SBQ 1 – Head and neck radiotherapy

Danny, a 36 year old, has been diagnosed with oral squamous cell carcinoma. His doctor had suggested a combination of surgery and radiotherapy which is going to begin the following week. Prior to it he was referred for a dental checkup. On examination you identified multiple carious teeth, grossly decayed 36, calculus and deposits. Patient's oral hygiene maintenance is satisfactory.

1.36 gave delayed response to cold test, you diagnosed it as irreversible pulpitis. The tooth is grade 1 mobile, how will it be best managed?

A Extraction

B Pulpectomy

C Cervical Pulpotomy

D No treatment

Ans A

36 is grossly decayed,so it should be extracted before radiotherapy as they might cause future problems.

Ref-odell Case 67 Page 378,379

Teeth that are **infected, unrestorable or have pockets of greater than 5 mm** depth should be extracted. Extraction of partially erupted third molars, as well as any teeth that are likely to become inaccessible after cancer treatment, is recommended, bearing in mind that there is a high risk of caries needing treatment in the future and of reduced mouth opening.A

Grossly decayed teeth will cause problems in the future, so the tooth should be extracted before starting radiotherapy.

2. While undergoing radiotherapy the patient complains of a painful mouth? How will you manage it?

A.Advise the patient to use analgesic mouth solutions, to try eating bland and soft food, brush using a soft toothbrush after bedtime and to rinse mouth with ½ teaspoon of salt in 1 cup of warm water.

B Advise the patient to use analgesic mouth solutions, to try eating bland and soft food, brush using a soft toothbrush after each meal and at bedtime to rinse mouth with ¼ teaspoon of salt in 1 cup of warm water

C Advise the patient to use Benzydamine hydrochloride 1.5% solution, , to try eating bland and soft food, brush using a soft toothbrush after bedtime and to rinse mouth with ½ teaspoon of salt in 1 cup of warm water.

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D Advise the patient to use analgesic mouth solutions like lidocaine 0.2% maximum 8 doses in 24 hours, to try eating bland and soft food, brush using a soft toothbrush after each meal and at bedtime to rinse mouth with ¼ teaspoon of salt in 1 cup of warm water

Ans B

Option A and C are ruled out as brushing is not done after bedtime,but at bedtime.Benzydamine hydrochloride is used in 0.15%

Option D is ruled out as lignocaine 2% is used, not 0.2%.

Ref-TG106,120,121,

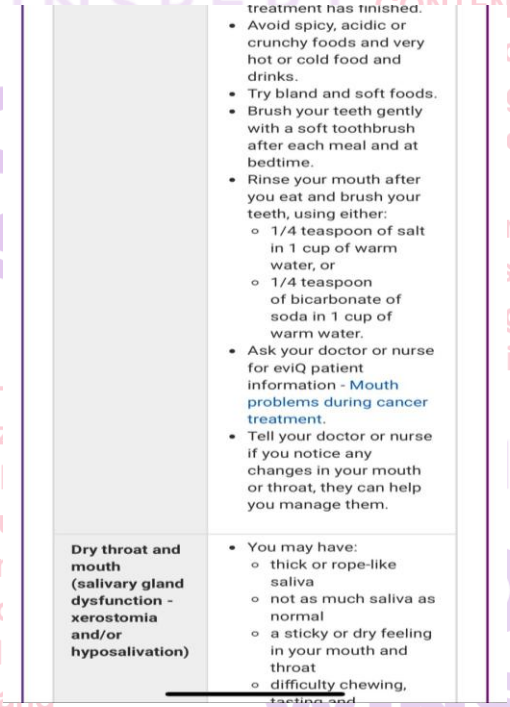
https://www.eviq.org.au/radiation-oncology/head-and-neck/3390-head-and-neck-squamous-cell-carcinoma-adjuvan/patient-information#side-effects

Initial and regular ongoing assessment of oral pain is essential. **Lubricants** and **analgesic mouth solutions** may reduce pain and inflammation.

1 benzydamine hydrochloride 0.15% solution 15 mL, rinsed in the mouth for 30 seconds then spat out, 1.5- to 3-hourly as necessary (use diluted with 15 mL of water if stinging occurs)

OR

2 lidocaine 2% viscous solution, use the lowest dose necessary up to 15 mL, rinsed in the mouth for 30 seconds then spat out, 3-hourly as necessary; maximum 8 doses in 24 hours.



	treatment has finished. • Avoid spicy, acidic or crunchy foods and very hot or cold food and drinks. • Try bland and soft foods. • Brush your teeth gently with a soft toothbrush after each meal and at bedtime. • Rinse your mouth after you eat and brush your teeth, using either: ◦ 1/4 teaspoon of salt in 1 cup of warm water, or ◦ 1/4 teaspoon of bicarbonate of soda in 1 cup of warm water. • Ask your doctor or nurse for eviQ patient information - Mouth problems during cancer treatment. • Tell your doctor or nurse if you notice any changes in your mouth or throat, they can help you manage them.
Dry throat and mouth (salivary gland dysfunction - xerostomia and/or hyposalivation)	• You may have: ◦ thick or rope-like saliva ◦ not as much saliva as normal ◦ a sticky or dry feeling in your mouth and throat ◦ difficulty chewing, tasting and

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3. Which is least likely to occur amongst the following in this patient ?

A presence of thin watery saliva

B problem with voice

C increased risk of systemic infection and require longer hospital admission

D Anorexia

Ans – A

Salivary glands are radiosensitive tissues,which get affected by radiation therapy causing reduction in saliva quality and quantity.

Radiation therapy to the head and neck region may result in a change in the amount and consistency of saliva, as mucous glands are highly sensitive to radiation. Thick saliva may begin during the first one to two weeks of radiation. Partial recovery of salivary gland function has been observed to occur as early as 2-6 months after cessation of treatment but may persist for more than five years. Major determinants include the patient's age, dosage of radiation and field of exposure.

Ref-Odell Page 377

TABLE 67.1 Adverse Effects of Radiotherapy To the Mouth and Adjacent Areas

Early
- Xerostomia
- Oral mucositis
- Skin burns
- Oral infections, particularly candidosis
- Taste alteration

Longer-Term
- Xerostomia
- Trismus
- Radiation caries
- Loss of periodontal attachment
- Osteoradionecrosis

General
- Weight loss
- Fatigue
- Eating difficulty
- Swallowing difficulty
- Speech difficulty

4. 5 years after cancer therapy, the left mandibular second molar (37) has fractured?

