Treatment Planning for the Periodontal Patient

Scaling & Root Planing (S + RP)

Scaling:- is the process by which plaque &calculus are removed from both supragingival & subgingival tooth surfaces. The supragingival scaling is the initial phase of debridement of the dentition in patients with periodontal disease to facilitate the subsequent subgingival scaling, thus supragingival calculus and gross overhang should be removed first, then the dentition is polished so that the patient can start a self-performed plaque control program. Calculus **does not** in itself induce inflammation, but has a deleterious effect because of its ability to provide an ideal surface for microbial colonization. Thus, the rationale for the removal of calculus relates to eliminating, as far as possible, surface irregularities harboring pathogenic bacteria.

Root planning:- is the process by which residual embedded calculus and softened cementum are removed from the roots to produce smooth, hard & clean root surfaces. Root planing instrumentation removes **"contaminated"** cementum and dentin to restore the biological compatibility of periodontally diseased root surfaces. The rationale for performing root planing was originally based on the concept that bacterial endotoxins penetrate the cementum, and for this reason, it was thought necessary to remove not only biofilms and calculus but also the underlying cementum.

Subgingival S&RP (**Scaling & Root planning**), although considered as two separated procedures with different objectives but in clinical work they always carried out together and can be carried out in sessions, the number of teeth included in each session for RP depends on the skills of the operator and the severity of the case, usually **(4-6)** teeth.

At the beginning the area is probed to identify:

1. The probing pocket depth (PPD)

   PPD measurement : is the distance from the gingival margin to the most apical penetration of the periodontal probe insert into the gingival crevice or periodontal pocket without pressure or force and measure in mm.
2. Anatomy of the root surface
3. Location of the deposits

Scaling & root planing aims to:

☒ **Restore gingival health** by completely removing elements that provoke gingival inflammation (biofilm, calculus &endotoxin) from the tooth surface. Deposits of calculus on root surfaces are frequently embedded in cemental irregularities. Subgingival calculus is porous and harbors bacteria and endotoxin and therefore should be removed completely. When dentin is exposed, biofilm bacteria may invade dentinal tubules. Therefore scaling alone is insufficient to remove them, and a portion of the root surface must be removed to eliminate these deposits. Furthermore, when the root surface is exposed to biofilm and the pocket environment, its surface is contaminated by toxic substances, notably endotoxins. Evidence suggests that these toxic substances are only superficially attached to the root and do not permeate it deeply. Removal of extensive amounts of dentin and cementum is not necessary to render the roots free of toxins and should be avoided.

☒ **The creation of a clean & hard root surface** that is as smooth as possible (which inhibits further plaque retention) must be achieved to promote tissue healing possibly with the formation of a long junctional epithelium and aids soft tissue reattachment.

Subgingival scaling & root planing are performed as either **closed or open procedures** under local anesthesia.

Closed subgingival scaling & root planing procedure

Implies subgingival instrumentation without displacement of the gingiva, thus **less** trauma, pain, bleeding and minimal recession (which is important for esthetics, especially anteriorly) were achieved. In addition, wound healing occurs **more** rapidly following closed procedures. Closed therapy is the **definitive** treatment for **mild & moderate** periodontitis and represents the initial therapeutic approach prior to surgical intervention for complex & severe cases.

Closed therapy **limitations** include its performance **without** direct vision & good access for the instruments, thus its success is dependent on tactile sensation & knowledge of root morphology. Even the experienced hygienist will not always effectively treat all root surfaces, nor completely remove all plaque & calculus from all surfaces, e.g. S+RP of poorly accessible, irregular root surfaces, in deep, narrow or distal pockets and substantial furcation involvement, even in patients with minimal mouth opening capacity & with expansively progressive disease.

Open subgingival scaling & root planing procedure

Include exposure the affected root surface by the displacement of the gingival tissue, thus gingiva is incised and reflected to **facilitate access for the instrument and visibility for the operator**.

Instruments used for scaling & root planing are classified as:-

- **Hand instruments.**
- **Ultrasonic & sonic instruments.**
- **Motor driven devices incorporating diamond-coated tips (reciprocating instruments).**
- **Rotating instruments.**
- **Laser-instruments.**

Reciprocating instruments: a special designed hand piece will give 20000-30000 strokes per min. with a 1.2mm reciprocating motion of a specially designed working tips for S & RP (e.g. a set of PER-IO-TOR instruments), its use is less time consuming than hand instrument , results in less root surface loss and produce equivalent clinical outcome compared to hand, sonic or ultrasonic scalers.

