CORONAL POLISHING
MEDICAL HISTORY

• Update at each appointment

• Complete new history each year (or whatever guidelines your office has set)
MEDICAL HISTORY:

Contraindications to Polishing:

- Communicable Diseases
  - patients with a communicable disease that could be spread by the aerosols created when polishing

- Respiratory Problems
  - Asthma or Emphysema

- Patients at risk for Bacteremia
  - Bacteria in the mouth introduced into the bloodstream

- Allergy to Polishing Products (ex. Artificial flavorings, rubber latex)
BACTERIAL ENDOCARDITIS

• Patients susceptible to bacterial endocarditis need premedication with antibiotics before coronal polishing
• Antibiotic needs to be taken at least 30 minutes before appointment

• Regiment
  • If no penicillin allergy
    • Adults: 2.0 grams of amoxicillin
    • Children: 50 milligrams/kilogram
  • If a penicillin allergy
    • Adults: 600 milligrams of clindamycin
    • Children: 30 milligrams/kilogram
INDIVIDUALS SUSCEPTIBLE TO BACTERIAL INFECTIONS

• Artificial heart valves
• Previous endocarditis
• Complex cyanotic congenital heart defect
• Congenital heart defect repair
  6 months if repair has no residual effects
  Always if there is a residual effect
• Heart transplant with valvular dysfunction
• Surgically constructed systemic pulmonary shunts or conduits
• Joint replacement
OTHER INDIVIDUALS WHO MAY NEED PRE-MEDICATION (Discuss with their physician)

- *****Anyone who is immunocompromised*****
- Rheumatoid Arthritis
- Lupus
- Drug induced immunosuppression
- Radiation induced immunosuppression
- Malnourishment
- Hemophilia
- Sickle Cell Anemia
- HIV/AIDS
- Uncontrolled diabetic
- Cancer
- Dialysis patient
- Transplant patient
The American Heart Association recommends pre-procedural antimicrobial rinses for those patients at risk for developing Bacterial Endocarditis
REVIEW OF INFECTION CONTROL

• Correct disinfection procedure is critical due to aerosol production and splatter

• Personal protection equipment must be worn
  • Gown, gloves, mask, glasses

• Handpiece must be sterilized for each patient

• Prophy cups/ brushes are disposable items
AEROSOLS and SPLATTER

- **AEROSOLES**: Invisible airborne particles dispersed into surrounding environment by the dental handpiece
  - Pre-Procedural rinse reduces bacterial load in aerosols

- **SPLATTER**: Consists of airborne particles that land on people and objects
  - Polishing splatter consists of polishing paste, microorganisms and saliva
  - Patients must have eyeglasses to protect their eyes from splatter
INDICATIONS FOR POLISHING

- Completed after hard calculus deposits have been removed by scaling

- Cosmetic removal of acquired extrinsic stains

- Improves aesthetic appearance

- A coronal polishing is a **cosmetic** procedure

- A **therapeutic** procedure is a dental procedure used to maintain health or treat a disease to restore health
Anatomical Crown Vs. Clinical Crown

- Anatomical crown:
  - The part of the tooth normally covered by enamel

- Clinical Crown
  - All of the tooth that is visible
ORAL ANATOMY REVIEW

- **Contours**
  - Posterior teeth have a lot of contours to navigate

- **Contacts**
  - Where the teeth meet
  - Stabilizes occlusion
  - Prevents food impaction
  - Protects the papilla

- **Gingiva**
  - Form a loose sulcus around the teeth where bacteria can hide
  - Concerns during polishing
    - Inflammation—irritated by polishing and paste
    - Gingival recession—exposed root surface can be delicate and sensitive
ORAL ANATOMY REVIEW

- Salivary glands
  - Moisturize the mouth and supply minerals for plaque and calculus
  - Polishing stimulates saliva flow
  - Locations of major salivary glands
    - Parotid gland
      - Near the maxillary molars
        - Stenson’s Duct
    - Submandibular and Submental
      - Below the tongue
      - Submandibular ~60% of saliva
        - Wharton’s Duct
        - Most of the saliva
DENTAL STAINS

