

VIEWPOINT

Dentist to Physician Patient Advocacy *for Health's Sake*

INTRODUCTION

An advocate is “one who speaks, pleads, or argues in favor of.” Every day, 12,500 Americans turn 50 years old.¹ Two in every 3 will contract heart disease;² one in 4 will become diabetic; and 6 of 10 will manage more than one disease which doubles needed doctor visits, worsening our present physician shortfall.³ At least 50% have periodontitis,⁴ a *bacterial infection* that can cause chronic inflammation.⁵ Patients are twice as likely to become diabetic if they have periodontitis⁶ and at least double their chance for cardiovascular disease.⁵

Because 70% of Americans will see their dentist this year,^{7,8} dentists have the opportunity, as health advocates, to co-manage care with a patient's physician. Here's how it can be done.



Leona Meditz

MINI CASE REPORTS

A Case As Treated in the Office of Walter Below, DDS

A 61-year-old male patient of record in the dental practice of Dr. Walter Below (Westlake, Ohio) was found to have nine 4.0-mm periodontal pockets with 10 bleeding sites. The standard of care for a diagnosis of Type II periodontitis would have been treating this patient with scaling and root planing (SRP), with 3-month periodontal maintenance follow-up appointments. However, Dr. Below looked deeper and discovered a way to reduce health risks *before* serious symptoms could erupt.

The patient's updated health history revealed mitral valve prolapse, high blood pressure, and that statins with daily baby aspirin had been previously prescribed by the patient's physician. The patient did not have any further appointments scheduled with his physician.

His family medical and dental histories revealed that his

mother had suffered from stroke, diabetes, cancer, and hypertension, then died from heart disease at age 70. His father had a history of heart disease, diabetes, and hypertension before dying from a heart attack at age 68. His father had periodontal disease and both parents had tooth loss.

The patient tested positive for pathogenic red bacteria: *Porphyromonas gingivalis* (PG), *Tannerella forsythia* (TF), and *Treponema genticola* (TD). A blood sample was sent for analysis and later showed C-reactive protein (CRP) was at 6.3 mg/L, indicating 6 times more inflammation than normal. The glycated hemoglobin (A1c) was measured at 6.3% (elevated). The patient's

physician was directly contacted and requested that the patient appoint with him before leaving the dentist's office that day.

Both the dentist and physician then co-managed this patient's care for 6 months. The physician continues to monitor medications and heart function and has recommended a diabetic workup. Periodontal therapy included laser bacterial decontamination before deep SRP to remove plaque and calculus without bacteremia. Laser assisted periodontal therapy (LAPT) was used to remove necrotic gum tissue to promote healing and kill pathogenic bacteria. To keep the bacteria in remission postoperatively, home care was replaced with Disease Control Kits (CloSYS rinse and toothpaste [Rowpar Pharmaceuticals]; Oralbiotic Research's Hydrabrush and Oral Care Technologies' Hydrofloss; and periodontal formula by Avalon Laboratories and Osteogenesis from Telos Labs).

A Case As Treated in the Office of Bradley Parker, DDS

A 50-year-old female patient of record in the dental practice of Dr. Bradley Parker (San Bruno, Calif) was found to have 14 probe scores

higher than 3.4 mm with 17 bleeding sites. The updated patient health history revealed that the patient had a heart attack 5 years prior at age 45. She was diagnosed as prediabetic and prescribed Metformin and had high blood pressure with no prescribed medication. She did not have a next-scheduled appointment with her physician.

Her family medical and dental histories revealed that her father had a heart attack with bypass surgery and died from heart disease in his 60s. Her mother had a history of diabetes and died in her 70s. Both parents were hypertensive. Her mother also had gum disease and tooth loss, resulting in dentures.

The patient tested positive for pathogenic red bacteria (PG, TF, TD). A CRP score of 3.7 mg/L is 300% higher inflammation than normal. The A1c of 7% showed elevated glycated hemoglobin at diabetic level despite current medication.

Initially, the physician was not available to discuss this case before the patient's scheduled treatment consultation appointment, and, in addition, the patient had also initially declined the suggested periodontal therapy.

