GINGIVECTOMY*

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By definition, gingivectomy is a method of pocket eradication which entails the removal of the diseased gingiva which forms the pocket wall. In practice it consists of two definite stages.
1. Scaling and planing of the root surface.
2. Removal of the gingiva.

For the purpose of this lecture I am using the term gingivectomy in its widest sense and thus including contouring of the gingiva as well as removal of true and false pockets.

Rationale:
The rationale is the removal of pockets thus rendering the area accessible to the patient for cleansing. For the operation to be successful all calculus must be removed and the root surface planed.

Indications:
1. Periodontal pockets.
2. Bifurcation and trifurcation involvements.
3. Periodontal abscess.
5. Pericoronal flaps.
6. Recontouring the gingiva.

Pockets:
At this stage let us pause to consider the subject of periodontal pockets. They have been defined as a pathological deepening of the gingival crevice. They are divided into true pockets due to a destructive lesion, and false pockets due to a proliferative lesion resulting in an increase in the height of the free gingiva. There can of course be a combination of both types. Where the base of a true pocket is coronal to the crest of the alveolar bone the term gingival pocket is used. While in cases where the base of the pocket is apical to the crest of the alveolar bone the term "intrabony pocket" is used. This classification of pockets is quite important and assists one in the selection of suitable cases for gingivectomy. Intrabony pockets for example are not suitable for gingivectomy.

Selection of Patients:
The selection of patients is a matter of major importance in periodontal treatment. The patient should be keen to have treatment and should be willing to carry out the prescribed home care. It is possible to test the patient's keenness by scaling the teeth and instructing him in

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oral hygiene at the first visit. The degree of co-operation can then be assessed after a few visits. If the patient has failed to persevere with the home care it is futile to carry out any periodontal surgery.

When the patient's attitude is satisfactory the choice of treatment is the next problem to consider. Major factors here are the depth of the pockets and the type of tissue present. In very deep or very shallow pockets the decision is simple. Cases of chronic marginal gingivitis with red, swollen, and oedematous gingivae are best treated by subgingival scaling and curettage. In curettage, pocketing is eliminated partly by shrinkage of the healed gum, partly by fibrosis and better adaptation of gum to tooth, and to some extent by re-attachment of the soft tissues to tooth surface. Many cases presenting 4-5 mm. pockets respond favourably to a thorough subgingival scaling and oral hygiene. Some moderately shallow pockets with very fibrous gingivae respond better to gingivectomy. If, on the other hand, the gingiva is so thin that curettage will produce vents in the gum, gingivectomy is the preferable treatment. If pockets are of such a depth that their obliteration by curettage is unlikely, then gingivectomy is indicated. The more experienced the operator is in subgingival scaling and curettage the less likely he is to require to do a gingivectomy.

It is hardly necessary to mention that periodontal surgery is to be avoided in the presence of acute periodontal infection or in other poor surgical risks.

While it is desirable that periodontal surgery should be performed only in cases where all aetiological and predisposing factors can be eliminated, I feel that certain exceptions can be made. Gingival enlargements associated with epanutin (dilantin sodium) or with an open lip habit, for example, are likely to recur after treatment but if, with adequate supervision by the dentist, a fair result is achieved for a few years, I feel that surgical treatment is justified.

Pre-operative Measures:

Scaling and instruction in oral hygiene should be carried out one or (preferably) two weeks before hand. This scaling lessens the oedema in the tissues, results in fewer cases of excessive bleeding during the operation and reduces the likelihood of postoperative complications.

Premedication is useful in the case of the excessively apprehensive patient, but is rarely found necessary.

Where there is generalised pocketing it is important to plan out the sequence of stages, taking into account the extent of the area to be treated, the time available, etc. If it is inconvenient for the patient to wear a pack, it is a good idea to do 3 - - - - / - - - - - - - - - - 8 at one visit, thus the upper front teeth are covered for only one week instead of having some upper incisors covered for one week and the remainder covered another week. Similarly if _____ is done one week it is better to operate on _____ at the next visit so that ----/ is free to allow the patient to eat.

Attention to such details reduces the discomfort and annoyance caused to the patient.

As in all surgical procedures in the mouth it is essential to have a