

# Periodontal Treatment: Flap Surgery vs. Laser

Vahini Pravalika K<sup>1\*</sup>, Baanu Prakash G<sup>2</sup>

<sup>1</sup>Department of Pharmacology, Vivekananda College of Pharmacy, India

<sup>2</sup>Department of Medicinal Chemistry, MNR College of Pharmacy, India

## Review Article

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### \*For Correspondence

Vahini Pravalika K, Masters in Pharmacology, Vivekananda College of Pharmacy, Hyderabad-500018, Telangana, India, Tel: +7799225867

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**E-mail:** [pravalika.vh@gmail.com](mailto:pravalika.vh@gmail.com)

### ABSTRACT

Constant periodontitis is characterized as irritation of the gingiva stretching out into the adjoining connection mechanical assembly. The sickness is described by loss of clinical connection because of demolition of the periodontal tendon and loss of the adjoining supporting bone. Non-surgical periodontal strategies like scaling and root arranging took after by periodontal surgical systems are done to re-establish the periodontal wellbeing and capacity. Late headways like lasers, microsurgery and other treatment helps have set a point of reference in the field of periodontics. Lasers have changed various ventures, and oral consideration is no exemption. Despite the fact that laser periodontal treatment is still in its outset – and not yet considered a demonstrated technique for treatment.

## PERIODONTAL DISEASE CONDITION

Periodontal or gum ailment is a contamination of the supporting tissues and bone that hold your teeth set up. The condition influences for the most part grown-ups in their 30s and 40s [1-5].

- Poor maintenance of oral hygiene
- Chronic illnesses, such as diabetes
- High dose specific medications
- Smoking and chewing tobacco

Regular treatment for periodontal malady is scaling and root planning (SRP), which is a non-surgical technique for cleaning the surfaces of the teeth and their root which might be presented because of gum subsidence. This evacuates tartar, plaque and microscopic organisms from the gum encompassing the root, and advances the solid recovery of the gum tissue [5-10]. In periodontal laser treatment, the supplier utilizes a dental laser to get to and expel the aroused gum tissue from around the foundation of the tooth. At the point when the contaminated tissue is expelled and the root is uncovered, the root scaling starts [11,12]. This includes scratching off the analytics and plaque developed underneath the gum line and around the root. The dental practitioner then smoothens the root with instruments to expel any harsh detects that may pull in microorganisms and cause future diseases. The zone between the gum and the root can then recover amid the mending procedure [13-21].

### Advantages and Disadvantages

- No general soporific is required, as is once in a while required for different types of dental surgery.
- Lasers can focus on the unhealthy ranges unequivocally and precisely.
- Bleeding, torment and swelling are constrained on the grounds that periodontal laser treatment is less intrusive than standard surgery.
- Recovery and recuperating times are shorter.

Constant periodontitis is a standout amongst the most common oral conditions the world over. Pathogenic plaque small scale greenery, host invulnerable reactions, and natural variables assume a noteworthy etiologic part and cause both immediate and also have interceded tissue harm [21-30]. Elimination or change of these variables is the essential part of treatment, which captures or controls the illness procedure. What's more, the point is to recover the tissues and re-establish capacity with strategies, which are unsurprising and accomplish long haul benefits [31-40].

Different strategies for improving recovery, for example, bio-mimetics, unions and obstruction layers have appeared to profit the treatment result, yet may expand the treatment costs, and extra intrusive methodology may not be adequate to the patient [41-43]. Laser innovation, particularly the diode laser is picking up prominence when all is said in done dental practice with potential advantages in an extensive variety of uses. Lasers have furnished us with a potential other option to at the same time expel the unhealthy delicate tissues, focus on the smaller scale living beings and in addition invigorate wound recuperating. A few lasers, for example, the carbon dioxide, Ho: YAG, Nd: YAG, diode, Er: YAG has been tentatively used for delicate tissue periodontal strategies. Laser use delivers less postoperative swelling, decreases aggravation and is likewise moderately effortless [44-58].

Complete mechanical debridement being the "highest quality level" of periodontal treatment, still does not dispose of the small scale living beings in the delicate tissue mass of the pocket, nor is finished resection of the sick tissues conceivable [59-63]. Extra delicate tissue curettage systems utilizing ultrasonic and different chemicals and in addition a few adjunctive privately conveyed specialists, for example, antimicrobials, sterile operators, mitigating operators, and host - regulating specialists have been assessed for improving the treatment result of ceaseless periodontitis with changing degrees of accomplishment. However, the consistency of these medications is not sure and antimicrobial medications may prompt the improvement of safe microbial strains [64-73].

