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Professor Kupsh December 13, 2019

New York City College of Technology
Department of Dental Hygiene
DEN 2300 Case Presentation

DENTAL MANAGEMENT of PATIENT 'X'

On September 4th, 2019, a clinic patient, male [whom we will call patient 'X'], approximately middle-aged, presented himself for a dental prophylaxis. Chief complaint "I am not satisfied with my previous dental cleaning that I had done two months ago. The dentist seemed to take literally five minutes to look at me, and did *nothing*. I don't feel that he did a good job, that is why am here do have a cleaning." Due to the fact that the patient had mild asthma, which is a chronic systemic condition, dental treatment had to be tailored with consideration to these factors.

Assessment of the patient began in the waiting room as the patient was making his way to the operatory, his gait and strides, were observed and he does not seem to have any difficulty with movement nor was is he afflicted or limited with any physical condition. An intake of his medical history revealed that he is a 51-year-old Caucasian male, and this is his first visit to the clinic [patient obtain information about connect via the internet]. He lives a in nearby town in Queens, and traveling to his appointment at the clinic was not difficult. He reports to be in relative good health, and the date of his last physical examination was July 19, 2019, and he has never been hospitalized. His current respiratory condition is being monitored by his doctor and his condition is stable therefore he can be treated. Vitals taken were: blood pressure 123/85, pulse was 75. This indicated an elevated blood pressure.

He does not uses drugs recreational or otherwise, and he is a non-smoker and a non-drinker. He does not uses any over-the-counter medication and or vitamins supplements. Daily home-care routine involves brushing three times with a hard toothbrush, with Colgate toothpaste, and hardly flossing, and he does not use any oral rinses. He considers his current dental health as

being 'okay' and indicated some interest in tooth whitening and an alignment of his teeth. Patient X has never had orthodontic work nor dental implants, there is no sensitivity to hot or cold nor does his gums bleed when he brushes. His last dental visit was approximately two months ago where he '*only'* had a dental check up and dental x-rays 4 BW's, were exposed. He hinted that his substandard treatment was due to the fact that he had a Medicaid type insurance. Casual conversations also hinted to the fact that he lives alone as he states he has plenty of time on his hands. He considers his current dental health as being 'okay' and indicated some interest in tooth whitening and of an alignment of his teeth.

Pt X is ASA II due to the fact that he is allergic to penicillin [that causes his throat to closes up], and has had asthma since childhood, which is controlled by Symbicort. And he carries a rescue inhaler at all times.Symbicort is a bronchodilator that is used to treat COPD and asthma. Patient X asthma is aggravated or triggered by every day condition or elements such as cats, dogs seasonal etc. On his initial visit the patient did not have his rescue inhaler as he had forgotten it because he had just changed his bags [he was encouraged to bring it on his next visit]. The patient reports that he has never had an episode, just a feeling of tightness in his chest. For prophylaxis purposes he takes two puffs of Symbicort daily and he reports feeling good for the duration of the day. The maximum daily recommended dose is 640/18 mcg budesonide/ formoterol (given as two inhalations of SYMBICORT 160/4.5 twice daily) for patients. On both his physical and digital record, a medical alert was recording highlighting these conditions.

After medical clearance was given from the professor an intro oral and extra oral examination was done. Extra Orally, there were generalized macules on his face and forehead. He reports no observably changes and he is being monitored by a dermatologist. Intra-orally however, the patient exhibits signs of inflammation, with elevated white patches/lesions, with irregular borders on his soft palate his uvula and pharynx. My initial diagnosis was oral candidiasis, possible a side effect of the use of the inhaler Symbicort. This was confirmed by Professor 'B'. Symbicort is an inhaled glucocorticoid and Long acting beta-2-agonist, used in the treatment of COPD asthma bronchitis and emphysema, with pressurized metered-dose dry powered inhaler. Effects and dental implication of the drug Symbicort was throat irritation, oral candidiasis and an altered taste that is metallic. There are other possible side effects that includes

headache, nausea, vomiting GI upset and an increased blood pressure. The professor further explained to the patient that the normal oral flora was disturbed/suppressed by incorrect angulation of his asthmatic pump which caused and overgrowth of the yeast candidiasis. A medical referral was given to the patient to see his doctor. She obtained pictures of the patients lesions, which she forwarded to him, and recommended that the patient shows them to his doctor. [fig **VI**] She also recommended that he consults with his doctor about correct angulation but in the meanwhile she recommended that, instead of aiming the pump upwards to the palate he should aim it lower going towards the throat, and rinse afterwards

