

Basic Periodontal Examination (BPE)

Careful assessment of the periodontal tissues is an essential component of patient management. The **BPE** is a simple and rapid screening tool that is used to indicate the level of further examination needed and provide basic guidance on treatment needed. These **BPE** guidelines are not prescriptive but represent a minimum standard of care for initial periodontal assessment. **BPE** should be used for screening only and should not be used for diagnosis.

The clinician should use their skill, knowledge and judgment when interpreting **BPE** scores, taking into account factors that may be unique to each patient. Deviation from these guidelines may be appropriate in individual cases, for example where there is a lack of patient engagement. General guidance on the implications of **BPE** scores is indicated in the table below. The **BPE** scores should be considered together with other factors when making decisions about referral (as outlined in the companion BSP document "Referral Policy and Parameters of Care").

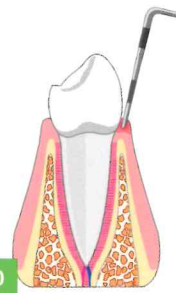
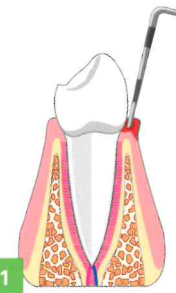
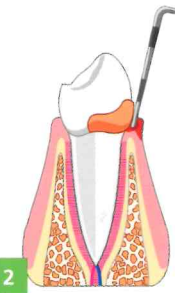



Guidelines for the use of **BPE** in younger patients can be found in the BSP document "Guidelines for periodontal screening and management of children and adolescents under 18 years of age."

The UK Implementation guidance of the 2017 Classification for periodontal and peri-implant diseases and conditions maps to the BPE guidelines and is documented in *Periodontal diagnosis in the context of the 2017 classification system of periodontal diseases and conditions – Implementation in Clinical Practice*, T. Dietrich, P. Ower, M. Tank, N. X. West, C. Walter, I. Needleman, F. J. Hughes, R. Wadia, M. R. Milward, P. J. Hodge, I. L. C. Chapple & on behalf of the British Society of Periodontology, *BDJ* volume 226, pages 16–22 (11 January 2019) <https://www.nature.com/articles/sj.bdj.2019.3>

How to record the BPE

- The dentition is divided into 6 sextants and the **highest** score for each sextant is recorded:
 - Upper right (17 to 14)
 - Lower right (47 to 44)
 - Upper anterior (13 to 23)
 - Lower anterior (43 to 33)
 - Upper left (24 to 27)
 - Lower left (34 to 37)
- All teeth in each sextant are examined (with the exception of 3rd molars unless 1st and/or 2nd molars are missing).
- For a sextant to qualify for recording, it must contain at least 2 teeth.
- A World Health Organisation (WHO) **BPE** probe is used. This has a 'ball end' 0.5mm in diameter and a black band from 3.5mm to 5.5mm. Light probing force should be used (20-25 grams).
- The probe should be 'walked around' the teeth in each sextant. All sites should be examined to ensure that the highest score in the sextant is recorded before moving on to the next sextant. If a code 4 is identified in a sextant, continue to examine all sites in the sextant. This will help to gain a fuller understanding of the periodontal condition and will make sure that furcation involvements are not missed.

Scoring Codes

 <p>0</p>	 <p>1</p>	 <p>2</p>	 <p>3</p>	 <p>4</p>	 <p>*</p>
<p>Pockets <3.5mm</p> <p>No calculus/overhangs, no bleeding on probing (black band entirely visible)</p>	<p>Pockets <3.5mm</p> <p>No calculus/overhangs, bleeding on probing (black band entirely visible)</p>	<p>Pockets <3.5mm</p> <p>Supra or subgingival calculus/overhangs (black band entirely visible)</p>	<p>Probing depth 3.5-5.5mm</p> <p>(Black band partially visible, indicating a pocket of 4-5mm)</p>	<p>Probing depth >5.5mm</p> <p>(Black band disappears, indicating a pocket of 6mm or more)</p>	<p>Furcation involvement</p>

An example BPE score grid might look like this:

4	3	3*
-	2	4*

Both the number and the * should be recorded if a furcation is detected. E.g. the score for a sextant could be 3* (indicating a probing depth 3.5-5.5mm plus a furcation involvement in the sextant).

