Management of Necrotising Periodontal Diseases

Carry out patient history and examination	Commonly found in those who smoke, are immunodeficient (HIV), stressed and have poor oral hygiene. It is caused by spirochaetal and fusiform bacteria.
Diagnosis is made based on history and clinical findings	A grey pseudomembranous slough covering a painful, ulcerated gingival margin. The papillae have a punched-out appearance and there can be a loss of crestal bone. Patients experience bad breath and a metallic taste.
Explain likely cause and reinforce the need for excellent oral hygiene despite the pain	Advise to stop smoking. Advise use of a soft toothbrush, toothpaste, interdental cleaning, and mouthwash (0.2% chlorhexidine 10ml 2x/day or 6% hydrogen peroxide 15ml diluted in half a tumbler of water 3x/day). Using benzydamine sprays or topical benzocaine gels prior to cleaning will help reduce pain whilst cleaning.
Administer LA and debride	Remove supra and sub gingival deposits as much as patient will allow (painful).
For pain relief advise paracetamol or NSAIDs. If local measure alone are not effective then prescribe antibiotics.	Metronidazole is the antibiotic of choice. If allergic, consider Amoxicillin or Clindamycin.
Review in 1 week	Review and consider further non-surgical periodontal therapy if required. Long term future craters may need gingivectomy. If HIV is suspected refer to GMP.

There are 3 types of necrotising periodontal diseases- necrotising gingivitis, necrotising periodontitis, necrotising stomatitis. The type is determined by the extent and tissues affected.
Necrotising gingivitis can be confused with Primary Herpetic Gingivostomatitis. This is a self-limiting condition and does not require treatment. There is usually a history of contact with someone with cold sores. Painkillers, bed rest, fluids, soft diet and intra oral ulcer management required.