Dental history [fig **II**] reveals that tooth number 1;16 and 32 were clinically missing. The patient had a three unit bridge, porcelain fused to metal crown [PFM]tooth number 2,3 and four. Tooth number two and four were the abutment and three was the Pontic. Tooth number 14 also had [PFM] All molars [except #17] had either a class I or II, of either an amalgam or composite restorations. The patient had a class I occlusion with a tendency towards a class II. Over by it was 50% and over-jet was 3 mm. Attrition on tooth number 6 to 11, and 22 to 27. The patient Carries Risk Assessment was moderate due to the fact that he had numerous restoration slight and crowding of the lower interiors.

Initial clinical periodontal assessment indicated [fig **III]** localized gingivitis. They were localized inflammation, where the gingival margins were slightly reddened and the interdental papillae slightly blunted, and rolled, at the CEJ The texture is normal stippled, the consistency was firm. Inter-proximal and supra and sub gingival calculus where detected and medium deposit on tooth number 22 to 27. Recession was noted on tooth #2, 2-5mm A plaque score was not obtained at this time due to an undiagnosed oral pathology. [Pathology was checked and confirmed at the end of the clinic]. Perio case is diagnosed as being stable despite not having previous recordings of his perio charting to compare. However a stable diagnosis was concluded due to the fact that overall his PD were 1-3 mm and there were localized 4 to 5 mm pockets only on the posterior molars, and localized BOP. Case type was determined to be Type II slight periodontitis 4-5 mm PD [without radiographic evidence of bone-loss] and medium occlusal staining.

Home-care that was demonstrated on the first visit was flossing since the patient reports that he hardly does so. The anterior teeth seem to be maintained as they were more easily accessible to the patient however he had difficulty accessing his posterior molars with the floss. He had large hands and dexterity seem to be a problem Next visit I will implement the use of a floss-reach[ie floss on a extended handle] so that his molars will be more easily accessible for him. Those were the '*infectious*' areas because there a pocket depth of 4-5 mm, and BOP.

Treatment was determined to take two visits. A Carries Risk Assessment form [fig **I**] was completed to ascertained the patients risk for caries. The information that was obtained indicated despite the fact that the patient X had no active carious lesions he is categorized as moderate risk due to the fact that due to crowding off his lower interiors numerous inter-proximal restorations and visible plaque, and over-hang tooth #30 DB,[Referral was given for him to see his dentist]. Therefore treatment intervention to reduce his risk would be increasing the amount of time that the patient flosses, and as an adjunct the use of fluoride rinses. Due to his chronic respiratory condition the use of an ultrasonic scaler was a contraindication. Therefore his entire dentition had to be *hand scaled,* engine polished and varnish using 5% neutral sodium fluoride [NaFl], as he had numerous restoration this fluoride treatment would not affect or caused damage to them. A treatment plan was written up and consented on by the patient's signature on the treatment plan, [fig **IV**] that had been authorized by the professor and later scanned into the patient's permanent dental record.

The first visit concluded hand-scaling debridement beginning in quadrant I tooth 3 to 4, which was the three unit bridge. There were no the re-scales. The patient tolerated treatment well and overall was pleased with the visit he reiterated next visit he only wants to come back and see me.

Revisit appointment a patient a week later, and patient prognosis was reevaluated and it indicated positive with compliance to home care. Medical history was reviewed and there were changes in his medical history. [PT is still ASA II]. Patient reported that he saw his medical doctor that has prescribed Diflucan, the brand name is fluconazole. It is an anti-fungal medication, used to treat his now confirmed oral candidiasis. He is currently taking one tab 1 time per day beginning just the day before and he reports no adverse effects. Adults—200

milligrams (mg) on the first day, followed by 100 mg once a day for at least 3 weeks. Dental implication: Diflucan would include an abnormal taste, and this was discussed with the patient. Drug interaction: local anesthetics and vascular constrictors. Patient X was interviewed about his previously instructed home care and he was compliant. Patient reports no post op complications, and has attempted to increase the amount of times that he flosses will still report some difficulties. Continue treatment included rechecking previously scaled tooth numbers 2 to 4 there were no residual calculus. Gingiva is slightly inflamed with pale pink and is flaccid around the margins which is slightly thickened.

