Optimizing Non-Surgical Periodontal Therapy: Hands-on Workshop

Paul A. Levi Jr., Rui Ma, Robert Rudy
Welcome to the Greater New York Dental Meeting

Greater New York Dental Meeting™
Executive Headquarters
200 West 41st Street, Ste. 1101, New York, NY 10036
Tel. (212) 398-6922, Fax. (212) 398-6934
E-mail: victoria@gnydm.com
www.gnydm.com
Sponsored by New York County & Second District Dental Societies

COURSE REGISTRATION
Pre-registration is required for all continuing education courses with the exception of the “Live” Dentistry and Affiliated Groups. Your seat will be held for 15 minutes after the start of the course; after that, those without tickets will be seated according to space availability. When the room is filled, no additional people will be admitted due to fire department regulations. If you have not pre-registered, please be prepared to select an alternate session to attend.

Tickets
Tickets are required for all courses excluding “Live” Dentistry. Tickets for all functions can be purchased at all general registration booths located in the Registration Area on the Upper Level in the Crystal Palace and online.

6 Days of Education Seminars, Hands-on Workshops & Essays
Friday - Wednesday
4 Days of Exhibits
Sunday - Wednesday

FREE “Live” Dentistry
Hi-Tech 450 Seat Arena

SUNDAY
9:45 - 11:45
VOCO America, Inc.
Drs. Ron Kaminer &
Marc Geissberger
Restorative

12:00 Noon - 4:30 P.M.
PHILIPS Sonicare
Dr. Gerard Kugel
Whitening

3:30 - 5:15
3Shape
Dr. Sundeep Rawal
Digital

MONDAY
9:45 - 11:45
Shofu
Dr. Ron Kaminer
Restorative

1:30 - 2:45
First Fit
Drs. Frederick E. Solomon
Cyrus Tahmasebi
Digital

3:30 - 5:15
Align I Invisalign I Itero
Drs. Karla Soto &
Christian Coachman
Restorative

TUESDAY
9:45 - 12:00
Millennium
Dr. Sunil D. Thanik
Laser

12:00 Noon - 2:00 P.M.
GlideWell
Dr. Justin Chi
Digital

3:00 - 4:15
Benco / Vatech
Dr. Aeklaaya Panjali
Implant

WEDNESDAY
9:45 - 12:00
Apa / CareCredit
Drs. Michael Apa
Aesthetic

2:00 - 4:15
John Quiñones
Monday, December 2
12:00 - 2:00 - Ticket 4010
$125.00

Celebrity Luncheon Speaker

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$595.00
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*Excludes Workshops, Botox & Fillers, Sleep Symposium and Invisalign

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Optimizing Periodontal Non-Surgical Therapy

The Greater New York Dental Meeting

Paul A. Levi, Jr., D.M.D.
Rui Ma, D.M.D., M.S.

December 1 and 2, 2019

Dr. Irving Glickman in 1967*

"Dentistry's mission under its franchise must be clearly defined as primarily the preservation of the health of the natural structures through the prevention of disease and deformities, and secondarily the repair of destroyed tissue; the replacement of lost parts and the correction of developmental anomalies."

The Goal of today's workshop...

To discuss concepts and practice many of the skills that will help to achieve and maintain periodontal, dental, and systemic health

Today's schedule

Introduction
- Motivation of the dental patient
- Probing measurements and calculus detection
- Hand instrumentation
- Hand instrument sharpening
- Specialized hand instruments
- Ultrasonic instrumentation
- Conclusion

Our goal is to assist our patients to prevent

Dental caries  Gingivitis  periodontitis  peri-implantitis

All have a bacterial etiology; with the biofilm attached to the tooth or implant
How do our patients prevent, achieve, or maintain dental health?

Three important factors:
- Patient motivation
- Patient ability and knowledge
- Patient and clinician accessibility to the tooth

Key is motivating your patient to move from Compliance to Concordance.

