# UAF VOL 2

## ULTIMATE ADVANCE FILE

# P.O.W.E.R

PREPARATION OF ADC WITH WINSPERT EXPERT REVIEW

# NOTES

## PERIODONTICS

By Dr. Jigyasa Sharma


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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!*

# PERIODONTICS

## SBQ 1

**IMPLANT UAF QUESTION VARIATION (SAME AS UAF) - OPG IS GIVEN. (ON OPG 25- POST AND CORE, 46 IMPLANT ABUTMENT ONLY.NO CROWN IS THERE) SHE DIDN'T HAVE MONEY TO COMPLETE THE TREATMENT BEFORE.NOW AFTER 1 YEAR SHE SHOWS UP FOR THE CROWN. 47 IS MESIALLY TILTED. PATIENT COMPLAINS OF PAIN ON BITING ON THE UPPER LEFT REGION AND MOBILITY SINCE THE LAST FEW DAYS. OVERALL HISTORY OF GENERALIZED PERIODONTITIS AND SMOKING HALF A PACK OF CIGARETTE A DAY. MEDICAL HISTORY OF OSTEOPOROSIS AND PT IS TAKING BISPHOSPHONATES**

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**I. You examine 25 , probing depth was around 8mm, and find mobility slightly higher than physiological mobility. What is the probable diagnosis?**

A. Split root
B. Irreversible pulpitis
C. Acute apical periodontitis
D. Periodontal abscess

**II. What would complicate implant placement?**

A. History/current periodontitis
B. History of smoking
C. Infection
D. Osteoporosis
E. Occlusal trauma

**III. You see mild inflammation around the abutment, not mobile, 3-4mm depth and 6mm distally. What is the diagnosis? (opg was not clear enough to check whether there was bone loss around the implant on distal side- it can be peri implantitis it was present or else failing implant)**

A. Peri Implant mucositis
B. Periimplantitis
C. Failing implant
D. Failed implant

**IV. What will you tell her regarding management of 46?**

A. The bone quality is good around 46
B. Ortho uprighting of 47 may be required before treating 46
C. Implants are contraindicated for osteoporosis

**V. You suspect split root. How will you examine the split root?**

A. Selective cuspal loading (not an option in some centers)
B. Raising buccal flap.
C. Probing
D. Selective cuspal loading and raising buccal flap (only in some centers)



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# PERIODONTICS

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

I. • 25 – post and core, deep narrow pocket measuring around 8mm, mobility present, pain on biting present.
   • These are classical signs of VRF/ Split root.

II. History of periodontitis vs history of smoking, smoking has more impact on implant failure.

III. • Failed implant is already mobile. In the scenario it's mentioned that theirs is no mobility. Option (D) is ruled out.
   • Failing implant has Progressive inflammation and progressive bone loss. Which means we need to assess and review the patient in each review appointment with XRAY. So, in each appointment if we are able to identify that the situation is getting worse; then we can diagnose it as "failing implant". Without review appointments with XRAY s we are not able to come to this diagnosis.
   • According to the scenario, there's only mild inflammation, not mobile, 3-4-6 mm probing depths, no evidence of bone loss around the implants. The diagnosis is more towards the "peri implant mucositis".

IV. 47 is mesially tilted. There may not be much space to place the crown over the 46. So, it's necessary to upright 47 orthodontically to gain space for the prosthesis.

V. How to identify VRF:
   • Probing around all the surfaces.
   • Surgical visualisation by raising the flap- it's not the 1st line of investigation. Option (B) is ruled out.

Cuspal loading is not for VRF, and it is for CTS. Options (A) and (D) are ruled out.

REFERENCE:

et al., 2018; Meister et al., 1980; Walton, 2017).

To detect a VRF, it is essential to use magnification and illumination. Further investigation to enhance visualization of a VRF may be performed using dyes and/or fibre optic transillumination. Removal of existing restoration

A narrow and/or flexible periodontal probe, for example, the UNC-15, PCP-12 or Click-Probe™ (Kershaw, Switzerland), should be aligned parallel to the long axis of the root being examined and gently 'walked' around the entire circumference of the tooth, to ensure that any isolated periodontal pockets are not missed.