A few clinical studies have bolstered the antibacterial impact of lasers in periodontal pockets. Some studies have even reported tissue recovery on histologic assessment taking after laser interceded periodontal treatment using the "laser helped new connection methodology." Furthermore, a few creators have reported improved results utilizing lasers to de-epithelize the inward coating of the fold in light of the guideline of guided tissue recovery [74-78].

### COST AND PROCEDURAL ASPECTS

Laser gum surgery costs about 8,000 USD, contingent upon the seriousness of your gum condition. The expense is practically identical to conventional fold surgery and ought to be secured under most dental protection arranged. The noteworthy target of fold surgery is to dispose of or diminish the pocket itself. To get to it, a fold like cut is made in the gum tissue. This permits unhealthy tissue to be expelled from inside the pocket, and gives access to the

teeth's root surfaces for an exhaustive cleaning, which kills hurtful plaque and math (tartar). A short time later, the "fold" is shut, fixing the zone. This starts the recuperating procedure, which happens quickly [79-82].

Fold surgery is commonly done under nearby anesthesia, here and there joined by oral hostile to nervousness solutions; on the other hand, it might be performed under intravenous cognizant sedation. After anesthesia has produced results, a little entry point is made to isolate the gums from the teeth. The external gum tissue is tenderly collapsed back to offer access to the roots and the supporting tendon and bone tissue [83-86].

Next, the aroused gum tissue can be expelled, and the tooth roots can be cleaned; if necessary, the territory may likewise be treated with anti-infection agents or different solutions. Bone deformities can be repaired with joining material, and appropriate recovery of the periodontal tendon can be empowered by physical (hindrance films) and concoction (development components) strategies. At long last, the cut is shut and the method is finished [87,88]. Performed by an accomplished hand, cutting edge fold surgery has a superb reputation and offers settled advantages. It's regularly the treatment of decision for calming periodontal ailment and keeping up your oral wellbeing-and save your teeth.

Relief from all the below aspects can be experienced slowly or immediately after the periodontal flap or laser surgery:

- Gum Bleeding
- Numbness or feeling of Sensitivity
- Gum/Nerve Swelling
- Bruising due to treatment
- Sutures as per procedure
- Surgical Dressings needs to be maintained regularly
- Dental Discomfort
- Staining or side effects due to certain Medications used

Laser-assisted new attachment procedure (LANAP) is a surgical treatment for the treatment of periodontitis, expected to work through recovery as opposed to resection [89-91]. One of the primary advantages for utilizing dental lasers is the capacity to decisively communicate and, at times, Expel very nearly a couple cell layers at once. Erbium lasers can have some selectivity in evacuating unhealthy tooth structure, since carious sores have much higher water content than solid tissue. Contemplates have indicated other favorable circumstances over ordinary rapid hand piece communication on the tooth surface, for example, the disposal of smaller scale breaks and a reported bringing down of pulpal temperature as the arrangement continues. Bony tissue expulsion and molding can likewise continue effortlessly with reported speedier recuperating. In addition, it has been shown that the lased veneer has a decent potential for reinforced reclamations the length of they are in this manner carved with corrosive [92-94].

Lasers likewise permit the clinician to diminish the measure of microscopic organisms and different pathogens in the surgical field and in the cavity readiness; and, on account of delicate tissue strategies, accomplish

great hemostasis with the lessened requirement for sutures and surgical pressing. A few original copies call attention to that post agent scar arrangement is minimized; since the laser entry point is more expansive and unpredictable than that of a surgical tool, the mending tissue better mixes with the encompassing structures. Periodontal unhealthy tissue can be sanitized and detoxified [95-98].

Lasers can effectively and securely be utilized on an extensive variety of the populace, for example, youngsters and pregnant ladies not at all like some endorsed and/or sulcularly conveyed drugs. Dissimilar to those prescriptions, the patient won't encounter unfavourably susceptible responses, bacterial resistance, or untoward symptoms when the laser is utilized. With great control of seeping, there is significantly enhanced perception of the surgical field, and numerous laser strategies can be performed with less injectable anaesthesia. In those circumstances, extra treatment may have the capacity to be performed on the same arrangement. Moreover, starting postoperative uneasiness and swelling are diminished as a result of the fixing of nerves and lymphatic's [99].

