Case 2

Ms. R

The case I will present focuses on a 62 year old Asian female that I was able to treat during my 3rd and 4rd semester of dental hygiene school. I will explain briefly the changes that I witnessed during every semester in my patient.

Her chief complain during the 3rd semester ( October 2023) was the following : “ I want to have a cleaning done in one appointment “.After all the assessments I explained that because she is in a learning facility it is not always possible to have a cleaning done in one visit and that I will do my best to provide a very good care of her.

In the 4th semester ( April 2024) patient stated in her chief complaint that after my recommendation she visited a dentist and a hygienist in January 2024. She wanted to have a deep cleaning and evaluate for the need of local antibiotic on the UL.

During Medical history review patient states that she was healthy. She was under the care of a physician periodically. She was taking the following medication during night time once a day: Aspirin 81mg, Amlodipine 5mg both for hypertension, Ezetimibe 10mg, Atorvastatin 40mg both for high cholesterol. Patient also was taking multivitamin complex everyday . Patient stated that the anesthetic used when she had a colonoscopy made her nauseous and she states that she has allergy to anesthetic. She did not report rash or swelling after anesthesia. ASA 2

Her BP was within the normal limits in every appointment.

Social history : Patient stated that she does not drink alcohol, smoke or take any drugs

During dental history in the recare appointment in 4th semester : Patient stated that she uses electric toothbrush with sensodyne toothpaste 2 times a day, floss pick and proxy brushes once a day. Patient had dental restorative work done in january 2024. Patient demonstrated compliance to my recommendations in 3rd semester. It is important to mention that during her dental visits patient did not complain about xerostomia or “mouth- burning “ which would have been a normal finding due to various medications that this patient takes on daily bases. However, I did recommended her to stay hydrated throughout the day to keep an optimal moisture in her oral cavity and prevent caries and infections. Also, according to my clinical judgment the salivary flow in this patient should be always evaluated due to her medications, but it did not represented one of the main concerns during Ms. R dental visits.

EO: Palpable lymph node was found on the sublingual gland on the right side . The size is approximate 1cm. Patient did not report pain upon palpation.

IO : Patient had bilateral linea alba and palatine torus. Sublingual node is also palpable intraorally on the right side of the floor of the patient’s oral cavity near the right lower canine. The size was approximately 1 cm. Patient did not report pain upon palpation.

Dental Charting updated in April 2024: Patient has multiple composite and amalgam fillings. Patient has also crowns and root canals. Missing #1.16.50 due to caries. Class 1 relation on canine on the right side and class 1 molar on the left side. Overjet 1 mm and overbite 10%.

Periodontal Assessment during 4th semester.

Gingival Statement: Patient has generalized moderate redness and inflammation on maxilla and mandibular molars. Marginal gingiva around teeth #8 and 9 is lightly purple. Mandibular anterior teeth have blunted papilla. Generalized gingival recession on mandibular teeth. Light BOP.

Perio Charting: Generalized 3-4 mm pockets localized CAL 3-5 MM

Calculus was compared in the 3rd and 4th semester.

3rd semester : Patient has generalized heavy sub-gingival calculus on the upper posterior, lower posterior and anterior mandibular teeth.

4th semester. Patient had moderate sub-gingival calculus on the posterior teeth

Pl score changed in the 3rd and 4rd semester from 1.16 to 1 that corresponds to fair.

Patient had FMS radiographs taken in our clinic in 2022 and the findings were the following: Patient had heavy calculus seen radiographically, caries on #19 D and #18 M. Generalized Horizontal RBL of 25%. Missing # 1-16.30.

Patient also stated that she had radiographs exposed in the dental office that she went in January 2024.

Upon clinical and radiological assessments I concluded that her Perio status was Localized Periodontitis stage 2 grade B

Caries risk: Moderate

Case Value changed from Heavy in the 3rd semester to Medium in the 4th semester.

After all the assessments were completed in 3rd and 4rd semester the treatment for this patient was to scale 4 quadrants using cavitron and hand scaling . Engine polishing and fluoride varnish 5%. I offered topical or local anesthesia for pain management, but patient declined it and tolerated the procedure well.

Finally, Patient was provided with referral forms as needed and 3rd and 4th semester. Patient demonstrated compliance to follow my guidance and manifested that she was happy to have received my care in the Dental Hygiene clinic.

I recommended recare every 3 months to prevent the progression of her existing periodontal disease

In the following images due to some restrictions in the school dental system, it was not possible to correct the position of the upper anterior periapical radiograph and to remove the caries in #4. The clinical notes reflects all the findings during assessments.

