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**WEEK 1- February 1, 2018**

During my first day at Flushing Hospital, I was given the chance to observe Dr. Warren and Annie on their daily practice. Similar to the precautions we take in school, I had to follow the PPE protocol. Given the responsibility, I was able to complete a “deep cleaning” on two patients. It was more challenging to give a quality cleaning when limited to only a few instruments such as the Ultra-sonic, the explorer, the 11/12 and 13/14 Gracies. The sickle scaler would have been a good addition.

Insurance played a big role when treating the patients. With great surprise, I learned that “deep” cleanings or sub-gingival cleanings are not classified as a regular cleaning. In addition, I was instructed to stop a patient’s “deep” cleaning due to their insurance not responding to the hospital. I realize that everyone must get paid for his or her services, but without disappointing the patient from their treatment. Contemplating on the situation, I think it is important for the dental hygienist to speak to their patient regarding these issues. The patient should not become discouraged and should understand that these procedures are necessary even when insurance does not cover it.

Furthermore, I observed local infiltrations, which I hope to later do as I progress. Other emergency procedures included the extractions of teeth that required signed consent forms. This experience so far has opened my eyes to the dental work field.

**WEEK 2- February 8, 2018**

An observation I had made this week had been on the teamwork that occurs among all the residents, dentists and dental assistance. Other people who came on the scene were translators for the patients who could not speak English. All of them worked as a team and communicated with each other in order to get the job done.

Some procedures that I observed were root canals and extractions. Local infiltrations were administered to anesthetize the area worked on. This was ideal for me to observe since we are studying about local anesthesia. A few endodontic cases were patients who had been getting their old dentures adjusted or new dentures created. Alginate impressions were formed; models were poured out at the office and then sent out to a dental technician. Again, teamwork was involved in order to produce a successful treatment outcome for the patient. Many of the endodontic procedures accomplished were by the dentists and the residents. This made me consider how I may be more involved as a dental hygienist in these circumstances. Since we are about preventive dentistry and the first to look into a patient’s mouth, it is our responsibility to intercept when we find a concern in the oral cavity. Another responsibility that we have as dental hygienists is to educate the patient about maintaining their restorations after their treatment.

**WEEK 3- February 15, 2018**

The morning started out with continuous x-ray and cleaning treatments. I had four patients to expose FMS radiographs and to remove calculus. After using the Ultra-sonic and hand scaling, I was also able to polish with fine paste. One of the patients was more challenging because she had been sensitive to the films placed in her mouth. Breathing techniques, as well as quick time management, helped me to reduce her heaving sensations. With some of the patients, I had the opportunity to teach them about oral home care. One of my patients had visible supra-gingival calculus accumulation on the lingual aspect of the lower anterior teeth. I was able to discuss with the patient on how to properly brush every surface of their teeth including the lingual areas.

An interesting conversation I had with one of the dentists on the floor today was of patients who are Anti-Fluoride. There are many holistic products out in the market but no real evidence-based data due to everyone’s body reacting differently to these therapies. According to the dentist’s opinion from his clinical practice, many mothers tend to pick up these trends on the Internet and do more harm not exposing their children to Fluoride than giving them the proper treatment of Fluoride. In the clinic, it is a concern because the rate of cavities seems to be constant in children and not decreasing. However, the lack of Fluoride is not the only cause of cavities.

Considering the hospital clinic is in New York, there are many types of patients of many cultures that walk in. With different beliefs, it is crucial to educate patients and give them evidence-based data that give results. It is also an exciting time for me to see the many different types of restorations that are less popular in the U.S. due to aesthetics, but still prevail in other countries. The more I am exposed to the variety of restorations and the materials used on them, the better the clinician I can be.

**WEEK 4- February 22, 2018**

For my first patient this week, a brave 12-year-old Korean girl arrived for a root canal therapy on her first permanent molar. I could not help but wonder how such a young child managed to need endodontic treatment. Speaking to the residents, this type of situation occurs very often. I questioned whether or not one of the risk factors could be cultural. However, the residents believe these cases are not cultural as all children like snacks and candy. They suspect that the children snack on treats before bedtime and not rinse with water or brush their teeth properly. Learning about nutrition this semester, I am more aware of the high sugar contents contained in most of our foods and drinks that eventually can decay our teeth. Diet plays a very important role in how our teeth and body develop. As dental hygienists, this is an opportunity where we can educate the patient and their caregiver on how to choose healthier foods or to at least brush properly after sugary meals.

