Journal 1- Arestin

Dates of services: 8/29, 9/1, 10/6

Visit #1 L.R. 28 years old. Hispanic. Male. Case H/ Type III.

**ASSESSMENTS**

**Medical History**

Updated medical history WNL. ASA I. Not taking medications. Patient was present for his 3-month recare. BP: 121/76 and P: 87.

**Oral Pathology**

 No pathology found in this patient.

**Dentition**

Patient is missing teeth #5, 12, 21 and 28. Patient stated these teeth were extracted prior to orthodontic treatment. Teeth #17 and 32 are partially erupted. Radiographs confirmed the extraction of the missing teeth and the soft tissue impaction of teeth #17 and 32. Diastema present between teeth #20-21, #24-25 and #27-28. Ortho-treatment was not completed due to patient's preference. Teeth #17 and #32 are partially erupted. Composite restorations on teeth #14 O, #18 OL and #31 O. Restorations are intact. Non-caries lesions were found. Patient has bilateral class I occlusion with no overjet and no overbite. Attrition present on all mandibular anterior teeth and tooth #18.

**Periodontal**

Patient is classified as a Type III periodontal case with mandibular localized Type IV. Moderate bleeding upon probing. Several pockets of 4-6 mm in the interproximal surfaces of posterior teeth and some in the lingual surfaces of mandibular anterior teeth. Localized mandibular marginal gingival was inflamed with blunted papilla. Lingual rolled and red marginal gingiva aspects on mandibular molars. Also, minimal gingival inflammation was observed on maxillary posterior teeth. Patient has localized 4-8 mm of recession on teeth #22-26. Tooth #25 has a recession of 8 mm with mucogingival involvement. Grade 1 mobility present on teeth #23 and 26 and grade 2 mobility on teeth #24-25. I explained to patient that his tongue piercing, he used it for years, was a contributing factor for his teeth mobility. Periodontal referral was provided to patient after the discussion of his periodontal case.

**Oral Hygiene**

Supra-gingival calculus was observed and mandibular anterior teeth. Subgingival calculus was present mostly interproximal on posterior teeth. It seemed to be residual calculus from his last visit. Since this patient was a re-care, I reviewed past oral hygiene instructions. He stated he has been using Listerine antiseptic twice a day and brushing using circular strokes. However, when the disclosing solution was applied, his score was fair. Most plaque was observed around the gingival margin around teeth #24-26, where mobility is present. Patient was very sensitive in these areas. Recommended proxy brush and technique was discussed.

**Radiographs**

Patient was exposed to a FMS last semester during his initial visit. Faculty and I observed these radiographs. Severity of bone loss was observed, especially on mandibular incisor teeth. A periodontal referral was given to the patient again. During his initial visit, a referral was provided, patient was not able to see a periodontist due to his low income.

**Other Findings**

Patient is non-smoker and doesn’t drink alcohol. Patient's source of income is low which stops him to see a periodontist. Faculty recommended him to visit school dental organizations as NYU to make payment plans and take care of his periodontal case. Also, patient used a tongue piercing for years and had it removed a couple years ago. He stated he usually play with it with the lingual surfaces of mandibular incisors.

**Time**

This patient was advised to be under a 3 month-recare. His last visit was on May, 2017. He come back on August 29th, 2017. for his recare appointment. I think the interval between the appointments is good because of his periodontal case and to know if he went to see a periodontist. Also, as oral care providers, we should observe if there are any good changes on his gingiva relating to home care or to see if there's lack of oral hygiene to emphasize new techniques or determine why the patient is not compliant with his oral routine.