A manage conservatively

B You can extract the tooth

C consult oral and maxillofacial surgeon/specialist

D consult patient's multidisciplinary team

Ans D

Ref-TG Page 175

Patients who have had head and neck radiotherapy are at increased risk of osteoradionecrosis. Encourage regular dental review and seek advice from the patient's multidisciplinary team before performing tooth extractions that are within the field of radiotherapy. If possible, choose conservative dental

5. Which among the following would have occurred as a long term side effect of head and neck radiation?

A Mucositis

B Taste alteration

C Trismus

D Loss of appetite

Ans C

Ref-Odell case 67,Page 377

TABLE 67.1 Adverse Effects of Radiotherapy To the Mouth and Adjacent Areas

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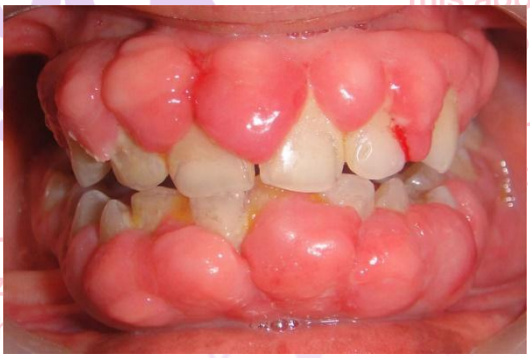
- Loss of periodontal attachment
- Osteoradionecrosis

General
- Weight loss
- Fatigue
- Eating difficulty
- Swallowing difficulty
- Speech difficulty

SBQ 2 – Epileptic patient- Gingival enlargement

A 46 year old female presented with a chief complaint of “My gums are swollen and bleed”. He has been taking Dilantin 500 mg daily. Additionally she also took 2000 mg Depakote(sodium valproate) daily and 10 mg Zyprexa(antipsychotic) at bedtime. No history of known allergies. The patient did not brush or floss her teeth consistently. Intraoral examination revealed generalized marginal erythema, enlarged papilla and bleeding on probing. Probing pockets depths ranged from 2-5mm. No CAL



1. What is the most common cause of gingival enlargements?

A Dental plaque-induced

B Drug induced

C Leukemic

D hereditary gingival fibromatosis

Ans A

Ref-Gingival enlargements and localised gingival growths-ADJ 2010 article

Gingival enlargement is a common finding in clinical practice and the appropriate treatment depends on correctly diagnosing the cause of the enlargement. The most common form of enlargement is due to plaque-induced inflammation of the adjacent gingival tissues (inflammatory hyperplasia) and this tends to be associated most commonly with the interdental papillae and may be localized or generalized. Such gingival enlarge-

2. Which drug is least likely to cause this type of gingival enlargement?

A Depakote

B Dilantin

C Zyprexa

D None of the above

Ans C

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Among the drugs the patient is using, Zyprexa is an antipsychotic drug,it will not cause gingival enlargement.

Ref-Carranza ,chapter 3,page 47

Gingival Diseases Modified by Medications. Gingival diseases that are modified by medications are increasingly prevalent as a result of the increased use of drugs known to induce gingival enlargement. These include anticonvulsant drugs such as phenytoin, immunosuppressive drugs such as cyclosporine (Figure 3-6), and calcium channel blockers such as nifedipine (Figure 3-7), verapamil, diltiazem, and sodium valproate.[15,26,39]

3. What will be the first step in your treatment plan?

A prescribe the patient an alternative medicine

B Oral hygiene instructions

C Initial phase therapy of subgingival scaling

D Gingivectomy

Ans B

Ref-Carranza,chapter 58 ,Page 588

Second, the clinician should emphasize plaque control as the first step in the treatment of drug-induced gingival enlargement. Although the exact role played by bacterial plaque is not well understood, evidence suggests that good oral hygiene, chemotherapeutics,[24] and the frequent professional removal of plaque decrease the degree of gingival enlargement and improve overall gingival health.[10,12,26] The presence of drug-induced enlargement is associated with pseudopocket formation, frequently with abundant plaque accumulation, which may lead to the development of periodontitis; meticulous plaque control therefore helps to maintain attachment levels. In addition, adequate plaque control may help to prevent the recurrence of gingival enlargement in surgically treated cases.

4. On the day of the scaling procedure, the patient reports that she has failed to take her medication, but she wants you to perform the procedure, what will you do?

A Do scaling as it is a minimal invasive procedure

B Refuse to do treatment

C Explain to the patient that drug omission can cause seizures

D Call in a specialist for help

Ans C

Patient should be explained about the probable consequences of not taking antiepileptic medication

Ref-TG Page 183

For patients with epilepsy, assess the stability of their condition, including how frequently seizures occur and what triggers them. At each appointment, check that the patient has taken their usual medication because omission of doses can cause seizures.

5. You go ahead with performing the oral prophylaxis, there is sudden jerky movement of the head, arms and legs, and you stop the dental treatment and manage the situation. Patient recovered completely. What further instruction is not needed for this patient?

A To keep patient under observation for a minimum of 4 hours

B Do not allow the patient to drive

C Advise patient to seek urgent medical review

D Provide a written summary of events directly to medical practitioner

Ans A

Ref-TG Page 248

For seizures of unknown cause or in patients with known epilepsy, if the patient recovers completely, keep under observation for at least a further 30 minutes. Do not allow the patient to drive home. Advise the patient to seek urgent medical review and provide a written summary of events of the seizure directly to the medical practitioner.

SBQ 3- Adrenaline insufficiency- Asthma

A 59 year old female patient reported pain in left lower back teeth region for the past one week. She also says that she has a bad oral odor since the last two days and has tried various home remedies for the same. Food gets stuck in that region frequently. Her past medical history revealed she is an asthmatic and is under medication for the same, frequently uses inhalers, she adds that she rinses her mouth after each puff. On examination, you found a mobile bridge irt 35-37, with gingival inflammation around the abutment teeth region. No pus discharge was seen.

1. What investigation will you do further?

A Percussion

B Probing

C Pulp vitality tests

D IOPA

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E Palpation

Ans D

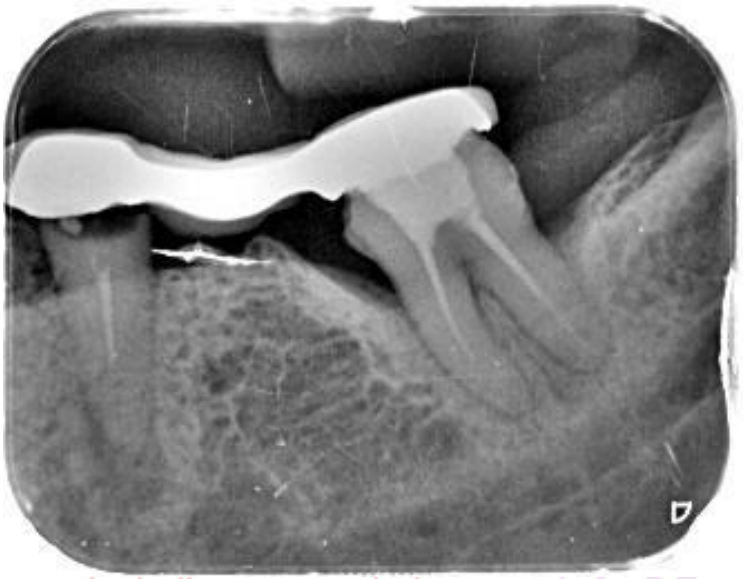
Ref-Odell case 43,page 239

Periapical radiographic imaging can provide information regarding the disease status of teeth – including caries, periodontal bone loss or other pathology such as periradicular involvement – requiring attention before a bridge can be provided. It may also be necessary to assess the quality of pre-existing root fillings or for root treatment if either abutment tooth proves to be nonvital on examination .

Odell case 12-Page 69

	resin models.
Long cone periapical radiographs and bitewing radiographs of all teeth with restorations	To detect carious lesions, assess bone levels and to determine if there is any pulp/periapical pathology as well as the quality of any existing endodontic treatments. To determine the pulp canal morphology in case root canal (re-) treatment is required or the root morphology, in case extraction is necessary.