Another patient I was able to examine was a little Hispanic boy that presented with a suspicious red lesion on the midline of the dorsum of his tongue and hard palate. Immediately, I knew that I was looking at a fungal infection, specifically median rhomboid glossitis. We had a Dermatologist confirm that it was indeed Candida Albicans and that it will eventually disappear on its own. The boy was not sensitive and did not feel any pain from the overgrowth. Thinking back to my Pathology class, I had recommended to use gauze to wipe the fungus off daily. Again, diet was also a concern because sugar is what feeds yeast.

A young 27-year-old with fillings on nearly every tooth and 12 cavities also made me wonder if diet was an additional risk factor to her being caries active. However, this young woman was not implementing good home care either. It is very alarming to have to observe these dental problems in such young people. There is a great need for educating patients and their caregivers on how serious these problems are and how they will affect their future. I believe it starts with implementing good oral hygiene at home and then focusing on better diet habits.

**WEEK 5- March 1, 2018**

Throughout this week’s session, I really got a chance to see what 6-handed-dentistry looked like. There were a few major procedures that required a dentist, a resident, and an assistant; and sometimes even a translator in the room. I found it to be time efficient and very effective as everyone played an important role. This time the operation was an alveolar ridge augmentation using an allograft bone. One dentist was cutting while the other resident was suctioning and keeping the area clear from any obstructions, together with the assistant who was handing over materials as needed for the procedure. Each operator was communicating or instructing and everyone kept each other in check. I felt that it was also a great system to use for learning. Residents that are still acquiring practice can observe, communicate and still be a part of the procedure. I truly appreciate the assistants who are always very compassionate with the patients and genuinely make them feel welcomed. They do most of the assisting and translating.

Furthermore, the benefits of teamwork were displayed during a patient’s chief complaint that could not be resolved without further examination. The course of action started with the resident noticing the patient’s distressed face and asked the assistant to translate the patient’s concern. The patient expressed irritation in the attached gingiva of the lower anterior teeth. While the resident was reviewing the patient’s medical history and examining her intra-orally, there was much communication and questioning between the patient, the assistant, and the resident. By working together, the outcome was that the patient’s bite placement was incorrect. Due to her missing posterior teeth, she had been putting all of her pressure on the anterior teeth, which led to gum sensitivity. As a team, the issue was uncovered and the proper steps were taken to help alleviate the patient’s pain.

**WEEK 6- March 8, 2018**

This week’s session was quite slow, most likely due to the snowstorm the day before. A few patients that had entered the clinic had come for endodontic therapy. Due to the advanced periodontal disease, most of these patients had all of their teeth extracted. As to attain a permanent full set of dentures, the residents utilized different types of molds to properly evaluate the patient’s alveolar mucosa. Some patients present a problem when they do not have enough bone structure to securely grip a denture. Dr. Krecko explained to me what form of alveolar ridge we look for to successfully place implants to support the dentures. In one circumstance, implants were not an option because of the patient’s extensive bone loss. Bone augmentation can fill the ridges horizontally, but not vertically. The best way we could treat this patient was by trying to make a denture that would cover the whole palate and provide a tight suction to hold the denture in place. In addition, I had learned how to instruct a patient on applying dental adhesive to a denture.

Before finishing up the day, I administered an ASA, MSA and PSA local anesthesia on a blind patient. I treated him with a “deep cleaning” and made sure there was verbal communication throughout the whole procedure. Afterwards, I spoke to the caregiver about his homecare and taught both of them how to floss the teeth properly.

**WEEK 7- March 15, 2018**

The day started out with a tissue reduction surgery. The patient was experiencing chronic inflammation on the distal of her terminal tooth. A small operation was done to remove the excess tissue and exudate from the area under the gingiva. By helping to suction, I was able to see the procedure up close and ask questions. Being in that environment, I am now seeing many of the dental tools and sutures that I have been previously learning in textbooks being applied now on patients. The resident used a silk non-absorbable suture to stitch the patient, as she is to return for an evaluation. For patients who get simple extractions, a synthetic absorbable suture called “CHROMIC GUT” is used instead. Post-op instructions were then discussed with the patient.

I was given the opportunity to observe the examination of a very young PEDO patient using the “knee-to-knee” positioning method. There was a lot of crying and yelling involved, which can be heartbreaking to see. However, with a little incentive using stickers, we were able to successfully count her teeth and polish with a fine paste. The resident had noticed black extrinsic staining on the patient’s teeth that could not be removed. She mentioned that she had seen this same staining on similar patients in other Indian cultures. To further investigate the cause, the mother was questioned about her daughter’s diet. We were not able to determine a definite cause, but we could assume that it is possibly from the type of food she consumes. I had recommended the girl brush her teeth or drink water after eating meals that may cause staining to flush the mouth.

