Nicky Joe Ly

Den 1200 - D206

Professor Ochiogrosso

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Journal Entry #1 - Cubicle 14B

1. Demographics:
* New patient A.L. is a 19 year old male that is a light/type I.

2) Assessment:

1. A.L. is an ASA I. Blood pressure is 109/77, pulse per minute is 72.
2. No history of smoking or tobacco use.
3. No use of any premedication.
4. No systemic conditions present.
5. No prescription medication and no over the counter medication.

3) Oral Pathology:

1. Both extraoral and intraoral have no significant findings.

4) Dentition:

1. Angle’s classification of occlusion is bilateral tendency to class III. Overjet is 2mm and overbite is 30%; #6, #7, #27 is edge to edge bite, slight attrition on the incisal surface of #6 and #11. There is also a composite restoration on the buccal surface of #18.
2. No tooth anomalies.
3. A.L. is a low caries risk patient and no carious lesions on any teeth.

5) Periodontal:

1. A.L. is a light/I case type. Probing depths are localized in 4mm molar regions and generalized 3mm or less elsewhere; minimal bleeding on probing.
2. Generalized uniform pink, stippled, firm/resilient with pointed papillae. Localized slight inflammation with 4mm probing depths on molar regions including #2,3,4,13,15,18,19,31,30,29 all buccal and lingual aspects.

6) Oral Hygiene:

1. Note: This patient was only disclosed once during the second session (revisit) because the initial visit ended with periodontal probing. Initial plaque index score is a 1 in all corresponding sextants, adding up to a total score of 1 (Fair).
2. Areas where calculus were found includes: #2 distal/mesial, #3 distal, #6 distal, #11 Mesial, #12 mesial, #14 distal, #22 distal and #27 distal.  Majority of the calculus detected was light supragingival and some light subgingival towards the posterior.
3. The planned oral hygiene interventions based on the findings include removing all light calculus from the surfaces of the above teeth and teaching the patient to utilize proper flossing technique with string floss and floss pick  at least once a day to remove biofilm interproximally.

7) Radiographs:

1. Yes, the patient requires 4 horizontal bitewings.
2. The radiographs were not available during data collection.
3. Unable to reveal any condition because the radiographs were not available during data collection.

8) Treatment Management - Utilizing the Patient Concept Map

1. My treatment plan is to educate the patient on proper flossing technique, followed by 4 HBWs, whole mouth debridement and coronal engine polishing with a medium grit paste. On the initial visit I was able to complete EO/IO, dental charting and periodontal charting. On the revisit, I continued with calculus detection, plaque index, taught proper flossing technique, whole mouth scaling and coronal engine polishing with medium grit paste.
2. No medical, social or psychological factors that impacted treatment.
3. Patient home care goals include using proper flossing technique and flossing at least once a day before brushing to break up and remove interproximal biofilm attachment. A.L. claims that sometimes it is frustrating to use string floss for his posterior teeth, so I recommended him to continue using the floss pick as an alternative to string floss. I advised him to rinse the floss pick with running water or a cup of mouthwash to prevent cross contamination between each interproximal space.
4. The patient showed some interest to the interventions introduced and had questions about when the best time is to floss and how often.
5. Yes, the patient seemed more interested in his oral health as treatment progressed because I was able to show him all the plaque and light calculus removed from his teeth during scaling. When I disclosed my patient, it became an important opportunity to show him all the areas that required more attention such as the posterior lingual and interproximal.
6. The patient’s gingival tissue on the initial visit was described as localized minimal inflammation to lingual and buccal regions of posterior teeth and generalized uniform pink, stippled, firm and resilient with pointed papillae. On the second and last visit, the localized inflammation was reduced to just the lingual aspects of the posterior teeth and showed the same healthy consistency on the anterior teeth.
7. As treatment progressed, I advised the patient to use a sensitive setting or brush more gently on the lingual aspects of each tooth because most people correlate brushing hard with a better cleaning but that is not true. Now that the patient is aware that he needs to focus more on the lingual aspects of his teeth he now understands that brushing gently and slowly gliding with the powered brush is very effective.
8. There was no reason for the patient to be referred to a DDS or MD.
9. No, I would not have changed any part of my treatment plan or patient education plan. I believe that I covered every aspect according to the needs of the patient. Considering that his inflammation was minimal and caries status was low; this treatment plan thoroughly accommodates this patient according to his needs.

9) Reflection:

1. No, I did not accomplish everything planned because I did not receive permission to use the radiation lab for diagnostic 4 horizontal bitewing radiographs. Other than this, I have completed both educational and mechanical interventions for this patient.
2. According to faculty feedback, I believe my strengths were periodontal probing, calculus detection and scaling. All probing depths were within the 1mm range and was praised during feedback. Calculus detection was also confirmed by faculty despite one or two spots that was considered to be rough tooth anatomy. Lastly, I scaled all quadrants and removed the light supragingival calculus that accumulated on the mesial and distal aspects of the affected teeth.
3. My clinical weakness for this patient was that I failed to sanitize the patient’s hand prior to demonstrating flossing technique. It is important for the patient to have clean hands before using floss because that will reduce the risk of exposure to pathogens and viruses going into the patient’s mouth. Despite making this mistake, I brought up this topic to my patient and advised him that washing hands before flossing must be done to prevent the spread of disease. Contact to the hands is the easiest way for pathogens to spread and transfer to other objects and people.