However, after successfully contacting the physician and after being presented a co-management plan by her dentist *and* physician, she began 6-month perio therapy including SRP, LAPT, and the Disease Control Kit as described above. She also returned to her physician for a diabetic workup and for medication management.

KEY ADVOCACY COMPONENTS

Updated health history—Often skipped, this step asks the patient's age at occurrence and if a future appointment to manage medications has been scheduled with the physician.

Detailed family health history—If the parents had inflammatory diseases, the patient could be going down the same path.

Blood pressure—Hypertension is the second highest reason patients visit their physician,⁹ and recent research supports inflammation as a cause.¹⁰ Imagine the impact dentistry can have on health if periodontal therapy can eliminate a key cause of high blood pressure!

Full periodontal probing—Six or more periodontal sites measuring 4.0 mm warrant an enzyme test for red bacteria.

Enzyme test for red bacteria (BANA test [Oratec])—This low-cost test takes 5 minutes to scan the most dangerous pathogenic “red” complex bacteria: PG, TF, and TD.

Blood sample sent for A1c and CRP testing—In-office finger stick test is sent to outside lab for processing.

Set separate review of findings/treatment plan appointment—The combination of personal and family health histories, plus blood pressure, enzyme pathogen, and A1c and CRP testing bridges the connection between mouth and body and requires a focused appointment to review and treatment plan.

Periodontal therapy with SRP using laser decontamination, laser assisted periodontal therapy and Disease Control Kits (as described previously)—The 100 practices I work with confirm this combination has the best outcomes for removing plaque, calculus, necrotic tissue, and controlling bacteria long term.

Co-management with physician—Even if the A1c or CRP test is normal, you may choose health advocacy if the patient has more than 6 probe sites greater than 3.4 mm, tests positive for red bacteria, and has any combination of the following: high blood pressure, medication for any inflammatory disease, or at-risk immediate family health history. Physician consults are

best performed before the patient returns for the “review of findings” appointment. It gives the call urgency for the physician and power to the importance of case acceptance for the patient.

THE AUTHOR'S VIEW

Assuming that one hygienist sees about 1,200 patients yearly: Applying statistics, the hygienist can help prevent 7 heart attacks, alert 34 patients with high A1c, reduce A1c in 22 patients, and even save 2 lives of diabetics who put periodontal disease in remission. Multiply this by 174,100 US hygienists for a potential health impact of 7.4 million lives, before even considering other inflammatory diseases!

After reviewing hundreds of practices, I find that only about 10% of patients with tissue damage measuring at least 4.0 mm (pockets) get treated for periodontal disease. Instead, the patients are “watched” as inflammatory causing bacteria increases their risk for heart attack, stroke, diabetes, cancer, even pre-term birth, the patients all the while believing pink toothbrush bristles are nothing to worry about.

These are not isolated cases from 2 special practices. No matter your insurance partners, if you do not get more than 50% of physicians agreeing to co-manage your patients, it is probably because you simply need to learn how.

How many patients can you help avoid serious systemic diseases caused by inflammation? You won't know if you don't look. ♦

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Ms. Meditz is a dental practice systems analyst with more than 30 years of experience in coaching new technologies, protocols, and systems for dental practitioners. She recently founded the Health Care Professionals Wellness Network (hcpwellnet.com), which promotes collaboration between health-care professionals for healthcare reform. Since 2007, she has co-developed new periodontal protocols for Centers for Dental Medicine (centersfordentalmedicineneeds.com) and is presently the director of development. Contact Ms. Meditz and mention this article, and receive a free one-hour consultation. She can be reached at (866) 546-5444.

Disclosure: The Dentist to Physician Patient Advocacy program described above is part of paid services designed for and offered by both Centers for Dental Medicine and Health Care Professionals Wellness Network. Both Drs. Walter Below and Bradley Parker are current clients of Centers for Dental Medicine and Leona Meditz and have received no compensation for sharing their results. The patients described are current patients of record for each respective dentist.