There are a few burdens to the present instruments. Without further ado accessible dental lasers just discharge vitality from the tip of the conveyance framework; and, in that sense, they are all "end cutting," which as a rule means an alteration of the expert's clinical procedure. In spite of the fact that they are helpful for caries evacuation and tooth arrangement, the Erbium group of lasers can't evacuate gold and vitreous porcelain, and has just a little collaboration with amalgam. Obviously, that reality is likewise favorable position while treating a repetitive carious injury nearby a lacquer or crown, for instance, since there will be no association with the therapeutic material. Nonetheless, most composite rebuilding efforts can be removed [98]. At times, the conveyance framework can be more awkward than an air rotor or electric hand piece, and availability to the treatment territory could be restricted. The clinician should deliberately watch and screen the rate of tissue expulsion to anticipate overheating and parallel warm harm. For veneer evacuation, the laser is not as quick as a turning burr, in spite of the fact that it can be more traditionalists by not evacuating as much solid tooth structure. The underlying venture for a few gadgets must be considered, and in addition required supplies and support. The instruments extend in size from a soft cover novel to a huge dental truck, so coordination of space can turn into a consideration. All units work at line voltage and the Erbium lasers require an extra air supply [100].

Preparing and proceeding with training are crucial, and most producer's give great backing. The Foundation of Laser Dentistry offers a Standard Proficiency Course that instructs the expert at a sensible starting competency. A few diaries and a couple of course books are promptly accessible for depictions of clinical systems and research.

## REFERENCES

1. Borisenko LG. Oral health and dental care of old adults in Byelorussia. *Oral Health Dent Manag.* 2003;2:155.
2. Jadidfard MP, et al. Social insurance for dental care in Iran: A developing scheme for a developing country. *Oral Health Dent Manag.* 2012;11:480.
3. Ahtari MD, et al. Dental care throughout pregnancy: what a dentist must know. *Oral Health Dent Manag.* 2012;11:477.

4. Somya K and Surendra L. Nanotechnology (nanohydroxyapatite crystals): recent advancement in treatment of dentinal hypersensitivity. *J Interdiscipl Med Dent Sci.* 2015;3:181.
5. Pravin M, et al. A critical analysis of dentation and dental care in ayurveda. *J Homeop Ayurv Med.* 2014;3:175.
6. Reis PF, et al. Dental care clothing: an investigation the presence of bacterial contamination by public health professionals in southern Brazil. *J Food Process Technol.* 2015;6:407.
7. Ranta TRV, et al. Mandibular advancement device therapy in obstructive sleep apnea and snoring in community dental care: two-year follow-up study on self-reported sleep quality, side effects, and compliance. *J Sleep Disord Ther.* 2014;3:180.
8. Hatami B, et al. Dental students' perceived barriers in geriatric dental care active involvement. *Oral Health Dent Manag.* 2014;13:650.
9. Sullivan AL, et al. Exploring obstacles for dental care among the SCI population. *Int J Phys Med Rehabil.* 2013;1:154.
10. Alshehri A. Social and behavioral determinants of early childhood caries in the aseer region of Saudi Arabia. *Pediatr Dent Care.* 2016;1:114.
11. Godzieba A, et al. An analysis of the variability of hemodynamic parameters in patients with ischaemic heart disease undergoing dental surgery: a randomized clinical trial. *Dental Sciences.* 2016;4:100-105.
12. Bhargava ASK, et al. Relation between water and salivary fluoride levels among children residing in communities having different naturally occurring water fluoride levels in Andhra Pradesh, India. *Biol Med.* 2013.
13. Ghimire N. Oral Health? An integral part of general health. *J Mass Communicat Journalism.* 2013;3:e138.
14. Boid A, et al. A comparative evaluation of systemic azithromycin and ornidazole-ofloxacin combination as an adjunct to scaling and root planning in the treatment of chronic generalised periodontitis. *Dentistry.* 2015;5:309.
15. Nanditha S, et al. A judicious treatment approach for the management of localized aggressive periodontitis: a case report. *J Interdiscipl Med Dent Sci.* 2015;3:174.
16. Alwithanani N, et al. Periodontal treatment improves prostate symptoms and lowers serum psa in men with high PSA and chronic periodontitis. *Dentistry.* 2015;5:284.
17. Pushparani DS. Low serum zinc and increased acid phosphatase activity in type 2 diabetes mellitus with periodontitis subjects. *Biochem Pharmacol (Los Angel).* 2015;4:162.
18. Evers F, et al. Periodontitis, an often-overlooked reservoir for bacteria, in a patient with decubital ulcer. *Clin Microbiol.* 2015;4:189.
19. Policicchio P. Diabetes and periodontitis: a two way relationship. *Dental Sciences.* 2014.
20. Kazi MM, et al. An approach to the microbiological diagnosis of chronic periodontitis: an overview. *Dental Sciences.* 2014.
21. Gokhale SA, et al. A study to evaluate the relationship between IL-1 $\beta$  and Tnf- $\alpha$  levels in Gcf in non-smoker, previous or current smoker female patients with chronic periodontitis. *Dentistry.* 2014;4:270.
22. Bulgin D. Chronic periodontitis and systemic health. *Oral Hyg Health.* 2014;2:e109.
23. Zaghloul MZ. Human herpes viruses in patients with chronic periodontitis and aggressive periodontitis. *Air Water Borne Diseases.* 2014:e131.
24. Mummolo S, et al. Oral antiseptic and periodontitis: a clinical and microbiological study. *Oral Health Dent Manag.* 2014;13:657.
25. Pillai H, et al. Primary sinus carcinoma masquerading as destructive periodontitis: report of a case. *Dentistry.* 2014;4:251.

