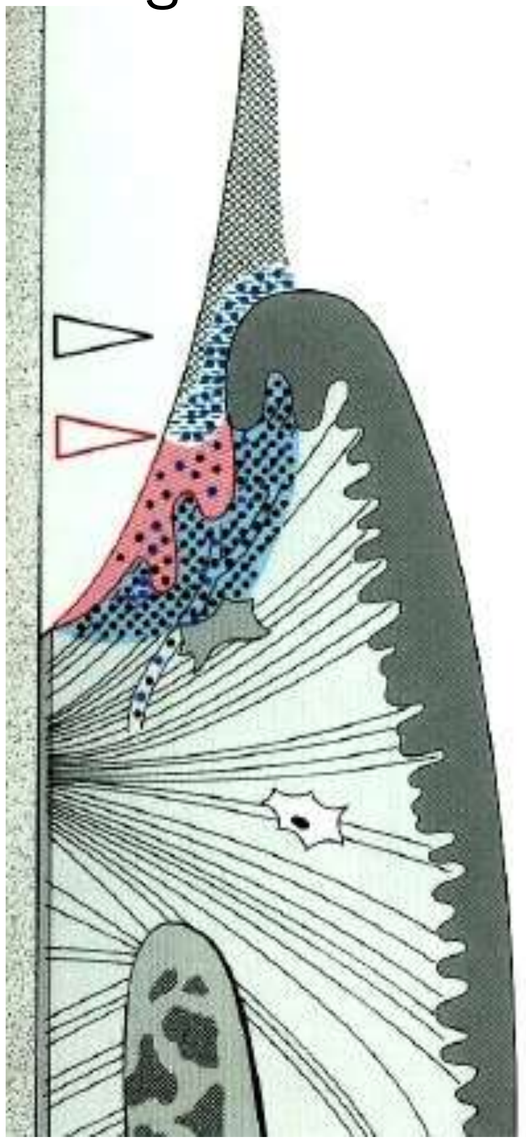
ESTADIOS

Gravedad de la enfermedad en el momento de su presentación

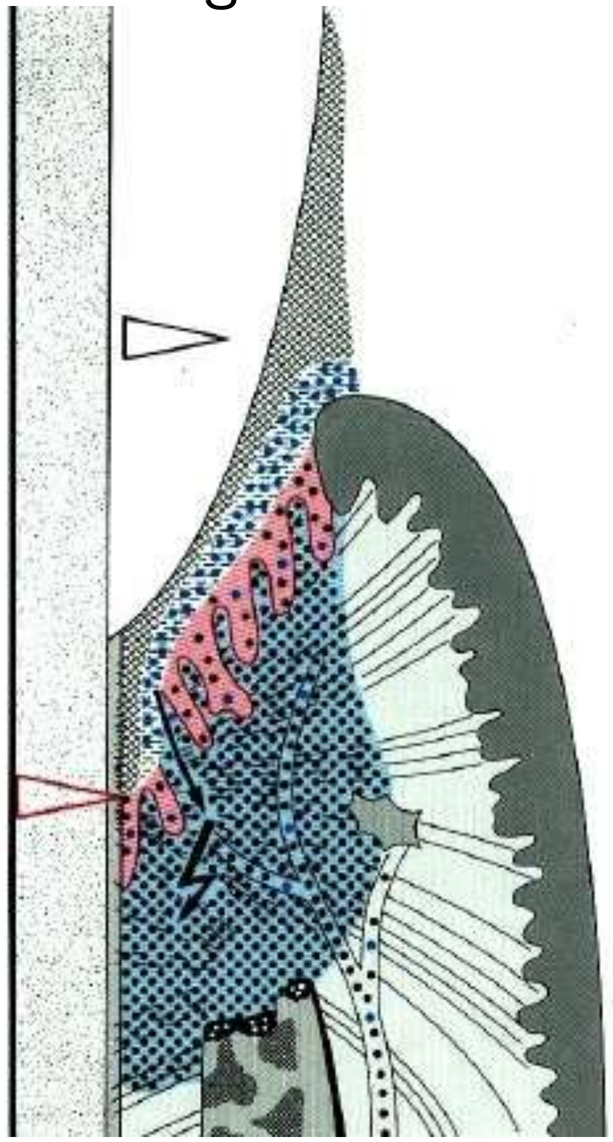
