Periodontal disease classification pdf

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The seminar was organized by the American Academy of Periodontology (AAP) and the European Federation of Periodontology (EFP) and included expert participants from around the world. Planning for the conference, which took place in Chicago from November 9 to November 11, 2017, began in early 2015. The AARP Organizing Committee and EPP commissioned 19 review papers and four consensus reports covering relevant areas in periodontology and dentistry implants. The authors were tasked with updating the classification of diseases and conditions of periodontal in 1999 and to develop a similar pattern of periimplant diseases and conditions. Reviewers and working groups were also asked to establish appropriate case definitions and provide diagnostic criteria to assist physicians in using the new classification. All the conclusions and recommendations of the seminar were agreed by consensus. This introductory paper provides an overview of the new classification of periodontal and periemplant diseases and conditions, as well as a condensed pattern for each of the four sections of the working group, but readers are sent to relevant consensus reports and review documents to carefully discuss the rationale, criteria and interpretation of the proposed classification. Changes in the 1999 classification are highlighted and discussed. While the purpose of the workshop was to base the classification on the strongest available scientific evidence, lower-level evidence and expert opinion were inevitably used whenever sufficient research data were lacking. The scope of the seminar was to provide and update the classification scheme with the current understanding of periodontal and periemplant conditions. This introductory review presents schematic tables for a new classification of periodontal and periemplant diseases and briefly highlights changes 1999.1 It could not provide the vast amount of information included in the reviews, case-identifying documents and consensus reports that had led the development of the new classification, and reference to consensus documents and case-setting was necessary to provide a deep understanding of its use for both case review and research. It is therefore highly recommended that the reader use this review as an introduction to these subjects. Access to this post on the Internet will allow the reader to use the links in this review and tables to view the original documents (table 1). The seminar addressed unresolved issues related to the previous classification by identifying the difference between gum inflammation at one or more sites and the definition of a case of gingivitis. She agreed that bleeding in sensing should be the main parameter for setting thresholds for gingivitis.2, 5 Workshop is also characterized by periodontal health and gum inflammation in reduced periodontal disease after the completion of successful treatment of a patient with periodontitis. Specific definitions have been agreed in cases of gum treatment or inflammation after the completion of periodontitis-based parodontitis treatment on the sensing and depth of the residual sulator/pocket. This distinction was made to highlight the need for more comprehensive care and monitoring of the successful treatment of a patient with periodontitis. It has been accepted that a patient with gingivitis may return to health conditions, but a periodontitis patient remains a patient of periodontitis for life, even after successful therapy, and requires lifelong supportive care to prevent recurrence of the disease.6 Seminar has also reorganized a wide range of non-patient-induced gum disease and conditions based on primary etiology (table 2).Table 1. Table 2. The 1989 seminar recognized that periodontitis had several different clinical presentations, different age of initiation and rate of progression.7, 8 Based on these variable seminar classified periodontitis as prepuberal, juvenile (localized and generalized), adult and fast progressive. The 1993 European Seminar determined that the classification should be simplified and suggested grouping periodontitis into two main headlines: adult and early periodontitis.9 Participants in the 1996 seminar determined that there was insufficient new evidence to change the classification.10 Major changes were made to the classification of periodontitis 1999, 11-13, which was used during the last 19 years. Periodontitis is reclassified as chronic, aggressive (localized and generalized), necrotizing and as a manifestation of systemic disease. After the 1999 seminar, there was significant new information from the demographic fundamental research and data from forward-looking studies evaluating environmental and systemic risk factors. The analysis of these data prompted the 2017 seminar to develop a new periodontite classification system.14 Over the past 30 years, the classification of periodontitis has changed several times in an attempt to bring it into line with new scientific evidence. The seminar participants agreed that, in accordance with modern knowledge in the field of pathophysiology, three forms of periodontitis can be identified: necrotizing periodontitis, 15 periodontitis as a manifestation of systemic disease16 and a form of the disease previously recognized as chronic or aggressive, now grouped into one category, periodontitis.14, 17-20 When reviewing the classification, the seminar agreed on the classification of bases for periodontitis, which was further characterized by a multidimensional system of staging and classification That over time can be adapted as new evidence emerges.20 Staging largely depends on the severity of the disease at the presentation, as well as on the complexity of disease management, while the classification provides additional information on the biological characteristics of the disease, including historical analysis of the rate of progression of the disease, an assessment of the risk of further progression, the expected poor treatment results, and an assessment of the risk that the disease or its treatment may negatively affect the overall health of the patient.14 20 Staging includes four categories (stages 1 to 4) and is determined after consideration of several variables including clinical loss of attachment, number and percentage of bone loss, depth of sensing, presence and degree of angular bony defects and the involvement of furcacia, tooth mobility, and loss of teeth due to periodontitis. The assessment includes three levels (Class A - low risk, grade B - moderate risk, class C - high risk of progression) and includes, in addition to aspects related to periodontitis progression, general health, and other effects such as smoking or metabolic control levels in diabetes. Thus, sorting allows the doctor to include in the diagnosis individual factors of the patient, which are crucial for complex vision (table 3). To fully describe the new periodontitis classification scheme, the reader is sent to the consensus report on periodontitis14 and the periodontitis case definition document.20 Table 3. The new classification of periodontal diseases and conditions also includes systemic diseases and conditions that affect periodontal supporting tissue.16 It is recognized that there are rare systemic disorders such as Papillon Lefevre syndrome, which usually lead to early representation of severe periodontitis. Such conditions are grouped as periodontitis as a manifestation of systemic diseases, and classification about primary systemic disease.16 Other systemic conditions, such as neoplastic diseases, may affect the periodontical apparatus regardless of plaque biofilm and induced periodontitis21 and such clinical results must also be classified on the basis of primary systemic disease and be grouped as systemic diseases or conditions affecting the periodontical supporting tissue. There are, however, common systemic diseases, such as uncontrolled diabetes mellitus, with variable effects that alter the course of periodontitis. They, appear to be part of the multifactorial nature of complex diseases such as periodontitis and incorporated into the new clinical classification of periodontitis as a descriptor in the staging and classification process.20 Although common periodontitis modifiers can significantly alter the occurrence of the disease, severity and response to treatment, current data do not support unique pathophysiology in patients with diabetes and periodontitis.22 New definitions of cases associated with gingle-related diseases. based on interproxymal loss of clinical attachment, and include an assessment of open root and cement-enamel compound.23 The consensus report presents a new classification of gingivale decline, combining clinical parameters including the phenotype of glything, as well as the characteristics of the open root surface.21 In the consensus report, the term periodontal biotype was replaced by a periodontal phenotype (4).21 Table. The traumatic occlusion force that replaces the term excessive occlusion force is a force greater than the adaptive capacity of the periodonium and/or teeth. Traumatic occlusion forces can lead to occlusion trauma (defeat) and excessive wear or fracture of teeth.21 There is a lack of evidence from human studies related to occlusion trauma in the progression of attachment loss in periodontitis (table 4).24 Section on factors associated with prostheses, was expanded in the new classification. The term biological width has been replaced by supracrestal attached tissues.21 Clinical procedures involved in the manufacture of indirect restorations has been added due to new data, indicating that these treatments can cause a decline and loss of clinical attachment (Table 4.25 New classification for peri-implant health,27 periemplant mucosites28 and perimimyitis29 was developed workshop (Table 5). That can be accepted worldwide. periimplant was determined by both clinical and histo logic.27 Clinically health periimplant periimplant lack of visual signs of inflammation and bleeding when sensing. Periemplant health can exist around implants with normal or reduced bone support. It is impossible to determine the range of probing depths compatible with periemplant health.26, 30 Peri-implanted mucositis characterized by bleeding and visual signs of inflammation.28 Although there is strong evidence that periemplanet mucositis is caused by plaques, there is very limited evidence for non-tablet-induced peri-implanted mucositis. Peri-implanted mucosite can be reversed with measures aimed at removing plaques. Peri-implantitis has been identified as plaque-related pathological condition occurring in the tissue around dental implants, characterized by inflammation in the peri implant mucosa and subsequent progressive loss of supporting bone.29 Peri-implanted mucositis is thought to precede perimimititis. Peri-implantitis is associated with poor plaque control and with patients with a history of severe periodontitis. The onset of periminitis can occur in the early stages after implant placement, as evidenced by radiographic data. Peri implantitis, if left untreated, seems to progress in a non-linear and accelerating model.29 Normal healing after tooth loss leads to a decrease in the size of the alveolar process/ridge, leading to both a deficiency of hard and soft tissues. Large ridge deficiencies can occur in places associated with serious loss of periodontal support, injury extraction, endodonal infections, root fractures, thin bushel bone plates, poor tooth position, injury and pneumatic maximatization of the sinuses. Other factors influencing the ridge may be associated with medications and systemic diseases, reducing the amount of naturally formed bone, dental abegenesis and pressure from prostheses.31 This review introduces an updated classification of periodontal diseases and conditions and a new classification of periemplant diseases and conditions. The publication presents the work of the world community of scientists and clinicians in the field of periodontology and implant dentistry. This paper provides an abbreviated overview of the results of the consensus seminar, and the reader is invited to review the entire publication in order to obtain comprehensive information on the rationale, criteria and implementation of the new classifications. 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