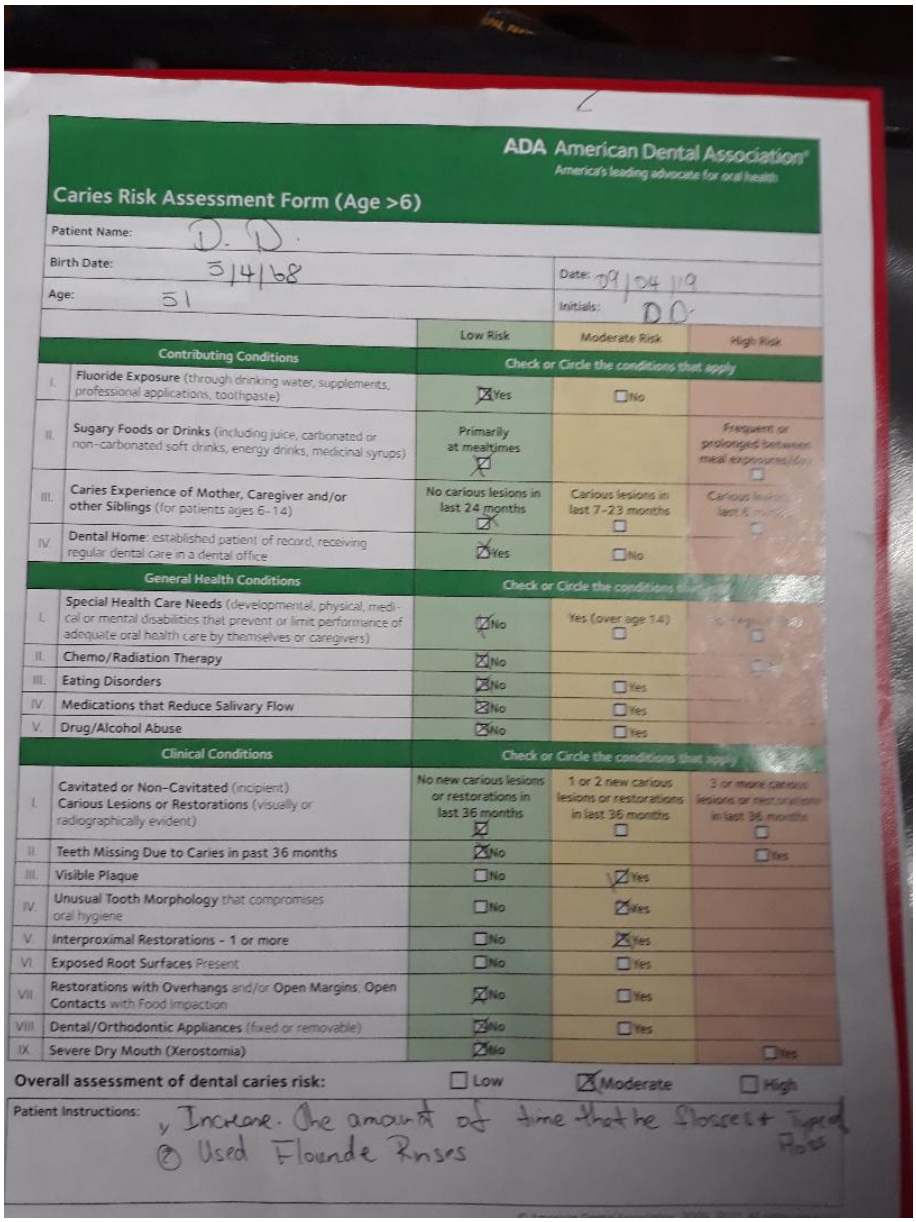
Due to the fact that patient X was having difficulty flossing his posterior molars he was introduced to the use of a floss reach which is a floss with an extended handle for easy access. The floss reach technique was demonstrated to the patient and he was able to obtain a pack. He had a positive response to the suggestion and indicated that he will attempt to implement it at home. Additionally the professor recommended the use of a floss threader or a proxy brush for the patient to use under his bridge, as there was evidence of food debris and material alba.