**Treatment Management**

**Visit 1**

I reviewed updated medical history with patient. His vital signs were within normal limits. I spoke with the patient about his last periodontal referral provided. He said he wasn't able to take care of this due to his low income. I proceeded to EO/IO. Bilateral cheek biting was observed by teeth #18-19 and #30-32. Then, I moved to dental charting. I compared last restorations filed in the computer from his last visit, they were the same and intact. No suspicious lesions found. Edge to edge canines biting was observed and patient also had mandibular incisors protruding over maxillary incisors. I believe is due to his mobility and his tongue piercing. During probing, moderate bleeding was observed. Several 4-6 mm pocket depths interproximal on posterior teeth. Patient was very sensitive when probing, so I applied benzocaine 20% topical to the tissue. It worked well. Localized 4-8 mm recession present on teeth #22-26. Tooth #25 has the most severe recession of 8mm with mucogingival involvement. Generalized pink gingiva with localized mandibular red and inflamed marginal gingiva on anterior teeth. Lingual marginal gingiva of mandibular posterior teeth was red and rolled with minimal inflammation. Generalized interproximal plaque around the cervical third on posterior teeth present. Supra-gingival calculus present on mandibular incisors and localized interproximal sub-gingival calculus present on posterior teeth. Patient had moderate bleeding upon exploring. Plaque score was fair. I interviewed the patient about his last visit oral hygiene. Patient said he uses Listerine antiseptic daily twice a day. For toothpaste he uses Crest Pro-health and he is comfortable with it. I recommended the patient to keep using it because this toothpaste is anti-cavity, anti-gingivitis and anti-sensitivity. I asked the patient to showed me how he was brushing using a manual toothbrush. I emphasized the angulation of the toothbrush to remove plaque with efficacy. Proxy brush technique was discussed with the patient. I discussed with patient about his Type III with localized Type IV periodontal case. I explained to him that besides maintaining his teeth free from biofilm and calculus, he will need to take care of his teeth mobility. Faculty provided 1/2 carpule of Lidocaine HCL 2% with epinephrine to teeth #29 and 30. Scaled teeth #29-30.

**Visit 2**

Reviewed medical history with patient. Gingiva is observed with less inflammation. Minimal bleeding upon exploring. Marginal gingiva on mandibular anterior teeth still red and inflamed due to supra-gingival calculus present. Treatment was not provided on those areas during last visit because of time. I disclosed the patient and the PI improved from fair to good. I suggested a tongue cleaner due to plaque observed on the dorsal surface. I discussed the technique of flossing for posterior teeth. Faculty provided 2 ¼ carpules of Lidocaine HCL 2% with epinephrine to UR and LR quadrant. Patient tolerated it well and anesthesia was achieved. Scaled UR and LR quadrants using ultrasonic and hand instruments.

**Visit 3**

Reviewed medical history with patient. Minimal marginal inflammation on mandibular anterior teeth. Tissue was healing very well on teeth #25-26. No residual calculus and minimal bleeding upon exploring. Plaque score increased from good to fair. Noticible plaque was observed on the maxillary molars. Patient stated he had difficulty reaching most posterior teeth when flossing. I introduced an end tufted brush. Patient loved it. He purchased two brushes. Faculty applied 3 carpules of Lidocaine HCL 2% with epinephrine to UL and LL quadrants. He was very sensitive but I managed it with hand instruments and lowering the power of the cavintron. Scaled to completion UL and LL quadrants using ultrasonic and hand instruments. Polished with fine paste. This patient was a good candidate for Arestin. I reviewed with patient about his periodontal case Type III. I explain to the patient about Arestin treatment. I informed him that it is an antibiotic that kills the bacteria and helps with the reduction of pocket depths. I told him how expensive can this be in private clinics and this is a great opportunity that he can take advantage. Patient signed Arestin consent. I determine the pockets of the previous scaled areas. Under the supervision of the faculty, I chose and placed Arestin on 6 sites: #2 distal-buccal, #2 mesial-buccal, #3 distal-buccal, #3 mesial-buccal, #4 distal-lingual and 30 distal-lingual. Post-instructions given to patient. Patient agreed to come back for Arestin re-evaluation.

**Arestin Re-evaluation**

Patient come back four weeks after the placement of Arestin for evaluation. Medical history is within normal limits. I did a quick IO examination and observed his gingival tissue. No inflammation seen. His home care was very good. Tissue for teeth #24-26 healed very well. I probed the same areas where I placed Arestin. Teeth #2 DB went from 5mm to 2mm, #2 MB from 6mm to 2mm, #3 DB from 5mm to 3mm, #3 MB from 6mm to 4mm, #4 DL from 5mm to 3mm and #30 DL from 5mm to 4mm. Faculty and I were impressed for the changes observed. We considered that his re-care appointment should be in 4 months.

**Student Reflection**