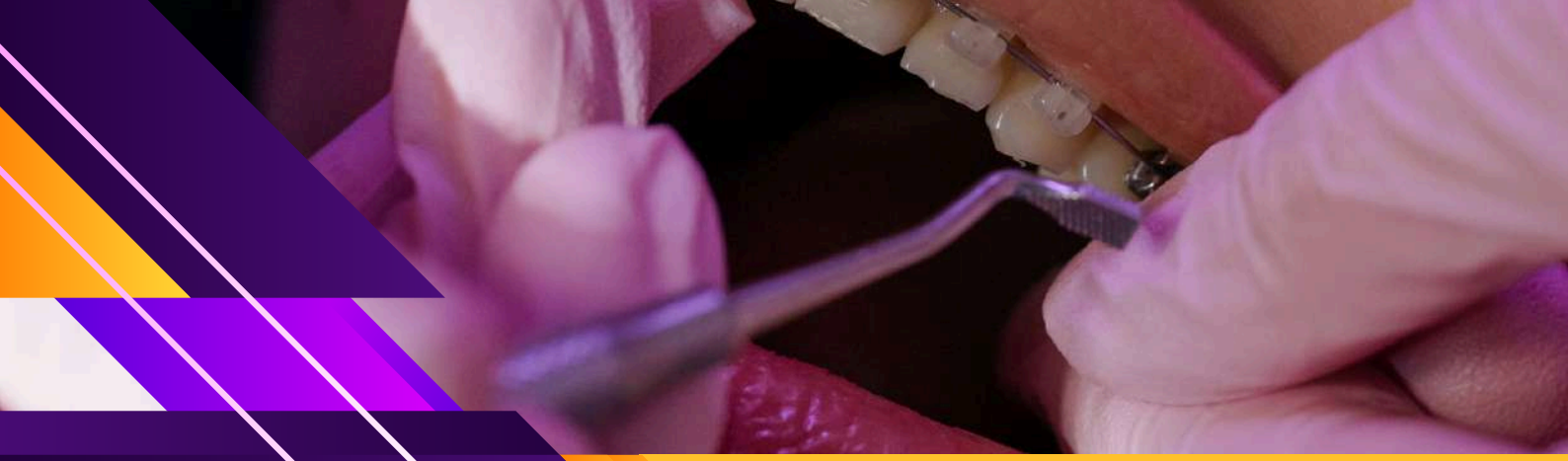

WINSPERT

WINSPERT P.O.W.E.R NOTES

PREPARATION OF ADC WITH WINSPERT EXPERT REVIEW

By Dr. Jigyasa Sharma

Dear Students,

We'd like to remind you about the importance of respecting the integrity of the resources provided in our app.

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We're committed to providing you with the best tools for your success, and we appreciate your cooperation in maintaining a fair and secure learning environment.

Thank you for your understanding and continued dedication.

Best regards,
WINSPERT TEAM

OPERATIVE

SBQ 1

A PATIENT IS 62 YEARS OLD. SHE HAS MANY ROOTS CARIES AND IT SAID SHE HAS INCIPIENT CARIES ON THE FRONT BUT IT IS NOT CAVITATED BUT IT IS VISIBLE WHEN IT IS WET. LIVES IN A PLACE WHICH HAS RETICULATED FLUORIDE TAP WATER. PATIENT DOESN'T LIKE DRINKING TAP WATER, DOESN'T LIKE THE TASTE OF IT, DRINKS BOTTLED WATER ONLY, DRYNESS OF MOUTH REPORTED, SJOGREN'S MENTIONED, VERY MUCOUS SALIVA, LOW SALIVARY FLOW RATE, SHE BRUSHES WITH FL TOOTHPASTE, TWO TIMES IN A DAY. COMPLAINS OF GENERALISED SENSITIVITY.

I. What is the cause of her root caries/caries?

A. Poor oral hygiene
B. Low salivary flow
C. Poor diet
D. Less fluoride

II. What do you advise regarding water?

A. Drink bottled water only
B. Drink bottled water that contains fluoride
C. Add bicarbonate to bottled water
D. Drink bottled water which has 'mineral' labelled on it
E. Ask patient to drink tap water only

III. What is the best management for her caries?

A. Give sodium bicarbonate mouthwash and 1500 FL toothpaste
B. Give ccp acp cream (only some centres gave this) and 5000 ppm FL toothpaste
C. Give saliva substitute and 900 ppm fluoride toothpaste
D. Mouth wash

IV. Which toothpaste to recommend for her sensitivity?

A. Strontium toothpaste
B. Normal toothpaste
C. Mouthwash containing triclosan
D. Mouthwash containing arginine
E. Fluoride toothpaste

OPERATIVE

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

IN HER CASE THE RISK FACTORS OF GETTING CARIES:

1. Sjogren's syndrome ⟶ Dry mouth ⟶ Caries ⟶ Sensitive teeth
2. Doesn't like to drink tap water (tap water has fluoride) ...but she brushes teeth twice with fluoridated tooth paste.

INCIPIENT CARIES VS HYPOPLASTIC/HYPO MINERALISED ENAMEL

INCIPIENT CARIES	HYPOPLASTIC/ HYPO MINERALISED ENAMEL
Doesn't appear at the time of tooth eruption	Appears at the time of tooth eruption
It is due to caries	It is due to defect in the enamel formation
White patches close to the gingival margins due to plaque accumulation	White or brown enamel defects, can be seen as pitted enamel in severe cases
Visible when the tooth surface is dried. But when caries has progressed halfway into the enamel it can be seen in wet tooth surface too.	It can be seen in both wet and dried situations.

- According to ICDAS classification incipient lesions and non cavitated lesions are not restored instead they are remineralised with the help of fluoride toothpaste, varnish, gel, cpp-acp.

I. Since she brushes twice daily, she maintains good oh.
Her dry mouth condition is a risk factor for caries.
In the question it's not mentioned about her diet.
She uses a fluoridated tooth paste though she doesn't drink tap water.
Therefore, cause for caries in this case is poor salivary flow.

II. Tap water has fluoride and tank water doesn't. As the patient doesn't like to drink tap water, we can't force her to do so. So, we can encourage the patient to have bottled water which has fluoride with it.

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

III. *(reference TG page no. 67 table 7)*: in high caries risk it's advised to recommend 5000ppm tooth paste. And cpp-acp will release Ca2+ and phosphate ions to remineralise the initial lesions. If the patient doesn't have milk protein allergy, its good advice cpp-acp along with F toothpaste.

And also, In case of xerostomia, hyposalivation and orthodontic demineralisation "fluoride alone" can't remineralise enamel. Fluoride with cpp-acp will be helpful in these circumstances.

Sodium bicarbonate mouth was is given in the management of dry mouth *(reference TG page no. 123)* but in this question it's asking about the caries management not the dry mouth management. And also, since she's using a fluoride tooth paste no point of prescribing a same concentration toothpaste. Need to prescribe a high concentration.

IV. In case of sensitive teeth, it's always good to recommend a desensitising agent. If a patient with caries, sensitivity is due caries, so, it's good to choose a desensitising agent which has fluoride with it. (eg: sodium monofluoro phosphate) but in this question this answer is not given. She already uses a fluoride tooth paste so it's better to change it to a desensitizing agent for a short period of time until her sensitivity issue gets resolved.

Best desensitizing agents in descending order:
Arginine / CaCO3 > KNO3 (mostly available) > stannous F > NaF/NaCl/Na-monofluorophosphate/stronthium Cl

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SBQ 2

LADY WORKS IN A FACTORY AND HAS MANY CERVICAL CARIES (RIGHT SIDE INTRA ORAL PIC WAS GIVEN, UPPER AND LOWER TEETH CERVICAL CARIES INCIPIENT). SHE EATS SNACKS AND SOFT DRINKS IN HER FREE TIME FROM WORK, EATS TAKEAWAY FOOD ALWAYS AND DOESN'T LIKE TO COOK AT HOME, AND SMOKES 10 CIGARETTES. HISTORY OF PERIODONTITIS. SHE IS WORRIED ABOUT LOSING HER TEETH.

I. She tried to quit smoking a few years back and was unsuccessful, and doesn't want to quit again. How will you help her quit smoking? Or how will you manage her?

A. Tell her to record her emotions the next time she thinks of losing her teeth
B. Record it in your notes to assess her willingness to quit in the next appointment and put her on recall Record her behaviour in her notes and review her willingness in next review appointment (mention in the records to inquire her willingness to quit in next session)
C. Ask her the what her real intention should be for quitting
D. Tell her she can call your clinic anytime she decides to quit again give her the number and give her clinics number
E. Reassure/Assure her that "yes 80 percent people who try quitting fail when they try first"
F. Tell her if she doesn't quit smoking, she can lose her teeth and give her no of Quitline.

II. In subsequent appointments you notice she is not changing her eating habits. How will you motivate her about eating habits? (In my station it said you notice/get to know that her eating habits are not healthy, how will you motivate her eating habits)

A. Talk to her about how she can manage her diet after discussing her diet diary
B. Showing her the clinical pictures, you have taken of her carious teeth and explain how it's affecting her teeth
C. Show her regret over something which she has already lost in her mouth

III. What is the reason for her cervical caries?

A. No balance b/w fast food and home food
B. Frequency of carbs intake
C. Eating sweet food and having sweet drinks together.
D. Smoking

IV. How will you check her white lesion?

A. Using sharp scaler tip
B. Use a sharp tip with pressure over the edges of the lesion.
C. Use ball end probe by passing it over the lesion gently
D. Use Briault probe

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SBQ 2

V. How would you manage dentinal sensitivity in her case?

A. Strontium salt toothpaste
B. Sodium monofluorophosphate toothpaste
C. Oxalate salt toothpaste
D. Sodium bicarbonate
E. Potassium phosphate

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

I. When it comes to quit smoking always try to encourage and reassure the patient. Always try to appreciate if the patient has tried quitting smoking once. And give a positive response. Never make the patient disappointed by giving a negative response.

II. Never discourage a patient. Always try to give a positive response. When it comes to dietary habits it's always good to maintain a diet chart and do modifications after discussing with the patient.

III. Frequency matters more than the quantity of food. Snacking and drinking soft drinks in between the main meals makes the situation worse compared to having sweets/soft drinks along with the mealtime.

IV. During inspection never use a sharp probe as it can damage the tooth structure and may lead to cavitation. Always use a blunt probe with a gentle force.