Before the commencement of treatment the patient's rescue inhaler was obtained and was out on the counter and easily accessible during treatment [in case of an emergency]. Completion of treatment would begin with the *hand-scaling debridement* of tooth number 5 to 31. The entire dentition was engine polish with a fine grit paste and [NaFl]neutral sodium fluoride 5% was applied and post-op instructions given. The patient tolerated treatment well and the recall appointment was 4 to 6 months, due to the fact that the inflammation was localized and home care instructions specifically targeted those problem areas. Patient seems highly motivated therefore prognosis indicates a positive resolution if he is compliant with home care.

In retrospect, since the patient had dental X-rays taken a few months prior; on subsequent visits I should have encourage him to bring a copy of his X-ray with him on his next visit. This would have enabled me to be/have a more accurate, conclusive assessments that would resulted in optimum care. [Later I was unsuccessful as a patient reports that he does not have any dental x-rays despite the fact that on initial intake he reported having4BW;s a few months prior].

CARIES RISK ASSESSMENT FORM

FIG I



ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age >6)

Patient Name: D. D.
Birth Date: 3/4/68
Age: 51
Date: 09/04/19
Initials: DD

		Low Risk	Moderate Risk	High Risk
Contributing Conditions		Check or Circle the conditions that apply		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☒ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☒		Frequent or prolonged between meal exposures ☐
III.	**Caries Experience of Mother, Caregiver and/or other Siblings** (for patients ages 6-14)	No carious lesions in last 24 months ☒	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
IV.	**Dental Home**: established patient of record, receiving regular dental care in a dental office	☒ Yes	☐ No	
General Health Conditions		Check or Circle the conditions that apply		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☒ No	Yes (over age 14) ☐	
II.	**Chemo/Radiation Therapy**	☒ No		
III.	**Eating Disorders**	☒ No	☐ Yes	
IV.	**Medications that Reduce Salivary Flow**	☒ No	☐ Yes	
V.	**Drug/Alcohol Abuse**	☒ No	☐ Yes	
Clinical Conditions		Check or Circle the conditions that apply		
I.	**Cavitated or Non-Cavitated** (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	No new carious lesions or restorations in last 36 months ☒	1 or 2 new carious lesions or restorations in last 36 months ☐	3 or more carious lesions or restorations in last 36 months ☐
II.	**Teeth Missing Due to Caries in past 36 months**	☒ No		☐ Yes
III.	**Visible Plaque**	☐ No	☒ Yes	
IV.	**Unusual Tooth Morphology** that compromises oral hygiene	☐ No	☒ Yes	
V.	**Interproximal Restorations - 1 or more**	☐ No	☒ Yes	
VI.	**Exposed Root Surfaces** Present	☐ No	☐ Yes	
VII.	**Restorations with Overhangs** and/or **Open Margins**, **Open Contacts** with Food Impaction	☒ No	☐ Yes	
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	☒ No	☐ Yes	
IX.	**Severe Dry Mouth (Xerostomia)**	☒ No		☐ Yes

