UAF VOL 2

ULTIMATE ADVANCE FILE

P.O.W.E.R

PREPARATION OF ADC WITH WINSPERT EXPERT REVIEW

NOTES

ENDODONTICS

By Dr. Jigyasa Sharma

Dear Students,

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Thank you for your understanding and continued dedication.

Best regards,
WINSPERT TEAM

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R.A.S.H TECHNIQUE

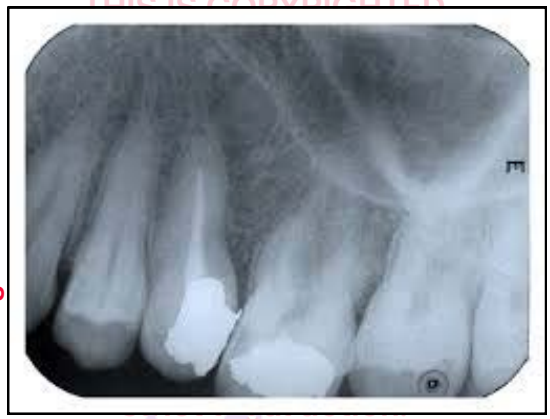
R- RULE OUT
A-DOES IT ANSWER OUR QUESTION
S- SEQUENCE WISE WHAT COMES 1ST
H-WHAT IS GIVEN IN THE HISTORY

SOLVE ADC QUESTIONS AT
lightning speed!

ENDODONTICS

SBQ 1

AS YOUR DENTAL COLLEAGUE IS ON MATERNITY LEAVE, SHE HANDED OVER A PATIENT WITH ALL RELEVANT DETAILS (CLINICAL RECORDS AND RADIOGRAPHS). PATIENT COMES TO YOU COMPLAINING OF 16, YOU TOOK IOPA AND YOU NOTICE THE INTERNAL RESORPTION IN 14 AND YOU TELL THE PATIENT AND PLAN TO TREAT 16 AND EXTRACT 14. WHEN YOU CHECKED PAST RECORDS, IT WAS WRITTEN IN THE CLINICAL RECORDS THAT YOUR COLLEAGUE HAD INFORMED THE PATIENT ABOUT INTERNAL RESORPTION AND DISCUSSED ABOUT 14. IT WAS OBSERVED IN THE RADIOGRAPH TAKEN 5 YEARS AGO. BUT THE PATIENT IS TELLING YOU THAT YOUR COLLEAGUE DIDN'T TELL HIM ABOUT THE ROOT RESORPTION.



I. What will you do?

A. Empathise the patient about the situation
B. Contact your indemnity insurer for advice
C. Print the clinical notes and show him.
D. Refer to oral surgeon
E. Refer them for a second opinion to another dentist

II. How will you manage ?

A. Refer to the endodontist
B. Start root canal treatment now
C. Wait and observe

III. After showing her evidence also, she's not agreeing and wants to complain to AHPRA, what will u do?

A. Give a copy of record
B. Ask her to call the previous dentist
C. Give her original records

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P.O.W.E.R NOTES SBQ 1

I.
- Previous dentist has informed about the root resorption and the records are available. So, theirs is no need of empathizing as it was well explained prior. Option (A) gets ruled out.
- 1st try to show the evidence. Among the given option (C) is the best.
- If the patient mentioned that, even though it's there in the records the doctor did not explain it to her, in that situation there's no use of showing a copy of the records. you need to get an advice from the indemnity insurer. If option (C) is not working then the next option would be (B).
- It's an ethical issue and not a clinical suggestion. Options (D) and (E) get ruled out.

Reference:

5. Possible consequences of not obtaining consent for treatment

Dentists must obtain the consent of a patient before providing treatment to that patient. Failure to obtain consent can give rise to any one or more of the following:

1. a cause of action against the dentist in assault or battery;
2. a negligence claim; or
3. a complaint of professional misconduct.

