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Dear reader,

“There this tooth is hard to pull out.”

Claudia Salwiczek
Editor

I just returned from the Greater New York Dental Meeting where I had the opportunity to conduct a number of interviews with well-known opinion leaders in dentistry. What struck me most about the line-up was that only 1 out of the 30 professionals that I spoke to was a woman.

It is a sad fact that compared to other fields in medicine dentistry is still predominantly a male profession. There are exceptions, of course, such as Dr. Catrine Austin, a New York-based dentist, who I recently met to talk about her decision to offer endodontic surgeries to her patients. Or Dr. Bo Chen from Beijing, who I met at the P.I. Bränemark symposium in Sweden where she presented a revealing study on patient satisfaction figures with facial and oral reconstruction. Unfortunately, though large in impact, these developments and ideas do not usually receive the recognition they deserve.

However, what these examples also demonstrate is that women often tend to develop solutions that are socially applicable and that offer benefits for all members of society; a fact endorsed by a recent World Health Organisation report. In the study on Women and Health, the question was also raised why women generally have to carry much of the health care burden while getting hardly anything back. It may be time for women, especially those working in medical and dental professions, to step up and make their message heard.

It may not happen overnight, but with more and more women overtaking high political and economical positions, it will be difficult for dentistry to hold up to its Boys Club status for much longer. I certainly hope that when I return to New York in 2010, there will be a larger share of female dentists to speak to.

Yours sincerely,

Claudia Salwiczek
Editor

Dental Tribune International

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Dear reader,

“This tooth is hard to pull out.”

Dr. Carsten Appel
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The International Diabetes Federation publication Guide- line: Oral Health for People with Diabetes addresses the reported bi-directional relationship of dia- betes mellitus and periodontal disease. It has long been recog- nised that periodontitis is a com- plication of diabetes mellitus, and periodontitis has been suggested as the sixth clinical complication of diabetes. More recently, data has been published that suggests that metabolic control in diabetes is adversely affected by peri- odontitis. The mechanism that accounts for this association is the production of inflammatory mediators in the periodontal tis- sues, with a resultant elevation of serum levels of these mediators, leading to the desensitisation of peripheral insulin receptors.

The guideline group that prepared and wrote this report addressed two questions: "What level of surveillance for periodon- tal disease should be recom- mended for people with know- n diabetes" and "Is active manage- ment of periodontitis particularly recommended for people with di- abetes?" In response to both ques- tions, the guideline group con- cluded that the evidence does not support an affirmative answer to either of these. Despite these con- clusions, the publication provides recommendations for oral health care for persons with diabetes. These include an emphasis on the need to educate patients with diabetes that their periodontal health can be adversely affected by diabetes, the importance of regular personal and profes- sional oral health care, and the need for periodontal care if peri- odontal disease is present.

The findings presented in this document are surprisingly lim- ited in scope. While it is recogn- ised that the committee did not have specific instructions regard- ing the amount of evidence re- quired in order to be able make a recommendation, the literature reviews cited in the guideline document provided solid evi- dence that periodontitis is more severe in patients with diabetes. Furthermore, while evidence suggesting that periodontal treat- ment can improve glycaemic con- trol in patients with diabetes is not as solid, the trend observed in these studies is that the greatest beneficial effects are seen in cases in which the glycaemic con- trol is very poor. It can thus be de- rived that these patients require the most attention, as they are at the greatest risk for clinical com- plications of diabetes.

The provision of appropriate oral care to patients with diabetes mellitus will improve oral health, which in itself is a desirable out- come. Diabetes is a chronic dis- ease that patients must manage on a daily basis. Appropriate oral health care, with a focus on pre- vention, can lead to a lifetime of good oral health, efficient mastic- ation and a better diet, the last two of which can have important positive effects on weight control. Weight control is critical for gly- caemic control.

Another important considera- tion is the likelihood that patients who target periodontal practice will have diabetes and not be aware of their diagnosis. In the US, approximately 25 per cent of patients with diabetes are not aware that they have diabetes. Given the increased prevalence of periodontitis in this patient group, careful examination by a dental professional (in identify advanced periodontal disease) and a thorough health history (that is, family history of diabetes, or a report by the patient of ex- cessive thirst, urination and/or hunger) can suggest the need for evaluation of diabetes. If dental professionals are to assume this more active role, they need to be familiar with all aspects of dia- betes mellitus, including risk fac- tors, health history and clinical complications, and treatment approaches. This may require ad- ditional training, but the outcome will be the improved general health, not only oral health, of patients treated in the dental practice.

The guideline document is important because it focuses at- tention on the oral health of the increasing number of patients across the globe with diabetes. Dental disease is a component of the diabetes clinical spectrum. Additional studies appear in peer- reviewed journals each month. Thus, the findings regarding the bi-directional relationship of diabetes mellitus and oral health presented in this guideline docu- ment are not final.

Endodontic therapy is often the last opportunity to preserve a natural tooth. If a tooth has a sufficient restorative and peri- odontal prognosis and the neces- sary endodontic treatment is done properly, the longevity of patients’ teeth can be extended to decades. There is ongoing de- bate comparing endodontics and implants as therapy alternatives. Yet, there seems to be a tendency towards the replacement of na- tural teeth with implants, some- times even in cases where the tooth could have been preserved.

Research figures show that there is a significant difference between the high success rates of endodontics in con- trolled studies and the incidence of apical periodontitis after en- dodontic treatment, as demon- strated in cross-sectional studies. This may be an indication of the difference created by endodontic treatment following a controlled protocol that is achieved in reality, thereby explaining the endodontic treatment results we often see in our patients.

Controlled studies in implan- tology have mostly presented data indicating implant survival and not implant success, as de- manded by Dale, Albrektsson and others. Even early implant loss, within the first weeks of placement, is often included in many statistical calculations. In the last two years, reports have indicated instances of peri-im- plantitis at a rate of 10 per cent and in some implant types of up to 29 per cent. Some studies have shown higher incidences of peri- implantitis in patients that have lost teeth because of periodonti- tis before and therefore suggest a possible predisposition. Addi- tionally, we are only beginning to understand the treatment of peri-implantitis.

In my opinion, implants are a very valuable instrument if the natural tooth has already been lost due to periodontal di- agnosis. But if a tooth has a sufficient restorative, periodontal and endodontic prognosis, it should be preserved in most cases. Thus, I consider that the situation is not one of endodontics vs. im- plants but that one or two disciplines working alongside in the goal of best serving our patients.

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