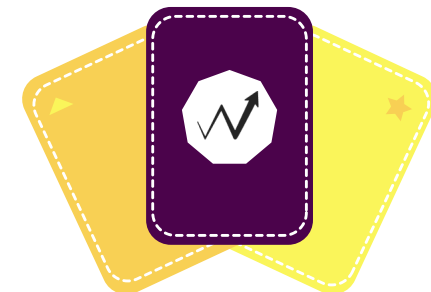


PERIODONTICS

PERIODONTITIS STAGING GRADING



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA

WINSPERT MIND MAP

STAGING AND GRADING OF PERIODONTITIS

Diagnostic Criteria for Periodontitis

- Interdental CAL detectable at ≥ 2 non-adjacent teeth defines periodontitis
- Buccal/oral CAL ≥ 3 mm with pocketing >3 mm at ≥ 2 teeth also meets periodontitis diagnosis

Forms of Periodontitis

- Necrotizing periodontitis: characterized by pain, ulceration, and necrotic gingival papillae
- Periodontitis as a manifestation of systemic diseases
- Classic periodontitis without necrotizing features or systemic link

Staging of Periodontitis: Severity and Complexity

- Stage I-IV based on severity (attachment loss) and management complexity
- Extent of disease classified as localized or generalized
- Factors: pocket depth, tooth loss due to periodontitis, infrabony defects, furcation involvement, tooth mobility, masticatory dysfunction

Complexity Factors Influencing Stage

- Furcation involvement stages III or IV
- High tooth mobility, posterior bite collapse can determine stage IV
- Presence of any complexity factor may upgrade the stage

Grading of Periodontitis: Rate of Progression

- Grading categories: Grade A (slow), B (moderate), C (rapid progression)
- Based on direct or indirect evidence of progression, including RBL-to-age ratio
- Risk factors like smoking or diabetes modify the grade assigned

Clinical Definition of Periodontitis

- Periodontitis involves microbially-associated, host-mediated inflammation causing periodontal attachment loss.
- Clinical attachment loss (CAL) is measured around teeth using a periodontal probe referencing the cemento-enamel junction (CEJ)

Understanding Clinical Attachment Loss (CAL)

- CAL = distance from CEJ to bottom of periodontal pocket
- Probing Depth (PD) measures gingival margin to pocket bottom; gingival recession = CEJ to gingival margin
- CAL excludes non-periodontal causes such as trauma-induced recession, cervical caries, third molar issues, endodontic lesions, or root fractures

Characteristics of Necrotizing Periodontitis

- History of pain and gingival ulceration
- Fibrin deposits and bone exposure in severe cases

Determining Initial Stage

- Use CAL primarily; if unavailable, radiographic bone loss (RBL) is alternative
- Tooth loss attributed to periodontitis may alter staging
- Complexity factors (e.g. furcation involvement, high mobility) can increase stage status

Post-Treatment Staging Considerations

- CAL and RBL remain primary evaluation metrics post-treatment
- Stage should not be downgraded even if complexity factor is resolved, due to maintenance needs

Criteria for Grading Disease Progression

- Direct evidence preferred, indirect relies on bone loss relative to age
- Start with Grade B as default; adjust to A or C upon evidence
- Grading also considers systemic health risks posed by individual's periodontitis

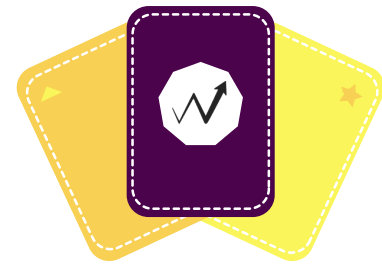


**WINSPERT
CUE CARDS**

**PERIODONTITIS
STAGING GRADING**

Question 1

**What is the clinical definition
of periodontitis?**



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PERIODONTITIS STAGING GRADING

Answer 1

Periodontitis is characterized by microbially-associated, host-mediated inflammation that results in loss of periodontal attachment. This is detected as clinical attachment loss (CAL) by circumferential assessment of the erupted dentition with a standardized periodontal probe with reference to the cemento-enamel junction (CEJ).



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**PERIODONTITIS
STAGING GRADING**

Question 2

**How is a patient clinically
diagnosed as having
periodontitis?**

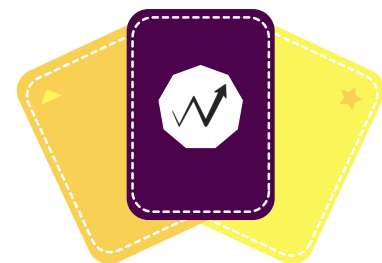


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PERIODONTITIS STAGING GRADING

Answer 2

Buccal or oral CAL of 3 mm or more with probing pocket depth greater than 3 mm is detectable at two or more teeth.



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**PERIODONTITIS
STAGING GRADING**

Question 3

What is clinical attachment loss (CAL) and how is it measured?



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PERIODONTITIS STAGING GRADING

Answer 3

Clinical attachment loss (CAL) is the distance from the cemento-enamel junction (CEJ) to the bottom of the periodontal pocket. It is calculated by combining probing depth (distance from gingival margin to pocket bottom) and gingival recession (distance from CEJ to gingival margin).



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**PERIODONTITIS
STAGING GRADING**

Question 4

Which conditions cannot be considered causes of clinical attachment loss (CAL)?



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**PERIODONTITIS
STAGING GRADING**

Answer 4

A vertical root fracture



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**PERIODONTITIS
STAGING GRADING**

Question 5

What are the three different forms of periodontitis identified based on pathophysiology?

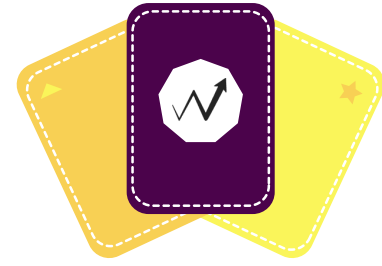


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**PERIODONTITIS
STAGING GRADING**

Answer 5

Periodontitis (chronic or other)



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**PERIODONTITIS
STAGING GRADING**

Question 6

**What are key clinical features
of necrotizing periodontitis?**



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PERIODONTITIS STAGING GRADING

Answer 6

Necrotizing periodontitis is characterized by pain history, ulceration of the gingival margin, fibrin deposits at sites with decapitated gingival papillae, and in some cases, exposure of marginal alveolar bone.



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**PERIODONTITIS
STAGING GRADING**

Question 7

**What factors are considered
when staging periodontitis?**



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PERIODONTITIS STAGING GRADING

Answer 7

Staging is based on severity and extent of disease at presentation, including clinical attachment loss (CAL), radiographic bone loss (RBL), tooth loss attributable to periodontitis, and complexity factors such as pocket depth, furcation involvement, tooth mobility, infrabony defects, and masticatory dysfunction.

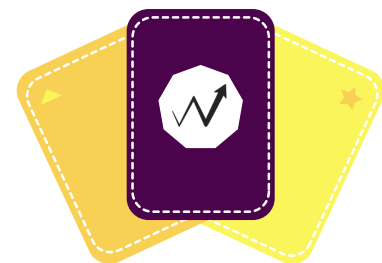


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**PERIODONTITIS
STAGING GRADING**

Question 8

**How does complexity
influence the staging of
periodontitis?**



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PERIODONTITIS STAGING GRADING

Answer 8

Complexity factors such as furcation involvement, high tooth mobility, or posterior bite collapse can shift the disease stage to a higher level (e.g., from stage III to IV), even if CAL or RBL remains unchanged.



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PERIODONTITIS STAGING GRADING

Question 9

What are the three categories for grading periodontitis progression?



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PERIODONTITIS STAGING GRADING

Answer 9

Periodontitis progression is graded into three categories: slow (Grade A), moderate (Grade B), and rapid (Grade C).

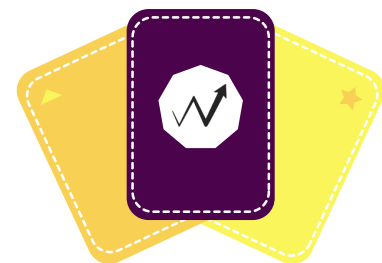


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**PERIODONTITIS
STAGING GRADING**

Question 10

How is grade determination primarily made and modified in periodontitis?



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PERIODONTITIS STAGING GRADING

Answer 10

Grade is primarily determined by direct evidence of progression or indirectly by radiographic bone loss related to age (RBL/age). Initial assumption is grade B unless specific evidence supports grade A or C. Grade can then be modified based on risk factors such as smoking and systemic health.

PERIODONTICS

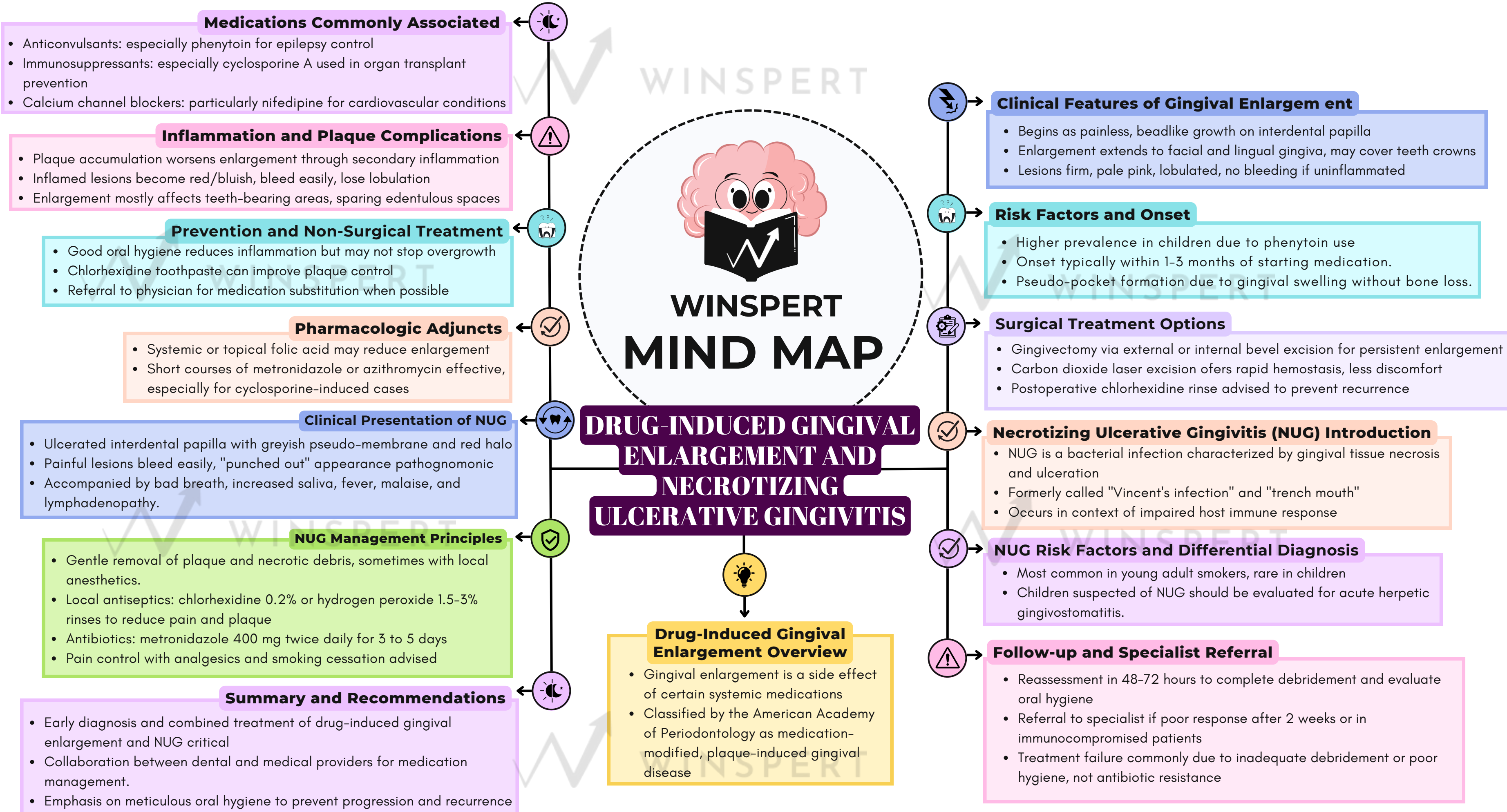
GINGIVITIS- DRUG INDUCED, ANUG



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA



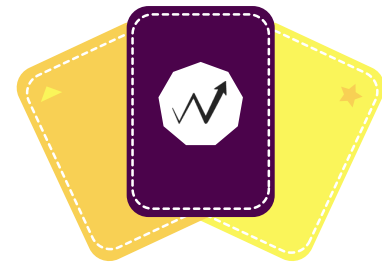


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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 1

What is drug-induced gingival enlargement and how is it classified by the American Academy of Periodontology?



**WINSPERT
CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 1

Drug-induced gingival enlargement is an abnormal growth of the gingiva caused by the use of systemic medication. It is classified by the American Academy of Periodontology as a form of dental plaque-induced gingival disease modified by medication.



**WINSPERT
CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 2

Which three pharmaceutical categories of medication are commonly associated with gingival enlargement?