How to Use BPE

- All new patients should have the **BPE** recorded
- For patients with codes 0, 1 or 2, the **BPE** should be recorded at every routine examination
- For patients with **BPE** codes of 3 or 4, more detailed periodontal charting is required
- **Code 3:** Initial therapy including self-care advice (oral hygiene instruction and risk factor control) then, post-initial therapy, record a 6-point pocket chart in that sextant only
- **Code 4:** If there is a Code 4 in any sextant then record a 6-point pocket chart throughout the entire dentition
- **BPE** cannot be used to monitor the response to periodontal therapy because it does not provide information about how sites within a sextant change after treatment. To assess the response to treatment, a 6-point pocket chart should be recorded pre and post- treatment
- For patients who have undergone initial therapy for periodontitis, and who are now in the maintenance phase of care, then full probing depths throughout the entire dentition should be recorded at least annually

In addition it is recommended that:

- **BPE** should not be used around implants (4 or 6-point pocket charting should be used)
- Radiographs should be available for all Code 3 and Code 4 sextants. The type of radiograph used is a matter of clinical judgement but crestal bone levels should be visible. Many clinicians would regard periapical views as essential for Code 4 sextants to allow assessment of bone loss as a percentage of root length and visualisation of the periapical tissues
- When a 6-point pocket chart is indicated it is only necessary to record sites of 4mm and above (although 6 sites per tooth should be measured)
- Bleeding on probing should always be recorded in conjunction with a 6-point pocket chart

