Sue Yi Ni (Susan)
DEN 1200 - D216
Mon PM/Wed AM, Cubicle #8
Journal 2

1. **DEMOGRAPHICS**
    a. *Identify the patient by: First and Last Initials of their name only, age, case/type*
    D.Q., 20 years old, Medium/Type I
2. **ASSESSMENT**
    a. *Patient History, Vital signs, ASA*
    The patient is an ASA 2 with a blood pressure of 131/69mmHg and a pulse of 73bpm. He currently does not take any medication except two puffs of Aerospan when he experiences asthma attacks. His last attack was on December of 2018, triggered by extreme stress or being in the Philippines. The patient had chlamydia in January of 2019 but has been resolved by antibiotics. The patient has environmental allergy to dust. He is social drinker (at least once a week) and is a periodic smoker (at most a pack a week). The patient also reports being susceptible to aphthous ulcer. His last medical exam was on August of 2017. His last dental exam was on December of 2018, cleaning was on August of 2018, and dental radiographs, four bitewings, was in 2014. The patient reported using a medium head manual toothbrush (once a day) with Colgate's total care toothpaste, listerine (twice a day), but no interdental aids.
    b. *Include smoking history (amount and duration)*
    The patient reports smoking since August of 2018 but no more than one pack a week.
    c. *List any premedication needed*
    The patient does not need to take any premedication.
    d. *Identify any systemic conditions present*
    The patient's only active disease is asthma. As mentioned in part A, he had chlamydia but it has been resolved by antibiotics. He is also prone to aphthous ulcers.
    e. *List all prescription medicine and any over the counter (OTC) medication.*
    As mentioned in part A, patient takes two puffs of Aerospan 80mcg two times a day when he experiences asthma attacks.

3. **ORAL PATHOLOGY (Extra and intraoral findings)**
    a. *Describe any abnormal findings of the head and neck exam. If lesion(s) present, describe by using the ABCD-T method.*

There were no significant findings extraorally and intraorally; everything was within normal limits. There was a slight crepitation on the right side of the TMJ. Patient also has dry lips. Intraorally, he had melanin pigmented gingiva, an uvula that deviates to the left, swollen red tonsils, opening on the retromolar pads possibly due to beginning of partial eruption of the third molars, and aphthous ulcers on the floor of the mouth, near the left lingual vein, and the ventral of the tongue. On revisits, a petechiae was found on the lower left buccal mucosa near tooth #18. New aphthous ulcers also appeared on the lower lip mucosal lining adjacent to tooth #26 and 27, on the alveolar mucosa near tooth #2 and on the buccal mucosa near tooth #31.

4. DENTITION

a. *Provide basic information; Angles classification, overbite, overjet.*
The patient has a 4mm overjet, 60% overbite and bilateral Class I occlusion. He has 1mm diastemas mesial to tooth #6, 7, 8, 10 and 11. Tooth #16 is congenitally missing (radiographic evidence), while tooth #17 and 32 are partially erupting. He also has one to two surfaces of resin-based composites on tooth #2, 3, 14, 18, 19, 30 and 31.

b. *Describe any tooth anomalies.*
There are no tooth anomalies present. The patient did not have abrasion, abfraction, attrition or erosion.

c. *Describe if caries active, and general location of caries.*
There are no active caries; the patient has a low risk for caries.

5. PERIODONTAL

a. *Describe periodontal findings; case type, probing depths, recession, bleeding upon probing (BUP)*
The patient was classified as type I gingivitis with minimal bleeding upon probing, moderate inflammation, generalized 1-3 probing depths and localized 4-5mm probing depths on the lower molars. The patient does not have recession, suppuration, furcation, and mobility. However, there is slight localized vertical bone loss seen on the radiographs.

b. *Provide a gingival statement assessing the presence of inflammation*
The gingiva had localized slight marginal inflammation on the posterior teeth. The gingiva was generally pink with localized marginal redness on the posteriors and localized anterior melanin pigmentation. It was generalized enlarged and localized snuggly with chronic rolled mandibular gingiva that was more pronounced on the lingual surfaces. It was spongy, smooth, shiny, and bleeding upon probing occured.