Later I was involved in a dental cleaning for a 13 year old boy who needed an extraction on #8 from a fracture that had not been taken care of. Even though the tooth was mobile, the resident wanted to keep it in place for as long as possible. Since his dentition was still changing, extracting the tooth could present further problems. In the case of an extraction, the boy would need a partial denture to secure the space for a future implant. We would have to wait until the boy’s bone was fully developed, around the age of 18, to place the implant. Before the boy left, we spoke to him about his dental hygiene care at home for preventing the same situation from occurring on the rest of his dentition.

**WEEK 8- March 22, 2018**

This week’s interesting case was a walk-in patient with a chief complaint that the area where her implant was recently placed was throbbing. The resident explained that it is normal to feel some pain in the area as the tissue heals, but that she would check for any signs of infection. We observed the slightly inflamed tissue and the granular tissue on the healing area, which was a good sign. As a part of her assessment, the resident had taken a periapical radiograph to be confident that there was no infection. The patient had been taking Advil to manage the pain and the resident recommended to take it only as needed but not to exceed 3000mg daily. The x-rays revealed that the tooth next to the implant had been infected, but was having no impact on the healing implant. Knowing this information, the patient asked about her options. The resident recommended that her best option was to pull the tooth out and to place another implant. This would allow for a better prognosis on the results and a less chance of implant failure.

Another case I found very interesting was a patient with all his teeth extracted who had made an appointment to start on his full-set of dentures. Since we had no reference of his previous bite, we had to use some imagination. We used a wax block and molded it accordingly to his occlusal vertical dimension. It was also very important to measure the maxillary-mandibular relation and the vertical dimension of rest. After a few corrections, we were able to find the right fit and the patient was asked to pick out the color of teeth he most desired. These procedures were all very important in order to achieve the first step in creating a confortable and well-fitted denture. In this case, the resident was acting as a dental technician and working with wax in order to start the process of creating a full-set of dentures.

**WEEK 9- March 29, 2018**

High energy filled the clinic as everyone was preparing for the placement of two maxillary implants on a patient. To prepare, I helped the dental assistant set up the instruments and a drip bag filled with 500 ml of 0.9% Sodium Chloride that was connected to the dental implant drill. I overheard the Periodontist discussing the surgical procedure with one of the residents confirming that the maxillary has less bone density and is softer; therefore, a fine drill tip was to be used. Due to the patient’s heart condition, Carbocaine (Mepivacaine HCI) was administered for local anesthesia. Without a vasoconstrictor, more bleeding was expected. We prepared a cup and filled it with gauze soaked in 0.9% Sodium Chloride saline solution to be used to stop extensive bleeding by adding pressure to the areas needed. Sodium Chloride was used in this case to help keep the surgical area clean. However, the hospital does not follow the CDC infection control guidelines and has not been using preprocedural mouthrinses for their patients, which by the ADHA has proven to reduce bactericides in aerosol and splatter. Not to mention, the Periodontist at some point was walking around with coffee checking on the resident working on a patient procedure. I thought that was very unprofessional and potentially unsafe. Nevertheless, the implants were drilled in and absorbable chromic sutures were used to stitch up the tissue.

Afterwards, I gave a few patients prophylactic treatment and I was able to speak to each of them about their oral home care. One of them was very interested in how plaque and tartar form, which allowed me to brush up on my microbiology in order to explain it thoroughly.

**WEEK 10- April 9, 2018**

The first dental emergency I was observing for the day involved a decayed tooth that needed extraction. The patient was already in great pain entering the clinic and anxious due to the language barrier. Beside the patient was her husband, who was able to help translate to the residents as well as calm her down. Giving local anesthesia was a concern due to the swelling and pain the patient was already experiencing. The infection could absorb the entire carpule of Lidocaine and fail to numb the rest of the area. If anesthesia did not work, the patient would be sent home to take antibiotics to minimize and localize the swelling. After about 10 days, she would come back to try the anesthesia again. Luckily, local anesthesia successfully numbed the whole area and an extraction was performed. The patient was very sensitive and I thought the residents did a great job calming her down by telling her and her husband each step before it was put into action, as well as holding her hand when possible.