IV. In this patient dentinal sensitivity is due to dental caries. Therefore, when we choose a toothpaste, it's always good to choose a desensitising agent which contains fluoride. Eg- sodium monofluorophosphate toothpaste. Otherwise in case of sensitive teeth due to cervical abrasions/attrition/erosion can be treated with potassium phosphate.

OPERATIVE

SBQ 3

VERMA, 29 YEARS, SMOKES, DRINKS A LOT OF ALCOHOL WITH FRIENDS OVER THE WEEKENDS, IS VERY STRESSED IN A HIGH POSITION IN HER JOB, DRINKS LOT OF COFFEE AND SUGARY SNACKS IN EVERY BREAK, CAN'T SLEEP PROPERLY, HAS HEADACHES, WAKES UP FEELING TIRED, STARTED TAKING ANTIDEPRESSANTS/ ANTIANXIETY RECENTLY, COMPLAINS OF DRY MOUTH, HAS A POOR ORAL HYGIENE. INTRAORAL PICTURE GIVEN OF UPPER ARCH CLICKED FROM LOWER ANGLE. INCISAL EDGE LOOKS EVENLY WORN AND ALSO SMOOTH WORN DENTITION ON PALATAL/ BUCCAL TOOTH SURFACES NOT VERY CLEAR (DID SHE COMPLAIN OF SENSITIVITY? OR SCARED ABOUT HER ORAL CONDITION OR TEETH GETTING WORSE? RAISED AMALGAM MARGINS ON UPPER MOLARS WERE NOTICED BY SOME STUDENTS.)

I. What is the reason for her condition?

A. Erosion
B. Abrasion
C. Attrition
D. Bruxism
E. Toothbrushing

II. What will you do for the above problem?

A. Give her occlusal splint
B. Ask her to reduce the dose of her medication
C. Ask her to limit her alcohol and coffee
D. Ask her to reduce the frequency of brushing
E. Reduce frequency sugary foods

III. What is the cause of her dry mouth?

A. Medication- antidepressants
B. Stress
C. High caffeine intake
D. Poor oral hygiene
E. Insufficient intake of water

IV. You did oral examination and find multiple caries. What will you give her?

A. All fluoride options(concentrations were wrong except one)
B. Single annual application of Fluoride varnish
C. 5000PPM Fluoride dentifrice

V. What will you do for the management of her dry mouth?

A. Frequent sips of water
B. Sugarless chewing gum
C. Limit both alcohol and caffeine
D. Ask her to reduce her medication

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

I. According to the aetiology both erosion and attrition answers are correct. Erosion happens due to alcohol and coffee intake. Attrition happens due to stress. The only clinical feature to pick one answer out of these two is, raised amalgam margins which happens only due to erosion. Smooth worn outs are seen in both erosion and attrition.

II. Occlusion splint can be given in case of attrition.
We are not medical practitioners to reduce her dose of medications.
Therefore, we can ask the patient to limit her alcohol and coffee intake which are the etiological factors for erosion.

III. Causes of Dry Mouth: *(reference TG page no. 121, 122)*
(A), (B), (C), (E) .. all these answers are correct. But among these (A) is the best. Because antidepressants have a direct anticholinergic effect on salivary glands which leads to stop secretions.

IV. Since she has multiple caries, she's at a high caries risk. In high risk patient's 5000ppm toothpaste is suggested. *(reference: TG page no. 67 table 7)*

IV. (A), (B), (C) are all correct. When all the answers are correct, you must follow the sequence given in the TG. *(reference: TG page no. 124 Box 14).*

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SBQ 4

30 YEARS OLD, CAME FOR TREATMENT. WANTS BLEACHING FOR HIS TEETH. HAD PAIN WITH 36, 36 & 37 HAD OPEN CONTACTS AND AN OVERHANG RESTORATION, WANTS TO GET 36 TREATED AND HAS EROSION, DRINKS A LOT OF ACIDIC DRINKS(COCA COLA).HAD NEVER VISITED A DENTIST IN 3-5 YEARS, POOR ORAL HYGIENE.

I. What will be the aetiology of the lesions?

A. Coca cola
B. Poor oral hygiene
C. Erosion

II. Iopa given and you diagnose that it is irreversible pulpitis. You want to do an rct of it. But patient refuses Rubber Dam. What will you do? (iopa given)

A. Refer to endo
B. Give alternate options like extraction
C. Respect his decision make him sign a waiver
D. Refuse to treat

III. Patient wants to get bleaching regardless. What will you tell him?

A. Need to stabilize his condition first
B. Do tooth whitening, an make her sign waiver

IV. What is the problem related to her chief complaint (36 overhang restoration & open contact)

A. Overhanging restoration.
B. Periapical area involvement
C. Secondary caries

V. Which restoration will you replace?

(Open contacts & overhanging restorations in both the teeth 35 &36, there was very initial signs of vertical bone loss mesial to 36)

A. Only 36
B. 35 & 36
C. 35 only

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

I. In the question it's mentioned about erosive lesions. The history denotes that the patient drinks a lot of acidic drinks (coca cola). Acidic drinks lead to erosion.

II.
- RCT must not be performed without a rubber dam.
- Because there's a high risk that the patient may aspirate files without a rubber dam.
- It helps to maintain a sterile area without saliva and blood contamination.
- It helps to prevent sodium hypochlorite accidents.

*If a patient refuses rubber dam you can offer these options:

a) Refer to an endodontist if the tooth is restorable.

b) Give alternate options like extraction if the tooth is not restorable.

You must see the picture and the IOPA to decide the restorability of the tooth.

III. Before performing a bleaching treatment, you must stabiles his conditions.
If erosions are present you need to control it with habit intervention and then temporisation.
If caries is detected, you must temporise them.
Because bleaching may lead to further damage if the dentine is exposed to the oral cavity and lead to more sensitivity and teeth may undergo with pulpitis.
After 2weeks time of bleaching we can proceed ahead with the permanent restorations. This waiting time period is to stabilize the colour after a bleaching treatment.

IV. Overhanging restorations alone will not give secondary caries unless there are marginal discrepancies.
Overhanging restorations will lead to periodontal complications.
Irreversible pulpitis results from caries, which is spreading to the pulp, so secondary caries is the direct course for pain.

V. Both 35 and 36 are having overhanging restorations. Therefore, need to restore both. If only one tooth has overhanging restoration, then replace only that.

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SBQ 5

GAP B/W TEETH & OPEN CONTACTS: BITEWING GIVEN. MULTIPLE COMPOSITE RESTORATIONS, ALL IN GOOD CONDITION. GAP BETWEEN 36 37 CLEARLY SEEN. PATIENT COMPLAINS THAT SHE FEELS SORE IN THE 36 37 REGIONS SPECIALLY AFTER SHE EATS MEAT.

I. What is the cause of her soreness?

A. Food impaction between 36 37
B. Bone loss
C. Secondary Caries
D. Leakage
E. Subgingival calculus

II. What is the problem in the fillings?

A. Open contact between 36 37
B. Leakage
C. Overhang

III. Iopa given You are restoring 36 MO In order to gain proper contact with 35 what will you do?

A. Using siqveland matrix and high viscosity packable composite.
B. Use pre burnish tofflemire band
C. Use clear matrix with light reflecting wedge
D. Use Sectional matrix system with small increments
E. Pack composite in big increments

IV. Same iopa as above in iopa 37 had enamel caries on one of the proximal surface and other proximal surface has filling.what will indicate that 37 needs filling?(gap)

A. Cavitation
B. Sensitivity
C. Pain

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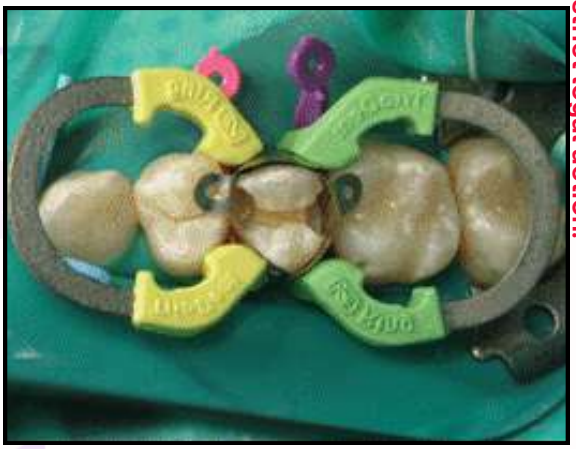
P.O.W.E.R NOTES SBQ 5

I. Patient complains of pain after she eats meat, which means the pain is due to food impaction between 36 and 37 because of the gap between them.
Open contact ⟶ Food impaction ⟶ Vertical bone loss (infra-bony pockets)
Leads to localise periodontal bone loss. Bone loss is the diagnose and the cause/aetiology for it is food impaction.
There are no overhanging restorations, no calculi, restorations are in good condition so no secondary caries.

II. Gap/open contact between 36 and 37 is the main problem for the food to get impacted in this area. No proper proximal contact will create problems. There are no overhanging restorations.
Open contact ⟶ Food impaction ⟶ Vertical bone loss (infra-bony pockets)

III. Reason for the open contact:
When you don't use a wedge, you can't compensate the thickness of the matrix band.
Successful contacts are achieved with the "sectional matrix system" with small increments.
When the word "system" is given it denotes the combination of tofflemire, band and wedge. All the 3 items should be present.

Reference:
It is widely accepted that proximal contacts are very important features in healthy teeth. A lack of proximal contacts contributes to food impaction, secondary caries, tooth movement and periodontal complications. These studies supported use of the sectional matrix with separating ring in order to achieve tight contacts. the sectional matrix with separation ring seems to be the most reliable device for restoring proximal contacts in posterior teeth.



IV. Sensitivity will be treated with desensitising agents. Doesn't required filling.
Pain is an indicator for pulp involvement (irreversible pulpitis) or reversible pulpitis.
Irreversible pulpitis needs RCT, reversible pulpitis -Rx differs according to the situation.
According to ICDAS classification only cavitation required restoration. Cavitation is the 1st indicator.