Rotating instruments: used to debride furcation areas and root surface in deep narrow pockets because in these situations cannot be properly debride with hand inst. A fine grained diamond bur is usually used with great care to avoid excessive removal of tooth substances.

Laser: recently laser devices been introduced to be used in different aspects of periodontal therapy including S&RP. Depending upon the wavelength and settings employed, some lasers can ablate subgingival calculus and exert antimicrobial effects. However recent guidelines did not suggest its use in periodontitis treatment due to low evidence available.

Removal of Plaque retentive factors

The relation between faulty dentistry **(overhang filling, defective crown margin & improperly situated clasp of P.D.)** and periodontal disease due to its plaque retentive property. Such conditions should be corrected either by correction or

replacement of the prostheses & restorations to prevent accumulation of plaque & facilitate self-performed tooth cleaning to maintain good periodontal health.

Recontouring defective restorations and crowns :- Corrections of restorative defects, which are plaque or biofilm retentive areas, may be accomplished by smoothing the rough surfaces and removing overhangs from the faulty restorations.

Caries Control:- Dental caries, particularly root caries, is a problem for periodontal patients because of attachment loss and exposed root surfaces associated with the disease process and periodontal therapy procedures. **Fluoride** is effective primarily by topical effects to prevent and reverse the caries process, whether in enamel, cementum, or dentin. **So:**

- ❖ All periodontal patients should be encouraged to use fluoride-containing toothpaste daily.
- ❖ Patients at high risk for caries should use higher-concentration fluoride toothpaste or gel. While a lower concentration can be used during maintenance therapy.
- ❖ A periodic chlorhexidine rinsing regimen to control cariogenic bacteria in the oral cavity is part of the caries risk management program for high-risk individuals.
- ❖ Other considerations in caries control, such as diet and reduced salivary flow, should be evaluated, and modifications should be made where possible.

Risk factor control

Smoking and diabetes are two proven risk factors in the etiopathogenesis of periodontitis, and therefore, their control should be an integral component in the treatment of these patients.

Evaluation of the effect of the initial, cause-related therapy:

A thorough evaluation of the effects of phase I therapy is made n**o less than 1 to 3 months** and sometimes as much as **9 months** after the completion of phase I therapy. Reevaluation of the patient's periodontal conditions & caries activity **should be performed no earlier than 4 weeks** following the last session of the S+ RP procedures, to provide time for the tissues to heal by the formation of a long junctional epithelium & sufficient practice with oral hygiene skills.

Although **smoothness** is the criterion by which scaling and root planing are immediately evaluated, the ultimate evaluation is based on tissue response. Clinical evaluation of the soft tissue response to scaling and root planing, including probing, should not be conducted earlier than 2 weeks postoperatively. Re-epithelialization of the wounds created during instrumentation takes **1 to 2 weeks**. Until then, gingival bleeding on probing can be expected even when calculus has been completely removed because the soft tissue wound is not epithelialized. Any gingival bleeding on probing noted after this interval is more likely the result of persistent inflammation produced by residual deposits not removed during the initial procedure or inadequate plaque control. Positive clinical changes after instrumentation often continue for weeks or months. Therefore, a longer period of evaluation may be indicated before deciding whether to intervene with further instrumentation or surgery.

Reevaluation of the periodontal condition includes repeat probing of the entire mouth. Calculus, root caries, defective restorations, and signs of persistent inflammation should also be evaluated.

Increased resistance of the periodontal tissues to probing and the absence of bleeding are **signs of resolution of the inflammatory lesion** related to a sufficient removal of biofilm/calculus. Thus, clinical endpoints of treatment success may be defined as **(1)** no bleeding on pocket probing and **(2)** "pocket closure" or reduction, that is a PPD of ≤4mm. Generally, clinical improvement is less pronounced at molars, particularly at furcation sites, than at single-rooted teeth. Smoking is proven to negatively affect the outcome of all modalities of periodontal therapies and hence, if the patient is a smoker, the inclusion of a smoking cessation program should be considered as an adjunctive measure.

The initial phase of the therapy is completed with a thorough analysis of the results obtained with respect to :-

1) Improvement of the self-performed plaque control.