(b) In determining what information to provide to a patient, a dentist should have regard to the following:

(i) the nature of the condition and its prognosis;

(ii) the nature of the proposed treatment - the proposed approach to the investigation, diagnosis and treatment;

(iii) other options for investigation, diagnosis and treatment;

(iv) the degree of uncertainty of any diagnosis arrived at;

(v) the degree of uncertainty about the therapeutic outcome;

(vi) the likely consequences of not choosing the proposed treatment;

(vii) the likelihood and nature of any adverse outcomes from the procedure/treatment;

(viii) the overall health and other circumstances of the patient;

(ix) the known or likely wishes of the patient;

(x) the maturity and cognitive capacity of the patient;

(xi) any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention; and

(xii) information about risks of any treatment, especially those that are likely to influence the particular patient's decisions. Known risks should be disclosed when an adverse event is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare.

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P.O.W.E.R NOTES SBQ 1

I. Reference:

(c) **Consents and restrictions on disclosure**

The dental record should include:

(i) a record of consents provided by the Patient. Please refer to the ADA's Policy Statement 5.15 *Consent to Treatment*;

(ii) if written consent is provided, the signed consent form;

(iii) if a patient information sheet has been provided to the patient, a copy of the patient information sheet or reference to the name and version/date of the patient information sheet;

(iv) if written consent is not provided, then:

- a description of the treatment as explained to the patient; and
- the consents provided by the patient, including consent to treatment, privacy consents and financial consent;

(v) advice given to the patient on:

- treatment options
- the relevant material risks and benefits of those options
- pre- and post-treatment instructions
- likely outcomes

(vi) relevant questions, comments or concerns expressed by patients over offered treatments;

(vii) any treatment advice that the patient was unwilling to accept;

(viii) any comments or complaints by patients about treatment provided;

(ix) if there are any restrictions on disclosures, including in relation to any directions from the patient or family law restrictions;

(x) if the patient has made a direction in relation to care, such as a restriction on blood transfusions, etc;

(xi) subject to discrimination laws, for workplace health and safety reasons you may wish to include a "flag" on the medical record for the treating provider within your dental practice to contact you, for example, if a patient has previously displayed aggression or inappropriate behaviour towards staff so that appropriate staff can be involved in treating the patient; and

(xii) if English is not the patient's first language, and if an interpreter is required to assist in communicating with the patient.

Ii. If the level of difficulty exceeds your experience and comfort, you might consider referral to an endodontist.

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P.O.W.E.R NOTES SBQ 1

II. If the level of difficulty exceeds your experience and comfort, you might consider referral to an endodontist.

Reference:

LEVELS OF DIFFICULTY

MINIMAL DIFFICULTY
Preoperative condition indicates routine complexity (uncomplicated). These types of cases would exhibit only those factors listed in the MINIMAL DIFFICULTY category. Achieving a predictable treatment outcome should be attainable by a competent practitioner with limited experience.

MODERATE DIFFICULTY
Preoperative condition is complicated, exhibiting one or more patient or treatment factors listed in the MODERATE DIFFICULTY category. Achieving a predictable treatment outcome will be challenging for a competent, experienced practitioner.

HIGH DIFFICULTY
Preoperative condition is exceptionally complicated, exhibiting several factors listed in the MODERATE DIFFICULTY category or at least one in the HIGH DIFFICULTY category. Achieving a predictable treatment outcome will be challenging for even the most experienced practitioner with an extensive history of favorable outcomes.

Review your assessment of each case to determine the level of difficulty. If the level of difficulty exceeds your experience and comfort, you might consider referral to an endodontist.

CRITERIA	MINIMAL DIFFICULTY	MODERATE DIFFICULTY	HIGH DIFFICULTY
RESORPTION	No resorption evident	Minimal apical resorption	• Extensive apical resorption • Internal resorption • External resorption

III.
- The previous dentist is on pregnancy leave, we can inform her that this situation is happening right now.
- But the patient wants to complain AHPRA. She was not happy even after showing the records. So, option (B) gets ruled out.
- We cannot give the original records to the patient, but we can give a copy of records to make a complain. It's patient right to make a complain.
- So, among the given option (A) is the best answer.

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SBQ 2

PATIENT COMES WITH UPPER MOLAR CARIES. SHE IS GETTING TREATED FOR CHRONIC NEUROPATHIC PAIN. AFTER EXAMINATION YOU DECIDED TO DO ROOT CANAL TREATMENT. YOU FOUND PALATAL MESIAL AND DISTAL CANAL, COMPLETE DEBRIDE AND OBTURATE AND RESTORE.