26. Cayci E, et al. Peripheral giant cell reparative granuloma of maxilla in a patient with aggressive periodontitis. *Oral Health Dent Manag.* 2014;13:642.
27. Fenol A, et al. Levels of interleukin-10 in gingival crevicular fluid and its role in the initiation and progression of gingivitis to periodontitis. *Oral Hyg Health.* 2014;2:135.
28. Kakade SP and Thakkar K. Inter-disciplinary approach ought to periodontitis and type 1 diabetes mellitus in india. *J Diabetes Metab.* 2014;5:385.
29. Herrmann JM and Meyle J. White blood cell signaling and defense mechanisms in patients with diabetes mellitus type 2 and periodontitis. *J Clin Trials.* 2014;4:171.
30. Mokeem SA, et al. Influence of smoking on clinical parameters and gingival crevicular fluid volume in patients with chronic periodontitis. *Oral Health Dent Manag.* 2014;13:611.
31. Iwai T and Umeda M. Smoking, periodontitis and vascular disease-collaboration study with dentists and vascular surgeons. *J Interdiscipl Med Dent Sci.* 2014;2:113.
32. Zaghloul MZ. The contribution of anaerobic bacteria that causes periodontitis in the pathogenesis of chronic obstructive pulmonary disease (COPD). *Air Water Borne Diseases.* 2014;3:e128.
33. Dababneh RH and Bissada NF. Syndromes that include both Palmoplantar keratoderma and severe periodontitis: A Review. *Dentistry.* 2014;4:186.
34. Robledo JG. Apical periodontitis treatment: surgical-non surgical? *Oral Hyg Health.* 2013;1:e104.
35. Goldberg MB, et al. Two case reports on refractory periodontitis: systemic implications and a potential new therapeutic strategy. *J Interdiscipl Med Dent Sci.* 2013;1:101.
36. Bey A, et al. Periodontitis: a significant risk factor for preterm low birth weight (PTLBW) babies. *Biology and medicine.*
37. Irina SA, et al. Generalised pre-puberal periodontitis: literature review and case presentation. *Oral Health Dent Manag.* 2007;6:318.
38. Maita E, et al. Oral hygiene instruction to arrest periodontitis in adolescents. *Oral Health Dent Manag.* 2004;3:167.
39. Leroy R, et al. Methodological issues in epidemiological studies of periodontitis: how can it be improved? *Oral Health Dent Manag.* 2010;9:415.
40. In vitro antifungal susceptibility of *Candida albicans* isolates from patients with chronic periodontitis and diabetes. *Clin Microbiol* 2013;2:103.
41. Nwhator SO and Adedigba MA. Is periodontitis the missing link? A metaethnographic review of glycemic control measures by Nigerian diabetologists. *Dentistry.* 2012;2:121.
42. Eskandari A, et al. Comparing the effect of one stage full mouth disinfection versus quadrant-wise scaling and root planning on clinical parameters and salivary inflammatory biomarkers in chronic periodontitis patients. *Dentistry.* 2012;2:118.
43. Michaela T, et al. Periodontitis and preterm low birth weight: is there any association? *Reprod Syst Sex Disord* 2012;S2:001.
44. Argento MA, et al. Flapless technique for periodontal bone grafts in treatment of severe periodontitis. Presentation and long-term retrospective study. *JMBT.* 2010;2:107-110.
45. Kim HD, et al. Omic paradigms enhance interface between periodontitis pathogenesis and human health. *J Nutr Food Sci.* 2016;6:506.
46. Zacarias JMV, et al. Letter to the editor concerning: the role of human leukocyte antigen typing in Libyan patients with chronic periodontitis. *J Infect Dis Ther.* 2016;4:279.
47. Edson da Silva, et al. Diabetes mellitus and periodontitis: molecular interrelationships. *J immuno Biol.* 2016;1:e102.
48. Rathod V, et al. Study to evaluate the effects of periodontitis and type ii diabetes on serum and salivary superoxide dismutase levels. *Dental Sciences.* 2015.
49. Daeki AO, et al. The role of human leukocyte antigen typing in Libyan patients with chronic periodontitis. *J Infect Dis Ther.* 2015;3:5.

