WINSPERT

HEALTH PROMOTION

ADA POLICIES

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

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MIND MAP

ADA POLICIES SUMMARY AND MIND MAP OUTLINE

Corrections and Disclosure of Records

- Corrections are made by striking out errors; liquid paper is prohibited.
- Records primarily serve treatment; secondary use includes billing or court orders; patient consent required for research use.

Dental Fees and Cost Transparency

- Dentists set their own fees; treatment costs communicated before procedures.
- Fees may be hourly or per procedure; no fixed fee scale due to case variability.

Prevention and Management of Oral Injuries

- Custom-fitted mouthguards recommended for high-risk sports and activities.
- Oral piercings and prominent front teeth increase injury risk; public education and mandatory policies advised.

Equal Opportunities and Workplace Diversity

- Employers must promote equity, diversity, and eliminate discrimination.
- Quick and appropriate responses to workplace issues are required by law.

Neurotoxins and Dermal Fillers in Dentistry

- Dentists are qualified to administer neurotoxins and fillers; regulated by TGA.
- Off-label use requires clinical judgment and patient consent; appropriate education and indemnity coverage essential.

Abuse and Violence Victims in Dentistry

- Abuse is unacceptable; dentists play a role in detection and support.
- Awareness of reporting laws and referral pathways is essential; safe environment encouraged.

Dental Records Management

- Dentists must maintain accurate, contemporaneous, and chronological dental records.
- Records include patient details, consent, clinical data, radiographs, referrals, and must be written with non-erasable pens.

Retention and Ownership of Records

- Adult records retained for at least 7 years; under-18 records until age 25.
- Dentists own records; secure destruction required after retention period; patient access facilitated with explanation.

Informed Financial Consent

- Patients should receive cost estimates and understand potential fee changes.
- Emergency care may exempt prior consent; patients encouraged to verify health fund coverage.

Management of Knocked-Out Teeth

- Baby teeth should not be replanted; adult teeth should be handled by crown and replanted immediately if possible.
- Use milk, saline, or saliva to keep teeth moist if immediate replanting is not possible.

Dental Amalgam Use and Regulation

- Bulk mercury banned post-2024; amalgam use restricted in children, pregnant women, and kidney patients.
- Proper mercury hygiene and waste disposal mandatory; unnecessary replacement discouraged.

Forensics in Dentistry

- Dental records assist in identifying deceased persons, especially in disasters.
- Original records must be kept legible, unaltered, and provided timely to law enforcement.

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MIND MAP

ADA POLICIES SUMMARY AND MIND MAP OUTLINE

Management of Ankyloglossia

- Non-surgical management is first-line therapy for functional limitations in infants.
- Surgical treatment is reserved for failed conservative management and should be done by trained professionals.

Community Oral Health Program

- Oral health care should be accessible to everyone, including people with special needs.
- Dentists lead mixed private-public dental service teams supported by government funding for promotion and training.

Tobacco and Vaping

- Dental professionals should provide tobacco cessation guidance and refer to support services.
- Vaping contains harmful substances, increases oral cancer and periodontal risks, and is discouraged.

Body Modifications in Oral Cavity

- Oral body modifications cause health risks including infection, nerve damage, and tooth damage.
- Valid informed consent, training of providers, mandatory waiting periods, and post-procedure reviews are required.

Diet and Nutrition

- High sugar and acidic foods damage teeth; WHO recommends reducing free sugar intake to below 5-10%.
- Governments should tax sugary products to fund oral health promotion and care for disadvantaged groups.

Emergency Overseas Dental Treatment

- Travellers should have dental checks 3 months before departure to prevent emergencies abroad.
- Consular services offer emergency dental treatment info; travellers should obtain written reports for return care.

Ankyloglossia and Oral Frena

- Oral frena connect surfaces inside the mouth (lingual and labial frenum).
- Ankyloglossia (tongue tie) restricts tongue movement and affects breastfeeding, speech, and dental health.

Diagnosis of Ankyloglossia

- Requires thorough case history and objective tongue function assessment.
- Functional impact evaluation by qualified practitioners, e.g., lactation consultants, is essential.

Oral Hygiene

- Brushing twice daily with fluoridated toothpaste and interdental cleaning are vital.
- Oral hygiene education must be integrated into school curricula and health professional training.

Betel Nut Use

- Betel quid (areca nut product) use should be avoided due to risk of oral precancerous and cancerous lesions.

Fluoride Use

- Community water fluoridation (0.6-1.1 ppm) is safe, effective, and ethical for reducing tooth decay.
- Fluoridated water is safe during pregnancy and breastfeeding; fluoridation benefits all age groups.

Elective Overseas Dental Treatment

- Overseas dental care poses risks; Australians should seek treatment locally to ensure standards and insurance.
- Australian dentists must advise patients before overseas treatment; promoters should indemnify consumers.

Tooth Bleaching Regulations

- Only registered dental practitioners may use/supply bleaching agents >3% hydrogen peroxide for safety.
- Bleaching requires justification and comprehensive dental examination before treatment.

Post-Treatment Radiographic Appearance

- After endodontic treatment or apical surgery, radiolucencies resembling rarefying osteitis may persist.
- These areas may contain dense fibrous scar tissue instead of normal bone.

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MIND MAP

DELIVERY OF ORAL HEALTH TO SPECIAL GROUPS

Oral Health for Adolescents and Young Adults

- Access to education, oral health products, and services is essential to maintain good oral health.
- Public funding should prioritize high-risk groups and financially disadvantaged adolescents for dental care.

Oral Health for Infants and Preschool Children

- Dental check-ups should begin by the eruption of the first teeth or first birthday, with guidance on hygiene, diet, teething, and fluoride use.
- Early childhood professionals should be knowledgeable and involved in oral health promotion and referrals.

Oral Health for Aboriginal and Torres Strait Islander Australian

- Indigenous Australians experience higher oral disease rates and reduced care access.
- Services should be culturally appropriate, involving Indigenous communities and practitioners in design and delivery.

Oral Health for Individuals Unable to Access Dental Clinics

- Dental care should be available outside clinics, including at home, hospitals, and aged care.
- Specialized equipment and careful planning are required; government support for travel reimbursement is necessary.

Child Dental Benefits Schedule (CDBS)

- Provides up to $1,132 over two years for basic dental services for eligible children aged 0-17.
- Eligibility depends on Medicare and receiving government payments, with benefits processed by Services Australia.

Oral Health for Children

- Children's caries risk has increased recently, highlighting the need for prevention and high-quality dental care.
- Regular dental exams should start by the eruption of the first tooth or by the first birthday, with periodic oral development assessments from around six years of age.

Oral Health for Older People

- Geriatric dentistry is part of special needs dentistry, ensuring timely and adequate care.
- Frail older adults in residential care should have onsite oral health access with government support for domiciliary dental providers.

Oral Health for Individuals in Remote Areas

- Remote residents face challenges accessing dental care due to workforce shortages.
- Teledentistry is beneficial but limited to cases without direct treatment; fluoridation of drinking water is crucial for prevention.

Oral Health for Individuals with Disabilities

- People with disabilities deserve equal access to dental care and facilities adapted to their needs.
- Dental professionals should be trained, and government funding must support improved access.

Residential Aged Care Facilities and Oral Health

- Staff must be trained to understand oral health impacts and provide promotion and screening.
- Facilities must comply with quality care principles and consult ADA for dental standards.

Additional Key Points on Policy Implementation

- Training in cultural safety is required for dental programs to improve indigenous oral health awareness.
- Regional and remote dentists should have professional support and continuing education opportunities.
- Government should support private practitioners for travel costs related to domiciliary care and remote services.
- Prevention is emphasized as the cornerstone of better oral health in all populations, especially vulnerable groups.

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ADA POLICIES

Question 1

What is the professional and legal obligation of dentists regarding dental records according to the ADA policy?

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ADA POLICIES

Answer 1

Dentists have a professional and legal obligation to maintain clinically relevant, accurate, and contemporaneous dental records of their patients.

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ADA POLICIES

Question 2

What should dental records contain as per the ADA dental records policy?

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Answer 2

Dental records should contain patient details, details of substitute decision maker if present, consent and restriction disclosure, clinical details including radiographs, examination details, batch control identification (BCI), advice, referrals, etc.

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ADA POLICIES

Question 3

How should corrections be made in dental records according to ADA guidelines?

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ADA POLICIES

Answer 3

Corrections should be made by striking out the incorrect words and rewriting the correct words. If the document is rewritten, the original document should be kept as a reference. Liquid paper and erasable pens should not be used.

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ADA POLICIES

Question 4

For what purposes can dental records be primarily used and disclosed?

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ADA POLICIES

Answer 4

Primarily, dental records should be used and disclosed for treating the patient. Secondary purposes include billing and if a court order such as a subpoena or warrant is provided.

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Question 5

What is the recommended retention period for dental records collected from adult patients?

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ADA POLICIES

Answer 5

Dental records collected while the patient is an adult should be retained for at least 7 years from the last occasion on which the health service was provided.

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Question 6

What is the retention policy for dental records collected from patients under 18 years of age?

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ADA POLICIES

Answer 6

Records collected while the patient was under 18 years should be retained until the individual has attended the age of 25 years.

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ADA POLICIES

Question 7

Who owns the dental records, and how should access to these records be handled?

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ADA POLICIES

Answer 7

The dentist or dental practice owns the dental records. When a patient seeks access, the dentist is recommended to meet with the patient to explain the records and provide the information preferably in a report, not just a copy of the records.

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ADA POLICIES

Question 8

What steps must a dentist take when a dental practice closes?

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ADA POLICIES

Answer 8

A dentist must notify patients in advance, facilitate the transfer of care of current patients to other practitioners, and securely and consensually transfer dental records of those patients.

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Question 9

According to the ADA, how should dentists determine and communicate their fees?

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ADA POLICIES

Answer 9

Dentists must be able to determine their own fees and provide patients with information about treatment costs prior to treatment. They should provide sufficient detail to identify the nature and cost of services and may charge hourly or per procedure.

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Question 10

What is informed financial consent in dental treatment, and when might it not be appropriate?

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ADA POLICIES

Answer 10

Informed financial consent involves providing patients with information about treatment costs before treatment as part of ethical practice. It may not be appropriate if it would delay or compromise emergency patient care.

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ADA POLICIES

Question 11

What should patients be informed about regarding estimated dental fees?

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ADA POLICIES

Answer 11

Patients should be informed that estimated fees may increase if procedures take longer or circumstances change. Any change in fees should be communicated at an appropriate time.

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ADA POLICIES

Question 12

Who are considered high-risk groups for oral injuries, and what is the most effective protection recommended?

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ADA POLICIES

Answer 12

Young children and teenagers are high-risk groups. The most effective protection against oral injuries is a custom-fitted mouthguard made with precision fit and quality materials.

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ADA POLICIES

Question 13

List some sports where mouthguards are strongly recommended according to ADA policy.

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ADA POLICIES

Answer 13

Mouthguards are strongly recommended for sports such as off-road bike riding, skateboarding, rock climbing, white-water rafting, trampolining, combat sports, football, basketball, squash, and field hockey.

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ADA POLICIES

Question 14

What should be done when a tooth is knocked out, according to ADA policy?

