

Periodontal Management strategies for the future in Korea

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I. Introduction

There has been much progress made in the understanding of periodontal disease from 1960s to 1990s. We are in a phenomenal period in periodontics in which we have the opportunity to integrate the best of past and current philosophies, refined non-surgical approaches and advanced surgical techniques for the future.

The management strategy of periodontal disease in any community depends on the disease epidemiology and social environment for health care. Therefore, this presentation will focus on demand for and provision of periodontal care, and the present statue of periodontal management in Korea, and then discuss how to control the periodontal disease efficiently in the future.

II. Demand for periodontal management

1. Epidemiology on periodontal disease

In Korea, epidemiological studies on

periodontal disease have been rare. However, since many clinicians and researchers recognized that epidemiological data is essential to manage the disease systematically and to establish public health plan under medical insurance policies, a few more sophisticated studies have been done, based on clinical examination and Community Periodontal Index of Treatment Need (CPITN) system.

As shown in Table 1, periodontitis appears increasingly in adult population over the age of 30. A prevalence of periodontitis from 31 to 46.7% was reported for the adult population. The prevalence of periodontal disease including gingivitis in adult population is approximately 80%

2. Demand for periodontal care

The need for periodontal care is determined by the prevalence and severity of disease in any population. Therefore, analysis of the epidemiology data for both the general and adult population will be required to evaluate

Table 1 Prevalence of periodontal diseases in Korea

Author	Population	Age	Prevalence(%)		Method
			Gingivitis	Periodontitis	
Kim, NH(1963) ¹		10-75		26.9	Radiography
KDA(1982) ²		0-65		35.1	
KDA(1989) ³	Randomized population	3-65-	29.7		CPITN
		30-65-		31.0	
Kim et al(1991) ⁴	Randomized population	15	40.1	0.2	CPITN
		35-44	52.1	17.8	
		65-74	30.0	50.2	
Medical insurance management center (1995)	Insured & dependent	40-		46.7	Screening
Kim, YJ(1995) ⁵	University faculties	23-65	42.3	37.2	Clinical exam
Medical insurance system integration organization(1996)	Gov. employees & school faculties	18-65		45.5	Screening

Table 2 Trend of population and proportion ratio by age group in Korea

age group	1975	1980	1985	1990	1993	1997	2000
0-9	25.6	22.3	19.1	16.6	15.0	14.5	14.2
10-19	25.5	23.5	21.8	19.7	18.5	16.4	15.0
20-29	15.9	18.8	20.5	20.0	20.6	18.9	18.8
30-39	12.7	12.6	13.8	16.6	18.3	18.3	18.0
40-49	9.1	10.3	10.8	10.9	11.1	13.1	14.7
50-59	6.0	6.5	7.2	8.5	9.0	9.2	9.5
60-64	2.0	2.2	2.5	2.7	3.0	3.6	3.9
65-	3.5	3.8	4.3	5.0	5.1	6.0	6.9
total	35,280,725	38,123,775	40,805,744	42,869,283	44,056,087	45,642,189	46,789,374
30-	11,748,481	13,495,816	15,751,017	18,733,876	20,486,040	24,330,000	25,266,261
40-	7,268,000	8,693,000	10,120,000	11,617,553	12,423,792	14,559,798	16,376,150
patients	3,912,000	4,500,000	5,250,000	6,200,000	6,829,000	8,110,000	8,422,000

The No. of periodontally diseased patients is roughly estimated as 1/3 of age>30. (Annals by the Ministry of Health and Welfare in Korea, 1995)

the quantity of the demand for periodontal health care services.