50. Barot VJ and Chandran S (2015) Statistical study on serum CRP levels in aggressive & chronic periodontitis: pre & post non-surgical periodontal therapy. *Anaplastology*.
51. Taani DS. Dental health of 13-14-year-old Jordanian school children and its relationship with socio-economic status. *Int J Paediatr Dent*. 1996;6:183-186.
52. Genco RJ. Current view of risk factors for periodontal diseases. *J Periodontol*. 1996;67:1041-1049.
53. Offenbacher S, et al. Periodontal infection as a possible risk factor for preterm low birth weight. *J Periodontol*. 1996;67:1103-1113.
54. Maurya DK, et al. Role of triphala in the management of periodontal disease. *Anc Sci Life*. 1997;17:120-127.
55. Arendorf TM, et al. Oral manifestations of HIV infection in 600 South African patients. *J Oral Pathol Med*. 1998;27:176-179.
56. Fontana G, et al. An immunological evaluation of type II diabetic patients with periodontal disease. *J Diabetes Complications*. 1999;13:23-30.
57. Barczyk MP, et al. Brain abscess as a rare complication in a hemodialysed patient. *Med Sci Monit*. 2001;7:1329-1333.
58. Rasmussen L, et al. Characterization of bone resorbing activity in gingival crevicular fluid from patients with periodontitis. *J Clin Periodontol*. 2000;27:41-52.
59. Brook I. Microbiology and management of periodontal infections. *Gen Dent*. 2003;51:424-428.
60. Seymour RA. Dentistry and the medically compromised patient. *Surgeon*. 2003;1:207-214.
61. Persson GR, et al. Influence of interleukin-1 gene polymorphism on the outcome of supportive periodontal therapy explored by a multi-factorial periodontal risk assessment model (PRA). *Oral Health Prev Dent*. 2003;1:17-27.
62. Takashiba S and Naruishi K. Gene polymorphisms in periodontal health and disease. *Periodontol* 2000. 2006;40:94-106.
63. Hullah E, et al. Self-reported oral hygiene habits, dental attendance and attitudes to dentistry during pregnancy in a sample of immigrant women in North London. *Arch Gynecol Obstet*. 2008;277:405-409.
64. Gajewska MC, et al. Influence of smoking on incidence and progression of periodontal disease. Review of the literature. *Przegl Lek*. 2008;65:249-251.
65. Cakić S. Gingival crevicular fluid in the diagnosis of periodontal and systemic diseases. *Srp Arh Celok Lek*. 2009;137:298-303.
66. Grant WB and Boucher BJ. Are Hill's criteria for causality satisfied for vitamin D and periodontal disease? *Dermatoendocrinol*. 2010;2:30-36.
67. Ramirez JH, et al. Why must physicians know about oral diseases? *Teach Learn Med*. 2010;22:148-155.
68. Wahlström M, et al. Clinical follow-up of unilateral, fixed dental prosthesis on maxillary implants. *Clin Oral Implants Res*. 2010;21:1294-1300.
69. Zulficar M, et al. Oral *Fusobacterium nucleatum* subsp. polymorphum binds to human salivary  $\alpha$ -amylase. *Mol Oral Microbiol*. 2013;28:425-434.
70. Ahmed U and Tanwir F. Association of periodontal pathogenesis and cardiovascular diseases: a literature review. *Oral Health Prev Dent*. 2015;13:21-27.
71. Novacek G, et al. Dental and periodontal disease in patients with cirrhosis--role of etiology of liver disease. *J Hepatol*. 1995;22:576-582.
72. Mengel R, et al. Periodontal health of the population in eastern Germany (former GDR). *J Clin Periodontol*. 1993;20:752-755.
73. Pommereau DV, et al. Insulin-dependent diabetes and periodontal disease in young patients. *Ann Pediatr (Paris)* 1991;38:235-239.