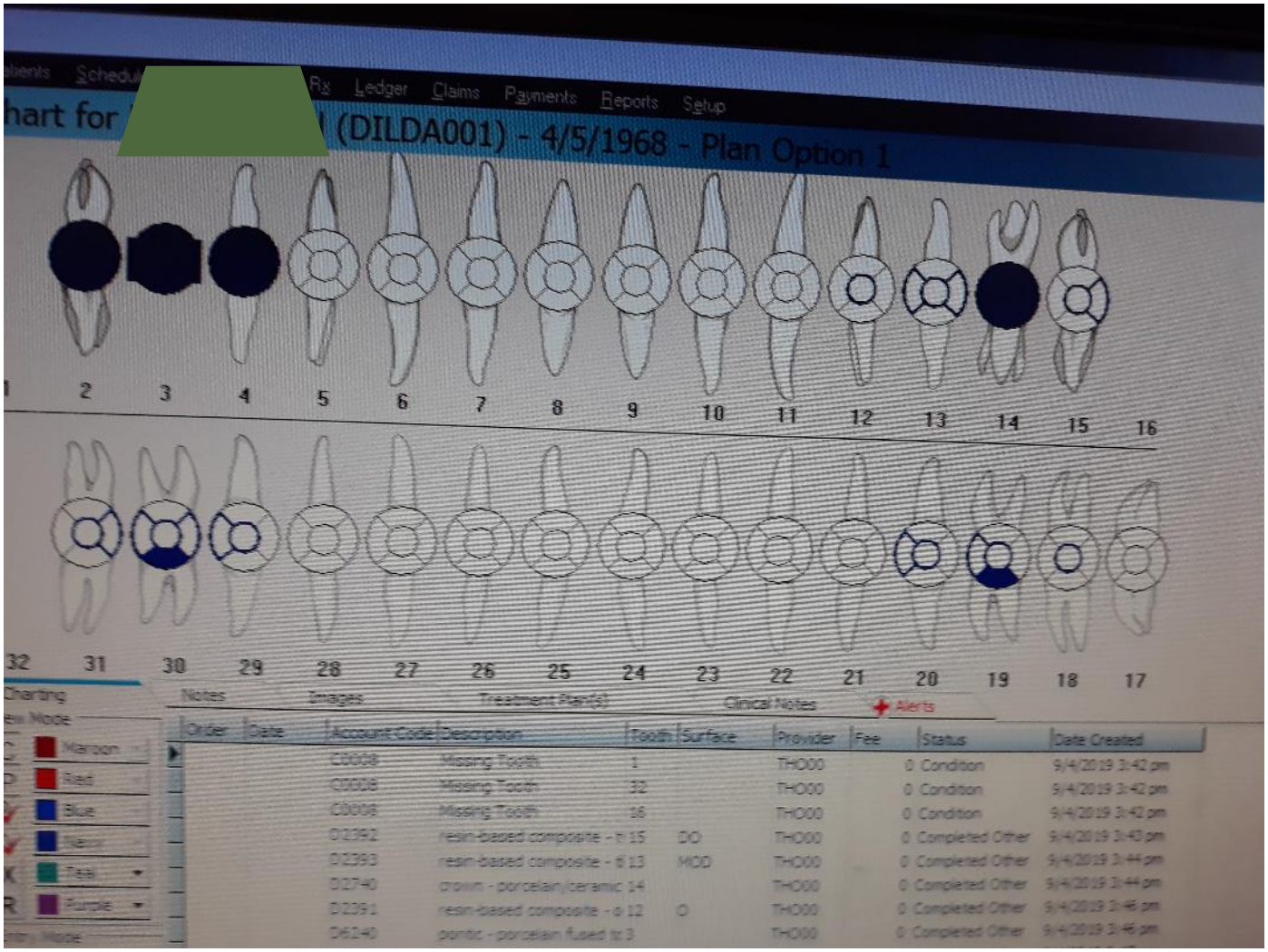
Overall assessment of dental caries risk: ☐ Low ☒ Moderate ☐ High

Patient Instructions: 1) Increase the amount of time that he flosses + Tyler Rolls
2) Used Flouride Rinses

The patient did not have any active carious lesion, but is considered to be of Moderate Risk due to numerous inter-proximal restorations, and open margins.

DENTAL CHART

FIG II



Tooth number 2-4 is a 3 unit PFM bridge[2 & 4 abutments, 3 pontic]