I. Patient comes after 5 days complaining of pain in that region. What could be the most possible reason?

A. Presence of extra roots or root canals
B. Extended gp
C. Her neuropathic pain has made her sensitised to dental pain

P.O.W.E.R NOTES SBQ 2

I.
- 80% of upper 1st molars have (MESIAL-MB1, Mb2), DISTAL and PALATAL canals.
- In the scenario it's mentioned that only 3 canals have been treated.
- Pain started coming after 5 days can be due to failure of RCT. This can be due to left over bacteria in the canals, missing canals, infected necrotic pulpal remnants.
- Among the given options, option (A) is the best.

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SBQ 3

RCT WAS DONE FOR A PATIENT. XRAY OF 36. TWO MESIAL AND 1 DISTAL CANALS WERE OBTURATED. PATIENT REPORTED AFTER 2-3 DAYS COMPLAINING OF SEVERE PAIN.

I. What is the most common reason for this pain?

A. Missed roots/canals
B. Over extruded sealer
C. Over instrumentation

II. You did pulp extirpation and did temporary restoration. Will you charge for the temporary restoration?

A. Charge him in full payment for temporary restoration
B. Charge him if more than one cavity was filled/wall was missing
C. Charge him half the price as the patient is on follow up
D. Don't charge him as it is a part of the root canal procedure

P.O.W.E.R NOTES SBQ 3

I.
- Most common cause for pain few days after RCT is the because of entrapped bacteria in the canal, incomplete obturation, left over necrotic pulp.
- Over extrusion of sealer and over instrumentation can cause pain soon after RCT on the same day.
- MMC – middle mesial canal which is seen in between the mesio- buccal and the mesio-lingual. This canal is very commonly missed. MMC is seen up to 80% in mandibular molars.
- There can be 2nd distal canal. But MMC is the most missed canal.

II.
- RCT is charged for the stages involved with it.
- Single visit RCT has a different cost compared to the multiple visit RCT.
- It also depends on the presence and absence of abscess, infection, inflammation etc and challenges associated with the RCT.
- Missing a canal is an error/ mistake that happened from the dentist's side. therefore, charging the patient for treating the missed canal would be wrong as it's a part of the root canal procedure.

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SBQ 4

A LADY CAME COMPLAINING OF UPPER BACK REGION SWELLING, ROOT STUMPS/GROSSLY DECAYED TEETH IDENTIFIED ON CLINICAL PICTURE.SHE SAID SHE GOT OCCASIONAL PAIN FROM THOSE TEETH.

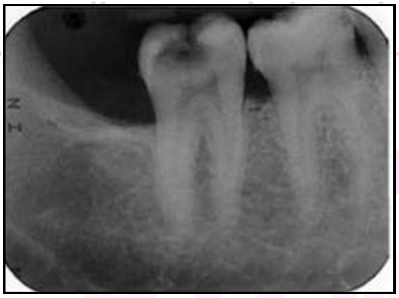
I. How will you identify the cause?

A. Percussing on all the teeth of the quadrant
B. Iopa
C. OPG
D. Probing

II. What specific question will you ask to differentiate from maxillary sinusitis?

A. Bending down increases the pain
B. How long the common cold persists

III. An xray was given of lower molar, in which the dentist observed considerable amount of reactionary dentine and pulp horn was low. What will be the immediate management option for the molar?



