“Good long-term treatment results depend on periodontal maintenance therapy”

An interview with Dr Oystein Fardal, Norway

According to Norwegian dentist Dr Oystein Fardal, quality control in periodontal therapy is significantly lacking. Today international had the opportunity to speak with him at Europerio 7 about the challenges of establishing a universal model and the benefit of quality control to periodontal treatment outcomes.

Today international: Dr Fardal, your presentation at this Europerio congress is titled “Quality control in periodontal therapy”. Could you explain this concept in more detail?

Dr Oystein Fardal: The aim of my presentation here at Europerio 7 is to describe how quality control can be measured and applied to periodontal therapy. The main objectives are to determine the stages of periodontal therapy during which control measures should be considered and which parameters are suitable for measurement. I will also aim at identifying benefits for patient and clinician, as well as the long-term implications of quality-control measures in periodontal therapy.

From your perspective, is quality control in periodontal therapy generally lacking?

Unfortunately, little work has been done with regard to this important aspect of periodontal therapy. What has been achieved so far has been somewhat sporadic, without an overall plan of what a quality-control model should be based upon.

What are the main challenges in periodontal treatment nowadays and which aspects of these methods are most affected?

The emphasis in periodontal therapy appears to have shifted somewhat from saving teeth with doubtful and poor prognoses to replacing them with implants. However, with more implants being placed, more complications need to be dealt with. This is already a challenge for periodontists today and most likely to increase with time. For example, we still do not have a proven universal protocol for the treatment of peri-implantitis.

When it comes to traditional periodontal therapy, the main challenges are associated with the management of maintenance treatment.

You have been campaigning for the use of periodontal maintenance therapy programmes for years. How could such a programme contribute to the quality of treatment?

Periodontal maintenance programmes have been in existence for a long time and so has the knowledge of the importance of such programmes. My research merely reiterates the fact that good long-term treatment results depend on periodontal maintenance therapy.

In your studies, you have found that compliance with these programmes is generally low among patients. Why is that and what are your recommendations for improving compliance?

With few exceptions, the literature reports low rates of compliance with maintenance therapy but this is not a problem specifically relating to periodontal therapy. All treatment protocols, medical or dental, for which the patient is required to participate are confronted with similar problems.

A number of psychological theories have been suggested to explain non-compliance. It is also known that age, sex, geographic and cultural differences play a significant role. One of my papers points out that the referring dental practitioner could be a decisive factor. Thus, differences in dental practice profile and treatment philosophies are likely to be important when considering improvements in patient compliance.

There are quality-control systems in development around the world. Are you aware of any systems that you are familiar with and their benefits and shortcomings?

I am aware of some excellent research being carried out that can be applied to quality-control systems. The fact that this work is being carried out in different areas of the world is beneficial for agreeing on a universal model for quality control of periodontal therapy. However, I do not know enough of the details of the work to comment on any shortcomings.

How do new treatment methods or tools contribute to quality control of periodontal therapy?

It is not so much that new methods or tools contribute to quality control as the fact that these new methods need to have quality control applied to them. Any model for quality control will have to be designed in such a manner that it can be applied to both new and established treatment methods or tools. The basic design of such a model requires the user to document outcome, deviations, financial implications and cost effectiveness of the particular treatment. For example, such a model could be applied to new regenerative procedures or materials.

Thank you very much for this interview.