Korean society is aging, as is apparent in Table 2. The percentage of the young population is shrinking and the percentage of

adults over the age of 30 increases from 33.3% to 50.2% during these 20 years. This indicates increase in the number of periodontally diseased patients because periodontitis usually appears since the age of

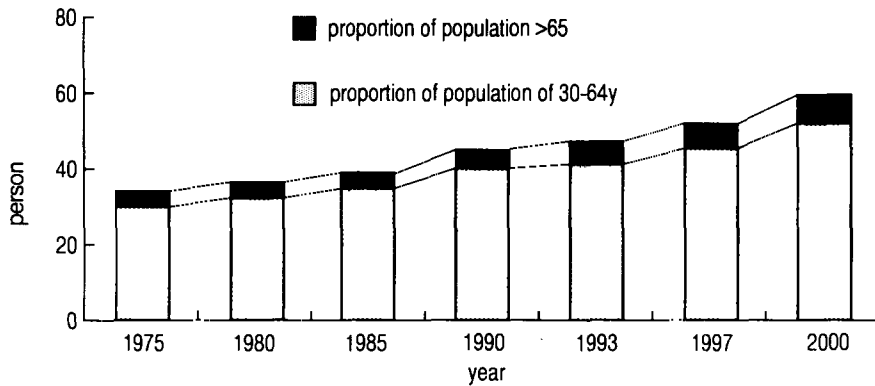


Fig 1 Trend of the population and proportion ratio in Korea.

population as 1/3 of the population over the age of 30, the size of periodontally diseased population in 1997 is approximately 8,110,000. The increasing proportion of elderly over the age of 65 from 3.5 to 6.0% during this period increases the need for complex periodontal care because the periodontal disease increases in severity and prevalence with age (Table 2, Fig 1.)

An epidemiological study (1995)⁷ examined the prevalence of periodontal disease for each age group in the adult population. The proportion of periodontally healthy people was 27% in 25 to 29 year group and decreased to less than 1% in 55 to 64 year group. The

proportion of severely diseased people was 1.7% in 30 to 34 year group and increased to more than 13% in 55 to 64 year group (Table 3a).

Seventy to ninety percent of the adult population needs periodontal care for health of periodontium and the proportion needing periodontal care increases by aging (Table 3b).

If we project these proportions onto the estimated national population in 1997, we can estimate the size of the patient population needing complex periodontal care from periodontists (Table 4). In total, 3.3% of the general population (approximately 1,500,000 patients) needs complex form of treatment by

Table 3a Prevalence of periodontal disease condition according to the age group (%)

age group	periodontal health	gingival bleeding	calculus attached	shallow pocket	deep pocket
25-29	27.0	2.4	67.2	3.3	0.1
30-34	19.3	3.5	64.8	10.6	1.7
35-44	17.3	3.0	60.1	15.2	4.4
45-54	9.1	2.9	50.8	31.3	5.4
55-64	0.7	1.3	38.0	41.3	13.3
65-	2.5	0.3	23.2	40.3	12.7

(1995's report⁷, cited from Moon HS, JKDA 6:351, 1997)

Table 3b Proportion(%) in population who need periodontal care according to the age group

age group	hygiene instruction	oral prophylaxis	complex perio. treatment
25-29	73.0	70.6	0.1
30-34	80.7	77.1	1.7
35-44	82.7	79.7	4.4
45-54	90.1	87.2	5.4
55-64	93.9	92.6	13.3
65-	76.5	76.2	12.7

(1995's report⁷, cited from Moon HS, JKDA 6:351, 1997)

Table 4 Estimation of patient population needing complex periodontal care in 1997

age group (year)	proportion in total population	proportion needing complex treatment in each group	proportion of complex treatment need in whole population
25-29	9.5	0.1	0.0095
30-34	9.2	1.7	0.1564
35-44	15.7	4.4	0.6908
45-54	11.1	5.4	0.5994
55-64	8.2	13.3	1.0804
65-	6.0	12.7	0.7620
total	45,642,000		1,496,501 (3.3%)

patients) needs complex form of treatment by periodontists.

these figures for the availability of general dentists considerably better than the figure for specialized periodontal care.