GRADOS

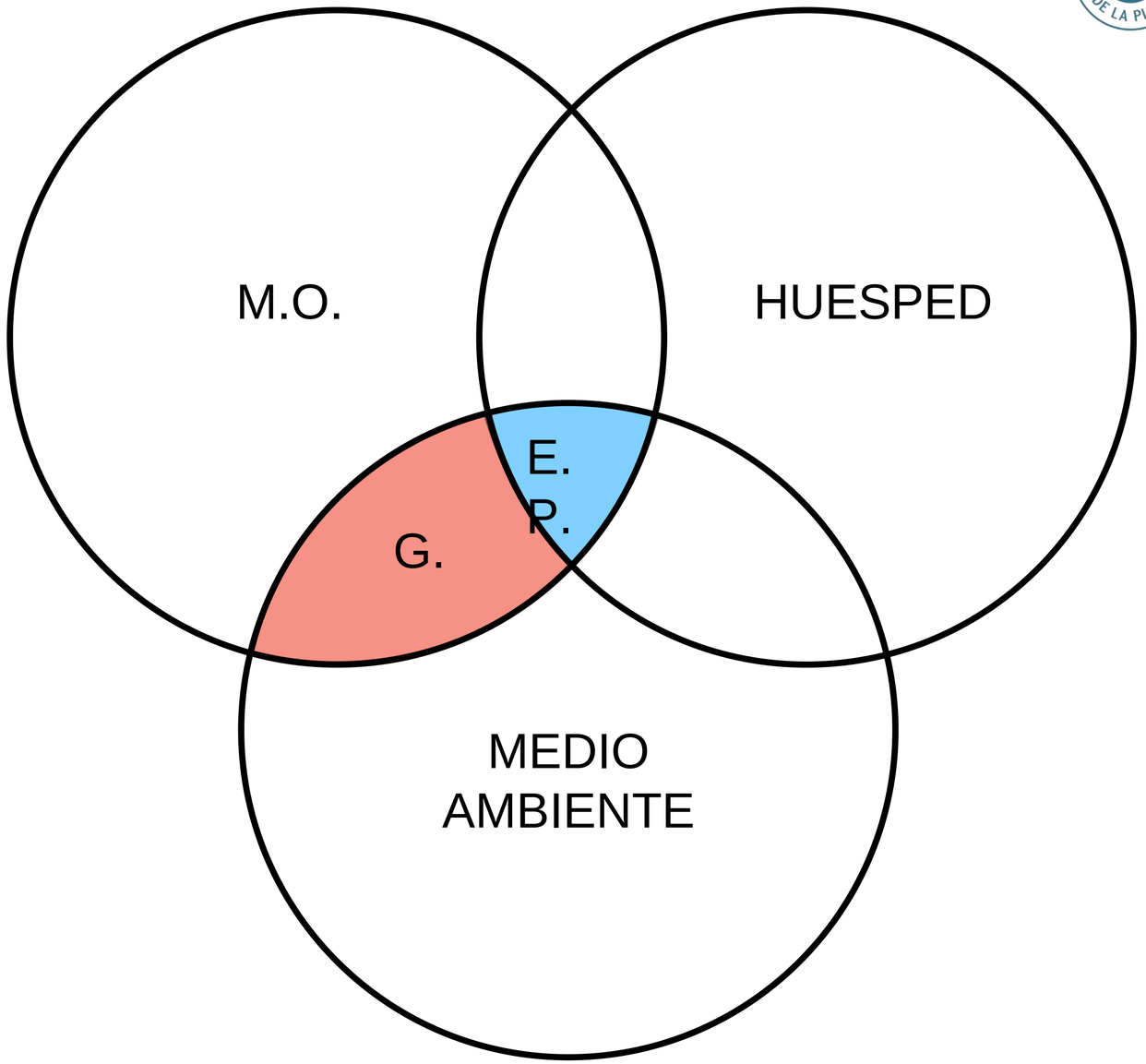
Proyección de la enfermedad teniendo en cuenta la tasa de progresión

