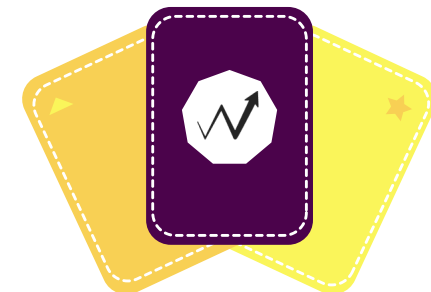


ORAL SURGERY

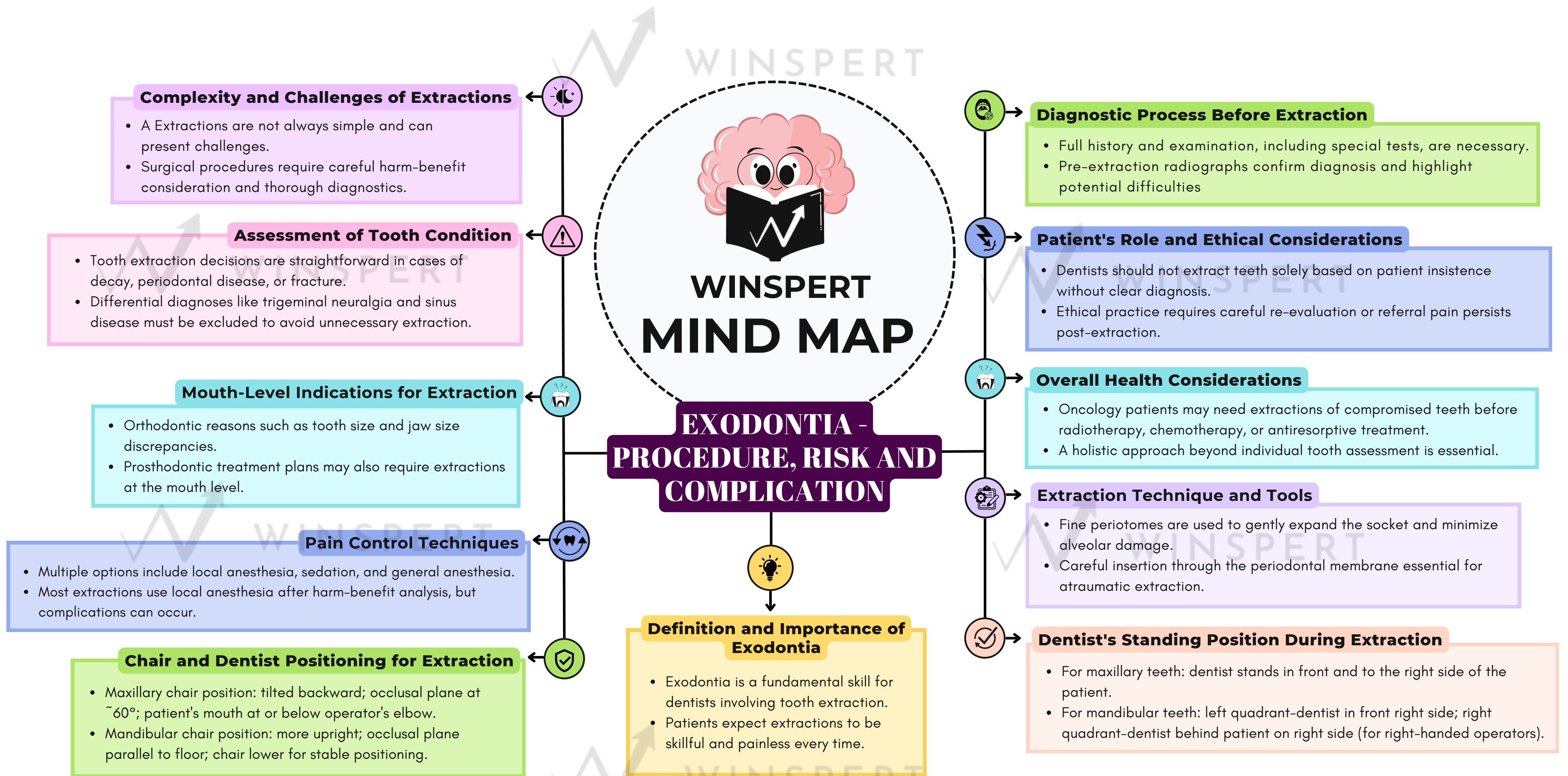
EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







**WINSPERT
CUE CARDS**

EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Question 1

What is the primary objective of exodontia?



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EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 1

The primary objective of exodontia is to remove the whole tooth while preserving the alveolus for future prosthetics or implants.



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EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Question 2

Why is it important to perform a full diagnostic process before tooth extraction?



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EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 2

A full diagnostic process including history, examination, special tests, and radiographs is important to weigh the harm and benefits of extraction, confirm diagnosis, identify potential difficulties, and rule out causes of pain that are not related to the tooth, such as sinus disease or trigeminal neuralgia.



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**EXODONTIA - PROCEDURES,
RISKS, COMPLICATIONS**

Question 3

What factors at the individual tooth level justify tooth extraction?



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EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 3

Tooth extraction is justified in cases of gross decay, advanced periodontal disease, and fracture, but it requires careful diagnosis to exclude referred pain or conditions that mimic toothache. Extraction should not be performed solely based on patient insistence without clear diagnosis.



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**EXODONTIA - PROCEDURES,
RISKS, COMPLICATIONS**

Question 4

What considerations are made when deciding to extract teeth at the mouth or overall health level?



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EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 4

At the mouth level, common indications include orthodontic extractions for tooth size/jaw size discrepancies or part of a prosthodontic plan. Regarding overall health, teeth may be extracted in oncology patients undergoing radiotherapy or chemotherapy to prevent complications.



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**EXODONTIA - PROCEDURES,
RISKS, COMPLICATIONS**

Question 5

List the main types of pain control options available during tooth extraction.



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EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 5

Pain control options include local anesthesia, local anesthesia combined with oral sedation, local anesthesia combined with intravenous sedation, and general anesthesia (in hospital or day surgery).



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**EXODONTIA - PROCEDURES,
RISKS, COMPLICATIONS**

Question 6

Describe the recommended chair position for extracting maxillary teeth.



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CUE CARDS**

EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 6

For maxillary teeth, the chair should be tipped backward so the occlusal plane is about 60 degrees to the floor, and the mouth should be at or slightly below the operator's elbow level.



**WINSPERT
CUE CARDS**

**EXODONTIA - PROCEDURES,
RISKS, COMPLICATIONS**

Question 7

What is the most common complication of exodontia, and what are its risk factors?



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CUE CARDS**

EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 7

The most common complication is alveolar osteitis (dry socket), a painful but self-limiting condition in which the blood clot dissolves exposing the bone. Risk factors include traumatic extraction, smoking, extraction of posterior teeth, and extraction in the mandible more than in the maxilla.



**WINSPERT
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**EXODONTIA - PROCEDURES,
RISKS, COMPLICATIONS**

Question 8

**How should an oro-antral
communication after maxillary
tooth extraction be managed?**



**WINSPERT
CUE CARDS**

EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 8

If the communication is small and the tooth is intact, compress the socket and suture it closed, advising the patient not to blow their nose or create negative pressure. For large communications (>4 mm) or missing tooth fragments, immediate referral to an oral and maxillofacial surgeon is required.



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EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Question 9

What actions are recommended when a tooth root is fractured and left in situ during extraction?



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CUE CARDS**

EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 9

If the fractured root tip is less than 5 mm, vital, and close to important structures like nerves, it can be left in place. If removal is necessary, it should be done via a small bony window to maintain alveolar bone height.



**WINSPERT
CUE CARDS**

EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Question 10

Name at least three hemostatic agents or methods used to control hemorrhage during exodontia.



**WINSPERT
CUE CARDS**

EXODONTIA - PROCEDURES, RISKS, COMPLICATIONS

Answer 10

Hemorrhage can be controlled by direct pressure with non-resorbable gauze, absorbable materials such as porcine gelatin sponge or oxidized cellulose (Surgicel), gelatin-thrombin mixtures (Floseal), bone wax, and topical application of tranexamic acid mouthwash or solution.

ORAL SURGERY

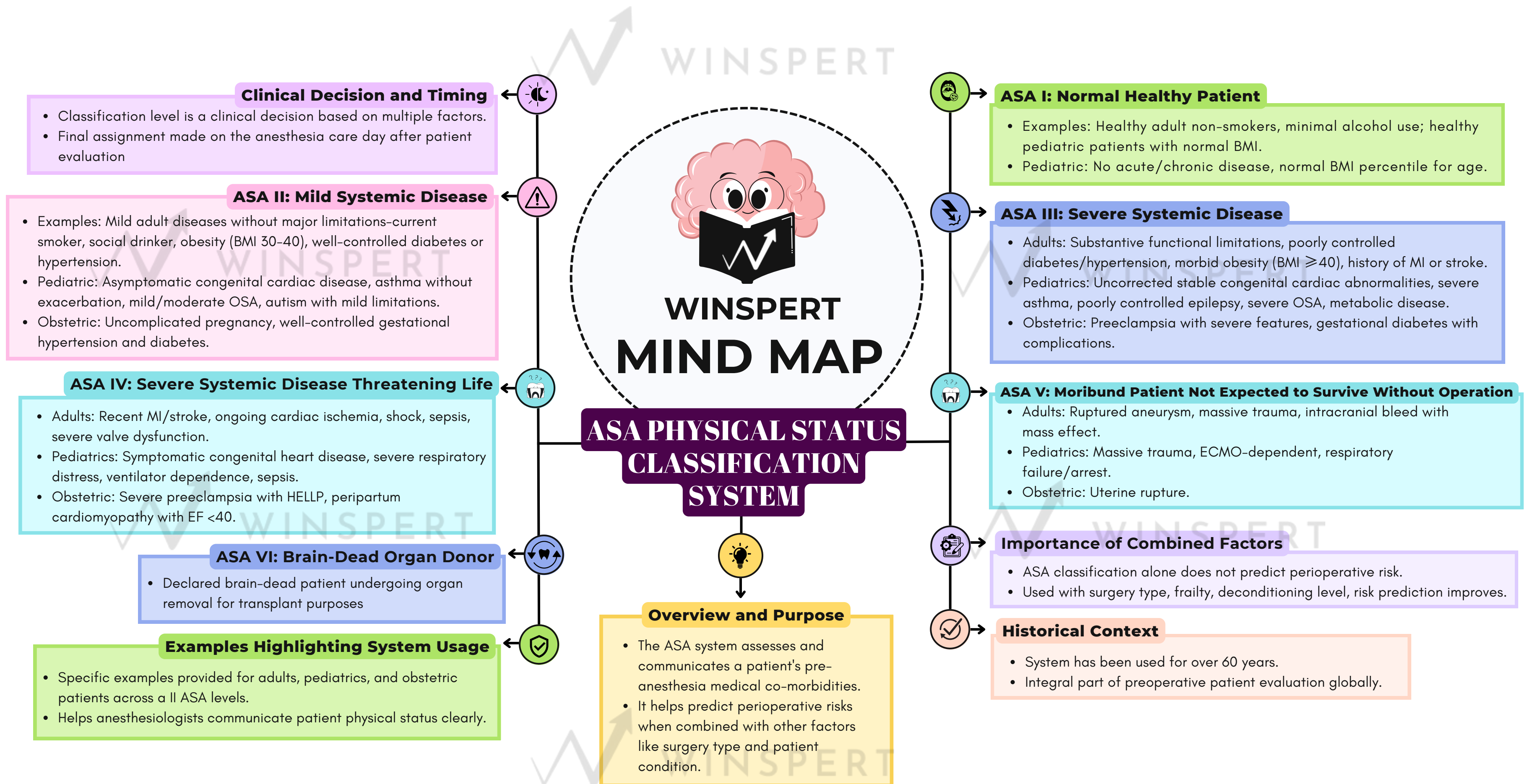
ASA - CLASSIFICATION



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA





**WINSPERT
CUE CARDS**

ASA - CLASSIFICATION

Question 1

What is the primary purpose of the ASA Physical Status Classification System?



