Visit #1: M.K. 30-year-old male. H/II

Date of service: 9/15/2017 and 10/20/2017

**Visit 1:**

**Assessment**

1. ***Patient health history and vital signs, ASA.***

The patient is an ASA II. He has a history of smoking for 19 years and currently smokes 1 pack of cigarettes per day. His vital signs were within normal limits: BP: 111/82 and pulse: 88. Patient is currently taking Adderall 10 mg/QD for ADHD. The therapeutic category of Adderall is CNS stimulant. This drug often causes xerostomia in patients. The patient also has a history of having a stomach ulcer for which is taking OTC Pepcid. The drug class of Pepcid is H2 antagonist. This drug may also cause xerostomia.

*B.* ***Oral Pathology*** *(only include if pathology requiring referral is present)*

The patient had no oral pathology requiring a referral.

*C.* ***Dentition***

The patient presents with a 40% overbite, and 4 mm overjet. He had attrition on #6-#11, and #27-#22. The patient has caries on #3-MO/Class II and #12-DO/Class II. He is considered high risk for caries because of his active caries.

*D.* ***Periodontal***

The gingiva has normal melanin pigmentation, it was firm with pointed interdental papillae, and no recession was present. He had moderate BOP and moderate inflammation. Based on his probing depths he was classified as a type II, localized type III. His generalized probing depths were between 5-6 mm. He had localized probing depth of 7 mm in the molars of the URQ and LRQ. Based on the periodontal findings, this patient would benefit from Arestin application in the URQ and LRQ molars. Tooth #2- DB (6 mm), #2-MB (7 mm), #3-DB (7 mm), #3-MB (6 mm), #31-DB (6 mm), #31-MB (6 mm), and #31-DL (6 mm), and #30-DB (6 mm).

*E.* ***Oral Hygiene***

The patient was a heavy case value based on the generalized heavy subgingival calculus deposits. He had minimal stains. I assessed the patient’s oral hygiene through interviewing the patient and then disclosing him. He reports using an electric toothbrush with Parodontax dentifrice, never flossing, and never rinsing with a mouth rinse. His initial plaque score was 2.2-poor. I recommended the patient continue using his electric toothbrush but to use Colgate total dentifrice because of its active ingredient Triclosan. I also recommended he begin rinsing with 4 tsp of Listerine antiseptic, full strength, for 30 seconds, 2 times a day.

*F.* ***Radiographs***

The patient required an FMS because his last x-rays was in 2009. We needed to evaluate him for any pathologies and abnormalities such as bone loss based on his deep probe readings. The radiographs revealed evidence of early bone loss, subgingival calculus, and caries on #3-M and #12-D.

*G.* ***Other findings***:

The patient has a history of smoking for 19 years. He smokes one pack of cigarettes a day. This affects his optimal health both orally and systemically.

***TIME*:** The patient’s last dental hygiene service was in 2013. This is an inappropriate amount of time between dental hygiene services. Based on his assessments he should be on a 3 to 6-month recall.

**TREATMENT MANAGEMENT during each visit:**

Visit 1: Reviewed medical history, obtained vital signs, EO/IO, dental charting, periodontal charting, and accretions assessment completed. Determined patient’s need for FMS. Plaque score: 2.2 (Poor). OHI- I taught patient flossing technique and he seemed comfortable flossing correctly. I also reviewed the correct use of electric toothbrush with him. I used instruments and cavitron to scale the LRQ. Exposed FMS and confirmed patient’s early bone loss, periodontal type, and caries. Patient given a referral for caries evaluation.

Visit 2: The patient returned the same day for the afternoon clinic session. I used the cavitron and hand instruments to scale residual calculus in LRQ, scale the URQ, and LLQ to completion. Patient approved for placement of Arestin in the LR and UR molars #2, #3, and #30, and #31.

Visit 3: Reviewed medical history and I/O. WNL. Patient still taking Adderall 10 mg/QD for ADHD and OTC Pepcid for stomach ulcer. He reports flossing once a week, brushing 2x a day, and reports less bleeding when flossing. Re-evaluation of the LRQ, URQ, and LLQ: Soft deposits present interproximally, less bleeding upon exploring, and decreased inflammation. Supragingival calculus present on the mandibular anterior regions. Plaque score: 1.6-fair, improvement since the last visit. Hand scaled the supragingival calculus on the mandibular anterior teeth. Used cavitron and instruments to scale the ULQ to completion. Engine polish with fine paste. I took probe readings of the molars in LRQ and URQ to evaluate for areas needed Arestin. The probe depths had increased in some locations revealing 8 mm pockets. This could be due to the removal of calculus allowing the probe to reveal the true pocket depths. The patient was approved for placement of Arestin and signed consent form. It was placed in 8 sites: #2- DB (6 mm), #2-MB (8 mm), #3-DB (8 mm), #3-MB (6 mm), #31-DB (8 mm), #31-MB (6 mm), #31-DL (8 mm), and #30-DB (6 mm). Patient was given post treatment instructions which also included not to smoke for 48 hours. He was instructed to return on November 21, 2017 for re-evaluation of the treated areas.

Based on analysis and interpretation of the data gathered during assessments I planned to begin treatment with scaling of the entire mouth to remove the calculus deposits. After scaling, I planned to deliver Arestin to the LR and UR molars to decrease the patient’s pocket depths. I also recommended the patient begin to use Listerine antiseptic mouth rinse 2x a day at full strength to help his periodontal condition improve. However, I think the patient’s smoking habit is going to impact the treatment provided. The Arestin therapy could fail if he smokes too soon after Arestin placement and if he does not comply with my recommendations and oral hygiene instructions.

The patient was given a referral to the DDS to evaluate caries on #3-M and #12-D.

**REVISITS**

**EVALUATION**

The patient’s response to the interventions in the first two visits was good. The patient seemed slightly more motivated and interested in his oral hygiene at the second visit compared to the first. He reported using floss at least once a week which is more than he was used too. His second plaque score was 1.6 compared to the initial plaque score of 2.2. He could be trying to incorporate recommendations and upkeeping his oral hygiene. Based on assessments, his tissue was less inflamed and there was less bleeding upon exploring.

At his revisit appointment, I completed the patient’s scaling, re-evaluated the probe depths of the areas approved for Arestin, and placed Arestin in 8 sites.