III. Provision of periodontal care in Korea

1. General dentist

In Korea, the first school for dentist opened in 1922 and the School of Dentistry at Seoul National University first held lectures in 1946. Today, there are 11 dental schools producing about 760 graduates every year. Currently, This makes approximately one dentist available for 2,933 people in 1997 although the care ratio continually improves. The ratio of adult population to dentist is 1,564. However,

2. Periodontists

Postgraduate courses of Periodontics first opened from 1957 at Seoul National University. Currently, such courses are offered in 10 Dental schools and less than 5 hospitals. Thirty periodontal specialists graduate every year. However, no form of board certification is available yet. The periodontists are educationally qualified in Korea. The Korean Academy of Periodontology lists 780 practicing periodontists, which constitutes

about 5% of the total number of acting dentists.

As shown in Table 5, the adult population to periodontist ratio this year is 31,192, which is more than 10 times higher than the figure for general dentists. The estimated number of periodontal patients per periodontist is 10,397 and it is also 3 times higher than the population to dentist ratio. Let's assume that the average periodontist treats 200 cases of severe destructive periodontitis per year. This means that it would take more than 50 years to treat all the patients. If we consider that at least 17% of these patients may have recurrent diseases or refractory forms

(Hirschfeld & Wasserman 1978, McFall 1982), there is obviously an abundance of disease that needs treatment. This means that it is impossible for periodontist themselves to manage all the periodontally diseased patients. Therefore, periodontists need all the help they can get from the general dentists to control periodontal disease.

If the periodontal care delivery system works well, cooperation between general dentists and periodontists should allow periodontists to concentrate on the complex treatment of advanced or severe form of periodontitis. This would reduce the number of patients per periodontist from 10,400 to

Table 5 Trend of population per dentist and periodontist in Korea

Year	dentist	population /dentist	periodontist	adult population /periodontist	p. ds. patient	p. ds. pt. /periodontist	complex tx need /periodontist
1975	2,512	14,045	141	82,571	3,881,000	27,524	5,091
1980	3,549	10,742	204	66,156	4,500,000	22,059	4,080
1985	5,375	7,592	310	50,810	5,250,000	16,936	3,133
1990	9,606	4,462	478	39,192	6,240,000	13,054	2,419
1993	12,167	3,354	570	35,940	6,830,000	11,982	2,216
1997	15,559	2,933	780	31,192	8,110,000	10,397	1,923
2000	18,110	2,583	880	28,711	8,422,000	9,570	1,750

abbr) p. ds. pt.= periodontally diseased patients

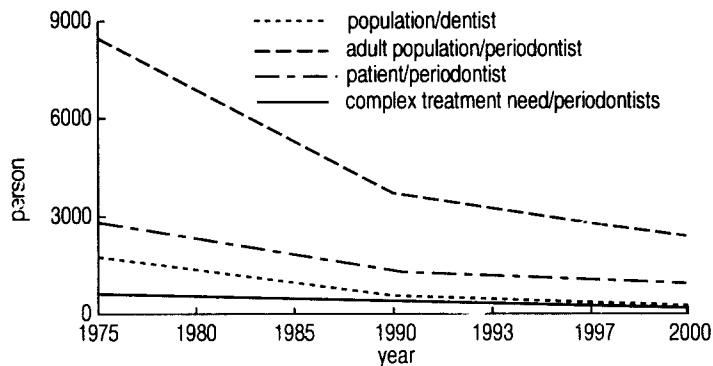


Fig 2 Trend of population per dentist and periodontist in Korea

1,920 in 1997. Assuming again that the average periodontist treats 200 cases of severe destructive periodontitis per year, it would take us less than 10 years to treat all the severely diseased patients.

Same calculation can be also applied to projection for the year 2000. Increase in the number of periodontists would result in decreases in the number of patients per periodontist to 9,570 and the number of patients per dentists to 465. Strategies to manage these large patient population should include general dentists as secondary service providers and public dentists in the delivery of primary preventive periodontal care.

3. Public dentists at the community level

The importance of the work of public dentist at the community level cannot be overemphasized. Since 1984, young dentists fresh from college have engaged in 3 years of community service instead of military service, delivering community oral health education and other prevention oriented service. Approximately 1,300 public dentists and 1,200 dental hygienists are currently serving.