Stains are discolorations of the teeth and are caused by a variety of things, including:
- Foods
- Bacteria
- Tobacco
- Metals
- Medications
- Imperfect tooth development
- Excess fluoride during tooth development
DEFINITIONS

• Intrinsic – located inside the tooth structure
  • Cannot be removed by hygienist

• Extrinsic – located outside of the tooth
  • Can be removed by hygienist

• Exogenous – originating from outside the tooth
  • May be extrinsic or intrinsic

• Endogenous – originating from inside the tooth
  • May be extrinsic or intrinsic
EXTRINSIC DENTAL STAINS

- Extrinsic stains are on the outside of the tooth structure and can be removed by scaling and polishing
- Only exogenous in origin
- Adhere to pellicle
- Adhere to calculus
- Adhere to soft deposits

- Stain does not cause issues like inflammation or decay, but is an esthetic concern
EXTRINSIC STAINS
YELLOW STAINS

• Associated with poor oral hygiene and are dull yellow to light brownish color

• Associated with plaque

• Most commonly found on buccal surfaces of maxillary molars and the linguals of mandibular incisors
**EXTRINSIC STAINS**

**GREEN STAINS**

- Green stains vary in color from light green to dark green or yellowish green and is found most frequently in children (Nasmyth’s Membrane)

- Located on the facial surface of the maxillary anterior teeth at the cervical 1/3,
  - Forms due to chromogenic bacteria, fungi, decomposed hemoglobin and inorganic elements
    - The organisms grow only in light.
  - Can be smeared irregularly or streaked
EXTRINSIC STAINS
GREEN STAINS

- Should not be scaled due to demineralization
- Can be lightly polished (preferably with manual stick)
- May use hydrogen peroxide or other bleaching agent (Talbots Iodine with combination pumice)
EXTRINSIC STAINS

ORANGE STAINS

• Less common than other stains

• Caused by chromogenic (microorganism that produces pigment) bacteria from poor oral hygiene

• Most often on anterior teeth

• If demineralized, scaling is contraindicated. Can use 3% hydrogen to loosen and bleach followed by selective polish
Black line stains

- Chromogenic bacteria cause stains, typically a thin line at the gingival margin of the tooth
  - Most common is ferric sulfide
    - Hydrogen sulfide from bacteria + iron in the saliva and gingival exudates
- Often seen in females with good oral hygiene
- Needs to be scaled because of calculus-like nature
- Followed by selective polish for complete removal
- Tends to reform after removal
EXTRINSIC STAINS
TOBACCO STAINS

- Coal tar combustion in cigarettes

- Pigments from chewing tobacco penetration the pits and fissures on the enamel and dentin surfaces

- Tenacious stains that can become intrinsic

- Needs to be lightly scaled and followed by selective polishing
EXTRINSIC STAINS
OTHER BROWN STAINS

• Food and beverage pigment
• Food with tannins such as:
  • Wine
  • Soda
  • Coffee
  • Tea
  • Dark colored fruits

• Lightly scaled, then selectively polished
EXTRINSIC STAINS
OTHER BROWN STAINS

• Certain drugs can also cause brown stains such as:
  • Chlorhexidine
  • Stannous fluoride
  • Extended antibiotic use

• Lightly scale, then selectively polish
EXTRINSIC STAINS
DEMINERALIZATION

- Tooth normally formed but becomes demineralized during first stage of caries
  - Leaking under orthodontic bands
  - Chalky appearance and soft enamel
  - Can treat with fluorides and hope for remineralization
ENDOWGENEOUS INTRINSIC STAINS: Stains inside the tooth from a source inside the body

- Antibiotic Use
  - TETRACYCLINE STAIN
  - Do not give antibiotic to mothers in last half of pregnancy or until child is 8 years old
- Fever
- Trauma
- Infection
- Exposure to large amounts of fluoride
INTRINSIC STAINS

Pulp damaged or Non-Vital Tooth

- Blood and pulpal tissues break down as a result of bleeding in the pulp chamber or death of the pulp tissue
- Pigments from blood and tissues penetrate the dentin and show through the enamel
- Not all discolor
- Variety of colors may appear
  - Light yellow
  - Gray
  - Reddish brown
  - Dark brown or black
  - Orange or greenish
EXOGENOUS INTRINSIC STAINS