Books can help to motivate our patients

Philosophy:
Uses clear pictures and clear text to educate patients

Inspired by:
Dr. Irving Glickman

Non-Surgical Control of Periodontal Diseases

Philosophy:
Uses clear pictures and clear text to educate patients

Inspired by:
Dr. Irving Glickman

Would you ignore this?

If you bled from any other part of your body, you would do something about it. Yet you suffer from traces of blood when you brush your teeth, risking gum disease and eventual tooth loss. Don't turn a blind eye to bleeding gums. Contact your dentist immediately.

For more information visit www.GUMSMART.co.uk

Flossing your teeth combats gum disease, another source of chronic inflammation.

Techniques that patients are brighten or warn us to achieve

I WANT YOU TO FLOSS
Technique is what counts!

It is not just the number of times a day that your patient brushes and flosses, it is the effectiveness with which a patient uses that provides health!

Stationary Bristle Tip (Base) Technique

1. Aim brush towards the middle of the tooth and apply pressure towards the gum margin.
2. Press the bristles into the gum crevice, where the tooth is in contact with the gum.
3. After brushing, apply circular movements to clean the contact area.
4. Use this gentle scrubbing motion to prevent gum recession.
5. This technique is particularly effective in removing plaque from hard-to-reach areas.

Patient proximal tooth implant therapy

Using a free-standing mirror is invaluable when coaching flossing

We ask: "How often do you brush, and floss your teeth?"

Yet, do we know what techniques they use?

"Always observe your patient before instruction"

How valuable would a music teacher or a sport coach be if they never listened or observed?

Masking tape
This model is unique as it has a supracrestal attachment apparatus.

Hold the probe using a modified pen grasp.

How deeply does the probe penetrate? What does the tip of the probe touch when the probe stops?

We will use the two explorers, the periodontal probe, the Goldenhohr probe, and the dental knife in the box.

Periodontal probe identification of parts:

Please hold the UNC periodontal probe.

A finger rest is necessary for stability.
The tip of the probe touches the most coronal part of the epithelial attachment (AKA the junctional epithelium).

What is the epithelial attachment? The epithelial attachment is a glycocalyx (protein) secreted by the epithelial cells.

Reading your probe
Place your probe on the facial of tooth #9. The probe is 15mm total. Read the millimeters that are visible and count from 15 back to 0.

Reading your probe for accuracy
If the margin of the gingiva rests between two numbers, read it as the higher number.

It is necessary to probe beyond calculus
If the probe hits something hard, it is NOT the attachment.

We must probe beyond calculus for an accurate measurement
Maintain the probe as parallel to the tooth as possible with the tip on the tooth surface.

Now probe the mesio-facial of tooth #7
Practice circumferential probing

- Walk the probe from distal to mesial at 2mm intervals
- Maintain the probe in the sulcus and measure the deepest depth mesial, facial, distal, and facial.

Correct angulation of the probe for interproximal pocket measurements

- Angle the probe so that the tip rests between the contact area and the side of the probe touches the proximal teeth.

Accurate interproximal probing

Incorrect

Correct

Now, practice interproximal probing and we will assist you. Please ask any questions.

Measuring probing depths interproximally

- Slant the probe in order that the tip rests on the epithelial attachment under the contact area.
- The side of the blade rests next to the contact between the two proximal teeth.

The Nabers furcation probe

Please detect the furcation on tooth # 30.

Note that the probes in the kit are marked in 3mm increments similar to the Marquis probe.
An exercise

On the paper in front of you, please write the probing Measurements for teeth #s 3, 9 & 28

An exercise

Answers for the pocket measurements

Please place your periodontal probe and Naber's probe in the red roll-up in the far left-hand-side slots.

Calculus detection

Please hold and examine this TU 17 explorer

Inserting the TU 17
Calculus detection

Please insert the #17 explorer subgingivally on the distal of teeth #7 and 10 and move it with a walking stroke towards the mesial.

Another exercise

Please write "yes" or "no" for detecting Calculus Teeth #5 12, 19, 25

Old Dominion 11/12

Please hold and practice the OD

11/12

When exploring, always move the explorer in the direction of the tip

Calculus detection

Detect the calculus on the lingual of tooth #22.