To further encourage preventive dental care, the Korean Ministry of Health and Welfare has established the following ten new policies for oral health promotion(1997)¹⁰:

1. National Survey for Oral Health Status and Database construction
2. Systematization of Oral screening at Community level
3. Nation-wide water fluoridation
4. Extension of fluoride mouth wash in non-fluoridated region
5. Extension of fissure sealant application

6. National advertisement for oral health education
7. Oral health enhancement for infants and mothers
8. Oral health enhancement for preschool children
9. Oral health enhancement for the vulnerable population
10. Establishment of an Oral health administration

IV. Past and Present status of periodontal management in Korea

1. Current status of periodontal management in Korea

We summarize here what we have done the past 30 years. Prior to 1965, dentists knew so very little about periodontics that all we ever did was scaling and root planing. The next era from 1965 to 1980 was the golden era of periodontics in USA. It was a time when surgical pocket therapy became very important and mucogingival procedures were taught and practiced by dentists and periodontists. However, the general dentists began to learn their limitations and began to develop strong relationships and to work closely with periodontists in treating patients. But In Korea, the referral was rarely made. Next era, the so-called non-surgical era of periodontics was ushered in 1980 by Paul Keyes. This concept had been explored and advocated across the country in USA and Korea, too. Since 1985, the new concept for guided tissue regeneration(GTR) was developed and introduced in Korea. Most periodontists have been interested in the GTR

procedure since around 1990, spurring much interest in researches. Some periodontists have also become involved in osseointegrated implant around 1991 and the importance of soft tissue management has been advocated for the long-term maintenance of implants.

Public awareness has increased in recent years. This greater public awareness and increased expectations among patients have led general dentist to make more referrals and better diagnosis. Some general dentists regularly refer patients to periodontists for GTR, implant surgery and periodontal plastic surgery.

Although the prevalence of periodontitis and the demand for periodontal care is as high as mentioned earlier, the proportion of periodontally managed cases reported to the Medical Insurance Management Center's was only 4.69% of the cases treated in dental clinics and hospital in 1995. Similarly, Yun et al(1989)¹² reported that periodontal care only comprises in 6.6% of dental care service delivery, of which periodontal therapy or surgery on periodontal disease makes up 3.5%. how can these low figures be explained?

According to studies, dentists and even periodontists are reluctant to provide sufficient periodontal care to the patients because of the current situation of medical insurance system which controls and dose surveillance the periodontal care. 20 years passed since the government guided medical insurance system had started. There are so many problems to prohibit periodontal patients from receiving optimized care by dentists.

Ryu(1996)¹³ reported on the state of periodontal management under current Korean medical insurance system, that 97% of

dentists recognized the vital importance of periodontal care. Although the proportion of total dental care taken up by periodontal care under current insurance policies is 4.69%, data from university dental hospital indicate that periodontal care comprises 31.0% of dental care done. This means periodontal care is mainly performed in University Dental hospital and rarely done in local dental clinic. The scope of periodontal care extends to surgery in more than 50% of periodontists and to subgingival curettage in 3/4 of general dentists. According to this study, even though the periodontists are doing more than general dentists, they are reluctant to provide sufficient periodontal care to the patients because of current medical insurance system which controls and supervise the periodontal care.

The major problem is that the fee schedule for periodontal care was fixed at half the Customary, Prevailing, Reasonable(CPR) fee when the insurance system began and has remained at lower rate ever since.

The Korean Dental Association is conducting a study on Resource-Based Relative Value Scale(RBRVS) to support the need for reestablishing the fee schedule for dental care. Another problem for periodontal management under the current Medical insurance system in Korea is that surveillance is too heavy and investigation is carried out too often.

Ryu reported that 25% of dentist are active attitude toward periodontal disease and more than 50% of the answerers usually change their attitude to minimize periodontal care. He also reported that this reluctance is founded on frequent surveillance and investigation and

inadequate fee under insurance management center.

Therefore, to provide adequate treatment to periodontal patients, treatment fees and surveillance system absolutely must be optimized and.