Answer 14

Keep the patient calm, find the tooth, and if it is a baby tooth, do not replace it but seek immediate dental treatment. If it is an adult tooth, handle by the crown, rinse if dirty, and replace it immediately in the socket, having the patient hold it in place. If unable to replace, keep the tooth moist in suitable medium like milk or saline.

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ADA POLICIES

Question 15

What are the ADA’s recommendations regarding the use of dental amalgam after January 1, 2024?

Answer 15

The use of bulk mercury is prohibited; amalgam can only be used in its pre-dosed encapsulated form. Use should be minimized in children, pregnant or breastfeeding women, and individuals with kidney disease. Mercury hygiene and correct disposal of amalgam waste must be practiced.

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ADA POLICIES

Question 16

Who is qualified to administer neurotoxins and dermal fillers in dentistry, and what must dentists ensure before use?

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Answer 16

Dentists trained in oral and maxillofacial anatomy are qualified. Dentists must complete appropriate education, confirm professional indemnity coverage, and not delegate treatment involving neurotoxins and dermal fillers.

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Question 17

What are the three primary forensic identifiers endorsed by international and Australian authorities?

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ADA POLICIES

Answer 17

The three primary forensic identifiers are friction ridge (fingerprint) analysis, comparative dental analysis, and DNA analysis.

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Question 18

How should dental practitioners respond to evidence or suspicion of abuse and violence?

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Answer 18

They should detect, intervene, provide advice and support, create a safe environment for disclosure, be aware of reporting laws, and have appropriate referral pathways to assist victims.

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ADA POLICIES

Question 19

What is ankyloglossia, and what is the recommended approach for its management according to ADA policy?

Answer 19

Ankyloglossia (tongue tie) is restricted tongue movement caused by the lingual frenum. Non-surgical management is the first line of therapy. Surgical treatment is considered only after non-surgical management fails and should be done by trained professionals in appropriate settings.

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ADA POLICIES

Question 20

What is the purpose of the Child Dental Benefits Schedule (CDBS), and who is eligible?

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ADA POLICIES

Answer 20

The CDBS provides eligible children with up to $1,132 over two years for basic dental services. Eligible children are those with Medicare, aged 0-17 at any time during the calendar year, and receiving relevant government payments like Family Tax Benefit Part A.

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HEALTH PROMOTION

PREGNANCY AND BREASTFEEDING

MIND MAP & CUE CARDS

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MIND MAP

PREGNANCY AND BREASTFEEDING: ORAL HEALTH OVERVIEW

Pregnancy Overview

- Pregnancy spans from conception to birth, involving profound hormonal changes.
- Divided into three trimesters: First (0-12 weeks), Second (13-27 weeks), Third (28-40 weeks).

Hormonal Influence on Oral Tissues

- Female steroid hormones (estrogen, progesterone) fluctuate, affecting periodontal tissues, especially gingiva.
- Hormonal changes alter gingival vasculature and immune response to dental plaque.

Periodontal Diseases

- Includes gingivitis and periodontitis; initiated by plaque accumulation.
- Immune changes in pregnancy reduce neutrophil and lymphocyte efectiveness,
- increasing vulnerability.

Periodontitis in Pregnancy

- Affects approximately 40% of pregnant women, with higher risk in smokers and certain demographic groups.
- Linked to possible adverse pregnancy outcomes (preterm birth, low birth weight, preeclampsia).

Dental Erosion (Perimylolysis)

- Vomiting from nausea exposes teeth to gastric acid, causing enamel erosion and xerostomia.
- Advisable to rinse with water or milk after vomiting and delay brushing for 30 minutes.

Periodontal Disease and Pregnancy Complications

- Inflammatory mediators and pathogens from periodontal disease may affect the feto-placental unit.
- Though associated, a definitive causal link to adverse outcomes like preeclampsia or preterm birth remains unproven.

Prevention Strategies in Pregnancy

- Emphasis on meticulous plaque control and oral hygiene education.
- Smoking cessation is critical to reduce periodontal disease risk and improve pregnancy outcomes.

Radiographs and Anesthesia Safety

- Dental X-rays are safe with proper shielding and collimation at any pregnancy stage.
- Local anesthetics do not increase pregnancy risks and are safe when used appropriately.

Patient Education Points

- Controlling maternal oral disease reduces bacterial transmission to infants, promoting long-term oral health.
- Dental care reassurance alleviates fears about safety of treatment during pregnancy and breastfeeding.

Common Oral Problems During Pregnancy

- Increased cravings and frequent snacking increase caries risk.
- Elevated Streptococcus mutans and saliva changes heighten susceptibility to caries.

Pregnancy Gingivitis

- Affects about 67% of pregnant women, peaking in the second trimester.
- Causes gingival swelling, bleeding, and enlargement due to heightened inflammatory response.

Pyogenic Granuloma (Pregnancy Tumor)

- Occurs in up to 5% of pregnant women as localized gingival growths, often bleeding and painful.
- Usually regresses postpartum but may require excision if problematic.

Oral Health Advice for Pregnant Women

- Treatment of caries and periodontal disease is safe and recommended during pregnancy.
- Preventive care reduces risks of early childhood caries and adverse pregnancy of outcomes.

Specific Pregnancy Conditions Linked to Oral Health

- Pre-eclampsia affects 5-10% of pregnant women and shares risk factors with periodontal disease.
- Gestational diabetes is associated with increased severity of periodontal disease.

Safe Dental Treatment During Pregnancy

- Most dental procedures, including fillings and root canals, are safe throughout pregnancy.
- Elective treatments are ideally done in the second trimester; avoid general anesthesia where possible.

Management of Oral Conditions Specific to Pregnancy

- Pyogenic granulomas often regress with good oral hygiene but may require surgical removal.
- After vomiting, rinsing with bicarbonate solution helps neutralize acids and protect enamel.

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MIND MAP

ASSOCIATION OF ORAL HEALTH CARE OF PREGNANT WOMEN WITH ORAL ISSUES IN NEWBORNS

Maternal Oral Hygiene and Diet
- Good oral hygiene and low sugar diet decrease caries risk in children
- Appropriate fluoride exposure further protects oral health

Use of Dummies (Pacifiers) and Oral Health
- Dummies reduce pain, hospital stay, and sudden infant death syndrome (SIDS)risk
- Prolonged use causes malocclusion and middle ear infections (otitis media)

Effects of Duration of Sucking Habits
- Use under 12 months: no harm to dentition
- Use over 36 months: increased risk of anterior open bite, Class II canine relationships, posterior crossbite, and excess overjet

Passive Smoking and Child Health
- Passive smoking harms babies' delicate lungs causing asthma, infections, and ear problems
- Children should be protected by having smokers smoke outside only

Breastfeeding and Oral Health Benefits
- Breast milk supports immune system and digestive development
- WHO recommends exclusive breastfeeding for 6 months, continued up to 12-24 months

Breastfeeding and Malocclusion
- Breastfeeding promotes facial muscle activity and proper craniofacial development
- Bottle feeding may cause poor oral alignment due to less flexible nipple materials

Drug Use in Pregnancy and Breastfeeding
- Drug efects depend on timing; organogenesis (17-70 days) most critical for teratogenicity
- Paracetamol is first-line analgesic; NSAIDS avoided after 32 weeks due to risks

Role of Dental Practitioners
- Encourage breastfeeding and educate on oral hygiene and diet for children
- Inform breastfeeding mothers about drug safety and smoking cessation support

Early Oral Colonization and Dental Caries
- Early colonization by
- Reducing maternal

Saliva Transfer and Parental Oral Care
- Parents should minimize saliva transfer to child to prevent bacterial transmission
- Maintaining excellent parental oral health is crucial for child's oral health

Non-Nutritive Sucking Habits
- Non-nutritive sucking (dummy, finger, thumb) common in children, can afect oral cavity
- Dummy sucking impacts occlusion more than finger/thumb but easier to stop

Smoking and Pregnancy Risks
- Smoking reduces oxygen and blood flow to fetus, causing stress and developmental risks
- Increases risks of ectopic pregnancy, miscarriage, premature birth, low birth weight, infant death, and SIDS.

Quitting Smoking During Pregnancy
- Quitting in first 16 weeks reduces harmful effects close to non-smoker levels
- Nicotine replacement therapy (NRT) preferred oral forms; patches used cautiously and removed at night

Breastfeeding's Role in Dental Caries Prevention
- Lactose in breast milk less cariogenic than sucrose in formula
- Breastfeeding up to 12 months reduces caries risk; over 12 months with frequent/night feeding may increase risk

Smoking Effects on Breastfeeding
- Smoking decreases breast milk quantity and quality; harmful substances pass to baby
- Breastfeeding still better than formula even mother smokes; precautions advised

NSAIDS and Breastfeeding
- Small NSAID amountsn breast milk generally safe; ibuprofen preferred
- Mothers advised to breastfeed before medication to reduce infant exposure

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PREGNANCY AND BREASTFEEDING

Question 1

What hormonal changes occur during pregnancy that affect oral tissues?

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PREGNANCY AND BREASTFEEDING

Answer 1

During pregnancy, there are profound hormonal changes, especially fluctuations in female steroid hormones such as estrogens and progesterones, which influence many tissues in the body including the periodontium and gingiva.

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PREGNANCY AND BREASTFEEDING

Question 2

How is the pregnancy period divided into trimesters?

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PREGNANCY AND BREASTFEEDING

Answer 2

Pregnancy is divided into three trimesters: First trimester from conception to 12 weeks, second trimester from 13 to 27 weeks, and third trimester from 28 to 40 weeks.

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PREGNANCY AND BREASTFEEDING

Question 3

What are common oral problems during pregnancy?

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PREGNANCY AND BREASTFEEDING

Answer 3

Common oral problems during pregnancy include dental caries, periodontal diseases (gingivitis and periodontitis), pregnancy gingivitis, pyogenic granuloma, and dental erosion (perimylolysis).

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PREGNANCY AND BREASTFEEDING

Question 4

How does pregnancy affect the risk of dental caries?

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PREGNANCY AND BREASTFEEDING

Answer 4

Pregnancy can increase caries risk due to cravings for sugary foods, frequent snacking, increased ingestion of carbonated drinks, elevated levels of Streptococcus mutans, and changes to salivary composition. Pre-existing untreated caries may progress more rapidly.

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PREGNANCY AND BREASTFEEDING

Question 5

What causes pregnancy gingivitis and when does it typically occur?

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PREGNANCY AND BREASTFEEDING

Answer 5

Pregnancy gingivitis is caused by hormonal changes (estrogen and progesterone) that increase inflammatory response to dental plaque, leading to swollen and bleeding gums. It commonly occurs in the second trimester and gradually diminishes after childbirth.

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PREGNANCY AND BREASTFEEDING

Question 6

What is pyogenic granuloma in pregnancy and how is it managed?

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PREGNANCY AND BREASTFEEDING

Answer 6

Pyogenic granuloma, also called pregnancy tumor, is a localized gingival inflammatory enlargement caused by increased progesterone combined with local irritants. It bleeds easily and is most common after the first trimester. Smaller lesions usually regress with good oral hygiene; larger or symptomatic lesions may be excised if no medical contraindications exist.

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PREGNANCY AND BREASTFEEDING

Question 7

Why is dental erosion more common during early pregnancy?

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PREGNANCY AND BREASTFEEDING

Answer 7

Dental erosion occurs due to increased vomiting caused by nausea (hyperemesis), which exposes teeth to gastric acid, leading to enamel demineralization and increased caries risk.