OPERATIVE

SBQ 6

THE PATIENT PRESENTED TO YOUR CLINIC COMPLAINING THAT HE DOESN'T LIKE THE LOOK OF HIS OLD AMALGAM FILLINGS (PICTURE GIVEN MOLAR WITH AMALGAM CREEP AND NO SYMPTOMS) AND HE WANTS TO REPLACE IT WITH TOOTH COLOURED FILLING DUE TO AESTHETIC REASONS. YOU EXPLAINED TO THE PATIENT THAT IT'S BETTER TO RETAIN THE OLD AMALGAM FILLING SINCE IT'S STILL SOUND. BUT DESPITE YOU INFORMED HIM OF THE ADVERSE EFFECT OF REMOVING ALL THE AMALGAM, HE STILL INSISTS ON REPLACING IT. HOW DO YOU DEAL WITH IT?

I. What is the risk of removing old amalgams

A. Generation of Amalgam vapour
B. Risk of teeth becoming non vital
C. Tooth fracture

II. IOPA of amalgam restorations given.
Lower 4, 5, 6 teeth were given and only 6 had overhanging restoration. Which one needs to be replaced?

A. 5 only
B. 6 only
C. 5 and 6 both
D. 4,5, 6 all

III. The patient insists on replacing all the amalgams due to aesthetics complaints even after you explained all the risks. How would you manage this?

A. Accept the patient's request with informed consent, documenting that you explained the adverse effects
B. Refer the patient to another practitioner for a 2nd opinion.
C. Accept the patient's request after he signs for a waiver
D. Refuse to do the treatment.

IV. What has caused the gap between the teeth?

A. No wedge
B. Wedge placed too gingivally
C. Use of sectional matrix
D. Use of Tofflemire system.

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P.O.W.E.R NOTES SBQ 6

I. Two main risk factors of removing old amalgams:
   a) Health hazard- generation of amalgam vapour which can damage brain and other organs. This is the main risk factor.
   b) Weakening of the tooth structure.

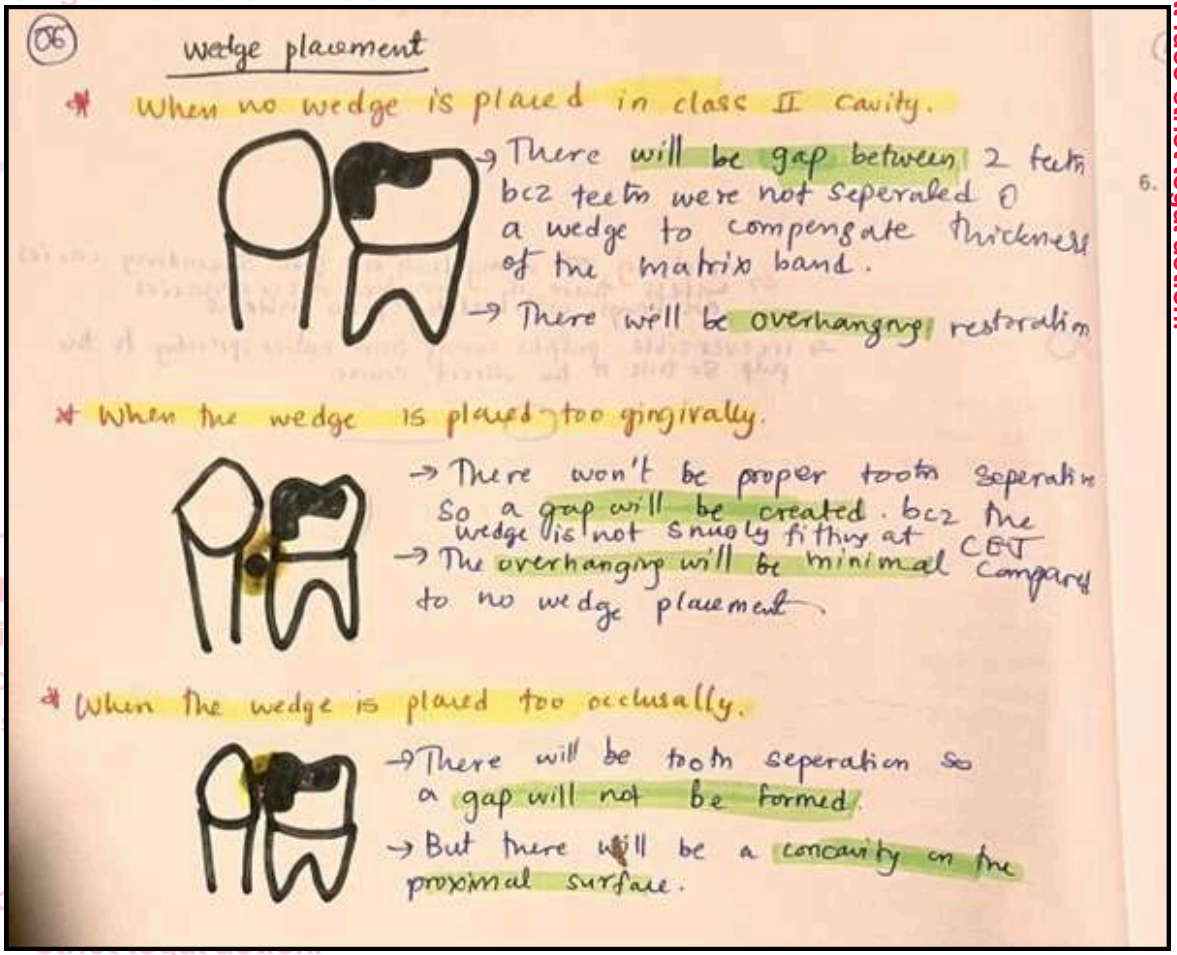
II. Based on the history, radiographs and pictures the answer may get changed. Only the teeth which have overhanging should be replaced. Only 6 has overhanging.

III. If the patient is concerned about aesthetics you can replace amalgam restorations, but don't remove the amalgam restorations unless they have been informed, explained and taken the consent.

Reference: ADA policies

Dental amalgam restorations should not be removed and replaced with alternative restorative materials for nonspecific or perceived health complaints unless the patient has been fully informed of the implication of this decision.

IV. Gap between the teeth/open contacts is due to: Not using a wedge
*when you don't use a wedge, you can't compensate the thickness of the matrix band.



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SBQ 7

QUESTION ABOUT A HUGE AMALGAM RESTORATION. CLINICAL PICTURE OF SWOLLEN GUMS COVERING THE DO PORTION OF THE FULLY ERUPTED TOOTH 48.PATIENT IS 20 YEARS OLD AND CAME TO YOUR CLINIC COMPLAINING OF PAIN ON HIS LOWER RIGHT LAST MOLAR.

I. What is your proposed treatment for amalgam restored tooth?

A. Composite
B. Gic core and full crown.
C. Pin amalgam restorations
D. Ceramic onlay
E. Full crown.

II. What is the medium term (mid to long term in some centres) prognosis of this tooth? The crack isn't involving the pulp.

A. Good
B. Excellent
C. Poor
D. Fair

III. What determines the prognosis of this tooth?

A. Cracks
B. Amount of tooth structure remaining
C. Vitality of the tooth
D. Duration of placement of restoration

IV. What mouthwash to be prescribed?

A. 0.2% or 0.12% Chlorhexidine gluconate
B. Hydrogen peroxide
C. Saline water

V. Patient will come back after 2 weeks for extraction of 48. What is your interim management?

A. Prescribe analgesic regimen ibuprofen and paracetamol
B. Advice to rinse with warm salt solution at home.
C. Localised Debridement and 1% Hydrogen peroxide irrigation
D. Apply locally the iodine with a cotton pellet.

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OPERATIVE

P.O.W.E.R NOTES SBQ 7

I. There's a lack of information in this question as there's no picture given. This needs a picture to choose the proper answer. Swollen gums (pericoronitis) present with another tooth -48. Amalgam filling is present in some other tooth.
   - If it's a minor cavity and if you can see the retentive features, then we can use composite.
   - If it is a large restoration as mentioned in the history, in which it's proximal contacts are lost (walls are lost), it's better to choose a full crown.
   - If it's severely broken, then a crown with a core build up is required. Crown with a composite build up would be a good Rx option in this case.

When to give an onlay?
When the tooth structure/the walls are all in contact in 360 degree up to the middle 3rd or occlusally.
When to give core build up + crown?
When 1 or more walls are broken below the middle 3rd and proper ferrule is available.
When to do crown lengthening+ core build up+ crown?
When 1 or more walls are broken up to the CEJ or below CEJ crown lengthening is done to create a ferrule to retain the crown.

II. When you remove the amalgam filling you can see a crack. That's why you recommend a crown in this case. This crack is not involving the pulp therefore, you don't need to perform RCT.
But still the prognosis is not GOOD or EXCELLENT, because the tooth is badly broken.
Prognosis is not POOR, because you are not going for extraction.
Tooth is moderately compromised with the remaining tooth structure. So, it has got a FAIR prognosis.

III. The crack determines the prognosis.
If the # line/crack is going below CEJ which means, it's a root # (VFR) so poor prognosis.
Doesn't matter how much tooth structure is available, if the tooth has a crack.

IV. According to TG both (A) and (C) are correct. Here we choose (A) because CHX is bactericidal and it's a pharmacological component.
It's case of pericoronitis or infection before extraction both 0.2%/0.12% CHX or warm saline can be given. If both options are given, select CHX.
In post extraction only warm saline is recommended. Because CHX is not given in open wounds.

V. For interim management before extraction in pericoronitis CHX, POVIDONE IODINE, WARM SALINE (warm salt water) mouth wash can be given.
CHX, POVIDONE IODINE mouth washes are superior to saline.
Here application of POVIDONE IODINE with a cotton is given. That's why that answer is not selected.
Analgesics are not needed for pericoronitis.

OPERATIVE

SBQ 8

TOOTH WAS BROKEN FROM BUCCAL & MESIAL SIDE. DISTAL WALL WAS INTACT. NO PAIN.
IOPA GIVEN. IT WAS AMALGAM RESTORATION.
IT FELL OUT ON TWO OCCASIONS.

I. The amalgam restoration fell out on 2 occasions. What would be the next management to avoid this issue?

A. Crown lengthening with inlay
B. Indirect ceramic inlay
C. Composite restoration
D. Pin amalgam
E. RCT post followed by crown

II. Which investigation would you do?

A. Pulp sensibility testing
B. Percussion
C. Pulp sensibility and cuspal loading
D. Probing

P.O.W.E.R NOTES SBQ 8

I. If there was an answer given such as CROWN LENGTHENING +FULL CROWN, that will be the best answer. Because it's conservative rather than doing elective RCT+POST.
Crown lengthening will help to increase the ferrule effect in the missing wall at least 1.5-2mm, so the crown will retain. Without crown lengthening crown will not retain.
In this case 2 walls are lost. That means 50% of walls are not there. If 50% or more walls loss, you need this type of management.