2) Reduction in plaque level **(plaque index).**

3) Resolution of gingival inflammation include less bleeding, redness & swelling **(gingival index and bleeding on probing).**

4) Shrinkage of the gingival soft tissue **(recession).**

5) Increased resistance to probe tip penetration by the tissues at the base of the pocket

6) Reduction of probing pocket depth, and if possible changes in clinical attachment level as a result of gingival shrinkage and formation of long junctional epithelium.

7) Reduced tooth mobility.

When we evaluate the results of our treatment according to these points we can see one of the following conditions :-

When we evaluate the results of our treatment according to these points we can see one of the following conditions:-

1- Patient with improved oral hygiene, no gingival inflammation, no bleeding on probing with a marked reduction in **probing pocket depth ≤4 mm**, in such a situation **no further periodontal treatment is required** and the patient is directly advanced **to the maintenance phase** of periodontal therapy (supportive periodontal therapy).

2- Patient with proper standard of oral hygiene but having some sites of bleeding on probing with no significant reduction in probing depth. Such a patient may need to be advanced to the corrective phase including periodontal surgery**. PPD ≤ 6mm or PPD ≤ 4mm with BOP.**

3- Patients with inadequate oral hygiene due to lack of motivation or lack of ability to do proper home care, such patient should be **remotivated and reinstructed** to improve their oral hygiene because if the oral hygiene not improved the periodontal disease will recurrent even if we conduct periodontal surgery.

BOP measurement: a periodontal probe is inserted to the bottom of the gingival crevice or periodontal pocket at six points around tooth surface,if bleeding occurs within 30 seconds the site gives score(1) and for non-bleeding site, score (0).

Chemical plaque control

Gingivitis and periodontitis are highly prevalent diseases and prevention of occurrence or recurrence is dependent on supra -gingival plaque control. The concept of using chemical plaque control is just an adjunctive mean to overcome inadequacies of mechanical cleaning.

Mechanism of action

Chemical plaque control may be achieved by different mechanisms of action with a **quantitative** (reduction of the number of microorganisms) and/or **qualitative** (altering the vitality of the biofilm).

Ideal features :

- ☒ **Specificity:-** Agents and formulations for chemical plaque control should demonstrate a wide spectrum of action, including bacteria, viruses, and yeasts. More specific products, such as antibiotics, must not be used in the prevention of periodontal diseases, and their use should be limited for the prevention of bacteraemia, at-risk patients, and for the treatment of some periodontal conditions .
- ☒ **Efficacy:-** Antimicrobial capacity must be demonstrated against microorganisms implicated in gingivitis and periodontitis. Although bactericidal effects may be only achieved at high dosages, antimicrobial effects should also be present at lower dosages.
- ☒ **Substantivity:-** defined as the duration of the antimicrobial and as a measurement of the contact time between the agent and the substrate in a defined medium. This time may be longer than expected with simple mechanical deposition.

- ☒ **Safety:-** This must be demonstrated in animal models, before its use in humans. Because of the chronicity of the conditions to be prevented and the foreseeable long-term use, the secondary effects must be minimal.
- ☒ **Stability:-** Agents must be stable at room temperature for an extended period of time. Care should be taken when mixing different ingredients in a formulation to avoid interference between molecules.

The action of the chemical agents could fit into four categories:

1. Anti-adhesive

2. Antimicrobial

3. Plaque removal

4. Anti-pathogenic

Anti-adhesive agents

Act at the **pellicle surface** to **prevent the initial attachment** of the primary plaque forming bacteria and development of biofilms, although the amine alcohol, delmopinol, which appears to interfere with bacterial matrix formation and therefore fits between the concepts of anti-adhesion and plaque removal, has been shown effective against plaque and gingivitis.

Antimicrobial agents:

They could inhibit plaque formation through one of two mechanisms alone or combined. The first would be the inhibition of bacterial proliferation therefore could exert their effects either at the pellicle coated tooth surface before the primary plaque formation bacteria attach or after attachment but before division of these bacteria, this effect would be bacteriostatic in type while, the second effect

could be bactericidal, whereby the antimicrobial agent destroys all of the microorganisms either attaching or already attached to the tooth surface.

Plaque removal agents:

Such agents contained in a mouth rinse to reach all tooth surfaces and act in an identical manner to a tooth brush and remove bacteria from the tooth surface have attracted the terminology of the chemical tooth brush e.g. Hypochlorite's.

