PERIO

Q&A with Dr. George K. Merijohn

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Dr. George K. Merijohn

Q. Dr. Merijohn, much of your passion in dentistry appears related to prevention and correction of gingival recession. Why is recession considered to be such a problem?

A. Gingival recession is highly prevalent worldwide. Depending on the population surveyed, the percentage of people affected ranges from 30 percent to 100 percent, with its prevalence and severity increasing with age. In the United States alone, the prevalence of ≥1 mm recession in people 30 years and older has been reported to be 58 percent, and averaged 22 percent teeth per person. What's more, it has been reported in the literature that gingival recession afflicts approximately 85 percent of dentists and dental students.

Dentists who treat the esthetic zone are especially frustrated with gingival recession returning after orthodontic tooth movement and/or after porcelain margins are perfectly placed. Clinicians invest substantial time and effort in the esthetic zone both in our continuing education and practice. The seminar and workshop I will be presenting for the ODA are especially designed to enhance esthetic zone clinical outcomes.

Dental hygienists and clinical staff always want to know, "How does one avoid getting gingival recession in the first place, and then after it's treated, how do we keep it from coming back?" The "Management and Prevention of Gingival Recession" seminar addresses these issues and provides evidence-based, practical, and systematic approaches that attendees will be able to use in their practices the next day.

We are all familiar with patient-driven concerns about gingival recession, such as when it interferes with comfort, function and esthetics. Anecdotal evidence suggests that the main reason for gingival recession treatment is the patient raising the issue. Unfortunately, most often it is only the high-smile-line patients who are concerned, and their focus rarely goes beyond the facial aspect of the anterior teeth.

An unfavorable consequence of gingival recession is the exposure of root surfaces to a potentially cariogenic supragingival microbiota. In the United States, the prevalence of root caries experience has been reported to be 55.9 percent among those age 75+ years. Of great concern is that the group age 65 and older, which was 12 percent of the population in 2000, is expected to exceed 20 percent by 2030; and root caries is expected to increase along with it.

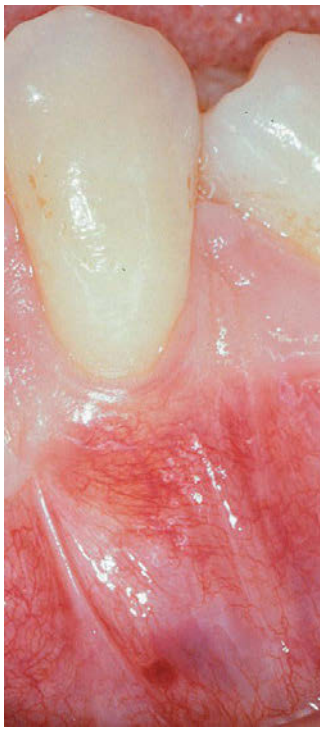
Nobody likes to have or treat root caries. Yet root caries and gingival recession are on a collision course. Our profession needs to connect the dots and do so quickly. Prevention of gingival recession is an essential element in the primary prevention of root caries. This alone is reason to incorporate practical protocols for management and prevention of gingival recession into daily clinical practice.

Q. What are some of the modifiable conditions that increase the risk of gingival recession?

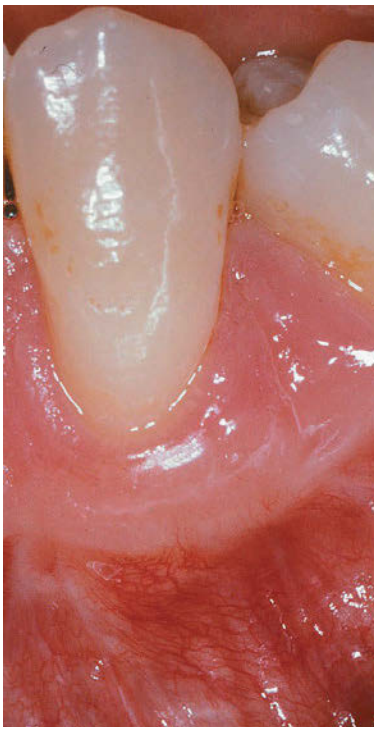
A. The published scientific evidence demonstrates that there are 14 core modifiable conditions associated with increased risk including damaging oral hygiene methods, damaging oral habits, oral appliances, certain common dental procedures and orthodontic tooth movement.

The key thing is that especially for the susceptible patient, decreasing exposure to modifiable conditions will decrease future risk for gingival recession and increase the likelihood of its long-term prevention. Attendees of the seminar will learn how to quickly spot who is susceptible to gingival recession and who is not so susceptible.

