I Don't Do Windows

Whether it's a periodontal infection or a caries infection, it's our job to be up on the most current research and treatment options and to educate our patients and provide them with the best evidence-based options for care. We are entering a new age in dentistry; the age of risk assessment-based diagnosis.

by Carri Cady, RDH

Have you ever had a housekeeper who said, "I don't do windows"? Now you might be thinking, What does that have to do with dental hygiene? Let me tell you. I can remember in my early years of practice when I was struggling just to get a periodontal charting, cleaning, and exam done in the hour. Then my dentist would come and ask, "Did you see any concerns with Mrs. Jones' teeth today?" And I would think to myself, Hey, I do gums; I don't do teeth! This may sound crazy, but if we are all honest, I would be willing to bet that, at one point or another, you shared a similar thought. Decay is the dentist's problem; gingivitis and periodontal disease are my problems. Right? Well, the fact of the matter is, none of it is our problem; these diseases belong to our patients. But it is our job. We did take that oath. So, whether it's a periodontal infection or a caries infection, it's our job to be up on the most current research and treatment options and to educate our patients and provide them with the best evidence-based options for care.

We are entering a new age in dentistry; the age of risk assessment-based diagnosis. This is to say, there is no one best treatment for any scenario for every patient. The end of the one-size-fits-all approach to treatment is now here. What will work best for each individual patient is most predictably based on addressing the risk factors associated with the patient's current state of health or disease. For the patient who is at high risk for dental caries and periodontal disease, it might turn out that saving a compromised tooth with root canal therapy and a crown while the available alveolar bone structure is decreasing may not be the best long-term option. An argument can be made that extrac-

tion of the tooth before the bone structure is too compromised and placement of an implant and crown (reducing both caries and periodontal risk to that tooth) may provide a more predictable outcome. We were educated to save every tooth at almost any cost, so this represents a paradigm shift in the way most of us were taught to think. But let's face it — has what we have been doing been working? Is the rate of decay or periodontal disease decreasing? By the continued surgical approach to bacterial diseases, have we successfully reduced our patients' caries or periodontal risks? (See Table 1.)

So, let's get back to my original question. As hygienists, are you implementing risk assessment, not just for periodontal disease but also for dental caries? There has been such a huge disconnect from what we learned in hygiene school. We were taught that decay is caused by a bacterial infection, and then we were taught to treat it by drilling and filling the teeth. What about the missing link, which would be addressing the bacterial infection?

Recent scientific studies are clear that drilling and filling does restore the teeth, but does little or nothing to treat the disease. It is time for a paradigm shift in dental caries management from a surgical model to a medical model. Caries Management by Risk Assessment (CAMBRA) is now being taught at most dental schools nationwide, and we need to be incorporating it into a comprehensive dental hygiene practice. As hygienists, we are the screening and preventive center of any practice. We do periodontal screening, intraoral and extraoral cancer screening, and hopefully caries risk screening.

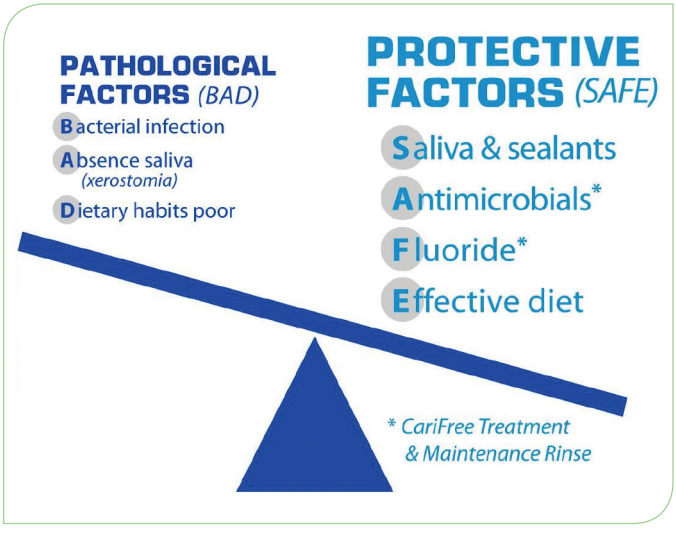

Table 1

CDC Trends in Oral Health Status United States

- Data from National Health & Examination Survey
- Ages 2 to 5 years old
- 1988 to 1994 caries increased 24 percent
- 1999 to 2004 caries increased 28 percent

CDC Periodontal Disease Surveillance Project: Background, Objectives, and Progress Report
Paul I. Eke and Robert J. Genco
Periodontal disease is highly prevalent in older adults, affecting 34 percent of the American population aged >30 years (36 million persons), and it is severe in 13 percent of adults.

Caries risk assessment can be as easy as a one to two minute questionnaire that allows us to assess our patients' caries balance. What risk or pathologic factors does my patient present with, and how might these fare against protective factors that are occurring naturally or have been put into practice? We know that our patients' diet and home care greatly affect their risk of decay. But I also think we can all relate to those patients who brush and floss diligently and still experience new and recurrent decay. As hygienists who have worked hard to create trusting relationships with our patients, we have the perfect opportunity to educate patients about their caries risk and then make preventive recommendations so they can reduce those risks and boost their protective factors.