Anti-pathogenic agents:

These agents might inhibit the expression of plaque microorganisms' pathogenicity without necessarily destroying them and directly approaches to alter plaque ecology to a less pathogenic flora, e.g. Antimicrobial agents with bacteriostatic effect.

Vehicles for the delivery of chemical agents

Tooth paste-mouth rinses-spray-irrigators-chewing gum-varnishes, gel, chips. These agents should have persistent action (**substantivity**) measured in hours which **depend on**:-

1. Adsorption and prolonged retention on oral surface including pellicle-coated teeth.
2. Maintenance of antimicrobial activity once adsorbed.
3. Slow release from the oral tissues.

After many studies and clinical trials it was found that the **chlorhexidine (CHX**) is the **best chemical supra-gingival plaque control** agent.

Chlorhexidine digluconate:

CHX is frequently used as a mouth rinse (0.2% or 0.12% w/v). The compound can also be applied as a gel, spray, varnishes and has been incorporated into tooth paste, chewing gum, slow release vehicles (perio chip), periodontal packs and sub-gingival irrigation.

Characteristics

CHX is nontoxic even if digested or topically applied and has a broad antimicrobial action including a wide range of gram-positive & gram-negative m.o.; it is also effective against fungi and yeast including Candida and some viruses including human immunodeficiency virus and hepatitis B virus (HIV and HBV). No report of bacterial resistance even after prolong use of CHX were recorded.

Antimicrobial effect. The mode of action of chlorhexidine in killing bacteria is dependent upon the drug having access to cell walls. This is facilitated by electrostatic forces, since chlorhexidine is positively charged, while the phosphate and carboxyl groups of bacterial cell walls carry negative charges. Binding disrupts the osmotic barrier , interference and disturbs membrane transport of bacteria & keeps them in a state of bacteriostasis.

Depending on the concentration, CHX may show different antimicrobial effects. At low concentrations, it increases the permeability of the plasmatic membrane, leading to a bacteriostatic effect. At higher concentrations, it induces precipitation of cytoplasm proteins and cell death, thus having a bactericidal effect. Against biofilms, CHX has demonstrated the capacity to penetrate and actively act inside the biofilm, both altering biofilm formation or having a bactericidal effect.

Rinsing with chlorhexidine reduces the number of bacteria in saliva by between 50% and 90%. A maximum reduction of 95% occurs around 5 days, after which the numbers of bacteria increase gradually to maintain an overall reduction of 70%-80% at 40 days.

Plaque inhibitory effect. In addition to the antimicrobial effect, CHX molecules adhere to the tooth surface and interact with bacterial cells that are also trying to adhere to the tooth surface; therefore, CHX interferes with bacterial adhesion ; also this interaction reduce bacterial ability to stick to tooth surface.

CHX also interacts with salivary glycoproteins, thus leading to reduced salivary pellicle formation. In addition, it has been suggested that CHX affects the activity of bacterial enzymes involved in glucan production (glycosil tranferase C)

Substantivity. CHX molecules bind reversibly to oral tissues, with a slow release that allows for sustained antimicrobial effects for up to **12 hours** . An important property of chlorhexidine is its substantivity, that is, the retention in the mouth and subsequent release from oral structures, After a 1 minute oral rinse of 10ml chlorhexidine 0.2% approximately 30% of the drug is retained, and within 15 seconds of rinsing, half will have bonded to receptor molecules.

Contra indications: History of hypersensitivity to CHX.

Clinical uses of chlorhexidine

Uses: Single use: Different objectives may be considered for single use.

1.To decrease the bacterial load

2.To decrease the risk of bacteremia

3.To decrease the risk of infection in the surgical area

Short-term use for the prevention of dental biofilm formation:

1. After subgingival instrumentation, periodontal surgery or root planing.

2. Prevention of postsurgical infection

3. Patients with intermaxillary fixations

4. Patients with mucosal or gingival acute Infections

Short-term use for therapy:

1. Gingivitis therapy As an adjunct to oral hygiene and professional prophylaxis

2. Candidiasis therapy(denture stomatitis).

3. Peri-implant mucositis therapy

4. Peri-implantitis therapy

Long-term use for the treatment and or prevention of:

1. Long-term use for the prevention of dental biofilm formation

2. Patients carrying fixed or removable orthodontic appliances

3. Patients with disabilities For oral hygiene and gingival health benefits in the mentally and physically handicapped.

4. Patients with gingival overgrowth or enlargement

5. Periodontitis patients

6. Patients with dental implants

7. Predisposed patients, with high risk of suffering oral infections

8. Oral mucositis prevention (associated with radiation or chemotherapy in head and neck cancer patients)

9. Caries prevention

10. Candidiasis prevention

11. Prevention of recurrent aphthous ulcers

12. Halitosis therapy and secondary prevention

The side effects:

1. Brown discoloration of the teeth and some restorative materials and the dorsum of the tongue.

2. Taste perturbation where the salt taste appears to be preferentially affected to leave food and drinks with a rather bland taste.