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PREGNANCY AND BREASTFEEDING

Question 8

What oral health advice is recommended for pregnant women experiencing vomiting?

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PREGNANCY AND BREASTFEEDING

Answer 8

Pregnant women should rinse their mouth with water or a bicarbonate of soda solution immediately after vomiting, wait at least 30 minutes before brushing teeth, and chew sugar-free gum to stimulate saliva and neutralize acids.

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PREGNANCY AND BREASTFEEDING

Question 9

Is dental treatment safe during pregnancy?

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PREGNANCY AND BREASTFEEDING

Answer 9

Yes, dental treatment is safe during pregnancy and does not cause adverse pregnancy outcomes. Elective dental treatments are best performed in the second trimester, but procedures such as fillings, root canals, and extractions can be done anytime if necessary.

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PREGNANCY AND BREASTFEEDING

Question 10

What is the relationship between periodontal disease and adverse pregnancy outcomes?

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PREGNANCY AND BREASTFEEDING

Answer 10

Periodontal disease is associated with adverse pregnancy outcomes like preeclampsia, preterm birth, and low birth weight. This may be due to translocation of pathogens to the feto-placental unit and inflammatory mediators affecting pregnancy, although a direct causal relationship has not been definitively proven.

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PREGNANCY AND BREASTFEEDING

Question 11

How does smoking during pregnancy affect the baby?

Answer 11

Smoking during pregnancy reduces oxygen supply to the baby, increases risks of ectopic pregnancy, miscarriage, premature birth, low birth weight, and sudden infant death syndrome (SIDS). It can also affect breast milk quality and quantity.

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PREGNANCY AND BREASTFEEDING

Question 12

What are recommendations for quitting smoking during pregnancy?

Answer 12

Pregnant women are encouraged to quit smoking as early as possible, ideally within the first 16 weeks. Nicotine replacement therapy (NRT) is preferably avoided but may be used if quitting without it fails. Oral forms of NRT are preferred, and patches should be removed at night.

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PREGNANCY AND BREASTFEEDING

Question 13

What is exclusive breastfeeding according to WHO?

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PREGNANCY AND BREASTFEEDING

Answer 13

Exclusive breastfeeding means giving the baby only breast milk and no other food or drink, not even water, for the first six months, except for oral rehydration solutions, syrups, vitamins, minerals, or medicines.

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PREGNANCY AND BREASTFEEDING

Question 14

How does breastfeeding affect dental caries risk in children?

Answer 14

Breastfeeding protects against dental caries compared to infant formula because breast milk contains lactose, which is less cariogenic than sucrose. However, breastfeeding beyond 12 months, especially frequent and nocturnal feeding, may increase caries risk.

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PREGNANCY AND BREASTFEEDING

Question 15

What impact does breastfeeding have on malocclusion in children?

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PREGNANCY AND BREASTFEEDING

Answer 15

Breastfeeding promotes greater facial muscle activity and proper development of facial bones. In contrast, bottle feeding may contribute to inadequate craniofacial growth, malocclusion, and improper teeth alignment due to less muscle activity and nipple rigidity.

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HEALTH PROMOTION

INDIGENOUS PEOPLE

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

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MIND MAP

ORAL HEALTH OF INDIGENOUS AUSTRALIANS AND NEWZEALANDERS

Oral Health Disparities

- Indigenous people have poorer oral health indicators compared to non-Indigenous counterparts.
- Oral health inequalities between Indigenous and non-Indigenous populations are increasing.

Permanent Dentition in Indigenous Children

- Indigenous children show higher dental caries in permanent teeth compared to non-Indigenous children.
- Gingivitis prevalence is 1.6 times greater among Indigenous children.

Dental Treatment Disparities

- Indigenous adults have a lower proportion of filled teeth than non-Indigenous adults.
- Indicates reduced access or utilization of dental restorative services.

Recommendations for Dental Practitioners

- Recognize Indigenous people are at higher risk for oral diseases.
- Collaborative efforts needed to reduce barriers o access and availability of dental care.

Policy and Strategy Reference

- For detailed policies and strategies, refer to ADA policies for Aboriginal and Torres Strait Islander peoples.
- Emphasis on collective action between policymakers and dental practitioners.

Indigenous Population Overview

- Indigenous Australians represent 3% of the Australian population.
- Includes people of Aboriginal and Torres Strait Islander descent.

Oral Health in Indigenous Children

- Untreated dental decay is 1.7 times higher in Indigenous children than non-Indigenous children.
- Total dental caries experience is 1.5 times greater in Indigenous children.

Oral Health in Indigenous Adults

- Higher levels of dental caries observed in Indigenous adults than non-Indigenous adults.
- Prevalence of untreated coronal caries is 2.3 times higher in Indigenous adults.

Periodontal Disease in Indigenous Adults

- Higher incidence of periodontal disease including gingivitis and moderate to severe periodontitis.
- Clinical attachment loss of 4 mm or more and deep periodontal pockets are more common.

Culturally Sensitive Care

- Develop culturally appropriate oral health promotion and preventive programs.
- Flexible appointment times and family involvement should be considered.

Summary

- Oral health of Indigenous Australians is significantly worse than non-Indigenous Australians.
- Addressing these disparities requires culturally sensitive, accessible, and preventive dental care programs.

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INDIGENOUS PEOPLE

Question 1

Who are referred to as Indigenous Australians in Australia?

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INDIGENOUS PEOPLE

Answer 1

People of Aboriginal and Torres Strait Islander descent are referred to as Indigenous Australians.

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INDIGENOUS PEOPLE

Question 2

What percentage of the Australian population do Indigenous Australians represent?

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INDIGENOUS PEOPLE

Answer 2

Indigenous Australians represent 3% of the Australian population.

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INDIGENOUS PEOPLE

Question 3

How does the oral health of Indigenous children and adults compare to their non-Indigenous counterparts?

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INDIGENOUS PEOPLE

Answer 3

The oral health of Indigenous children and adults is overall poorer on all indicators compared to their non-Indigenous counterparts.

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INDIGENOUS PEOPLE

Question 4

By how much is the prevalence of untreated dental decay greater in Indigenous children compared to non-Indigenous children?

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INDIGENOUS PEOPLE

Answer 4

The prevalence of untreated dental decay in Indigenous children is 1.7 times greater than in non-Indigenous children.

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CUE CARDS

INDIGENOUS PEOPLE

Question 5

How much higher is gingivitis experience in Indigenous children compared to non-Indigenous children?

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CUE CARDS

INDIGENOUS PEOPLE

Answer 5

Gingivitis experience is 1.6 times greater in Indigenous children than in non-Indigenous children.

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INDIGENOUS PEOPLE

Question 6

What is the difference in prevalence of untreated coronal caries between Indigenous and non-Indigenous adults?

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INDIGENOUS PEOPLE

Answer 6

The prevalence of untreated coronal caries is 2.3 times higher in Indigenous adults than in non-Indigenous adults.

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CUE CARDS

INDIGENOUS PEOPLE

Question 7

What is noted about the proportion of filled teeth in Indigenous adults compared to non-Indigenous adults?

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INDIGENOUS PEOPLE

Answer 7

A lower proportion of Indigenous adults have filled teeth compared to the non-Indigenous population.

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INDIGENOUS PEOPLE

Question 8

Which periodontal disease indicators are higher in Indigenous Australians compared to non-Indigenous Australians?

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INDIGENOUS PEOPLE

Answer 8

Indigenous Australians have higher prevalence of gingivitis, moderate to severe periodontitis, deep periodontal pockets, and clinical attachment loss of 4 mm or more.

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INDIGENOUS PEOPLE

Question 9

What should dental practitioners recognize about the oral health risk of Indigenous people?

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INDIGENOUS PEOPLE

Answer 9

Dental practitioners should recognize that Indigenous people are at higher risk for oral diseases than non-Indigenous people.

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INDIGENOUS PEOPLE

Question 10

What strategies are recommended for dental practitioners to improve oral health care for Indigenous people?

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INDIGENOUS PEOPLE

Answer 10

Dental practitioners should reduce access and availability barriers, develop culturally sensitive oral health promotion and preventive programs, provide appropriate preventive and rehabilitative services, offer flexible appointment times, and allow family members to observe in the clinic.

WINSPERT

HEALTH PROMOTION

ORAL HEALTH OF MEDICALLY COMPROMISED PATIENTS

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

WINSPERT

MIND MAP

ORAL HEALTH OF MEDICALLY COMPROMISED PATIENTS

General Health Conditions Related to Poor Oral Health

- Uncontrolled periodontal disease is associated with:
  - Type 2 Diabetes
  - Cardiovascular diseases
  - Respiratory diseases
  - Adverse pregnancy outcomes

Oral Complications in Nil by Mouth (NBM) Patients

- Xerostomia (dry mouth) and thick saliva
- Dry, cracked lips and difficulty in swallowing/speaking
- Halitosis and denture wearing difficulties

Oral Complications from Chemotherapy and Radiotherapy

- Oral mucositis: inflammation, ulceration, pain
- Xerostomia and salivary gland dysfunction (sialadenitis)
- Taste disturbances: dysgeusia and ageusia
- Risk of osteoradionecrosis causing poor bone healing

Oral Mucositis

- Characterized by erythema, ulcerations, pain, bleeding, dificulty eating and denture wearing
- Develops 1-2 weeks after chemo/radiotherapy and heals spontaneously 2-4 weeks after treatment stops.
- Management: topical analgesics, bland rinses, systemic painkillers in severe cases

Overall Management Strategies

- Multidisciplinary approach involving dentists, medical specialists, dieticians, speech therapists, and carers
- Dental practitioners play a key role in referral and integrated care

Denture Care Recommendations

- Clean dentures twice daily with mild soap and soft brush
- Avoid harsh cleaning agents like hot water, bleach, or abrasives
- Store dentures dry overnight
- Remove hard deposits by soaking dentures in diluted white vinegar solution overnight

Importance of Oral Care

- Oral care is crucial for maintaining overall oral health.
- Strong evidence links oral health with general health outcomes.

High-Risk Patient Groups

- Patients Nil by Mouth (NBM)
- Patients on Feeding Tubes
- Patients undergoing Chemotherapy, Radiotherapy, and Palliative Care

Oral Health Issues in Patients on Feeding Tubes

- Altered saliva composition and disrupted oral microbial balance
- Xerostomia, oral infections (e.g., candidiasis), and ulcers
- Increased risk of aspiration pneumonia due to pathogenic bacteria

Xerostomia (Dry Mouth)

- Subjective feeling of dry mouth, may may not include reduced saliva flow
- Symptoms: thick saliva, cracked lips, tongue fissuring, oral pain, difficulty eating/speaking
- Management: frequent water sips, moisturizing gels/sprays, artificial saliva, sugar-free gum, sugar restriction

Oral Candidiasis

- Opportunistic fungal infection caused by overgrowth of Candida albicans
- Common in chemo/radiotherapy patients with altered oral/systemic environment.
- Treatment includes antifungal medications and denture disinfection:

Oral Care Practices for Medically Compromised Patients

- Maintain good oral hygiene with soft toothbrush and fluoridated toothpaste twice daily
- Use powered toothbrushes for patients with manual dexterity issues
- Use non-/low-foaming toothpaste for patients with dysphagia
- Use gauze for debris removal in patients unable to rinse or with poor oral control
- Avoid rinsing after brushing i maximize fluoride benefit

Map Your Way to ADC Success!