Tooth number 14 PFM

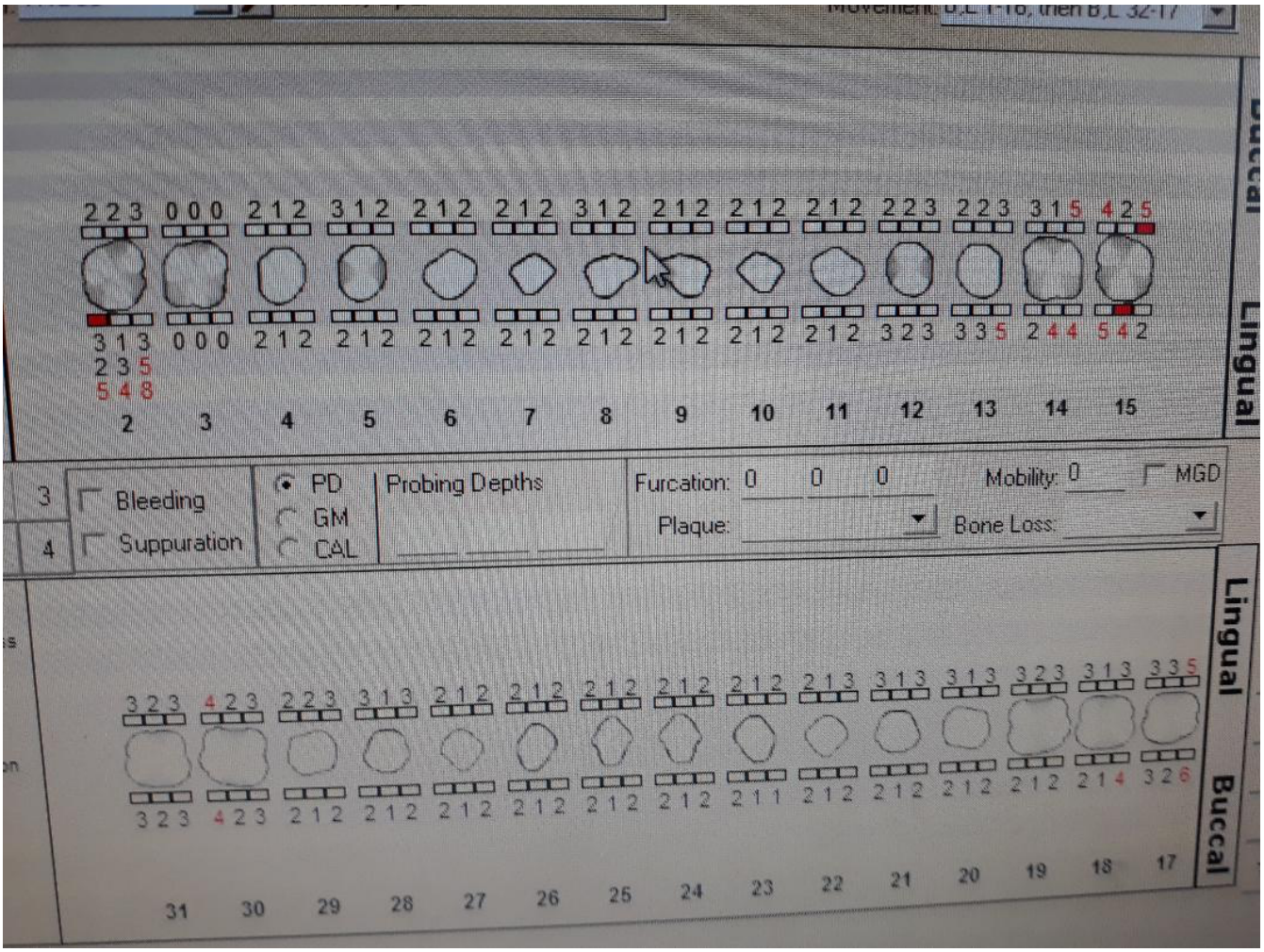
Class II and II Restorations

Composite: Tooth number #12 O; 13 MOD; 15 DO; 18 O; 19 MOB; 20 MO; 29 DO; 30 MOD [30# DB open margin]

Amalgam: Tooth number # 19 B; 30 B;