Maintain the back side of the blade touching the epithelial attachment during the apical stroke as the explorer is walked apico-occlusally towards the mesial or the distal.

The tip of the explorer MUST always be on the tooth or calculus
Nomenclature of the blade for ANY periodontal scaler or curette

Lateral surfaces (sides)

Drawings courtesy of Drs. Esther Wilkins, CPDH, and Robert Rudy, DMD

Blade angulation for scalers and curettes

The ideal angle of the face of the blade to the tooth for efficient scaling or root planing is 70°.

Scaling*

Instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus and stains.

*American Academy of Periodontology Glossary of Terms

Root planing*

Is done subgingivally with curettes

Root planing: a treatment procedure designed to remove cementum or surface dentin that is rough, impregnated with calculus, or contaminated with toxins or microorganisms.

*American Academy of Periodontology Glossary of Terms

Scaling and root planing objectives:

- Remove calculus, plaque and stain from the tooth surfaces
- Achieve a smooth root surface
- Remove as little tooth surface as possible to achieve a smooth surface
- Ensure that the patient is as comfortable as possible
Root planing and patient comfort
As root planing is done subgingivally, patients must be comfortable!
This means using local anesthesia either topical or injectable, usually injectable.
When root planing, it is necessary to access the root to or apical to the epithelial attachment.
With plaque and calculus on the root there is inflamed sulcular gingiva with ulcerations in the epithelium exposing nerve endings.
The root has dentinal tubules with nerve fibrils.

Root planing – Where and When
- Is done during active or maintenance therapy for patients with present or past periodontitis
- Is for the removal of subgingival plaque and calculus and cementum to smooth the root surfaces.
- It needs only to be done if the roots are rough regardless of the probing depths

Root planing - Why?
To achieve a very smooth root surface
Coronal cementum is 16-60 microns thick about the thickness of a hair.
When Sharpey's fibers have vacated, they leave rough root surfaces.

Root planing: Limits?
General rule:
Pockets 5 mm or greater have a high probability of incomplete root debridement and calculus removal.

The use of gauze when doing scaling and root planing
The importance of using 2X2 gauze with hand scaling or root planing
1. Dampen it and roll it tight like a cotton roll
2. Place it in the vestibule facial and lingual of the mandible and facial of the maxilla

More reasons to use 📋 when doing scaling and root planing
3. Helps to keep tongue away from work area
4. Retracts lip and cheek
5. Provides access and more visibility 🌟

Looking at your H6/7 scaler note:
There are two lateral cutting edges. The tip is never a cutting edge

Perfect site to use a scaler!

Please hold the H6/7 curved scaler as pictured
Generally used supragingivally
Good for heavy calculus deposits
Particularly useful just under contact areas for the anterior teeth
Practice using the H 6/7 on the maxillary and mandibular anterior teeth.

Hand curettes: Subgingival scaling and root planing and for supragingival scaling.

Universal curettes:
- This is your Y-G 7/8.
- The face of a universal curette is a 90° to its terminal.”

The ideal angle for scaling or root planing is with the face of blade 70° to tooth surface.

Universal Curettes:
- Can be adapted to most tooth surfaces.
- Useful for gingival curettage.

Please hold the Younger-Good 7/8 curette.

ROOT
Please place the Y-G 7/8 curette on the mesial of tooth #27 or #6. Tip the handle in order that the blade will create a 70° angle of the face of the blade to the tooth.

Blade actions (strokes)
Practice the strokes on the molars and anterior teeth:
- Vertical stroke
- Oblique stroke
- The toe points apically
- Horizontal stroke

Drawings courtesy of Dr. Stephen Cornstock

Use the Y-G 7/8 on all the anterior teeth then do the posterior teeth.

Try all of the strokes: horizontal, oblique and apico-occlusal.

Please hold the three Gracey curettes.
What surfaces of the teeth were they designed to be used?