As an effort to solve the irregularities in care under medical insurance system, the Government Organization for Medical care Reform(1997)¹⁴ has made following six suggestions for the 21st century: Effective control and management system for medical insurance, Reformation of the fee schedule under medical insurance, Internal validation for the system, Support for medical organizations, Establishment of effective control system for medical disputes, and Quality control for medical professionals graduated from foreign dental school.

Hopefully, under these reforms, the prospects for periodontal for periodontal insurance coverage will be improve in the future under improved insurance system.

V. Clinical Management for the periodontal disease

1. Prevention is the best policy in the future.

Considering the demand of periodontal management and the need to minimize patient's expenses, disease prevention and early detection is the best policy in the future also. Treatment of gingivitis prior to periodontitis and supportive maintenance therapy is important.

Besides, other preventive modalities in the future could include immunization for periodontitis

and use diagnostic technology to detect susceptible subjects risk factors such as genetic, host defense, or specific microorganisms. But these promising modalities of intervention are not yet available now, although they soon may be.

2. Role of General dentists in periodontal management

General dentists should share the responsibility for early detection and treatment of periodontal disease by diagnosing the periodontal disease and distinguishing types of patients, based on what level of periodontal therapy do they require. The patients who don't require surgery could be managed by general dentists.

For early detection and treatment, every oral examination should include an evaluation of the periodontium. However, general dentists do not consistently perform a comprehensive periodontal examination as a part of the daily practice of dentistry. In USA, a Proctor & Gamble Survey states that only 38% of dentists surveyed perform a comprehensive periodontal examination¹¹). Although no equivalent data is available in Korea, we can assume that only the periodontist in dental hospital and university dental hospital(less than 5% of dentists) regularly conduct comprehensive periodontal examinations.

For generations, periodontists have strongly advocated the comprehensive periodontal examination in an effort to promote early detection of periodontal disease. However, classic oral examination needs longer time and sophisticated probing skill and the presumed inconsistency in its use and the resultant failure in early diagnosis have been perplexing

challenges to dental professionals and especially to periodontists.

VI. Periodontal screening & recording(PSR)

In an effort to overcome that problem, Periodontal screening and recording was developed by American Academy of

Periodontology¹⁵⁾. PSR system is an adaptation of the Community Periodontal Index of Treatment Needs(CPITN), which is endorsed by the WHO and the Federation Dentaire Internationale(FDI) for periodontal screening. The ADA and the AAP recommend that PSR be conducted by dentists for all patients as an integral part of

Table 6 Scoring system of PSR and Guideline of patient management

Code	Description	Guideline for pt management
0	Colored area of probe remains completely visible in the deepest crevice in the sextant. No calculus or defective margins. Gingival tissues are healthy with no bleeding after gentle probing.	Appropriate preventive care
1	Colored area of probe remains completely visible in the deepest probing depth in the sextant. No calculus or defective margins. Bleeding after gentle probing.	Oral hygiene instruction(OHI) and appropriate therapy, including subgingival plaque removal.
2	Colored area of probe remains completely visible in the deepest probing depth in the sextant. Supra- or subgingival calculus or defective margins.	OHI and appropriate therapy, including subgingival plaque removal, plus removal of calculus and correction of plaque-retentive margins of restoration.
3	Colored area of probe remains partly visible in the deepest probing depth in the sextant.	A comprehensive periodontal examination and charting of the affected sextant to determine an appropriate treatment plan.
4	Colored area of probe completely disappears, indicating probing depth of greater than 5.5mm.	A comprehensive full mouth periodontal examination and charting to determine an appropriate treatment plan.
*	Denotes clinical abnormalities including but not limited to: · furcation invasion · mobility · mucogingival problems · recession extending to the colored are of the probe(>3.5mm)	If an abnormality exists in the presence of Code 0, 1, 2, specific notation or treatment for that condition is warranted. If an abnormality exists in the presence of Code 3 or 4, a comprehensive periodontal examination and charting is necessary to determine an appropriate treatment plan.