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CUE CARDS**

ASA - CLASSIFICATION

Answer 1

The primary purpose of the ASA Physical Status Classification System is to assess and communicate a patient's pre-anesthesia medical co-morbidities.



**WINSPERT
CUE CARDS**

ASA - CLASSIFICATION

Question 2

**Does the ASA Classification system
alone predict perioperative risks?**



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CUE CARDS**

ASA - CLASSIFICATION

Answer 2

No, the ASA Classification system alone does not predict perioperative risks, but when combined with other factors like the type of surgery, frailty, and level of deconditioning, it can help predict perioperative risks.



**WINSPERT
CUE CARDS**

ASA - CLASSIFICATION

Question 3

**Who makes the final
assignment of the ASA
Physical Status classification?**



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CUE CARDS**

ASA - CLASSIFICATION

Answer 3

The final assignment of the ASA Physical Status classification is made by the anesthesiologist on the day of anesthesia care after evaluating the patient.



**WINSPERT
CUE CARDS**

ASA - CLASSIFICATION

Question 4

**What defines a patient
classified as ASA I?**



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CUE CARDS**

ASA - CLASSIFICATION

Answer 4

An ASA I patient is a normal healthy patient with no systemic disease. Examples include a healthy adult who is a non-smoker with minimal alcohol use or a healthy pediatric patient with no acute or chronic disease.



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CUE CARDS**

ASA - CLASSIFICATION

Question 5

Give examples of conditions that classify an adult patient as ASA II



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CUE CARDS**

ASA - CLASSIFICATION

Answer 5

Examples for ASA II adult patients include mild systemic diseases without substantive functional limitations, such as current smoker, social alcohol drinker, pregnancy, obesity (BMI between 30 and 40), well-controlled diabetes mellitus or hypertension, and mild lung disease.



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CUE CARDS**

ASA - CLASSIFICATION

Question 6

What kinds of systemic disease characterize an ASA III patient?



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CUE CARDS**

ASA - CLASSIFICATION

Answer 6

An ASA III patient has severe systemic disease causing substantive functional limitations, such as poorly controlled diabetes or hypertension, COPD, morbid obesity (BMI ≥ 40), active hepatitis, alcohol dependence, implanted pacemaker, or history of myocardial infarction, cerebrovascular accident, or coronary artery disease.



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CUE CARDS**

ASA - CLASSIFICATION

Question 7

**Describe an ASA IV patient
and provide examples.**



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CUE CARDS**

ASA - CLASSIFICATION

Answer 7

An ASA IV patient has severe systemic disease that is a constant threat to life. Examples include recent (less than 3 months) myocardial infarction, stroke, ongoing cardiac ischemia, severe valve dysfunction, shock, sepsis, or end-stage renal disease not on regular dialysis.



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ASA - CLASSIFICATION

Question 8

**What clinical situations place
a patient into ASA V
classification?**



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CUE CARDS**

ASA - CLASSIFICATION

Answer 8

ASA V patients are moribund and not expected to survive without the operation. Examples include ruptured abdominal or thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel with significant cardiac pathology, or multiple organ/system dysfunction.



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ASA - CLASSIFICATION

Question 9

Who is classified as ASA VI?



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ASA - CLASSIFICATION

Answer 9

ASA VI is assigned to declared brain-dead patients whose organs are being removed for donor purposes.



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ASA - CLASSIFICATION

Question 10

Why are pregnant women with uncomplicated pregnancy classified as ASA II?



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ASA - CLASSIFICATION

Answer 10

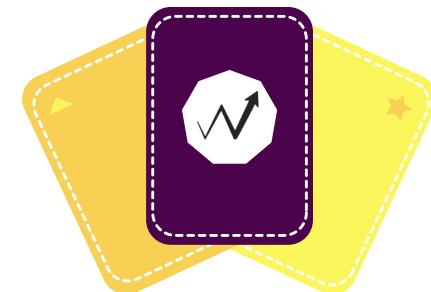
Pregnancy is not a disease, but the physiologic state of a pregnant woman is significantly altered from her non-pregnant state; therefore, an uncomplicated pregnancy is classified as ASA II.

ORAL SURGERY

THIRD MOLAR EXTRACTION AND COMPLICATIONS



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA



Classification of Third Molars

- Disease positive/negative
- Symptom positive/negative

Management of Asymptomatic Third Molars

- Symptom free but disease positive third molars: evidence supports removal in young adults.
- Symptom and disease free third molars pose clinical challenges and require careful decision matrices.

Prophylactic Removal Groups

- Contact sports and military personnel for performance and safety.
- Patients with neuromuscular conditions or mental capacity issues (dementia, cognitive delay).
- Patients on bisphosphonates, anticoagulants, or undergoing radiotherapy/chemotherapy.
- Tissue transfer or immunomodulator therapy patients with higher infection risks.

Postoperative Complications

- Common: pain, swelling, hemorrhage, infection, alveolar osteitis, hematoma, trismus.
- Rare but serious: mandibular angle fracture, nerve injury, oroantral communication, delayed healing.
- Patient anxiety affects outcomes; younger patients have better prognosis for prophylactic extraction.

Informed Consent Process

- Consent educates patients legally and ethically prior to treatment.
- Must include nature of treatment, risks/benefits, alternatives, consequences of no treatment, and surgeon identity.
- Disclosure tailored to what reasonable and individual patients need to know.
- Consent must be voluntary and by competent individuals; can be written, verbal, or implied.

Legal and Ethical Considerations

- Valid consent protects against claims of trespass and negligence.
- Written consent standard in Australian hospitals for invasive procedures.
- Survey data guides consensus on risk disclosure for third molar extraction complications.

Financial and Social Factors Influencing Decision

- Patient's financial capacity may affect choice to undergo surgery.
- Social support systems also modify surgical decision-making and postoperative care.

THIRD MOLAR EXTRACTION AND COMPLICATIONS

Overview of Third Molars

- Third molars (wisdom teeth) are the last teeth to erupt and highly variable in morphology and eruption timing.
- Often impacted due to limited space, obstruction by other teeth, or abnormal positioning.

Decision-Making for Removal

- Straightforward removal for symptom positive and/or disease positive teeth.
- Symptom positive but disease negative removals generally accepted by surgeons and patients.

Indications for Extraction

- Disease or symptom presence (e.g., caries, pericoronitis, cysts, tumors)
- Prophylactic reasons including prevention of root resorption, crowding, or damage to adjacent teeth.

Surgical Difficulty and Risk Assessment

- WHARFE system used to evaluate: Winter's lines, Height of mandible, Angulation, Root form, Follicular sac size, Exit pathway.
- Surgeon's capability must match procedure complexity; referral advised if outside surgeon's competence.

Advantages and Disadvantages

- Advantages: resolution of caries, periodontal defects, cysts, tumors, prevention of crowding/damage.
- Disadvantages: increased probing depth, attachment loss near second molars, no bone height gain, 10% complication rate.

Risks to Disclose in Consent

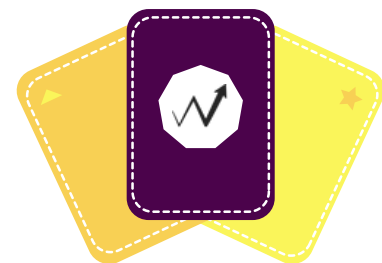
- Lingual and inferior alveolar nerve damage (temporary or permanent)
- Postoperative pain, alveolar osteitis, general infection risks
- Excessive bleeding, unexpected soft tissue injury, oroantral communication
- Bone fractures and other rare but severe complications.

Surgeon Experience and Patient Outcomes

- Experienced surgeons have lower complication rates.
- Surgeon skill is crucial especially when considering prophylactic removal of asymptomatic third molars.

Summary

- Removing third molars requires multifactorial assessment: symptoms, disease status, surgical risk, patient health, social, and financial context.
- Thorough informed consent and risk discussion are essential parts of ethical surgical practice.
- Ongoing research and clinical guidelines continue to evolve best practices for managing third molars.

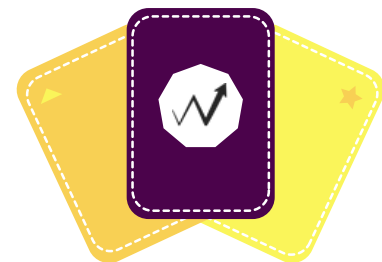


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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 1

**What is the third molar (M3),
and why is it considered the
most variable tooth?**



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 1

The third molar (M3) is the last tooth to appear in the mouth and is considered the most variable tooth due to differences in its morphology, eruption period, and the presence of oligodontia or hypodontia.



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 2

What is an impacted third molar, and what causes impaction?



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 2

An impacted third molar is a wisdom tooth that has not completely erupted despite having a fully formed root. Impaction occurs due to inadequate space in the mouth, obstruction by another tooth, or abnormal tooth positioning. The impacted tooth is often covered partially or fully by soft tissue, bone, or both.



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 3

**How are third molars classified
according to recent literature?**



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 3

Third molars are classified based on disease and symptom status as disease positive or disease negative, and symptom positive or symptom negative.



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 4

What factors influence the decision to remove third molars?

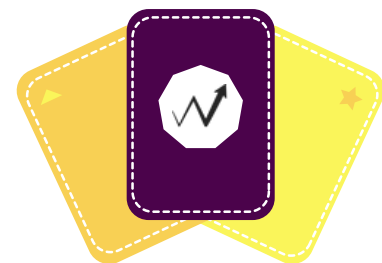


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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 4

The decision to remove third molars depends on the presence of symptoms and disease, surgical difficulty, procedural risks, patient's current and future health, social support, and financial capacity.