3. Enhanced supra-gingival calculus formation. The supragingival calculus formation may due to precipitation of salivary protein onto the tooth surface there by increase pellicle thickness & or precipitation of inorganic salts onto or into the pellicle layer. This type of calculus is free of bacteria.

4. Unilateral or bilateral parotid swelling.

5.Oral mucosal erosion.

6. Chlorhexidine also has a bitter taste which is difficult to mask completely.

For these reasons, the prolonged use of CHX should be avoided in normal periodontal patients. It is useful for short periods (up to two weeks) when oral hygiene may be difficult or impossible, such as during acute oral infections or following periodontal surgery.

It was demonstrated that **rinsing for 60 seconds twice per day** with l0 ml of a 0.2% CHX gluconate solution in the absent of tooth cleaning inhibited plaque regrowth and development of gingivitis, after that the patient should not eat or

drink anything for **up to 30min**. With tooth brushing by using tooth paste, CHX mouthwash **should be used after** brushing otherwise cross reaction may occur and reduce the plaque inhibition of CHX since chlorhexidine is neutralized by common toothpaste additives such as **sodium lauryl sulfate (SLS)** and **sodium monofluorophosphate (MFP).** To maximize effectiveness it may be best to keep a **30-minutes to 2-hours** interval between brushing and using the mouthwash (rinse thoroughly with water after brushing if it precedes the use of chlorhexidine or use at a different time of the day).

CHX mouth rinse adsorbed to the pellicle-coated enamel surface of the tooth surface, bacterial surface, oral mucosa and produces a persistent bacteriostatic action with slow sustained release into the oral cavity **lasting 12** hours so it is used twice daily

Nonprescription Essential Oil Rinse

Essential oil mouth rinses contain thymol, eucalyptol, menthol, and methyl salicylate. These preparations have been demonstrated plaque biofilm reductions of 20% to 35% and gingivitis reductions of 25% to 35%. This type of oral rinse has had a long history of daily use and safety . These products also **contain alcohol** (up to 24% depending on the preparation), which must be a consideration for some patients **not to use** these products.

Other Products

A preparation containing triclosan has shown some effectiveness in reducing plaque biofilm and gingivitis. It is available in toothpaste form . Other oral rinse products on the market have shown some evidence of plaque biofilm reduction. These include stannous fluoride, cetyl-pyridinium chloride (quaternary ammonium compounds). Evidence suggests that these and other available mouth rinse products

do not possess the antimicrobial potential of either chlorhexidine products or essential oil preparations. The active ingredient is sodium benzoate. It has been reported that chemical plaque biofilm control has been effective for both plaque biofilm reduction and improved wound healing after periodontal surgery. Both **chlorhexidine and essential oil mouth rinses** have significant positive effects when prescribed for use after periodontal surgery for 1 to 4 weeks.

Antimicrobials

The use of systemic antimicrobials in the management of periodontal disease **should be restricted** to the following conditions:-

1. Severe necrotizing ulcerative gingivitis.

2. Multiple or sever periodontal abscesses with involvement of regional lymph nodes.

3. Some cases of aggressive periodontitis.

4. Refractory periodontitis.

Routs of administration

Two disadvantages of the nonspecific mechanical treatment which repeated at recall visits are the irreversible and ever increasing damage to tooth hard structure especially roots within pockets as well as gingival recession. In addition, it is impossible to mechanically remove plaque completely from narrow grooves, narrow furcation's and other bacterial reservoirs within the pockets. Thus it is appropriate to combine mechanical plaque control with antimicrobials. Since only a few bacterial species are potentially periodontal pathogenic, it is reasonable to eliminate these groups specifically. These groups contain bacteria can invade periodontal tissues, making mechanical therapy alone in-effective. This situation can be effectively combated using systemic or topically applied antimicrobials to achieve, within the periodontal environment a concentration of the drug that is

sufficient either to kill (bactericidal) or arrest growth(bacteriostatic) of pathogenic microorganisms.