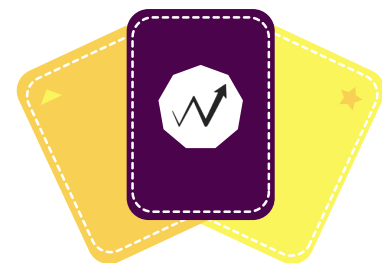


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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 2

The three pharmaceutical categories associated with gingival enlargement are anticonvulsants, immunosuppressants, and calcium channel blockers.

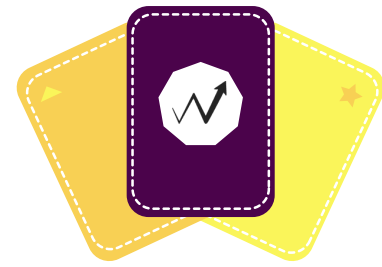


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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 3

Which specific drugs have the strongest association with drug-induced gingival enlargement?



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**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 3

Phenytoin (an anticonvulsant), cyclosporine A (an immunosuppressant), and nifedipine (a calcium channel blocker) have the strongest association with drug-induced gingival enlargement.



**WINSPERT
CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 4

What are the initial clinical features of drug-induced gingival enlargement?



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**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 4

The growth starts as a painless, beadlike enlargement of the interdental papilla and extends to the facial and lingual gingival margins. It is usually firm, pale pink, mulberry shaped, resilient, with a minutely lobulated surface and no tendency to bleed unless complicated by inflammation.

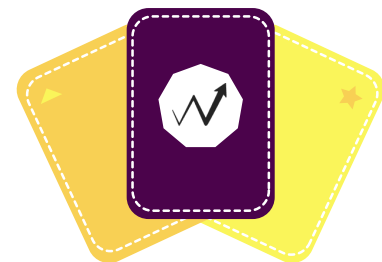


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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 5

**How does secondary inflammation
affect drug-induced gingival
enlargement?**

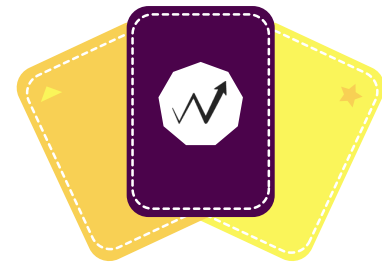


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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 5

Secondary inflammation caused by plaque accumulation increases the size of the lesion, produces a red or bluish-red discoloration, obliterates lobulated surface demarcations, and increases bleeding tendency.



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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 6

What is a “pseudo-pocket” in the context of drug-induced gingival enlargement?



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**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 6

A “pseudo-pocket” is an increase in pocket depth greater than 3–4 mm caused by gingival swelling without apical migration of the junctional epithelium or bone loss.

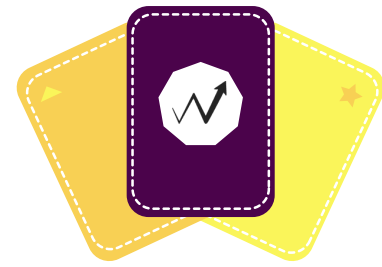


**WINSPERT
CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 7

What are the main treatment options for drug-induced gingival enlargement?

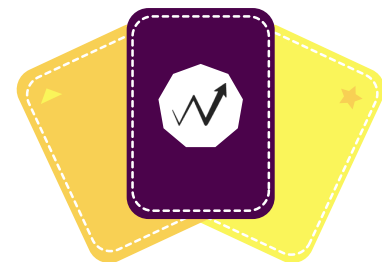


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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 7

Treatment includes oral hygiene instructions, supra- and subgingival scaling and polishing, referral to a physician for possible substitution of medication, and if necessary, surgical excision using external or internal bevel gingivectomy or carbon dioxide laser surgery.



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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 8

What are the characteristics and clinical features of necrotizing ulcerative gingivitis (NUG)?

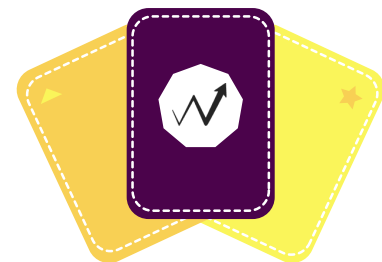


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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 8

NUG is a microbial disease characterized by ulceration and necrosis of interdental papillae, covered by a whitish-yellow pseudomembrane, surrounded by an erythematous halo. Symptoms include pain, bleeding, oral malodor, lymphadenopathy, fever, and malaise. The ulcers look punched out and are highly sensitive.

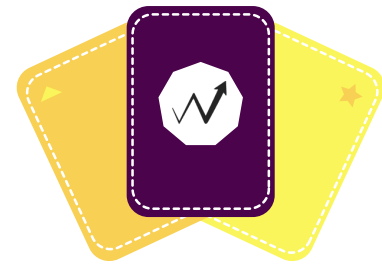


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CUE CARDS**

**GINGIVITIS- DRUG
INDUCED, ANUG**

Question 9

How is necrotizing ulcerative gingivitis (NUG) initially managed?



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**GINGIVITIS- DRUG
INDUCED, ANUG**

Answer 9

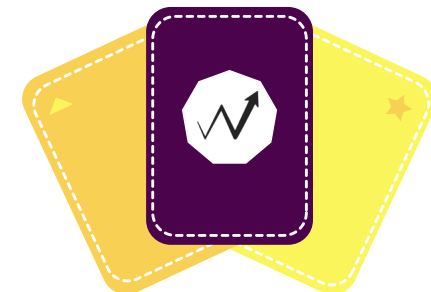
Management begins with gentle removal of plaque and necrotic debris, local irrigation with chlorhexidine 0.2% mouthwash or hydrogen peroxide solution, antibiotic therapy (metronidazole), analgesics, and smoking cessation advice.

PERIODONTICS

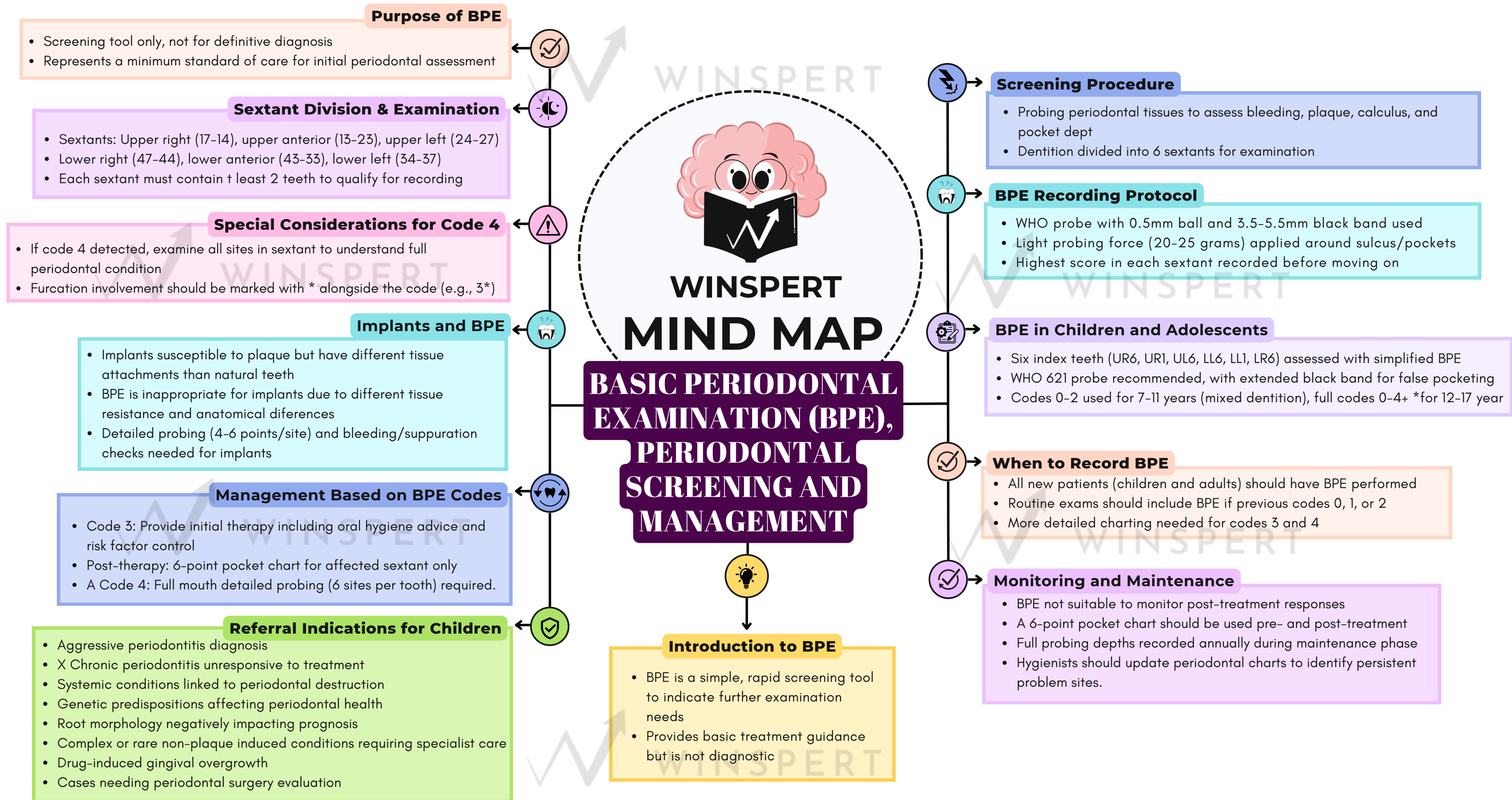
PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

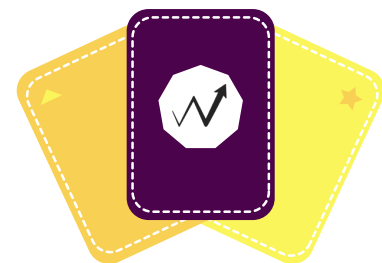


MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA



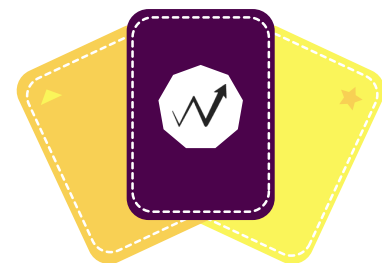


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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Question 1

What is the primary purpose of the Basic Periodontal Examination (BPE)?

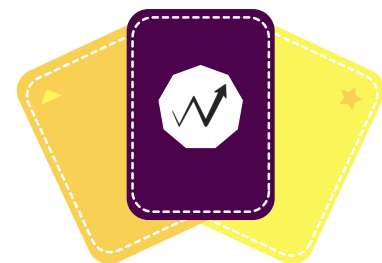


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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 1

The BPE is a simple and rapid screening tool used to indicate the level of further examination needed and to provide basic guidance on required treatment. It is used for screening only and not for diagnosis.

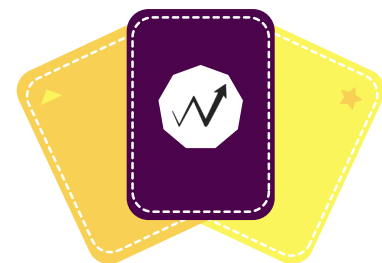


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PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Question 2

How is the dentition divided when recording the BPE for adults?

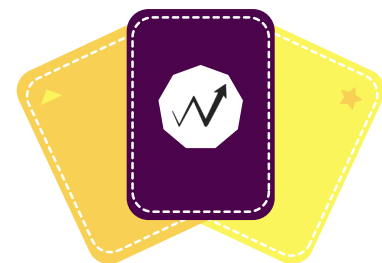


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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 2

The dentition is divided into 6 sextants: upper right (17 to 14), upper anterior (13 to 23), upper left (24 to 27), lower right (47 to 44), lower anterior (43 to 33), and lower left (34 to 37).

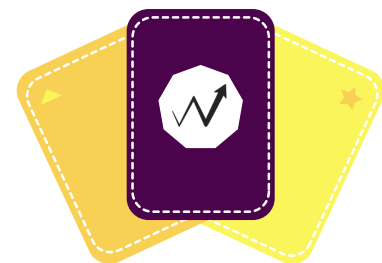


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CUE CARDS**

**PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL
EXAM/SCORING/MANAGEMENT**

Question 3

What are the criteria for a sextant to qualify for BPE recording?



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PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 3

A sextant must contain at least 2 teeth to qualify for recording in the BPE.



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**PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL
EXAM/SCORING/MANAGEMENT**

Question 4

Describe the type of probe used for the BPE and the probing force applied.

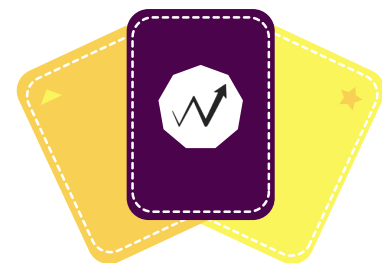


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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 4

The WHO probe (BPE probe) has a ball end 0.5mm in diameter with a black band from 3.5 to 5.5mm. A light probing force of 20-25 grams should be used.

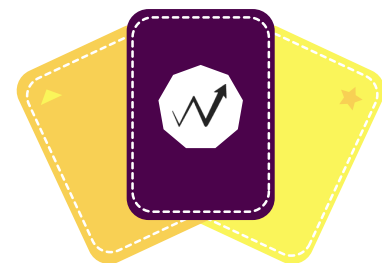


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PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Question 5

What is indicated by a BPE score with an asterisk (*) such as "3"?