Stain Inside the Tooth Originating outside the tooth

- Restorative Materials: Dental amalgam
- The metallic ions adhere to the pellicle and other soft deposits or they penetrate the tooth surface to become part of the tooth structure
EXOGENOUS INTRINSIC STAINS

Metallic stains

• Can be intrinsic or extrinsic
  • Can adhere to the pellicle (extrinsic)
  • They penetrate the tooth surface (intrinsic)

• Causes
  • Metals and metallic salts inhaled in industrial settings
    • Copper dust: green to bluish green
    • Iron dust: brown stain
  • Taken orally in certain drugs
    • Iron drugs black stain
Imperfect Tooth Development

Intrinsic Endogenous

- Genetic Hypoplasia – (imperfect development)
  - Amelogenesis Imperfecta
    - Disturbance of ameloblasts (cells that make enamel)
    - Teeth yellow/brown in color
    - Much of the enamel is missing
  - Dentogenesis Imperfecta
    - Disturbance of odonblasts (cells that make dentin)
    - Dentin is soft and causes enamel to chip away
Imperfect Tooth Development

- Enamel Hypoplasia
  - White spots on tooth due to short term disturbance of ameloblasts. Possibly due to high fever at early age

- Hypocalcification
  - Vitamin D deficiency prevents proper enamel calcification and results in white areas or pits or teeth
  - Mottled Enamel – Excessive fluoride in water
TERMINOLOGY

• PELLICLE

• PLAQUE - BIOFILM

• CALCULUS

• MATERIA ALBA
PELLICLE

- Thin, clear, tenacious film
- Acellular
  - Insoluble proteins, fats, etc
- Source is saliva and sulcular fluids
- Forms within minutes of removal
- Provides barrier to acids
- Provides an attachment for plaque and calculus
PLAQUE - BIOFILM

- Soft, dense, furry-like deposit
- Organized mass of microorganisms in a sticky matrix
- Attaches to gingival areas difficult to clean & lingual and occlusal grooves
- Can cause caries, gingivitis and periodontal disease

- Patient must be responsible for removing plaque on a daily basis;
  - Re-forms within 12-24 hours of polishing
CALCULUS

- A hard calcified deposit that forms on the teeth, restorations and dental appliances
- Also called tartar
- Mineralized plaque
- Often covered with a layer of plaque
MATERIA ALBA

- Soft bulky mass, cottage cheese-like white to yellow
- Accumulation of materials and bacterial growth
  - Unstructured living and dead microorganisms
  - Food debris
  - Desquamated epithelial cells
- Provides source for plaque
EFFECT OF POLISHING

• Excessive polishing can damage tooth structure

• Polishing at high speeds or at length can cause heat
  • Heat generation could damage pulp of tooth

• Dentin/Cementum are less resistant to abrasion than enamel
EFFECTS OF POLISHING

• Enamel is thin at the cervical areas
  • Tooth sensitivity may occur

• Demineralized tooth surfaces lose three times more surface structure than intact enamel

• Coarse abrasives may actually roughen tooth surfaces causing increased plaque and biofilm accumulation
CONTRAINDICATIONS FOR CORONAL POLISHING

• Sensitive teeth – application of fluoride can help reduce sensitivity, polishing removes fluoride rich outer layers of enamel

• Lack of stain or plaque – tooth surfaces with no extrinsic stain and no visible plaque

• Exposed Cementum or Dentin – polishing can remove significant amounts of these structures

• Restored tooth surfaces – restored tooth surfaces are not as hard as enamel and therefore can be scratched easily
  • There are preparations made for restorative materials
CONTRAINDICATIONS FOR CORONAL POLISHING

- Newly erupted teeth
  - mineralization of these teeth is incomplete

- Implant abutments
  - should not be polished
  - the implant super-structure can be polished if needed as needed
CONTRAINDICATIONS
FOR CORONAL POLISHING