6. ORAL HYGIENE

a. *State initial and revisit plaque scores*
   The initial plaque score was 1.0 (fair) and then decreased to 0.83 (fair) but then increase to 1.0 (fair) again on the last visit.
b. *Identify areas of calculus found.*
   There was generalized subgingival calculus on the lingual surfaces of the mandibular anterior teeth with localized subgingival calculus on a few maxillary molars. There was no supragingival calculus present.
c. *State planned oral hygiene interventions based on findings.*
   My patient did not have the best oral hygiene; as mentioned in assessment part A, he only brushes his teeth once a day without the use of interdental aids. His plaque index score remained in the fair portion for all visits. There was slightly visible plaque on the gingival margin and interproximal areas. There was also certain areas of teeth that he should focus more on such as the occlusal surfaces of the lower left quadrant. He has many deep grooves, pits and fissures that causes it to be more difficult to clean thoroughly. Additionally, certain teeth, particularly tooth #6, protrudes out and is slightly angled causing him to miss cleaning tooth #5. Thus, my planned oral hygiene intervention was to teach him the modified Bass toothbrushing technique and introduce him to flossing. Additionally, the modified Bass method is a great technique to clean subgingivally because he does have localized pockets and no recession. Furthermore, I would suggest the patient to change the dentifrice with a brand that does not have sodium lauryl sulfate since it is associated with aphthous ulcers.

7. RADIOGRAPHS

a. *Does the patient require radiographs? If yes, what type?*
   Yes, a panoramic was recommended since he has partially erupted third molars and periodically felt pain.
b. *If radiographs were available during data collection, did they support findings?*
   The horizontal bitewings radiographs was unable to support clinical findings of areas with calculus; calculus was not radiographically evident. However, impaction of tooth #17 was visible but not for tooth #32 due to bad film placement. Areas with resin-based composites were also verified. On the panoramic taken by a senior, impaction of tooth # 17 and 32 was confirmed.
c. *Did they reveal any condition not evident on the clinical exam?*
   Yes, the radiographs revealed that my patient was congenitally missing tooth #16 and that there was localized vertical bone loss.

8. TREATMENT MANAGEMENT-Utilizing the Patient concept map

a. *State your proposed treatment plan and then elaborate on each visit; including clinical treatment provided as well as preventative services.*

The proposed treatment plan included teaching the patient better homecare, complete debridement with 20% benzocaine topical and oraqix (1 capsule of 2.5% lidocaine and prilocaine gel) for pain management if necessary, and air polishing. During the patient's initial visit, medical history was reviewed, extraoral and intraoral examination was completed, dental charting was completed and periodontal assessment was started. On the second visit, periodontal charting was completed and calculus detection was started. During the patient's third visit, calculus detection was completed. The patient's case value was confirmed as a medium/type I. I also was able to take my prevention competency part I on this visit. After the gingival assessment and using the disclosing solution, the initial plaque index was 1.0 (fair). I introduced the patient to the modified Bass method. The treatment plan was developed, discussed with the patient and informed consent was obtained. On this visit, I also started scaling quadrant III with the pain management methods mentioned earlier. During the patient's fourth visit, a panoramic was exposed by a senior since he reported experiencing tremendous pain influencing his daily routine. I also took the prevention competency part II in which the plaque index score decreased to 0.83 (fair). I reviewed the modified Bass technique and introduced flossing. I completed quadrant III after rescaling the lingual surface of tooth #18, mesial surfaces of tooth #21-23 facial, and the distal, facial, mesial, and lingual surfaces of tooth #24. On the final visit, the plaque score increased to 1.0 (fair); the patient reported not brushing that morning. Thus, I reminded him of the 2-2 rule, two minutes of brushing two times a day. I reviewed the modified Bass method, flossing and introduced tongue cleaning and mentioned switching dentifrice. Thereafter, I completed scaling quadrants I, II, and III. The treatment plan was modified; engine polishing with the fine abrasive was implemented instead of air polishing because the resource was unavailable. I was able to take my competency for engine polishing on this visit. After the completion of treatment, 6 months recare was recommended. Extraction referral, copies of the bitewing and the panoramic radiographs was given to the patient.

b. *Any medical, social or psychological factors which impacted on the treatment?*
   No, there was not any medical, social or psychological factors that influenced treatment.
c. *State your patient home care goals for this patient and identify the physiotherapeutic aid(s) recommended along with rationale.*
   The patient's plaque index score ranged on the fair portion of the scale. My goal was to decrease the score to become on the good portion of the scale. As answered in the oral hygiene section, part C, there was slightly visible plaque on the gingival margin, interproximal areas and certain hard to reach areas. My

patient did not have recession and has localized pockets, so I taught my patient the modified Bass toothbrushing technique, introduced flossing, tongue cleaning and recommended another dentifrice.