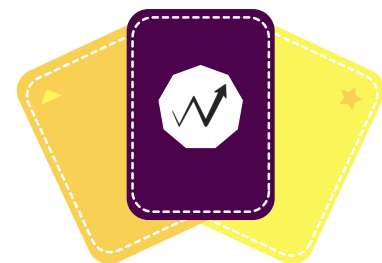


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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 5

The asterisk (*) indicates the presence of furcation involvement along with the probing depth indicated by the number (e.g. 3.5-5.5mm probing depth plus furcation involvement).



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PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Question 6

How is the BPE recorded differently for children?

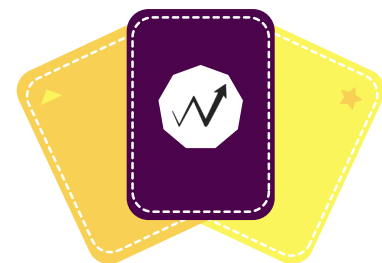


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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 6

In children and adolescents, six index teeth (UR6, UR1, UL6, LL6, LL1, LR6) are assessed with a simplified BPE to avoid false pockets. Codes 0-2 are used for 7 to 11-year-olds, while the full range of codes 0,1,2,3,4, and * can be used for 12 to 17-year-olds.

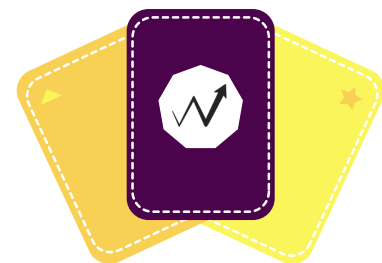


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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Question 7

Why is the BPE not appropriate for assessing implants?



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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 7

The tissues around implants differ anatomically and are less resistant to probing, often producing deeper probing depths in healthy sites. Therefore, detailed probing and bleeding/suppuration assessment are preferred for implants instead of BPE.



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CUE CARDS**

**PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL
EXAM/SCORING/MANAGEMENT**

Question 8

**When is detailed 6-point
periodontal charting required
based on the BPE codes?**

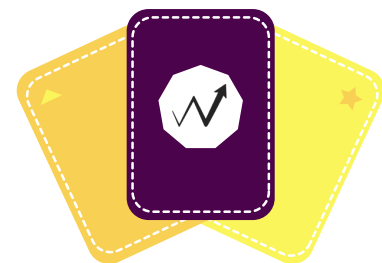


**WINSPERT
CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 8

For patients with a BPE code 3, 6-point pocket charting is done in the affected sextant after initial therapy. For code 4 in any sextant, detailed 6-point probing for the entire dentition is required.

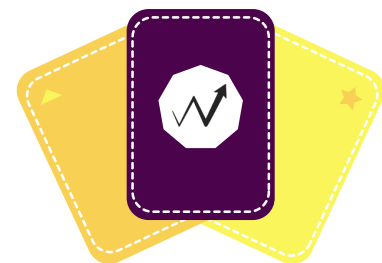


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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Question 9

Why can BPE not be used to monitor the response to periodontal therapy?

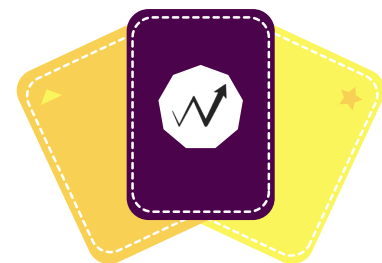


**WINSPERT
CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 9

Because BPE records only the highest score per sextant and does not document individual sites, it lacks detail to track site-specific changes after treatment, so a 6-point pocket chart is necessary pre- and post-treatment.



**WINSPERT
CUE CARDS**

**PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL
EXAM/SCORING/MANAGEMENT**

Question 10

List some indications for referring a child to a periodontal specialist.



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CUE CARDS**

PERIODONTAL SCREENING (BPE) BASIC PERIODONTAL EXAM/SCORING/MANAGEMENT

Answer 10

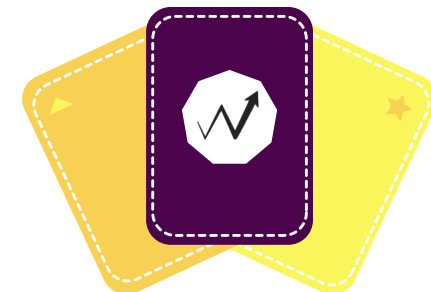
Indications include diagnosis of aggressive periodontitis, incipient chronic periodontitis not responding to treatment, systemic conditions affecting periodontal health, genetic predispositions, root morphology affecting prognosis, non-plaque induced conditions requiring specialist care, drug-induced gingival overgrowth, and complex or rare clinical pathology cases requiring specialist evaluation.

PERIODONTICS

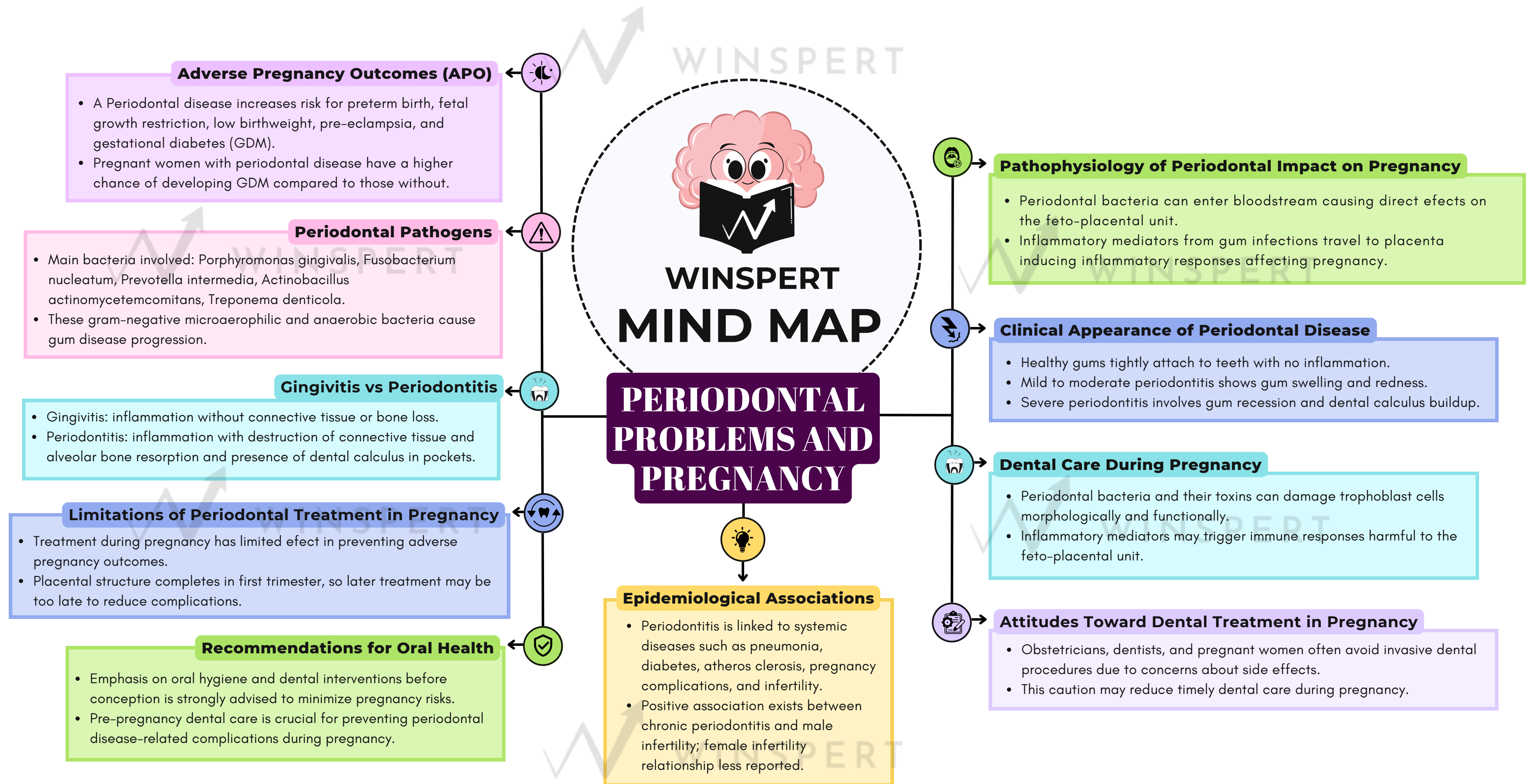
PERIODONTAL PROBLEMS - PREGNANCY



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA





**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 1

What systemic diseases have recent epidemiological studies suggested periodontitis can be a risk factor for?

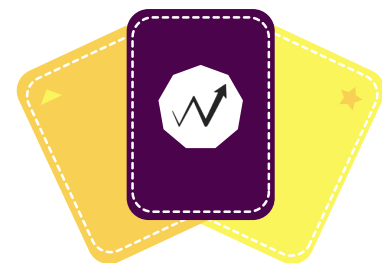


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PERIODONTAL PROBLEMS - PREGNANCY

Answer 1

Periodontitis is a risk factor for pneumonia (especially aspiration pneumonia) in the elderly, diabetes mellitus, atherosclerosis, pregnancy complications, and male and female infertility.



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 2

What adverse pregnancy outcomes (APO) are associated with periodontal diseases?

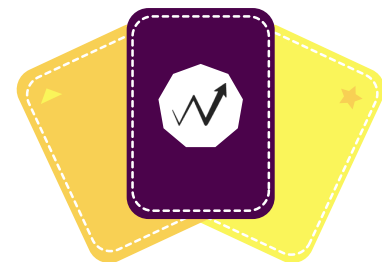


**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 2

Periodontal diseases are associated with preterm birth, fetal growth restriction, low birthweight, pre-eclampsia, and gestational diabetes.



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 3

How is periodontal disease linked to gestational diabetes mellitus (GDM) among pregnant women?



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 3

Periodontal disease is associated with an increased risk of gestational diabetes mellitus (GDM) among pregnant women compared to those without periodontal disease.



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 4

What are the two pathogenic mechanisms that explain the potential impact of periodontal diseases on pregnancy outcomes?



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 4

Inflammatory mediators secreted at the subgingival inflammatory site are carried to the feto-placental unit, causing an inflammatory response.



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 5

Which bacteria are commonly involved in causing periodontal diseases?

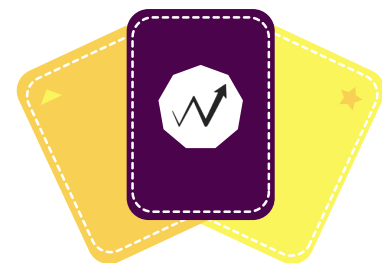


**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 5

Periodontal diseases are caused by multiple gram-negative microaerophilic and anaerobic bacteria such as Porphyromonas gingivalis, Fusobacterium nucleatum, Prevotella intermedia, Actinobacillus actinomycetemcomitans, and Treponema denticola.



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 6

How does the clinical appearance of gingiva differ between healthy individuals and those with periodontitis?

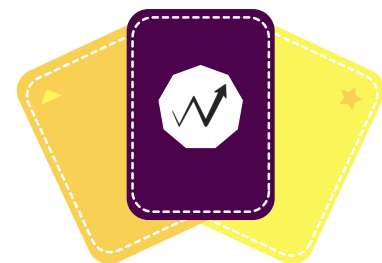


**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 6

In healthy individuals, the gingiva is tightly located against the teeth. In mild to moderate periodontitis, swelling and redness are present. In severe periodontitis, gingival recession and dental calculus are observed.

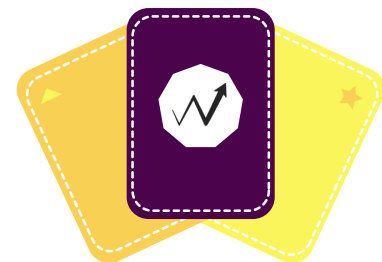


**WINSPERT
CUE CARDS**

**PERIODONTAL
PROBLEMS - PREGNANCY**

Question 7

What is the difference between gingivitis and periodontitis in the context of periodontal disease?

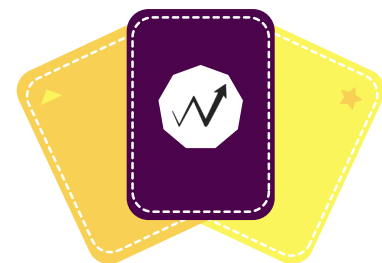


**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 7

Gingivitis involves gingival inflammation without destruction of connective tissue or alveolar bone resorption, while periodontitis is characterized by gingival inflammation along with the loss of connective tissue and alveolar bone.

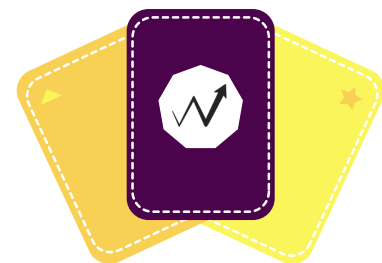


**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 8

Why might dental care during pregnancy have limited effect on preventing adverse pregnancy outcomes?