- Demineralization – polishing removes small amounts of enamel

- Rampant caries

- Immediately following deep scaling and root planing or if gingival tissues are very inflamed
  - Irritation and delayed healing can occur with the soft tissues
CONSTITUENTS OF A COMMERCIAL PREPARATIONS

• Abrasive: 50-60%
  • main ingredient
• Water: 10-20%
  • provides desired consistency
• Humectant: 20-25%
  • Moisture retainer, stabilizes ingredients (ex. Glyercin)
• Binder: 1.5%-2.0%
  • Prevents splatter, separation (ex. agar, sodium silicate powder)
• Sweetener: artificial, noncariogenic flavoring and coloring agents
ABRASIVE AGENTS

• Silex (Silicon Dioxide)
  • Super fine silex can be used for stain removal

• Pumice (volcanic origin)
  • Pumice flour or superfine pumice can be used for stain removal

• Calcium Carbonate (whitening, calcite chalk)
  • Various grades are used for different polishing techniques

• Tin Oxide (Putty Powder, Stannic Oxide)
  • Polishing agents for teeth and metallic restorations
REMINERALIZING AGENTS

- Some prophy pastes containing minerals and compounds to help reinforce tooth structure
- Fluoride
  - Utilizing a fluoridated polishing paste does not take the place of a fluoride treatment

- CPP: Casein Phosphopeptide
- ACP: Amorphous Calcium Phosphate
  - Milk based product (casein)
  - Hydroxyapatite precipitate on tooth surfaces
    - Occurs within 10 seconds
  - Calcium and phosphate bind with other FL- ions to release during acid attacks.
ADVANTAGES OF ACP/CCP

- Re-mineralization
- Enhances fluoride delivery
- Fast acting
- Desensitization
  - Occludes dentinal tubules
- Good patient compliance for those who do not wish to use fluoride products
  - Available through several different companies
DESENSITIZING POLISH

• Pro Argin Desensitizing technology
• Alginine and Calcium Carbonate are used to block open dentinal tubules.
• Prophy paste used at start of appointment for those with hypersensitivity issues due to pressure or air stimulation
COMMERCIAL PASTES

• Grit refers to particle size

• Fine Grit *
  • Recommended for less abrasion to the tooth surface*

• Medium Grit

• Coarse Grit
  • 80%+ of commercial sales!
PRINCIPLES FOR APPLICATION OF ABRASIVES

- Quantity - Wet Agent
  - More particles applied per unit time, the faster the rate of abrasion

- Speed of Application
  - The greater the speed, the faster the rate of abrasion
  - Handpiece speed should be 10,000 rpm or less

- Pressure of Application
  - The heavier the pressure, the faster the rate of abrasion
PROPHY CUPS: Characteristics

• Material
  • Natural or Synthetic Rubber
    • Natural rubber are more flexible
  • Non-latex cups are used for latex sensitive patients

• Texture
  • Firm or soft
  • Ribbed or smooth
  • Webbed: stain removal
PROPHY CUPS: Characteristics

• Length and Diameter
  • Standard length
  • Shorter lengths for smaller mouths
  • Smaller diameter for access
    • Rotated or overlapping anterior teeth
    • Orthodontic appliances

• Shape
  • Cup
  • Tapered
BRISTLE BRUSHES

• Brushes may be utilized to remove stains from the pits and fissures of occlusal surfaces ONLY

• Brushes should not be used on facial, lingual or proximal surfaces because the bristles could lacerate the tissues
DISCLOSING AGENTS

• Temporary coloration that makes plaque biofilm visible

• Motivating factor in oral hygiene

• Helps the operator see plaque for selective polishing
DISCLOSING AGENTS

Absorbs the dye:

- Pellicle
- Plaque
- Biofilm
- Debris
- Calculus

Areas that are clean but rough may also absorb the dye:

- Decalcification
- Hypocalcification
- Restorations
- Cementum
DISCLOSING AGENTS

• Erythrosin dye is the most common
  • It stains plaque red
• Fluorescein is a dye that can be applied to the teeth without obvious staining
  • Uses ultraviolet light to the agent visible
• Two tone disclosing agents:
  • Stain thicker plaque biofilm
  • Thinner plaque red
DISCLOSING AGENTS