2. What does the IOPA reveal?



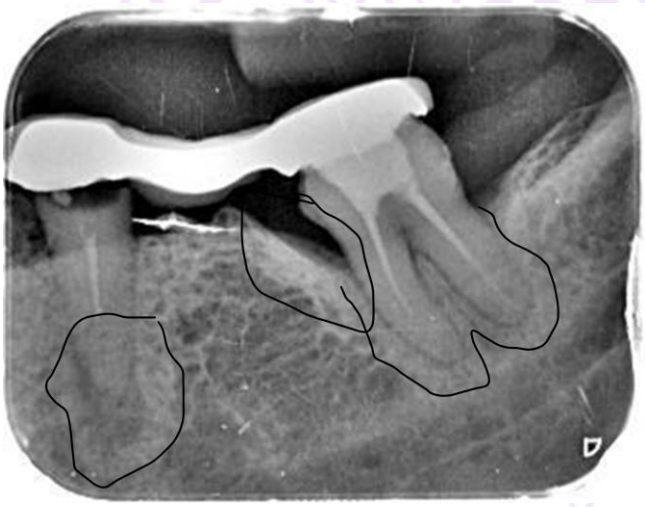
A radicular cyst in relation to 35 and 37

B Periapical pathology in relation to 35 and PDL widening in 37

C severely curved root anatomy of 37

D external root resorption

Ans B



AS shown in the radiograph,the findings are

1. radiolucency in relation to apex of 35
2. mesial angular bone loss 37
3. widening of PDL in relation to 37

3. You removed the bridge and assessed the tooth 35 for prognosis. Which of the following will not indicate poor prognosis of the tooth?

A minimal remaining tooth structure

B grade III mobility

C periapical pathology

D vertical root fracture

Ans C

Ref

Periapical pathology can be managed by endodontic treatment,

Minimal remaining tooth structure-poor prognosis **(present status of VRF - latest article folder)**

Grade 3 mobility-poor prognosis**(12th edition carranza)**

VRF-Poor prognosis **(present status of VRF -article)**

4. Which of the following is true in management of this patient?

A Schedule an appointment in the morning as they can precipitate emergency like adrenal crisis

B Schedule an appointment in the morning as during that time they are less prone to asthmatic attacks

C Schedule as the last patient of the day to reduce risk of asthmatic attacks

D Schedule an appointment in the afternoon as during that time they are less prone to asthmatic attacks

Ref-TG Page 163

Ans A

types of oral and dental procedures. Perform dental treatment in the morning so that if an adrenal crisis occurs, symptoms present while the patient is awake. After dental treatment, ensure the patient remains in the care of a responsible adult for the rest of the day, and the carer remains in contact with the patient for the following 2 to 3 days. Advise the patient and the carer to seek urgent medical attention if the patient experiences symptoms of adrenal insufficiency.

5. While performing the extraction, you observe that the patient is having difficulty in breathing and you observe she uses her abdominal muscles to breathe? What is your immediate action?

A Stop dental treatment, give 4 puffs of salbutamol inhaler via a spacer, 1 puff at a time.

B Stop dental treatment, sit patient upright, call 000

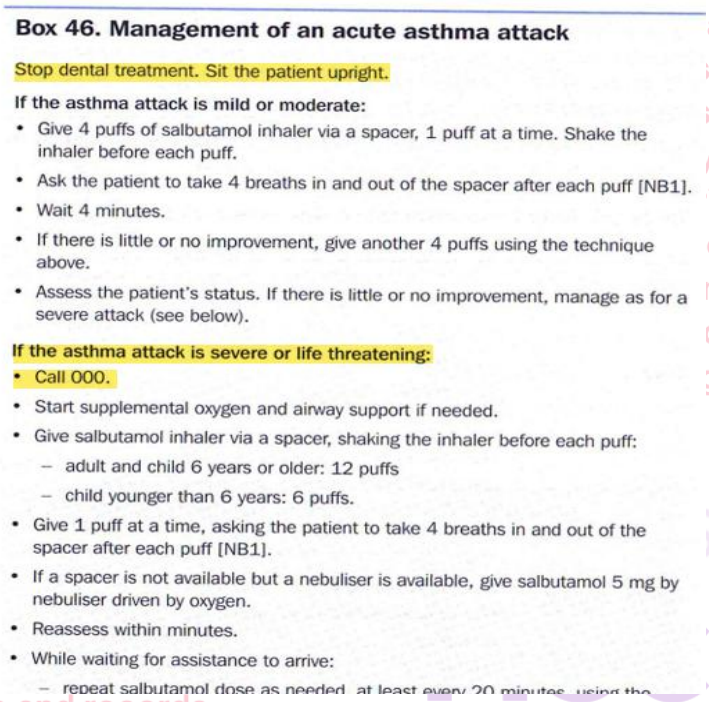
C Stop dental treatment, lie the patient flat and assess breathing

D Stop dental treatment, sit patient upright and give 4 puffs of salbutamol inhaler via a spacer, 1 puff at a time.

Ans B

Ref-TG Page 255,256

As the patient uses her abdominal muscles to breathe ,she is having a severe asthma attack.



Box 46. Management of an acute asthma attack

Stop dental treatment. Sit the patient upright.

If the asthma attack is mild or moderate:

- Give 4 puffs of salbutamol inhaler via a spacer, 1 puff at a time. Shake the inhaler before each puff.
- Ask the patient to take 4 breaths in and out of the spacer after each puff [NB1].
- Wait 4 minutes.
- If there is little or no improvement, give another 4 puffs using the technique above.
- Assess the patient's status. If there is little or no improvement, manage as for a severe attack (see below).

If the asthma attack is severe or life threatening:

- Call 000.
- Start supplemental oxygen and airway support if needed.
- Give salbutamol inhaler via a spacer, shaking the inhaler before each puff:
  - adult and child 6 years or older: 12 puffs
  - child younger than 6 years: 6 puffs.
- Give 1 puff at a time, asking the patient to take 4 breaths in and out of the spacer after each puff [NB1].
- If a spacer is not available but a nebuliser is available, give salbutamol 5 mg by nebuliser driven by oxygen.
- Reassess within minutes.
- While waiting for assistance to arrive:
  - repeat salbutamol dose as needed, at least every 20 minutes, using the

SBQ 4- Caries Risk Assessment

A 13 year old patient has come for a routine dental checkup. She says she brushes her teeth twice daily, but eats a lot of sugary foods, snacks on cakes and cookies quite often. She enjoys drinking coke by swishing it in her mouth. She doesn't drink tap water. Her 11 and 21 showed white spots that remained even after drying the teeth, occlusal decay was present with respect to 36, 46 and 26. 16 is restored.

1 What is the WHO recommendation of free sugar consumption daily?

A. free sugar consumption should be less than 15% of total dietary energy intake

B free sugar consumption should be less than 25% of total dietary energy intake

C. free sugar consumption should be less than 10% of total dietary energy intake and that restricting free sugar intake to less than 6% of total dietary energy intake has additional oral health benefits

D . Free sugar consumption should be less than 10% of total dietary energy intake and that restricting free sugar intake to less than 5% of total dietary energy intake has additional oral health benefits

Ans D

Ref=sugar rich diet and oral health:information for dental practitioner

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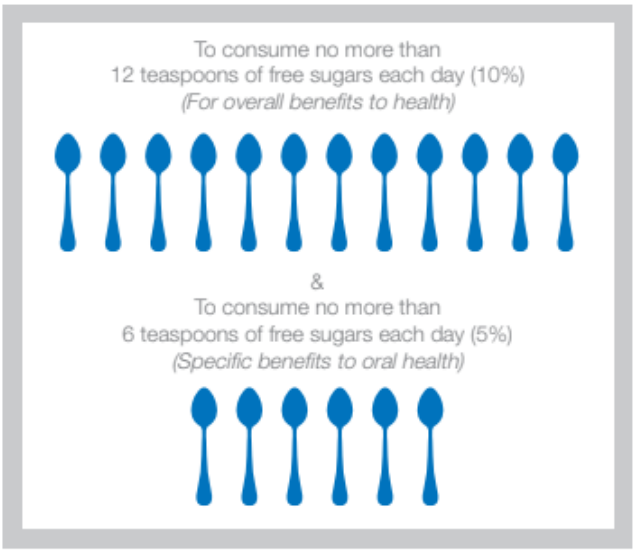

Figure 4: World Health Organisation free sugar intake recommendations[3]

2 Oral health care professionals should include?

A diet assessment when the patient is identified to be prone to dental caries.