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# PERIODONTICS

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

### V. REFERENCE:

approximated contact areas. If the VRF is still not readily visible, exploratory surgical procedures may be necessary to visualize the presence and nature of an apical fracture

(PradeepKumar et al., 2016). A recent study demonstrated that when a sinus tract is present in relation to a VRF, it may be located more coronally, either at the mid-root level (77.8%) or at the gingival margin (22.2%) (Kasahara et al., 2020). Multiple sinus tracts are also common pathognomonic features of a VRF; taking a radiograph with a gutta-percha tracer inserted into the sinus tract will allow its source to be determined and facilitate diagnosis (Tamse,



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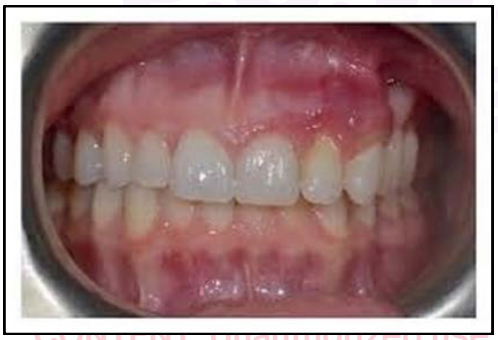
# PERIODONTICS

## SBQ 2

**A YOUNG FEMALE PATIENT AGED 28 COMES TO YOU. SHE COMPLAINS OF DISCOMFORT, WHEN YOU DID AN EXAMINATION YOU OBSERVED A SWELLING ON THE GINGIVA.**



**I. What will you ask the patient to come to a diagnosis?**

A. Recent or current history of pregnancy.
B. Pus coming from the lesion
C. Change in size or shape of lesion

**II. What would be your provisional diagnosis?**

A. Pyogenic granuloma
B. Fibroma.
C. Peripheral giant cell granuloma
D. Epulis

**III. You plan to do scaling and debridement. What risk should you inform the patient before taking consent?**

A. Risk of excessive bleeding
B. Chances of recurrence

**IV. What medication can cause such a lesion?**

A. Thyroxine
B. Calcium channel beta blockers C. Ssri
D. Antihistamines
E. Calcium and vit D



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# PERIODONTICS

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

I.
- Pus can be draining from multiple lesions. E.g. periodontal abscess, periapical abscess, Langerhans cell histiocytosis (LCH). Option (B) is ruled out.
- Change in the shape and size is not helpful to come to a diagnosis.
- Among the given the best answer is (A).

II.
- There's no pulpal pain, there's no restoration. There's no periodontal condition. It's a vital tooth.
- So, the diagnosis is more towards the pyogenic granuloma or fibroma.
- Among the given the best answer is (A).

III.
- Calcium channel blockers are associated with gingival enlargements.
- Need to explain the patient that there's a chance of recurrence and you might have to treat again if recurs.
- If you are not going to tell about the chances of recurrence and in case if it happens, patient won't be happy. He might start complaining.



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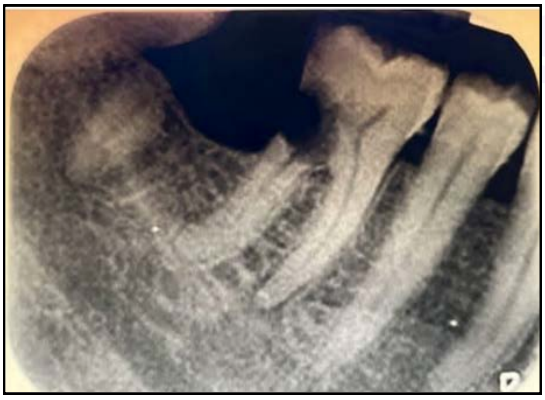
# PERIODONTICS

## SBQ 3

**PATIENT COMES TO YOU COMPLAINING OF PAIN IN THE LOWER BACK REGION. PATIENT DID NOT SAY PAIN TO COLD HOLD (NOT TO ANY STIMULUS) BUT PAINFUL AT TIMES (SUGGESTIVE OF PERIO PAIN FROM FOOD LODGEMENT)**



**I. What will you ask from the patient that will help you with diagnosis? (You suspect food lodgement)**

A. Any bad smell or taste specific to that area
B. Her oral hygiene practices, interdental cleaning habits
C. What happened to adjacent teeth

**II. How will you manage the patient ,In the X-ray you could see calculus build up in between the teeth.**

A. Do a professional scale and clean.
B. Use mouthwash
C. Use high strength fluoride
D. Refer to medical specialist

**III. What will be your home care advice to the patient?**

A. Use mouthwash
B. Use high strength fluoride
C. Use interdental cleaning aids

**IV. Patient comes back after a few weeks and says that the bad odour from the mouth is persisting despite giving dental treatment. What will you do next?**