• Ideal properties:
  
  • Provide a distinct staining of deposits that does not rinse off immediately
  
  • Should not rinse off immediately
  
  • Should have a pleasant taste
  
  • Should be nonirritating to tissues
DISCLOSING AGENTS
Methods of Application

• Solutions can be applied as a concentrate with a cotton swab or diluted with water in a cup for the client to rinse
• Tablets are chewed and swished in the mouth
• Excess disclosing agent is expectorated or suctioned and evacuated
• If you are not sure if is gingival margin or plaque, use air to make distinction.
• Record the areas of plaque
PLAQUE INDEX

INSTRUCTIONS

1. Cross off missing teeth by BLUE line.
2. Indicate location of plaque on axial surfaces by marking appropriate area in RED.
3. Compute plaque index as follows:

\[
\text{No. of surfaces with plaque} = \frac{2.8}{\text{No. of teeth}} \times 4 = 11.2
\]

\[
3 \times 100 = 2.7\% 
\]

4. Place score in the appropriate blank under the chart.

Client's Plaque Index \(2.7\%\)
PATIENT EDUCATION

• After disclosing
  • Show patient the areas of plaque
  • Discuss their homecare
    • Ask what they do each day for oral hygiene
    • Ask them what kinds of products they use
    • Advise them on what products may be helpful
    • Ask them what types of products they may be interested in trying
CORONAL POLISHING TECHNIQUE
Modified Pen Grasp

- All fingers in contact as a unit
  - Offers the most control
- Facilitates movement of handpiece
- Facilitates wrist arm movement
- Rest handpiece in V of hand
  - Transfers weight from fingers to hand
  - Decreases fatigue
NEUTRAL WRIST AND FULCRUM

• Neutral wrist
  • Straight, not bent
  • “Handshake position”
  • Avoid a pinched wrist

• Fulcrum with the ring finger
• Establish intraoral fulcrum close to working area
• Use moderate pressure
CORONAL POLISHING TECHNIQUE

Ergonomics

• CORRECT
  • Back straight, neck and shoulders relaxed

• INCORRECT
  • Back and neck straining forward
CORONAL POLISHING TECHNIQUE: APPLICATION OF POLISHING AGENT

• Fill cup with paste and evenly apply to surfaces to be polished
ADAPTATION

- Angle cup at the gingival margin
- Apply just enough pressure to make the cup flare

*Figure 26-16. Illustration showing correct adaptation of a rubber cup.*

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WORKING STROKE

• Cup in contact with tooth

• 1-2 seconds with each stroke

• Use intermittent dabbing/wiping strokes

• Stroke from the gingival third to the incisal/occlusal third
WORKING STROKE

• Moderate pressure

• Slow speed on the handpiece

• Remove rubber cup from tooth at completion of stroke and readapt cup for next stroke
ADAPTATION

• Adapt rubber cup to reach distal

Figure 26-25A. Technique practice—rubber cup polishing—adapt cup to the distal portion of the facial aspect.
ADAPTATION

• Adapt rubber cup to facial/lingual

Figure 26-25B. Technique practice—rubber cup polishing—adapt to the middle portion of the facial aspect by "swinging" the entire handpiece.
ADAPTATION

• Adapt rubber cup to mesial

Figure 26-26. Technique practice—rubber cup polishing—adapt to the mesial portion of the facial aspect.
ADAPTATION

• Maintain adaptation of cup by rotating handpiece or pivoting on fulcrum as necessary.