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 5

What is prophylactic removal of third molars, and what are some common indications for it?



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CUE CARDS**

THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 5

Prophylactic removal refers to the extraction of third molars that are symptom-free and disease-free to prevent future complications. Indications include patients in contact sports or military, those with reduced physical dexterity, altered mental capacity, pre-medication with bisphosphonates or anti-coagulants, pre-treatment for radiotherapy or chemotherapy, and those undergoing immunomodifier therapy or tissue transfer.



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 6

**What is the WHARFE system,
and what does it assess?**



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 6

The WHARFE system is a method used to predict the difficulty of third molar removal. It assesses Winter's lines (W), Height of the mandible (H), Angulation (A), Root form (R), Size of follicular sac (F), and Exit pathway of the tooth (E).



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 7

What are common advantages and indications for third molar extraction?



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 7

Advantages include removal of impacted teeth associated with dental caries, periodontal defects near the second molar, pericoronitis, odontogenic cysts, and dental tumors. Prophylactic removal may be indicated to prevent root resorption, crowding of lower incisors, and damage to adjacent teeth.



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 8

What are some disadvantages and complications associated with third molar extraction?

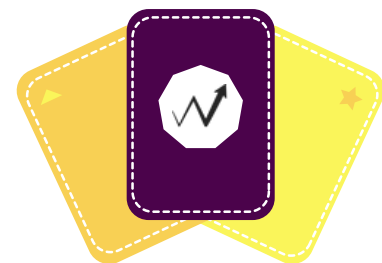


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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 8

Disadvantages include increased probing depth and reduced attachment level on adjacent molars, no gain in alveolar bone height after removal, and a complication rate of about 10%. Complications can include pain, swelling, hemorrhage, infection, alveolar osteitis, nerve injury, hematoma, lockjaw, bone fracture, oroantral communication, incomplete root removal, and delayed healing.



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 9

**How does surgeon experience
impact third molar extraction
complications?**



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 9

Surgeon experience decreases the likelihood of significant post-surgery complications. Experienced surgeons tend to have better outcomes, making their involvement particularly important for prophylactic surgeries in asymptomatic patients.



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Question 10

What does informed consent for third molar extraction involve according to Australian standards?



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THIRD MOLAR EXTRACTION AND COMPLICATIONS

Answer 10

Informed consent requires educating the patient on the nature of the treatment, risks and benefits, alternative options, consequences of not proceeding, and the person performing the procedure. Consent must be voluntary, informed, and given by a competent patient, either verbally, in writing, or by implication. Known risks to disclose include common minor and rare severe complications such as nerve damage