A. Dentine bonding and composite restoration
B. Caoh2 lining and composite restoration
C. GIC

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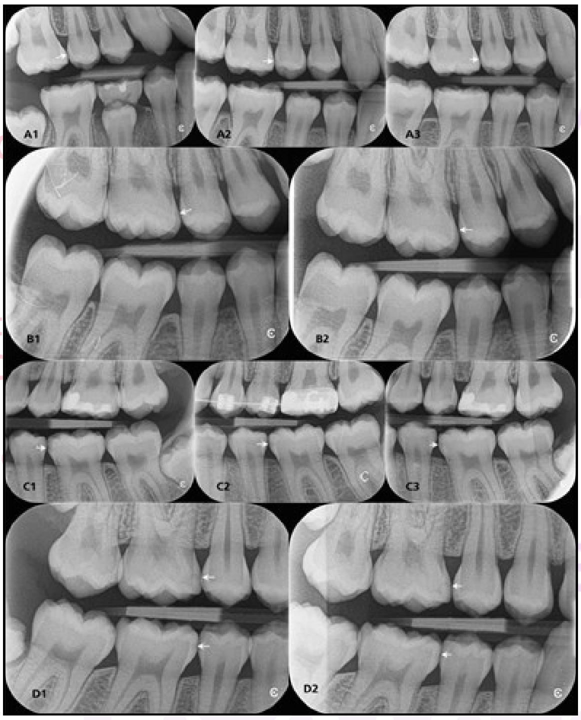
SBQ 4

IV. Full mouth bitewings were given. What will you do for this patient? (the radiograph had many c1,c2, some c3 proximal lesions)

A. Fluoride varnish
B. Review the patient in next appointment
C. Remove caries and restore
D. Fluoride gel



V. You want to diagnose if the caries is active or not , how can you recognize?

A. Color
B. Size
C. Texture
D. Depth

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P.O.W.E.R NOTES SBQ 4

I.
- There is infection going on – swelling in the upper back region
- Source of infection-root stumps/ grossly decayed teeth
- Provisional diagnosis – infected root stumps
- It's a localised swelling. So, it can be due to a periapical abscess or periodontal abscess.
- In the presence of facial swelling and reduced mouth opening can be related with spreading odontogenic infection.
- When a patient is already in pain percussion on all the teeth is not something good to perform. And all teeth can give positive response to percussion. Option (A) is ruled out.
- There can be increased probing depth in all root stumps due to inflammation. So, option (D) is not the best answer.
- To confirm the diagnosis and identify the cause, XRAY is required.
- Need to see the periapical area of the tooth. IOPA is helpful in this case.
- In the scenario it's clearly mentioned "upper back region". Therefore, full mouth XRAY (OPG) is not required.

II. Presence of upon bending down is a classic sign of maxillary sinusitis.

III.
- There's already 2-3mm reactionary dentin present. Reactionary dentin is harder. More sclerosed and more resistant to secondary caries. Caries is already arrested because of the formation of reactionary dentin.
- Cavity is not that deep. Therefore, IPC is not required. Calcium hydroxide lining is an IPC technique.
- We can directly restore the tooth with composite restoration.
- GIC is not a final restoration.

IV.
- C1, C2, C3 caries are not restored. But fluoride application is done. Option (C) is ruled out.
- Doing not treatment is not a good option as caries might progress further. Option (B) is ruled out.
- Among fluoride gel and fluoride varnish, fluoride varnish is the best. As the patient is at a high caries risk. (A) is the best option given among all.

REFERENCE:

Table 6. Protocol for the management of lesions in permanent teeth diagnosed clinically (ICDAS II) or from bitewing radiographic images in relation to children and adolescents

Lesion code		Management
ICDAS II	1–2	• Apply fluoride varnish to (1) arrest and remineralize active lesions and (2) maintain arrested lesions
	3–4	• Restore with UCSR* *only if* associated radiolucency extends deeper than C4 *otherwise* apply resin-based sealant and review in 6 months (bitewings)
	5	• Restore with UCSR*
	6	• Restore
Bitewing	C1	Do not restore – apply topical fluoride and monitor
	C2	Do not restore – apply topical fluoride and monitor
	C3	Do not restore – apply topical fluoride and monitor
	C4	Do not restore *without further consideration*
	C5	Restore now
		
Further consideration of C4 surfaces		• If possible, separate teeth and restore *only if* cavitated is revealed • If *not possible to separate*, restore only if radiolucency extends *fully* ½ through dentine • Otherwise, do not restore because it is more likely than not that the approximal surface – is *not* cavitated – and lesion progression *could be* arrested or *has already* arrested • Implement preventive strategy to: – arrest active lesions – remineralize lesions – maintain arrested lesions

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P.O.W.E.R NOTES SBQ 4

V.
- Size and depth are not the criteria to see whether the lesion is active or not. options (B) and (D) get ruled out.
- Black caries is mostly arrested caries. Yellowish-brown caries is mostly active caries.
- White lesion- rough and chalky – active
- White lesion -smooth- arrested
- Black lesion- rough and soft – active
- Black lesion- hard, smooth and shiny- arrested
- Therefore, more than the colour, the texture become an important criterion.