Figure 26-17. Correct adaptation of a rubber cup with the cup parallel to the tooth surface and the cup rim flared slightly.
SELECTIVE POLISHING

• What is Selective Polishing?
  • The practice of omitting tooth polishing in areas where there is no stain, plaque or when tooth polishing can cause damage

• Must be explained to patient
  • Polishing is a cosmetic procedure with no health benefits
  • If polishing is done too often, it can damage the teeth
  • Most patients expect to have all surfaces polished

• Current Theory:
  • With onset of new products with remineralizing agents, all natural tooth surfaces would benefit from polishing agents
SEQUENCE OF POLISHING

• Mandibular Right Linguals

• Mandibular Anterior Linguals

• Mandibular Left Linguals
SEQUENCE OF POLISHING

• Mandibular Left Buccals

• Mandibular Anterior Facials

• Mandibular Right Buccals
SEQUENCE OF POLISHING

• Maxillary Right Buccals
• Maxillary Anterior Facials
• Maxillary Left Buccals
SEQUENCE OF POLISHING

- Maxillary Left Lingual
- Maxillary Anterior Lingual
- Maxillary Right Lingual
• Polish Occlusals
  • As needed

Figure 26-27B. Technique practice—rubber cup polishing—use bristle brush or rubber cup on the occlusal surface.

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• Evacuation
  • Rinse and suction
  • At least once per arch
  • At the end of polishing

Figure 26-28A. Irrigate and evacuate to remove residual paste from around the teeth (illustration).

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PROPHY JET

- Alternative to prophy cup polishing
- Teeth are sprayed with an abrasive powder
  - Sodium bicarbonate (ProphyJet®)
  - Non-sodium (JET Fresh®) powder
    - Aluminum Trihydroxide
- Handpiece similar to cavitron tips
- Setting up the Prophy Jet Video
PROPHY JET
Indications

- Removal of extrinsic stains: e.g. tobacco, coffee, tea, chlorhexidine.
- Prophylaxis of orthodontic patients.
- Preparation of tooth surfaces prior to bonding and sealant procedures.
CONTRAINdications and WARNings

- Do not direct the air-polishing stream at soft tissue or into the sulcus.
  - Tissue emphysema has been reportedly caused by this.
- Baking soda and salt based powder may be contraindicated for patients on low sodium diets.
- Never operate the system without fluid flowing through the handpiece.
- A dampened 2x2-gauze pad can be placed on the patient’s lip to protect the skin and increase patient comfort.
- Direct contact of prophy powder with dental restorations should be avoided.
PROPHY JET
Polishing Technique

- Place nozzle tip 3 to 4 mm angled slightly apically on the incisal to middle third of the tooth
- Angulation: Posterior 80°; Anterior 60°; Occlusal 90°
- Constant circular motion, interproximal to interproximal (sweeping motion).
- Polish 1 to 2 teeth per 1 to 2 seconds and rinse.
- Use your hand and patient’s cheeks or lips to contain aerosols.
- Rinse slurry from patient’s mouth as needed.
- Tap On Technology with Prophy Jet Video
PROPHY JET
Cleaning

• Preparation for Cleaning:
  • Remove excess powder from the insert nozzle by inserting the applicable cleaning wire(s) into the center tube and moving the wire back and forth several times.
    • Avoid kinking or bending the wire.
    • Remove wire for cleaning and sterilization.
  • May be cleaned using an ultrasonic water bath for 15 minutes.
  • Be sure to air-dry the inside diameter of the center tube.
  • Steam autoclave the tip
SUMMARY

• Evaluate patients’ need for polishing
• Educate patients re: selective polishing procedure
  • Implement selective polishing procedure OR
  • Full mouth polishing if using a remineralizing agent
• Use fine grit polishing paste
• Use wet polishing paste
• Use low speed
• Use light to moderate pressure
DENTAL FLOSS

• Floss at the End of Polishing
  • To remove any residual plaque
  • To remove any residual paste
  • To educate the patient on technique
DENTAL FLOSS
Educating the Patient

• Toothbrushing does not reach the proximal surfaces or the area immediately under the contact point of adjacent teeth

• This is known as the interdental area

• Must find a means to clean the plaque and biofilm from this area
DENTAL FLOSS

- The most frequently recommended aid for cleaning proximal tooth surfaces

- More effective on adults when interdental spaces area covered by the papillae

- Teach children so that they habituate the behavior in adulthood
Which one should I use?

