Webinar Clinical Pearls & Q&A

Clinical Pearls

1. Dental caries is not simply a cavity.
Caries should be viewed as a biofilm-mediated, diet- and host-modulated disease process that results in net mineral loss of tooth structure.

2. pH is a key driver of disease.
Sugar matters, but the real issue is the acidic environment created when oral bacteria metabolize sugars. Frequent acid challenges shift the biofilm toward disease.

3. Saliva is one of the most important protective factors.
Patients with dry mouth, medication-induced hyposalivation, autoimmune conditions, or reduced buffering capacity may spend much longer in a demineralization state.

4. Risk assessment should guide care.
A standardized caries risk assessment helps identify the specific risk factors driving disease and supports a more consistent treatment plan.

5. Restorative dentistry alone does not control the disease.
Restoring lesions without addressing the microbiome, saliva, pH, and risk factors may leave the underlying disease process unchanged.

6. Salivary diagnostics can help reveal what is happening below the surface.
Testing can help identify bacterial load, dysbiosis, yeast involvement, and whether treatment is moving the patient toward stability.

7. Time matters in microbiome management.
Biofilm change is not usually a quick fix. Several cases demonstrated improvement over months to years, not days or weeks.

8. Treatment and maintenance are different phases.
Treatment rinses may be used to help shift an unhealthy microbiome, while maintenance rinses may be used once the patient has reached stability.

9. Order of homecare matters.
A suggested sequence discussed was: clean interproximally first, use prescribed rinse, then brush with therapeutic toothpaste last so the paste remains on the teeth.

10. Low-risk and moderate-risk patients may not need the same level of intervention as high-risk patients.
High-risk and extreme-risk patients require deeper evaluation of bacterial challenge, saliva, pH, and behavioral risk factors.

11. Not every radiographic lesion should automatically be restored.
Radiographs show changes in mineral density, not necessarily cavitation. Clinical evaluation is essential before deciding when to surgically intervene.

12. The goal is stability, not simply repair.
The most important question becomes: did we change the disease pattern, reduce risk, and prevent new lesions?

Attendee Q&A Summary

Salivary Diagnostics & Testing

Q: Does the salivary test discussed include active MMP-8?

A: No. Active MMP-8 requires a separate test or device. The test discussed during the webinar did not include active MMP-8.

Q: Is diagnostic testing the only way to know when to stop using a treatment rinse?

A: Testing provides the clearest way to measure whether the microbiome has shifted. The speakers emphasized that treatment duration varies by patient and that many clinicians may stop microbiome therapy too soon.

Q: How long should patients use treatment rinse?

A: There is no one-size-fits-all answer. Some cases may require months or longer. The key point was to think longer-term when trying to shift a dysbiotic microbiome, especially in high-risk patients.

Treatment Rinse & Microbiome Management

Q: Can children use CariFree Treatment Rinse?

A: If a child can reliably swish and spit, the speakers indicated it may be appropriate. One suggestion was to demonstrate rinsing in front of the child so they understand what to do.

Q: Is there an age that is too young for treatment rinse?

A: The practical guidance shared was less about age and more about ability. If the patient can swish, spit, tolerate the rinse, and has a dysbiotic microbiome, it may be considered.

Q: Does treatment rinse negatively affect the healthy oral microbiome?

A: Dr. Kutsch discussed data suggesting CariFree Treatment Rinse acted more like a "reset button," reducing cariogenic bacteria while supporting a healthier, more diverse biofilm.

Q: Can treatment rinse be used for periodontal patients?

A: Dr. Thompson shared that he uses it off-label in periodontal care as part of microbiome management, especially when paired with salivary diagnostics and long-term follow-up.

Q: Should antimicrobial rinses be rotated to prevent bacterial resistance?

A: The speakers indicated that bacterial resistance is not a concern with sodium hypochlorite in the way it is with some antibiotics.

Maintenance After Disease Control

Q: After a patient's microbiome stabilizes, do they stay on treatment rinse forever?

A: Not necessarily. Dr. Thompson described transitioning patients from a disease-active treatment rinse to a stability or maintenance rinse once the microbiome is re-established.

Q: Was the pediatric patient still using treatment rinse after leaving the practice?

A: No. Once stabilized, she was moved to a maintenance approach and continued to show long-term stability with no new lesions.

Products, Homecare & Protocols

Q: How long should patients wait after using treatment rinse before brushing with Pro Gel 5000?

A: The speakers suggested patients can rinse, spit, then brush with Pro Gel 5000 right away. The bigger priority is making the routine practical enough that patients will actually follow it.

Q: Should patients avoid eating or drinking after brushing with Pro Gel 5000?

A: While longer contact time is ideal, the speakers emphasized practicality. If strict timing prevents patients from using the product, it may be better to keep the instruction simple and achievable.

Q: What is the recommended homecare sequence?
A: The sequence discussed was: clean between the teeth first, use prescribed rinse, then brush with Pro Gel 5000 last.

Listerine, Chlorhexidine & Nitric Oxide Concerns
Q: Does Listerine affect the gut microbiome?
A: The speakers stated there is no data showing Listerine affects the gut microbiome. They also noted that essential oil rinses tend to have a lighter antimicrobial effect compared to stronger therapeutic rinses.
Q: What about chlorhexidine and concerns around nitric oxide production?
A: The speakers discussed that dysbiosis itself can negatively affect nitric oxide pathways. Their emphasis was that the first priority is shifting a dysbiotic microbiome toward health.

Restorative Decision-Making
Q: Should high-risk patients have D1 or D2 lesions restored earlier?
A: Dr. Young emphasized separating caries risk from the decision to surgically treat a tooth. Risk assessment guides disease management, but surgical intervention should be based on clinical evidence of cavitation.
Q: Are radiographs enough to determine when to restore?
A: No. Radiographs show mineral density changes, not cavitation. Clinical evaluation is needed to determine whether a lesion is truly cavitated and requires restoration.
Q: What is selective caries removal?
A: Selective caries removal focuses on cleaning the perimeter of the lesion while preserving affected dentin near the pulp when appropriate. The goal is to seal out nutrient sources and avoid unnecessary removal of tooth structure.
Q: What role do SDF and glass ionomer play?
A: Silver diamine fluoride may be used to arrest caries, while glass ionomer may be used as a minimally invasive restorative or sealing option in appropriate cases.

Curodont & Early Lesions
Q: What about using Curodont for early lesions instead of SDF?
A: The speakers described Curodont as a promising tool for certain non-cavitated lesions, especially anterior white spot lesions where esthetics are important. They noted that it creates a scaffold for remineralization and should be paired with a source of calcium and phosphate, such as nano-hydroxyapatite, and potentially fluoride.