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SBQ 5

THE PATIENT HAD OCCLUSAL CARIES ON EXCAVATING THE CARIES; IT WAS CLOSE TO PULP SO A BARRIER OF CALCIUM HYDROXIDE WAS GIVEN AND RESTORATION WAS PLACED, AT THAT TIME HER PERIODONTITIS WAS DIAGNOSED TO BE STAGE 2 GRADE A (PATIENT HAD PRIOR 7 MM POCKET TOOTH ON 27 OCCLUSAL RESTORATION). AFTER INITIAL APPOINTMENT PATIENT WAS PUT ON RECALL AFTER 4 MONTHS, AND IN THAT APPOINTMENT SHE CAME BACK WITH PAIN AND TOOTH HAD PROGRESSED TO IRREVERSIBLE PULPITIS.SHE ALSO HAS DIABETES.

I. Asking about the lesion, what is the diagnosis DM

A. True combined lesion
B. Primary perio secondary endo
C. Primary endo
D. Primary endo secondary perio
E. Primary perio

II. What treatment will u do now? TE

A. Access opening debride the pulp
B. Scaling and review after 3 months

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P.O.W.E.R NOTES SBQ 5

I.
- In this tooth, it had a pre-existing independent periodontal problem- patient had a 7mm periodontal pocket
- it had a pre-existing independent endodontic problem- deep cavity closer to pulp and restored with Ca (OH)2 lining.
- Both the conditions are present independently.
- All the true combined lesions appear similar in both clinically and radiographically.
- Proper history is needed to identify and understand the endo-perio lesions.
- Two separate conditions which require 2 separate treatments is a true combined lesion.

REFERENCE:

True combined lesions

Probably the least common type of the 'endodontic – periodontal' lesions, true combined lesions really are where two worlds meet. They are formed when endodontic disease travelling coronally meets a concurrent, but otherwise unrelated infected periodontal pocket as it deepens apically along the root.[52] True combined lesions may be clinically and radiographically indistinguishable from primary endodontic, secondary periodontal and primary periodontal, secondary endodontic conditions. Because true combined lesions are essentially two separate conditions, management must involve both endodontic and periodontal treatment.

Due to the nature of combined lesions, the amount of bone loss is generally substantial and this has a negative impact on prognosis. This reduced prognosis must be disclosed and taken into consideration when recommending treatment options to patients. In multirooted teeth where the condition is localized to one particular root, hemisectioning of the tooth or resection of the affected root may be considered if the tooth is amenable and the patient motivated. Extraction is often the end result in single-rooted teeth.

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P.O.W.E.R NOTES SBQ 5

II.
- 1st treatment would be endodontic treatment. prognosis is decided by the periodontal condition.
- There is a waiting period to start to periodontal treatment. waiting period is 6months.

REFERENCE:

Non-surgical treatment of endodontic-periodontal disease

The treatment of endodontic-periodontal conditions usually involves a multi-disciplinary approach. The sequencing and emphasis of treatment may be dictated by the primary disease, if this can be determined during the diagnostic phase, but such a determination is not always possible.

Generally, treatment involves initiating endodontic treatment followed by a period of monitoring, thus allowing the endodontic component of the disease to settle. It is often only after this monitoring phase that the extent of the endodontic contribution can be fully assessed. This, in turn, allows for a more accurate assessment of the periodontal condition and periodontal treatment needs. In combined lesions, the prognosis is heavily influenced by the extent of the periodontal attachment loss, and significant attachment loss has a negative effect on prognosis and tooth survival.[46,53,54]

The length of the monitoring period before periodontal treatment is commenced is contentious, and recommendations range from immediate treatment to a delay of up to six months. A systematic review on

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