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 8

Because the placental structure is completed in the first trimester, and trophoblast cells migrate early in pregnancy, dental care during pregnancy may occur too late to reduce pregnancy complications despite being effective in curing periodontal diseases.



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 9

What is the role of P. gingivalis and its components in pregnancy complications related to periodontal disease?

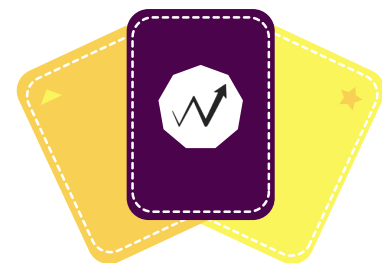


**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 9

P. gingivalis and its components can injure the trophoblast morphologically and functionally, and inflammatory mediators from periodontal pockets can trigger an immune response at the feto-placental unit.

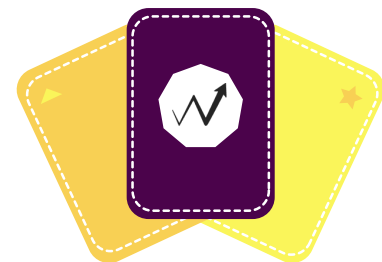


**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Question 10

What is the recommendation regarding oral health care and dental interventions in relation to pregnancy?



**WINSPERT
CUE CARDS**

PERIODONTAL PROBLEMS - PREGNANCY

Answer 10

Oral health care and dental interventions are strongly recommended before conception because invasive dental treatment is often avoided during pregnancy due to concerns about possible side effects.

PERIODONTICS

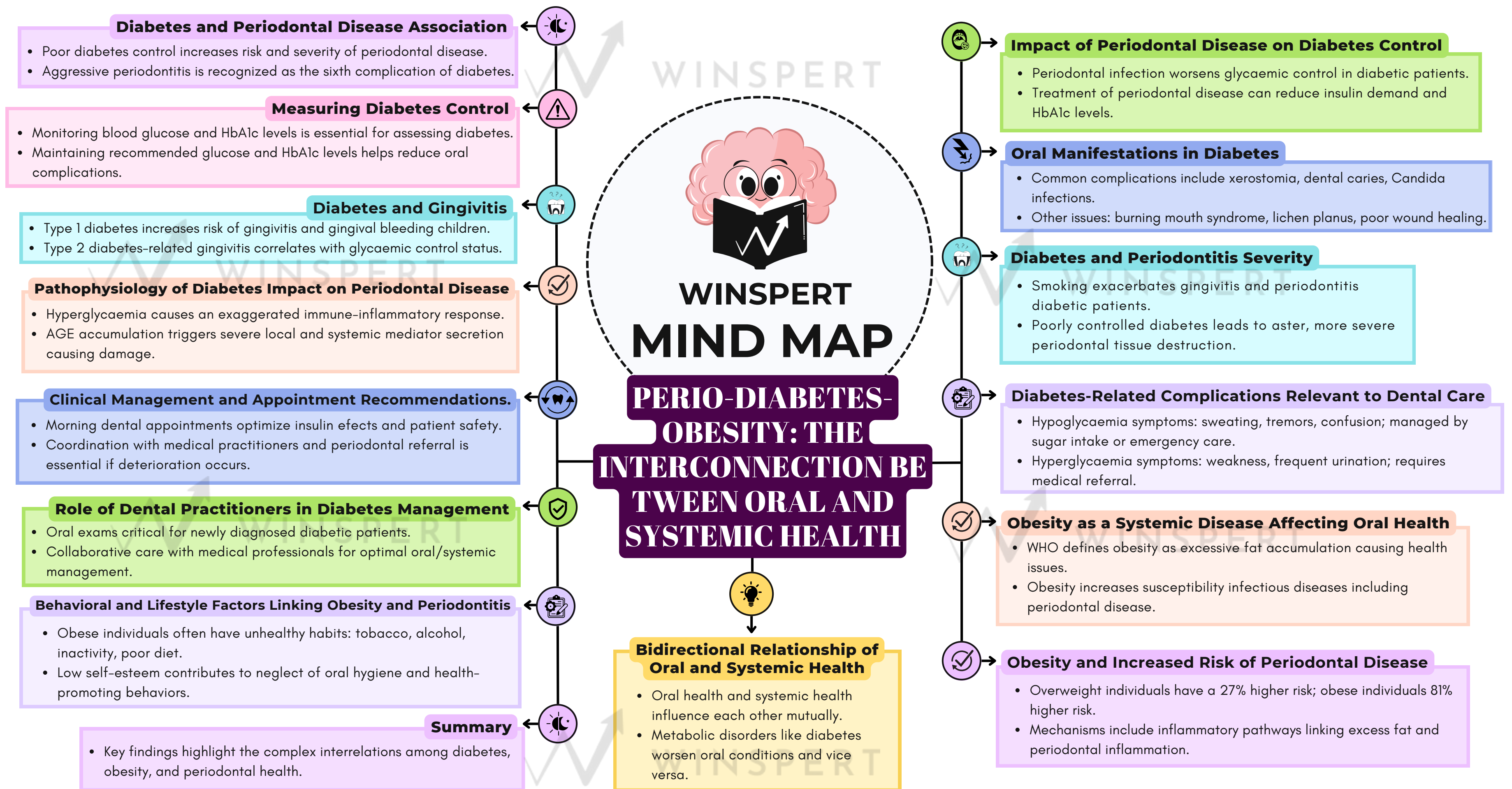
PERIO - DIABETES AND OBESITY



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA





**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 1

What is the nature of the relationship between oral health and systemic health in metabolic disorders like diabetes?



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 1

The relationship between oral health and systemic health is bidirectional; systemic illnesses such as metabolic disorders affect oral health, and oral health may also impact systemic health.

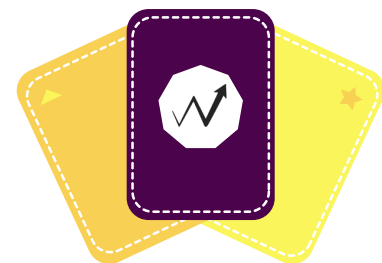


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 2

**How does diabetes affect
periodontal disease
progression?**

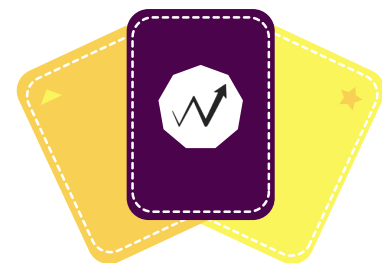


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 2

Diabetes exaggerates the host response to local microbial factors, causing unusually destructive periodontal breakdown. Poor glycemic control increases the risk and severity of periodontal disease and leads to rapid progression and more severe tissue destruction.



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 3

**Why is periodontal disease
considered the sixth
complication of diabetes?**

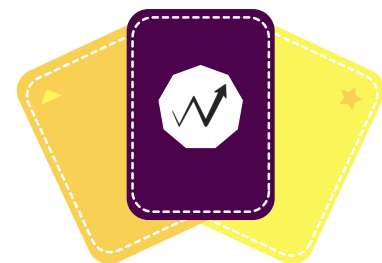


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 3

Because research shows that people with diabetes, especially when poorly controlled, have a higher prevalence of gingivitis and periodontitis, which in turn worsens diabetes control, making periodontal disease recognized as the sixth complication of diabetes.



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 4

**How does periodontal
treatment impact diabetes
management?**

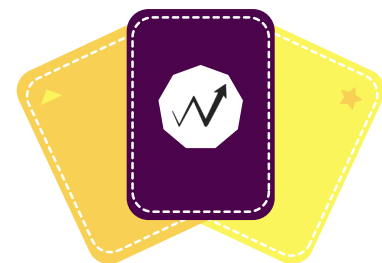


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 4

Controlling periodontal infection can improve glycemic control, evidenced by a decreased insulin demand and lower hemoglobin A1c levels.



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 5

**What oral complications
besides periodontal disease
are commonly reported in
patients with diabetes?**



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 5

Common oral complications reported in diabetic patients include xerostomia, dental caries, Candida infection, burning mouth syndrome, lichen planus, and poor wound healing.

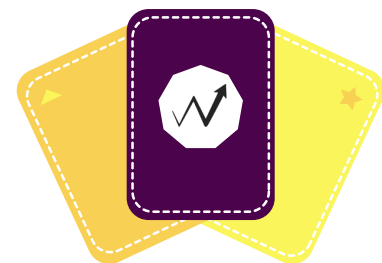


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 6

How does diabetes influence gingivitis according to the type of diabetes?

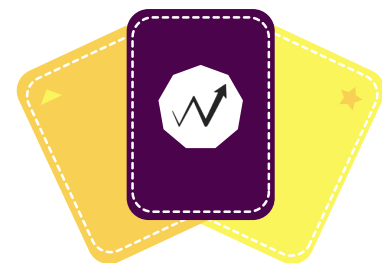


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 6

Type 1 diabetes increases the risk of gingivitis with more gingival inflammation and bleeding, particularly in children. Type 2 diabetes is also associated with gingivitis related to glycemic control.

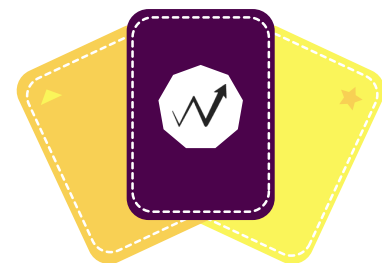


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 7

**What role does smoking play
in periodontal disease among
diabetic patients?**

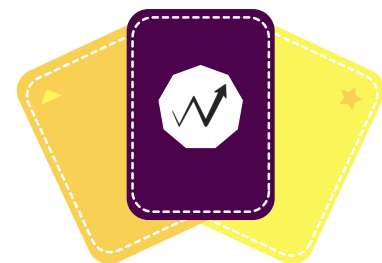


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 7

Smoking makes both gingivitis and periodontitis more severe in diabetic patients, especially when diabetes is poorly controlled, increasing the risk of periodontal disease progression.



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 8

What is the primary mechanism by which diabetes exacerbates periodontal tissue destruction?

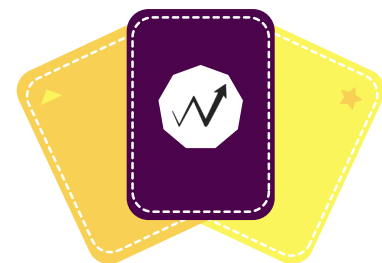


**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 8

Persisting hyperglycemia leads to an exaggerated immuno-inflammatory response to periodontal bacteria, involving AGE accumulation and excessive secretion of local and systemic inflammatory mediators, causing more rapid and severe tissue destruction.



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 9

What modifications are recommended for periodontal treatment in poorly controlled diabetic patients?



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 9

Treatment may require modifications due to poorer response and wound healing, including the use of systemic antibiotics alongside other therapies and scheduling morning appointments when insulin levels are optimal.



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Question 10

How does obesity relate to periodontal disease risk and oral health habits?



**WINSPERT
CUE CARDS**

**PERIO - DIABETES
AND OBESITY**

Answer 10

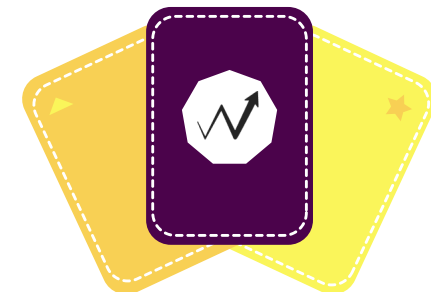
Obesity increases susceptibility to periodontal diseases due to systemic inflammation and unhealthy habits such as tobacco use, alcohol consumption, poor diet, and neglect of oral hygiene, often linked to low self-esteem and negative body image. Obese individuals have significantly higher risks of developing periodontal disease compared to normal-weight individuals.