Advantages of systemic route of administration

- ☒ **Eliminating pathogens, not only from periodontal lesions but also from the oral cavity. (Reach widely distributed microorganisms).**
- ☒ **Prophylactic benefits and reduce the risk of reinfection of the periodontal sites.**
- ☒ **Broad spectrum of activity.**

Disadvantages of systemic route of administration

- ❖ **Systemic side effects.**
- ❖ **The possible elimination of non-pathogenic "beneficial" bacteria.**
- ❖ **Low concentration within the tissues.**
- ❖ **Bacterial resistance.**
- ❖ **Requires good patient compliance.**
- ❖ **Interaction with other medications.**
- ❖ **Allergic reactions.**
- ❖ **Super infections of opportunistic bacteria.**
- ❖ **High doses of antimicrobials are administered.**

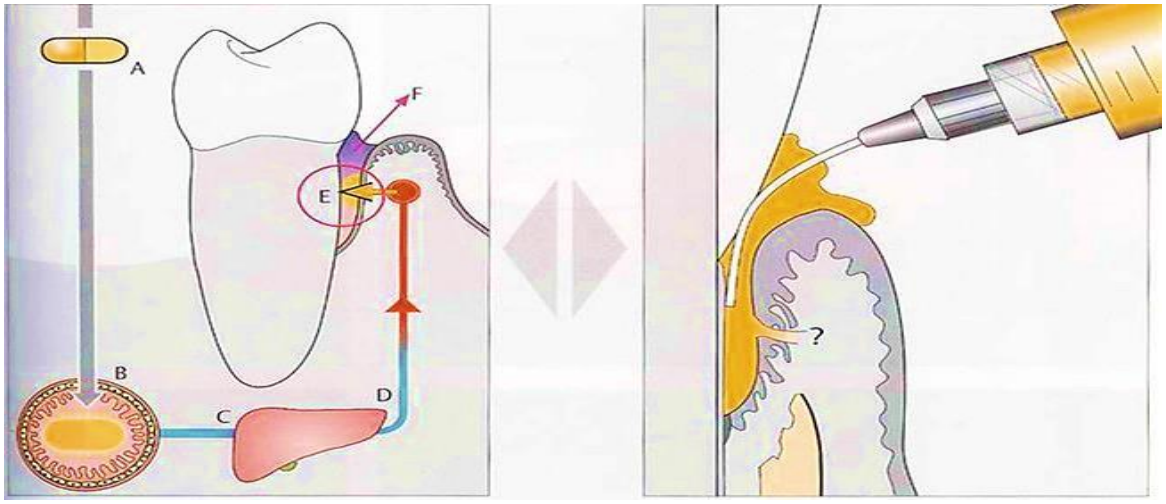

Fig. :- Systemic & local route of antimicrobials administration.

Antimicrobials have also been incorporated into formulation that can be applied **locally** into periodontal pockets.

Advantages of local route of administration

- ☒ **Lower dose of antimicrobials are administered.**
- ☒ **High local concentrations of the drugs are achieved locally in periodontal pockets so better effect against biofilms.**
- ☒ **Minimal or no side effects.**
- ☒ **Administration is not dependent upon patient compliance.**
- ☒ **Placement is site specific.**
- ☒ **When the matrix (vehicle) biodegrades to release the drug (controlled slow release device), an antimicrobial sustain its**
- ☒ **localized concentration of effective levels for a sufficient time.**

Disadvantages:

- ❖ **Narrow, limited spectrum of efficacy**
- ❖ **Possible reinfection of non-treated sites**
- ❖ **The placement can be time consuming when the treatment of multiple sites is indicated.**
- ❖ **The extent to which the drug penetrates the connective tissues may be less predictable than when systemic dosing is undertaken.**

Choice of antimicrobial agent :

The Tetracycline and metronidazole are the drugs that have been evaluated most expensively in the treatment of periodontal disease as an adjunct to mechanical therapy.