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CUE CARDS

MEDICALLY COMPROMISED PATIENTS

Question 1

What general health conditions are commonly associated with poor oral health, especially uncontrolled periodontal disease?

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MEDICALLY COMPROMISED PATIENTS

Answer 1

Type 2 Diabetes, Cardiovascular diseases, Respiratory diseases, and Adverse pregnancy outcomes are commonly associated with poor oral health, particularly uncontrolled periodontal disease.

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MEDICALLY COMPROMISED PATIENTS

Question 2

Who are considered at greater risk for deterioration of oral health and present additional challenges for dental practitioners?

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MEDICALLY COMPROMISED PATIENTS

Answer 2

Patients who are Nil by Mouth (NBM), patients on feeding tubes, and patients undergoing chemotherapy, radiotherapy, or palliative care are at greater risk for deterioration of oral health and present additional challenges for dental practitioners.

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MEDICALLY COMPROMISED PATIENTS

Question 3

What are some common oral complications observed in patients who are Nil by Mouth (NBM)?

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MEDICALLY COMPROMISED PATIENTS

Answer 3

Common oral complications in Nil by Mouth patients include xerostomia (dry mouth), thicker saliva, dry cracked lips, difficulty swallowing and speaking, halitosis (bad breath), and difficulty wearing dentures.

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MEDICALLY COMPROMISED PATIENTS

Question 4

What are the two main methods of enteral feeding used for patients unable to take adequate oral nutrition?

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MEDICALLY COMPROMISED PATIENTS

Answer 4

The two main methods of enteral feeding are Nasogastric (NG) tube, which is connected to the stomach, and Percutaneous Endoscopic Gastrostomy (PEG), which is connected to the small bowel.

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MEDICALLY COMPROMISED PATIENTS

Question 5

What oral complications are commonly seen in patients on feeding tubes?

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MEDICALLY COMPROMISED PATIENTS

Answer 5

Patients on feeding tubes commonly experience xerostomia, thicker saliva, oral infections such as candidiasis, difficulty swallowing, and oral ulcerations.

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MEDICALLY COMPROMISED PATIENTS

Question 6

Why is there an increased risk of aspiration pneumonia in tube-fed patients?

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MEDICALLY COMPROMISED PATIENTS

Answer 6

The increased risk of aspiration pneumonia in tube-fed patients is mainly due to the overgrowth of pathogenic gram-negative bacteria in the oral cavity, as natural oral feeding protects against colonization with these harmful bacteria.

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MEDICALLY COMPROMISED PATIENTS

Question 7

What are common oral complications in patients undergoing chemotherapy, radiotherapy, or in palliative care?

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MEDICALLY COMPROMISED PATIENTS

Answer 7

Common oral complications include oral mucositis, xerostomia, oral infections (including candidiasis and viral/bacterial infections), salivary gland dysfunctions (such as sialadenitis), taste dysfunctions (dysgeusia and ageusia), and osteoradionecrosis in radiotherapy patients.

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CUE CARDS

MEDICALLY COMPROMISED PATIENTS

Question 8

Define xerostomia and explain its clinical signs and symptoms.

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MEDICALLY COMPROMISED PATIENTS

Answer 8

Xerostomia is the subjective sensation of dry mouth, which may or may not be accompanied by reduced salivary flow (salivary gland hypofunction). Clinical signs include thick and sticky saliva, dry cracked lips, tongue atrophy and fissuring, fragile oral mucosa, difficulty speaking, eating, chewing, swallowing, oral burning sensation, pain or sensitivity to spicy foods, difficulty wearing dentures, taste disturbances, and increased thirst.

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MEDICALLY COMPROMISED PATIENTS

Question 9

What management strategies are recommended for patients suffering from xerostomia?

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CUE CARDS

MEDICALLY COMPROMISED PATIENTS

Answer 9

Management includes frequent sips of water (unless restricted), application of moisturizing gels, sprays, or mouthwashes, use of artificial saliva or salivary stimulants, chewing sugar-free gum to stimulate saliva, restriction of sugar intake, and regular monitoring for oral thrush and dental caries.

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CUE CARDS

MEDICALLY COMPROMISED PATIENTS

Question 10

How should dentures be cared for in medically compromised patients?

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MEDICALLY COMPROMISED PATIENTS

Answer 10

Dentures should be cleaned twice daily with mild soap and water using a toothbrush, denture brush, or soft nail brush. Hot water, toothpaste, kitchen detergents, bleaches, methylated spirits, antiseptics, or abrasives should be avoided. Dentures should be dried overnight in a dry environment. If hard deposits accumulate, dentures can be soaked overnight in diluted white vinegar (1:4) before cleaning.

WINSPERT

HEALTH PROMOTION

HEART DISEASE

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

WINSPERT

MIND MAP

ORAL HEALTH OF PATIENTS WITH HEART DISEASE

Risk Factors for Cardiovascular Disease (CVD)

- Modifiable: Dyslipidemia, smoking, diabetes mellitus, hypertension, physical inactivity, obesity
- Non-modifiable: Age, ethnicity, sex, family history of CVD

Microbial and Socioeconomic Influences on PD

- Key pathogens: Porphyromonas gingivalis, Tannerella forsythia, Actinobacillus actinomycetemcomitans
- Low income and rural residence are significant risk indicators for attachment loss.

Non-Modifiable Risk Factors for Periodontal Disease

- Genetic predispositions: IL-1 gene polymorphisms linked to PD
- Osteoporosis related to alveolar bone loss, not clinical attachment loss
- Ageing increases incidence of periodontal disease

Shared Risk Factors and Confounding Between PD and CVD

- Smoking, sex, ethnicity, diabetes, socioeconomic status, stress, and obesity impact both PD and CVD
- Cardiovascular events can occur in non-smokers with PD, indicating independent association

Role of Health Care Professionals in Prevention and Control

- Unified approach by medical and dental professionals to educate patients on modifiable risk factors
- Promote dietary changes: reduce calories, cholesterol, saturated/trans fats, salt;increase fiber intake
- Encourage weight control through diet and physical exercise
- Smoking cessation and sugar intake reduction reduce cardiovascular risk

Summary

- PD and CVD share many risk factors and pathogenic mechanisms
- Managing PD may help reduce CVD risk
- Integrated care by healthcare providers is key for prevention and control of both diseases

Associations Between Cardiovascular Diseases and PeriodontalDisease

- Emerging evidence links periodontal disease (PD) with cardiovascular disease (CVD) and other systemic conditions
- Both CVD and PD have multifactorial etiologies involving several overlapping risk factors

Risk Factors for Periodontal Disease (PD)

- Modifiable: Smoking increases risk of clinical attachment and alveolar bone loss
- Poorly controlled diabetes aggravates periodontal infection and vice versa

Psychological and Stress Factors in PD

- Psychological stress downregulates immune response and disrupts nervous-end ocrine-immune networks
- Higher stress levels correlate with more widespread and severe periodontal disease

Systemic Conditions Associated with Periodontal Disease

- Diabetes mellitus, osteoporosis, rheumatoid arthritis, respiratory diseases contribute to PD development
- Other factors: Age, ethnicity, smoking, sex, stress, poor coping behavior, obesity

Pathogenic Mechanisms Linking PD and CVD

- Periodontal bacteria (P. gingivalis, S. sanguis) stimulate platelet aggregation and thrombosis
- Autoimmune reactions to bacterial and human heat shock proteins induce endothelial damage and atherosclerosis
- Periodontal bacteria invade endothelial cells and phagocytes
- Elevated systemic inflammation marker C-reactive protein (CRP) found in both PD and CVD, predicting future CVD

Management of Periodontal Disease in Cardiovascular Patients

- Standard PD treatment is safe and effective for patients with established CVD
- Includes plaque and gingivitis control, oral hygiene instructions, mouth rinses, anti-plaque toothpaste, interproximal cleaning
- Patients with moderate to severe PD should be informed of increased CVD risk
- PD patients with CVD risk factors should seek medical evaluation regularly
- Collaboration between dental and medical professionals is essential to control shared risk factors

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HEART DISEASE

Question 1

What systemic conditions have been significantly associated with periodontal disease according to emerging evidence?

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HEART DISEASE

Answer 1

Periodontal disease has been significantly associated with cardiovascular disease, respiratory disease, diabetes and its complications, and adverse pregnancy outcomes.

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HEART DISEASE

Question 2

What are the modifiable risk factors for cardiovascular disease (CVD)?

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HEART DISEASE

Answer 2

Modifiable risk factors for CVD include dyslipidemia, smoking, diabetes mellitus, hypertension, physical inactivity, and obesity.

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HEART DISEASE

Question 3

Name three non-modifiable risk factors for cardiovascular disease.

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HEART DISEASE

Answer 3

Non-modifiable risk factors for CVD are age, ethnicity, sex, and family history of cardiovascular disease.

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HEART DISEASE

Question 4

Which microorganisms are implicated as etiologic agents in periodontal disease?

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HEART DISEASE

Answer 4

Porphyromonas gingivalis, Tannerella forsythia (formerly Bacteroides forsythus), and Actinobacillus actinomycetemcomitans are implicated as etiologic agents in periodontitis.

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HEART DISEASE

Question 5

How does smoking affect periodontal disease?

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HEART DISEASE

Answer 5

Smoking increases the risk of developing periodontal disease as measured by clinical attachment loss and alveolar bone loss.

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HEART DISEASE

Question 6

What role does psychological stress play in periodontal disease?

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HEART DISEASE

Answer 6

Psychological stress can downregulate the cellular immune response, disrupt the network linking nervous, endocrine, and immune systems, and cause periodontal disease to be more widespread and severe in individuals with higher levels of stress.

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HEART DISEASE

Question 7

What genetic factor is linked to periodontal disease?

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HEART DISEASE

Answer 7

Polymorphisms in the Interleukin 1 (IL-1) gene have been linked to periodontal disease.

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HEART DISEASE

Question 8

Explain one pathogenic mechanism that links periodontal disease (PD) with cardiovascular disease (CVD).

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HEART DISEASE

Answer 8

Porphyromonas gingivalis and Streptococcus sanguis associated with PD can stimulate platelet aggregation and thrombosis, which may lead to cardiovascular disease.

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HEART DISEASE

Question 9

What is the role of C-reactive protein (CRP) in the association between PD and CVD?

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CUE CARDS

HEART DISEASE

Answer 9

C-reactive protein (CRP) is a systemic inflammatory marker increased in both PD and CVD and is considered an independent predictor of future cardiovascular disease.

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CUE CARDS

HEART DISEASE

Question 10

What standardized approach should healthcare professionals take to help prevent and control both periodontal disease and cardiovascular disease?

Answer 10

Healthcare professionals should educate patients to reduce calorie intake, decrease consumption of foods high in cholesterol, saturated and trans-fatty acids, and salt; increase intake of low saturated fat and high fiber foods; control weight through diet and exercise; discontinue smoking; and reduce sugar intake along with other lifestyle changes.

WINSPERT

HEALTH PROMOTION

NUTRITION AND ORAL HEALTH

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

WINSPERT

MIND MAP

NUTRITION AND ORAL HEALTH

Impact of Poor Diet on Health

- Poor diet and nutritional deficiencies increase risk of systemic and oral diseases.
- Nutrition directly affects oral health outcomes.