PERIODONTAL CHARTING

FIG III

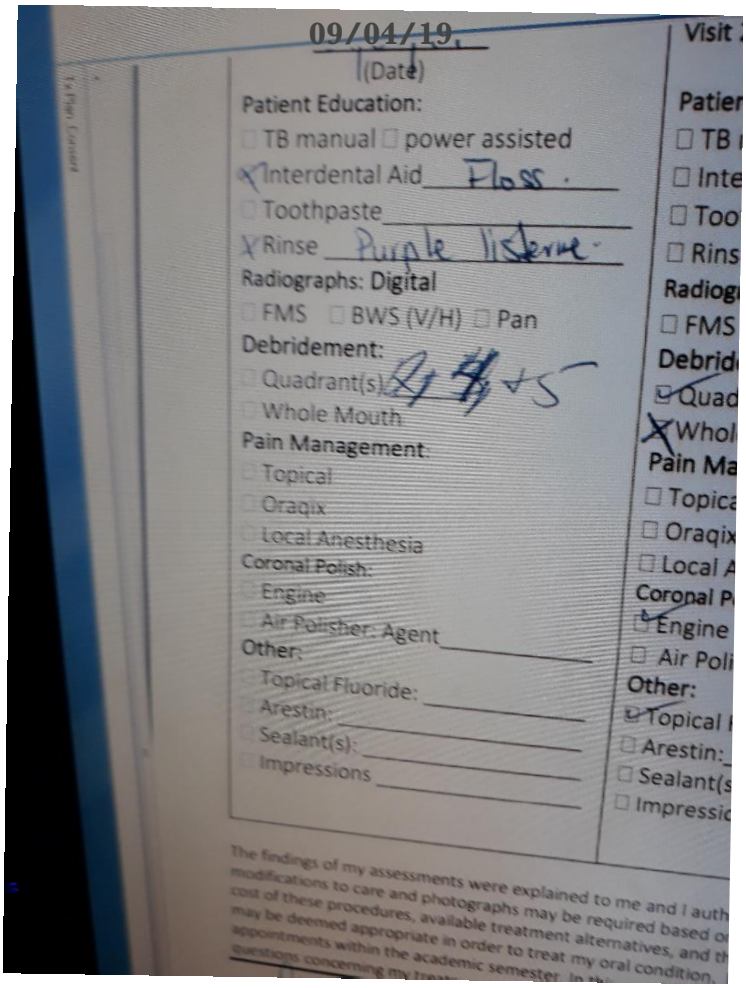


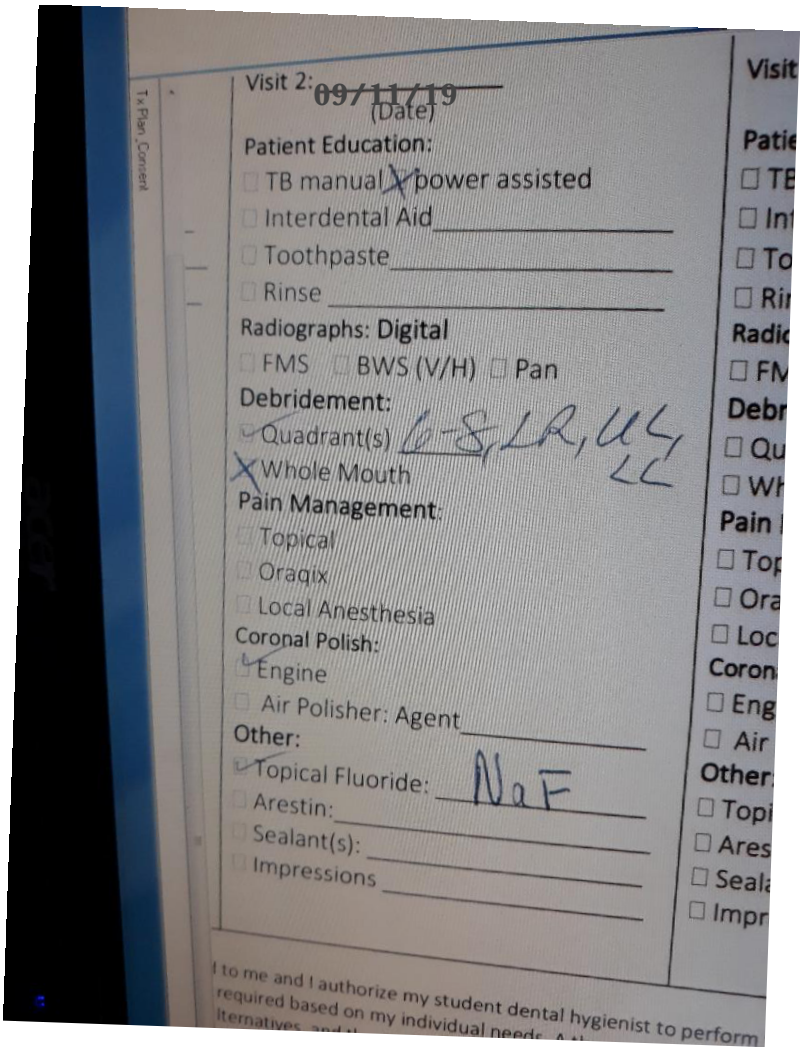
Clinical localized inflammation with redden gingival margin's and BOP on the posterior molars. PD were 1-3 mm [Ant] and there were localized 4 to 6 mm pockets only on the posterior molars, and localized BOP. Recession & CAL # 2