(adapted from PSR Training manual¹⁵⁾

oral examinations to detect gingival health and early disease and record it with a minimum of documentation, thus increasing its utilization. In Korea, this kind of screening system is very valuable.

PSR has many benefits in assessing periodontal condition: 1) it allows for early detection of periodontal disease and all sites are evaluated; 2) it is easy to perform and fast to use, taking only a few min. to perform; 3) it is cost-effective for dentist and patient; 4) it helps you simplify record keeping and track each patient's condition on an ongoing basis; 5) proper use of PRS ensures that you are evaluating your patients' periodontal status and thereby satisfies the dental-legal requirements for monitoring and record keeping; and 6) it helps motivate them to use proper preventive measures to protect their dental health.

There are some limitations. PSR is a screening system designed to detect periodontal disease, not intended to replace a comprehensive periodontal examination when indicated. It is designed primarily for use with adult patients, age 18 and older, and has limited utility in screening children and adolescents. Patients,

treated for periodontal disease and in a maintenance phase require periodic comprehensive periodontal examinations.

For screening, the dentition is divided into sextants. The probe with a ball end 0.5mm in diameter and a color coded areas extending from 3.5 to 5.5mm and a gentle probing is recommended. At least six areas in each tooth should be examined: mesiofacial, midfacial, distofacial and the corresponding lingual areas.

For each sextant with one or more teeth or implants, only the highest score is recorded. The scoring system of PSR and guidelines of patient management are shown in Table 6.

An efficient and practical approach for the diagnosis and treatment planning of patients with periodontal diseases was suggested by Kornman(1994)¹⁶, using PSR. This approach is based on the recognition that dental plaque is a necessary but not sufficient for disease and that there are multiple diseases, including gingivitis, chronic adult periodontitis, and other more aggressive forms of periodontitis, based on responsiveness to plaque-focused therapy. The efficient management of adult patients requires the earliest possible recognition of

Table 7 Differentiation between chronic adult and aggressive periodontitis

	Chronic adult periodontitis	Aggressive periodontitis
A. Presumptive diagnosis		
Complete clinical examination		
Systemic factors modifying the response	-	+
Severe destruction around multiple teeth	-	+
Destruction inconsistent with plaque and age	-	+
B. Final diagnosis		
Response after SRP+OHI		
Bleeding eliminated	+	-
Probing depth decrease >1mm	+	-