Another patient that had come for a dental cleaning also had a case of Pericoronitis on her last molar. I had learned from the resident that Pericoronitis was different from operculum. Pericoronitis is an infection that needs antibiotics to help eliminate the swelling of tissue and most importantly the removal of bacteria causing it. The patient must then maintain the area clean. An operculum is healthy tissue that is growing over the crown of the tooth and must be surgically removed (Operculectomy).

There were a few problems encountered today with radiographs. The machine at the hospital that exposes the radiographs is supposedly old. The radiographs appear on the computer very grainy and sometimes superimposed by previously exposed radiographs making it a challenge to read the x-rays properly. Unfortunately, the hospital will probably not get a new machine any time soon and the problem will endure. Other issues I noticed were the use of protective eyewear for patients. During a procedure, I noticed a patient squinting as water from one of the instruments was splashing into their eyes. This is not only uncomfortable for patients but it can also harm the patient if infectious material is being transferred. Even as the residents place sutures, they will ask the patients to close their eyes so that the needle does not injure them as they knot it. I was able to find a small box of different types of plastic glasses that could be used for the patients; however, they are not being utilized. I have been using them for every dental cleaning I give.

**WEEK 11- April 16, 2018**

This week I noticed a little bottle of mouthwash near every sink. I asked an assistant how often they have mouthwash and they replied that it comes and goes. The mouthrinse is called “Sparklefresh Mouthwash” and is alcohol free. I looked closely at the ingredients to try and find the active ingredient only to discover that it contained nothing else but sugar, flavoring and preservatives. The whole purpose of a patient using mouthrinse at the clinic is to kill unwanted bacteria. The only thing the clinic’s mouthwash can help with is mouth odor. I wondered if there was a significant price difference for the clinic to select that type of mouthwash.

After setting up, an emergency patient had entered with her partial denture complaining about pain in her teeth. We had examined her gums and her teeth to see if the denture was ill fitting. The resident had palpated her gingiva, and used the dental percussion method and radiographs to determine the root of her pain. The radiographs revealed periapical radiolucency on the patient’s root canal. Options given to the patient were either extraction or re-treatment of the root canal. The decision is usually heavily based on whether or not the patient has an insurance to cover re-treatment of a root canal. Looking at the patient’s medical history, she was already prescribed Chlorohexidine 0.12% mouthrinse and 800mg of Ibuprofen (NSAID) for the pain. Adding to her medication, she was now prescribed antibiotics (Amoxicillin) to control infection before coming back in for an extraction. Luckily, the extraction did not affect the placement of her dentures.

A frustrating appointment for one of the residents was a woman who lost her provisional crown and did not come back until weeks after. Due to the loss and time, her gingiva grew over the tooth multiplying the work intended for the resident. Not only did the resident now have to make a new crown, but also do a surgical procedure for a Gingivectomy to fit the crown properly. In this case, it is important for dentists to communicate to their patients so that they are aware the consequences when they neglect to follow-up after knowing that the crown had fallen out.

Towards the end, the clinic became extremely busy and I saw how the clinic manager began to regulate the residents’ time. She had also been helping translate for patients because all the assistants were already being utilized. Everything was rushed and my cleaning time had been reduced from the expected time of 30 minutes per patient to about 15 minutes, but the residents I had observed still gave their full attention to the patients and the patient’s concerns.

**WEEK 12- April 23, 2018**

As soon as I walked in, I was informed that there were no more over gowns or masks with eye protection. This was already the third day without these supplies; therefore, the staff had already been prepared to bring in their own lab coats and plastic glasses. I was concerned on why the hospital was lacking essential supplies and it all emerges from the hospital budget. Luckily by the afternoon, the shipment had come and we were all wearing PPE.

An emergency patient had come in due to pain she was experiencing on her upper left quadrant. Looking at previous documentation, the patient had experienced the same pain last year. The resident had tried to locate the source of the pain; so a few tests were performed such as the palpation and percussion tests and applying cold. The patient was only sensitive to percussion on her last tooth. Radiographs were exposed and the only things that were found suspicious were her occlusal-buccal amalgam that was placed closely to her nerve, and the generalized bone loss. Once the dentist on the floor came to check, he had noticed a very fine crack running through the mesial to distal portion of the restoration. The resident had to remove the amalgam to determine if the tooth could be saved. Unfortunately, the tooth had to be extracted. This patient was very emotional and started crying. The residents and I were able to calm the patient by talking her through every step of the process, reassuring her that it the procedure will be successful and listening to her fears. I held her hand through the extraction. Once the tooth was removed, it had fallen apart into little pieces. It seemed that the restoration had been broken for quite some time considering she had been experiencing the pain since last year.