GINGIVITIS



PERIODONTITIS





The long-term effect of a plaque control program on tooth mortality, caries and periodontal disease in adults

Results after 30 years of maintenance

P. Axelsson[1,2], B. Nyström[2] and J. Lindhe[1]

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Axelsson P, Nyström B, Lindhe J: The long-term effect of a plaque control program on tooth mortality, caries and periodontal disease in adults. Results after 30 years of maintenance. J Clin Periodontol 2004; 31: 749–757. doi: 10.1111/j.1600-051X.2004.00563.x. © Blackwell Munksgaard, 2004.

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Abstract

Background: The biofilm that forms and remains on tooth surfaces is the main etiological factor in caries and periodontal disease. Prevention of caries and periodontal disease must be based on means that counteract this bacterial plaque.

Objective: To monitor the incidence of tooth loss, caries and attachment loss during a 30-year period in a group of adults who maintained a carefully managed plaque control program. In addition, a comparison was made regarding the oral health status of individuals who, in 1972 and 2002, were 51–65 years old.

Material and Methods: In 1971 and 1972, more than 550 subjects were recruited. Three hundred and seventy-five subjects formed a test group and 180 a control group. After 6 years of monitoring, the control group was discontinued but the participants in the test group was maintained in the preventive program and was finally re-examined after 30 years. The following variables were studied at Baseline and after 3, 6, 15 and 30 years: plaque, caries, probing pocket depth, probing attachment level and CPITN. Each patient was given a detailed case presentation and education in self-diagnosis. Once every 2 months during the first 2 years, once every 3–12 months during years 3–30, the participants received, on an individual need basis, additional education in self-diagnosis and self-care focused on proper plaque control measures, including the use of toothbrushes and interdental cleaning devices (brush, dental tape, toothpick). The prophylactic sessions that were handled by a dental hygienist also included (i) plaque disclosure and (ii) professional mechanical tooth cleaning including the use of a fluoride-containing dentifrice/paste.

Results: Few teeth were lost during the 30 years of maintenance; 0.4–1.8 in different age cohorts. The main reason for tooth loss was root fracture; only 21 teeth were lost because of progressive periodontitis or caries. The mean number of new caries lesions was 1.2, 1.7 and 2.1 in the three groups. About 80% of the lesions were classified as recurrent caries. Most sites, buccal sites being the exception, exhibited no sign of attachment loss. Further, on approximal surfaces there was some gain of attachment between 1972 and 2002 in all age groups.

Conclusion: The present study reported on the 30-year outcome of preventive dental treatment in a group of carefully monitored subjects who on a regular basis were encouraged, but also enjoyed and recognized the benefit of, maintaining a high standard of oral hygiene. The incidence of caries and periodontal disease as well as tooth mortality in this subject sample was very small. Since all preventive and treatment efforts during the 30 years were delivered in one private dental office, caution must be exercised when comparisons are made with longitudinal studies that present oral disease data from randomly selected subject samples.

Key words: caries; longitudinal study; periodontal disease; tooth mortality

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Table 5. Reasons for teeth that were lost between 1972 and 2002 in the 257 subjects that returned for the 30-year follow-up examination

Reason	Root fracture	Root resorption	Caries	Trauma	Perio	Endo	All
Group 1 ($n = 133$)	31	6	4	6	2	9	58
Group 2 ($n = 100$)	49	4	3	2	4	10	72
Group 3 ($n = 24$)	28	2	5	0	3	5	43
All subjects ($n = 257$)	108	12	12	8	9	24	173

Experimental Gingivitis in Man

BY HARALD LÖE,* D.D.S., DR. ODONT., ELSE THEILADE,** D.D.S. AND
S. BÖRGLUM JENSEN,*** D.D.S., LIC. ODONT., AARHUS, DENMARK

INCREASING evidence from different fields of dental research has indicated that oral deposits play a major role in the development and maintenance of periodontal disease.