A. Do a professional scale and clean.
B. Send the patient to a medical practitioner.

**V. What kind of habit causes this pattern of lesion in 36?**

A. Aggressive use of interdental brushes
B. Aggressive use of floss
C. Food lodgement



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# PERIODONTICS

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

I.
- Provisional diagnosis is food lodgement.
- Any bad taste or bad smell which is localised in that area is related to the food lodgement and it's confirming the provisional diagnosis.
- Oral hygiene practices are not confirming the present provisional diagnosis.
- Food impaction is happening as the adjacent tooth is extracted and there is proximal cervical caries present on the tooth.
- But option (C) is not confirming the provisional diagnosis.
- Among the given the best answer is (A).

II.
- According to the XRAY you could identify that calculus build up in between the teeth.
- Calculus can be removed only with the professional scale and clean.
- Among the given the best answer is (A).

III.
- Based on the main chief complaint which is food impaction and calculus build up mainly due to the poor interdental cleaning.
- Chief complaint is not caries rather food lodgement and calculus. So, option (B) gets ruled out.
- Both options (A) and (C) are involved with managing oral hygiene. Mouth wash is optional and adjunct. Most important thing is to use interdental cleaning aids. tooth brushing and interdental cleaning are the daily mandates. Among the given the best answer is (C).

IV.
- Even after a professional scale and clean the patient comes back with the complaint of bad odour.
- The patient should be referred to the medical practitioner to rule out extra oral causes.

**REFERENCE:**

> Management of **intraoral causes** of halitosis depends on the origin of the malodour—see Box 15 (p.126). Promote oral hygiene for patients with an intraoral cause of halitosis (see pp.273–5). If improved oral hygiene and management of intraoral causes does not resolve halitosis, referral to a medical practitioner is appropriate to investigate for extraoral causes.

V.
- Tooth 36 as proximal cervical caries. This lesion can be due to both carious and abrasive aetiology.
- Aggressive use of interdental brushes can lead this type of lesion. In the question it's asking about the causing habit.
- Food lodgement can lead to bad odour and bad taste and localised periodontitis. Food lodgement is not a habit.



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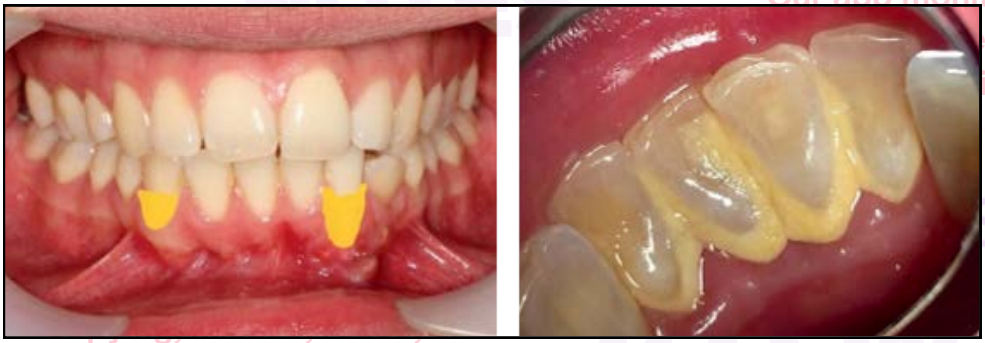
# PERIODONTICS

## SBQ 4

**A PICTURE WAS GIVEN. IN THE YELLOW MARKED PLACES, THERE WAS CALCULUS (I.E LOCATION WAS- ON YELLOW MARKS IN 1ST PICTURE BUCCALLY, LIKE SHOWN IN 2ND PICTURE). (JUST LIKE THE NEXT IMAGE TEXTURE).PATIENT DID NOT HAVE ANY PLAQUE, STAIN OR ANYTHING AT OTHER SITES.**



**I. Question asked about the oral hygiene status of a patient?**

A. Poor plaque control
B. Localised moderate calculus.
C. Mild calculus deposits.

**II. What would you advise regarding oral hygiene to this pt?**

A. Use dental floss
B. Toothpaste 5000 ppm
C. Mouthwash

**III. You diagnosed a tooth having reversible pulpitis. What specific question will support your diagnosis of reversible pulpitis?**

A. Duration of pain after initial onset
B. Response to cold stimulus



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# PERIODONTICS

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

I.
- Patient doesn't have plaque or calculus on any other area apart from the lower anterior region. So, it's not because of poor plaque control. And the condition is localised.
- It's not mild rather moderate because it's covering more amount of the tooth surface.
- Among the given the best option is (B).