ORAL SURGERY

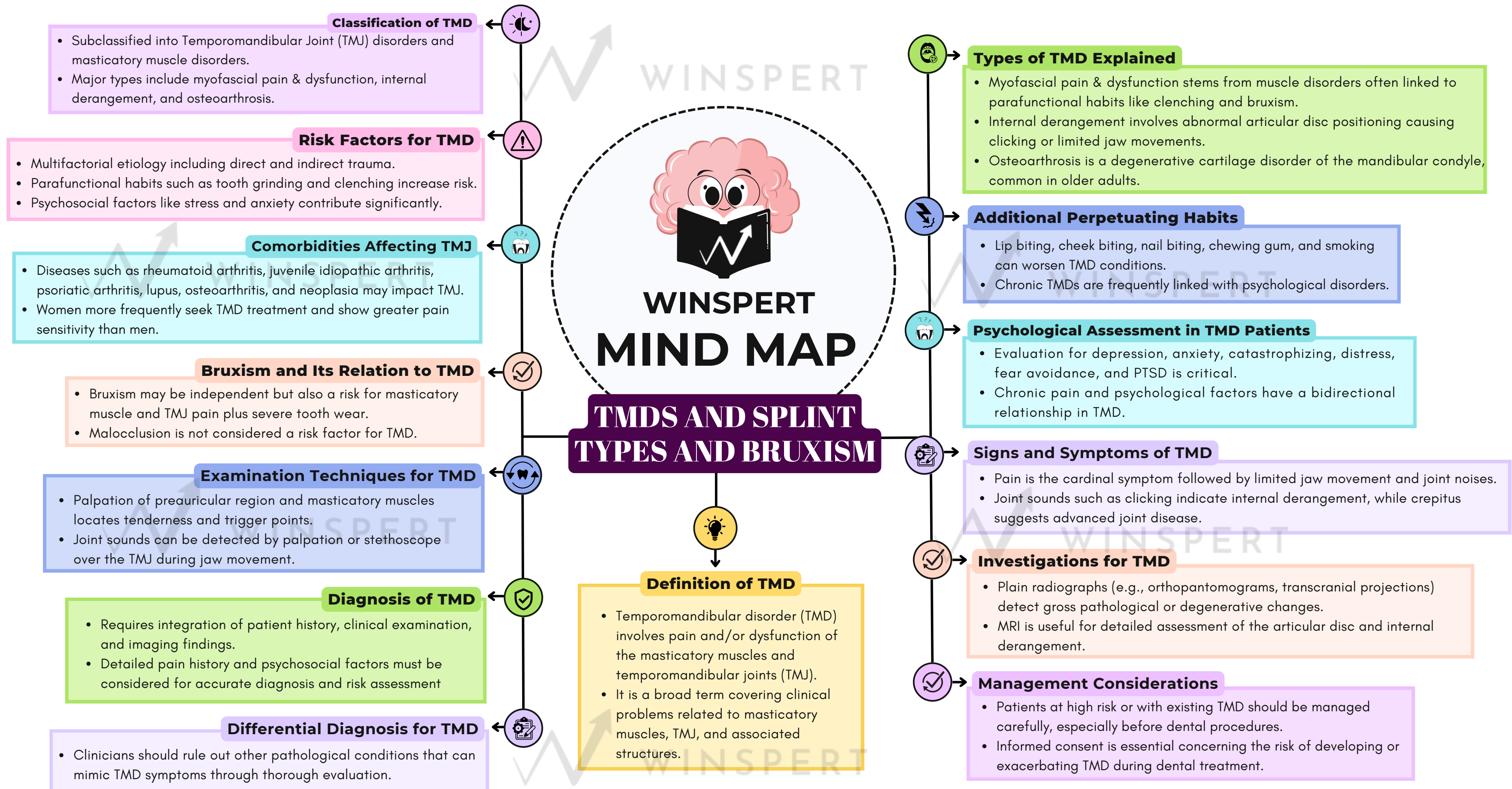
TMD'S AND SPLINT TYPES AND BRUXISM

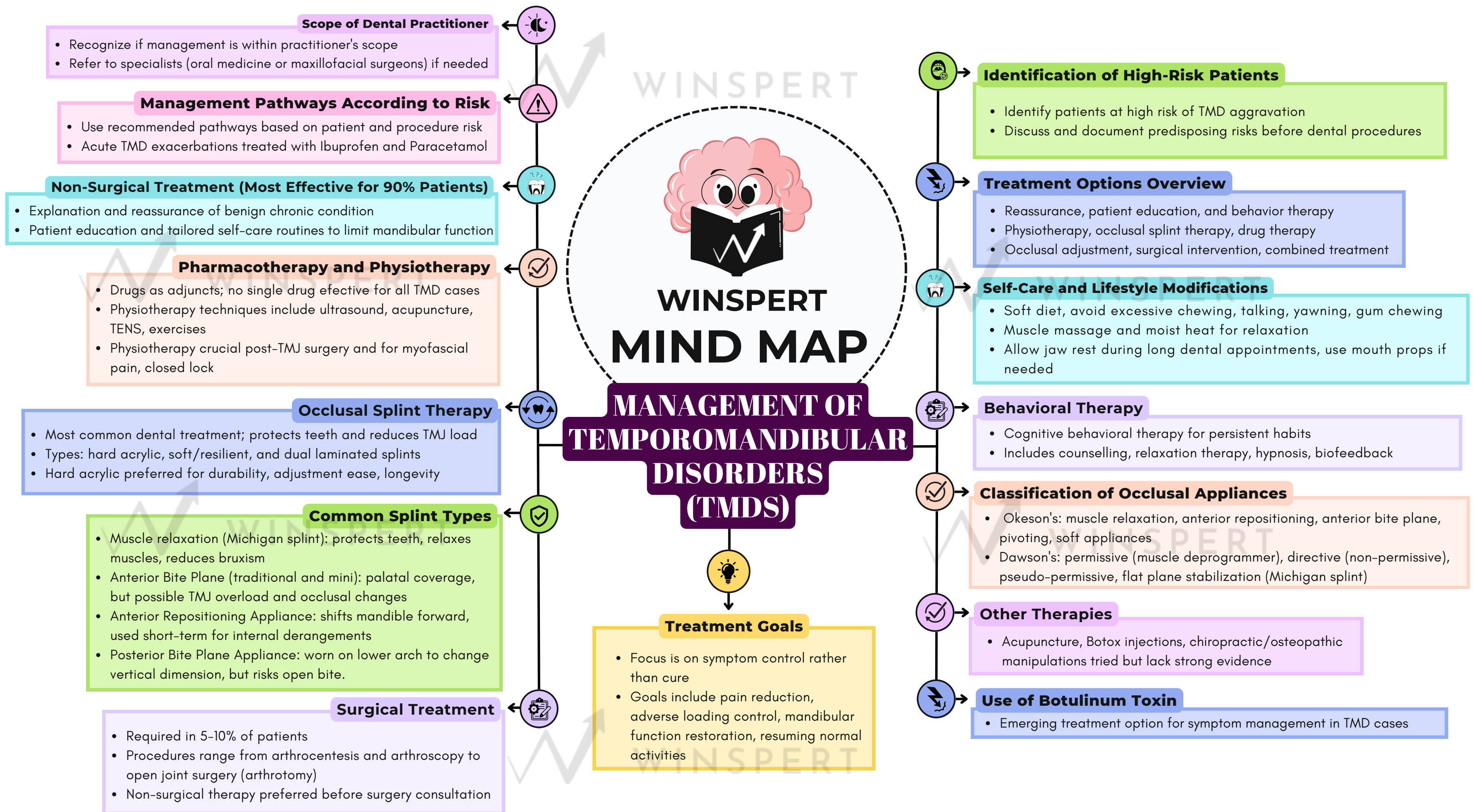


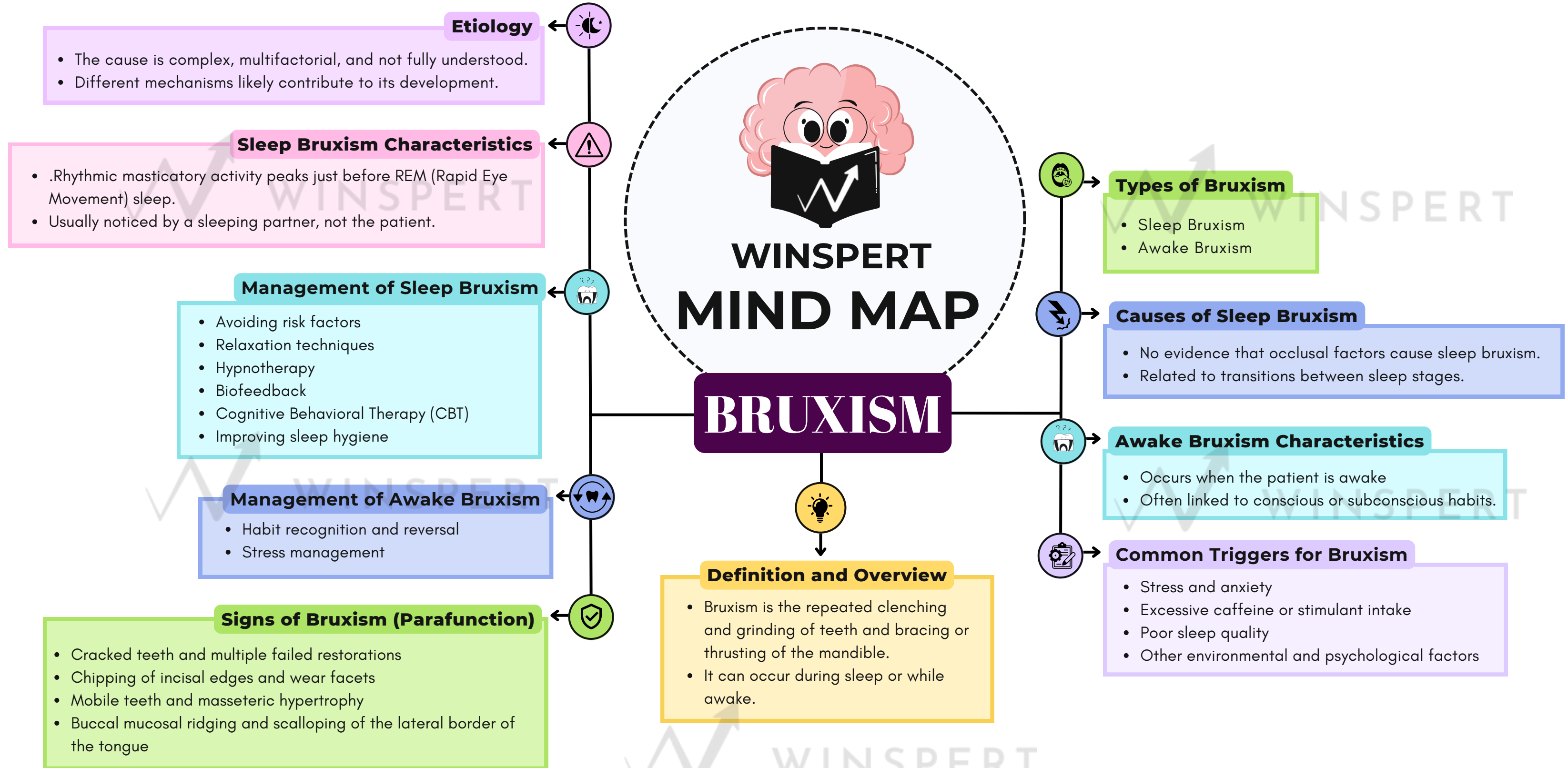
MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA









**WINSPERT
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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 1

What is Temporomandibular Disorder (TMD) and what anatomical structures does it involve?



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CUE CARDS**

TMD'S AND SPLINT TYPES AND BRUXISM

Answer 1

Temporomandibular Disorder (TMD) is a broad term encompassing pain and/or dysfunction of the masticatory musculature and the temporomandibular joints. It is a collective term for clinical problems involving masticatory muscles, temporomandibular joints (TMJ), and associated structures.



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 2

**What are the key risk factors
contributing to the
development of TMD?**



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CUE CARDS**

TMD'S AND SPLINT TYPES AND BRUXISM

Answer 2

Key risk factors for TMD include direct trauma, indirect trauma (acceleration and deceleration injury), parafunctional habits (tooth grinding and clenching), psychosocial issues such as stress and anxiety, habitual behaviors like lip biting, cheek biting, nail biting, chewing gum, smoking, and chronic psychological disorders.



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 3

How is pain in the pre-auricular area assessed and what does it indicate?



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TMD'S AND SPLINT TYPES AND BRUXISM

Answer 3

Pain in the pre-auricular area is assessed by placing the fingertips in the depression in front of the ear canal where the condyle translates when the mouth opens. Pain specifically localized here is a good sign of actual temporomandibular joint pathology.



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 4

Which investigation methods are commonly used to evaluate TMD and associated joint pathology?



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TMD'S AND SPLINT TYPES AND BRUXISM

Answer 4

Common investigation methods include plain radiographs such as orthopantomograms and transcranial projections for baseline imaging, as well as magnetic resonance imaging (MRI) to assess the status of the articular disc and detect internal derangements of the TMJ.



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 5

What are the primary goals in the management of temporomandibular disorders?



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CUE CARDS**

**TMD'S AND SPLINT
TYPES AND BRUXISM**

Answer 5

The primary management goals are to reduce pain, reduce adverse loading on the joint and muscles, restore mandibular function, and enable the patient to resume normal daily activities.



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 6

**What are the key components
of conservative non-surgical
treatment for TMD?**



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CUE CARDS**

**TMD'S AND SPLINT
TYPES AND BRUXISM**

Answer 6

Conservative treatment includes patient education and reassurance, self-care routines such as limiting mandibular function and habit modification, physiotherapy, pharmacotherapy, behavioral therapy, and occlusal splint therapy.



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 7

Describe the hard acrylic occlusal splint and its advantages over soft occlusal splints.



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CUE CARDS**

TMD'S AND SPLINT TYPES AND BRUXISM

Answer 7

The hard acrylic occlusal splint is a rigid, tooth-borne appliance made from self-cured or heat-cured acrylic resin. Advantages include ease of adjustment and repair, more accurate fit, greater longevity, color stability, less food debris accumulation, better durability, and more reliable fabrication compared to soft splints.



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 8

**What types of occlusal splints
are used in TMD treatment
according to Okeson's
classification?**



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Answer 8

Soft/resilient appliances



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**TMD'S AND SPLINT
TYPES AND BRUXISM**

Question 9

What are common signs and triggers of bruxism?



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TMD'S AND SPLINT TYPES AND BRUXISM

Answer 9

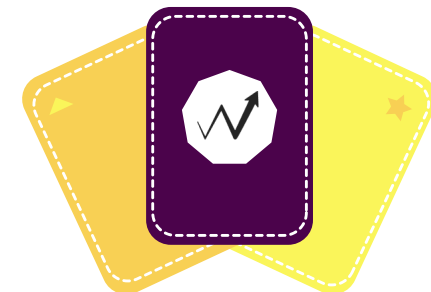
Common signs of bruxism include cracked teeth, multiple failed restorations, chipping of incisal edges, wear facets, mobile teeth, masseter muscle hypertrophy, buccal mucosal ridging, and scalloping of the lateral tongue border. Triggers

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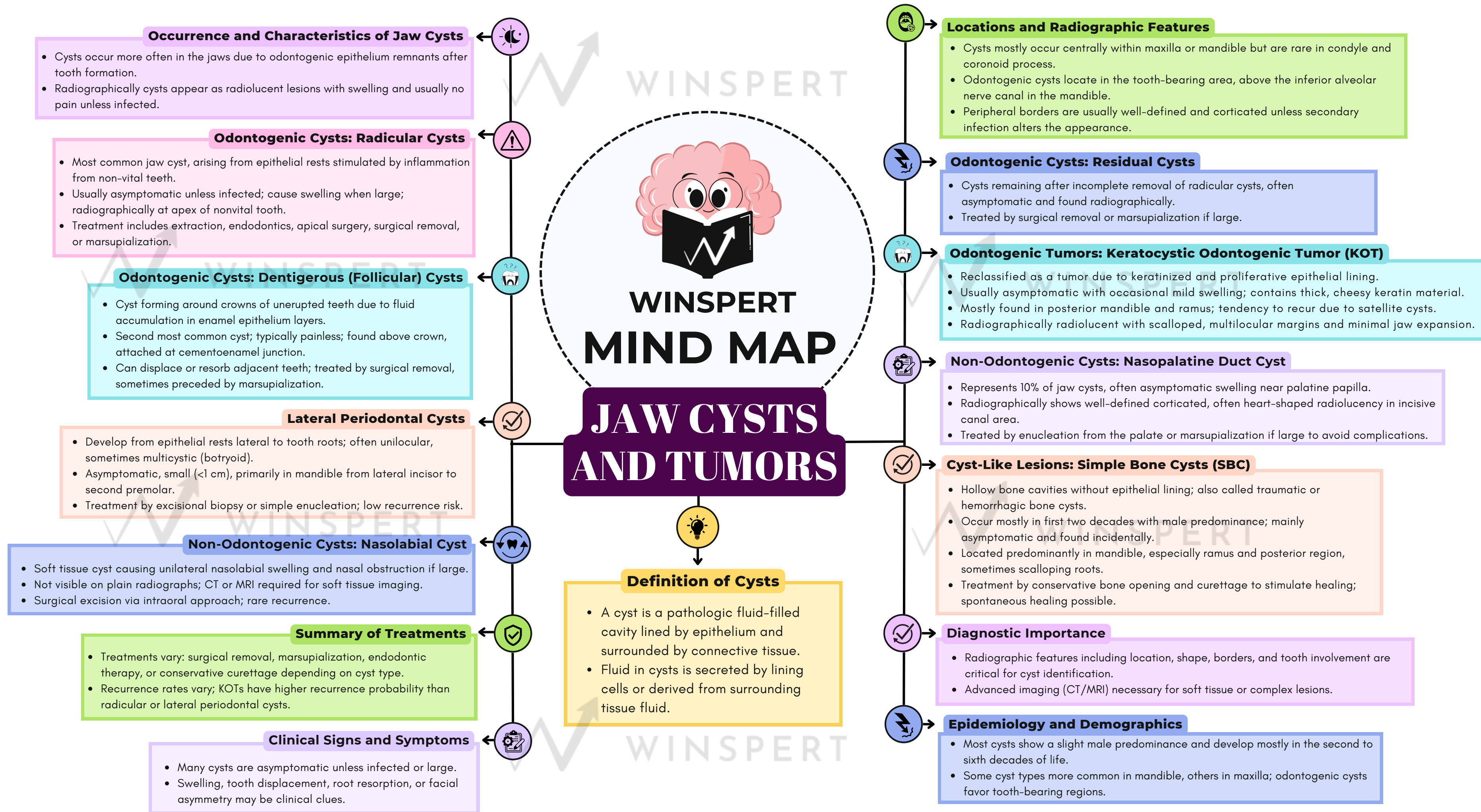
JAW CYSTS AND TUMORS