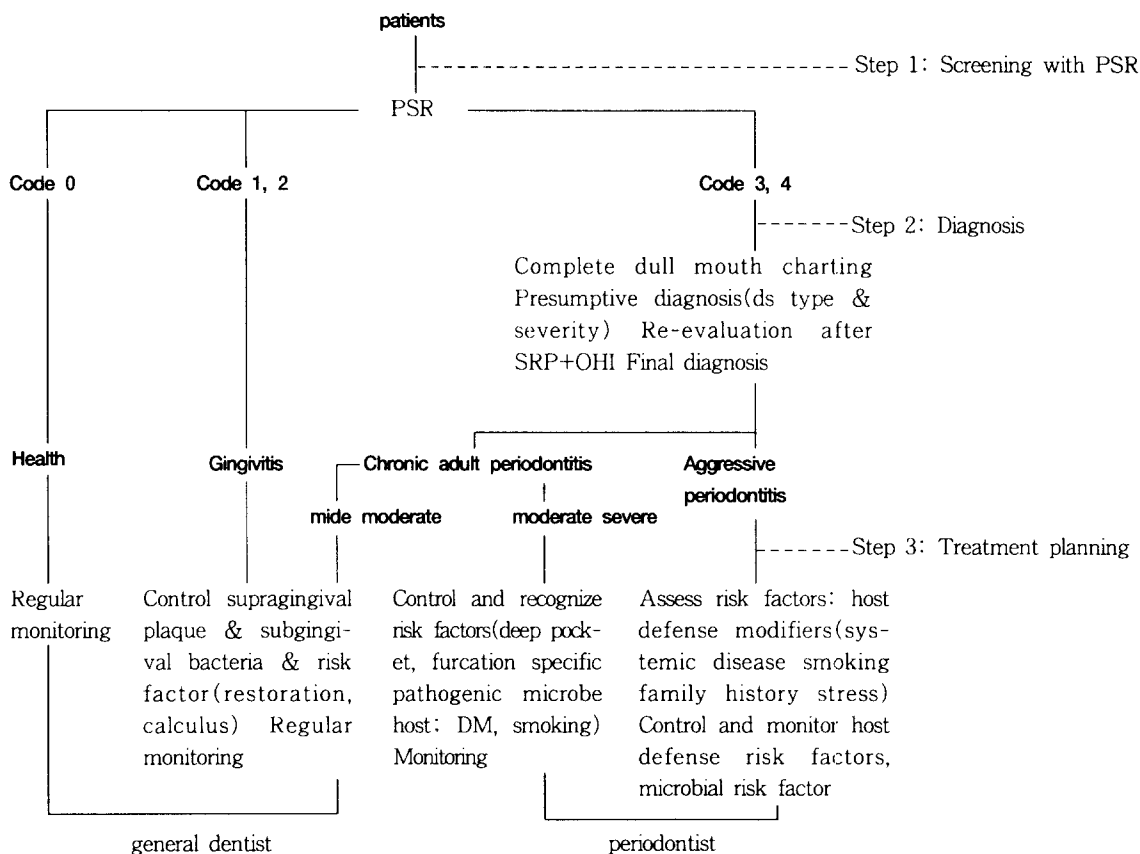


Fig 3 Efficient and practical approach on diagnosis and management of periodontal disease(suggested by Komman⁶⁾)

with different PSR scores. In step 2, for patients with PSR screening scores consistent with periodontitis, a complete periodontal charting and reevaluation to response after scaling and root planing and oral hygiene instructions is suggested to distinguish chronic adult from more aggressive forms of periodontitis (Table 7). In step 3, treatment planning for both types of periodontitis patients is done. Gingivitis and mild periodontitis are treated by “plaque is everything” concept.

Moderate to severe adult periodontitis is treated by recognizing and controlling and monitoring risk factors. Aggressive periodonti-

tis responds less predicably to plaque control and conventional therapy and has potential for very rapid bone loss and may benefit from the newer approaches to diagnostic monitoring as well as anti microbial approaches.

3. Referral system

In periodontics, one of the hallmark of good practice is the ability to customize an appropriate treatment plan for patients. According to Fether(1994)¹⁷⁾, there are three types of patients, based on the level of periodontal therapy do they required: 1) patients who

In periodontics, one of the hallmark of good practice is the ability to customize an appropriate treatment plan for patients. According to Fetner(1994)¹⁷⁾, there are three types of patients, based on the level of periodontal therapy do they required: 1) patients who don't require surgery-early periodontitis with no furcation involvement should be treated by the general practitioner who has good skill level in nonsurgical therapy; 2) patients who may require surgery; and 3) patients who will require surgery. Latter tow types of patients are referred to periodontists with the data concerning original condition diagnosis, charting, completed procedure, charting at reevaluation, plaque score, OH aids and patient motivation.

Currently, referrals are common in Korea. In my university hospital, 4.5% of all dental outpatients and almost half of the periodontal patients have been referred by general dentists. The referred patients could be managed with additional treatment by periodontists to achieve their health, functional, and esthetic goals. The choices are highly individualized and depend upon the finacial and emotional preferences of the patient as well as a complete oral and periodontal examination. Thus a full range of treatment alternatives is available for a wide spectrum of disease severity and patient circumstances.

VII. Summary

A strategy of future periodontal management in Korea consists of prevention, early detection and treatment of periodontal diseases. General dentists must cooperate with

periodontists and refer the aggressive and refractory cases to periodontists.

Improvement of periodontal care provision under medical insurance policies and use of easy periodontal examination and diagnosis system such as PSR could facilitate these processes. Additional treatment should be optimized as evidence-based approach and help the patients achieve their health, functional, and esthetic goals.