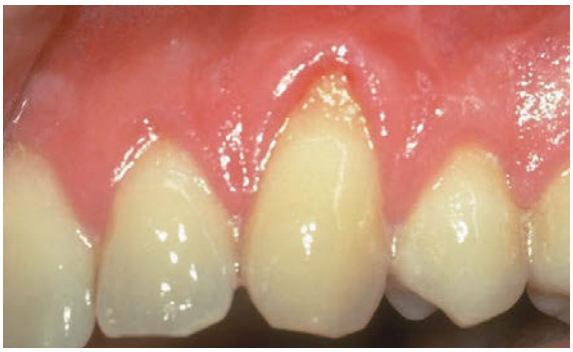
Q. What is the difference in a traditional gingival graft compared to your minimally invasive technique?



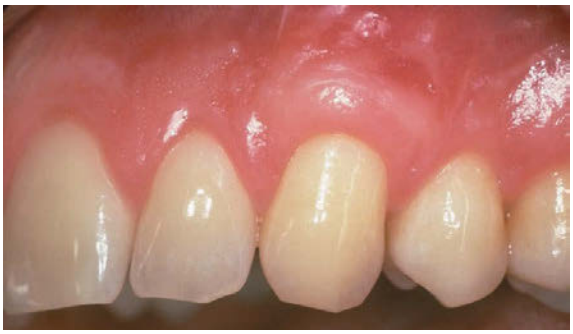
Case A. Before.



Case A. After.



Case B. Before.



Case B. After.

A. Conventional palatal tissue harvesting is often associated with notable disadvantages. Patients fear having tissue peeled off the roof of their mouths, there often is protracted pain at the palatal harvest site, people experience difficulty chewing and talking — with and without wound protection materials, and excessive postoperative bleeding and complications are not unusual. The minimally invasive techniques I teach in KIWImethod Workshops substantially reduce these disadvantages; and, as a result, the patient experience is more positive and appreciative. Additionally, the nonpalatal gingival harvesting method taught in the workshop often provides superior color and texture match because it is gingiva/gingival connective tissue rather than palatal mucosa/submucosal mixed tissue.

Q. What are some of the advantages of using autologous tissue compared to cadaveric dermal tissue?

A. There are three main advantages:

1. Compared with any other tissue source and/or regenerative materials, over the years our best systematic reviews have repeatedly demonstrated that autogenous tissue is the gold standard for root coverage, reducing recession, gaining clinical attachment and increasing keratinized tissue.
2. With autogenous tissue, there is zero risk of disease transmission, and there are no cadaver skin "yuck factor" objections from patients.
3. With autogenous tissue, the dentist does not have to buy expensive donor tissue or biomaterials.

Q. What can the general dentists in your course take home for use when they get back to the office on Monday?

A. I strongly recommend that every dentist taking the "KIWImethod Minimally Invasive Gingival Grafting" hands-on workshop also take the interactive seminar, "Management and Prevention of Gingival Recession."

The seminar "Management and Prevention of Gingival Recession" is an interactive, fun format for dentists, dental hygienists, all staff members and dental specialists alike.

Seminar

- Learn the three major factors associated with increased susceptibility to gingival recession.
- Take away practical concepts regarding the recognition and

management of risk exposures that can be implemented in the busy clinical setting.
- Understand what essential data should be collected and recorded for monitoring patients.
- Practice with chairside clinical decision-support tools designed to help the clinician focus on triage, evaluation, planning and patient communication regarding the prevention and management of gingival recession.
- Discover clinical decision-making criteria for when and how to monitor gingival recession, when a patient is a candidate for surgical evaluation or referral to a periodontist, and, if surgery is the treatment of choice, what should be considered key surgical outcome objectives.

Workshop

- When to consider surgery.
- Surgical outcome objectives.
- Surgical procedure selection.
- Donor tissue options.
- Minimally invasive surgical procedures for root coverage and non-root coverage outcomes.
- Minimally invasive autogenous donor tissue harvesting.
- Postoperative instructions.
- Practical tips on post-operative phase patient management.
- When to treat, when to refer.

Dr. Merijohn has practiced for 28 years and is an associate clinical professor in postdoctoral periodontics at UCSF and the University of Washington. He is a leading clinician and educator in periodontics and an authority on gingival recession prevention, management and minimally invasive surgery. Dr. Merijohn serves on the editorial board of the Journal of Evidence-Based Dental Practice.