d. *What was the patient's response to the interventions introduced and taught?*
With candor, my patient seemed uninterested and unopinionated in regards to interventions taught. He was open minded to learn but motivating him to comply at home was difficult. I tried to arouse his interests and stress the importance of good homecare by creating reasonable goals, showing areas with plaque stain by the disclosing solution, explaining what gingivitis is, what it could lead to providing evidence from the periodontal chart, explaining the prognosis and showing areas of improvement after scaling. Unfortunately, the patient informed me that he tried the new method but reverts back to his old habits.

e. *Did the patient seem more interested in his/her oral health as treatment progressed?*
Unfortunately, as mentioned above, my patient did not seem more interested in his oral health as treatment progressed.

f. *Describe changes in the patient's gingival tissue from initial visit to completion.*
There was consistent decrease in inflammation, redness and bleeding when comparing the areas scaled to the areas not scaled.

g. *Identify any additional interventions developed with the patient as treatment progressed.*
There was no additional interventions developed with the patient as treatment progressed.

h. *Identify whether patient was referred to DDS, or MD and reason.*
Yes, as mentioned in treatment planning part A, a referral to an oral surgeon was given to the patient due to impaction of tooth #17 and 32.

i. *In hindsight would you have changed any part of your treatment plan or patient education plan?*
No, I would not have changed any part of my treatment plan or patient education plan. I felt that my treatment plan was appropriate for my patient. This was justify by the changes in the gingiva from disease to health. I know I had tried my best to encourage implementing the new homecare methods but ultimately it is up to every individual's willingness to comply. Additionally, I did offer to modify my treatment plan to include 2% sodium fluoride. However, my patient rejected this after hearing the post-op instruction of not eating for 30 minutes after application.

j. *Additional questions from the prevention exam: Was your home care plan successful? Were you stated outcomes achieved? What worked? What didn't? How were you able to motivate your patient to comply with your instructions?*

As mentioned in parts C and D, my homecare plan was unsuccessful because the goal was not reached and there was a lack of compliance on the patient's part. However, the stated prognosis of decrease inflammation, redness and bleeding of the gingiva was achieved after a full mouth scaling but the results could have improved faster and better if there was patient compliance. Motivation factors included: stressing the importance of good homecare by creating reasonable goals, showing areas with plaque stained by the disclosing solution, explaining what gingivitis is, what it could lead to providing evidence from the periodontal chart, explaining the prognosis and showing areas of improvement after scaling did not establish patient compliance. Hopefully, the patient's mindset can be changed in the next recare visit.

9. REFLECTION

a. *Did you accomplish everything you planned; both educational and mechanical, for this patient?*

   No, I did not accomplish everything that I have planned in regards to educational and mechanical implementation. I wished I was able to motivate my patient, provided fluoride and air polishing treatment. However, I do understand that these factors are not within my limits to control.

b. *Reflecting on your clinical treatment and faculty feedback, identify what you feel was your clinical strength or a positive experience which may have occurred during the treatment of this patient.*

   Although patient noncompliance was not the greatest experience, looking at it from a positive perspective, I am thankful for this experience. This encounter taught me to have a balance attitude, set reasonable expectations and reminded me to be modest. Even if I only want the best for my patient, I was reminded that I have my limits and can only do so much. As long as I am aware that I have tried my best, I should be proud of myself no matter what the outcome is. Thus, I will keep this experience in mind for future patients and for the rest of my career.

c. *Reflecting on your clinical treatment and faculty feedback, identify what you feel was your clinical weakness or a negative experience which may have occurred during the treatment of this patient.*

   I think my clinical weakness is time management. It took me two visits to complete all assessments with most of the time spent on periodontal charting and calalcus detection. I need to stop second guessing myself. Additionally, it took me two visits to scale one quadrant. I know that I can definitely do better because with ambition and self pressure, I was able to review medical history, complete extraoral and intraoral examination, implement homecare, complete scaling three quadrants and engine polishing all in the last visit. Although taking away clinical time to take the panoramic radiographs, completing three competencies and the

instructor's time management has a great impact on my time management, in the future I do plan to set goals for myself and make sure I attain them.