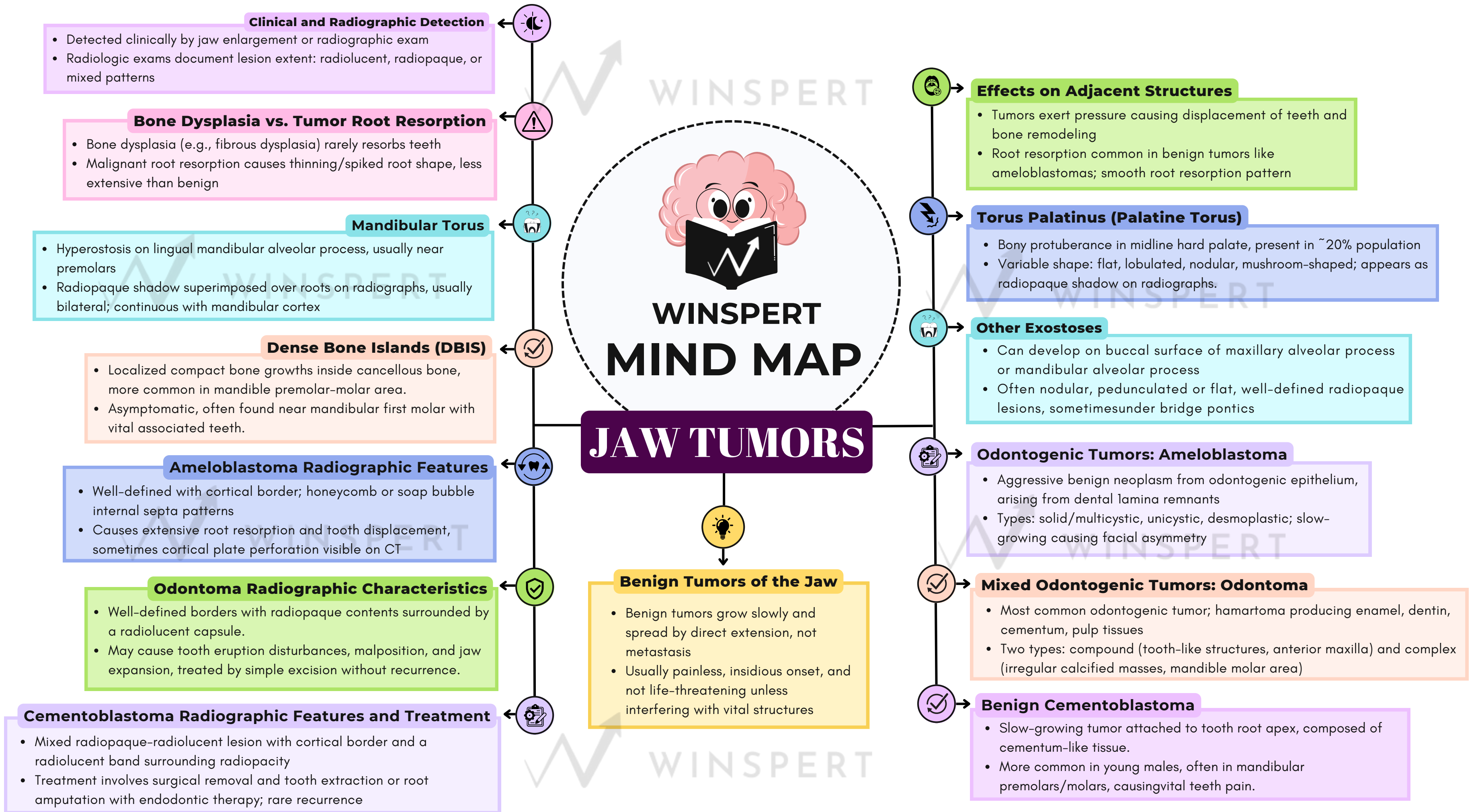


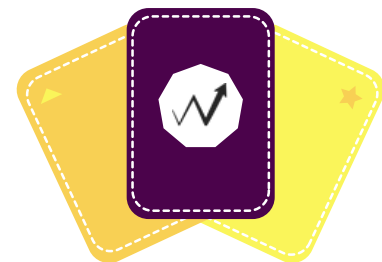
MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







**WINSPERT
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JAW CYSTS AND TUMORS

Question 1

What is a cyst and why do cysts occur more often in the jaws than in any other bone?



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CUE CARDS**

JAW CYSTS AND TUMORS

Answer 1

A cyst is a pathologic cavity filled with fluid, lined by epithelium, and surrounded by a definite connective tissue wall. Cysts occur more often in the jaws than in any other bone because most cysts originate from the numerous rests of odontogenic epithelium that remain after tooth formation.



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CUE CARDS**

**JAW CYSTS AND
TUMORS**

Question 2

What are the most common clinical and radiographic features of jaw cysts?



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CUE CARDS**

JAW CYSTS AND TUMORS

Answer 2

Jaw cysts are radiolucent lesions often presenting with swelling and usually lack pain unless secondarily infected. They are associated with unerupted teeth, especially third molars. Radiographically, cysts typically have a well-defined, corticated periphery.

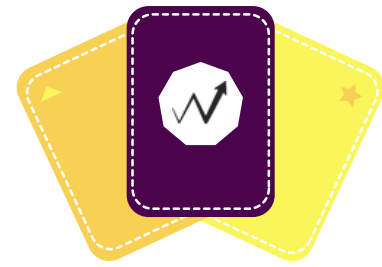


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**JAW CYSTS AND
TUMORS**

Question 3

**What is a radicular cyst and
how is it typically treated?**



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CUE CARDS**

JAW CYSTS AND TUMORS

Answer 3

A radicular cyst is the most common type of jaw cyst that results from inflammatory stimulation of epithelial cell rests by a nonvital tooth. Treatment includes extraction, endodontic therapy, apical surgery, or surgical removal/marsupialization for large cysts, with low recurrence if completely removed.



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CUE CARDS**

**JAW CYSTS AND
TUMORS**

Question 4

How is a dentigerous cyst formed and what are its key diagnostic features?



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CUE CARDS**

JAW CYSTS AND TUMORS

Answer 4

A dentigerous cyst forms around the crown of an unerupted tooth due to fluid accumulation between reduced enamel epithelium layers or between epithelium and the crown. Key features are its attachment at the cemento-enamel junction and radiographic location just above the crown of the involved tooth, commonly mandibular/maxillary third molar or maxillary canine.



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CUE CARDS**

**JAW CYSTS AND
TUMORS**

Question 5

What distinguishes a keratocystic odontogenic tumor (KOT) from other jaw cysts radiographically and clinically?



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CUE CARDS**

JAW CYSTS AND TUMORS

Answer 5

KOTs have a distinctive keratinized, thin epithelial lining with potential satellite microcysts. Radiographically, KOTs are radiolucent with scalloped margins, tend to grow along the internal jaw bone causing minimal expansion, and commonly occur in the posterior mandible. Clinically, they show a high recurrence rate and may present with mild swelling or secondary infection pain.



**WINSPERT
CUE CARDS**

**JAW CYSTS AND
TUMORS**

Question 6

What are lateral periodontal cysts, and how are they diagnosed and treated?



**WINSPERT
CUE CARDS**

JAW CYSTS AND TUMORS

Answer 6

Lateral periodontal cysts arise from epithelial rests lateral to tooth roots, usually asymptomatic and less than 1 cm. Radiographically, they appear as well-defined, round or oval radiolucencies mostly in the mandibular lateral incisor to second premolar region. Treatment is simple enucleation or excisional biopsy, with low recurrence risk.



**WINSPERT
CUE CARDS**

**JAW CYSTS AND
TUMORS**

Question 7

Describe the nasopalatine duct cyst and its common clinical and radiographic features.



**WINSPERT
CUE CARDS**

JAW CYSTS AND TUMORS

Answer 7

The nasopalatine duct cyst is a non-odontogenic cyst occurring in the nasopalatine canal, more common in males and often asymptomatic. Clinically, it may cause a small swelling near the palatine papilla. Radiographically, it appears as a well-defined, oval or heart-shaped radiolucency between central incisors, often causing root divergence.



**WINSPERT
CUE CARDS**

**JAW CYSTS AND
TUMORS**

Question 8

How are simple bone cysts (SBC) characterized and what is their usual treatment?



**WINSPERT
CUE CARDS**

JAW CYSTS AND TUMORS

Answer 8

Simple bone cysts are cavities within bone lacking an epithelial lining, often empty or containing fluid, commonly found in younger patients with male predominance. Radiographically they are smooth, oval or scalloped radiolucencies usually scalloping between tooth roots. Treatment is conservative opening and curettage, which promotes healing.



**WINSPERT
CUE CARDS**

**JAW CYSTS AND
TUMORS**

Question 9

What are the typical features and radiographic appearance of an ameloblastoma?



**WINSPERT
CUE CARDS**

JAW CYSTS AND TUMORS

Answer 9

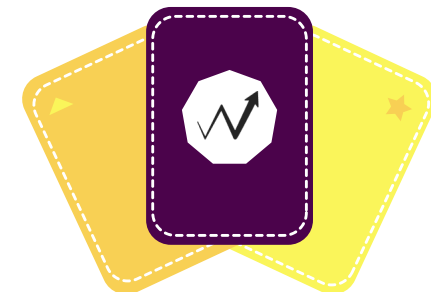
Ameloblastomas are benign but aggressive odontogenic tumors arising mostly in the mandibular molar-ramus region, showing slow growth and presenting with facial asymmetry. Radiographically, they are well-defined radiolucent lesions with curved cortical borders and internal septa creating honeycomb or soap bubble patterns, often causing root resorption and tooth displacement.

ORAL SURGERY

LA TECHNIQUES AND COMPLICATIONS



MIND MAP & CUE CARDS

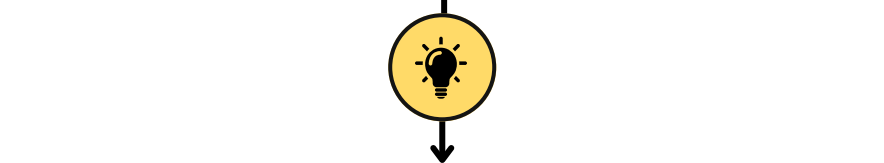


BY DR. JIGYASA SHARMA

WINSPERT



LOCAL ANESTHESIA TECHNIQUES AND COMPLICATIONS IN DENTISTRY



Understanding Pain & Local Anesthesia

- Pain is an unpleasant sensory and psychological experience linked to tissue damage.
- Local anesthesia manages pain safely and effectively during dental treatment.