What's a prophylactic RCT?
When more walls are broken and grossly destructed, it required post and core Rx. In this type of grossly destructed teeth, even though the pulp is not involved RCT is required to place a post.

III. To check pulp vitality, we can do the pulp sensibility test. If it's non vital we can perform RCT.
Since it's a broken tooth we must do "cuspal loading" to check cracks.
Probing is usually done when u suspect a VRF.

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OPERATIVE

SBQ 9

LADY WITH OVER CONTOURED, VERY WHITE RESTORATION. SHE IS NOT HAPPY WITH THE APPEARANCE OF ONE OF HER UPPER LEFT TEETH. (ON A RETAINED PRIMARY CANINE.) RETAINED DECIDUOUS 63. XRAY SHOWED IMPACTED 23.

I. What is true regarding the impaction of Maxillary Canine?

A. 20%impacted
B. 12%impacted
C. Max Canine more commonly impacted buccally
D. Max Canine more commonly impacted palatally.
E. % of the impacted maxillary canine cause resorption of the premolar.

II. What treatment is unlikely to improve on the esthetics of c?

A. Increasing the value of the tooth shade for composite veneer replacement?
B. If you use multi layering technique of composite restoration you can improve the colour or shade)
C. Reducing the buccal contours of the tooth.
D. Change the veneer and improve on the size and shape of the tooth?

III. Best x-ray for impacted canine (best x Ray to locate the position of impacted canine)

A. CBCT
B. MRI
C. Another x-ray from different horizontal angulation
D. Occlusal

IV. For aesthetics, the patient requested direct veneer. What is not needed?

A. Increase the Composite color value
B. Wax up and die and putty
C. Reduction of buccal contour

OPERATIVE

P.O.W.E.R NOTES SBQ 9

I.
- Maxillary canine gets impacted = 3%
- Out of that 80% gets impacted palatially.
- So maxillary canine more commonly gets impacted palatially than buccally.
- Impacted maxillary canines lead to resorption of incisors.

II. When a value is high, it means the colour is very bright and opaque.
When chroma is high, it means the colour is very dull.
When value is high, the chroma will be low. They oppose each other.

III. Usually SLOB TECHNIQUE (same lingual opposite buccal) is preferred for impacted canines. Another XRAY from a different horizontal angulation.
But in the question if they ask "THE BEST" Xray for impacted canine and if the CBCT option given, then you must select CBCT.

IV.
- In the question it is mentioned "VERY WHITE RESTORATION". This denotes the value is already high so what is not needed is ...increasing the colour value.
- For direct veneers 1st need to get impressions then make cast, wax up and die and make putty impression. So, it will be easy to make contours in teeth. It can guide the direct veneers. Even the patient can get the direct idea about the restoration.
- It's a tooth with an over contoured restoration so reduction is needed.

OPERATIVE

SBQ 10

SERENA CASE (VERSION 1)

THERE WAS A STAINED DISCOLOURED RESTORATION ON PATIENT'S 13 AND 14 WITH CARIES APPEARING MENTIONED IN QUESTION THAT CARIES ARE EXTENDING 0.5 MM SUB GINGIVALLY. PATIENT WANTS AN AESTHETIC TREATMENT DONE ON THESE TEETH BECAUSE THEY ARE VISIBLE ON SMILING AND IT MAKES HER CONSCIOUS. THE PATIENT HAD IMPROVED HER OH AND DIET BUT IS STILL SMOKING. THE SBQ PREVIOUSLY MENTIONED THAT SHE ONLY WANTS A TREATMENT THAT IS NEITHER EXPENSIVE NOR TIME CONSUMING.

I. What will be your treatment?

A. PFM crowns
B. Ceramic crowns
C. Bonded composite restoration
D. GIC Fuji VII (brand names were used)
E. Ceramic veneers

II. This was also slightly different from mmf. After 5 years she's all good. In this whole period you had given the required treatment and removed two teeth which were non saveable and given an RPD (immediate was not mentioned nor was mentioned when you gave her) now she came saying it's loose?

A. Give her new acrylic rpd New co cr rpd
B. Reline the rpd
C. Implant

OPERATIVE

P.O.W.E.R NOTES SBQ 10

I. The most important points in this question:

Extending 0.mm sub gingivally- if caries extending more than 0.5mm sub gingivally, it will violate the BW and crown lengthening is needed in such cases.

Concerned about aesthetics but need neither expensive nor time consuming Rx- in such cases RMGIC would be the best answer. RMGIC is better than GIC as it has reduced solubility in saliva and better retention. RMGIC is Fuji II. Therefore, composite is most suitable from the given.

- Type I - Luting cement used for cementation of crowns and bridges
- Type II - Restorative cement used for aesthetic fillings
- Type III – GIC used as liners and bases
- Type IV – GIC used as pit and fissure sealants
- Type V – GIC used for orthodontic cementation
- Type VI – GIC is used for core build-up in highly mutilated teeth
- Type VII – Fluoride releasing light-cured GIC
- Type VIII – GIC for atraumatic restorative treatment (ART)
- Type IX – GIC used for pediatric and older adult restorations

PFM and CERAMIC crowns, CERAMIC veneers are invasive treatment options which damage more tooth structure, and which is not required in minimal caries Rx.

II. If it was an immediate RPD there will be so much resorption after extraction, so only relining would not be enough. A new RPD should be constructed. Therefore, if it was an immediate RPD, the answer would be (A)
Since she got a conventional RPD, answer would be (B).

OPERATIVE

SBQ 11

EROSION CASE (DRINKS 5 GLASSES OF WINE DAILY, SMOKES 40 CIGARETTES, OBESE 128KGS, NOT A REGULAR ATTENDEE TO DENTIST) COMES TO SEE YOU WAITING FOR MY TEETH TO BE WORN OUT JUST LIKE ME AND NEED HELP?

I. Etiology of lesions?

A. Alcohol
B. Smoking
C. Poor oral hygiene

II. Dentist decided to increase the VDO by 4mm. Treatment with composite build up on anterior teeth was decided and the patient also consents to that. Has 14,15,16,24,25 missing. Picture given. How do you proceed with treatment?

A. Raise VDO with acrylic appliance with missing tooth for a period of at least two weeks
B. Posterior Dahl appliance
C. Anterior composites build-up with composite on few posterior teeth to aid other posteriors to re erupt
D. Wait for 12 months to stabilize the risk factors reduction
E. Replace all premolars and 16 with RPD and allow rest of posteriors to erupt.

OPERATIVE

P.O.W.E.R NOTES SBQ 11

I. Erosion can be of 2 types. Extrinsic and intrinsic erosion.
Alcohol, carbonated beverages leads to extrinsic erosion.
Medical conditions such as GERD, Bulimia, Anorexia leads to intrinsic erosion.
Smoking leads to periodontal destruction and poor OH leads to caries risk.

II. Missing teeth-
- 14,15,16,24,25

Teeth present in the posterior-
- 17,26,27
- 37,46,47 *(only 3 posterior contacts)*

Only 3 posterior contacts are left to increase VDO. Extrusion of these molars are required to increase VDO.

OPTION A:
Acrylic appliance with increased VDO on the missing teeth helps to extrude the posterior teeth. This RPD is not the definitive RPD and that's why it's given for short duration of 2weeks time to check how much increased VDO can be achieved. Due to this short duration this answer is incorrect as much change won't be achieved in that short duration.

OPTION B:
Posterior Dhal appliance leads to anterior teeth extrusion. For this case anterior Dhal appliance is needed as it will help in the extrusion of posterior teeth.

OPTION C:
Among the given answers this is the best. But still it has a little mistake. Only 3contacts are left to place composites over them and there's no any other posterior to extrude.

OPTION D:
When there's active erosion you can't do any restoration. So, it's better to wait to stabilise the risk factors reduction. But to wait 12 months is quite long. This answer would have been correct if it says 2 months.

OPTION E:
In this option it was not mentioned RPD with increased VDO. There's no point of having a RPD with same VDO. Then it would not helpful in extrusion of posteriors.

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SBQ 12

CENTRAL INCISORS 11 21 (IOPA) WAS GIVEN. THEY SAID THERE WAS INTERPROXIMAL DEMINERALISATION SPOTS BETWEEN THEM (ONLY MENTIONED IN THE QUESTION IN X-RAY IT WAS NOT VISIBLE, MAYBE DEMINERALISATION SEEN IN X-RAY AFTER 40% OF DEMINERALISATION OCCURS IN THE TEETH).

I. How to treat it? Options were given?

A. Fluoride varnish
B. Fluoridated TP
C. Restoration with rmgic

II. What to check in a patient's history?

A. Diet
B. Fluoridated water
C. Flossing

P.O.W.E.R NOTES SBQ 12

I. Early lesion/incipient caries can be arrested/remineralised with the help of fluoride treatment.

For the white spot lesions F varnish along with home care is the best.

- Low caries risk- 12 months review
- Moderate caries risk- 6 months review
- High caries risk- 3 months review

In the absence of hx of sugary drinks/snacks intake, excessive plaque, saliva contribution, we consider this case a low risk. Therefore, can apply varnish once a year.

According to ICDAS classification restoration is required in the presence of cavitation.

III. In the patient hx we must check for the diet, salivary test, plaque index, OH maintenance, type of water, fluoride hx. Among all diet is the most important as it is a contributary factor for caries incidents. Therefore, maintaining a diet chart is very important.

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SBQ 13

BROKEN AMALGAM (OLD) CUSP LM BROKEN, THEY GIVE A PIC, SAYING THAT AFTER REMOVAL OF AMALGAM THE DENTIST SAW A GOOD REMAINING STRUCTURE, SOME CUSP SEEMED TO HAVE 1-2MM. WHAT IS THE BEST MANAGEMENT TO RESTORE? THERE WAS ONLY DISTAL, HALF BUCCAL N HALF LINGUAL WALLS REMAINING .. N ON MESIAL SIDE ITS MO WALL TILL 1-2MM BELOW MARGIN.