PERIODONTICS

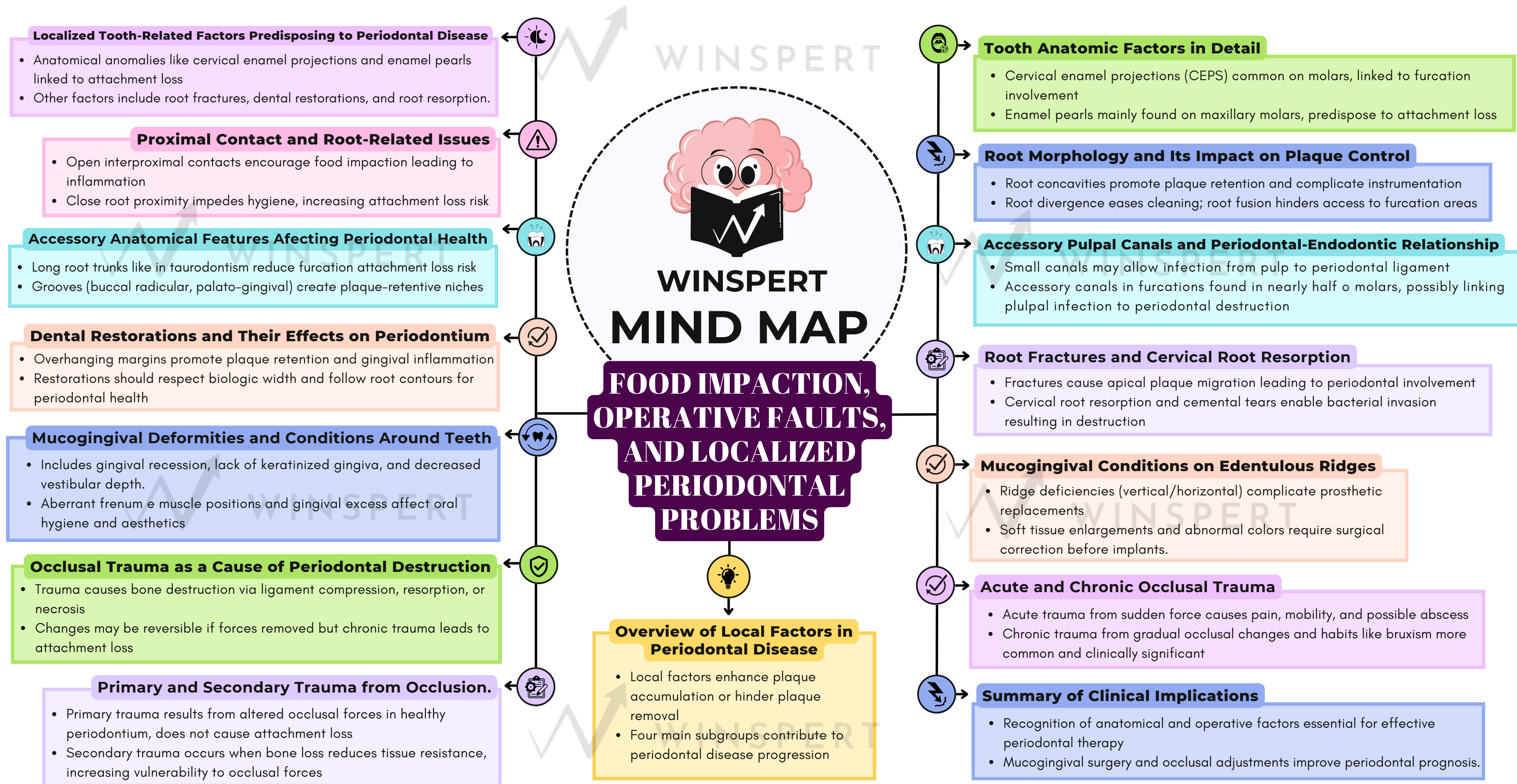
FOOD IMPACTION/ OPERATIVE FAULTS/ LOCALISED PERIO PROBLEMS



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA





**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 1

What are the four subgroups of local factors that contribute to the initiation and progression of periodontal disease?

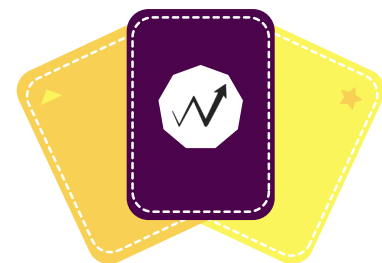


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Answer 1

Occlusal trauma



**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 2

**What are cervical enamel
projections (CEPs) and how
do they affect periodontal
health?**



**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Answer 2

Cervical enamel projections are extensions of enamel onto the furcal area of the root surface. They may predispose a furcation to attachment loss because they prevent connective tissue attachment, allowing periodontal pockets to form and plaque to accumulate, which can lead to furcation invasion.

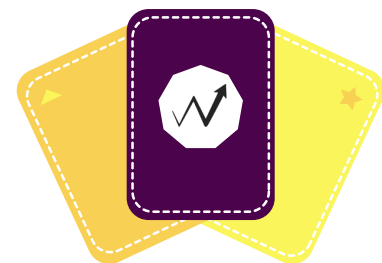


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 3

Which teeth are most commonly affected by cervical enamel projections?

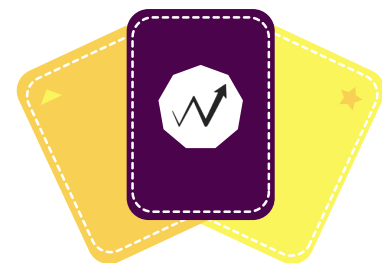


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Answer 3

CEPs are most commonly found on mandibular second molars, maxillary second molars, mandibular first molars, and maxillary first molars, usually on the buccal surfaces.

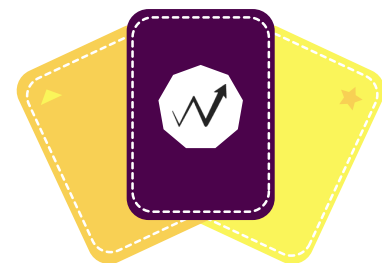


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 4

How can enamel pearls contribute to periodontal disease?

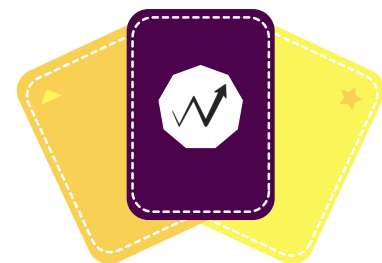


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Answer 4

Enamel pearls are ectopic enamel globules usually found near the cementoenamel junction that may predispose furcations to attachment loss by creating plaque-retentive areas difficult to clean, leading to periodontal problems.



**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 5

What is the significance of proximal contact relations in periodontal disease?

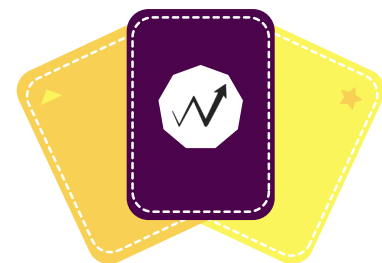


**WINSPERT
CUE CARDS**

FOOD IMPACTION/ OPERATIVE FAULTS/ LOCALISED PERIO PROBLEMS

Answer 5

Open interproximal contacts or uneven marginal ridge relations can encourage food impaction between teeth, which, without proper oral hygiene, can lead to inflammation and potential attachment loss in the interproximal area.

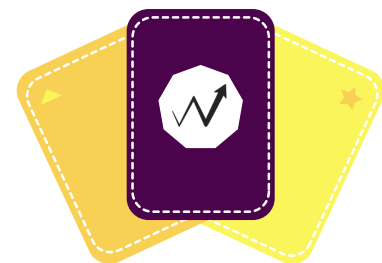


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 6

**How does root proximity
affect oral hygiene and
periodontal health?**



**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Answer 6

Close root proximity between adjacent teeth makes oral hygiene difficult to maintain for both patients and dental professionals, increasing the risk of attachment loss if proper cleanliness is not achieved.

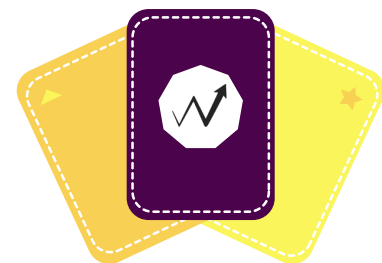


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 7

**What periodontal problems
are caused by dental
restorations with overhangs or
open margins?**

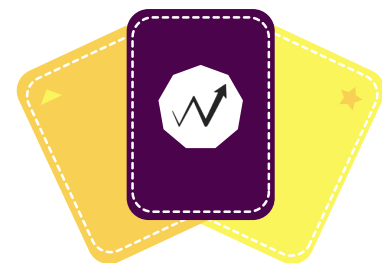


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Answer 7

Overhangs or open restoration margins are plaque-retentive areas that can lead to gingival inflammation and attachment loss. Margins that violate the biologic width may cause gingival recession, bone loss, and exposure of the restoration margin.



**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 8

**What is the difference
between primary and
secondary occlusal trauma?**

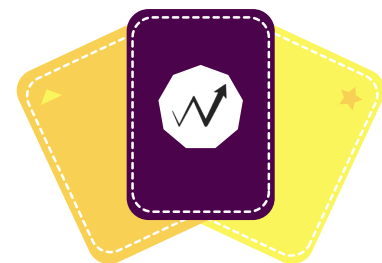


**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Answer 8

Primary occlusal trauma is caused by altered occlusal forces on a tooth with a healthy periodontium, while secondary occlusal trauma occurs when reduced periodontal support due to bone loss renders normal occlusal forces traumatic.



**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Question 9

**What are the effects of acute
trauma from occlusion?**



**WINSPERT
CUE CARDS**

**FOOD IMPACTION/ OPERATIVE
FAULTS/ LOCALISED PERIO
PROBLEMS**

Answer 9

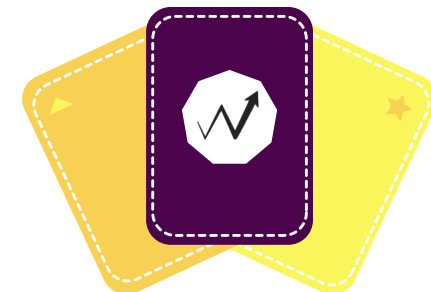
Acute trauma results from abrupt occlusal forces and can cause tooth pain, sensitivity, increased mobility, possible periodontal abscess, cementum tears, and potential necrosis if not resolved.

PERIODONTICS

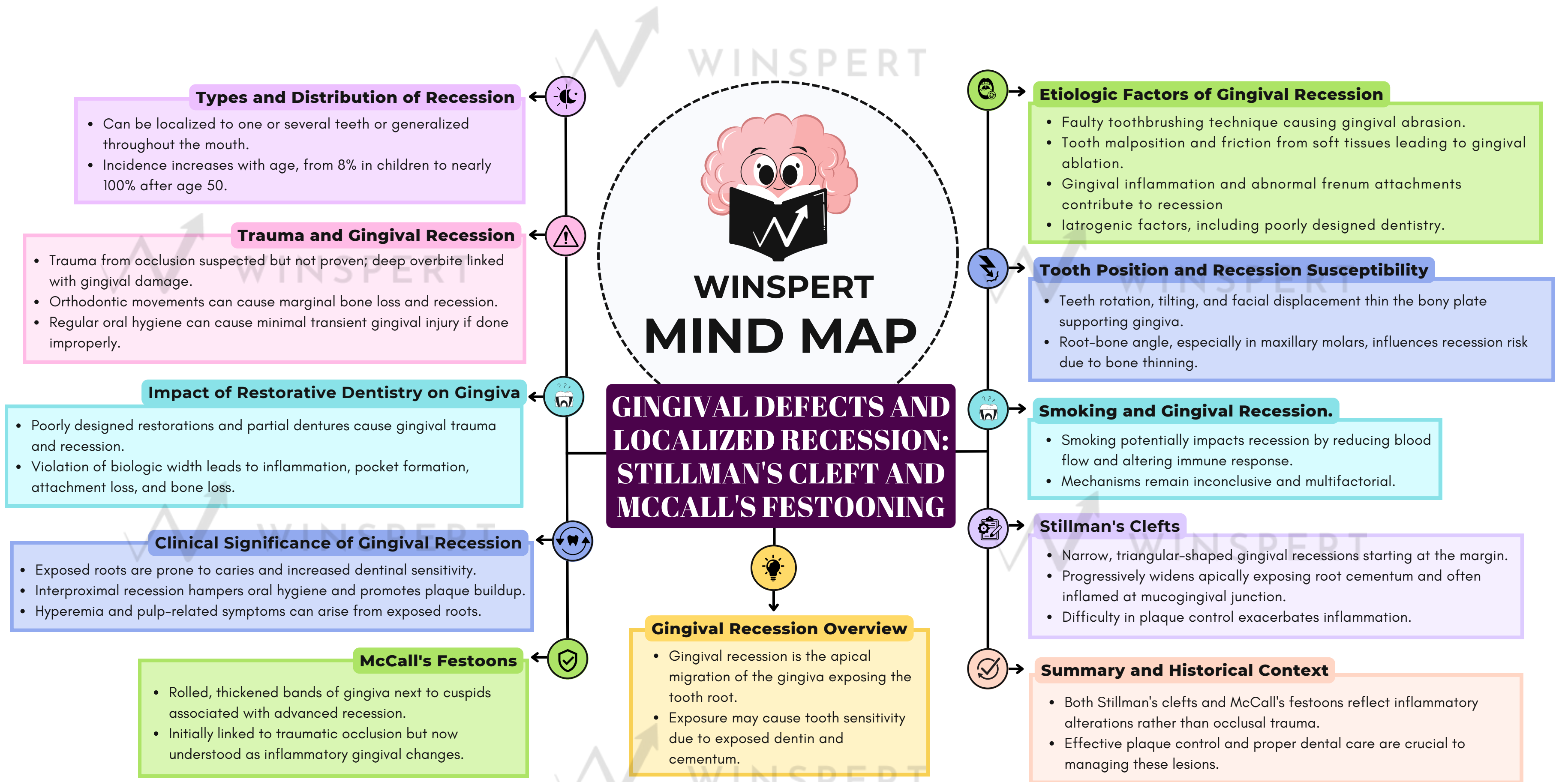
GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS
CLEFT/ MCCALLS FESTOONING



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA



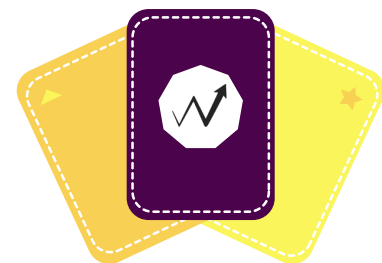


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 1

**What is gingival recession and
what causes it?**

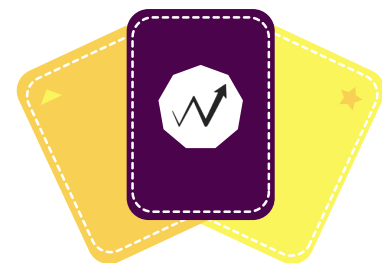


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 1

Gingival recession is the exposure of the tooth caused by the apical migration of the gingiva. It may result in increased sensitivity due to exposed dentin and the exposure of cementum to the oral environment, often due to loss of attachment in pocket formation.



