Where does the need for this guideline come from?

- Implementation of the new classification of periodontitis should facilitate the use of appropriate preventive and therapeutic interventions, depending on the stage and grade of the disease. The application of this S3-level clinical practice guideline will allow a homogeneous and evidence-based approach to the management of stage I–III periodontitis.

What do patients need to know?

- An essential prerequisite to therapy is to inform the patient of the diagnosis, including causes of the condition, risk factors, treatment alternatives and expected risks and benefits including explanations regarding consequences of refused treatment.
- This discussion should be followed by agreement on a personalized care plan.
- The plan might need to be modified during the treatment journey, depending on patient preferences, clinical findings and changes to overall health.

How do we interpret these infographics?

- **Blue colour:** Recommendations in favor of a particular strategy of treatment or specific procedure.
- **Orange colour:** Open recommendation in which the clinician is responsible for the final choice of a particular strategy of treatment or specific procedure based on specific patient characteristics.
- **Red colour:** Recommendations against a particular strategy of treatment or specific procedure.

### TABLE

<table>
<thead>
<tr>
<th>Grade of recommendation grade&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Description</th>
<th>Syntax</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Strong recommendation</td>
<td>We recommend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We recommend not to</td>
</tr>
<tr>
<td>B</td>
<td>Recommendation</td>
<td>We suggest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We suggest not to</td>
</tr>
<tr>
<td>O</td>
<td>Open recommendation</td>
<td>May be considered</td>
</tr>
</tbody>
</table>

<sup>a</sup> If the group felt that evidence was not clear enough to support a recommendation, statements were formulated, including the need (or not) of additional research.
Aim: guiding behaviour change by motivating the patient to undertake:

- Successful removal of supragingival dental biofilm.
- Risk factor control.

It should be implemented in all periodontitis patients, irrespective of the stage of their disease.

It should be frequently re-evaluated in order to:

- Continue to build motivation and adherence, or explore other alternatives to overcome the barriers.
- Develop skills in dental biofilm removal and modify as required.
- Allow for the appropriate response of the ensuing steps of therapy.

This document is a graphic adaptation of the actual clinical practice guidelines and the reader is referred for the correct explanation to the original article: “Treatment of stage I-III periodontitis - The EFP S3-level clinical guideline” by Sanz and coworkers, J Clin Periodontology 2020.


**Patient supragingival dental biofilm control**

<table>
<thead>
<tr>
<th>Recommended interventions</th>
<th>Recommended</th>
<th>Suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral hygiene practices are crucial throughout all steps of treatment and achieved through patient engagement in behavioural changes (see specific recommendations in the section ‘Supportive periodontal care’).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Motivational interviewing or cognitive behavioural therapy have not shown a significant impact.**

**Professional supragingival dental biofilm control**

<table>
<thead>
<tr>
<th>Recommended interventions</th>
<th>Recommended</th>
<th>Suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional mechanical plaque removal (PMPR) and control of plaque retentive factors is a fundamental part of the first step of therapy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Risk factor control**

<table>
<thead>
<tr>
<th>Recommended interventions</th>
<th>Recommended</th>
<th>Suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of risk factors is recommended as part of the first step of treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco smoking cessation interventions are recommended as part of the first step of treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes control interventions are necessary.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Unclear**

- It is not known if increasing the physical activity has an impact.
- It is not known if reducing weight through dietary and lifestyle has an impact.
**STEP 2**

**Aim:**
- Controlling (reducing/eliminating) the subgingival biofilm and calculus (subgingival instrumentation) with possible removal of root surface (cementum).
- Subgingival instrumentation may be supplemented with the following adjunctive interventions: physical or chemical agents, host-modulating agents (local/systemic), topical antimicrobials, subgingival locally administered or systemic antimicrobials.
- It should be implemented in all periodontitis patients, irrespective of the stage of their disease and it should be re-evaluated after an adequate healing period.

Subgingival periodontal instrumentation can be performed with either traditional quadrant-wise or full mouth delivery within 24 hours.

**Recommended interventions**

- Use of adjunctive physical agents to subgingival instrumentation
- Use of adjunctive antiseptics/antibiotics (local or systemic) to subgingival instrumentation
- Use of adjunctive host-modulating agents (local or systemic) to subgingival instrumentation
- Use of prosthetic care, orthodontic care, endodontic care

**Endpoints:**
- No periodontal pockets ≥ 5 mm with bleeding on probing.
- No deep pockets [≥ 6 mm].
- If these endpoints are achieved, the patient should join a SPC program.

---

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---

**Recommended interventions**

- Subgingival periodontal instrumentation is recommended to treat chronic periodontal disease with medical and/or surgical management.
- Subgingival instrumentation is performed with either hand or powered (sonic/ultrasonic) instruments, either alone or in combination.

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**Use of adjunctive physical agents to subgingival instrumentation**

- Not recommended
- **Not recommended**
- **Not recommended**
- **Not recommended**

---

**Use of adjunctive antiseptics/antibiotics (local or systemic) to subgingival instrumentation**

- Not recommended
- **Not recommended**
- **Not recommended**
- **Not recommended**

---

**Use of adjunctive host-modulating agents (local or systemic) to subgingival instrumentation**

- Not recommended
- **Not recommended**
- **Not recommended**
- **Not recommended**

---

**Open recommendation**

Chlorhexidine mouth rinses for a limited period of time may be considered as adjuncts to subgingival instrumentation.

Locally administered sustained-release chlorhexidine may be considered as an adjunct to subgingival instrumentation.

Specific locally administered sustained-release antibiotics may be considered as an adjunct to subgingival instrumentation.