Mechanism of Action of Anesthetic Agents

- Anesthetics bind reversibly to sodium channels, blocking nerve impulse propagation.
- Pain impulses do not reach the brain; patient experiences no pain.

Classification of Local Anesthetic Agents

- Amides: lidocaine, prilocaine, mepivacaine, bupivacaine (common in dentistry).
- Esters: less common, e.g., benzocaine for topical anesthesia.
- Lidocaine is the gold standard, often combined with adrenaline to prolong effect and reduce toxicity.

Infiltration Injection Techniques

- Submucous injection: under mucous membrane, mainly for soft tissue anesthesia.
- Supra-periosteal injection: outside periosteum; most common infiltration technique.
- Buccal infiltration: needle 2-3 mm into buccal sulcus adjacent to target tooth.
- Palatal infiltration: anesthetizes palatal gingiva; may be painful due to tight mucoperiosteum.

Regional (Nerve Block) Anesthesia Techniques

- Anesthetic injected near nerve trunk proximal to treatment site.
- Onset of analgesia in 4-5 minutes.
- Blocks pain in entire nerve distribution area.

Palatal Anesthesia Techniques

- Greater Palatine block: anesthesia to posterior hard palate.
- Nasopalatine block: anesthesia to anterior hard palate and palatal premaxilla.
- Palatal anesthesia can also be achieved via infiltration adjacent to the target tooth.

Types of Local Anesthesia in Dentistry

- Infiltration anesthesia: commonly used in maxilla.
- Block anesthesia: frequently used in mandible.

Methods of Local Anesthesia Administration

- Topical: applied to skin/mucosa, anesthetizes superficial nerve endings; onset ~3 mins.
- Infiltration: anesthetic near nerve terminals locally; onset 2-3 mins.
- Subdivisions of infiltration: submucous, supra-periosteal, buccal, palatal, sub-periosteal.

Specialized Injection Techniques

- Sub-periosteal injection: between periosteum and bone; painful.
- Intra-osseous injection: into medullary bone using drills and special needles.
- Intra-ligamentary injection: into periodontal ligament sulcus, for terminal nerve endings.
- Intra-pulpal anesthesia: direct injection into pulp chamber for pulpal procedures.

Maxillary Nerve Blocks

- Posterior Superior Alveolar (PSA) block: anesthetizes maxillary molars except mesio-buccal root of first molar.
- Middle Superior Alveolar (MSA) block: anesthetizes premolars and mesio-buccal root of first molar.
- Anterior Superior Alveolar (ASA) block: anesthetizes maxillary incisors and canines.
- Infraorbital block: anesthetizes ipsilateral maxillary teeth, soft tissues, and facial regions.

Summary and Clinical Relevance

- Choice of anesthetic and technique depends on site and type of dental procedure
- Awareness of painful techniques (e.g., sub-periosteal) and patient comfort methods is essential.
- Understanding onset times and areas anesthetized guides effective pain management.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 1

What is the primary mechanism by which local anesthetic agents work to prevent pain perception?



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CUE CARDS**

LA TECHNIQUES AND COMPLICATIONS

Answer 1

Local anesthetic agents work by reversibly binding to sodium channels, preventing sodium from entering the cells, which inhibits the propagation of nerve impulses so that nociceptive signals associated with pain do not reach the brain, and the patient does not perceive pain.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 2

What are the two main types of local anesthesia administration used in dentistry, and where are they typically applied?



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CUE CARDS**

LA TECHNIQUES AND COMPLICATIONS

Answer 2

The two main types are infiltration anesthesia, commonly used in the maxilla, and block anesthesia, which is frequently used in the mandible.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 3

What are the two chemical classes of local anesthetic agents, and which is most commonly used in dental practice?



**WINSPERT
CUE CARDS**

LA TECHNIQUES AND COMPLICATIONS

Answer 3

Local anesthetics are divided into amides and esters. Amide anesthetics (such as lidocaine, prilocaine, mepivacaine, and bupivacaine) are most commonly used in dentistry, with lidocaine considered the gold standard.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 4

What is the role of adrenaline when added to lidocaine in dental anesthesia?



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CUE CARDS**

LA TECHNIQUES AND COMPLICATIONS

Answer 4

Adrenaline is added to lidocaine to counteract its vasodilating properties, delay drug absorption, prolong the duration of anesthesia, and reduce the risk of toxicity.

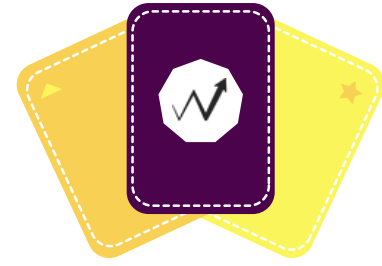


**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 5

Describe the infiltration method of local anesthesia administration and its common applications.



**WINSPERT
CUE CARDS**

LA TECHNIQUES AND COMPLICATIONS

Answer 5

Infiltration anesthesia involves depositing the anesthetic solution near terminal nerve fibers, allowing it to diffuse through tissues to block sensation in a localized area. It is commonly used for most teeth except lower molars, with analgesia occurring about 2 to 3 minutes after injection.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 6

What is the difference between submucous injection and supraperiosteal injection techniques in local anesthesia?



**WINSPERT
CUE CARDS**

LA TECHNIQUES AND COMPLICATIONS

Answer 6

Submucous injection deposits anesthetic just beneath the mucous membrane and is mainly used to anesthetize the long buccal nerve or for soft tissue surgery, but rarely anesthetizes the dental pulp. Supraperiosteal injection deposits anesthetic outside the periosteum where it infiltrates through the periosteum and bone to anesthetize nerve fibers, commonly used in areas like the maxilla.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 7

Which regional block is most commonly used to anesthetize the inferior alveolar nerve in the mandible?



**WINSPERT
CUE CARDS**

LA TECHNIQUES AND COMPLICATIONS

Answer 7

The direct inferior alveolar nerve block (IANB), also called the direct thrust approach, is the most commonly used technique to anesthetize the inferior alveolar nerve in the mandible.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 8

What are some common complications related to local anesthesia in dentistry?

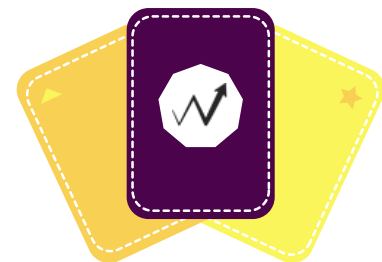


**WINSPERT
CUE CARDS**

LA TECHNIQUES AND COMPLICATIONS

Answer 8

Complications include local neurological issues (paresthesia, dysesthesia, temporary or rarely permanent nerve paralysis), trauma to tissues causing hematoma or trismus, equipment failure, and systemic toxicity such as neurological, cardiovascular, respiratory effects, allergic reactions, and rarely methemoglobinemia.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 9

What signs and symptoms indicate early systemic toxicity of local anesthetics?



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CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Answer 9

Early indicators include minor central nervous system effects such as restlessness, anxiety, dizziness, blurred vision, tremors, CNS depression, and drowsiness.



**WINSPERT
CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Question 10

Which local anesthetic agents are most commonly associated with methemoglobinemia?



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CUE CARDS**

**LA TECHNIQUES AND
COMPLICATIONS**

Answer 10

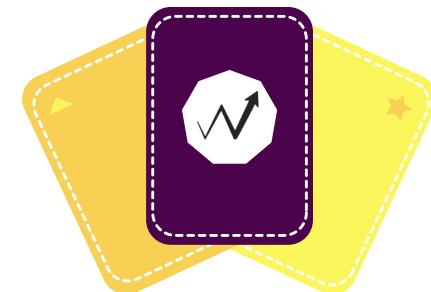
Prilocaine (especially above 600 mg) and benzocaine are most commonly associated with methemoglobinemia; it has also been occasionally reported with lidocaine, articaine, and tetracaine.

ORAL SURGERY

PYOGENIC GRANULOMA



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA

Etiology and Predisposing Factors

- Caused by reactive hyperplasia of connective tissue in response to local irritants like trauma and poor oral hygiene.
- Hormonal factors, especially in females during pregnancy, significantly influence its development.

Locations and Variants

- Commonly found on gingival mucosa and lips; pregnancy-associated form called granuloma gravidarum or epulis gravidarum.
- Usually occurs during the second or third trimester in pregnant females.

Differential Diagnosis

- Fibrous epulis is firmer, less vascular, rarely ulcerated, and arises from fibrous hyperplasia linked to irritants.
- Diagnosis primarily clinical but confirmed by histopathology to exclude malignancy or other lesions.

Management Strategies

- Initial management includes elimination of irritants, oral prophylaxis, and improved oral hygiene.
- Complete surgical excision is the definitive treatment to prevent recurrence.

Prognosis and Recurrence

- No malignant potential but may recurrently bleed or ulcerate.
- Partial excision or curettage increases risk of recurrence; complete removal is preferred.

Summary of Key Points

- Pyogenic granuloma is a benign hyperplastic vascular lesion responsive to irritants and hormones.
- Early diagnosis and complete excision with removal of triggers ensure best outcomes and prevent recurrence.

WINSPERT MIND MAP PYOGENIC GRANULOMA

Definition and Nature

- Pyogenic granuloma is a benign vascular tumor arising on skin and mucous membranes.
- The term is a misnomer; it neither contains pus nor is a true granuloma.

Clinical Presentation

- Appears as a painless, mostly pedunculated, soft, vascular mass that bleeds easily
- Lesion colors vary: pink, red, reddish-brown, or purple, often ulcerated with rapid growth.

Pathogenesis and Histology

- Lesion consists of lobular aggregates of capillary-sized vessels within highly vascular granulation tissue.
- Contains thin-walled capillaries embedded in loose fibrous stroma with scattered inflammatory cells.

Diagnostic Approach

- History should review trauma, pregnancy, medications; biopsy required if diagnosis uncertain.
- Histopathology essential for confirmation and to rule out sinister lesions.

Special Considerations in Pregnancy

- Oral hygiene and prophylaxis prioritized; surgical excision avoided due to recurrence risk.
- Lesions often resolve spontaneously after delivery.

Patient Counseling and Advice

- Patients need reassurance about benign nature and counseling on avoiding trauma.
- Warn about recurrence risk and possible scarring after surgery; treatment decisions made jointly.