II.
- 5000ppm fluoride toothpaste is given in high caries risk.
- Mouth wash is an adjunct.
- Brushing along with flossing will reduce the interdental plaque build up and will prevent calculus build up.
- Among the given the best option is (A).

III.
- Response to cold comes from both reversible and irreversible pulpitis. Duration of pain will be helpful to differentiate between reversible and irreversible pulpitis.
- Among the give the answer is (A).



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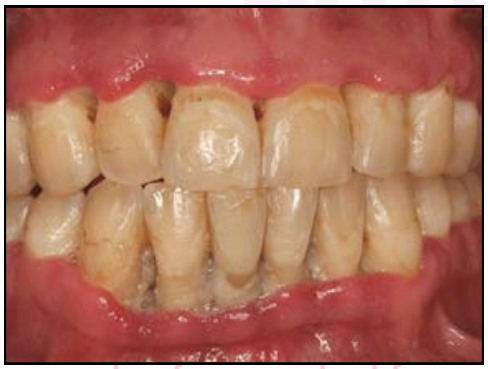
# PERIODONTICS

## SBQ 5

**PATIENT WITH POOR ORAL HYGIENE. CAME FOR ORAL PROPHYLAXIS. SHE SAID SHE IS TAKING MEDICATIONS FOR HEART MURMUR, AND IS A SMOKER 5-10 CIGARETTES PER DAY. SHE RETURNED AFTER 2 WEEKS WITH SEVERE DISCOMFORT AND PAIN IN THE GINGIVA WITH ULCERATIVE SLOUGH (OBSERVATION).**



**I. What is the diagnosis?**

A. Herpetic gingivostomatitis.
B. Necrotising periodontal disease.
C. Erythema multiforme
D. Chronic periodontitis

**II. You did gentle debridement. What is the next IMMEDIATE management?**

A. Prescribe antibiotics.
B. Refer to specialist

**III. Patient says she has a heart murmur and says used to take antibiotics for all procedures. Which prophylaxis will you give ?**

A. Amox 2g
B. Clindamycin
C. Some antibiotic with dose
D. Send her to Gp for info regarding cardiac condition.

**IV. Infective endocarditis prophylaxis would be needed for which procedure?**

A. Subgingival placement of matrix band
B. Pulpal treatment
C. Restorations



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# PERIODONTICS

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

I.
- The pain is severe, and it seems to a chronic condition. There is an ulcerative slough. There is bone involvement and recession according to the given picture.
- As the bone is involved it's not a gingivitis condition rather a periodontitis condition.
- Patient has a history of smoking and poor oral hygiene.
- Among the given the best answer is (B).

II.
- In NUG management would be involving scale and clean, antibiotic treatment with follow up review appointment.
- But NUP is not in the hands of a general dentist. So, the patient should be referred to the specialist.

III.
- AB prophylaxis is not usually given for the heart murmurs. But in this patient, there might be some added complications associated with the heart murmur and that can be the reason that she might be taking the AB prophylaxis.
- So, it's better to refer to the GP and get the opinion prior to administration of AB prophylaxis.

IV.
- AB prophylaxis is indicated when:
  i. There is a tendency to bleed during the procedure
  ii. Gingival manipulation
- Subgingival placement of the matrix band can cause bleeding.
- Among the given the best is (A).



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# PERIODONTICS

## SBQ 6

**A QUESTION WAS GIVEN REGARDING PERIODONTITIS. AND THE HISTORY MENTIONED THAT THE PT IS STRESSED AND HAS GAINED WEIGHT ALSO. WHICH FACTOR HAS MORE EFFECT ON PERIODONTITIS?**

A. Obesity
B. Stress

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

- Both stress and obesity have an impact on periodontitis. Among these obesities will increase the inflammatory load of the body.
- Body has time to repair stress. With the help of sleep, meditation etc stress can be managed.
- In obese patients there is constant physical stress in the body.
- Psychological stress is situational. Obesity is a permanent physical stress.
- Among the given the best answer is (A).