Case type was determined to be Stable Type II localized periodontitis 4-6 mm PD [***without radiographic evidence of bone-loss***]

TREATMENT PLAN CONSENT FORM

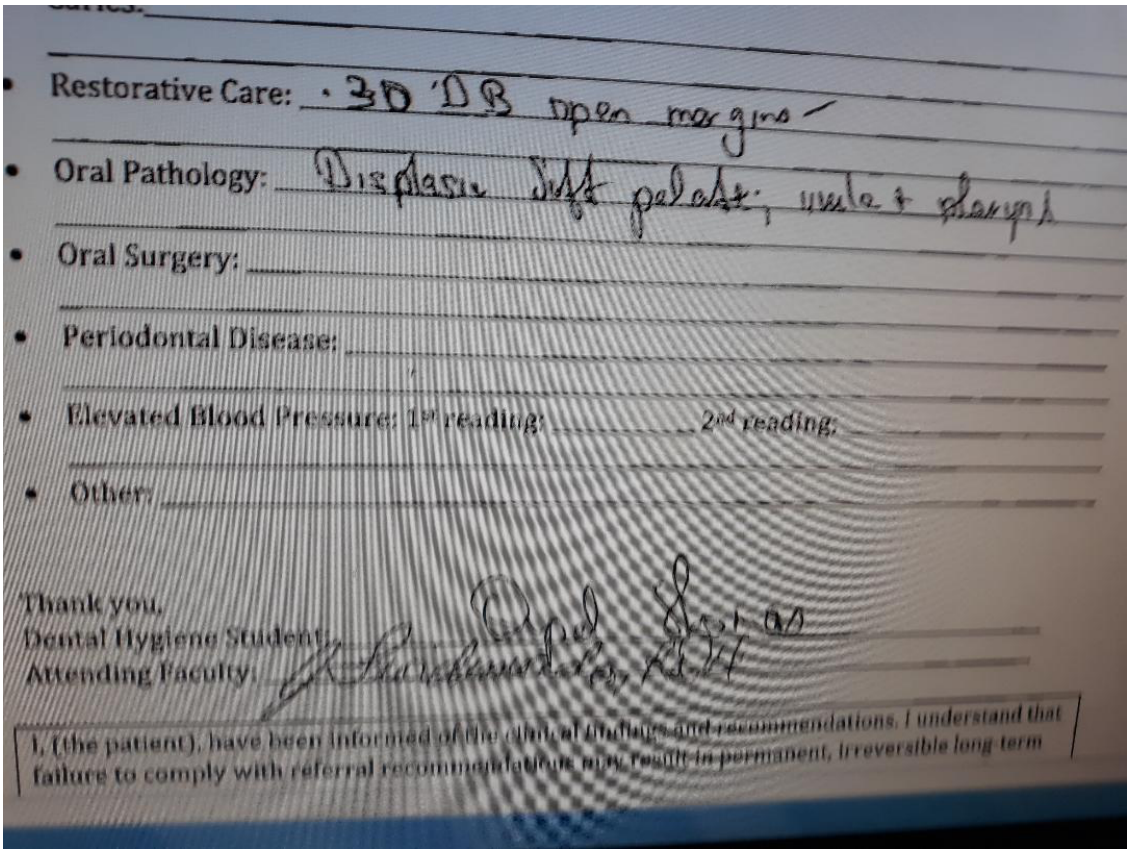
fig V





REFFERAL

Fig VI



The patient was referred to:

Oral Pathology: Dysplasia on the soft-palate, uvula and pharynx.

Restorative Care Dentist] for # 30 DB open margins

Reference:

Drug Information Handbook for Dentistry
By: Richard L. Wynn, BSPharm, PhDRichard L.Publisher: Lexi-Comp
Print ISBN: 9781591953784, 1591953782
eText ISBN: 9781591953784, 1591953782
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"MayoClinic.org,"Drug information provided by: IBM Micromedex