

selling and referring the patient to a nutritionist if the problem persists.

Low Tissue Tolerance Due to an Underlying Disease

Low tissue tolerance due to uncontrolled diabetes, pemphigus vulgaris or some other diseases may be the cause of pain. The patient should be referred to a physician for diagnosis and treatment.

Xerostomia

Lack of the antimicrobial and lubricating benefits of saliva will severely compromise tissue tolerance. If xerostomia is drug induced, the physician may be able to adjust the dose or change medications to reduce this side effect. An implant-supported prosthesis may be the solution for a xerostomic edentulous patient.

Dentists should be aware that in dealing with the geriatric population, especially edentulous patients, various factors may lengthen treatment

time. Taking a thorough medical and dental history during the initial consultation will reduce the number and length of follow-up visits in this frequently forgotten population. ♦

THE AUTHOR



Dr. Cecilia Aragon is assistant professor in the division of restorative dentistry, Schulich School of Medicine & Dentistry, The University of Western Ontario, London, Ontario. Email: cecilia.aragon@schulich.uwo.ca

Further Reading

Budtz-Jorgensen E. *Prosthodontics for the elderly: diagnosis and treatment*. Hanover Park, Ill.: Quintessence Publishing; 1999. p. 107–22.

Rhodus NL, Brown J. The association of xerostomia and inadequate intake in older adults. *J Am Diet Assoc* 1990; 90(12):1688–92.

Shigli K, Angadi GS, Hegde P. The effect of remount procedures on patient comfort for complete denture treatment. *J Prosthet Dent* 2008; 99(1):66–72.

Zarb GA, Bolender CL, Eckert S, Jacob R, Fenton A, Meriscke-Stern R. *Prosthodontic treatment for edentulous patients: complete dentures and implant-supported prostheses*. 12th ed. St. Louis: Mosby; 2004. p. 404–15.

QUESTION 2

What should I do if a police officer contacts me and requests the record of one of my patients?

Background

The use of dental records to help identify a presumed deceased person has become routine forensic practice in Canada. Nevertheless, for any dentist, the arrival of a police officer with a request for the release of a dental record is a rare event. When you release personal information for this purpose, you need to consider the following important factors.

Depending on the location of your practice, the local coroner or medical examiner initiates the request for a dental record after the recovery of a body whose identification by visual means, fingerprints or DNA may be problematic. The office of the coroner or medical examiner usually provides a written warrant for the release of a specifically named dental record. A police officer or, in some cases, a coroner's agent executes this warrant. Occasionally, instead of a warrant, the coroner or medical officer may give a verbal order. You can check whether this is the case by calling the coroner's or medical examiner's office.

In the case of a missing person, the police may wish to upload a dental record to one of a number of searchable databases of unidentified bodies. To do this, the police must first produce a general or search warrant obtained from a judge or justice of the peace. Because it is not a crime to go missing, the investigator must convince the issuer of the warrant that the missing person may be dead. You should not release dental records of missing persons without such a warrant.

Management of the Requested Dental Records

Because you do not know which part or parts of the person's body have been recovered, you should provide the entire original dental record, apart from the financial ledger. You should not provide only what you think is the critical component of the person's dental record. It is helpful to :

- include all correspondence
- mount, identify and date all radiographs (if your record contains copies of radiographs, note the right and left sides)

- add a glossary of terms or abbreviations, if you use unique notations
- include study models, lab prescriptions and photographs
- clearly identify treatment done since the last radiograph was made
- provide your contact information

You should keep a list of all the records that you release and make copies for your records. Have the police officer sign and time-stamp a receipt for all the information you provide.

The dental records you supply will be transported to a forensic dentist who will use them in confidence and only for the intended purpose. You do not need to call your regulatory authority, and you should never call the next of kin. You will not be reimbursed for supplying your records, but on occasion, you may be asked to appear in court to testify to their authenticity. Such a request rarely occurs in civil matters, but is more common in

criminal cases. In due course, the records will be returned to you.

It is not unusual for the police to ask for, or for the warrant to read, “provide the dental chart.” Providing only the odontogram is insufficient; you must provide the entire original dental record.

Providing dental records for personal identification can be of great social benefit. In most cases, dental identification can be completed quickly and is both exceedingly accurate and relatively inexpensive. Identification of a person by dental means is dependent on dentists’ timely and full cooperation in the release of their patients’ records. ❖

THE AUTHOR



Dr. Stan Kogon is professor in the division of oral medicine and radiology, Schulich School of Medicine & Dentistry, The University of Western Ontario, London, Ontario. Email: stan.kogon@schulich.uwo.ca

QUESTION 3

Can a regimented 3-month maintenance program be used as a definitive treatment for patients with periodontitis?

Background

Scaling and root planing (SRP), typically used in the initial or maintenance phase of periodontal treatment, is a mainstay of periodontal therapy. SRP is an efficacious treatment used to debride tooth surfaces of the pathogenic bacterial biofilms implicated in the onset and progression of periodontitis. However, conventionally desired outcomes for the treatment of periodontal disease, such as shallow probing depths, minimal inflammation and stable attachment levels, may not be predictably attained with SRP alone.

Clinicians should be aware of the limitations of SRP in achieving thorough subgingival debridement, particularly when probing depths are ≥ 5 mm.^{1,2} These limitations are more pronounced in areas exhibiting complex nonplanar anatomy, such as in root concavities and around multirooted teeth. Failure to remove all etiologic agents will not create conditions favouring healing of the dentogingival complex and will result in the proliferation of pathogenic biofilms and poten-

tially progressive loss of attachment (in one study,³ only 11% of sites with a probing depth > 5 mm reformed a junctional epithelium following SRP).

Indeed, other therapeutic options should be considered if SRP does not provide the desired outcomes, namely shallow probing depths and minimal inflammation. Although bleeding on probing (measure of inflammation) alone appears to be a poor predictor of future progression of periodontal disease, 50% or more of sites with residual probing depths of 5–6 mm combined with the presence of bleeding on probing following initial SRP therapy will worsen over a 3-year time span.⁴ Another study found that, compared with teeth that have probing depths ≤ 3 mm, those with residual probing depths of 5–6 mm have an odds ratio of 7.7–11.0 for tooth loss following 11 years of maintenance therapy.⁵ Therefore, some caution should be exercised before indiscriminately placing patients with residually deep probing depths and inflammation on prolonged 3-month maintenance without consideration of other treatment modalities.