

## New mouthrinse to support dental periodontal treatment combines plaque inhibition and remineralisation

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Münchenstein, April 11, 2005 – To support dental measures in gingivitis and periodontitis treatment a temporary drastic reduction in plaque bacteria may be necessary to promote the healing process. Because of its antibacterial effect, higher concentrations (0.2%) of chlorhexidine are seen as the gold standard.

To complement meridol toothpaste and meridol mouthrinse with their combination of active substances amine fluoride/stannous fluoride (AmF/SnF<sub>2</sub>), which are tailored for preventive long term care of gingivitis and periodontitis patients, GABA has now launched meridol chlorhexidine 0.2% mouthrinse for short-term use during dental periodontal treatment. This newly developed product is based on the gold standard CHX 0.2%: it inhibits the attachment of plaque bacteria as well as reducing bacterial growth. But thanks to the combination with fluoride (250 ppm of sodium fluoride), meridol chlorhexidine 0.2% mouthrinse acts differently from fluoride-free mouthrinses with 0.2% CHX, additionally remineralising on the dental enamel.

The plaque-inhibiting and antibacterial efficacy of the new meridol chlorhexidine 0.2% mouthrinse and the associated decrease in gingival inflammation have been confirmed in clinical studies. Thus in a double-blind, randomised clinical in-vivo study the working group associated with Prof. Thomas Hoffmann of the University of Dresden, Germany, examined the effect of CHX mouthrinses on the development of gingival inflammation. During the 21 day study period the test subjects used as their sole oral hygiene measure either meridol chlorhexidine 0.2%



meridol chlorhexidine 0.2% mouthrinse for short-term use combines plaque-inhibiting and antibacterial efficacy with protection against caries.

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mouthrinse, a commercial mouthrinse with 0.2% CHX or a placebo mouthrinse 2x daily. Whilst the chlorhexidine-containing mouthrinses displayed no statistically significant difference with regard to gingival index and plaque index, the difference was clearly and statistically significant for the placebo mouthrinse.

In a further randomised, double blind crossover study at the Aster-Cephac Clinical & Bioanalytical Research Center, Paris, Dr. Alice Bordas and her co-workers examined in 30 test subjects plaque inhibition through use of meridol chlorhexidine 0.2% mouthrinse (alcohol-free). Here too a commercial mouthrinse with 0.2% CHX (containing alcohol) and a placebo mouthrinse were compared, and the plaque index (PI) in accordance with Turesky was determined at the beginning and end of each 4-day study period: it transpired that there was clear and, in comparison with the placebo, statistically significant plaque inhibition as a result of use of the two CHX mouthrinses. This study also confirmed that the clinical effect of the alcohol-free meridol chlorhexidine 0.2% mouthrinse is equivalent to that of similar alcohol-containing products.

The aim of the in-situ study performed by the working group associated with Prof. Elmar Hellwig of the Policlinic for Dental Preservation of the University of Freiburg, Germany, was the determination of remineralisation of initial caries lesions following use of the newly developed product. 21 test subjects carried demineralised samples of cow dental enamel in their lower jaw, and during the 14-day study periods used meridol chlorhexidine 0.2% mouthrinse (with fluoride), a fluoride free CHX mouthrinse or the placebo mouthrinse 2x daily. Fluoride uptake by the dental enamel samples was measured using an ion-selective fluoride electrode, and the mineral content of the dental-enamel samples was determined microradiographically. In comparison with fluoride-free CHX mouthrinse and placebo mouthrinse, use of meridol chlorhexidine 0.2% mouthrinse led to 20- to 33-fold greater fluoride enrichment in the enamel samples. Remineralisation of the demineralised enamel samples was also significantly higher. Thus with meridol chlorhexidine 0.2% mouthrinse the teeth and in particular the exposed root surfaces are protected after dental intervention in the event of caries.

As well as the dental measures against gingivitis and periodontitis, daily oral hygiene plays a focal role in the success of treatment. Thus following dental intervention and during use of a CHX mouthrinse, plaque should as far as possible also regularly and consistently be mechanically removed using toothpaste and a toothbrush. But since the effect of chlorhexidine is influenced by anionic tensides such as sodium lauryl sulphate, when using a toothpaste containing sodium lauryl sulphate you should wait for at least

30 minutes between brushing and rinsing with a CHX mouthrinse. meridol toothpaste with amine fluoride/stannous fluoride does not contain any sodium lauryl sulphate, and it can thus be combined with meridol chlorhexidine 0.2% mouthrinse without there being any need to wait.

Thanks to its powerful antibacterial and plaque-inhibiting effect, CHX 0.2% is suitable as supportive measure during treatment of gingivitis and periodontitis, but it should not be used for longer than two weeks. After this, however, it is important to restore healthy oral flora. meridol mouthrinse with amine fluoride/stannous fluoride, which was conceived for long-term use, is recommended for this purpose: it chiefly deactivates bacteria associated with gingivitis and thus promotes both healthy gingival conditions and healthy oral flora.

### **Source**

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  - Altenburger MJ, Klasser M, Umland N, Hellwig E. In situ remineralisation of demineralized enamel using CHX/NaF mouthrinse. J Dent Res 83 (2004), Special Issue A (abstract 3584)
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