B an assessment of diet-related caries risk factor in the patient's initial health history.

C diet assessment following examination of oral cavity.

D diet assessment following stabilization of caries if any.

Ans B

Ref-Chair side diet assessment of caries risk article in operative folder

Oral health care practitioners should include an assessment of diet-related caries risk factors in the patient's initial health history. Administering this assessment before performing the oral examination will not interrupt the flow of the oral examination and can improve patients' perception of dietary questions and honesty of response. In contrast, if the oral health care practitioner has a wide-eyed look after performing the oral examination and asks the patient vague questions about dietary habits, a patient's defenses may be raised and he or she may minimize reporting actual behaviors.

3 What is the most important contributing factor in a patient's history for dental caries?

A Low salivary buffering capacity

B Poor oral hygiene

C Not drinking tap water

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D coke consumption containing sugar and lower pH

AnsD

Ref-Sugar rich diet and oral health-university of Adelaide article in operative folder

Roles of Sugars in dental caries

Many factors can contribute to the development of dental caries (both dietary and non-dietary factors). These include the presence of plaque-producing bacteria, susceptibility of tooth surfaces, frequency of eating, oral hygiene practices, fluoride availability, and salivary flow. Of all these factors, diet plays an important role and within diet, **sugars** are the major cause of dental caries[8].

4 How will you manage 11 and 21

A Apply 3%NaF varnish on the lesion and 1.23% NaF gel at recall appointments

B Apply 4%NaF varnish to occlusal and approximal surfaces and 2% NaF gel at recall appointments

C Apply 5%NaF varnish to occlusal and approximal surfaces and 1.23% NaF gel at recall appointments

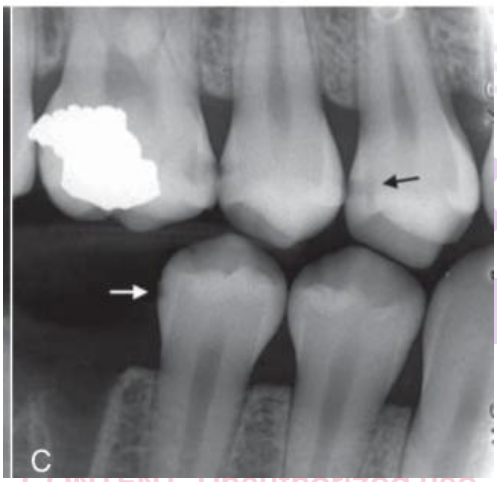
D Apply 6%NaF varnish to occlusal and approximal surfaces and 1.23% NaF gel at recall appointments

Ans C

Ref-Evans article -caries management system for child and adolescents

Caries risk	Fluoride varnish (Duraphat) 5% NaF (22 600 ppm) and GIC (Fuji 7)	Fluoride gel 1.23% NaF (12 300 ppm)
At-risk	• Apply varnish or GIC (e.g., Fuji 7) to occlusal and approximal surfaces of newly erupted primary and permanent molars • Apply varnish to surfaces with lesions (clinical and radiographic) and the respective apparently sound surfaces on homologous teeth at *every treatment session*, then • Application as above at each review and recall appointment until patient becomes low risk.	*Not to be used under the age of 10* For age groups 10 and above: • At recall appointments instead of varnish (for whatever reason)

5 14 in bitewing depicts which lesion?



A C1

B C2

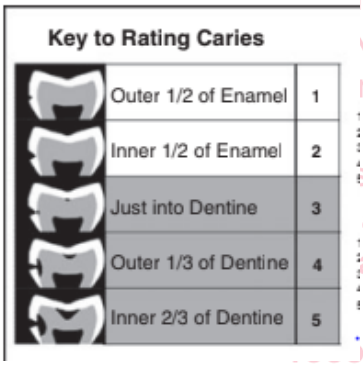
C C3

D C4

Ans D

as the caries is seen within the outer ⅓ of dentin -it is C4 lesion

Ref-Caries management system-Evans article



6 On observing the IOPA,,radiolucency extends completely into third of dentin.How will you manage 14?

A restore

B extract

C use remineralizing agent

D Apply GIC

Ans A

Ref-Evans article

C4 in permanent teeth in an adolescent at risk child involving ⅓ of dentin is restoration

Bitewing	C1	Do not restore – apply topical fluoride and monitor
	C2	Do not restore – apply topical fluoride and monitor
	C3	Do not restore – apply topical fluoride and monitor
	C4	Do not restore *without further consideration*
	C5	Restore now

Further consideration of C4 surfaces	• If possible, separate teeth and restore ***only if*** cavitated is revealed • If ***not possible to separate,*** restore only if radiolucency extends ***fully ⅓*** through dentine • Otherwise, do not restore because it is more likely than not that the approximal surface: – is ***not*** cavitated – and lesion progression ***could be*** arrested or ***has already*** arrested • Implement preventive stategy to: – arrest active lesions – remineralize lesions – maintain arrested lesions

SBQ 5 – Dry socket

A 25 year old female patient reported severe pain in left lower back teeth region for the past three days.The symptoms aggravated since yesterday . She has the habit of smoking 4 cigarettes per day.She informs you that she had peptic ulcer disease which is cured now. On intraoral examination 36, 37 ans 38 were restored. There was an inflamed pericoronal flap on the distal of 38. No tender lymph nodes, no facial swelling , no raise in axial temperature. You have planned for extraction of 38.

1.All of the following are indications for third molar extraction except ?

A Extensive caries

B Severe periodontal disease

C Fracture of mesiobuccal cusp

D Cyst

Ans C

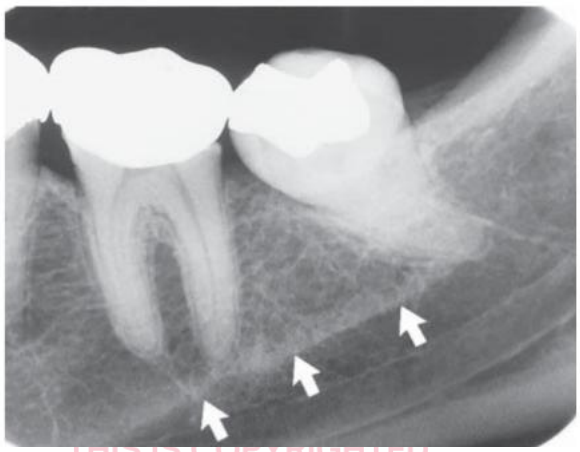
Fractured cusp can be restored by direct or indirect cusp capping.

