

Thompson Periodontal Disinfection Protocol -The Integrative Oral Medicine Way

1. Complete an occlusal analysis to evaluate any bite issues that may aggravate periodontal disease. Occlusal guard therapy may be considered.
2. Attack the bacteria in the pockets and on the teeth mechanically. This is traditional scaling and root planning or bacterial disruption by mechanical means however you do it most effectively. It could be done with hand instruments, Cavitron, Piezo, a rotary bur, abrasive powder, etc. The goal is to remove deposits and diseased cementum from the root surfaces of the teeth and the epithelial lining of the pocket.
3. Attack the bacteria in the pockets and on the teeth chemically. Currently, the irrigant of choice is CTX4 Treatment Rinse. For stronger concentration you may choose to use B bottle only but it is not necessary. Use a 23 gauge side port cannula to irrigate all sulci thoroughly twice after scaling and root planning. This takes less than five minutes. Be aware that sodium hypochlorite is not as effective in the presence of blood so a thorough rinse is necessary. In addition, place the most effective time release antibiotic into the sulcus (currently Arestin) of all pockets 5mm or greater.
4. Attack the bacteria in the rest of the oral cavity and disrupt the oral bacterial biofilm twice daily for two months after disinfection therapy. Do this by instructing your patient to rinse one minute twice daily with CTX4 Treatment Rinse. This will help reduce the bacterial load living on the cheeks, tongue, tonsillar crypts, and on the outside surfaces of the teeth that come in contact with the rinse. This rinse has an elevated pH, xylitol, fluoride and sodium hypochlorite all products to create an oral environment unfavorable for pathogenic bacteria to grow.
5. Attack the bacteria in the bloodstream and in the periodontal tissues. Bacteria exist in areas that are unreachable with localized mechanical and chemical therapy. Use systemic antibiotics as recommended by a salivary diagnostic or molecular diagnostic report. Currently, OralDNA, Hain Diagnostic and Oravital provide easy, effective, inexpensive reports to assist with antibiotic selection.
6. Personalize all home care adjuncts to allow the patient to be as successful as possible. Consider a mechanical tooth brush, floss, Stimudents, soft pics, proximal brushes, water flosser or some sort of lavage system to “power wash” the teeth. Any methodology that the patient can use to effectively manage bacterial growth on the buccal, lingual, and occlusal surfaces, and not harm the teeth or gums is acceptable. Prescribe an antimicrobial rinse either natural or medicinal depending upon your judgment and patient preference. There are many rinses available, designed for long term use, to maintain the bacterial load living on the cheeks, tongue, tonsillar crypts, and on the outside surfaces of the teeth that come in contact with the rinse. Current rinse of choice is ProFresh, a chlorine dioxide based rinse. It is possible to substitute ProFresh for a drug store equivalent like Cloysis or Smartmouth. IOM has not evaluated these two rinses as substitutes. Additionally, you can coach patients to put some water flosser enhancements into the reservoir of the device (may void device warranty). Powdered Xylitol, Grapefruit Seed Extract, or even diluted household bleach (see Jorgen Slots research for proper dilution ratios) are possibilities.
7. Keep patients on an 8 week re evaluation cycle after SRP until there is zero bleeding. Bacteria retesting to evaluate disinfection results on the microbial load could be done then. Shorten the recare at the slightest signs of regression in efficient bacterial load control at home. Check biofilm loads every two years post treatment.