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 2

**How does the prevalence of
gingival recession change
with age?**

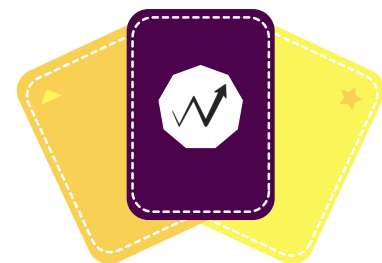


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 2

Gingival recession increases with age, ranging from about 8% in children to nearly 100% in individuals over 50 years old. Some believe it might be a physiological process related to aging, but there is no convincing evidence supporting this.



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 3

What are the main etiologic factors implicated in gingival recession?

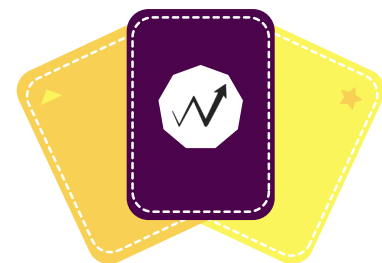


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 3

The main factors include faulty toothbrushing technique (leading to gingival abrasion), tooth malposition, friction from soft tissues (gingival ablation), gingival inflammation, abnormal frenum attachment, and iatrogenic dentistry.

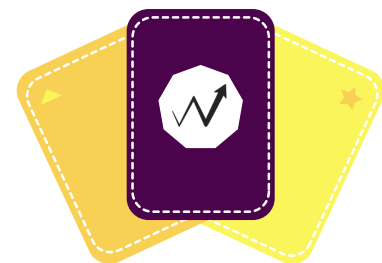


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 4

**What role does trauma from
occlusion play in gingival
recession?**



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 4

Although previously suggested, trauma from occlusion as a cause of gingival recession has never been definitively demonstrated. However, conditions like deep overbite may be associated with gingival inflammation and recession due to traumatic injury to the gingiva.

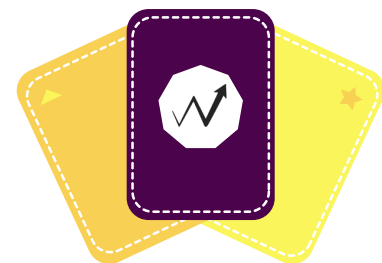


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 5

**How can orthodontic
movement affect gingival
recession?**

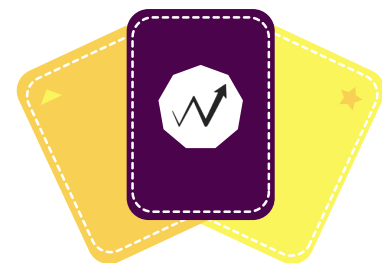


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 5

Orthodontic movement, particularly in a labial direction, can cause loss of marginal bone, connective tissue attachment, and gingival recession, as demonstrated in animal studies.



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 6

Why might faulty toothbrushing lead to gingival recession even if oral hygiene is otherwise good?



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 6

Faulty toothbrushing, especially with hard bristles or incorrect technique, can cause lacerations, abrasions, keratosis, and recession, particularly affecting the facial marginal gingiva despite good oral hygiene.



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 7

**How does tooth position affect
susceptibility to gingival
recession?**

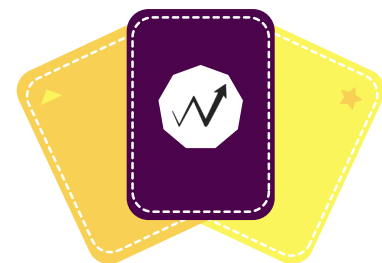


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 7

Teeth that are rotated, tilted, or facially displaced often have thinner or reduced height of the bony plate. This makes the gingiva unsupported and more prone to damage from mastication or toothbrushing, leading to recession.



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 8

**What impact do poorly
designed restorative materials
have on gingival health?**



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 8

Poorly designed and placed restorations, such as ill-fitting denture clasps or overhanging margins, can cause gingival trauma, inflammation, attachment loss, and recession by violating the biologic width.

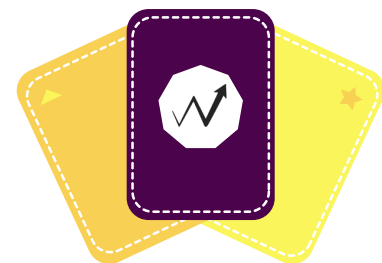


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 9

What clinical problems are associated with exposed root surfaces due to gingival recession?

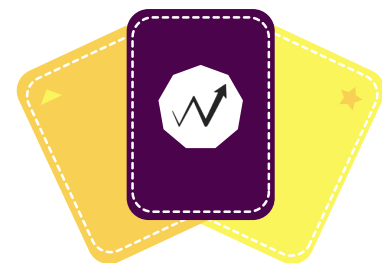


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 9

Exposed root surfaces are prone to caries, abrasion or erosion of exposed cementum, dentinal sensitivity, pulp hyperemia, and plaque accumulation, particularly in interproximal areas, complicating oral hygiene.

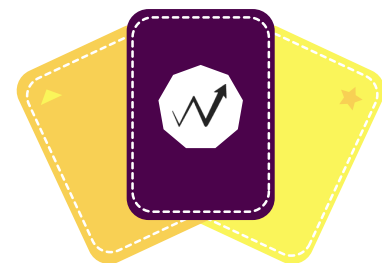


**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Question 10

What are Stillman's clefts and McCall festoons, and what is their clinical significance?



**WINSPERT
CUE CARDS**

**GINGIVAL DEFECTS/ LOCALISED
RECESSIONS/ STILLMANS CLEFT/
MCCALLS FESTOONING**

Answer 10

Stillman's clefts are narrow, triangular gingival recessions that broaden apically, often leading to inflamed mucosa at the mucogingival junction. McCall festoons are rolled, thickened gingival bands near cuspids seen with recession. Both represent inflammatory changes of marginal gingiva, not traumatic occlusion as previously thought.

PERIODONTICS

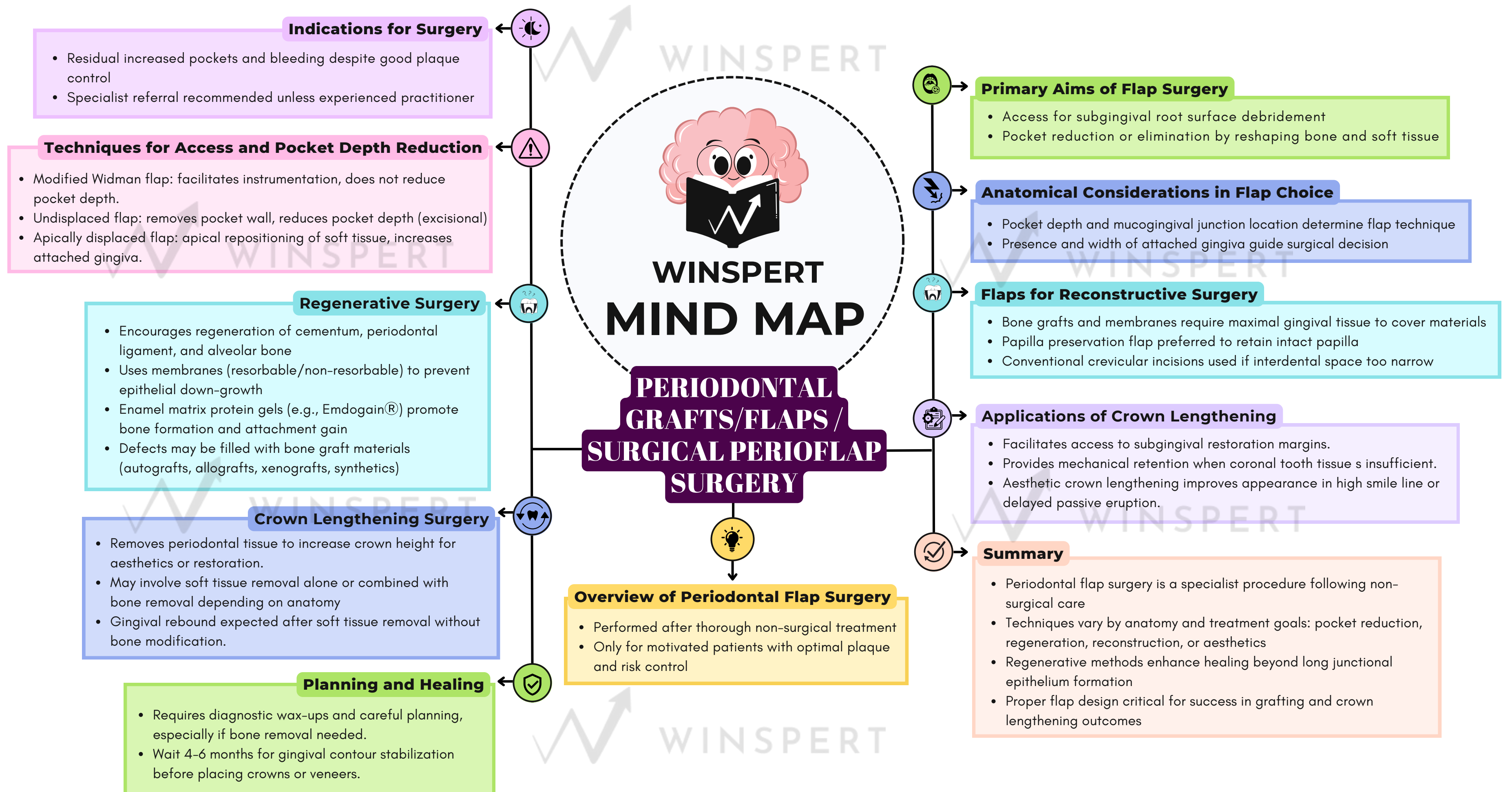
PERIO GRAFTS, FLAPS, SURGICAL PERIO

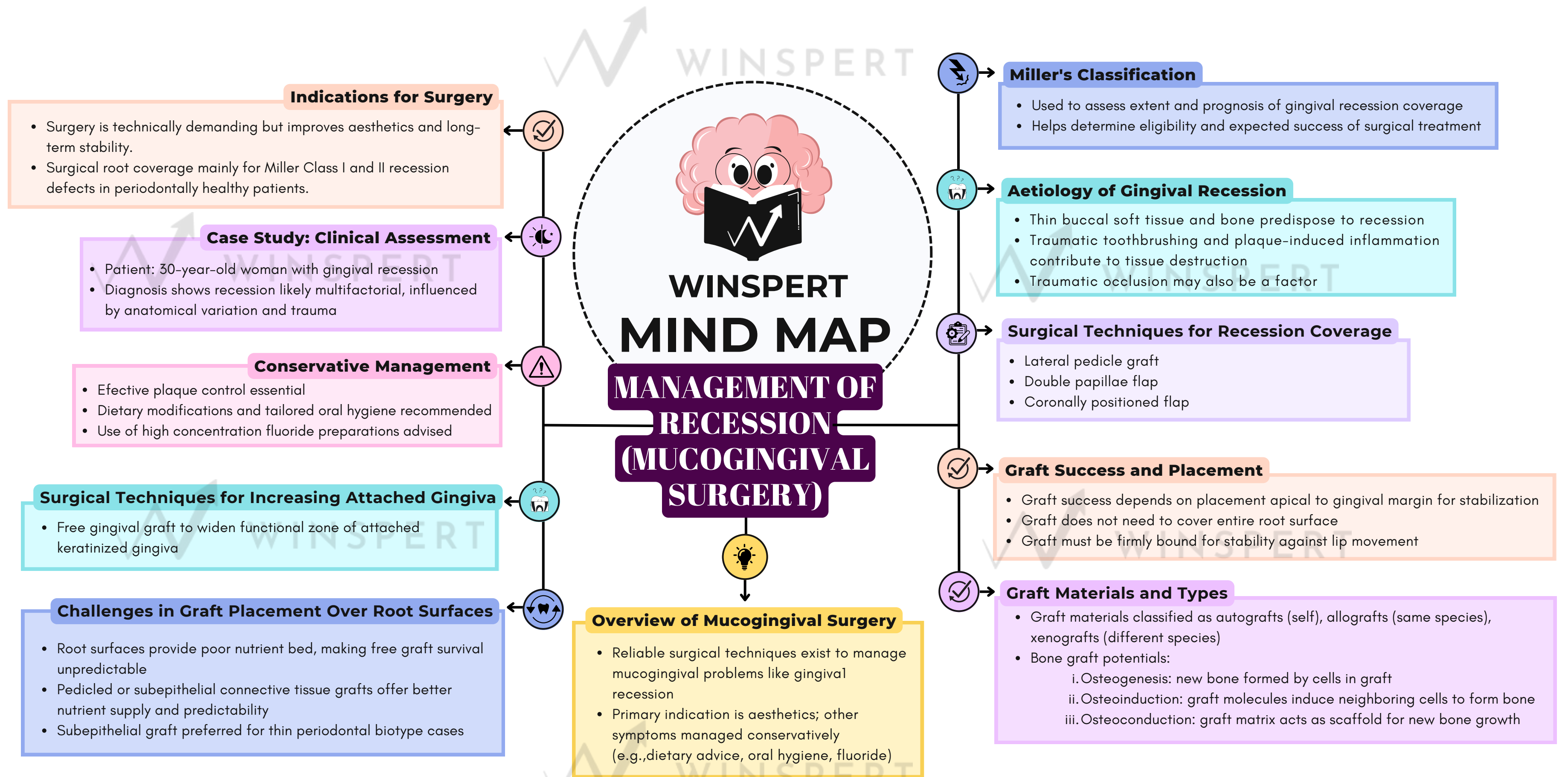


MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 1

What is the primary prerequisite before performing periodontal flap surgery?