It is important to understand that whether or not our patients are actively getting decay is not always representative of whether or not they are at high risk for caries. Their caries risk is better determined by whether their caries balance is currently shifted toward their protective or pathologic factors. Consider this analogy: Anytime you go to your medical doctor, he or she will, without fail, do these things — update your health history and medications, ask if you exercise frequently, drink or smoke, have a healthy diet, and then take your blood pressure, right? Regardless of your age and appearance of health, your doctor will take

the opportunity to use these simple, inexpensive, fast, painless ways of screening for your risk of cardiovascular disease. Now, if you do have high blood pressure and lifestyle risk factors, it doesn't mean that you have ever had a heart attack or stroke, or that you necessarily ever will. It means that you are at potentially greater risk for cardiovascular disease, and that your doctor would definitely be doing his or her job — fulfilling the oath — to make you aware of those risk factors and then make recommendations for modifications with the goal of preventing cardiovascular events from ever occurring. So, it is likely you will hear recommendations to decrease your fat and cholesterol intake, quit smoking and reduce drinking to moderation, increase exercise frequency, and in some cases, perhaps take a medication (for blood pressure, cholesterol, etc.) to reduce your risk for cardiovascular disease. These simple measures could change a person's experience and quality of life over time. I'm sure that not many of us would continue to go to a doctor who practiced the "wait and see" philosophy, all the time assuring you that if you ever have a heart attack or stroke, he or she will be "on call" to do surgery for you.

Well, I pose this question to you: can we as hygienists not do this same thing for our patients with regard to reducing their caries risk? Whether you are talking to a patient who has experienced chronic decay or to one who has never had a cavity, the idea of the needle, drill, and associated time and money spent in the dental chair is not their idea of a good time. In fact, it likely sparks fear in the hearts of many! So if you could predictably reduce either of these two patients' likelihood of having to do the drill-and-fill thing, you stand in a pretty amazing place to change their experience and quality of dental health over a lifetime. Interested? I hope so, because your patients are counting on you to bring them this kind of knowledge and treatment options.

Some would argue that the idea called Caries Management by Risk Assessment is the standard of care. We often make the assumption that standard of care refers to what your neighboring practices are doing. Regardless of our numerous opinions on what standard of care is or isn't, the bottom line remains what we prudently should be doing for our patients. Caries risk assessment is not only taught and practiced as standard of care by most dental schools, but it is also being implemented into board exams. Even the ADA Council of Scientific Affairs has established definitions, guidelines, and recommendations. CAMBRA is being routinely practiced by hundreds of dental practices in the United States alone. We are definitely now at a point of accountability regarding caries risk assessment for our patients.

"Dentists who do not practice caries risk assessment and do not treat the disease that causes caries as well as the symptoms of the disease — caries lesions — beware ... Zinman is proving the point in court. In the past five years, he has mitigated at least a dozen dental negligence cases where the dentists did not practice caries risk assessment and management." — Dental Practice Report, July/August 2003

There really are two parts to this equation. One is identifying those patients with high caries risk; the other is offering them a way to reduce their risk. I would encourage you to explore easy "plug and play" systems such as the CariFree System, www.carifree.com, which offers not only simple risk forms for caries risk assessment along with screening tools to identify the bacterial infection component, but a defined, ongoing protocol for corrective actions for your moderate and high caries risk patients in order to manage and reduce their risk over time. We have the opportunity to begin identifying and treating the bacteria that cause decay and make recommendations to reduce the factors that contribute to our patients' susceptibility.

The other key component to a successful CAMBRA model in private practice must address the implementation process. How will we prepare our patients for a new experience at their next visit, and how will we build value for this service we are offering them? What will it cost our practice to get started, and what will it cost our patients over time? What operatory and which team member will perform the initial risk assessment? Who is responsible for ongoing reassessment of caries risk and follow-up appointments? What materials are available to educate our patients and market our practice based on this standard of care? How might the practice, and potentially even us personally as hygienists, benefit financially over time?

Oral BioTech, manufacturers of the CariFree System, has also developed in-depth, clinical CAMBRA training as well as implementation training to support practices in making this paradigm shift successfully, providing better treatment outcomes and benefiting financially all at the same time. There is a huge market in terms of dental prod-

ucts for us to reclaim from the drugstores that are making millions of dollars off our patients. They are selling "dentist recommended" products that may or may not be at all what we would prescribe for our patients.

Our only other option is to remain in the "wait and see/drill and fill" mindset, doing what we've always done and seeing the same decay and failures we've always seen, which hasn't provided the best results for our patients. Or, we can be an innovator in our practices, do the research, educate ourselves, and fulfill our oath to our patients — they are lucky to have us!

About the Author

Carri Cady, RDH, is the sales director for Oral BioTech, manufacturers of the CariFree System. She also lectures on the topic of caries risk assessment and treatment. In clinical practice, Carri specialized in laser-assisted periodontal therapy as well as restorative dentistry, and has provided private instruction to dental hygiene students working to improve their restorative skills. She can be contacted at ccady@carifree.com.