Role of Sugars in Dental Caries

- Total sugar includes monosaccharides (glucose, fructose) and disaccharides (lactose, sucrose).
- Intrinsic sugars (in whole fruits, vegetables) are less cariogenic than extrinsic or free sugars (added sugars, honey, syrups).

Starch Consumption and Oral Health

- Rapidly digestible starch (RDS) increases dental caries risk.
- Slowly digestible starch (SDS) from whole grains, fruits, and vegetables is recommended.

Nutrition and Periodontal Health

- High saturated fat intake is linked with increased periodontal disease.
- Deficiency in vitamins C and D raises risk of gingivitis and periodontitis.
- Diets rich in antioxidants, polyunsaturated fatty acids, and high-fiber foods protect against periodontal disease.

Other Oral Health Outcomes Related to Nutrition

- Dental erosion is caused by dietary acids.
- Micronutrient deficiencies (Iron, folate, vitamins A, C, D, B12) contribute to various oral diseases.
- High-risk groups for micronutrient deficiencies include elderly, mentally ill, substance abusers, indigenous populations, homeless, fad diet followers, children, pregnant and lactating women.

Overview of Nutrition

- Nutrition involves ingestion, digestion, absorption, transportation, utilization, storage, and excretion of food and drink.
- Six main nutrients for proper body function: Carbohydrates, Lipids, Proteins, Vitamins, Minerals, and Water.

Nutrition and Dental Caries

- Dental caries is the most common oral and chronic systemic disease worldwide.
- Nutrition plays a key role in the initiation and progression of dental caries.

WHO Guidelines on Sugar Intake

- Free sugars should be less than 10% of total dietary energy intake for all ages.
- Reducing free sugars to less than 5% offers additional oral health benefits.

Protective Role of Dairy and Water

- Adequate intake of milk and dairy products protects against root caries.
- Drinking fluoridated tap water supports oral health by providing fluoride's anti-cariogenic effect.

Nutrition and Oral Cancer

- Slowly digestible starch may have a protective effect against oral cancer.
- Consumption of vegetables and fruits is associated with reduced oral cancer risk
- Preserved vegetables are linked to increased cancer risk.

Role of Dental Practitioners in Nutrition

- Dental practitioners can detect micronutrient deficiency disorders early due toperi-oral clinical features.
- They have a responsibility to educate patients on individualized dietary advice promoting oral and general health.
- Recommendations should focus on reducing cariogenic foods and encouraging nutrient-rich diets for optimal oral health.

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NUTRITION AND ORAL HEALTH

Question 1

What are the six main nutrients obtained from food that are essential for proper body functioning?

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NUTRITION AND ORAL HEALTH

Answer 1

The six main nutrients obtained from food essential for proper body functioning are Carbohydrates, Lipids, Proteins, Vitamins, Minerals, and Water.

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NUTRITION AND ORAL HEALTH

Question 2

How does poor diet and nutritional deficiencies affect health?

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NUTRITION AND ORAL HEALTH

Answer 2

Poor diet and nutritional deficiencies increase the risk of contracting both systemic diseases and oral diseases.

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NUTRITION AND ORAL HEALTH

Question 3

What role does nutrition play in dental caries?

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CUE CARDS

NUTRITION AND ORAL HEALTH

Answer 3

Nutrition plays a key role in the initiation and progression of dental caries, which is the most common oral disease and prevalent chronic systemic disease worldwide.

WINSPERT
CUE CARDS

NUTRITION AND ORAL HEALTH

Question 4

What are intrinsic and extrinsic sugars, and how do they differ in their effects on dental health?

Answer 4

Intrinsic sugars are sugar molecules held within the cell structure of foods like whole fruits, vegetables, and grains and are less cariogenic with health benefits. Extrinsic sugars are outside the cellular structure or added sugars, including milk sugars and free sugars (added sugars, honey, syrups, fruit juices), which are highly cariogenic and contribute to unnecessary calories with no nutritional value.

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NUTRITION AND ORAL HEALTH

Question 5

What are the WHO guidelines on free sugar intake for children and adults?

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NUTRITION AND ORAL HEALTH

Answer 5

The WHO recommends that free sugar consumption should be less than 10% of total dietary energy intake for both children and adults, with additional oral health benefits if restricted to less than 5%. Free sugars should be reduced throughout life.

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CUE CARDS

NUTRITION AND ORAL HEALTH

Question 6

What is the difference between rapidly digestible starch (RDS) and slowly digestible starch (SDS) in relation to dental caries?

Answer 6

Rapidly digestible starch (RDS) consumption significantly increases the risk of dental caries across all age groups, while total starch consumption shows no association with caries risk. Slowly digestible starch (SDS), found in whole grains, fruits, and vegetables, is recommended as protective against dental caries.

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NUTRITION AND ORAL HEALTH

Question 7

How do milk and dairy products affect oral health?

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NUTRITION AND ORAL HEALTH

Answer 7

Adequate daily intake of milk and dairy products such as cheese and yoghurt has a protective effect against root caries.

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CUE CARDS

NUTRITION AND ORAL HEALTH

Question 8

What is the relationship between nutrition and periodontal health?

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CUE CARDS

NUTRITION AND ORAL HEALTH

Answer 8

High saturated fatty acid consumption is associated with more periodontal disease. Deficiencies in vitamins C and D increase the risk of gingivitis and periodontitis, while diets rich in antioxidants, vitamins C and D, polyunsaturated fatty acids, and high-fiber foods protect against periodontal disease.

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CUE CARDS

NUTRITION AND ORAL HEALTH

Question 9

What nutritional factors are associated with oral cancer risk?

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CUE CARDS

NUTRITION AND ORAL HEALTH

Answer 9

Slowly digestible starch consumption has a protective effect against oral cancer. Consumption of vegetables and fruits is associated with reduced oral cancer risk, while preserved vegetable consumption is linked to increased cancer risk.

WINSPERT
CUE CARDS

NUTRITION AND ORAL HEALTH

Question 10

Which populations are at high risk of developing micronutrient deficiencies affecting oral health, and what role do dental practitioners play?

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CUE CARDS

NUTRITION AND ORAL HEALTH

Answer 10

Populations at high risk include the elderly, mentally ill, alcohol/drug addicts, Indigenous people, homeless people, those on fad diets, children, pregnant, and lactating women. Dental practitioners can be the first to detect micronutrient deficiency disorders through peri-oral clinical features and play an important role in referring patients for further management.

WINSPERT

HEALTH PROMOTION

DISABILITIES

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

WINSPERT

MIND MAP

DENTAL CARE FOR PEOPLE WITH DISABILITIES

Education and Training

- Health workers and carers need education on oral hygiene, diet, and dental awareness
- Training should be readily accessible to improve care quality

Clinical Care by Dental Professionals

- Dentists provide clinical care and advice to prevent gum disease and tooth loss
- Oral health affects eating, sleeping, and overall comfort for patients

Daily Home Care Guidelines

- Balanced diet rich in fruits and vegetables with limited sugary foods and drinks
- Rinse mouth with tap water after meals to remove food particles

Assistance Tips for Carers

- Carers should work in pairs: one supports head, the other brushes teeth
- Use mouth props if needed to keep mouth open during brushing

Managing Food Pouching

- Inspect mouth after meals or medication doses for retained food
- Remove food with gauze-wrapped finger or disposable swab

Special Techniques for Gag Reflex or Rinsing Issues

- Use smear of fluoride toothpaste if patient cannot spit or rinse.
- Dip toothbrush head in fluoride rinse or CHX for brushing

Accessibility Considerations

- Allow carers and assistance animals access when needed
- Ensure facilities are appropriate and accommodating for individuals with disabilities

Dependence on Carers

- People with mild to severe disabilities rely partially or fully on carers for daily care
- Those receiving such care are referred to as care-recipients

Team Effort in Dental Care

- Dental care involves both carers at home and dental professionals
- Emphasis on daily hygiene, healthy diet, screening, and regular dental visits

Challenges in Prevention

- Preventing oral diseases is challenging for carers and dental teams
- Encouragement and support for self-care when possible are important

Oral Hygiene Practices

- Brush teeth twice daily with pea-sized fluoride toothpaste and soft brush
- Electric or battery-operated toothbrushes and interdental brushes are preferred

Adaptations for Toothbrush Use

- Modify toothbrush handle by heating and bending for better angles
- Use a second toothbrush if patient bites the brush

Use of Fluoride and Antimicrobials

- High-strength fluoride toothpaste, gels, or rinses for high-risk patients (professional advice needed)
- Chlorhexidine (CHX) gel for gum disease applied before bedtime

Importance of Regular Dental Visits

- Maintain regular dental check-ups, especially if changes in mouth or behavior are noticed
- Dental staff should be trained to care for people with disabilities in various settings

WINSPERT
CUE CARDS

DISABILITIES

Question 1

Who are referred to as care-recipients in the context of dental care for people with disabilities?

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DISABILITIES

Answer 1

Care-recipients are people with mild to severe disabilities who depend partially or completely on their carers for their daily care.

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CUE CARDS

DISABILITIES

Question 2

What is emphasized as important for health care workers and carers of individuals with disabilities regarding oral health?

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CUE CARDS

DISABILITIES

Answer 2

Education and training about oral hygiene maintenance, dietary instructions, and basic dental awareness should be readily available for health care workers and carers.

WINSPERT
CUE CARDS

DISABILITIES

Question 3

Why is dental care described as a team effort for people with disabilities?

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CUE CARDS

DISABILITIES

Answer 3

Because it involves carers providing daily oral hygiene care, a healthy diet, screening for oral changes, and maintaining regular dental visits, while dental professionals provide clinical care and advice to prevent gum disease and tooth loss.

WINSPERT
CUE CARDS

DISABILITIES

Question 4

What challenges might people with disabilities face that make healthy teeth and gums especially important?

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CUE CARDS

DISABILITIES

Answer 4

They may not be able to communicate the cause of their problems, and sore or bleeding gums can make it difficult for them to eat and sleep.

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CUE CARDS

DISABILITIES

Question 5

What dietary recommendations are given for people with disabilities to maintain oral health?

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CUE CARDS

DISABILITIES

Answer 5

They should eat a well-balanced diet high in fruits and vegetables, limit sugary foods and soft drinks to meal times, and drink tap water after meals to rinse the mouth.

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CUE CARDS

DISABILITIES

Question 6

What are the recommended toothbrushing practices for people with disabilities?

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CUE CARDS

DISABILITIES

Answer 6

Brushing twice a day after breakfast and dinner using pea-sized fluoride toothpaste and a soft brush is recommended, with electric or battery-operated toothbrushes and interdental brushes preferred.

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CUE CARDS

DISABILITIES

Question 7

What assistance tips are given for carers helping with toothbrushing?

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CUE CARDS

DISABILITIES

Answer 7

Carers should work in pairs, one supporting the care-recipient’s head while the other brushes teeth; mouth props can be used to keep the mouth open; toothbrush handles can be softened and bent for better angles; and a second toothbrush can be used if the care-recipient bites the brush.

WINSPERT
CUE CARDS

DISABILITIES

Question 8

How should carers manage food pouching in care-recipients?

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CUE CARDS

DISABILITIES

Answer 8

Carers should inspect the mouth after each meal or medicine dose and remove any leftover food or medicine by sweeping the mouth with a finger wrapped in gauze or using a disposable swab.