Tetracycline:

Tetracycline is a group of related **bacteriostatic** antimicrobials. Provide a board spectrum of activity against both gram-positive and gram-negative microorganisms. Tetracycline is effective against most spirochetes and many anaerobic and facultative bacteria. Additional properties of Tetracycline that may be valuable in the management of periodontal disease are:-

- ✓ **Inhibition of collagenase (inhibit tissue destruction).**
- ✓ **Anti-inflammatory actions.**
- ✓ **Enhancement of fibroblast attachment to root surfaces.**
- ✓ **Inhibition of bone resorption and may aid bone regeneration.**
- ✓ **High drug concentration to be delivered into pocket (concentration in gingival sulcus 2-10 times that in serum)**
- ✓ **Inhibition of neutrophil chemotaxis**
- ✓ **Inhibition of microbial attachment**
- ✓ **Host modulation**
- ✓ **antimicrobial**

Systemic Tetracycline is **valuable** in the management of **localized aggressive periodontitis and refractory periodontitis**. In localized aggressive periodontitis, the **prime pathogen** is Aggregatibacter actinomycetem comitans(A.a), which is **very susceptible** to tetracycline. This microorganism is difficult to eliminate from patients with aggressive periodontitis by mechanical debridement alone, presumably because of its ability to invade the gingival connective tissues. A **3-6 weeks** course of **tetracycline of 1g per day** will halt the progression of aggressive periodontitis, although it is more usual to give the tetracycline in a **2 weeks** course as an adjunct to non-surgical or surgical management. Tetracycline medication should be **continued for 1 week** after obtaining **negative** culture results for A.a. this **minimizes the chance of recolonization**.

Sub-antimicrobial dose of **doxycycline 20 mg (periostat) 2/d for 3 months** for a maximum of 9 months approved and indicated as an adjunct to S+RP in the treatment of periodontal diseases, e.g. refractory periodontitis, which act by a mechanism called (**host modulation therapy)** that refers to the concept of modulating the host response to the presence of bacteria with methods such as inhibiting collagen destructive enzymes hence, this regimen create no bacterial resistance.

Tetracycline has been incorporated into **slow release devices** for adjunctive local treatment following S+ RP. **e.g.** Minocycline ointment, Minocycline in biodegradable powder **(Arestin)**, doxycycline hyclate in a biodegradable polymer gel**(Atridox)** and tetracycline in a non-resorbable fiber **(Actisite)** have also been available for local application.

Metronidazole

Antibacterial activity against anaerobic-cocci, gram-negative and gram-positive bacilli has led to the use of metronidazole in the treatment of periodontal disease. The microbial effects of the drug depend upon its selective reactivity, which is achieved through the actions of electron transport proteins of susceptible bacteria. Once in the cell, **metronidazole binds and disrupts DNA synthesis leading to cell death**. This process results in rapid killing of anaerobic microorganisms (Bactericidal). It is **effective against porphyromonas gingivalis**.

In periodontal treatment, metronidazole has been used systemically; common dosage is **200mg three times a day for 3-5 days**. For more severe infections the dose is increased to 400mg twice daily for 3-5 days. **Metronidazole is effective in controlling necrotizing gingivitis**. Gingival ulceration, bleeding, pain and halitosis usually resolve rapidly within about 48-72 hours of starting therapy.

Metronidazole has been found to be **very effective** when combined with amoxicillin in the **treatment of refractory localized aggressive periodontitis** that has not responded to conventional periodontal treatment and tetracycline therapy. A 7 days (250mg of each drug) regimen three times a day, combined with further sub-gingival debridement results in almost total elimination of A.a. In addition this combination used for treatment of **periodontal abscess**. Efficacies studies suggest that two applications of **25% metronidazole gel** (1 week apart)in periodontal pocket are as effective as conventional non-surgical management in reducing probing depths and bleeding on probing.

Amoxicillin:

Extended antimicrobial spectrum that includes gram positive and gram negative bacteria by **inhibiting bacterial cell wall production** and therefore are bactericidal, hence may be useful in the management of patients with aggressive periodontitis, the **dosage is 500 mg 3/d for 8 days**.

Augmentin (Amoxicillin with clavulanic acid),this combination makes it resistant to penicillinase enzymes produced by some bacteria, hence may be useful in the management of patients with refractory or localized aggressive periodontitis. The Augmentin with Metronidazole combination have an additive effect regarding suppression of A.a in localized aggressive periodontitis.

Non-steroidal anti-inflammatory drugs (NSAID):

May be of therapeutic value in treating periodontal disease because of their ability to inhibit the inflammatory process, **drugs such as flurbiprofen ,ibuprofen ,mefenamic acid and naproxen.**