Editorial
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Patient Centered Outcomes in Periodontal Treatment

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The global burden of disease represented by chronic periodontitis is proved by its position as the sixth most prevalent disease. The periodontal disease activity and severity is routinely measured by clinicians using different clinical parameters such as probing pocket depth, bleeding on probing and clinical attachment level.[1] Hujoel PP et al. remarked that these clinical periodontal parameters widely used in research are not the true endpoints and merely just surrogate outcomes.[2]

True endpoints are those outcomes that directly measure patient's perception and how a patient feels about treatment. True endpoints also include subjective oral health related quality of life measurements or simple self-reported symptoms such as bleeding after brushing, mobility of teeth, foul smell from mouth, food lodgment, sensitivity, etc., whereas, surrogate endpoints are being used as a substitute for true endpoints. Surrogate endpoints are recorded by the clinician as they are objective and do not rely on patient's subjective views. True endpoint trials may also provide a first mover advantage. The first mover advantage is the one where outcomes measured after the clinical trial itself motivates vast number of patients to undergo the same treatment therapy with positive outcomes.[3] For example, following root coverage procedure more weightage is given to recession measurement than the amount of patient satisfaction achieved by self-reported aesthetic improvement. So, the endpoints measured for any disease condition should include patient's perspective too and not just from clinician's point of view.

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Currently there is lack of scientific bias for the measurement of periodontitis which has led to changing opinions as to what measures should be used to access periodontal treatment efficacy and how to interpret changes. It is notable that upto the 1970s, pocket depth was the fundamental measure of periodontal treatment success[4] and surgical periodontal therapy, which aimed at eliminating pocket depth, was the treatment of choice. But from the 1970s until 1992, attachment levels became the gold standard[5] and nonsurgical periodontal therapy, which aimed at maintaining attachment level, became a commonly recommended treatment. More recently, expert panels again switched to the pre-1970s philosophy of considering probing depths the primary outcome measure, thereby allowing site-specific antibiotics to make their entry onto the periodontal pockets.[1]

Despite growing recognition of their importance, patient-centered outcomes still remain understated in periodontal research. Majority of practice still continue to prioritize surrogate clinical endpoints while giving limited attention to patient experiences. Future studies should incorporate standardized patient-reported outcome measures (PROMs) alongside clinical measures to generate evidence that is both scientifically rigorous and meaningful to patients. Such an approach will strengthen the relevance of research findings and support the development of truly patient-centered treatment guidelines.[6]

In conclusion, current healthcare increasingly recognizes that optimal treatment outcomes extend beyond clinical improvements to incorporate the patient's perception of health, function, comfort and quality of life. This paradigm shift has brought patient-centered outcomes to the forefront of periodontal research and clinical practice. Hence, the future of periodontology lies not only in preserving

periodontal tissues but also in enhancing the overall well-being and experiences of patients. This patient focused perspective will ultimately lead to more comprehensive, effective and empathetic periodontal care.

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