Gracey Curets
- Gracey 1/2, 7/8 (mesial and distal anterior teeth)
- Gracey 11/12 (mesial posterior teeth)
- Gracey 13/14 (distal posterior teeth)

Gracey site specific curettes
- Very useful for fine subgingival root planing.
- Large variety of styles each of which is designed to root plane or scale all root surfaces.

Site specific Gracey curette
There are two cutting edges: the lateral edge and the toe.
Determining the cutting edge of any Gracey curette

Hold ANY Gracey curette vertically and look at the inferior (lower) blade with the toe pointed towards you. 

Like this

Site/area specific Gracey Curette

When the terminal shank of any Gracey curette is held perpendicular to the floor, then the cutting edge slopes towards the floor.

Universal vs. Gracey curette

Please compare the Y-G 7/8 with a Gracey curette

The face of a universal curette is 90° to the terminal shank.
The face of a Gracey curette is offset by 120° to the terminal shank.

The many areas of use for a Gracey curette

The TERMINAL SHANK of any Gracey curette should be maintained PARALLEL to the tooth surface that is being scaled using any stroke (vertical, oblique, horizontal) and root planed so that the blade will be 70° to the tooth.

This means that any Gracey may be used to scale or root plane any surface where the terminal shank can be maintained parallel to the tooth surface being treated.

Area/site specific Gracey curette (13/14)

The practice of using the Gracey curette 1/2

1) Place a Gracey 1/2 curette on the mesial of tooth #27 and use a vertical stroke.
2) Practice the interproximal and facial of the anterior teeth.
3) Next use it with a horizontal stroke for the facial and lingual of the posterior teeth.
Please remove and hold the five special instruments from the middle of your kit.

Please compare the regular 11/12 (light blue band) with the "After Five" Gracey 11/12 (Green band) Then compare with the "Mini" 11/12 (yellow band) Practice with the Mini Gracey 11/12 after five mini yellow band

The Gracey 15/16 is designed for patients who have difficulty in opening their mouth wide

Comparing Gracey Curettes 13/14 vs 17/18

All have "regular" terminal shanks

Gracey curette 15/16 vs 11/12

Gracey 15/16 "Mini"

Regular Gracey 11/12

Regular shank Gracey 13/14 after five elongated shank

Gracey 17/18 "After five" (dark blue)
The Gracey 17/18 is designed for patients who have difficulty in opening their mouth wide.

Curvettes are similar to Gracey curettes in design with respect to cutting edges. There are two cutting edges, one lateral side and the toe.

Comparison of Vision Curvette with Gracey Curette:
- Blade length reduced by 50%
- Increased blade curvature
- Corrugated shank
- 3 and 10 mm markings
- Blade ID mark

Please take the red banded 1/2 Vision Curvette from your red roll up and compare it with any of the Gracey curettes in your instrument pack.
Please take your 1/2 Curette and use it with a vertical stroke on the mandibular anterior.

The 1/2 Vision Curette

Hand Instrumentation sharpening

The sharpening instruments are only the four dull instruments on the far right.

On the right-hand side of your red roll-up, remove the four instruments: the scaler, the y-g 7/8 and two Gracey curettes. Also the plastic test stick.
There are a variety of sharpening devices
- Sharpening stone (India)
- Sharpening cards
- Sharpening stone (ceramic)
- Manualized sharpening stone

Sharpening cards
- For today's workshop we will use the cards. Please try all three grits.

Advantages of Sharp vs. Dull Instruments
- Much more precise in cutting
- Less pressure against the tooth
- Good control of the instrument with optimum tactile sensitivity
- Less chance of the instrument slipping
- Less operator fatigue and frustration

Goals of instrument sharpening...
- To restore a fine, thin, linear cutting edge, in order to facilitate the removal of calculus and to allow for root planing leaving a smooth, hard surface.
- To minimize the amount of instrument removed during the process of sharpening.

Goals of instrument sharpening (Cont.)
- To maintain the original shape of the instrument and angles of the cutting edge.

It is important not to distort the angles of the blade as the effectiveness of the instrument is greatly diminished, and operator stress is significantly increased.
The shape of the blade becomes distorted when the wrong edge of a Gracey curette is sharpened or the toe is not rounded.