Therefore, dentists should be prepared to formulate a precise and organized treatment plan and to treat of refer the patient appropriately.

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2000년대 치주처치의 전략

전남대학교 치과대학 치주과 정현주
삼성의료원 치과부 치주과 손성희

과학기술이 발전함에 따라 치주과학 영역에서도 1960년 이후 1980년대에 걸쳐 괄목할 만한 학문적 발전이 이루어졌으며 1990년에는 이에 의거한 치주질환의 예방 및 조절방법이 개발되어 사용되고 있다. 미래의 치주처치전략은 대상 지역의 특성과 보건환경에 따라 달라지므로 여기에서는 한국내 치주치료요구도와 치주치료 담당 일반치과의와 치주전문의의 수, 처치 내용에 대해 점검하고 현재의 치주처치 추세를 검토한 후 향후의 치료전략에 대해 언급하고자 한다.

1980년도 역학조사에 의하면 전체 인구의 82%가 치주질환(치은염+치주염), 35세 성인 인구의 30-40%가량이 치주염에 이환되어 있고 15세 청소년 인구중 0.1%가 유년형치주염에 이환되고 있다. 평균 수명이 증가하면서 65세 이상의 노년층도 전인구의 6%(성인 50%), 2000년대에는 6.9%(성인 52%)로 증가하고 치아보유율도 증가하므로 치주질환 치료요구도는 상승하리라 전망된다.

현재 한국내 치주전공 과정을 거친 치과의사는 약 780인 정도이다. 1996년 류의 연구에 의하면 이들도 대부분 일반치과의 (개원의, 공중보건의 포함)로서 진료하고 있으며 의료보험하에서의 치주치료의 비중은 매우 낮다(4.66%). 포괄적 치주적 검사도 보편적이지 않고 대학병원급의 극히 일부에서만 이행되고 있는 실정이다.

향후의 치주질환이 처치전략에는 의료보험 운용시 치주적 배려와 간편한 치주검사과정을 통한 조기진단 및 조기치료, 진행기질환 및 난치성질환자의 치주전문의로의 의뢰가 포함될 것이며 각 환자에게는 개별적이며 임상시험 결과에 근거하는 evidence-based approach에 의한 치료선정 과정이 활용되리라 전망한다.

-Abstract-

In periodontics, much progress was made in the understanding of periodontal disease from 1960s to 1980s and in prevention and management of periodontal disease since the end of 1980s. This presentation will discuss about the prevalence of periodontal disease, treatment need, and provision of periodontal treatment in Korea, and how we could manage the periodontal disease efficiently in the future.

According to an epidemiological study in Korea, periodontal disease(including gingivitis) was present in 82% of general population and periodontitis in 30-40% in adult population over 30y and juvenile periodontitis in 0.1% of adolescents.

If we consider that at least 17% of these patients may have recurrent or refractory forms, there is obviously an abundance of disease that needs treatment.

As a result of increase in life expectancy, senile population over 65 y will be increased from 6% in 1996 to 6.9% in 2000, and tooth retention rate and periodontal treatment need are expected to increase. Periodontists need all the help they can get from the general dentists to control periodontal disease.

As for provision, postgraduate course in periodontics started in 1957 in Korea and produced over 700 specialized dentists in periodontics. One report indicated that the periodontists as well as general practitioners did periodontal therapy on only a few periodontal patients, because of specific control by current medical insurance system in Korea. Comprehensive periodontal examination is rarely done in local dental clinic. Therefore, enhancement of periodontal care in medical insurance system and education of simplified periodontal examination such as Periodontal Screening & Recording will make dentists diagnose and manage the management of adult patients is based on the recognition that there are multiple diseases, including gingivitis, chronic adult periodontitis, and other more aggressive forms of periodontitis, and requires the earliest possible recognition of these three disease categories. In this presentation, we discuss practical approach using PSR to diagnose, manage and refer the patients, to facilitate the separation of the simple from the complex and the predictable from the unpredictable form of periodontal diseases and to integrate diagnostic and therapeutic techniques into private practice today.