The multidisciplinary management of Drug Induced Gingival Overgrowth

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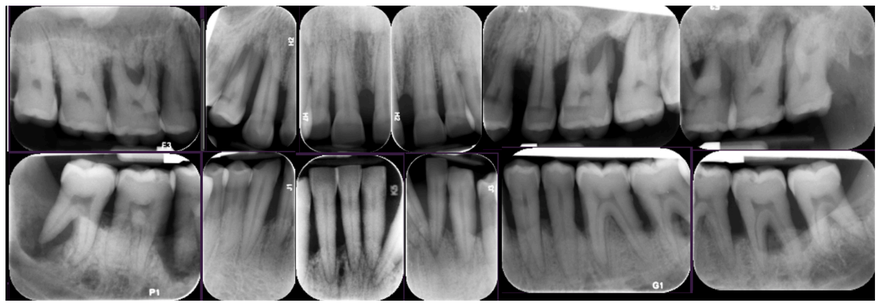
A 59 Year Old Patient attended with complaints of sore gums and poor aesthetics. He had felt as though his teeth had drifted rapidly over the previous 18 months. His hopes were to stabilise any gum disease that was present and to improve his appearance when smiling.

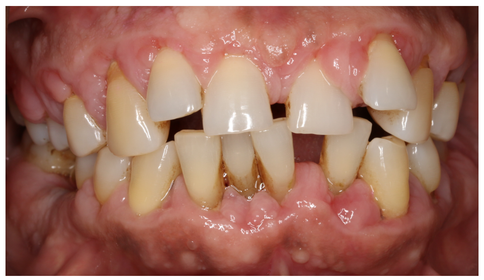
The patient was a smoker of 5 cigarettes a day and had been a smoker for over 40 years. He had poorly controlled hypertension for which he had recently been prescribed Amlodopine. He was also informed that a recent blood test indicated that he had Type II diabetes mellitus. He had yet to follow this up with his doctor.

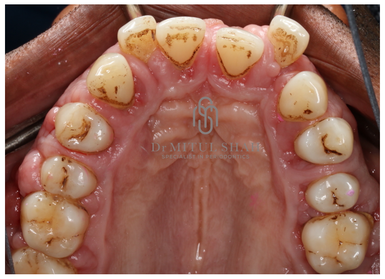
Clinical examination revealed overt signs of severe gingival overgrowth. Generalised pocketing of 6-15mm was detected throughout the dentition. His bleeding score was 96%.

Following clinical and radiographic examination the following diagnoses were made:

•Generalised Periodontitis Stage IV Grade C- Currently unstable, risk factors: cigarette smoking.
•Generalised Drug Induced Gingival Overgrowth.
•Chronic Periapical Periodontitis UR4, LR8, LR6 and UL7.



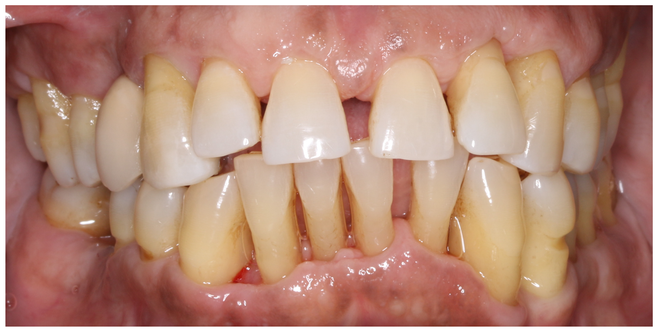


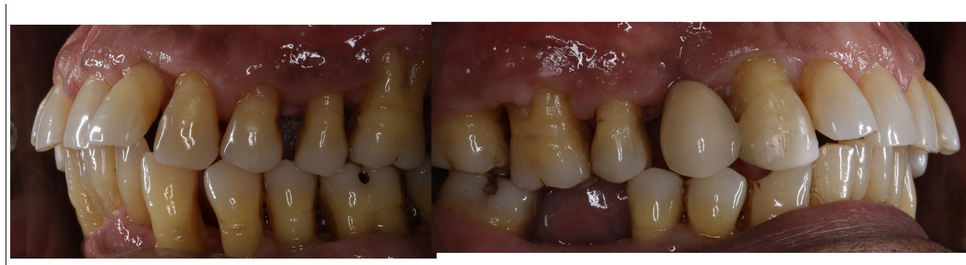


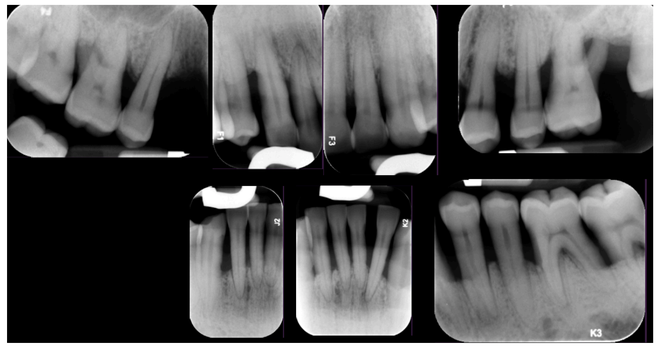
Initial management involved collaboration with medical professionals including the patients GP and Diabetic nurse. The patient was informed of the bidirectional relationship between diabetes and periodontitis and advised to make lifestyle changes alongside commencing 500mg Metformin OD.

His GP made arrangements to cease the use of Amlodopine and prescribed Verapamil hydrochloride. The patient also enrolled onto a smoking cessation programme.

Periodontal management comprised of:
•Oral Hygiene Instruction
•Non-Surgical Periodontal Therapy
•The extraction of the UR4, LR8, LR6 and UL7.
•Periodontal Surgery – open flap debridement with osseous recontouring.
•3-monthly supportive periodontal therapy recalls
•The replacement of the UR4 with an adhesive cantilever bridge.







Post treatment examination shows no probing pocket depths above 4mm and a bleeding score <10%. These results have been maintained for the 12 months following the completion of 'active' periodontal therapy. The patient has been compliant with supportive periodontal therapy appointments.

The appearance of the gingival overgrowth has markedly improved. One can also observe the changed tooth positions in relation to the baseline photographs.

The patient has made significant changes to his lifestyle, having lost 6kg of weight through a combination of diet and regular exercise. His most recent HbA1c was 48mmol/mol (6.5%). He also has successfully stopped smoking for the duration of his periodontal therapy.

I feel this case demonstrates the profound impact medical collaboration and high quality periodontal therapy can have in the management of stage IV periodontitis in a patient with multiple complicating factors.

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