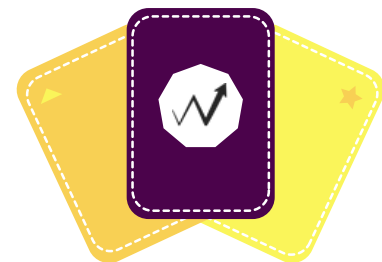


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CUE CARDS**

**PYOGENIC
GRANULOMA**

Question 1

What is a pyogenic granuloma and why is the term considered a misnomer?

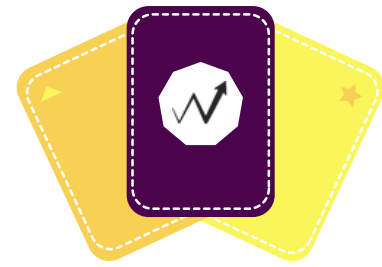


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CUE CARDS**

**PYOGENIC
GRANULOMA**

Answer 1

A pyogenic granuloma is a common, acquired, benign vascular tumor that arises in tissues such as the skin and mucous membranes. It is a reactive hyperplasia of connective tissue in response to local irritants, characterized by a highly vascular lesion that bleeds easily. The term "pyogenic granuloma" is a misnomer because the lesion does not contain pus ("pyogenic") and is not truly a granuloma histologically.



**WINSPERT
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**PYOGENIC
GRANULOMA**

Question 2

What causes or contributes to the development of pyogenic granuloma?



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**PYOGENIC
GRANULOMA**

Answer 2

Pyogenic granuloma arises due to local irritants such as trauma, poor oral hygiene, calculus, or irritation from dental restorations. Hormonal factors, especially female sex hormones during pregnancy, and certain drugs can also act as triggers. Approximately one-third of lesions occur due to trauma or irritation.



**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Question 3

Which population and clinical context is most commonly associated with the variant known as "pregnancy tumor" or "epulis"?



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CUE CARDS**

**PYOGENIC
GRANULOMA**

Answer 3

The pregnancy tumor or epulis, a variant of pyogenic granuloma, commonly occurs in females during the second or third trimester of pregnancy. It is linked to elevated steroid hormone levels and mostly appears on the gingiva of pregnant women.



**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Question 4

Describe the typical clinical presentation of pyogenic granuloma.



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CUE CARDS**

**PYOGENIC
GRANULOMA**

Answer 4

Pyogenic granuloma typically appears as a painless, solitary, red or reddish-brown pedunculated or sometimes sessile mass, mostly on the gingiva or mucosa. It is soft, highly vascular, friable, bleeds easily, and often has an ulcerated surface. The lesion shows rapid growth and may be pink, red, or purple in color.



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CUE CARDS

**PYOGENIC
GRANULOMA**

Question 5

What is the most scientifically accurate term for pyogenic granuloma based on its histological features?

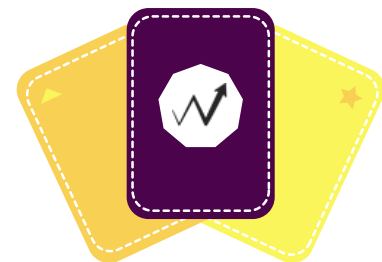


**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Answer 5

The most scientifically accurate term for pyogenic granuloma is "lobular capillary hemangioma," reflecting its lobular aggregates of capillary-sized blood vessels seen microscopically.



**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Question 6

How does a fibrous epulis differ from a pyogenic granuloma in terms of clinical features?



**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Answer 6

A fibrous epulis is a firm, fibrous hyperplastic nodule that is usually not ulcerated and does not bleed readily, unlike the more vascular, friable pyogenic granuloma. Fibrous epulis may develop from pyogenic granuloma through fibrous tissue maturation and is similarly associated with local irritants.



**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Question 7

What histopathological features characterize pyogenic granuloma?



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CUE CARDS**

**PYOGENIC
GRANULOMA**

Answer 7

Histologically, pyogenic granuloma consists of lobular aggregates of capillary-sized vessels with central feeder vessels, embedded in highly vascular granulation tissue. The stroma is loose and fibrous, containing scattered fibroblasts and mixed inflammatory cells such as lymphocytes, neutrophils, plasma cells, and mast cells, resembling normal granulation tissue.



WINSPERT
CUE CARDS

**PYOGENIC
GRANULOMA**

Question 8

What non-surgical management techniques are recommended for pyogenic granuloma, especially during pregnancy?



**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Answer 8

Non-surgical management includes elimination of causative local irritants, removal of calculus, and improved oral hygiene to induce partial or occasional complete resolution. During pregnancy, oral prophylaxis and oral hygiene instructions are preferred to avoid surgical intervention and because surgical excision carries a higher risk of recurrence in pregnancy.



**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Question 9

What is the definitive treatment for pyogenic granuloma and why is complete excision preferred?

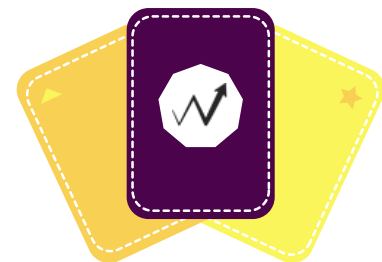


**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Answer 9

The definitive treatment of pyogenic granuloma is complete surgical excision of the lesion, along with elimination of any predisposing factors. Complete excision is preferred because partial removal by shave excision or curettage often leads to recurrence. For recurrent lesions, complete excision is again warranted.



**WINSPERT
CUE CARDS**

**PYOGENIC
GRANULOMA**

Question 10

What advice should be given to patients regarding pyogenic granuloma and its management?



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**PYOGENIC
GRANULOMA**

Answer 10

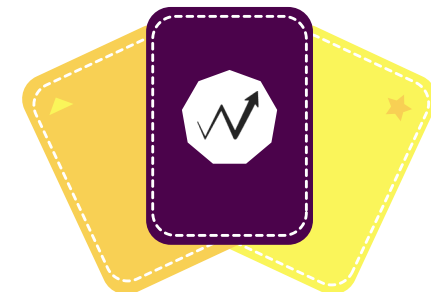
Patients should be reassured that pyogenic granuloma is benign with no malignant potential. They should be advised to avoid trauma or picking at the lesion to prevent secondary infection. Counseling should include information about the risk of recurrence after partial excisions and the possibility of scarring following surgery. Treatment decisions should be made jointly with the healthcare provider considering the risks and benefits.

ORAL SURGERY

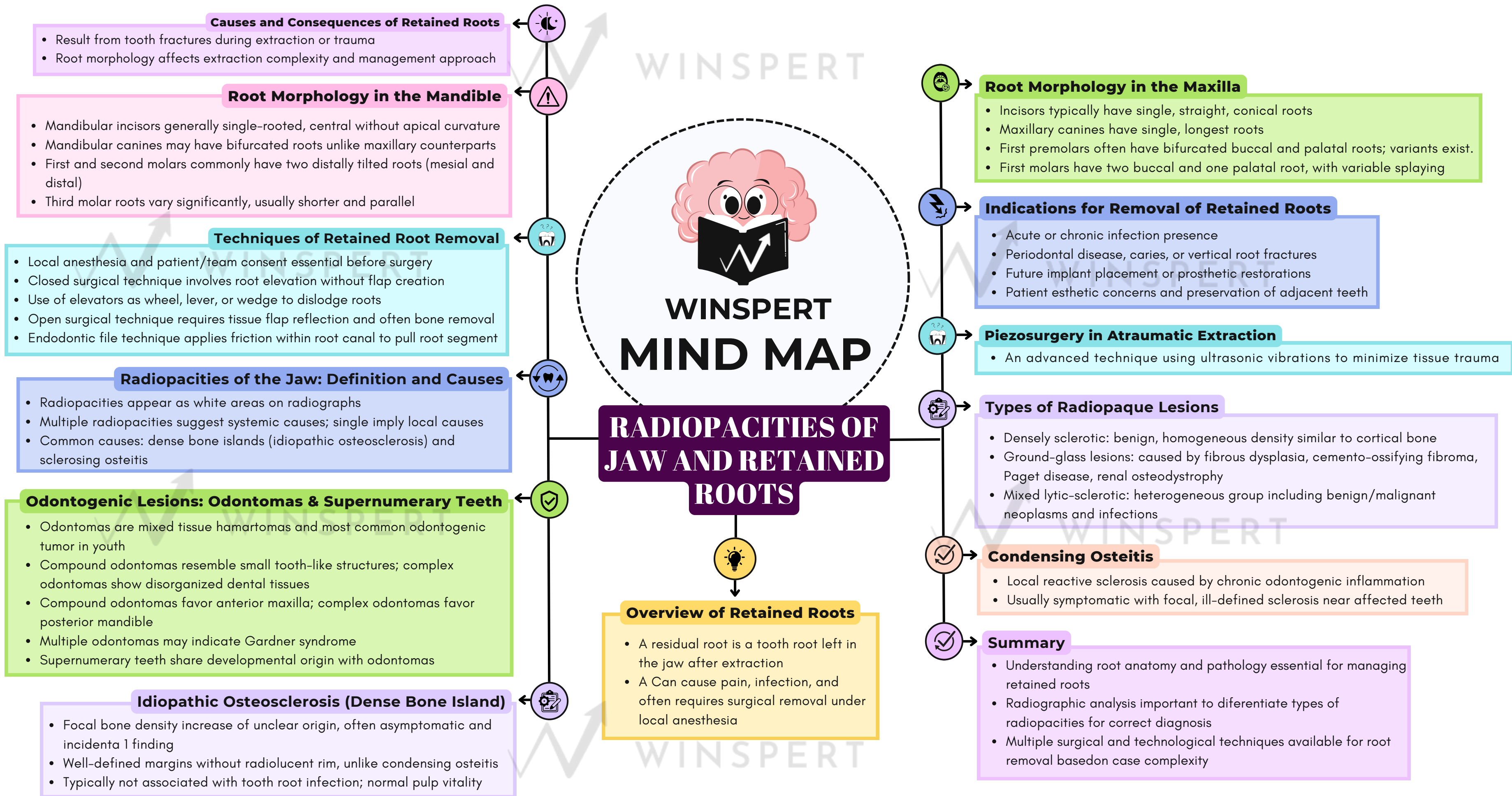
RETAINED ROOTS/ ODONTOMAS/ RADIOOPACITIES OF JAW



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA





**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 1

What is a retained root in dental context, and what problems can it cause?



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CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 1

A retained root is a tooth root left in the jaw after a previous extraction. It can cause problems such as pain and infection and usually requires surgical removal under local anesthetic.



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 2

What are the typical root morphologies of maxillary central and lateral incisors and maxillary canines?



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CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 2

Maxillary central and lateral incisors typically have single, straight, conical roots. Maxillary canines are also single-rooted and have the longest roots among all teeth.