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CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 1

Periodontal flap surgery is almost always performed after thorough non-surgical treatment and should only be considered in highly motivated patients with optimal plaque and risk factor control.



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 2

**What are the main aims of
periodontal flap surgery?**



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 2

The main aims are to provide access for debridement by removing subgingival root surface deposits, reducing or eliminating pockets by reshaping bone and soft tissues, and creating gingival tissues that are easier to maintain.



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 3

What is the difference between the modified Widman flap and the undisplaced flap?



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CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 3

The modified Widman flap facilitates instrumentation but does not reduce pocket depth, while the undisplaced flap improves accessibility and removes the pocket wall, reducing or eliminating the pocket as an excisional procedure.



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 4

How does the apically displaced flap technique function in pocket reduction?

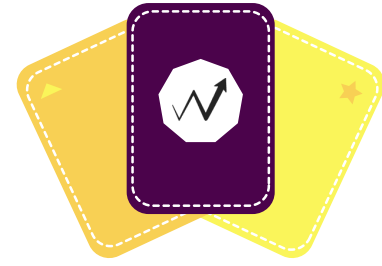


**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 4

It improves accessibility and eliminates the pocket by repositioning the soft tissue wall apically, preserving or increasing the width of attached gingiva by shifting the mucogingival junction and muscle attachments apically.



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 5

What is the purpose of regenerative periodontal surgery compared to conventional flap surgery?



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CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 5

Regenerative surgery aims to promote the regeneration of lost periodontal tissues—cementum, periodontal ligament, and alveolar bone—rather than just healing with a long junctional epithelium as in conventional surgery.

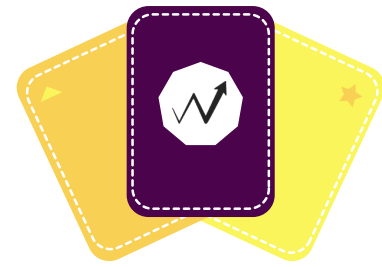


**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 6

**What is Guided Periodontal
Tissue Regeneration (GPTR)
and how does it work?**



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 6

GPTR uses membranes (resorbable or non-resorbable) to prevent rapid epithelial cell growth into surgical defects, creating a protected space for slower-growing tissues such as bone and periodontal ligament to regenerate.



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 7

What flap designs are preferred for reconstructive periodontal surgery and why?



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 7

The papilla preservation flap is preferred because it retains the entire papilla and covers the graft materials. If interdental space is too narrow, a conventional flap with only crevicular incisions is used.



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 8

What is the goal of crown lengthening surgery and what considerations determine whether bone removal is necessary?

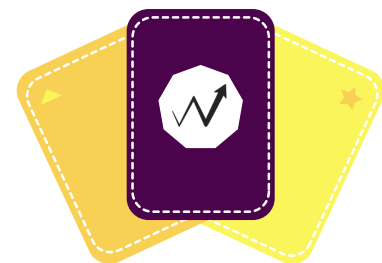


**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 8

Crown lengthening increases clinical crown height for aesthetics or restorative access. If soft tissue removal alone does not maintain crown exposure due to gingival rebound dictated by underlying bone, bone removal and raising a flap are necessary.



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 9

What is the primary indication for mucogingival surgery to manage gingival recession?

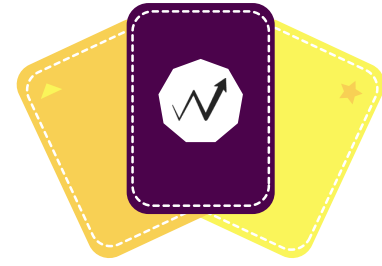


**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 9

The main indication is aesthetic improvement, though recession may also cause sensitivity and root caries; surgical root coverage is generally considered for Miller Class I and II recession defects in healthy patients.



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Question 10

What are the three biological potentials of bone graft materials used in periodontal therapy?



**WINSPERT
CUE CARDS**

**PERIO GRAFTS, FLAPS,
SURGICAL PERIO**

Answer 10

Bone grafts can be osteogenic (forming new bone by cells in the graft), osteoinductive (inducing neighboring cells to become bone-forming osteoblasts), or osteoconductive (providing a scaffold that supports new bone growth from outside cells).

PERIODONTICS

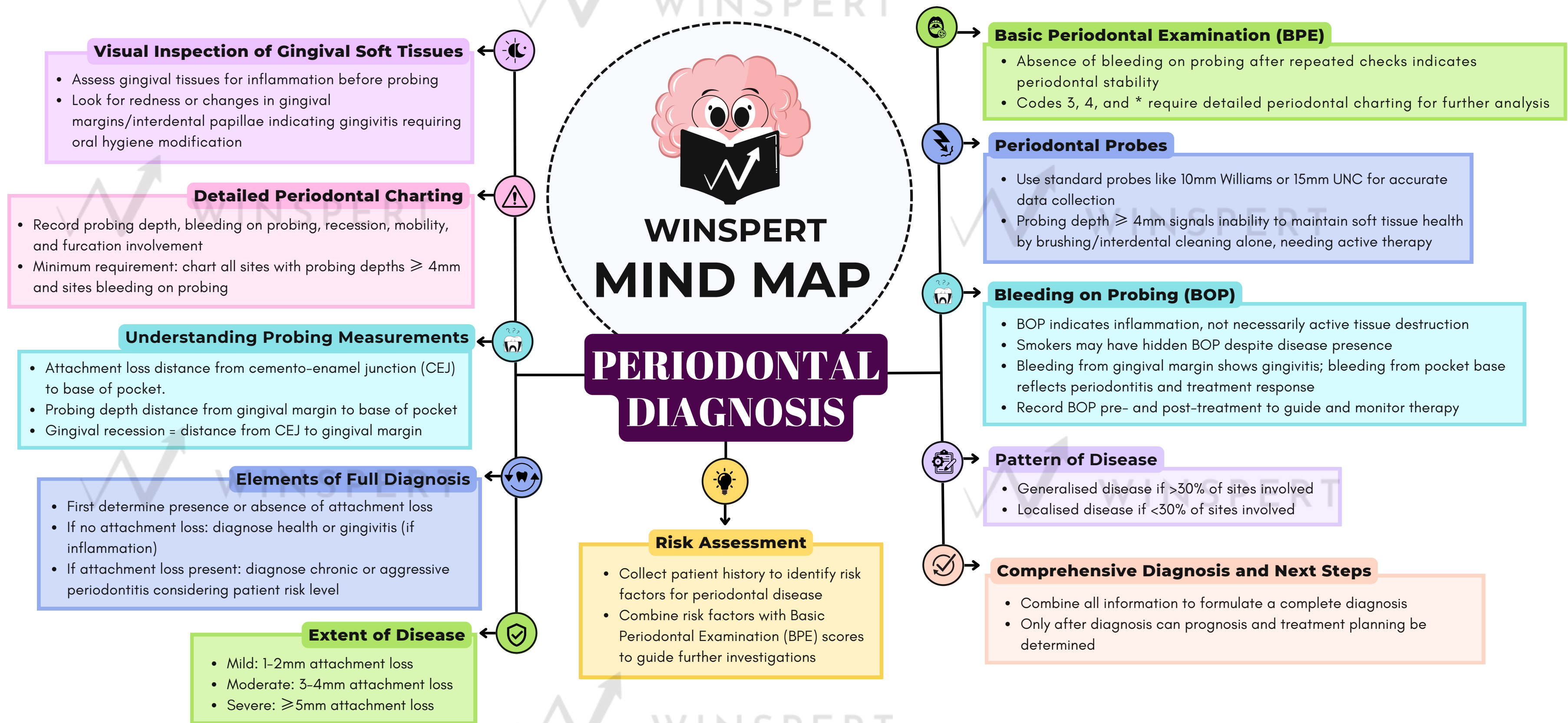
PERIODONTAL DIAGNOSIS



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA



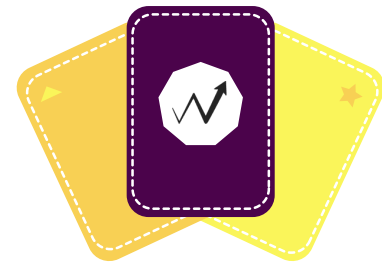


**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 1

What is the initial step in periodontal risk assessment during patient history taking?

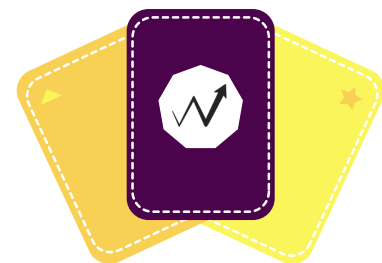


**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 1

Collecting information about risk factors for periodontal disease during the history taking phase is the initial step in periodontal risk assessment.



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 2

**What does redness or change
in contour of gingival margins
or interdental papillae
indicate?**

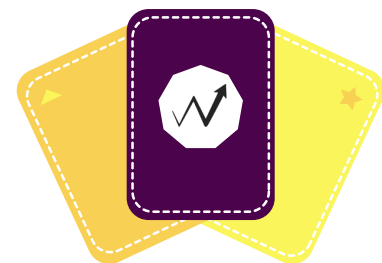


**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 2

Redness or changes in contour of the gingival margins or interdental papillae indicate gingivitis and a need for oral hygiene modification.



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 3

What is the best indicator of periodontal stability during repeated examinations?

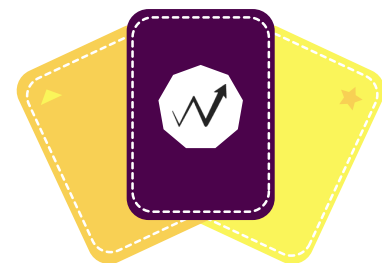


**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 3

The absence of bleeding on probing (BOP) over repeated examinations is the best indicator of periodontal stability currently available.



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 4

Which BPE codes require further detailed periodontal charting?



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 4

BPE codes 3, 4, and * require further investigation and detailed periodontal charting.



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 5

What measurements should be recorded during detailed periodontal charting?



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CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 5

Measurements such as probing depth, bleeding on probing, recession, mobility, and furcation involvement should be recorded, with a minimum requirement to record all sites with probing depth $\geq 4\text{mm}$ and any bleeding on probing.



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 6

Why are probing depths of 4mm or more significant in periodontal assessment?



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CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 6

Probing depths of 4mm or more are considered too deep to be controlled by tooth brushing and interdental cleaning alone, indicating a need for active periodontal therapy.



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 7

**What two main questions
does a periodontal probe
answer during assessment?**



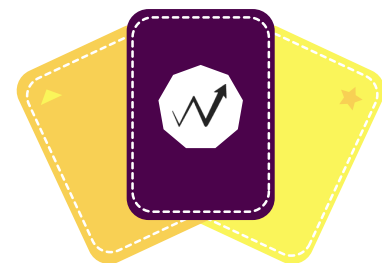
**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 7

A periodontal probe answers:

- 1. Where is the base of the gingival crevice? (attachment loss and probing depth)**
- 2. Does the tissue bleed on probing (BOP), indicating inflammation.**

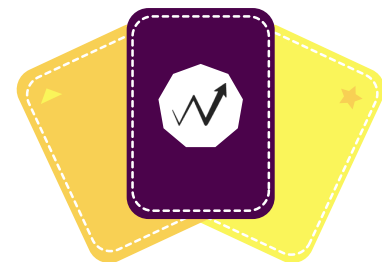


**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 8

What does bleeding on probing (BOP) signify in periodontal evaluation?

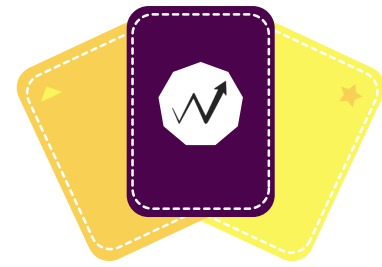


**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 8

Bleeding on probing is a measure of inflammation; bleeding from the gingival margin indicates gingivitis, while bleeding from the base of the pocket indicates periodontitis and helps guide treatment.



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 9

How is the distinction made between localized and generalized periodontal disease based on affected sites?