Guidance on Interpretation of BPE Scores



0
No need for periodontal treatment



1
Oral hygiene instruction (OHI)



2
As for Code 1, plus removal of plaque retentive factors, including all supra and subgingival calculus



3
As for Code 2 and RSD if required



4
OHI, RSD. Assess the need for more complex treatment; referral to a specialist may be indicated

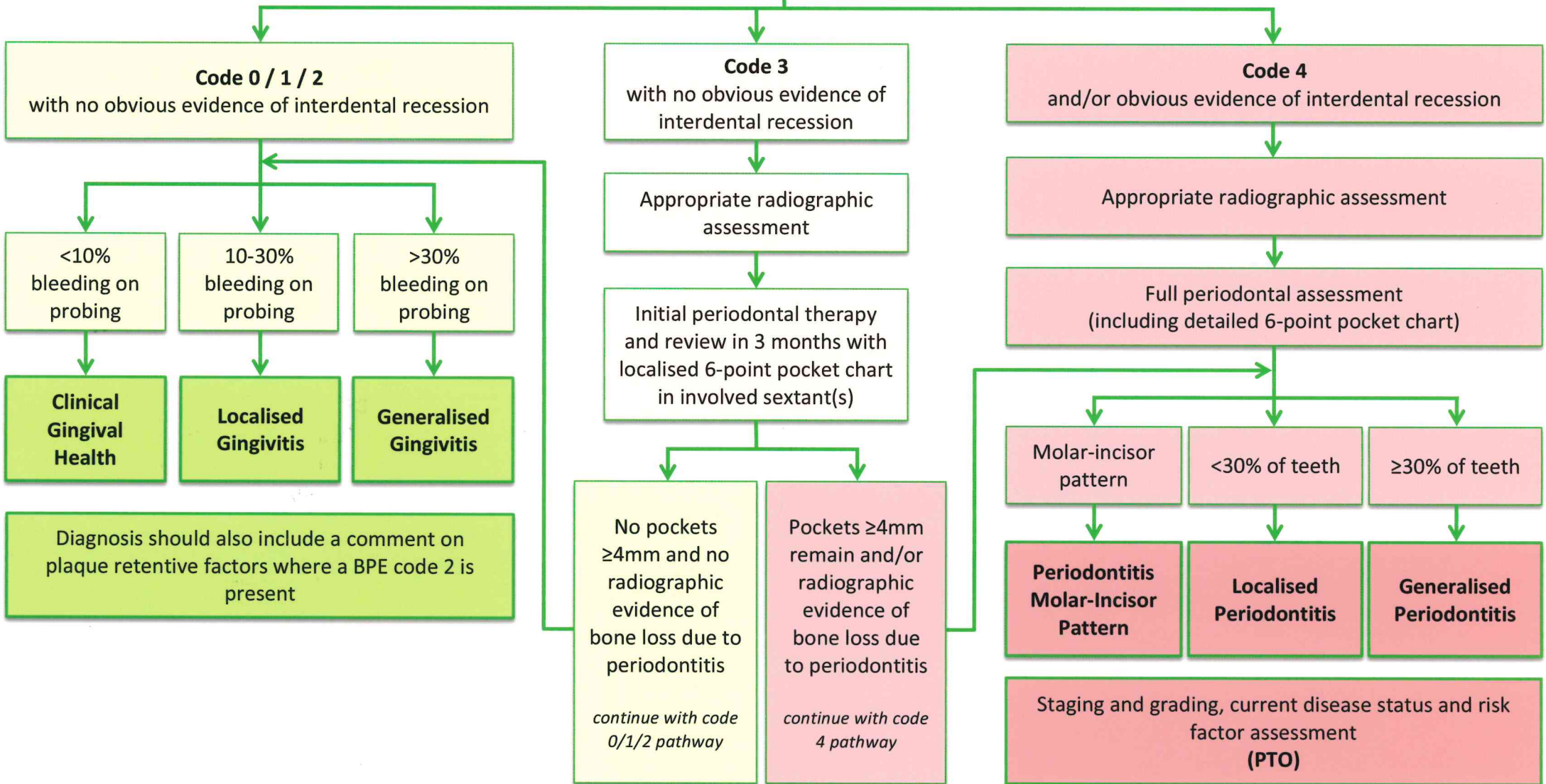


*
Treat according to BPE Code (0- 4). Assess the need for more complex treatment; referral to a specialist may be indicated

Implementing the 2017 Classification of Periodontal Diseases to Reach a Diagnosis in Clinical Practice



History, examination and screening for periodontal disease
including BPE and assessment of historic periodontitis (interdental recession)



Staging

Grading



Radiographic Assessment
(periapicals or OPG/DPT)
if not clinically justified or if bitewings only available use CAL or bone loss from CEJ

Interproximal bone loss
(use worst site of bone loss due to periodontitis)

% bone loss ÷ patient age
(use worst site of bone loss due to periodontitis)

<15%
(or <2mm
attachment loss
from CEJ)

Coronal third
of root

Mid third of
root

Apical third of
root

<0.5

0.5-1.0

>1.0

Stage I
(Early/Mild)

Stage II
(Moderate)

Stage III
(Severe)

Stage IV
(Very Severe)

Grade A
(Slow rate of
progression)

Grade B
(Moderate
rate of
progression)

Grade C
(Rapid rate of
progression)

Assessment of Current Periodontitis Status

Risk Factor Assessment

Currently Stable
BoP <10%
PPD ≤4mm
No BoP at 4mm sites

Currently in Remission
BoP ≥10%
PPD ≤4mm
No BoP at 4mm sites

Currently Unstable
PPD ≥5mm or
PPD ≥4mm & BoP

For example:

- Smoking, including cigarettes/day
- Sub-optimally controlled diabetes

Diagnosis Statement: Extent – Periodontitis – Stage – Grade – Stability – Risk Factors
e.g.: Generalised Periodontitis Stage 3 Grade B – Currently Unstable – Risk(s): Smoker 15/day