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 3

**Describe the root anatomy of
maxillary first and second
premolars.**



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 3

The maxillary first premolar often has a long root trunk with bifurcated buccal and palatal roots, though single root variants exist. The maxillary second premolar is usually single-rooted and rarely bifurcated.



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CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 4

What are the common root characteristics of mandibular first and second molars?



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 4

Mandibular first and second molars usually have two distally tilted roots: a mesial and a distal root. The second molar roots are typically shorter with less splay than the first molar roots.



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 5

List some indications for the removal of retained tooth roots.

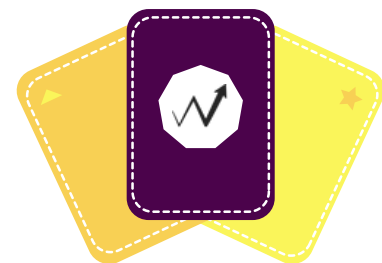


**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 5

Indications include acute or chronic infection, partial or complete crown fracture, future dental implant placement, pain, vertical root fractures, periodontal disease, caries, presence of pathology, future prosthetic restoration, preservation of adjacent teeth, esthetic concerns, and sometimes prophylactic removal in asymptomatic patients.



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 6

What are the three fundamental physical concepts used when using dental elevators to remove retained roots?



**WINSPERT
CUE CARDS**

Answer 6

The three concepts are:

- 1) Wheel,**
- 2) Lever, and**
- 3) Wedge.**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 7

**What is the difference
between the closed and open
surgical techniques for
retained root removal?**



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 7

The closed technique involves elevating and luxating the root from the socket coronally without creating a mucoperiosteal flap. The open technique requires reflecting a tissue flap and often removing cortical bone for better visualization and surgical access.



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 8

How does the endodontic file technique assist in removing retained root segments?



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CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 8

An endodontic file is inserted through the root canal orifice and advanced apically until friction develops in the canal. The file's contact surface generates pullout force on the root segment, aiding in coronal extraction.



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 9

**What are the two most
frequent causes of
radiopacities in the jaws?**

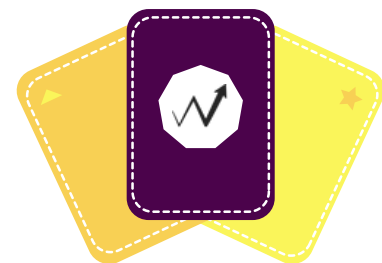


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CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 9

Dense bone islands (idiopathic osteosclerosis) and sclerosing osteitis are the two most frequent causes of radiopacities in jaw radiographs.



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Question 10

What distinguishes idiopathic osteosclerosis from condensing osteitis radiographically and clinically?



**WINSPERT
CUE CARDS**

**RETAINED ROOTS/
ODONTOMAS/
RADIOPACITIES OF JAW**

Answer 10

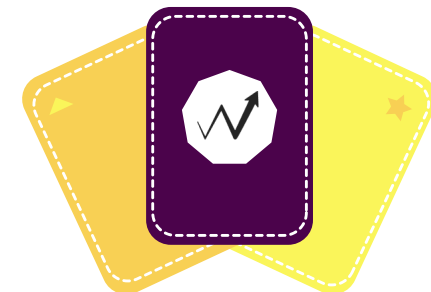
Idiopathic osteosclerosis shows a well-defined sclerotic focus with no radiolucent rim, is usually asymptomatic, and often incidental. Condensing osteitis appears as ill-defined focal sclerosis associated with chronic inflammation and symptoms, usually related to periodontal or endodontic disease.

ORAL SURGERY

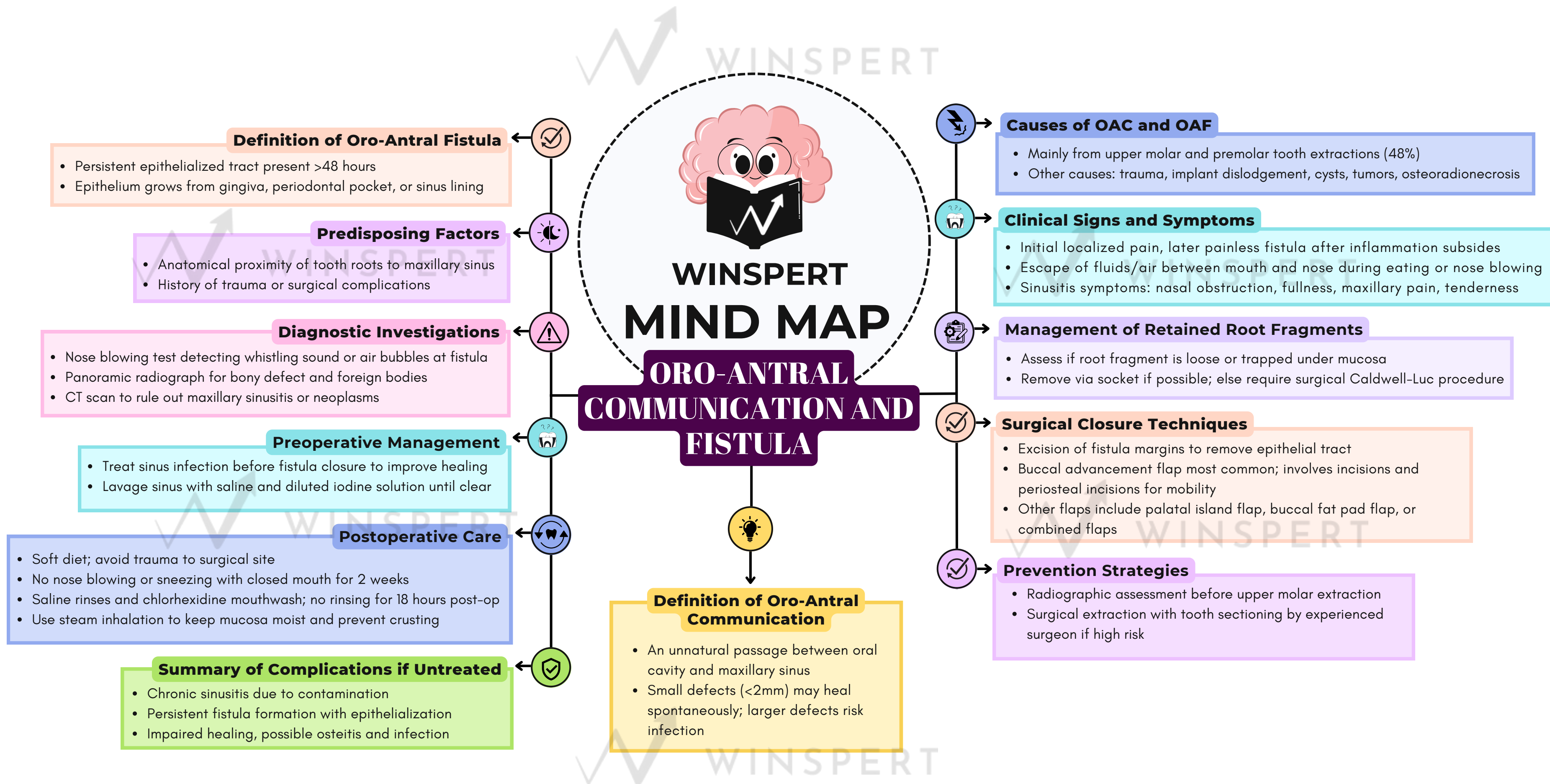
OROANTRAL COMMUNICATION AND FISTULA



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA





**WINSPERT
CUE CARDS**

**OROANTRAL
COMMUNICATION
AND FISTULA**

Question 1

**What is oro-antral
communication (OAC)?**



**WINSPERT
CUE CARDS**

OROANTRAL COMMUNICATION AND FISTULA

Answer 1

Oro-antral communication is an unnatural opening between the oral cavity and the maxillary sinus, which may close spontaneously if small, but larger defects can lead to sinus infections and require surgical closure.



**WINSPERT
CUE CARDS**

**OROANTRAL
COMMUNICATION
AND FISTULA**

Question 2

How do defects smaller than 2 mm in oro-antral communication typically heal?



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CUE CARDS**

OROANTRAL COMMUNICATION AND FISTULA

Answer 2

Defects smaller than 2 mm can heal spontaneously through blood clot formation and secondary healing, provided there is no maxillary sinus infection.



**WINSPERT
CUE CARDS**

**OROANTRAL
COMMUNICATION
AND FISTULA**

Question 3

**What defines an oro-antral
fistula (OAF)?**



**WINSPERT
CUE CARDS**

OROANTRAL COMMUNICATION AND FISTULA

Answer 3

An oro-antral fistula is a persistent epithelialized communication between the maxillary sinus and the mouth that remains open for more than 48 hours, with epithelium lining the tract.



**WINSPERT
CUE CARDS**

**OROANTRAL
COMMUNICATION
AND FISTULA**

Question 4

What causes oro-antral fistula formation?



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Answer 4

OAF forms when an oro-antral communication fails to close spontaneously, remains open, and the oral epithelium migrates into the defect, epithelializing it usually after 48-72 hours.



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Question 5

What are the most common causes of oro-antral communications and fistulas?



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Answer 5

The majority result from dental extractions, especially upper molars and premolars due to their proximity to the maxillary sinus. Other causes include malignant tumors, trauma, infections, implant complications, and surgical procedures like Caldwell-Luc.



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Question 6

**What symptoms characterize
an oro-antral communication
or fistula?**



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Answer 6

Symptoms include initial localized pain at the tooth socket, escape of fluids from mouth to nose when eating, air or fluids passing into the mouth on blowing the nose, nasal regurgitation of liquids, and possibly sinusitis symptoms such as nasal obstruction and maxillary pain.



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Question 7

Which clinical test is used to detect a small oro-antral communication?



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Answer 7

The nose blowing test: the patient closes their nostrils and gently blows with their mouth open, observing for whistling sounds, air bubbles, or fluid passage through the fistula.



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Question 8

What imaging techniques help diagnose and assess oro-antral communications or fistulas?



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Answer 8

Panoramic radiographs are used to estimate bony defect size and check for foreign bodies or roots, while computed tomography (CT) can rule out maxillary sinusitis. Additional radiographs at different angles may help localize root fragments.



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Question 9

What is the common surgical technique for closing an oro-antral fistula?



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Answer 9

The buccal advancement flap is the most common technique, involving creating incisions, elevating a mucoperiosteal flap, making periosteal releasing incisions to advance the flap, and suturing it over the defect.



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Question 10

What postoperative instructions are important for patients after oro-antral fistula repair?



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Answer 10

Patients should avoid hard food, blow their nose or sneeze with an open mouth, avoid strenuous activities, not use straws or smoke, keep the wound clean with saline rinses, use decongestants and chlorhexidine mouthwash, and avoid tongue movement over the suture line to ensure successful healing.