

**From The Editorial Desk  
The Oral Route To Heart Disease: Point To Ponder**

Preetinder Singh<sup>1</sup>

Singh P. **The oral route to heart disease: point to ponder.** J Periodontal Med Clin Pract 2014;01: 1

**Dr. Preetinder Singh (Medalist), Assoc. Prof. (Periodontology & Oral Implantology)  
SDD Hospital & Dental College, Barwala, Panchkula (Haryana) INDIA  
(Editor-in-Chief)  
Journal of Periodontal Medicine and Clinical Practice  
Email: editor@jpmpc.com**



**Editor in Chief of JPMCP, I anticipate that this first issue would be of immense value and will be definitely useful to dental science and its care providers in their practice or thinking process. This collection will also offer a window for new perspectives and directions in the area of oral research in the readers' mind for long. I extend my warmest thanks to the authors for their interest, enthusiasm and timely submission of manuscripts for JPMCP.**

Oral infections have appeared as cardiovascular risk factors in cross-sectional and in follow-up studies, and the association has been independent of the "classic" coronary risk factors. Periodontitis and dental procedures can be potential factors in transient bacteremia.<sup>[1]</sup> Schwartzman reactions have been reported following full mouth debridement. Thus, gentle mastication can release bacterial endotoxins into the bloodstream in patients with periodontitis. In addition, oral microorganisms can be spread from an infected root canal into the blood stream during and after endodontic therapy.<sup>[2,3]</sup> Two pathways are suspected to be involved: a direct pathway where the oral bacteria invade the arterial wall or an indirect pathway where bacterial products from the oral cavity exert a systemic effect on atherosclerosis development.<sup>[4,5]</sup> Due to the high prevalence and seriousness of these troubles, the dental surgeon must be aware of them and should be able to act quickly and effectively in the case of an acute cardiovascular event. In patients with a history of cardiovascular disease, attention must center on the control of pain, the reduction of stress, and the use or avoidance of a vasoconstrictor in dental anesthesia. In turn, caution is required in relation to the antiplatelet, anticoagulant and antihypertensive medication typically used by such patients.<sup>[6]</sup>

So, the point to ponder is - Should dental health scores and oral disease knowledge to practitioners be used in addition to classical risk factors to predict an individual's risk of Coronary Artery Disease?

**References**

1. Srinivasan MP, Kamath PK, Manjrekar PA, Unnikrishnan B, Ullal A, Kotekar MF, Mahabala C. Correlation of severity of coronary artery disease with insulin resistance. North Am J Med Sci 2013;5:611-4.
2. Daly CG, Mitchell DH, Highfield JE et al. Bacteremia due to periodontal probing: a clinical and microbiological investigation. J Periodontol 2001;72:210-4.
3. Debelian GJ, Olsen I, Tronstad L. Bacteremia in conjunction with endodontic therapy. Dent Traumatol 1995;11:142-9.
4. Chiu B. Multiple infections in carotid atherosclerotic plaques. Am Heart J 1999;138:S534-S536.
5. D' Aiuto F, Ready D, Tonetti MS. Periodontal disease and C-reactive protein-associated cardiovascular risk. J Periodontal Res 2004;39:236-241.
6. Hupp JR. Ischemic heart disease: dental management considerations. Dent Clin North Am. 2006 Oct;50(4):483-91.