Harald Löe
(1926-2008)

The purpose of this investigation was to attempt to produce gingivitis in patients with healthy gingivae by withdrawing all active efforts directed towards oral cleanliness, and to study the sequence of changes in the microbial flora and in the gingivae thus produced.

The Natural History of Periodontal Disease in Man

The Rate of Periodontal Destruction Before 40 Years of Age*

by
HARALD LÖE†
AGE ANERUD
HANS BOYSEN
MARTYN SMITH

MOST CROSS-SECTIONAL data suggest that periodontal disease is universal: that it starts early in life and increases in severity with age.[1-5] However, since no longitudinal studies on the life-time characteristics of periodontal disease have been made, it is not known to what extent the progress of the lesion is continuous or if the disease is characterized by intermittent periods of activity and inactivity in people of different ages and around specific teeth. Also the cross-sectional studies have failed to provide accurate accounts of the rate with which the lesion progresses during different age periods of human life. This paper attempts to address these problems.

The present study was part of a longitudinal investigation, the purpose of which was to describe the natural development and progress of periodontal disease in man. The study started in Oslo, Norway in 1969 and in Sri

Mean loss of attachment (LA) on mesial root surfaces in Norway and Sri Lanka, based on all valid observations (AVC) (——) and on participation in all surveys (IAS) (×××).

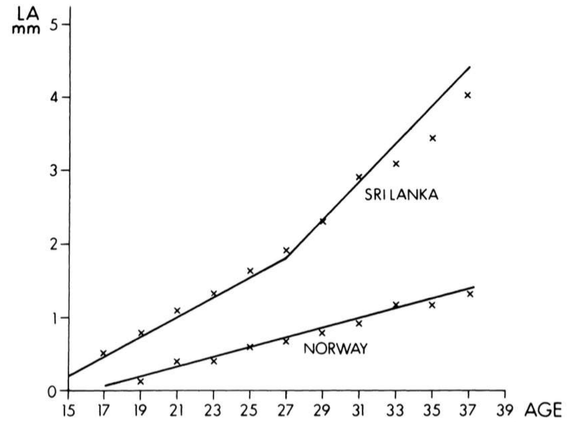


FIGURE 5. *Mean loss of attachment on mesial root surfaces in Norway and Sri Lanka in those who participated in some (——) and in those who appeared in all surveys (×××).*

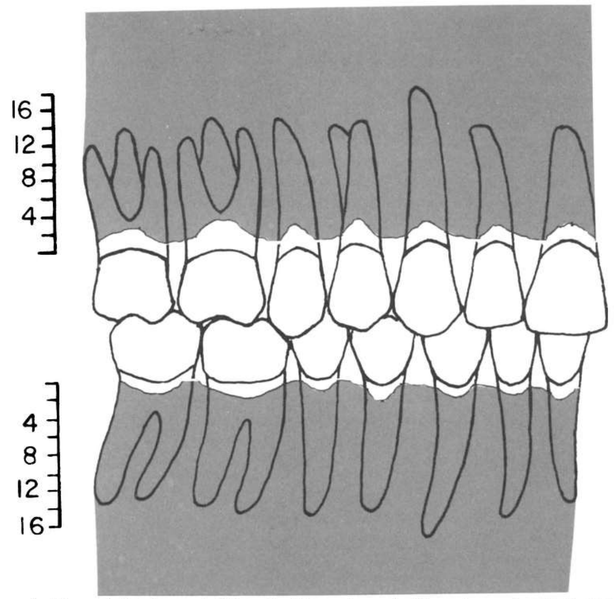


FIGURE 9. *Mean periodontal support of the teeth of Norwegian academicians at approximately 40 years of age.*