A. Resin composite
B. Indirect resin composite
C. Indirect resin composite w/ cusp coverage
D. GIC core and Full Crown
E. Post core and Full crown

P.O.W.E.R NOTES SBQ 13

I. Mesial wall= MO involvement 1-12mm below the margin
Distal wall= completely present. No damage.
Buccal wall= ½ of the wall is present
Lingual wall= ½ of the wall is present

- There's no 360degree complete ferrule as the mesial wall is broken below the gingival margin.When there's no 360degree ferrule, we must do crown lengthening. When 1 or more walls are broken up to the CEJ or below CEJ crown lengthening is done to create a ferrule to retain the crown.
- When more than 180degree walls are lost, even though ferrule present or not we need to give a post for good retention. In this case 3 walls are broken. which is more than 180degree.
- If crown lengthening is not done at least post should be given to create a wall.
- How to build a core without a support to build it? without a ferrule can't build a proper core.

OPERATIVE

SBQ 14

12 YEARS OLD HE GETS HIS 6 MONTHS FLUORIDE TREATMENT BUT DOESN'T BRUSH WELL. HE PLAYS SPORTS? BUT DOESN'T LIKE SPORTS DRINKS AND DRINKS LESS WATER AS STAYS BUSY WHEN DOING SPORTS, EATS DRY FRUITS FOR ENERGY. HE HAS OCCLUSAL LESIONS ON HIS PRIMARY TEETH AND PERMANENT MOLARS HAS DEMINERALISED AREAS ON BUCCAL SURFACES.

I. What is the most appropriate advice for him?

A. Replace energy bars
B. Replace sports drink with water?
C. Ask him to drink sports drinks for energy
D. Replace nuts with fruit juices.

II. What is most appropriate advice for his Caries Management? (patient has high caries risk)

A. Neutrafluor 5000 Tooth paste
B. Fluoride varnishes every 6 months.
C. Brush and floss in the morning
D. Include 900 ppm mouthwash in his daily regimen

III. How do you improve his water intake?

A. Advice his mom to remind him of drinking when playing.
B. Give him an expert opinion on the effects of hydration on Oral health.
C. Tell him about the consequences of less water intake on his teeth and help him improve his water intake.
D. Asked him to set a date when he would start drinking 2 liters of water everyday.

OPERATIVE

P.O.W.E.R NOTES SBQ 14

I. Risk factors for caries:
Doesn't brush well
Less water intake ⟶ dryness in mouth ⟶ caries
Dry fruits for energy ⟶ tend to stick on the tooth surface and good source for bacteria

OPTION A:
in the hx it's not mentioned about the energy bars and also in the answer it's not mentioned to replace with what. Incomplete answer too.

OPTION B:
It's mentioned that he doesn't like to drink energy drinks but that doesn't mean that he doesn't drink energy drinks. Energy drinks has sugar and it's a risk factor for both caries and erosion. It's good to replace it.

OPTION C:
There are other good sources of energy rather than sports drinks.

OPTION D:
Fruit juice is high sugar source. It's good to eat the natural fruits rather than drinking juice. Nuts are better than fruit juice. Replacing nuts to fruit juice will worsen the condition as fruit juice is both cariogenic and erosive.

III. OPTION A:
5000ppm toothpaste is recommended for adolescent and adults. We can prescribe it from 13yrs of age onwards. Still the patient is 12yrs old.

OPTION B:
He's already getting the Fluoride varnish treatment.

OPTION C:
It's recommended to brush twice daily. But this is the best answer among the given as in the hx it's mentioned that he doesn't brush well.

OPTION D:
According to TG 900ppm mouth wash is recommended once weekly.

III. Since he's a child patient option (B), (C), (D) won't work for him. Mother can always pay attention and remind him during his practice.

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SBQ 15

12 Y.O. PRIVATE SCHOOL BOY COMES FOR HIS 6 MONTHLY REVIEW. YOU'VE BEEN APPLYING VARNISH EVERY 6 MONTHS FOR 5 YEARS. HE PLAYS SPORTS, WEARS A MOUTH GUARD, DOES NOT DRINK MUCH WATER AND DOES NOT LIKE SPORTS DRINKS. ALMOST ALL HIS MEALS INCLUDE SUGAR, BUT HE TENDS TO SNACK ON CHEESE AND FRESH FRUITS. WHAT IS THE MAIN PREVENTIVE FACTOR THAT PROTECTS HIM FROM CARIES?

A. Fluoride applications
B. Non sugary snacks
C. His good socio-economic condition
D. The fact he doesn't like sport drinks
E. Genetics

P.O.W.E.R NOTES SBQ 15

CARIES RISK FACTORS	PREVENTIVE FACTORS
Excessive plaque	Good OH
High sugar intake	Reduced intake of sugar
Lack of fluoride	F applications and F toothpaste
Less salivary flow (medication, medical conditions can affect saliva)	Unstimulated flow=0.3-0.4ml/min Stimulate flow= 1-2ml/min
Less water intake	Good hydration 2-3 L/day

But when you compare the preventive factors fluoride application and reduced sugar intake, fluoride application is the most important as it strengthens the tooth. It has the highest predictability of protection of the teeth.

It's the every 6months interval fluoride application gives him most of the protection.

Causative factor = SUGAR comes number one
Preventive factor= FLUORIDE comes number one

*STRONGEST PROTECTOR = FLUORIDE
*STRONGEST ATTACKER= SUGAR

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OPERATIVE

SBQ 16

HOW DO YOU ASSESS THAT THE EROSION IS ACTIVE?

A. Basic erosive wear index less than 2
B. Absence of lower lingual calculus
C. Lack of lustre after gentle air blow on teeth
D. It was about the staining? (Dentin stain)
E. Exposed Secondary dentin feels hard on probing

P.O.W.E.R NOTES SBQ 16

I.

ACTIVE EROSION

↓

MAKE A STAIN ON THE TOOTH
AND CHECK THE STAIN IN THE NEXT VISIT

↓

IF IT DISAPPEARS THEN IT'S ACTIVE EROSION

In the absence of the option (D), the next best option is absence of lower lingual calculus.

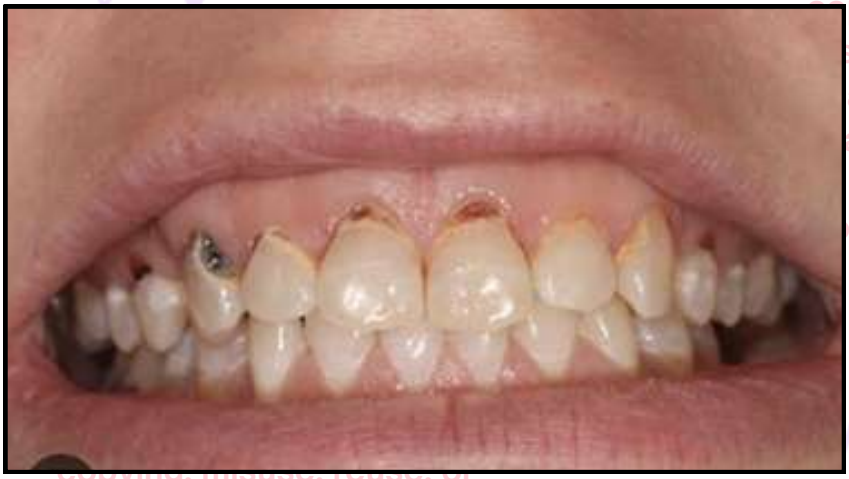
Erosive wear index denotes how much destruction due to erosion has happened. It can be in relation to present or past erosion, but it doesn't indicate about the active erosion.

Lack of lustre means the dull appearance. But in erosion the tooth surface appears shiny. But shiny appearance of the tooth doesn't indicate active/inactive erosion.

Secondary dentin feels hard may be due to the occurrence of erosion. But it doesn't explain that it's active/inactive erosion.

OPERATIVE

SBQ 17



I. You are a dentist in a correction center. LA given- patient had palpitations for sometime and then went away . The reason?

A. Adrenaline effect
B. Lignocaine effect
C. NRT effect with La.
D. Pt smuggling methamphetamine just before the appointment
E. LA allergy

II. Dentist visiting the prison for oral health checkup for inmates. A new inmate had come in a week ago. He has drug issues. Methamphetamine use. Pic given with cervical caries. Also a smoker(currently NRT patch as he is in the cell) - He just stopped because not allowed to smoke in prison, hence he is on nicotine patches. What effect does meth have in this particular presentation (cervical caries) ? Along with methamphetamine, what is most likely responsible for his dental condition. What was associated with methamphetamine? (There were cervical caries all over. Well demarcated black spots in cervical areas)

A. Bruxism
B. Xerostomia I definitely didn't have this option- no, it wasn't an option
C. Craving for sugary food/drinks
D. Alcohol abuse

III. Pt has minimal BOP - but has deep pockets. What is masking his Perio condition?

A. Reduced gingival blood supply
B. Cigarette smoking
C. Suppression of inflammation due to compromised immunity by methamphetamine
D. Improved oral hygiene

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WINSPERT

OPERATIVE

SBQ 17

IV. What are the most common side effects of Nicotine Replacement Therapy?

A. Headache
B. Ulcers
C. Bradycardia
D. Hypertension
E. Obesity
F. Craving for Sugary Drinks

P.O.W.E.R NOTES SBQ 17

I. Many patients feel "adrenalin rush" or "vasovagal reaction" when injected with lidocaine and epinephrine during wide awake surgery.

Adrenaline rush symptoms:
Nervousness, anxiety, tremors, shaky feelings, flushing, light headedness, tingling and heart racing.
Vasovagal response:
Nausea, a feeling of being unwell, faint, light headedness, pallor

NRT is not a contraindication for LA. So, no effect even though the patient is wearing NRT.
Methamphetamine smuggling just before the appointment would results in more systemic and more long-lasting effects. MA duration of action can be up to 24hrs. If the patient has used MA within last 24hrs the vasoconstrictor in LA could result in hypertension, MI, cardiovascular accidents.
LA allergy will result in urticaria, angioedema and anaphylaxis.

II. Dry mouth and craving for sugar are the side effects of methamphetamine use which leads to dental caries.
There's a significant association between MA use and sugar soda consumption. In addition, sugar soda consumption is associated with more dental problems among MA users.
MA users crave beverages high in sugar while they are high mainly because they experience dry mouth. The bacteria that fed on the sugars in the mouth will secrete acids which can lead to more tooth destruction. With MA users tooth decay will start at the gum line and eventually spread.
Therefore, dry mouth comes first and craving for sugar comes second as the risk factors for caries risk in MA users.
MA users feel anxious, hyper or nervous. So, they will clench or grind their teeth. You may see sever ware patterns of their teeth. Sometimes even bite or chewing on soft food like smashed potato, will cause their teeth to break.