WINSPERT
CUE CARDS

DISABILITIES

Question 9

What dental products can be recommended for care-recipients at higher risk of tooth decay or gum disease?

Answer 9

High strength fluoride toothpaste, gels, or rinses can be used with professional advice, and chlorhexidine (CHX) gel can be applied on gum margins before bed for gum disease.

WINSPERT
CUE CARDS

DISABILITIES

Question 10

What is recommended regarding regular dental visits for people with disabilities?

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CUE CARDS

DISABILITIES

Answer 10

Regular dental visits should be maintained as recommended or if any changes in the mouth or behavior are noted, and dental personnel should be trained to provide care within clinics, nursing homes, and residential facilities, allowing access with carers and assistance animals when needed.

WINSPERT

HEALTH PROMOTION

DEMENTIA PATIENTS

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

WINSPERT

MIND MAP

ORAL HEALTH CARE FOR DEMENTIA PATIENTS

Types of Dementia

- Alzheimer's disease accounts for 50–70% of dementia cases worldwide.
- Other types include vascular dementia, frontotemporal dementia, and dementia with Lewy bodies.

Communication Challenges in Dementia Dental Care

- Major challenge is effective communication with cognitively impaired patients.
- Use multiple communication forms and maintain sensory contact.

Holistic Patient Understanding

- Consider medical history, medications, functional and cognitive status, behavioral issues, and social support.
- Understand how oral health care fits into the patient's overall environment and support systems.

Oral Hygiene Support and Caregiver Education

- Patients often depend on caregivers for daily hygiene and dental visits.
- Educate caregivers to integrate oral hygiene into daily activities.

Minimally Invasive Treatment Techniques

- ART (Atraumatic Restorative Technique): use of hand instruments to remove caries and Glass Ionomer Cement (GIC) for restoration without extensive tissue removal.
- SMART Technique: combines Silver Diamine Fluoride (SDF) with ART to arrest caries and restore teeth without aerosol generation.

Recommended Clinical Procedure for SMART

- Follow stepwise clinical protocol combining SDF application and ART restoration.

Understanding Dementia

- Dementia is a syndrome involving over 100 diseases impairing brain functions such as memory, language, perception, personality, and cognition.
- It is progressive, irreversible, and varies in type and symptom severity.

Stages of Dementia (Clinical Dementia Rating Scale)

- Mild (55%): Memory and personal care deficits, minimal assistance needed.
- Moderate (30%): More severe deficits, increased assistance required.
- Severe (15%): Almost total dependence, mostly in residential care.

Informed Consent and Legal Considerations

- Dentists must obtain informed consent from patients with legal capacity.
- If capacity is doubtful, seek clinical advice and consent from legally authorized substitute decision makers.

Dental Examination Adaptations for Dementia Patients

- Use a flexible, patient-centered approach rather than systematic examination.
- Prioritize easily accessible or visible teeth; anterior teeth may be examined before posterior.

Caries Prevention Strategies

- Use high concentration fluoridated toothpaste twice daily for high caries risk patients.
- Apply fluoride varnishes every 3 to 6 months for additional protection.

Advantages and Limitations of SMART Technique

- Benefits: Arrests carious lesions and restores teeth minimally invasively, suitable during COVID-19 to reduce aerosols.
- Limitation: Black staining from SDF affects esthetics, limiting broader acceptance.

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Question 1

What is dementia and what are some of its key characteristics?

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Answer 1

Dementia is a syndrome associated with more than 100 different diseases characterized by impairment of brain functions including language, memory, perception, personality, and cognitive skills. It usually has a gradual onset, is progressive, and irreversible, with symptoms varying by type of dementia.

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Question 2

What is the most common type of dementia and what percentage of cases does it account for worldwide?

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Answer 2

Alzheimer’s disease is the most common type of dementia, accounting for 50-70% of dementia cases worldwide.

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Question 3

Name the different types of dementia mentioned besides Alzheimer’s disease.

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Answer 3

Other types of dementia include vascular dementia, frontotemporal dementia, and dementia with Lewy bodies.

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Question 4

What are the three stages of dementia based on the Clinical Dementia Rating Scale, and what percentage of people fall into each stage?

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Answer 4

Severe or late (15%) – almost total dependence on care and supervision, often in residential care.

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Question 5

What is one of the major challenges dentists face when treating cognitively impaired older adults?

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Answer 5

One of the major challenges is communication with patients who have cognitive impairments.

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Question 6

What communication techniques can dentists use to aid communication with dementia patients?

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Answer 6

Dentists can use multiple forms of communication, maintain sensory contact, and adapt communication techniques to the patient’s needs.

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Question 7

How should dentists handle informed consent in patients with dementia?

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Answer 7

Dentists must obtain informed consent from patients with legal capacity. If there is doubt about the patient’s capacity to understand and make decisions, dentists should seek clinical advice and obtain consent from a legally authorized substitute decision maker.

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Question 8

What factors should be considered during the initial dental visit for a patient with dementia?

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Answer 8

Dentists should review the patient’s medical history, medications, functional status, cognitive status, behavioral issues, social support, and consider all these factors when making a treatment plan.

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Question 9

What are the recommended oral hygiene strategies for dementia patients who depend on carers?

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Answer 9

Dentists should educate carers to integrate daily oral hygiene activities into the patient’s routine and may refer carers to specific instructions and tips for oral care in people with disabilities.

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Question 10

Describe the SMART technique and its benefits in treating dental caries in dementia patients.

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Answer 10

The SMART technique combines Silver Diamine Fluoride (SDF) with the Atraumatic Restorative Technique (ART) to arrest carious lesions and restore teeth without aerosol-producing instruments. It is minimally invasive and particularly useful in patients with dementia or in situations like the COVID-19 pandemic where aerosol generation should be limited.

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HEALTH PROMOTION

DENTAL FEAR AND ANXIETY

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

WINSPERT

MIND MAP

DENTAL FEAR AND ANXIETY

The Vicious Cycle of Dental Fear

- Fear leads to avoidance of dental visits, worsening oral health
- Delayed treatment causes more intensive procedures, reinforcing fear

Causes of Dental Fear

- Negative past dental experiences or perception of dental environment
- Specific fears: gagging, injections, sight of blood
- Trust issues with dental practitioners

Pain Concerns

- Fear of pain remains a primary cause despite advances in dental techniques

Working with Anxious Patients

- Effective communication and building trust essential
- Acknowledge concerns, listen actively, show empathy
- Attend to non-verbal cues and use appropriate tone

Techniques to Help Manage Dental Anxiety

- Providing patient control through Tell-Show-Do, rest breaks, signaling
- Distraction via music, videos, games to reduce anxiety
- Relaxation breathing exercises taught in clinic and for home practice
- Progressive muscle relaxation requiring patient commitment and practice
- Systematic desensitization with gradual exposure and relaxation strategies

Prevalence and Impact

- Approximately 5% of Australians suffer from dental phobia (high dental fear)
- About 1 in 6 adults and 1 in 10 children experience high dental fear

Consequences of High Dental Fear

- Frequent appointment cancellations and no-shows
- Poorer dental health requiring complex treatments
- Behavioral challenges making treatment stressful for dentists and patients

Psychological and Social Factors

- Social phobia, obsessive-compulsive disorders, panic disorder may contribute
- Depression linked to reduced dental visits
- History of sexual abuse associated with increased dental anxiety

Assessment of Dental Anxiety

- Observing patient behavior for early anxiety signs
- Directly asking patients about their fears
- Using validated self-report dental anxiety questionnaires

Treatment Planning Modifications

- Flexible, phased treatment plans based on patient fears and priorities
- Initial phase: building rapport and introducing clinic environment
- 2 Early treatment phase: preventive care and gradual tolerance building
- 3 Later phases: comprehensive dental treatment

Pharmacological Management

- Combined behavioral and psychological approaches preferred for long-term success
- Sedation may be effective for some patients when necessary
- Only dental board-endorsed dentists should perform conscious sedation
- Anxiolysis involves minimal sedation to alleviate fear without deep sedation

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DENTAL FEAR AND ANXIETY

Question 1

What percentage of the Australian population is affected by dental phobia, and how does high dental fear impact adults and children in Australia?

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Answer 1

Dental phobia affects about 5% of the Australian population. High dental fear affects approximately 1 in 6 Australian adults and about 1 in 10 children.

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DENTAL FEAR AND ANXIETY

Question 2

What is the "vicious cycle of dental fear" and how does it affect patients?

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DENTAL FEAR AND ANXIETY

Answer 2

The "vicious cycle of dental fear" occurs when a patient avoids dental visits due to fear, leading to worsening dental problems that require more intensive and potentially traumatic treatment. This reinforces or worsens the fear, causing the patient to continue avoiding dental care.

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DENTAL FEAR AND ANXIETY

Question 3

What are some consequences of high levels of dental fear on patients and dental practitioners?

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DENTAL FEAR AND ANXIETY

Answer 3

Patients with high dental fear are more likely to avoid or delay dental visits, cancel or miss appointments, leading to poorer dental health and more complex treatments. They may also display behavioral problems, making treatment stressful and unpleasant for both patient and dentist. Managing these patients causes considerable stress for dentists.

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DENTAL FEAR AND ANXIETY

Question 4

What are some potential reasons for dental fear aside from direct negative dental experiences?

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DENTAL FEAR AND ANXIETY

Answer 4

Dental fear can stem from perceptions of the dental environment, fear of specific treatment aspects (such as gagging, injections, or sight of blood), concerns about pain or numbness, trust issues with practitioners, and other conditions like social phobia, obsessive-compulsive disorder, panic disorder, depression, or a history of sexual abuse.

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DENTAL FEAR AND ANXIETY

Question 5

How important is communication in managing dental fear, and what are the essential elements of good communication?

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DENTAL FEAR AND ANXIETY

Answer 5

Communication is crucial in managing dental fear. Essential elements include establishing effective two-way interaction, genuinely acknowledging patient concerns, attending to non-verbal cues, effective listening, accurately reflecting the patient's words, showing empathy, and using appropriate voice and tone.

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DENTAL FEAR AND ANXIETY

Question 6

Describe the phased treatment planning approach for dentally anxious patients.

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DENTAL FEAR AND ANXIETY

Answer 6

Second/third phase: Address other dental treatment areas as patient tolerance improves.

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DENTAL FEAR AND ANXIETY

Question 7

What techniques can help patients with mild to moderate dental anxiety during dental visits?

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DENTAL FEAR AND ANXIETY

Answer 7

Techniques include providing control to the patient (Tell-Show-Do technique, rest breaks, signaling), distraction through visual or auditory stimuli (music, TV, games, videos), relaxation breathing exercises, and progressive muscle relaxation.

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DENTAL FEAR AND ANXIETY

Question 8

What is systemic desensitization in the context of dental anxiety management?

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DENTAL FEAR AND ANXIETY

Answer 8

Systemic desensitization involves gradually exposing the fearful patient to the dental stimuli they find frightening while encouraging the use of relaxation strategies to reduce anxiety.

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DENTAL FEAR AND ANXIETY

Question 9

When might pharmacological strategies be used for dental anxiety, and what is the general recommendation regarding their use?