Ref-extraction of first ,second,third molars-ADJ article in oral surgery folder

Table 2. Indications, disadvantages and proposed timing for extraction of molar teeth

Tooth/condition	First molar	Second molar	Third molar
Indications	Caries, endodontic problems, hypomineralization	Caries, ectopically eruption, severely rotated, orthodontic treatment	Caries, periodontal defects, pericoronitis, odontogenic cyst, dental tumours

2.You took an IOPA , What is the white line depicted by arrows?



A External oblique ridge

B Mylohyoid ridge

C Superior border of mandibular canal

D bony exostoses

Ans B

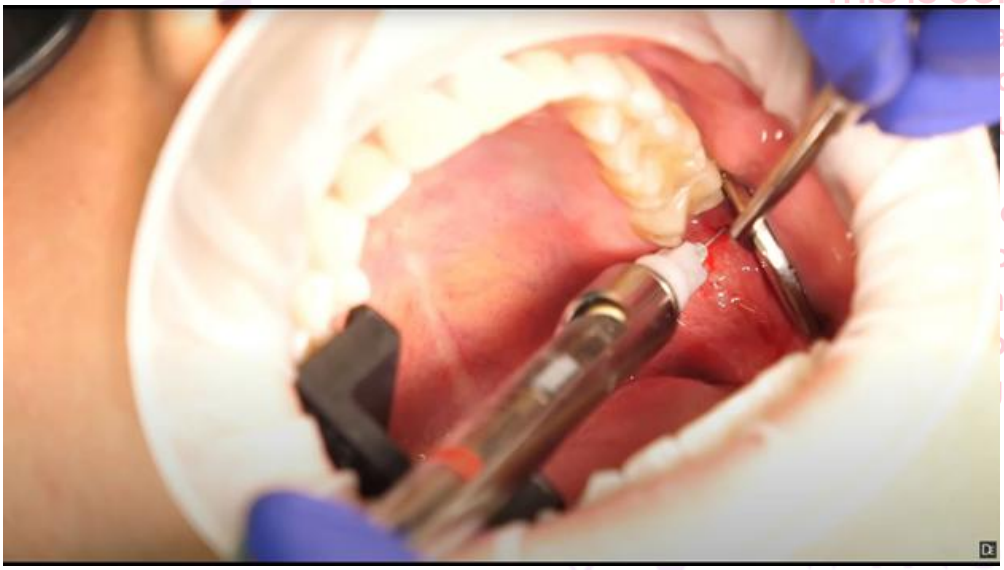
That white line is internal oblique ridge or mylohyoid ridge

Ref-White and pharoah Page 169

Mylohyoid Ridge

The mylohyoid ridge is a slightly irregular crest of bone on the lingual surface of the mandibular body. Extending from the area of the third molars to the lower border of the mandible in the region of the chin, it serves as an attachment for the mylohyoid muscle. Its radiographic image runs diagonally downward and forward from the area of the third molars to the premolar region, at approximately the level of the apices of the posterior teeth (Fig. 10-55). Sometimes this image is

3. Advantage of the mandibular nerve block technique in image is that it can anesthetize two nerves in addition to direct technique . What are they?



A Nerve to mylohyoid and Lingual nerve

B Auriculotemporal and long buccal

C Mental nerve and lingual nerve

D Buccal nerve and marginal mandibular nerve

Ans B

IAN Nerve block techniques -articles in oral surgery folder

3.4. Gow-Gates Mandibular Block Technique. The Gow-Gates mandibular block is often referred to as a true mandibular block as the distribution of its effect is larger than that of lower-level nerve block techniques and it anaesthetises the auriculotemporal and long buccal nerves in most cases [1].

A combination of intraoral and extraoral landmarks are used for the Gow-Gates mandibular block technique. Firstly, the height of injection is established by the mesiopalatal cusp of the maxillary second molar [1]. Secondly, the site of injection is the tissue immediately distal to the maxillary second molar (or maxillary third molar if present) [1]. The

4.It was a difficult extraction. On the 4th day after surgery the patient reported to the nearby medical practitioner with severe pain in that region , disrupting her sleep. The doctor prescribed the patient which of the following drugs ?

A Amoxicillin + Paracetamol

B Paracetamol + Ibuprofen

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C Paracetamol

D Paracetamol + oxycodone

Ans D

Ref-TG Page 190,138

Patient is having severe pain 4 days after extraction, suggestive of dry socket.

Option A-is ruled out as antibiotics are not needed in dry sockets as there is no spreading infection.

Option B is ruled out -As Patient had peptic ulcer history, ibuprofen is contraindicated

Option C is ruled out as Paracetmol alone is not sufficient for severe pain.

5.What could be the etiology of such symptoms ?

A Dry socket

B Premature lysis of clot or Dislodgement of clot

C Post extraction infection

D MRONJ

Ans B

Ref-TG Page 190

The condition is dry socket,etiology is premature lysis of blood clot or clot dislodgement

> Alveolar osteitis (dry socket) is a localised painful osteitis of an extraction socket following premature lysis of the blood clot. It complicates approximately 5% of tooth extractions. The condition presents as postoperative pain in and around an extraction socket that increases in severity between 1 and 4 days after the extraction. A disintegrated blood clot within the socket, with or without halitosis, is diagnostic. Although alveolar osteitis

SBQ 6- Pedo case

A father brought his 8 year old son to your clinic, he reported that the kid fell down while skating and broke his teeth, about 2 days ago. He then had a wound in his lower lip, which is not very prominent now . The kid avoids eating and says he feels pain in the front teeth region.

1 What is the lesion seen on the lower lip ?

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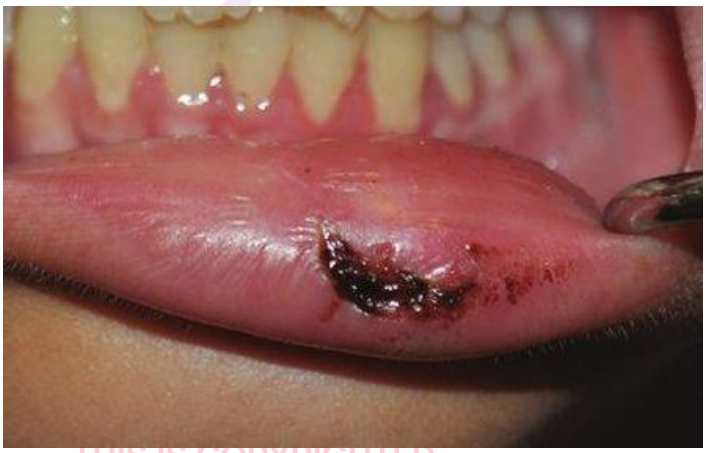


A Abrasion

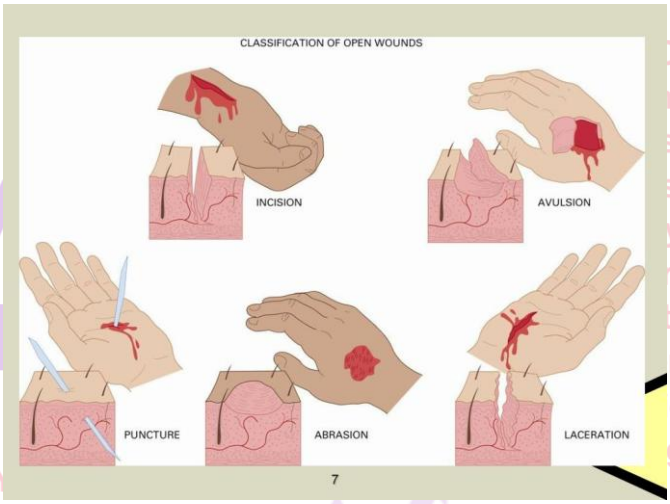
B Laceration

C Puncture

D Avulsion

Ans B

It is a cut in the lip, indicating laceration.



