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Den 1200 - D206

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Journal Entry #2 - Cubicle 14B

1. Demographics:

* New patient J.C. is a 23-year-old male that is a Medium/type I.

2) Assessment:

1. J.C.
2. is an ASA I. Blood pressure is 120/70, pulse per minute is 81.
3. No history of smoking or tobacco use.
4. No use of any premedication.
5. No systemic conditions present.
6. No prescription medication and no over the counter medication.

3) Oral Pathology:

1. Extraoral finding includes TMJ bilaterally pops out of place when opening the mouth. Intraoral finding includes bilateral linea alba and a small 1x1mm abrasion on maxillary labial frenum from toothbrush injury. In addition, on the right lateral surface towards the tip of the tongue there is a 2x3mm shiny red lesion and the right dorsal surface under the tip of the tongue a 6x4mm shiny red lesion, both described as having no discomfort.

4) Dentition:

1. Angle’s classification of occlusion is bilateral class I. Overjet is 3mm and overbite is 50%; attrition found on incisal edges of #6, #9, #10, #11,#22,#23,#24,#25,#26,#27. There is also a composite restoration on the occlusal surface of #30, #31 and #14. Sealant was applied on #19-occlusal and possible decay on #14-occlusal (referral was given and signed).
2. No tooth anomalies.
3. J.C. is a moderate caries risk patient due to possible decay on #14-occlusal.

5) Periodontal:

1. J.C. is a Medium/I case type. Probing depths are localized in 4mm posterior regions and generalized 3mm or less elsewhere; minimal bleeding on probing.
2. Generalized uniform pink, localized slight inflammation on papillary lower anterior and localized slight marginal lower molars of the lingual aspect.

6) Oral Hygiene:

1. Initial plaque index score is 1.66 (Fair). Second Plaque index score is 0.33 (Good).
2. Areas where calculus were found includes mostly localized in posterior teeth and lower anterior. Majority of the calculus detected was light supragingival and some medium subgingival towards the posterior.
3. The planned oral hygiene interventions based on the findings include removing all light/medium 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. I also recommended the patient to purchase an electric toothbrush and taught him the gentle gliding motion of brushing with an electric toothbrush.

7) Radiographs:

1. Yes, the patient requires 4 horizontal bitewings.
2. Yes, the radiographs were available during data collection.
3. Radiographic findings include general slight bone loss. There is no radiographic evidence of decay and no evidence of calculus.

8) Treatment Management - Utilizing the Patient Concept Map

1. My treatment plan is to educate the patient on proper brushing and flossing technique, followed by 4 HBWs, whole mouth debridement and coronal engine polishing with a fine grit paste. On the initial visit I was able to complete EO/IO, dental charting and some perio charting. On the 2nd revisit, I continued with perio charting, calculus detection, plaque index, OHI and completed hand scaling of quadrant 4. On the 3rd Revisit, I reviewed OHI, completed 2nd plaque index, full mouth hand scaling, 4 HBW, full mouth engine polishing with fine paste and applied 5% sodium varnish on all teeth.
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 biofilm attachment interproximally. J.C. 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 electric toothbrushes and whether it was worth the investment.
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 medium/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 buccal/lingual and interproximally.
6. The patient’s gingival tissue on the initial visit was described as generalized uniform pink, localized slight inflammation on papillary lower anterior and localized slight marginal lower molars of the lingual aspect. 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 linguals 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. The patient was referred to see his dentist about the possible decay on #14 occlusal.
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 moderate; this treatment plan thoroughly accommodates this patient according to his needs.

9) Reflection:

1. Yes, I have accomplished everything as planned for this patient.
2. According to faculty feedback, I believe my strengths were perio 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 medium/light supragingival and subgingival calculus that accumulated on the posterior and lower anterior teeth.
3. My clinical weakness for this patient was that I tend to lose my neutral positioning when working on the maxillary posterior lingual aspects. Sometimes I would find it easier to just bend my back and neck to see better rather than adjusting the patient’s head and seating position. In the long run I will experience wrist, neck and back pain if I allow this to keep happening. I need to remember to adjust my patient first then myself to achieve the optimal neutral position.