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P.O.W.E.R NOTES SBQ 17

III. **Gum Disease** – Methamphetamine users do not seek out regular dental treatment. Lack of oral health care can contribute to periodontal disease (destruction of the bone that supports the teeth). Teeth and gums need blood to stay healthy. Methamphetamines cause the vessels that supply blood to oral tissues to shrink in size. A reduction in blood flow will cause the tissues to break down. Over time the blood flow cannot recover, and the tissue will become necrotic.

Therefore, the best answer is (A) and the second best is (C).

IV. **Side effects of NRT**

- Nausea, vomiting, indigestion, and gastrointestinal disturbances
- Insomnia and sleep apnoea
- Headaches
- Oral ulcers
- Skin irritation
- Heart palpitations/chest pains
- Coughing
- Throat soreness
- Dry mouth
- Increase caries-risk profile
- Taste impairment
- Difficulty in speech in denture wearers
- Hyperkeratosis
- Localized mucosal irritation

So, both (A) AND (B) options are correct.

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SBQ 18

SERENA CASE (VERSION 2)

SHE HAS DARK DISCOLOURATION, LESS EXPENSIVE AND LESS TIME-CONSUMING TREATMENT. NOW SHE WANTS AESTHETICS AS THEY ARE VISIBLE WHILE SMILING AND HER ORAL CONDITION HAS IMPROVED AND SHE SMOKES LESS?

I. How will u restore her 0.5 mm subgingival caries on 13, 14 with many times restored teeth?

A. GIC
B. Polyacid modified resin composite
C. Resin composite

II. Pt is diabetic. You have planned for extraction of 46,47 as patient doesn't want RCT But she is concerned about post op infection,
What do u suggest to avoid post op infection in extraction area?

A. Give her Amox 5 days
B. Nystatin 7 days
C. Metronidazole 5 days
D. Rinse warm water saline three times a day after extraction
E. Chlorhexidine

P.O.W.E.R NOTES SBQ 18

I. GIC can only be used as a PR in patients with dementia, mental incapacities, who can's stay longer in dental chair.
Resin composite is expensive.
Compomer/resin modified composite is cheaper than resin composite and will provide good aesthetics.
If RMGIC is given then that would be the best answer.

II. According to TG no AB or antifungal is given after extraction.
CHX is not used after extraction or in open wounds.
Warm saline rinse is recommended after extraction according to TG. It's not done soon after extraction and it's recommended after 24hr of extraction.

OPERATIVE

SBQ 19

BITEWING RADIOGRAPHS GIVEN FOR ALL SEXTANTS. QUESTION ASKED ABOUT A TOOTH 27, HAS BIG FILLING AND CAN SEE CARIES IN THE DISTAL OF THE TOOTH. PT REPORTS PAIN ON DRINKING HOT TEA DRINK, GETTING WORSE, AND IS KEEPING HIM UP AT NIGHT. (CANALS LOOKED OBLITERATED TO ME IN THE X RAY)

I. You decided to do a sensitivity test which the following is correct (precise, adequate)?

A. Heat test
B. Cold test with co2
C. Tetrachloroethane
D. Ept

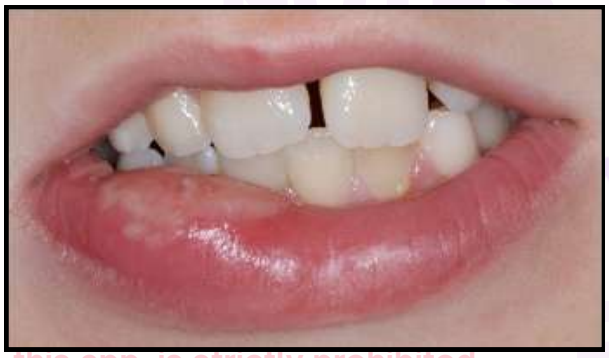
II. What is the variation you expect in treating the tooth 27?

A. 2 canals in palatal root
B. 2 canals in MB with one foramen
C. 2 canals in MB with 2 foramen
D. 2 canals in DB with one foramen
E. 2 canals in DB with 2 foramen

III. What is the maximum cartridge of 2.2 ml of Lignocaine 2% (1:80000) that you can give to the child 25kg ?(in my centre said 48 kg)

A. 1 cartridge
B. 2 cartridges
C. 3 cartridges
D. 4 cartridges
E. 5 cartridges

IV. The child comes with the lesion in her lip the next day? The cause for that is:



A. Patient bite his lip while still numb
B. Dentist accidentally hurt patient
C. Allergic reaction to LA

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P.O.W.E.R NOTES SBQ 19

I. Patient has pain on drinking hot tea. Therefore heat test will be preferred
Among sensibility tests cold tests are the best and among them tetrachloroethene is the best. Second best is dry ice/CO_2 snow.

II. Single MB canal= 10-15%

2MB canals= 80-90%
- 2MB canals in 1 foramen (60%)
- 2MB canals in 2 foramens (40%)

III. Max amount of LA that can be given for 1kg body weight= 7mg
Max amount of LA that can be given for 25kg body weight= 7x25mg
Lidocaine 2% = 20mg/ml
Maximum dose of LA in (ml) that can be given to the patient = [(7x25)/20| =8.75ml

IV. The lesion appears keratotic and inflamed. This usually happens when patient bites the lip as the area is num and patient can't feel it.
If the dentist hurts the patient it should have appeared on the time of the appointment.
Allergic reaction to LA is very rare and appears as urticaria, angioedema, anaphylaxis.

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OPERATIVE

SBQ 20

PATIENT HAVING A STAIN IN BETWEEN 11 AND 21. (FULL CONTACT BETWEEN TEETH) (NO GAP)

I. What is the diagnosis of the stain between 11 and 21

A. Incipient caries
B. Caries

II. What additional measure to give apart from fluoride toothpaste

A. Interdental brushes
B. Floss

III. What will help you with identifying what's the stage of the periodontal condition?

A. His alcohol intake
B. His smoking habit
C. His clinical attachment loss
D. His hba1c percentage

P.O.W.E.R NOTES SBQ 20

I. If it's a white stain, then answer would be (A)
If it's a dark colour stain, then the answer would be (B)
Answer depends on the given picture.

II. In case of caries OH, brushing techniques, fluoride tooth paste, F varnish/gel , floss is important.
In tight contacts floss is helpful and in open contacts/gaps interdental brush is helpful.

III. Smoking and diabetes (HbA1C percentage) are indicators which helps in grading.
Attachment loss will be helpful in staging.
Alcohol intake is not associated with periodontitis. It's associated with dry mouth and erosion.

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OPERATIVE

SBQ 21

I. Clinical picture showing lower molar with crack extending to the bifurcation. How to check the cracks /fracture, the crown has a ceramic crown.

A. Closed debridement
B. Surgical flap to visualise confirm the crack/fracture
C. Percussion test

II. Patient has pain how will you investigate?

A. Probing
B. Remove crowns and observe
C. Take OPG

III. The patient need extraction, tooth pain and swelling, and also she will have prosthetic joint surgery in a week time. You performed extraction. What antibiotic regime you provide?

A. No antibiotics as source of infection removed
B. Amoxicillin 500mg 5days
C. Phenoxy penicillin 500mg 5days
D. Amox plus clav 875 + 125 mg

P.O.W.E.R NOTES SBQ 21

I. If a tooth is restored and you are suspecting a crack, you can inspect it visually. And if the crack is extending to the bifurcation area can be visually check by removing the crown/removal of the restoration and raising a flap.
Close debridement is needed in the presence of deposits.
Percussion test is done to see the periapical involvement.

II. IIt's natural to have pain in the presence of cracked tooth.
Probing will be helpful in the presence of VRF.
IOPA/OPG will not be helpful in investigating cracks.
Removal of crowns/restoration and using the transillumination will be helpful in finding cracks.

III. Localised infection doesn't need therapeutic AB as the active dental Rx will remove the source of infection.
Spreading infection will require therapeutic AB.
Prosthetic joint surgery is not a requirement to give prophylactic AB.
Prophylactic AB is given in endocarditis and few other cardiac conditions which is mentioned in TG. *(reference page no: 194 box 24)*

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SBQ 22

THERE WAS A CLINICAL PICTURE GIVEN WITH WHITE SPOTS ON UPPER ANTERIOR INCISORS, THESE SPOTS DISAPPEAR WHEN THE SURFACE WAS WET. SHE ALSO HAD WHITE SPOTS ON THE CERVICAL AREA WHICH WERE VISIBLE BOTH WET AND DRY SEEN AFTER PLAQUE REMOVAL. PT HAS A HISTORY OF FINANCIAL CONSTRICTIONS. SHE LOST HER FATHER. AND SHE HAS TO LOOK AFTER HER FAMILY. THE WHITE SPOTS APPEAR IN SUCH A WAY THAT ORTHODONTIC DEMINERALIZATION SPOTS. (SHAPE OF THE BRACKETS WERE VISIBLE IN THE GIVEN PICTURE), THE WHITE SPOTS WERE ONLY SEEN ON THE INCISORS. SHE HAD CHRONIC MIDDLE EAR INFECTIONS AND CHICKEN POX. (SPOTS LOOK SQUARISH LIKE YOU LL FIND AROUND THE BRACKETS) DENTIST NOTED WHITE SPOTS WERE VISIBLE ON THE MID BUCCAL AREA TOO. (IT WAS MENTIONED). THE DENTAL SURGEON 1ST THOUGHT IT WAS MOLAR INCISOR HYPOMINERALIZATION SPOTS. BUT LATER HE CONCLUDED THAT IT'S NOT MIH SPOTS, BECAUSE MOLARS WERE NOT INVOLVED.