2 What will you evaluate first?

A radiograph to check for missing fragment of teeth

B the possibility of luxation injury

C the chipped of portion of tooth if present

D the possibility of head injury

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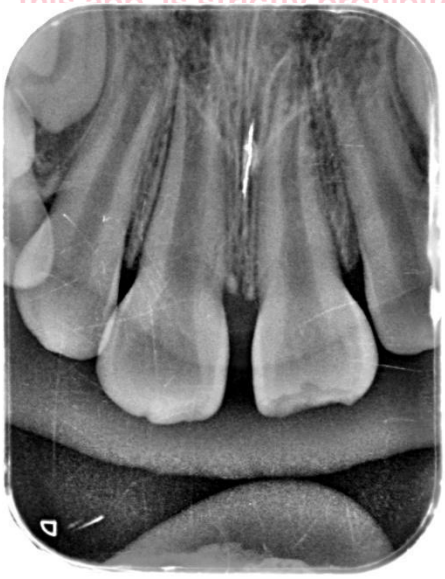
Ans B

For all the traumatic injuries causing tooth fractures, clinical examination involves evaluation of possibility of luxation injuries.

Clinical findings

- No sensitivity to percussion or palpation
- Evaluate the tooth for a possible associated luxation injury or root fracture, especially if tenderness is observed
- Normal mobility
- Pulp sensibility tests usually positive

3 IOPA given . What is your diagnosis of 11 and 21



A Complicated crown fracture in relation to 11 and 21
B Uncomplicated crown fracture in relation to 11 and 21
C Complicated crown fracture in relation to 11 and uncomplicated crown fracture in relation to 21
D Uncomplicated crown fracture in relation to 11 and complicated crown fracture in relation to 21

Ans B

Ref-Trauma guidelines -fractures and avulsion

As the fracture line is not involving the pulp chamber in 11 and 21,it is uncomplicated fracture

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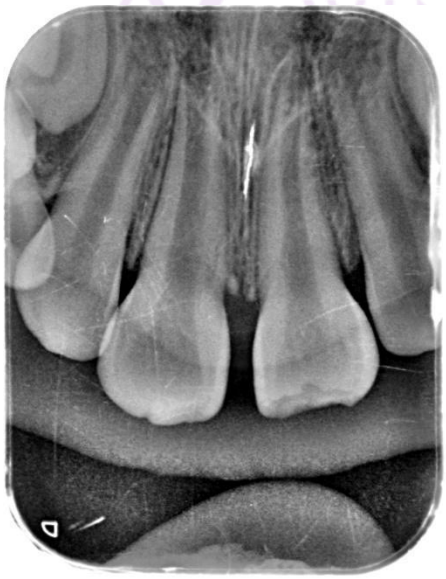
4 How will you manage 11 and 21



A Smoothen sharp edges in relation to 11 and resin composite restoration in relation to 21

B Partial pulpotomy in 11 and 21

C Resin composite restoration in relation to 11 and Partial pulpotomy in 21

D Wait and observe in follow ups

Ans A

Ref-VPT Document,trauma guidelines page 319

smoothen the sharp edges for 11 as the fracture is only in enamel

composite restoration for 21 as dentin is also involved

Treatment for11

Treatment
• If the tooth fragment is available, it can be bonded back on to the tooth • Alternatively, depending on the extent and location of the fracture, the tooth edges can be smoothed, or a composite resin restoration placed

treatment for 21

Treatment	F
• If the tooth fragment is available and intact, it can be bonded back on to the tooth. The fragment should be rehydrated by soaking in water or saline for 20 min before bonding • Cover the exposed dentin with glass-ionomer or use a bonding agent and composite resin • If the exposed dentin is within 0.5 mm of the pulp (pink but no bleeding), place a calcium hydroxide lining and cover with a material such as glass-ionomer	C • • •

\

5. 11 and 21 had mild mobility in the horizontal plane , but radiographically no abnormal changes of periodontium was noted ? What has to be done to stabilize the tooth ?

A Passive and flexible splint for upto 2 wk

B Passive and flexible splint for upto 4 wk

C No treatment is needed

D Rigid splinting for upto 4 wks

Ans C

As there is only mild mobility,so no splinting is needed

Ref-Trauma guidelines page 325

Treatment

- Normally no treatment is needed
- A passive and flexible splint to stabilize the tooth for up to 2 wk may be used but only if there is excessive mobility or tenderness when biting on the tooth
- Monitor the pulp condition for at least one year, but preferably longer

6.Which of the follow up sequence Is correct for this patient ?

A After 4 week, 8 week, 12 week, 6 months and 1 year

B After 4wk , 1 year later

C After 4 weeks, 12 weeks, 6 months , 1 year

D After 6-8 week, 1 year

Ans C

As there is no splinting needed first follow -up will be at 4 weeks instead of 2 weeks

Ref-Trauma guidelines page 325

Follow up
Clinical and radiographic evaluations are necessary: • after 2 wk S+ • after 12 wk • after 6 mo • after 1 yr

SBQ 7- Pedo case

Kate comes with her daughter Rhea, reports to your dental practice for routine dental check up. She has undergone numerous dental treatments to manage her carious teeth. She is worried if her daughter will inherit the same and wants to get them checked early and managed appropriately . She says that her daughter is very irregular with brushing and takes a lot of time to chew her food and swallow it.

1 Your assistant brings the patient into the pediatric room , you observe that rhea is very stubborn to leave her mother and keeps holding her hand. After some effort she agrees to sit on the chair , she is reluctant to answer your questions , but allows you to examine her. What is her attitude towards dental treatment ?

A Extremely negative

B Negative

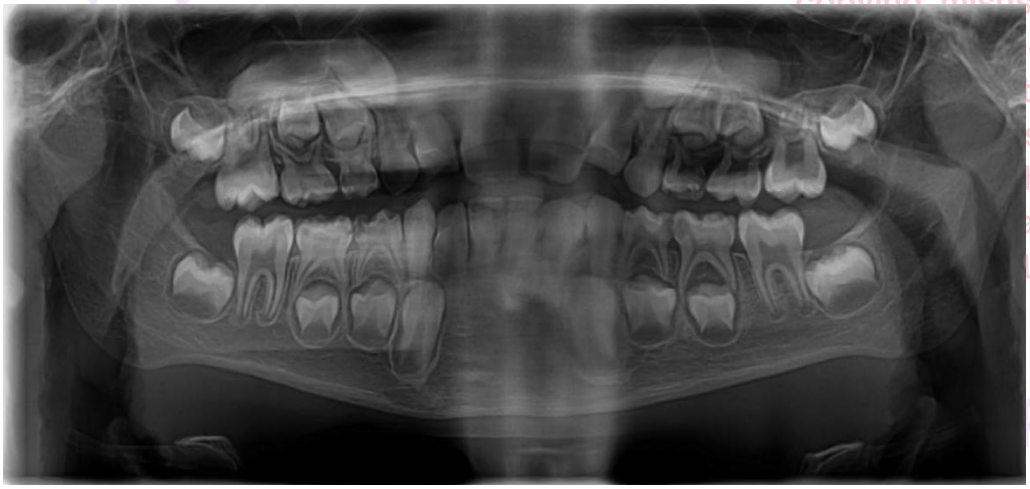
C Positive

D Extremely positive

Ans B

FRANKL BEHAVIOR RATING SCALE		
RATING	**ATTITUDE**	**DEFINITION**
1	Definitely negative	Refusal of treatment, crying forcefully, fearful or any other overt evidence of extreme negativism.
2	Negative	Reluctant to accept treatment, uncooperative, some evidence of negative attitude but not pronounced, i.e./ sullen, withdrawn.
3	Positive	Acceptance of treatment; at times cautious, willingness to comply with the dentist, at times with reservation but patient follows the dentist's directions cooperatively.
4	Definitely positive	Good rapport with the dentist, interested in the dental procedures, laughing, and enjoying the situation.