In addition, I learned a lot about dentures today and measuring the muscles of the mouth through impressions to make sure the denture is not too high. We used undercuts to support the denture and planned to use the patient’s cusps to place metal rests. It was really neat to see the process of creating an ideal denture for this particular patient.

Another patient came in for a consultation on placing a new bridge and was complaining about his suggested treatment plan. The patient had previous work done at a different office and felt that his past gave him enough experience to know what was best for him. I always felt that the patient should be given every option possible so that they could decide on what they prefer. In this situation, the patient asked for his bridge to consist of two root canals on either side of his pontic rather than porcelain crowns. He had argued that every time the dentist placed a crown, he had felt pain and sensitivity, which eventually led to a root canal. The patient wanted an “end product” as oppose to having to come back to fix the same restoration. He was also taking into account his insurance. Our dentist reassured him that he would not have the same traumatizing experience here. He stressed to the patient that it would be foolish to do a root canal if he didn’t need it. Furthermore, he mentioned that just the heat of reduction could damage nerves and perhaps that is why he felt sensitivity. He explained that by placing a metal crown, there is less reduction of the tooth structure. The patient was happy to try this idea and agreed to have metal crowns placed on either side of the pontic. It was great to observe how the dentist had dealt with the situation. He did not take advantage of the patient and communicated in such a way that the patient felt informed and satisfied with his treatment plan.

**WEEK 13- April 30, 2018**

This week I had a lot of practice with exposing FMS radiographs and analyzing them, as well as dental prophylaxis. I would notice where most of the visible biofilm or tartar was present in the patient’s mouth and by that observation, try to educate them on what home care they most needed. The vocal patient from last week came back to have his bridge placed. This time, he had a different resident treating him. I felt that because he did not know this dentist, he felt most comfortable speaking to me since he recognized me from his last visit. Even though I was observing, I had started to build a relationship with this patient and tried to be the liaison between the patient and the new resident on his case. It was really wonderful to be working as a team to provide the best quality of care and comfort for the patient.

**WEEK 14- May 3, 2018**

Today was slower, but I was able to observe a patient with a very interesting restoration that she had done in her home county of Mexico. These types of restorations are usually popular with patients from other countries abroad. A way to describe it would be a veneer on tooth #9 with a thin metal border that the patient had stated was there due to her sensitivity. The amalgam veneer was not well made as it had some overhangs, which would make it very difficult to keep clean. The patient expressed her desire to remove the restoration and replace it with a composite. While assessing the tooth, the resident had noticed a gray spot under the restoration that may have indicated decay. In order to place the composite, an evaluation of the tooth had to be done to determine whether a filling or crown would be needed. I found that with these types of restorations, sometimes a dental hygienist has to be creative in the patient’s oral home care. The overhangs could cause unnecessary damage if proper care is not implemented.

**WEEK 15- May 10, 2018**

Today was the last day of my internship. It was bittersweet, as I will miss everyone in the clinic. I had a great opportunity getting to observe everyone’s role and learning about many interesting cases. On this last day, I had some patients that were very sensitive to the ultra-sonic and had displayed anxiety in the dental chair. By talking to the patient through every step of their dental cleaning so that there were no surprises and allowing them to feel in control, I was able to successfully finish my task. Other patients had come in for a consult with the dentist. One patient in particular came in to evaluate her bone loss as she has been trying to maintain a healthy oral cavity. Her periodontal readings were 4mm pocket depths including 2-3mm visible recession. The resident had recommended gingival flap surgery; however, the dentist on the floor believed that 4mm pocket depths could still be maintained without surgery. It was essential for the patient to floss daily. A suggestion was made to use a *Waterpik* flosser with the rubber tip in the deepest pockets to help manage the areas.

Another case I found to be interesting was a patient that I had exposed FMS radiographs on. The x-rays exhibited a peri-apical abscess on teeth #7 and 8. After doing a couple of tests, it was determined that tooth #7 was sensitive and #8 was not, indicating a necrotic root. A treatment plan to proceed with a root canal for #8 was composed and the patient signed consent. Once the root canal is complete, the abscess will heal on its own. It is so remarkable how the body takes care of itself when healing.

All 15 weeks of my internship were truly an eye-opener to the field of dentistry. I am thrilled to have had such a wonderful experience!