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DENTAL FEAR AND ANXIETY

Answer 9

Pharmacological strategies are used when behavioral and psychological approaches alone are insufficient. They are often more effective short-term and should be combined with patient-centered care. Sedation is reserved for certain patients and must be practiced only by dentists endorsed by the Dental Board of Australia.

WINSPERT

HEALTH PROMOTION

CARIES RISK ASSESSMENT AND SWEETENERS

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

WINSPERT

MIND MAP

CARIES RISK ASSESSMENT AND SWEETENERS

Objectives of CRA in Children

- Maintain good oral health in low-risk children
- Improve oral health in high-risk children through targeted care and more frequent dental visits

Risk Indicators for Caries

- Past caries experience is the most consistent predictor, though less useful in very young children
- White spot lesions are effective early indicators in young children

Sugar Consumption and Oral Hygiene

- Both amount and frequency of sugar intake increase caries severity
- Evidence linking oral hygiene habits directly to caries prevalence is inconsistent

Protective Factors for Caries Prevention

- Fluoride (water fluoridation, toothpaste, professional applications) is well documented to prevent caries
- Fissure sealants effectively protect tooth pits and fissures from decay

Overview of Sweeteners and Sugar Alternatives

- Sweeteners provide intense sweet taste without added calories
- Can help reduce calorie intake and potentially support weight loss
- Both sugar-sweetened and artificially sweetened fizzy drinks may still cause dental issues

Details on Natural Intense Sweeteners.

- Stevia: 200-300 times sweeter than sugar, zero calories
- Monk Fruit Extract: 250-400 times sweeter than sugar, zero calories
- Both approved for use in Australia

Importance of Caries Risk Assessment

- Early identification of individuals with varying caries risk levels is crucial for planning preventive measures
- Population-level caries risk assessment (CRA) programs are more efficient and cost-effective

Use of Caries Risk Assessment

- CRA should be routine during new and periodic dental examinations
- Combines risk indicators, protective factors, and social, cultural, behavioral elements

Socioeconomic Status and Caries

- Inverse relationship: lower socioeconomic status correlates with higher caries prevalence
- Social disadvantage is a significant risk factor

Bacteria and Saliva Factors

- Streptococcus mutans and Lactobacilli play major roles in caries development
- Reduced salivary function (xerostomia) is a strong predictor of high caries risk

Common Caries Risk Assessment Tools

- Caries Risk Assessment Tool (CAT)
- Caries Management by Risk Assessment (CAMBRA)
- Cariogram
- Traffic Light Matrix (TLM)
- No single tool is definitive; clinicians should use judgment and experience

Categories of Sweeteners

- Artificial/Non-nutritive sweeteners: calorie-free, commonly used in Australia
- Nutritive sweeteners: carbohydrate-based, lower calorie than sugar but not calorie-free
- Natural intense sweeteners: plant-derived, very sweet, calorie-free (e.g., Stevia and Monk Fruit Extract)

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Question 1

What is the purpose of caries risk assessment (CRA) for individuals and populations?

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Answer 1

For individuals, CRA helps in early identification of different caries risk levels to plan appropriate preventive measures. At a population level, CRA-driven dental programs are more efficient and cost-effective, aiming to maintain good oral health in low-risk individuals and improve oral health in high-risk individuals through targeted care.

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Question 2

Which factors are considered in caries risk assessment for children?

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Answer 2

Caries risk assessment for children is based on the child’s age, biological factors, protective factors, and clinical findings, combined with social, cultural, and behavioral factors.

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Question 3

What is the most consistent predictive factor for caries risk according to studies?

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Answer 3

Past caries experience is the most consistent predictive factor observed in caries risk assessment studies.

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Question 4

Why are white spot lesions important in caries risk assessment for young children?

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Answer 4

White spot lesions are considered good indicators to predict future caries development in young children before the disease fully manifests.

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Question 5

How does socioeconomic status (SES) relate to dental caries risk?

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Answer 5

There is an inverse association between caries and SES, with higher caries experience observed in socially disadvantaged individuals.

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Question 6

What role does sugar consumption play in dental caries risk?

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Answer 6

Both the quantity and frequency of sugar intake contribute to dental caries; higher consumption and more frequent intake increase caries severity.

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Question 7

Which bacteria are primarily involved in the caries process?

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Answer 7

Streptococcus mutans and Lactobacilli are the main bacteria involved in the dental caries process.

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Question 8

What protective factors help reduce the risk of dental caries?

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Answer 8

Protective factors include fluoride (from water fluoridation, toothpaste, professional applications, and varnishes) and fissure sealants, which boost resistance to carious lesions.

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Question 9

Name the four commonly used caries risk assessment tools mentioned.

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Answer 9

The four commonly used tools are: Caries Risk Assessment Tool (CAT), Caries Management by Risk Assessment (CAMBRA), Cariogram, and Traffic Light Matrix (TLM).

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Question 10

What are the three major categories of sweeteners and their characteristics?

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Answer 10

Natural intense sweeteners — plant-derived like Stevia and Monk Fruit Extract, much sweeter than sugar and contain no calories.

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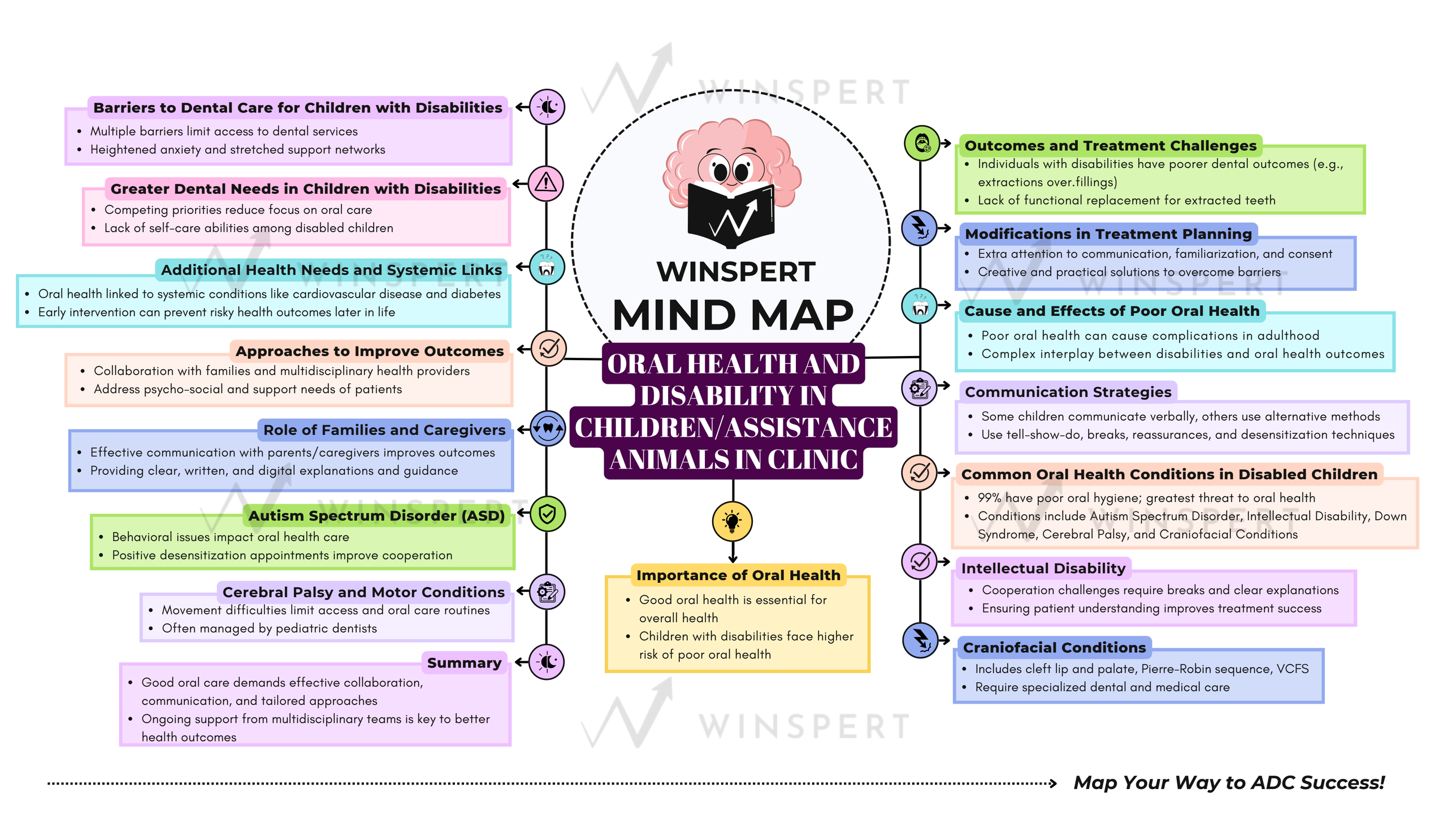
HEALTH PROMOTION

ORAL HEALTH AND DISABILITY IN CHILDREN

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA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MIND MAP
ORAL HEALTH AND DISABILITY IN CHILDREN/ASSISTANCE ANIMALS IN CLINIC
Barriers to Dental Care for Children with Disabilities
Multiple barriers limit access to dental services
Heightened anxiety and stretched support networks
Greater Dental Needs in Children with Disabilities
Competing priorities reduce focus on oral care
Lack of self-care abilities among disabled children
Additional Health Needs and Systemic Links
Oral health linked to systemic conditions like cardiovascular disease and diabetes
Early intervention can prevent risky health outcomes later in life
Approaches to Improve Outcomes
Collaboration with families and multidisciplinary health providers
Address psycho-social and support needs of patients
Role of Families and Caregivers
Effective communication with parents/caregivers improves outcomes
Providing clear, written, and digital explanations and guidance
Autism Spectrum Disorder (ASD)
Behavioral issues impact oral health care
Positive desensitization appointments improve cooperation
Cerebral Palsy and Motor Conditions
Movement difficulties limit access and oral care routines
Often managed by pediatric dentists
Summary
Good oral care demands effective collaboration, communication, and tailored approaches
Ongoing support from multidisciplinary teams is key to better health outcomes
Importance of Oral Health
Good oral health is essential for overall health
Children with disabilities face higher risk of poor oral health
Outcomes and Treatment Challenges
Individuals with disabilities have poorer dental outcomes (e.g., extractions over.fillings)
Lack of functional replacement for extracted teeth
Modifications in Treatment Planning
Extra attention to communication, familiarization, and consent
Creative and practical solutions to overcome barriers
Cause and Effects of Poor Oral Health
Poor oral health can cause complications in adulthood
Complex interplay between disabilities and oral health outcomes
Communication Strategies
Some children communicate verbally, others use alternative methods
Use tell-show-do, breaks, reassurances, and desensitization techniques
Common Oral Health Conditions in Disabled Children
99% have poor oral hygiene; greatest threat to oral health
Conditions include Autism Spectrum Disorder, Intellectual Disability, Down Syndrome, Cerebral Palsy, and Craniofacial Conditions
Intellectual Disability
Cooperation challenges require breaks and clear explanations
Ensuring patient understanding improves treatment success
Craniofacial Conditions
Includes cleft lip and palate, Pierre-Robin sequence, VCFS
Require specialized dental and medical care
Map Your Way to ADC Success!