---

**Re-evaluation after step 2**

Endpoints:
- All perimplant pockets ≤ 3 mm after finishing treatment.
- No new or deep pockets (≥ 6 mm).
STEP 3

Aim: Treating those sites non-responding adequately to the second step of therapy with the purpose of getting access to deep pocket sites, or aiming at regenerating or resecting those lesions, that add complexity in the management of periodontitis (infrabony and furcation lesions).

If periodontal pockets > 4 mm with bleeding on probing and/or deep pockets [≥ 6 mm] are still present at re-evaluation, different options for step 3 can be considered:

- Repeated subgingival instrumentation with or without adjunctive therapies.
- Access flap periodontal surgery.
- Resective periodontal surgery.
- Regenerative periodontal surgery.

General aspects of step 3

As a minimum requirement, repeated subgingival instrumentation, with or without access flap of the area, in the context of high-quality step 1 and 2 treatment, and a frequent program of supportive periodontal care including subgingival instrumentation, are recommended.

Surgery should be performed by dentists with additional specific training or by specialists.

In presence of moderately deep residual pockets (4-5 mm), non-surgical subgingival instrumentation should be repeated.

Access and resective surgery

Different flap design can be used.

In presence of deep residual pockets (PPD ≥ 6 mm) access flap surgery should be performed.

Resective periodontal surgery is recommended but increase of gingival recession is possible.

Management of intrabony defects

Teeth with residual deep pockets associated with intrabony defects 3 mm or deeper should be treated with periodontal regenerative surgery.

When using regenerative barrier membranes or other periodontal regenerative interventions, it is recommended to perform subgingival instrumentation as well.

Periodontal regenerative surgery should be performed with the use of a barrier membrane.

Papilla preservation flaps should be used.

Management of furcation lesions

In class III furcation defects and maxillary interdental class II or multiple class II defects, nonsurgical instrumentation, open flap debridement, tunneling, root separation or root resection may be considered.

In class II furcation on mandibular teeth and class II buccal furcation on maxillary teeth should be treated with periodontal regenerative surgery.

Regeneration of furcation can be performed with enamel matrix derivative alone or bone-derived graft with or without resorbable membranes.

Periodontal therapy is recommended in molars with class II and III furcation involvement and residual pockets.

Furcation involvement is no reason for extraction.

Re-evaluation after step 3

Endpoints:

- No periodontal pockets ≥ 5 mm with bleeding on probing.
- No deep pockets [≥ 6 mm].

If these endpoints are achieved, the patient should join a SPC program.

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Recommended interventions

Suggested interventions

Not recommended

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The use of adjunctive antiseptics may be considered in periodontitis patients in support of periodontal care in helping to control gingival inflammation, in specific cases.

Recommended

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STEP 4: Supportive periodontal care (SPC)

Aim: Preventing periodontitis recurrence/progression after successful completion of active treatment. It must be performed in all patients, regarding their condition of being at high risk for periodontitis recurrence/progression.

This step comprises specifically designed supportive periodontal care (SPC), consisting of a combination of preventive and therapeutic interventions rendered at different intervals:

· No presence of pockets > 4 mm with bleeding on probing.
· No presence of deep periodontal pockets [≥ 6 mm].

Professional care

Adherence to supportive periodontal care is crucial for long-term periodontal stability and potential further improvements in periodontal status.

Recommended

Supportive periodontal care visits should be scheduled at intervals of 3 to a maximum of 12 months, and ought to be tailored according to patient’s risk profile and periodontal conditions after active therapy.

Recommended

Repeated individually tailored instructions in mechanical oral hygiene, including interdental cleaning, in order to control inflammation and avoid potential damage for patients in supportive periodontal care.

Supragingival biofilm control by the patient

Taking into account patients’ needs and preferences when choosing a toothbrush and interdental brush design.

Recommended

Tooth brushing should be supplemented by the use of interdental brushes.

Recommended

In interdental areas not reachable by toothbrushes, supplementing tooth brushing with the use of other interdental cleaning devices in periodontal maintenance patients is suggested.

Suggested

Flossing is not suggested as a first choice of interdental cleaning in periodontal maintenance patients.

Powered toothbrush may be considered as an alternative to manual tooth brushing.

Risk factor control

Tobacco smoking cessation interventions need to be implemented.

Recommended

Diabetes control interventions are necessary.

Suggested

It is not known if increasing the physical activity and reducing weight through dietary and lifestyle modification has an impact in patients in supportive periodontal care.

Unclear

The use of adjunctive methods (sub-antimicrobial dosedoxycycline, photodynamic therapy) to professional mechanical plaque removal (PMPR) in supportive periodontal care is not suggested.

NOT suggested

The replacement of conventional professional mechanical plaque removal (PMPR) with the use of alternative methods (Er: YAG laser treatment) in supportive periodontal care is not suggested.

NOT suggested

Performing routine professional mechanical plaque removal (PMPR), as a part of supportive periodontal care, to limit the rate of tooth loss and provide periodontal stability/improvement.

Suggested

Adjunctive measures for gingival inflammation

If an antiseptic dentifrice formulation is going to be adjunctively used, products containing chlorhexidine, triclosan-copolymer and stannous fluoride-sodium hexametaphosphate are suggested.

Suggested

If an antiseptic mouth rinse formulation is going to be adjunctively used, products containing chlorhexidine, essential oils and cetylpyridinium chloride are suggested.

Suggested

It is unknown if other adjunctive agents (such as probiotics, prebiotics, anti-inflammatory agents, antioxidant micronutrients) are effective in controlling gingival inflammation in patients in supportive periodontal care.

Unclear