I. Dentist thinks these are MIH spots. How will you confirm this is not MIH?

A. Did you take ortho treatment before
B. History of middle ear infection
C. Did you have any infectious disease at your childhood
D. History of chickenpox

II. Dentist thinks it might be caries as well, how will you confirm this is not caries?

A. It was visible when both wet and dry
B. Surface feels rough when probed with blunt probe

III. Dentist thinks it might be ortho demineralisation spots, how will he confirm?

A. Spots were present at the location of orthodontic brackets

IV. You used the blunt end probe around the white spots, and felt rough when you did so. What does it indicate?

A. Cavitation present
B. Active lesion
C. Remineralized
D. Progressing towards arrested

V. As a preventive measure, what will you recommend?

A. Restore with composite
B. Restore with GIC
C. Fluoride varnish every three months
D. 1200 ppm toothpaste twice daily
E. SDF application

VI. What advice can you give to the patient to prevent caries in the future, (in the history it was given the patient has a very busy life schedule and se brushes only in the morning)

A. Pay more attention more on your oral hygiene

OPERATIVE

P.O.W.E.R NOTES SBQ 22

I. Childhood infection can lead to disturbance in enamel matrix formation and later results in MIH. Options (B), (C), (D) can be excluded as all these 3 options are about childhood infections.
Orthodontic Rx can result in orthodontic demineralisation spots in patients who don't maintain good OH.

II. In the presence of caries, the surface feels rough when probed with a blunt probe.
Incipient caries: Visible when the tooth surface is dried. But when caries has progressed halfway into the enamel it can be seen in wet tooth surface too.
Hypoplastic/hypo mineralised enamel: It can be seen in both wet and dried situations.
Both the given options are incorrect.
The only information that rules out caries is history of orthodontic treatment.

III. When the spots are located at the area where orthodontic brackets were placed and when the spots appear squarish in shape, it will confirm the orthodontic remineralisation spots.

IV.
- Active enamel lesions are whitish, chalky and feels rough.
- Inactive enamel lesions appear shiny, glossy and smooth. As an example, arrested or progressing towards arrested or remineralized.
- Cavitation means "a break under depression.

V. Fluoride tooth paste with CPP-ACP is recommended for orthodontic demineralising spots. But that option is not given.
There's no cavitation therefore, restoration is not required. Option (A), (B) and (E) are ruled out.
1200ppm toothpaste won't be helpful I this case.
So, varnish application is the best option.

VI. In her situation oral hygiene is the matter as she brushes only once daily due to her busy life.
Improving OH will prevent from further caries progression.

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SBQ 23

QUESTION RELATED TO AMALGAM RESTORATION THAT WE DID IN OUR CLASS.HER NATUROPATH SAID IT'S NOT GOOD FOR HER, THE PHOTO IS SHOWING MULTIPLE AMALGAM (TOOTH 17, 16 MOD, PREMOLARS.

I. To manage tooth 16 had a huge amalgam mod filling discoloured from distal side and had secondary caries

A. Replace half amalgam
B. Remove and replace whole restoration
C. Repair only buccal groove by composite
D. Replace all the restorations with composite
E. Replace only disto palatal part of restoration

II. Her dietician says to remove all the amalgam fillings as she has allergy to nickel

A. Explain the no relation with amalgam
B. Do as per the patient demand
C. Ask suggestions from GP

P.O.W.E.R NOTES SBQ 23

I. In the presence of secondary caries, the complete restoration must be removed and replaced. If you don't remove the whole amalgam restoration, then you won't be able to remove all the secondary caries. Then it will lead to incomplete cleaning.

II. Explain the patient that there's no association with the nickel allergy and amalgam restoration. PFM restorations can't be given in nickel allergy.
Even after explaining if the patient still wants to get the amalgams replaced, then get the informed consent, make them understand the drawbacks and proceed ahead with replacement. When you replace them use rubber dam, high vac evacuation system by doing so you can prevent yourself, staff and the patient getting exposed to unnecessary amalgam vapour generation.

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SBQ 24

TRUCK DRIVER CASE

PAIN IN UPPER RIGHT BACK REGION. HE CAME TO THE EMERGENCY DEPARTMENT - DRANK COLA THE WHOLE DAY, SMOKED 5 CIGARETTES IN A DAY, DECAYED TEETH MENTIONED IN EXAM, NO PIC GIVEN. AND MENTIONED BOTH HIS PARENTS WEAR DENTURE, NO OTHER DIET HISTORY GIVEN AND NOTHING ABOUT ORAL HYGIENE

I. Other than oral hygiene instruction what other main component could be contributing to his high caries risk.

A. Smoking
B. Genetic predilection
C. High sugar intake

P.O.W.E.R NOTES SBQ 24

I. Smoking is associated with periodontitis.
Plaque and sugar intake are associated with high caries risk.
Patients drinks cola.
There's no genetic predilection for caries risk.

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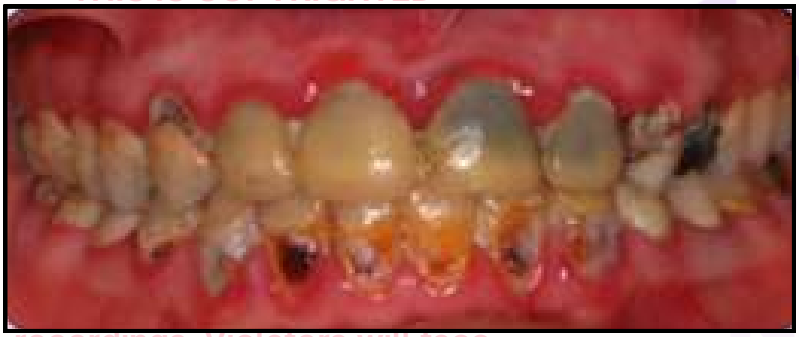
SBQ 25

METHAMPHETAMINE USER CASE. QUIT ABOUT 6 MONTHS AGO

A 20 YEAR OLD PATIENT WAS REFERRED TO YOU, ADMITTING HE WAS A METHAMPHETAMINE USER BUT HAD QUIT 6 MONTHS AGO. HE IS CONCERNED AND WOULD LIKE TO IMPROVE HIS ORAL HEALTH. PICTURE GIVEN: FULLY DENTATE PATIENT WITH PLAQUE ON ALL TEETH, GINGIVITIS, STAINS AND WHITE LESIONS ON CERVICAL SURFACES AS WELL AS TOOTH WEAR (ATTRITION/BRUXISM).
(SOMEWHAT SIMILAR PIC BUT HAD MORE CARIES CERVICALLY AND THAN IN THIS PIC AND PLAQUE)



I. What is the long term effect that he still would be having after quitting methamphetamine?
OR
What would be your (as a dentist) challenge to treat him?

A. Obesity
B. Paranoia
C. Hypersomnia
D. Hypoglycemia

II. Which local anesthetic agent can you use in this patient for an extraction?

A. Local (dental) anesthesia with vasoconstrictor
B. Local (dental) anesthesia without vasoconstrictor
C. Local (dental) anesthesia double dose
D. Local (dental) anesthesia reduced to half dose
E. Topical local anesthesia (for some)

III. Where are the carious lesions usually found in these patients?

A. Labial and buccal surfaces
B. Incisal and buccal surfaces
C. Cervical and approximal surfaces
D. All tooth surfaces
E. Occlusal and palatal surfaces

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SBQ 25

IV. What are the caries risk factors in this patient's case?

A. Low frequency of dental visits
B. Poor oral hygiene
C. Long intoxication periods
D. Consumption of sugary/carbonated drinks
E. Lack of fluoride

V. What are the other factors which caused caries other than poor oral hygiene and dry mouth?

A. Low Frequency of dental visit
B. Not using fluoride toothpaste
C. Consumption of carbohydrate drinks
D. Long intoxication period

P.O.W.E.R NOTES SBQ 25

I. The acute phase of MA withdrawal was characterised by increased sleeping and eating, a cluster of depression related symptoms and less severely, anxiety and craving related symptoms. Following the acute withdrawal phase most withdrawal symptoms remained stable and at low level for the remaining 2 weeks of abstinence.
Obesity and hypoglycaemia are not known withdrawal symptoms.
Paranoia and hypersomnia are known withdrawal symptoms.
Paranoia- *It's a rare mental health condition in which you believe that others are unfair, lying, or actively trying to harm you when there's no proof.*
Hypersomnia- *It's the inability to stay awake and alert during the day despite having more than an adequate amount of night-time sleep.*

As a dentist paranoia is a challenge to treat him.
The mental capacity to make consents, to understand information and to calmly take the treatment has been disturbed in paranoia.

II. Methamphetamine smuggling just before the appointment would results in more systemic and more long-lasting effects. MA duration of action can be up to 24hrs. If the patient has used MA within last 24hrs the vasoconstrictor in LA could result in hypertension, MI, cardiovascular accidents.
In this case patient quit MA use 6months ago. Therefore, it's safe to use LA with vasoconstrictor.

OPERATIVE

P.O.W.E.R NOTES SBQ 25

III. Cervical and the approximal surfaces are the carious lesions usually found in these patients. With MA users tooth decay will start at the gum line and eventually spread.
The dental effects of long-term methamphetamine use are often attributed to its effects on saliva. The reduction in saliva increases the likelihood of dental caries, enamel erosion, and periodontal disease.
A chronic dry mouth combined with high-sugar and carbonated drinks intake causes rampant caries that has a classical pattern known as "Meth Mouth".

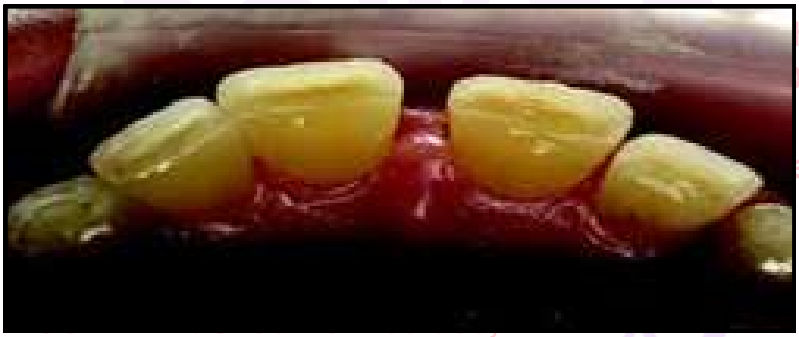
IV. Patient quit MA use 6months back. But this caries occurred when he was in MA use.
If dry mouth is given that would be the best option.
Second best answer is excessive consumption of carbonated drinks.
Dry mouth and Craving for Sugar are the side effects of methamphetamine use which leads to dental caries.
There's a significant association between MA use and sugar soda consumption. In addition, sugar soda consumption is associated with more dental problems among MA users.
MA users crave beverages high in sugar while they are high mainly because they experience dry mouth. The bacteria that fed on the sugars in the mouth will secrete acids which can lead to more tooth destruction.