74. Suzuki JB. Diagnosis and classification of the periodontal diseases. *Dent Clin North Am.* 1988;32:195-216.
75. Wolff LF, et al. Salt and peroxide compared with conventional oral hygiene. II. Microbial results. *J Periodontol.* 1987;58:301-307.
76. Newman MG. Anaerobic oral and dental infection. *Rev Infect Dis.* 1984;6:S107-S114.
77. Wierzbicka M, et al. Dental caries, periodontal diseases and the condition of mouth mucosa in workers of the petrochemical industry. *Med Pr.* 1983;34:275-281.
78. Maeda N. Anaerobic, gram-positive, pleomorphic rods in human gingival crevice. *Bull Tokyo Med Dent Univ.* 1980;27:63-70.
79. Bjorvatn K, et al. Oral aspects of osteopetrosis. *Scand J Dent Res.* 1979;87:245-252.
80. Markkanen H, et al. Evaluation of periodontal status in a Finnish industrial population. *Community Dent Oral Epidemiol.* 1979;7:96-100.
81. Merle JP. Gingivectomies. Flap operations. *Rev Stomatol Chir Maxillofac.* 1979;80:12-15.
82. Gordon HA, et al. Blood flow, collagen components of oral tissue and salivary kallikrein in young to senescent, germfree and conventional rats. A study on the etiologic factors of periodontal disease. *Gerontology.* 1978;24:1-11.
83. Ramfjord SP. Surgical pocket therapy. *Int Dent J.* 1977;27:263-269.
84. Melnick M, et al. Tricho-dento-osseous syndrome: a scanning electron microscopic analysis. *Clin Genet.* 1977;12:17-27.
85. Graf E. Functional analysis in orthodontics: diagnosis of mandibular positions and movements. *SSO Schweiz Monatsschr Zahnheilkd.* 1977;87:245-256.
86. Curilović Z and Renggli HH. Peridontal conditions in a group of Tibetans. *SSO Schweiz Monatsschr Zahnheilkd.* 1976;86:1135-1143.
87. Baker JJ, et al. Importance of Actinomyces and certain gram-negative anaerobic organisms in the transformation of lymphocytes from patients with periodontal disease. *Infect Immun.* 1976;13:1363-1368.
88. Penzer V. Letter to the editors: Re: A new concept of peridontal disease by Walter Drum, *J Periodontol* 46:504, 1975. *J Periodontol.* 1976;47:104.
89. Ketterl W. Pharmacology and periodontology. *Dtsch Zahnarztl Z.* 1975;30:368-371.
90. Longhurst P. Peridontal disease in childhood. *Proc Br Paedod Soc.* 1974;4:17-20.
91. Ruben MP, et al. The histopathology of peridontal disease in children. *J Periodontol.* 1971;42:473-484.
92. Tanzer JM and Hageage GJ. Polyphosphate inhibition of growth of plaques formed by streptococci and diphtheroids implicated in oral disease. *Infect Immun.* 1970;1:604-606.
93. Pezzoli M and Borio PS. The treatment of acute pulpal and peridontal disease by means of the para-apical infiltration of corticosteroids]. *Minerva Stomatol.* 1969;18:549-556.
94. Powell RN and Alexander AG. The treatment of peridontal disease. 5. Elimination of the lesion-subgingival scaling and curettage. *Br Dent J.* 1966;120:10-11.
95. Chawla TN, et al. Blood changes in peridontal disease. *J All India Dent Assoc.* 1965;37:224-227.
96. Fullmer HM. A critique of normal connective tissues of the periodontium and some alterations with peridontal disease. *J Dent Res.* 1962;41:223-234.
97. Baer PN and Newton WL. Studies on peridontal disease in the mouse. The germ-free mouse and its conventional control. *Oral Surg Oral Med Oral Pathol.* 1960;13:1134-1144.
98. Chawla TN and Mehta FS. Review on epidemiology of peridontal disease. *J All India Dent Assoc.* 1960;32:121-129.
99. Patrone A and Colli JC. Natural amino acids in the diet & the treatment of periodontal diseases. *Sem Med.* 1958;27:1000-1003.

100. Gebhardt H. Criticism of customary peridental therapy with reference to the hypotension theory and its practical results. Zahnarztl Rundsch. 1954;20:698-701.