The curette can become like a scaler and can seriously damage the subgingival root surface.

When to sharpen hand instruments...

- Always before they are to be used
- When they become dull during use

The cutting edges to sharpen

- Sickle scalers (2)
- Universal curettes (3)
- Gracey Curettes (2)

Please take and hold your H 6/7 scaler

Place it on the corner of a desk, counter, or table that has a barrier. The tip of the blade should point towards you with the face of the blade parallel to the table top. The instrument should be held firmly against the corner with your non-dominant hand.

How to evaluate sharpness

Reflected light:
A sharp cutting edge will not reflect light. A dull edge shows a bright line of reflected light coursing the length of the blade.

"Test stick":
A sharp instrument "bites" (catches) into the acrylic stick.

"Use it":
As you are working you will know when the instrument is dull due to loss of efficiency
Sharpening technique:

"Stationary instrument moving

Please return the four instruments and the test stick to the roll-ups in this order.

Ultrasonecs

Role

Air Polishing

New Paradigm

Protocol Maintenance

You might need this...

When you see this...
**POWER vs. HAND**

- No significant difference between hand or ultrasonic scaling regarding calculus/plaque removal
- Ultrasonics can be superior to hand instruments in access to furcations and grooves
- Standard ultrasonic and microultrasonic inserts were able to reach and debride the apical plaque border of pockets ranging from 4 to 7 mm

**POWER vs. HAND**

- Differences in smoothness between power and hand scaling appears to have no effect on resolution of inflammation
- There could be 20% to 50% time reduction with ultrasonics
- No sharpening needed with ultrasonics
- The combination of ultrasonics and hand instrumentation is more effective than either technique alone

**Access with power**

- Thin tips; large variety with power
- Effective in anatomicallly difficult access areas
- Concavities, root proximity,
- Deep narrow pockets, at CEJ
- Effective in Class II and III furcations

**Comparison of instrument tip thickness**

- Gracey curette
- Piezoelectric insert
- Magnetostrictive insert
- Periodontal Probe UNC 1-15

**Ease of use**

- Less technically demanding than hand instrumentation
- Effective with light pressure
- Reduced fatigue
- Reduced time
- Increased stain removal
- No sharpening necessary

**Antimicrobial**

- Lavage: flushes pocket
- Cavitation: may disrupt the bacterial cell wall
- Acoustic microstreaming/turbulence

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**POWER vs HAND**

Reduced tissue damage

- Less destructive to root surfaces (Ultrasonics do not root plane)
- Less soft tissue damage
- Can work coronal-apically

**Disadvantages of power instrumentation**

- Loss of tactile sensitivity with power
- Aerosol carries bacteria and blood
- Patient comfort (sensitivity, water, noise)
- Changing tips is more time consuming than changing a hand instrument
- Cost is greater with power instruments

**Types of Ultrasonics Scalers**

- Magnetostrictive
- Piezoelectric

**Magnetostrictive ultrasonic scalers**

Characteristics

- 25-30K Cycles Per Seconds
- Electric/alternating magnetic fields
- Elliptical motion
- All tip surfaces active

**Piezoelectric ultrasonic scalers**

**Characteristics of piezoelectric ultrasonic scalers**

- 27-50K CPS
- Electric deformation of quartz or ceramic discs within the handpiece
- Linear motion of the tip
- Sides of tip most active
Using the Correct Tip for Implant Maintenance

Tips on Tips

Tips wear!
- 1mm of wear = 25% loss of power
- 2mm of wear = 50% loss

Power instrumentation technique
Adapt the tip similar to periodontal probe
Correct adaptation

Power instrumentation technique
Incorrect adaptation

Ultrasonic instrumentation technique vs.
Hand curette
- Constant light contact with tooth
- Constant movement of tip
- Sweeping, overlapped strokes with light pressure
Ultrasonic instrumentation technique

- Systematically cover entire surface of tooth by cross hatching
- Can remove deposits in a coronal-apical manner
- Avoid using end of tip
- Avoid keeping tip stationary