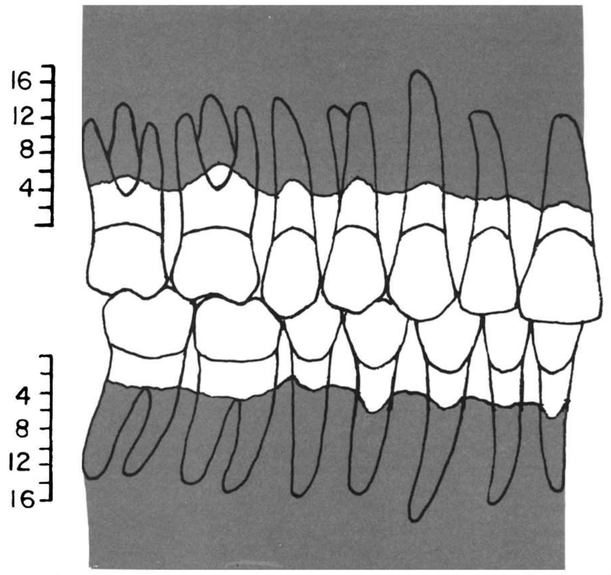


FIGURE 8. *Mean periodontal support of the teeth of Sri Lankan tea laborers at approximately 40 years of age.*

¿ Que es el plan de tratamiento periodontal ?

Secuencia estructurada de pasos terapeuticos que vamos a seguir durante todo el tratamiento. Es individual para cada caso clínico.

Objetivos

Corto Plazo = Recuperar SALUD

Mediano Plazo = Mejorar la FUNCIÓN y la ESTÉTICA

Largo Plazo = Conservar salud, función y estética

Recolección de información

↓

DIAGNÓSTICO

↓

PRONÓSTICO

↓

PLAN DE TRATAMIENTO

Recolección de información

1- Antecedentes personales

2- Antecedentes familiares

3- Estudios complementarios

4- Estudios radiográficos

5- Inspección clínica

6- Imágenes

7- Impresiones/escaneos

Diagnóstico

“Proceso sistemático cuyo fin es determinar la naturaleza y extensión de la enfermedad periodontal. Establece la base para un plan de tratamiento adecuado”

Nos permite:

- Identificar la etiología
- Conocer la probable evolución
- Determinar el pronóstico
- Realizar un plan de tratamiento relacionado con la causa