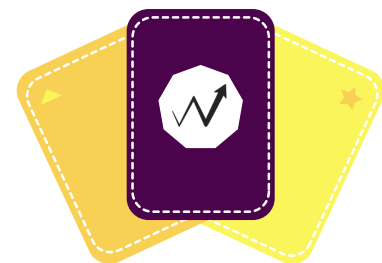


**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 9

If more than 30% of sites are involved, the disease is classified as generalized; if less than 30% of sites are involved, it is classified as localized periodontal disease.



**WINSPERT
CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Question 10

How is the extent of periodontal disease classified based on attachment loss?



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CUE CARDS**

**PERIODONTAL
DIAGNOSIS**

Answer 10

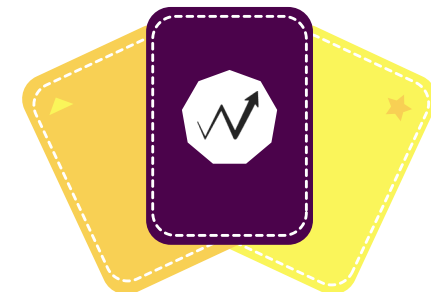
The extent of disease is classified as mild (1–2mm attachment loss), moderate (3–4mm), or severe (≥ 5 mm) depending on the amount of attachment loss present.

PERIODONTICS

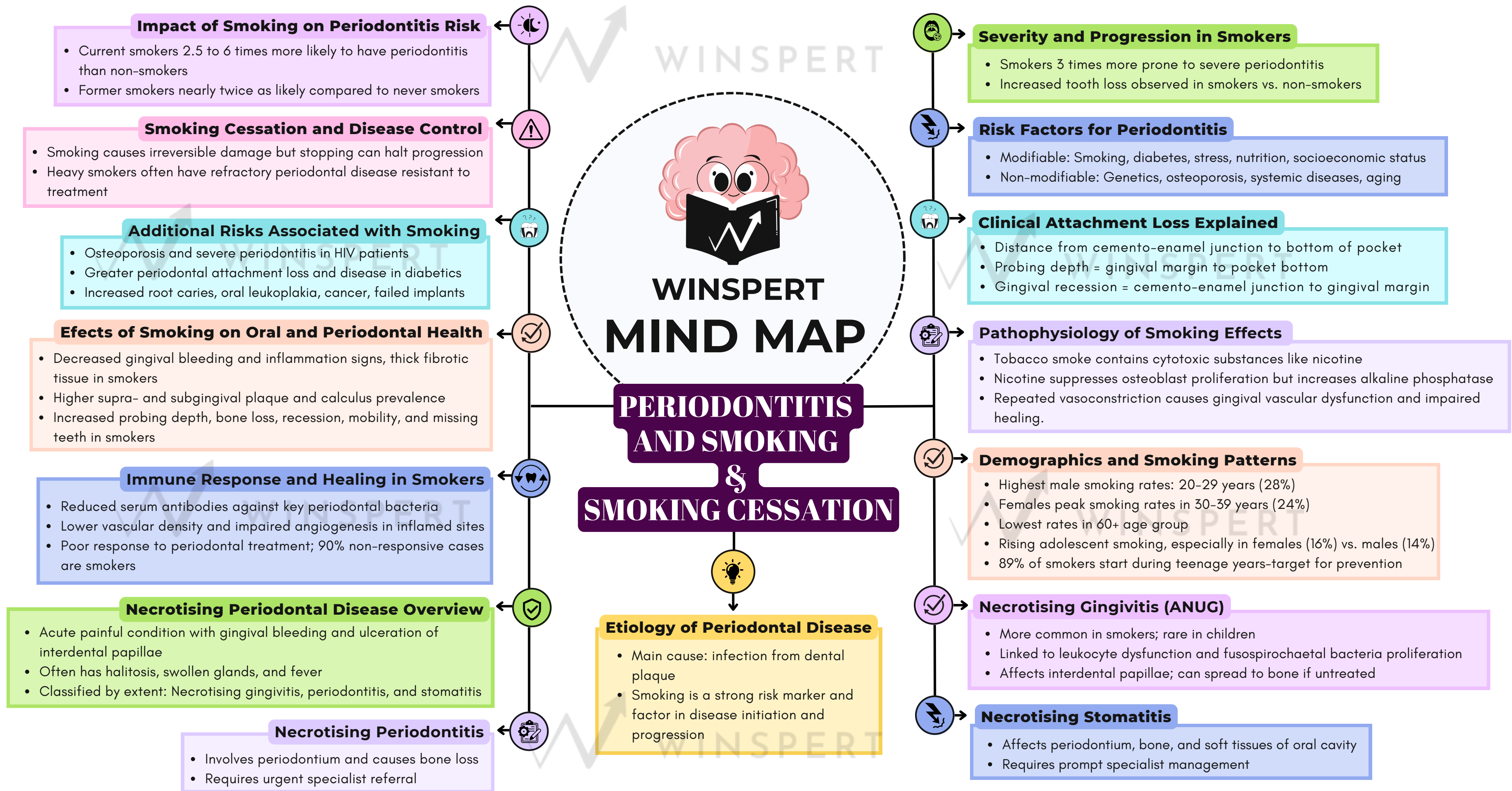
PERIODONTITIS AND SMOKING AND SMOKING CESSATION

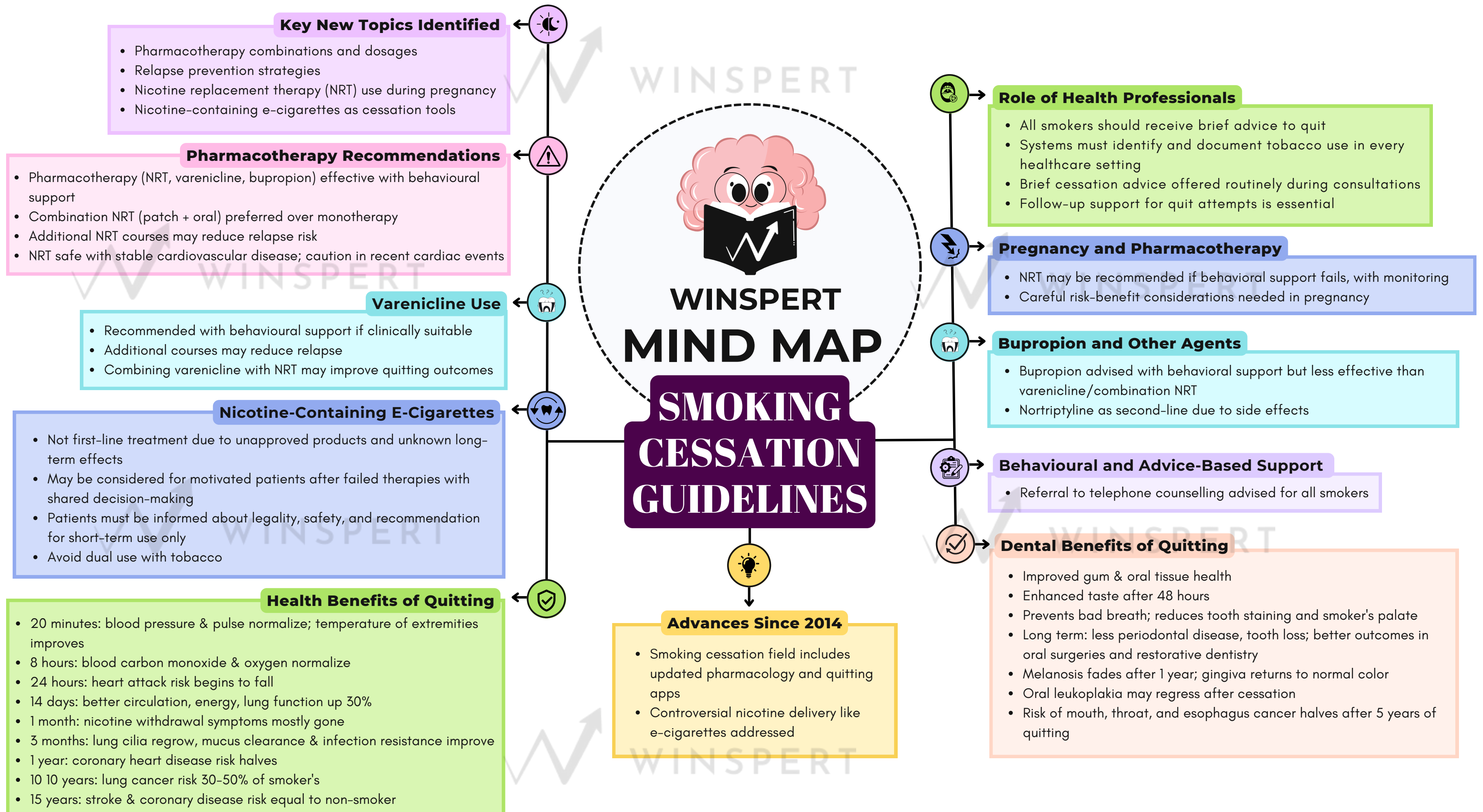


MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 1

What is the main etiologic factor causing the initiation and progression of periodontal disease?

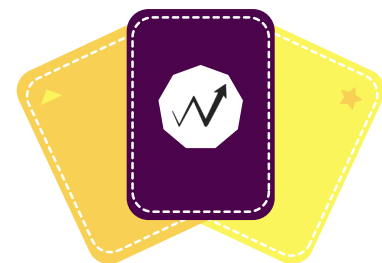


**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 1

The main etiologic factor is the infection produced by dental plaque.



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CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 2

How does smoking influence the risk of developing periodontitis compared to non-smokers?



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 2

Current smokers are 2.5 to 6 times more likely to have periodontitis than non-smokers, and former smokers are almost twice as likely to have periodontitis compared to people who have never smoked.



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 3

What are some modifiable risk factors for periodontitis?



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 3

Modifiable risk factors include smoking, diabetes mellitus, socio-economic status, psychological factors, stress, and nutrition.



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 4

Define clinical attachment loss in periodontal disease.

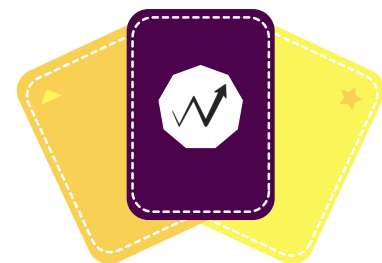


**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 4

Clinical attachment loss is the distance from the cemento-enamel junction to the bottom of the periodontal pocket.



**WINSPERT
CUE CARDS**

**PERIODONTITIS AND
SMOKING AND SMOKING
CESSATION**

Question 5

**Describe the effects of
smoking on gingival bleeding
and tissue appearance.**

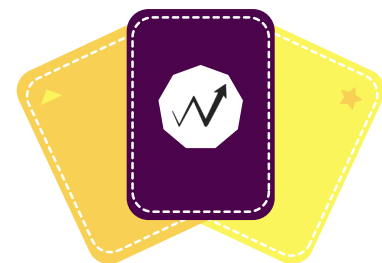


**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 5

In current cigarette smokers, gingival bleeding and all signs of gingival inflammation are considerably less, and gingival tissue has a thickened and fibrotic appearance compared to non-smokers.



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 6

What impact does smoking have on the immune response and wound healing in periodontal disease?



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CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 6

Smoking causes deficient host immune function, reduces vascular density and angiogenesis in inflamed sites, impairs inflammatory response, and compromises wound healing and revascularisation of bone and soft tissues.



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 7

**What is necrotising
periodontal disease, and how
is it characterized?**

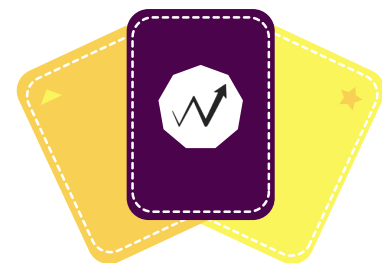


**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 7

Necrotising periodontal disease is an acute painful condition featuring gingival bleeding, necrosis or ulceration of interdental papillae often covered with a greyish pseudomembrane, halitosis, and may be associated with swollen glands (lymphadenopathy) and fever.



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 8

**What are some key
recommendations for health
professionals regarding
smoking cessation?**



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 8

All people who smoke should be offered brief advice to quit, tobacco use should be identified and documented in every practice, routine brief smoking cessation advice and follow-up should be offered, and pharmacotherapy combined with behavioral support should be recommended when appropriate.



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 9

**What are the health benefits of
quitting smoking within the first
1 year?**



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 9

Within 20 minutes, blood pressure and pulse return to normal; within 24 hours, heart attack risk starts to fall; in 14 days, circulation and lung function improve; in 3 months, lung cilia regrow; and after 1 year, the risk of coronary heart disease is half that of a smoker.

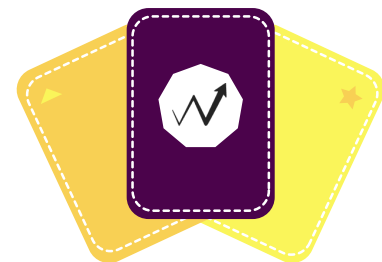


**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Question 10

List some dental benefits of quitting smoking.



**WINSPERT
CUE CARDS**

PERIODONTITIS AND SMOKING AND SMOKING CESSATION

Answer 10

Improved gingival and oral tissue health, improved taste after 48 hours, prevention of bad breath, minimized tooth staining, reversal of smokers' palate, reduced risk of periodontal disease and tooth loss, and better treatment outcomes for oral surgery, periodontics, implants, and restorative dentistry.