2 You take an OPG , Identify the age of the child ?



A 5-6 year
B 6-7 years
C 7-8 years
D 8-9 years

Ans D

upper laterals also erupted ,which indicates that age is around 8-9 years

Ref-Trauma guidelines Page 269

Upper Teeth	Erupt
central incisor	7 to 8 years
lateral incisor	8 to 9 years
canine (cuspid)	11 to 12 years
first premolar (first bicuspid)	10 to 11 years
second premolar (second bicuspid)	10 to 12 years
first molar	6 to 7 years
second molar	12 to 13 years
third molar (wisdom tooth)	17 to 21 years

3. With respect to 74,75 and 36, what is the score for her bitewing radiolucencies?

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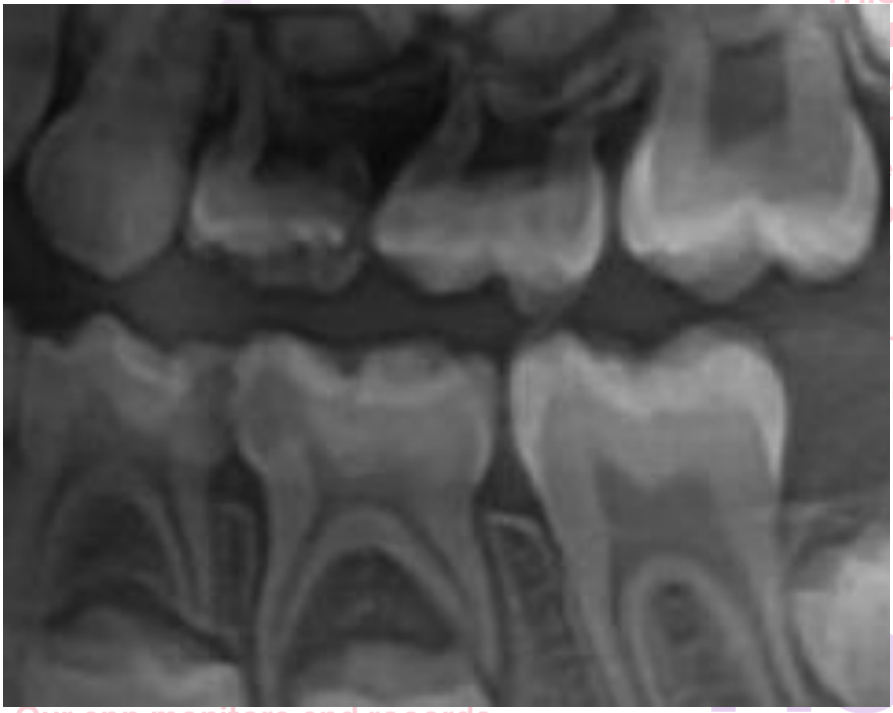

A C4,C5 and C3

B C5,C5 and C0

C C5,C5 and C3

D C4,C5 and C1

Ans C

Ref-Evan's article -caries management system

74,75-involving the entire dentin- so C5

36-involved entire enamel and reached just beyond DEJ

Criteria for Bitewing Radiolucency Scores	
C0	No radiolucency evident (not recorded)
C1	Radiolucency is evident within the ***outer half*** of enamel
C2	Radiolucency extends to the ***inner half*** of enamel and may reach the DEJ
C3	Radiolucency extends ***just beyond*** the DEJ
C4	Radiolucency is evident within the ***outer third*** of dentine
C5	Radiolucency extends to the ***inner two thirds*** of dentine and may reach the pulp

4. How will you manage 75, which is asymptomatic and carious to a great extent ?

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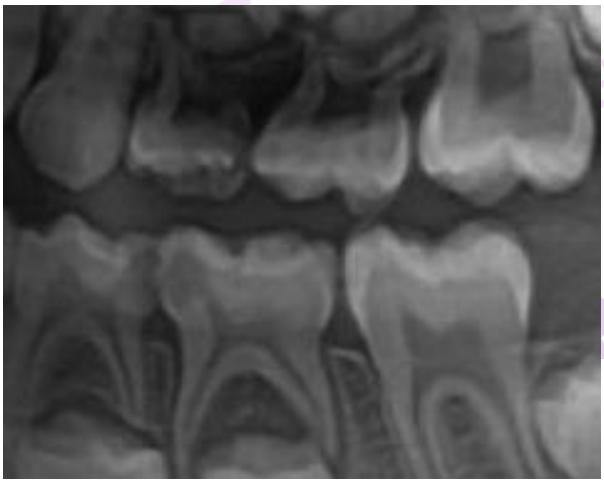


A Pulpotomy and SCC

B Pulpectomy and SCC

C DPC

D IPC

Ans B

Ref-Evans article,restorative treatment of primary teeth article

The patient is 8-9 yrs old and still more than a year is present for exfoliation,so we need to restore it. asymptomatic teeth in presence of deep caries suggests-necrosis so pulpectomy is needed

best restorative material for class 2 primary teeth is SSC,to maintain arch length and to give complete seal

PULPECTOMY of a primary molar is indicated when the pulp is non-vital, cellulitis is not present, and the tooth is still restorable. Extirpation of both the coronal pulp chamber, and the root canals is performed, the tooth is filled with a semi-permanent, resorbable, dressing, and restored with a SSC. The

5.What is the toothpaste recommendation for this patient ?

A use of 1000 to 1500 ppm of fluoride twice daily

B more frequent use of 500 to 550 ppm fluoride toothpaste

C 5000 ppm fluoride twice daily

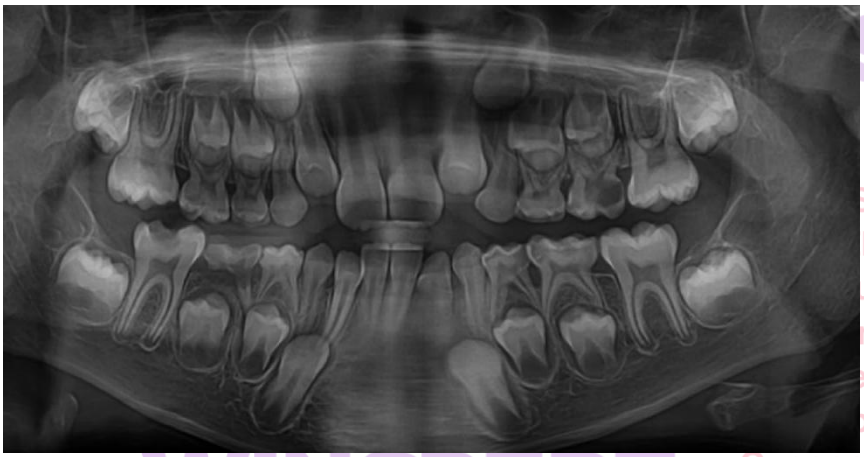
D more frequent use of 1000 to 1500 ppm of fluoride under adult supervisionAns D