Ultrasonic instrumentation technique

Instrument PS

Air Polishing: History

- Abrasive slurry of particles propelled by pressurized air and water
- First used in dentistry in 1945 with aluminum oxide particles for cavity preparation
- Air polishing with Sodium Bicarbonate NaHCO₃ introduced in the late 1970's
- Primarily used for supragingival stain and plaque removal

Air Polishing: History

- Additional powders introduced:
  - Calcium Carbonate: CaCO₃
  - Calcium Sodium Phosphosilicate: CaNa₆PsI
  - Aluminum Trihydroxide: Al(OH)₃
  - Glycine Powder introduced in 2001
  - Erythritol Powder 2013
New Paradigm in Air Polishing with the introduction of Glycine Powder

- Introduced in 2001
- Amino Acid, water soluble, non-toxic
- Small particles 20-65 microns
- Less Abrasive than NaHCO₃
- Antimicrobial activity
- More effective biofilm removal than hand instruments
- New subgingival delivery systems

Glycine Powder causes minimal abrasion

- Small particle size: 20-65 microns vs 250 microns for NaHCO₃
- Minimal abrasion to root surface
- Minimal abrasion to restorative materials
- Minimal soft tissue damage
- Insignificant abrasion on titanium surfaces

Air Polishing Biofilm Removal following 5 seconds of treatment

Air polishing will NOT remove calculus

Plaque/Biofilm stained tooth with erythrosine before Rx.

Plaque/Biofilm stained tooth with erythrosine after 5 sec treatment with air polishing with Glycine powder

What Limited the use of Air Polishing in Periodontal Treatment?

- Aerosol (infection; air emphysema/embolism)
- High Na content contraindicated in certain patients (hypertension, renal deficiency)
- Not effective on calculus removal
- Messy, poor taste, expense

Glycine Air Polishing

- Less then 5 cases of air emphysema reported over a ten year span all resolved in 3-5 days
- No sodium disadvantages
- High Volume Evacuation and antimicrobial rinse minimizes infective aerosol

EMS glycine vs rubber cup polishing
Air Polishing and Dental Implants

- High prevalence of inflammatory diseases about dental implants
  
  - Per-implantitis: M, 34%, 56% of sites
  
  - Per-implantitis treatment, 60% reduction in inflammation

Glycine Powder Air Polishing

- Subgingival delivery
  
  - 5-10 sec per tooth surface (20-40 sec per tooth)

Glycine Powder Air Polishing: Subgingival Delivery

Treatment with Air Polishing: Per-implant mucositis
A six month maintenance interval is NOT for everyone!

The maintenance interval depends upon:

1. The patient’s present dental and physical health status
2. The patient’s degree of susceptibility to dental diseases
   a. Smooth surface caries: (Presence of Class 2, 3, 4, 5, restorations)
   b. Periodontal bone loss

What is achievable with non-surgical therapy?

With hygiene therapy only using a Sonicare® and floss

The key to hygiene success is frequent initial visits until the patient is consistent with daily plaque removal using non-abrasive techniques.

Non-surgical therapy sometimes reduces recession

Non-surgical therapy sometimes increases recession and increases health

Rx: Plaque control technique instruction, scaling and root planing

Rx: Plaque control technique instruction (bass interscalar) and submarginal scaling

Courtesy: Dr. Brian D. Shuman
The power of non-surgical periodontal therapy

Active periodontal therapy
Case report: 4 1/2 years

Prior to Scaling and Root Planing

4.5 years following Scaling and Root Planing

Active therapy, ScRP

Before ScRP
Following ScRP
The **Goal** today’s workshop was...

to help provide each of you with some new knowledge and a review of the already known concepts and skills to assist your patients in reaching excellence in **dental and general health**

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**Who bears the responsibility for dental/medical health?**

Our responsibility is to do more than clean teeth

*We all do!* Preventative treatment for health

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**Thank You!**

Dental health can only be achieved and maintained by the patient’s daily hygiene therapy and regular professional dental hygiene therapy visits