Recognized risk factors, such as cigarette smoking or metabolic control of diabetes, affect the rate of progression of periodontitis and, consequently, may increase the conversion from one stage to the next. Emerging risk factors like obesity, specific genetic factors, physical activity, or nutrition may one day contribute to assessment, and a flexible approach needs to be devised to ensure that the case-

| 1. Systemic disorders that have a major impact on the loss of periodontal tissues by influencing periodontal inflammation | |
|---|---|
| **1.1. Genetic disorders** | ICD-10 code |
| 1.1.1 Diseases associated with immunologic disorders | |
| Down syndrome | Q90.9 |
| Leukocyte adhesion deficiency syndromes | D72.0 |
| Papillon-Lefèvre syndrome | Q82.8 |
| Haim-Munk syndrome | Q82.8 |
| Chediak-Higashi syndrome | E70.3 |
| Severe neutropenia | |
| Congenital neutropenia (Kostmann syndrome) | D70.0 |
| Cyclic neutropenia | D70.4 |
| Primary immunodeficiency diseases | |
| Chronic granulomatous disease | D71.0 |
| Hyperimmunoglobulin E syndromes | D82.9 |
| Cohen syndrome | Q87.8 |
| 1.1.2. Diseases affecting the oral mucosa and gingival tissue | |
| Epidermolysis bullosa – Dystrophic epidermolysis bullosa | Q81.2 |
| – Kindler syndrome | Q81.8 |
| Plasminogen deficiency | D68.2 |
| 1.1.3. Diseases affecting the connective tissues | |
| Ehlers-Danlos syndromes (types IV, VIII) | Q79.6 |
| Angioedema (C1-inhibitor deficiency) | D84.1 |
| Systemic lupus erythematosus | M32.9 |
| 1.1.4. Metabolic and endocrine disorders | |
| Glycogen storage disease | E74.0 |
| Gaucher disease | E75.2 |
| Hypophosphatasia | E83.30 |
| Hypophosphatemic rickets | E83.31 |
| Hajdu-Cheney syndrome | Q78.8 |
| **1.2. Acquired immunodeficiency diseases** | |
| Acquired neutropenia | D70.9 |
| HIV infection | B24 |
| **1.3. Inflammatory diseases** | |
| Epidermolysis bullosa acquisita | L12.3 |
| Inflammatory bowel disease | K50 |
| | K51.9 |
| | K52.9 |

| 2. Other systemic disorders that influence the pathogenesis of periodontal diseases | |
|---|---|
| | ICD-10 code |
| Diabetes mellitus (type 1) | E10 |
| (type 2) | E11 |
| Obesity | E66.9 |
| Osteoporosis | M81.9 |
| Arthritis (rheumatoid arthritis, osteoarthritis) | M05 |
| | M06 |
| | M15-M19 |
| Emotional stress and depression | F32.9 |
| Smoking (nicotine dependence) | F17 |
| Medications | |

| 3. Systemic disorders that can result in loss of periodontal tissues independent of periodontitis | |
|---|---|
| | ICD-10 code |
| **3.1. Neoplasms** | |
| Primary neoplastic diseases of the periodontal tissues | |
| – Oral squamous cell carcinoma | C03.0 – 1 |
| – Odontogenic tumors | D48.0 |
| – Other primary neoplasms of the periodontal tissues | C41.0 |
| Secondary metastatic neoplasms of the periodontal tissues | C06.8 |
| **3.2. Other disorders that may affect the periodontal tissues** | |
| Granulomatosis with polyangiitis | M31.3 |
| Langerhans cell histiocytosis | C96.6 |
| Giant cell granulomas | K10.1 |
| Hyperparathyroidism | E21.0 |
| Systemic sclerosis (scleroderma) | M34.9 |
| Vanishing bone disease (Gorham-Stout syndrome) | M89.5 |

# PERIODONTICS

## SBQ 7

**A PATIENT WITH SEVERE PERIODONTITIS. HIS HB1AC RANGE WAS 7.EFFECT OF DIABETES IN HIS PERIODONTAL STATUS?**

A. Significant as periodontal condition will decline
B. Minimal, as periodontal condition is controlled

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

- Anything which is below 7 is grade B. But anything which is above 7 falls under grade C.
- So, HBA1C = 7 has a significant effect on periodontal condition.



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