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MIND MAP

DENTAL TREATMENT PATHWAYS FOR CHILDREN WITH DISABILITIES

Treatment Pathway for Dental Practitioners

- Dental practitioners should follow a structured treatment pathway during appointments.
- Use outlined questions and suggestions to make oral care plans effective.

In-Clinic Care Practices

- Define roles and interactions among family members, carers, and support professionals within the clinic.
- Focus on communication behavior and obtaining consent during care.

Assistance and Therapy Dogs in Dental Practice

- Therapy and assistance dogs increasingly support children with disabilities in dental settings.
- There are three scenarios for dogs entering dental clinics: assistance dogs with patients, private pets, and therapy dogs.

Private Pets in Dental Clinics

- No obligation exists to allow private pets of patients or staff in dental practices.

Therapy Dogs in Dental Practice

- No published studies exist on therapy dog use specifically in dental settings.
- Dogs undergo extensive training, veterinary health checks, and infection control compliance.
- Protocols include hand hygiene, keeping dogs away from patient care areas, and supervision by trained staff.

Infection Risks Associated with Dogs

- Dogs can carry zoonoses and infectious agents like MRSA, Salmonella, Campylobacter, Giardia, and others.
- Infection risk increases with dog licking faces and in immunocompromised patients.

Summary

- Integrating communication, access, in-clinic care, home care, and the careful use of assistance/therapy dogs can improve dental treatment for children with disabilities.
- Awareness of infection control, legal responsibilities, and patient well-being is essential for safe dental practice environments.

Communication and Collaboration

- Good oral health requires effective communication between patients, caregivers,dental clinics, and allied health professionals.
- Reporting and monitoring channels must be developed and maintained for sustained care.

Access to Services

- Improve access by preparing for appointments, arranging transport, and ensuring clinic accessibility.
- Consider how patients reach and enter dental clinics.

Oral Home Care Plan

- Management of oral care at home is crucial for sustained oral health.
- Develop individualized home care plans for children with disabilities.

Assistance/Service Dogs

- These dogs are rigorously trained to assist with disabilities such as sight loss and epilepsy.
- Legally protected under the Commonwealth Disability Discrimination Act 1992 with defined accreditation and hygiene standards.
- Permitted in all areas of dental practice, including clinical zones.

Therapy Dogs in Healthcare

- Therapy dogs provide mental well-being benefits in healthcare, supported by specialized training and certifications.
- Infection control protocols are integral to therapy dog handling.

Staff Responsibilities for Therapy Dogs

- Two trained staff members are needed to manage therapy dogs, ensuring proper care and supervision.
- Responsibilities include comfort breaks, feeding, veterinary visits, and after-hours care.

Legal and Safety Considerations.

- Liability issues include personal injury, property damage, and lease compliance regarding animals.
- Psychological and immunological reactions (fear, allergies) to dogs must be considered even if the dog is not present.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 1

What is the relationship between oral health and overall health, especially in children with disabilities?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 1

Good oral health is central to good overall health. Children and young people with disabilities are at increased risk of poor oral health and face multiple barriers to accessing dental services, which can lead to worse overall health outcomes.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 2

What are common barriers children with disabilities face in accessing dental care?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 2

Barriers include heightened anxiety, stretched support networks, infrequent dental care, and procedures that require multiple appointments.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 3

How should treatment planning be modified for patients with intellectual disabilities?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 3

Treatment planning may require additional attention to communication, familiarization, and consent, as well as creative and efficient solutions to practical barriers experienced by the patient.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 4

Why is collaboration important in dental care for children with disabilities?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 4

Effective collaboration among parents, caregivers, families, health providers, and allied health professionals ensures optimal health outcomes by addressing the support and psycho-social needs of the patient.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 5

What communication strategies are recommended for children with complex communication needs?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 5

Use techniques like Tell-Show-Do, providing breaks and reassurances, allowing extra time for responses, desensitization, and clear communication with the child's family through written, printed, or emailed information.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 6

What are some common oral health conditions found in children with intellectual disabilities?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 6

Common conditions include poor oral hygiene, challenges related to Autism Spectrum Disorder (ASD), intellectual disability, Down syndrome, cerebral palsy, and craniofacial conditions such as cleft lip and palate.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 7

What is the role of assistance/service dogs in dental practices?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 7

Assistance dogs are rigorously trained to help people with disabilities and are legally permitted in dental clinics, including clinical areas, to facilitate participation and alleviate effects of disabilities.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 8

Are private pets allowed in dental clinics?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 8

No, there is no obligation for dental practices to accept private pets of staff or patients.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 9

What precautions must be taken when therapy dogs are used in dental practices?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 9

Precautions include maintaining infection control protocols, hand hygiene before and after contact, ensuring dogs are healthy and vaccinated, keeping dogs away from patient care areas, and training staff to supervise the dog properly.

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ORAL HEALTH AND DISABILITY IN CHILDREN

Question 10

What are the potential infection risks associated with therapy dogs in dental clinics?

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ORAL HEALTH AND DISABILITY IN CHILDREN

Answer 10

Risks include zoonoses (infections transmitted from dogs), acting as reservoirs for infectious agents like MRSA, and carrying pathogens such as Salmonella, Campylobacter, Leptospira, Giardia, dermatophytes, Toxocara, and hookworms, especially if patients are immunocompromised or if the dog licks a person’s face.

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HEALTH PROMOTION

MEDICO-LEGAL CONSIDERATIONS IN AGED POPULATION

MIND MAP & CUE CARDS

BY DR. JIGYASA SHARMA

WINSPERT MIND MAP

GERIATRIC ORAL HEALTH

Challenges in Elderly Oral Health

- Older adults sufer from oral diseases complicated by chronic conditions, impacting healthy ageing.
- Poor oral health leads to pain, infection, and tooth loss, significantly affecting quality of life.

Barriers to Dental Care for the Elderly

- People over 75 visit dentists less due to physical, cognitive impairments, transport issues, anxiety, or dissatisfaction.
- Oral health is often misunderstood as a natural part of ageing, leading to late dental visits.

Multidisciplinary Approach to Oral Health

- Cooperation among doctors, nurses, care workers, and dental professionals is essential for screening, planning, hygiene, and treatment.
- Oral health assessment by GPS/RNs on admission triggers care planning and dental referrals.

Quality Dental Care Barriers and Solutions

- RACFs lack dental rooms and equipment, limiting care quality.
- Portable dental equipment and mobile services improve access to clinical care.
- Oral health therapists are underutilized but crucial for improving elderly oral health.

Major Problems in Elderly Oral Health

- Inadequate hydration, poor manual dexterity, and lack of cooperation hinder oral care.
- Polypharmacy causes salivary gland hypofunction, worsening oral health.

Delayed Restoration Technique

- Used for fearful or frail patients, allowing softened caries to be removed with minimal intervention after 2-3 weeks.
- Enables restoration without invasive drilling, beneficial for subgingival lesions.

Government Initiatives and Models

- The Better Oral Health in Residential Care Model (2010) promotes quality dental care in RACFS.
- Encourages partnerships between aged care and dental services to improve clinical outcomes for elderly residents.

Australian Aged Care Support System

- The Australian Government supports around 2800 Residential Aged Care Facilities (RACFS) and community aged care programs.
- Increasing dementia and chronic illness rates will drive demand for more complex aged care services.

Oral Health and General Health Link

- Chronic diseases like cardiovascular and respiratory illnesses have links with oral diseases.
- Periodontal disease and diabetes have a bi-directional relationship affecting overall health.

Dental Care Provision in RACFS

- Few dentists provide services in aged care due to lack of facilities and referral pathways.
- Involving dental hygienists/oral health therapists in RACFS is a promising model.

Roles in Oral Health Care

- Oral health care planning is managed by GPs and RNs with dental input.
- Daily oral hygiene support is provided by care workers following personalized care plans.
- Dental professionals perform assessments and treatments, preferably onsite with portable equipment.

Clinical Approaches by Risk Categories

- Elderly are categorized by dental competence, cooperation, and mobility to tailor treatment.
- Progression from cooperative to non-cooperative requires different strategies and consent processes.

Treatment Strategies

- High viscosity glass ionomer cements (GICs) and atraumatic restorative treatment (ART) are preferred.
- Silver fluoride techniques (SDF/AgF-SnF2) effectively arrest caries, with considerations for aesthetics and tissue sensitivity.

Preventive Regimes

- Regular high-fluoride toothpaste and fluoride varnishes are recommended.
- Chlorhexidine mouthwash and remineralizing agents protect root surfaces.
- Preventive treatments should be tailored to the patient's risk profile and adherence ability.

Map Your Way to ADC Success!

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MEDICO-LEGAL CONSIDERATIONS IN AGED POPULATION

Question 1

What types of aged care services does the Australian Government currently support for elderly oral health?

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Answer 1

The Australian Government supports approximately 2800 Residential Aged Care Facilities (RACFs), community aged care support through Home Care programs, and the National Respite for Carers Program.

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Question 2

Why is the demand for more complex aged care services expected to grow in the coming years?

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Answer 2

The demand is expected to grow due to an increase in the incidence of dementia and other age-related chronic illnesses, combined with a decrease in the number of family and friends able to act as informal carers.

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Question 3

What are the common consequences of poor oral health in older people?

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Answer 3

The most common consequences are pain, infection, and tooth loss.

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Question 4

How is oral health related to general health in elderly individuals?

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Answer 4

Oral health is integral to general health, with chronic conditions like cardiovascular, cerebrovascular, and respiratory diseases sharing links with tooth decay, oral cancer, and periodontal disease. There is also a significant bi-directional relationship between periodontal disease and diabetes.

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Question 5

What are some reasons elderly people over 75 years visit the dentist less frequently?

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Answer 5

Reasons include physical and cognitive impairment, difficulties with transport, past negative experiences, anxiety, and dissatisfaction with dental services.

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Question 6

What multidisciplinary approach is recommended to improve oral health care in Residential Aged Care Facilities (RACFs)?

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Answer 6

A multidisciplinary approach involving doctors, nurses, care workers, and dental professionals is recommended to share responsibility for oral health screening, oral health care planning, daily oral hygiene, and access to dental treatment.

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Question 7

What role do General Practitioners (GPs) and Registered Nurses (RNs) play in oral health care in aged care facilities?

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Answer 7

GPs and RNs use oral health assessment tools on admission for screening, monitor oral health, plan oral health care with dental professional input, and trigger dental referrals.

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Question 8

What are the barriers to providing quality dental care in Residential Aged Care Facilities, and how can they be alleviated?

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Answer 8

Barriers include lack of dental rooms, chairs, and equipment. These can be alleviated by providing portable dental equipment and mobile service delivery options, along with better utilization of dental hygienists and oral health therapists.

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Question 9

What clinical approaches are used to treat elderly patients with varying levels of dental competence and cooperation?

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Answer 9

Elderly patients are categorized by risk based on dental competence, ability to cooperate, and mobility. Treatment approaches vary accordingly, from general practice care for cooperative patients to specialized care in aged care facilities for non-cooperative patients, including preventive strategies and consent management.

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Question 10

What preventive regimes are recommended to protect root surfaces in elderly patients?

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Answer 10

Preventive regimes include regular use of 5000 ppm fluoride toothpaste, monthly or three-monthly applications of 22,600 ppm fluoride varnish, three-monthly applications of 4% chlorhexidine varnish and 5% sodium fluoride varnish, and annual application of 38% silver diamine fluoride, based on the patient's risk profile.