• Bottom line- whatever the patient likes, encourage its use

• Please, please floss every patient because if you don’t think it is important then the patient will not think it is important.
DENTAL FLOSS

- Most types of dental floss are made of nylon and some are impregnated with flavorings, fluoride, baking soda, or calculus–inhibiting agents

- Types available (just some examples, there are more!):
  - Unwaxed
  - Waxed, including tape
  - Polytetrafluoroethylene (Glide)
  - Braided and Woven
  - G-floss and tapered G-floss –(like mesh or gauze)
  - Tufted (Super floss)
DENTAL FLOSS

• Studies have shown no difference in the effectiveness of unwaxed versus waxed dental floss

• Unwaxed is recommended for patients with normal tooth contacts because it slides through the contact area easily

  • Unwaxed is the thinnest floss available

  • When it separates during use, it covers a larger surface area of the tooth than waxed floss
DENTAL FLOSS

• Waxed dental floss is recommended for:
  • Patients with tight proximal contacts
  • Patients with defective and overhanging restorations

• Waxed is preferred by some because of its ability to slide through tight contacts and resist fraying

• Research has shown that it does not leave a wax residue on teeth coated by saliva
DENTAL FLOSS

• Dental tape or ribbon is a waxed floss product that is wider and flatter than conventional dental floss

• It is sometimes preferred by people with large surface areas to be flossed
DENTAL FLOSSING TECHNIQUE

• Break off 12-18” of floss

• Wrap around middle fingers – around one finger 2 -3 times – the remaining floss around the other finger

• Grasp between thumbs and index fingers using ½ inch between finger tips
TECHNIQUE

INCORRECT

CORRECT
DENTAL FLOSSING TECHNIQUE

• Select an area to begin flossing and establish a pattern

• Set a fulcrum

• Use a gentle seesaw motion to pass through the contacts
DENTAL FLOSSING TECHNIQUE

• Pass floss below gingival margin

• Wrap tightly in C shape around tooth

• Make a tight C going on both proximal surfaces
DENTAL FLOSSING TECHNIQUE

• Move the floss up and down on tooth 3-4 strokes, then move above papilla to the contact

• Wrap in C shape of distal of adjacent tooth, moving up and down 3-4 strokes
DENTAL FLOSSING TECHNIQUE

• Use a seesaw motion to remove floss through contact

• Advanced floss to new area by unwrapping floss from left hand middle finger and wrapping onto right-hand middle finger
DENTAL FLOSSING TECHNIQUE

- Mandibular arch – use index fingers to guide the floss
DENTAL FLOSSING TECHNIQUE

• Maxillary – use thumb and index fingers to guide the floss
FLOSSING AIDS

• With Floss
  • Floss picks
  • Floss holders
  • Floss threaders
FLOSSING ALTERNATIVES

- Interdental brush
  - Proxabrush
- Stimdents or toothpicks
- Air Flosser
- Oral irrigator
  - “water pik”
- Rubber gum stimu
FLOSSING AIDS
FLOSS HOLDER

- To direct floss in a C shape toward mesial and distal, use a push or pull motion with floss holder
FLOSSING AIDS

• Floss threaders assist in introducing floss into an area such as between an abutment tooth used for support of a fixed bridge and a pontic or orthodontic appliances.
FLOSSING AIDS
INTERDENTAL BRUSH

• Studies have shown that interproximal brushes are equal to or more effective than floss for biofilm removal
• Come in conical or tapered shapes
  • Several sizes
FLOSSING AIDS
INTERDENTAL BRUSH

- They are used for:
  - Embrasures (area below the contact)
  - Furcation areas (areas between the branching roots of posterior teeth)
  - Cleaning under abutments and wires
FLOSSING AIDS STIMULATORS

- Place side of rubber tip interdentally and slightly pointing coronally at 45 degree angle
TALK ABOUT BRUSHING TO THE PATIENT
Motivational Interviewing

• Ask the patient questions.
  • How they feel about their health, teeth, etc (whatever you want to impact)
  • Get them to tell you what they are unhappy with/want to change
  • Get them to express what they feel they could do better on
  • Get them to set a goal (even if it is the goal of thinking about making a change rather than actually doing it)

• You will not “should” anyone.

• Offering advice and options rather than lecturing.

• Being supportive rather than authoritative