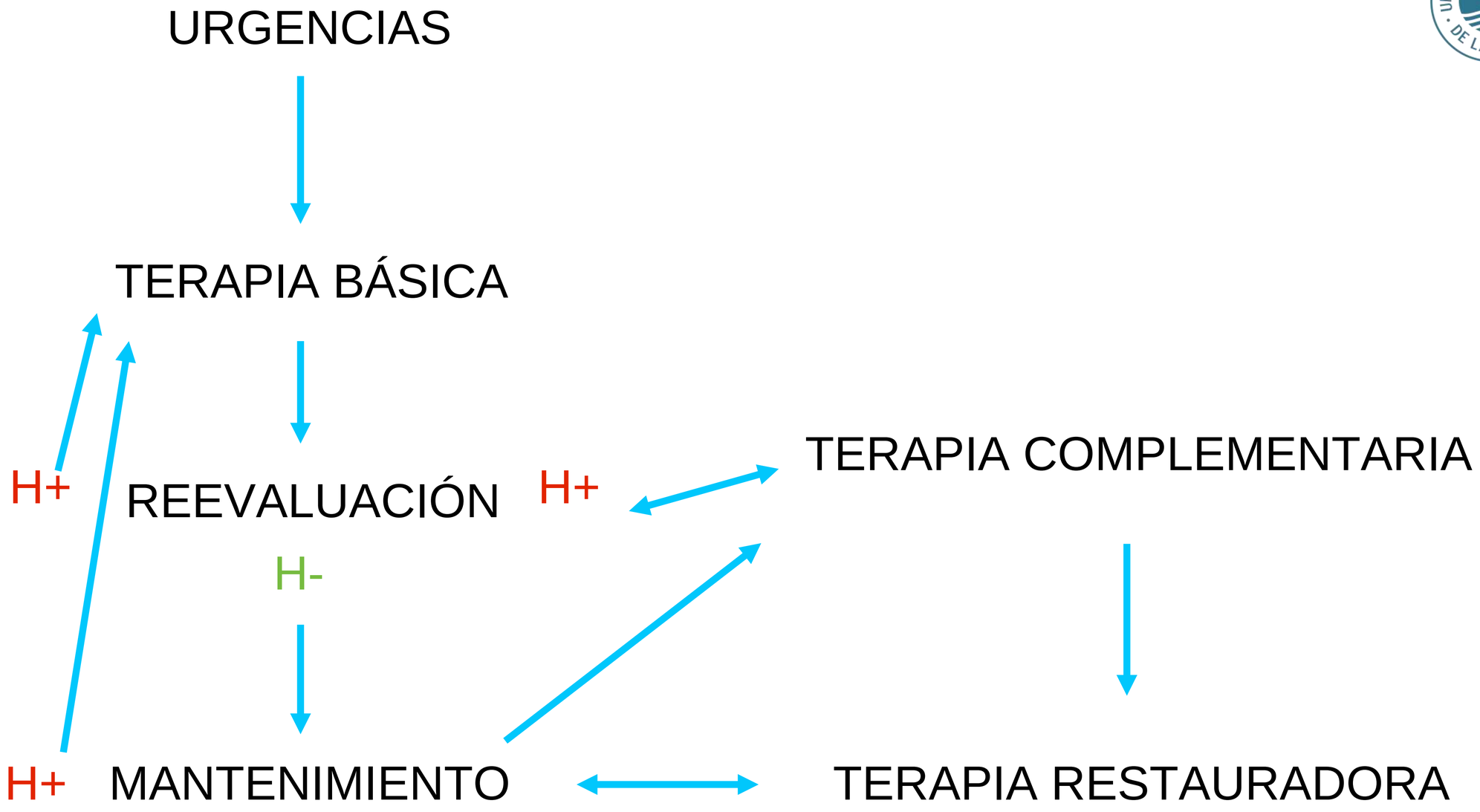
Pronóstico

“Es la predicción fundamentada del curso o desenlace de la enfermedad”

1) Tenemos en cuenta factores de riesgo y factores diagnósticos.

2) Puede ser general o individual de cada pieza.

BUENO ⟶ DUDOSO ⟶ IRRECUPERABLE


URGENCIAS
TERAPIA BÁSICA
H+
REEVALUACIÓN
H+
TERAPIA COMPLEMENTARIA
H-
H+
MANTENIMIENTO
TERAPIA RESTAURADORA

Urgencias

Buscamos solucionar procesos inflamatorios o infecciosos agudos de los tejidos periodontales que demandan intervención rapida para aliviar el dolor, controlar la infección y evitar complicaciones locales o sistémicas.

Terapia básica

“Primera etapa del tratamiento periodontal destinada a eliminar la inflamación gingival y controlar los factores etiologicos locales”

También llamada CAUSAL, ya que buscamos remover la causa que está provocando la enfermedad.

Secuencia clínica:

Motivación

Enseñanza de higiene oral

Raspaje y alisado radicular

Eliminación de factores retentivos de placa bacteriana

Exodoncia de piezas irrecuperables

Terapia farmacológica

Armonización oclusal

Ferulización

Prótesis provisionales

Reevaluación

Reevaluación

“Fase del tratamiento periodontal en la que se valora la respuesta de los tejidos periodontales a la terapia básica”

A partir de los resultados de esta podemos:

1) Pasar a fase de mantenimiento
2) Pasar a terapia complementaria
3) Volver a terapia básica

Terapia complementaria

Solo pasamos a esta etapa una vez conseguido la estabilidad periodontal (salud)

Consta de todas las medidas protesicas, ortodonticas o implantológicas

Buscamos mejorar función y estética

Terapia restauradora

Solo pasamos a esta etapa una vez conseguido la estabilidad periodontal (salud)

Destinada a corregir defectos en dientes o restauraciones que afectan la salud periodon

Buscamos mejorar la función y estética

T . P . S

Terapia Periodontal de Soporte

Fase de mantenimiento

Destinada a preservar la salud, prevenir la recurrenciade la enfermedad y detectar tempranamente posibles nuevas lesiones

Se lleva a cabo mediante controles periodicos individualizados

Fundamental para mantener en el tiempo todo lo logrado en fases anteriores del plan de tratamiento.