V. Explanation is the same as the above question.

OPERATIVE

SBQ 26

EROSION CASE



I. How will you monitor the progression of erosion ?

A. VDO decrease
B. By taking impression with alginate and study models to compare
C. Measuring using periodontal probe
D. By Taking pictures

P.O.W.E.R NOTES SBQ 26

I. It's difficult to monitor the VDO in each appointment. As it varies due to the posture, muscle fatigue and so many other reasons.
So, it's difficult to measure and re-create the VDO at each and every appointment.
Accurate physical evidence can be measured by taking impressions with alginate and study models. And it's 3D model.
Picture are helpful but not as much as study model.

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SBQ 27

SECONDARY CARIES IN MOLAR WITH AMALGAM

A MALE PATIENT CAME TO YOUR CLINIC,CHIEF COMPLAINT WITH RESPECT TO TOOTH 27, PATIENT HAD PAIN (SECONDARY CARIES UNDER AMALGAM),HE WAS TAKING VITAMIN D SUPPLEMENTS,NO OTHER MEDICAL HISTORY WAS PRESENT. X-RAYS SHOWED ALMOST ALL MOLARS HAD AMALGAM, SEVERE WEAR AND ATTRITION WAS VISIBLE.

I. What will you ask the patient about/ regarding his concerns?

A. Diabetes
B. Frequency of sugar intake
C. Psychological stress

P.O.W.E.R NOTES SBQ 27

I. His concern is pain due to secondary caries under amalgam. Therefore, pulpitis and secondary caries are his problems.
Stress is a causative factor for attrition and sever wear.

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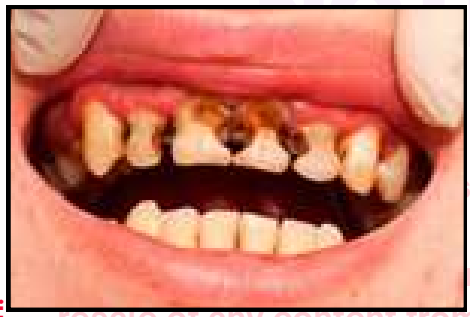
SBQ 28

DECAYED CANINE

PATIENT HAD GROSSLY DESTRUCTED CANINE. SHE FEELS SENSITIVITY TO COLD. WHAT IS DIFFICULT IN THIS CASE WITH RESPECT TO CANINE (CANINE HAD MESIAL CARIES EXTENDING BUCCALLY AND PALATALLY BUT HALF OF PALATAL AND FULL DISTAL TOOTH STRUCTURE WAS SOUND)



THE CARIES IN THIS PICTURE IS ON TOOTH 12 BUT IN THE EXAM IT WAS WITH CANINE, CANINE WAS SLIGHTLY OUT OF ARCH (DISTAL HALF OF PALATAL TOOTH STRUCTURE INTACT)

I. What difficulty will you face while restoring this tooth?

A. Creating mesial contact with lateral incisor
B. Canine guided occlusion.
C. Achieving Marginal integrity

P.O.W.E.R NOTES SBQ 28

I.
- When the mesial part of the canine is missing due to proximal caries - this leads to difficulty in building up the proper contact with the lateral incisor. It's a one-point contact with the lateral incisor which is difficult to re-create.
- When the canine is grossly destructed- this leads to difficulty in maintaining the marginal integrity, so crown lengthening is required.
- In the presence of palatal caries- its difficult to maintain canine guided occlusion as the lower teeth slides and glides on the palatal surface of the canine.

In this case there's mesial caries in the canine.

OPERATIVE

SBQ 29

(NEW)

A PATIENT COMES TO YOU, COMPOSITE RESTORATION WAS DONE FOR HIM 1 MONTH BACK . NOW AFTER A MONTH A PATIENT HAS COME BACK TO YOU AND SAYS THAT INITIALLY HE HAD SENSITIVITY AND PAIN FOR 2 TO 3 DAYS AFTER RESTORATION BUT SHE HAD NO PAIN AND SENSITIVITY SINCE THEN. NOW WHAT INVESTIGATION WILL YOU DO TODAY?

A. Pulp sensitivity test
B. Review after few weeks
C. Remove restoration to see the reparative dentin formation
D. Start root canal treatment
E. Start pulpotomy
F. Take IOPA

P.O.W.E.R NOTES SBQ 29

I. Immediate sensitivity in a composite restoration is due to polymerisation shrinkage. It's natural to have sensitivity for 2-3days. If sensitivity persists then it's due to the micro leakage. (due to the sever shrinkage) this will lead to reversible pulpitis.
So, review is important to check where it is still progressing or to where it has a marginal discrepancy. When you don't need to any investigation, review is the best thing to do.

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SBQ 30

CARIES ASSESSMENT

PATIENT HAS COME TO YOU FOR FOLLOW-UP AFTER 3 MONTHS OF FIRST VISIT .YOU DID A CLINICAL EXAMINATION AND THE PATIENT IS FULLY DENTATE, THIRD MOLARS HAVE ERUPTED.

I. What will be the next investigation to check for caries?

A. Probe pit and fissures
B. Opg
C. Take bitewing

II. Which investigation/imaging to take?

A. MRI
B. Opg
C. Cbct

P.O.W.E.R NOTES SBQ 30

I. We start doing the investigations with clinical examination. When you clinically find white spots, and proximal caries where you are not able to separate the contacts to check for the caries, then bi bitewing would be preferred.

II. When no radiographs are done before, as the baseline investigation OPG is best among the given.

OPERATIVE

SBQ 31

FIBRE POST

I. Patient was given a fiber post to retain the core.Which cement will you use to cement it?

A. Zinc phosphate
B. Polycarboxylate
C. Rmgic
D. GIC
E. Resin based cement

II. After giving post what is the most common site of fracture?

A. At the terminal portion of the post
B. Cervical region
C. Middle third of the root

P.O.W.E.R NOTES SBQ 31

I. VRF can be associated with both endodontically treated and not endodontically treated teeth.

- Fibre post is a bonded post system. It's not cemented with mechanical cements.
- GIC can be used for crown cementation and post cementation. Mostly used in metal posts for mechanical retention.
- Fibre post/ resin post can chemically bond with the resin-based cements. Resin composite is a restorative material. And resin cement is a luting cement.
- zinc phosphate, zinc polycarboxylate, GIC, RMGIC are mechanical cements. They don't require curing and bonding. They can be used for zirconia post/ metal posts which are cemented mechanically. Out of the above mentioned 4 cements RMGIC is not used as cement as it expands when it comes in contact with the moisture. RMGIC is not used even in crown cementation due to this. Therefore, RMGIC is not used for any cementation purpose.

REFERENCE:

Fibre posts are linked with minimal VRF. The most common type of failure when using fibre post is post debonding and it's generally agreed that achieving stable adhesion to intraradicular dentin is more challenging than to coronal dentin. The most reliable results in fibre post cementation are obtained by etch and rinse adhesives in combination with dual cure resin cements. The use of self-adhesive resin cements has also been proposed.

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P.O.W.E.R NOTES SBQ 31

I. **REFERENCE:**

Since fibre posts are passively retained into the root canal, the effectiveness of the adhesive cement and the luting procedure plays a relevant role in the overall clinical performance of the restorations.

Achieving stable adhesion to intraradicular dentine, particularly at the apical level, remains a clinical challenge, due to the negative influence of several factors. Among them endodontic irrigants, such as sodium hypochlorite, EDTA, H2O2, RC prep, as well as calcium hydroxide and eugenol medicaments and sealers.

The post space preparation for cast post results in undesirable removal of peri-cervical dentine. The use of screw post generates unfavourable stress concentration on the radicular root dentin, increasing the risk of VRF when compared to “passive post system”. For an example, the use of prefabricated fibre post system requires minimal, if any post-space preparation and do not create any undesirable force during the adhesive cementation process.

I. In the question it doesn’t ask about the pre-existing cracks. It asked about the fracture that occur after post placement.

REFERENCE:

For the pre-existing cracks:

A significant association was found between the pre-existing microcracks in mandibular teeth (10.3%) when compared with maxillary teeth (2.9%). All pre-existing microcracks were located mesiodistally; 66% occurred in the cervical and middle 3rd of the root. Only 33% of the pre-existing microcracks were complete in nature, showing canal involvement.

For fracture that occur after post placement:

Fracture originating in the cervical region was significantly more common than a fracture originating in the apical region. Fracture originating in the mid-region were extremely scarce.

OPERATIVE

P.O.W.E.R NOTES SBQ 31

EXTRA IMPORTANT INFORMATION:

Two important factors to prevent fractures:
Post should be placed passively and excessive "post-space" should be avoided.

Predisposing factors for VRF:

- Structural integrity of the tooth
- Presence of pre-existing cracks and fractures
- Change in the biomechanical properties of dentine of root treated teeth.
- Anatomy and the root canal morphology
- Location of the tooth
- Parafunction and/ or unfavourable occlusal arrangement
- Diet

Contributary factors for VRF

- Excessive removal of sound dentin during RCT
- Prolong exposure to intracanal disinfectants and medicaments
- Inappropriate execution of post endodontic restoration

Typical clinical and radiographic features of VRF:

Clinical Features:

- +/- symptoms of apical periodontitis (e.g. tenderness to palpation and percussion, abscess etc)
- Direct visualisation of a fracture
- Isolation, narrow, dep periodontal pocket
- Presence of a sinus/multiple sinuses
- Mobility

Radiographic features of VRF:

Early stage VRF:

- No obvious change +/- subtle crestal bone loss
- The thickening of the PDL along axial root walls

Advanced stage VRF:

- J-shaped radiolucency
- Halo radiolucency
- (In)complete separation of root fragments

OPERATIVE

P.O.W.E.R NOTES SBQ 31

Flattened roots with narrow mesio-distal cross section, such as the mesial root of mandibular molars and mesio-buccal root of maxillary molars, are also more prone to fracture, due to the reduced thickness of the dentin on the proximal aspect of the root. These have been described as the "danger zones" as they are predisposed to excessive thinning of the furcal root canal dentin during instrumentation.

A recent study demonstrated that when a sinus tract is present in relation to VRF, it may be located more coronally, either at the mid root level (77.8%) or at the gingival margin (22.2%) .

Multiple sinus tracts are also common pathognomonic feature of a VRF; taking a radiograph with a GP tracer inserted into the sinus tract will allow its source to be determined and facilitate diagnosis.