Ref-TG Page-67

Toothpaste for people not at elevated risk of dental caries	
child younger than 18 months	twice-daily brushing without toothpaste
child 18 months to younger than 6 years	500 to 550 ppm (0.5 to 0.55 mg/g) fluoride twice daily, pea-sized amount [NB2]
child 6 years to adolescent	1000 to 1500 ppm (1 to 1.5 mg/g) fluoride twice daily
adolescent or adult	1000 to 1500 ppm (1 to 1.5 mg/g) fluoride twice daily

SBQ 8 – Pedo case

Arona school kid reported with a chief complaint of severe pain in the left lower back teeth region. He was highly uncooperative for clinical examination.You identified caries in relation to 74,75,85,46,55,65,84 .OPG was taken .



1. In order to manage the child you send the patient's parents out ? Is this acceptable behavior management technique

A Encouragement of favorable parental involvement is more effective than parental absence

B Parental absence is an effective management technique

C Parental absence is discouraged now

D Parental absence is not a contingent reinforcement technique

Ans A

Ref-contemporary behaviour management techniques article

Setting limits and boundaries for parental participation and encouragement of favorable parental involvement (i.e., sitting within view of the patient and offering an appropriate and timely reassuring touch or phrase) may be more effective than parental presence/absence.[6]

2 What indicates a poor prognosis of 85 in this patient ?

A Less remaining tooth structure

B Root resorption

C Irreversibly inflamed pulp

D periapical radiolucency

Ans B

Ref-Cameron Page 118

Severely resorbed distal root indicates poor prognosis for retaining the tooth,it is indicated for extraction.

Pulpectomy is the complete removal of all pulpal tissue from the tooth. Pulpectomy can only be considered for primary teeth that have intact roots. Any evidence of root resorption is an indication for extraction. Severe infections including acute facial cellulitis associated with primary teeth do not respond well to pulpectomy. Extraction is usually recommended in these cases.

3 How will you manage 85 ?

A Extraction of 85

B Extraction of 85 and band and loop space maintainer

C No treatment is needed

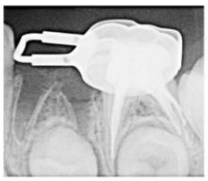
D Extraction of 85 and Lower lingual arch space maintainer

Ans B

Ref-Cameron 417

Patient is 8-9 yrs old,since 46 is already erupted,a band and loop space maintainer can be given.

Only extraction is not sufficient as the second permanent molar is erupting; it will push the first molar into the edentulous area.



Posterior teeth

- Whenever a primary second molar is lost prematurely, whether before or after the eruption of the first permanent molar, there will be some loss of arch length caused by the mesial drift of the permanent molar.
- Space maintenance is critical in children who have a normal arch length and lose a primary molar. Any loss of space in these children will result in crowding of the permanent teeth.
- Where space has already been lost, it is necessary to regain space and then fit a space maintainer.

SBQ 9- Angular Cheilitis

A 62 year old patient has been a complete denture wearer for the past 10 years. He now feels his lower denture is not staying in his mouth. Extraoral images are given. Intraoral examination revealed a highly resorbed ridge in the mandibular ridge and increased saliva pooling in the floor of the mouth and the maxillary ridge was well rounded. The denture teeth have worn down completely. Owing to the discomfort, patients resort to not wearing dentures most of the time.

1. What is the problem with worn out dentures?

A Decreased VDO

B Increased VDO.

C Decreased VDR

D Increased VDR

Ans A

Ref-Occlusal parameters and wear of artificial teeth in complete dentures with lingualized versus bilateral balanced occlusion: a randomized clinical trial

The wear of resin artificial teeth affected the clinical performance of complete dentures, which might reduce vertical distance and chewing efficiency, leading to masticatory muscle fatigue

2. Which comes first amongst the management of this patient's condition

A Vitamin deficiency status

B Checking adequacy of denture

C Assessing Immune deficiency

D Smear test

Ans B

Clinical cases of prosthodontics-case 1,Prosthodontic treatment for edentulous patients-Zarb

Since the VDO is reduced,first we have to observe the adequacy of the denture including fit,comfort ,function,esthetics, bite.

dentist should focus on adequacy of basal seat adaptation, elimination of overextended denture borders, and presence and adequacy of maxillary posterior palatal seal. Once these are established, the occlusion is best checked with remount procedures (Landa 1977; Ettinger and Scandrett 1980; Shigli, Angadi et al. 2008).

Patients who have had dentures successfully for a long time often present complaining of looseness, soreness, chewing inefficiency, and perceived esthetic changes. These difficulties may have been caused by (1) an incorrect or unbalanced occlusion that existed when the dentures were inserted or, more likely, (2) changes in the structures supporting the dentures that are now associated with a disharmonious occlusion. It is essential that the cause or causes of the reported difficulties be determined before any attempt is made to correct them, and a diagnosis of the changes that have occurred must be made before any clinical procedures are started. It is also necessary to determine their nature, extent, and location and to understand what changes may occur and their associated signs and symptoms.

3.The patient developed sensitive cracks at the junction of upper and lower labia oris. How will you manage the condition?

A Clotrimazole 1% cream topically to the angles of the mouth for at least 14 days, continue the treatment for 14 days after symptoms resolve

B Hydrocortisone 1% cream topically to angles of the mouth, twice daily until inflammation subsides

C Clotrimazole 0.1% ointment topically to the angles of the mouth for at least 14 days, continue the treatment for 7 days after symptoms resolve

D Miconazole 1% ointment topically to the angles of the mouth for at least 14 days, continue the treatment for 14 days after symptoms resolve

Ans A

Ref-Therapeutic guidelines-Page 119

Antifungal therapy for angular cheilitis

Treat angular cheilitis with a topical antifungal cream; use:

1. clotrimazole 1% cream topically to the angles of the mouth, twice daily for at least 14 days; continue treatment for 14 days after symptoms resolve

   OR

2. miconazole 2% cream topically to the angles of the mouth, twice daily for at least 14 days; continue treatment for 14 days after symptoms resolve.

4. If the condition is persistent, which of the following systemic conditions the patient may have?

A Behcet's syndrome

B Coeliac disease

C Crohn's disease

D Ulcerative colitis

Ans C

Ref-TG Page 116

Predisposing factors

see Table 10 (p.114) for risk factors for oral candidiasis

deep skin folds around the mouth (associated with worn down teeth, ill-fitting dentures or not wearing dentures)

iron, folate or vitamin B_{12} deficiency

Crohn disease

granulomatous disease

atopic and seborrhoeic dermatitis

5. After the condition has settled, the patient comes back for fabrication of a new set of dentures. How will you educate the patient on denture hygiene?

A Denture should be cleaned every day to remove plaque and tartar

B Denture should be cleaned after each meal in warm water using mild soap

C Denture should be cleaned twice a day, in warm water, mild soap or toothpaste and toothbrush

D Denture should be cleaned twice a day, in warm water, mild soap and a soft nail brush

Ans D

Ref-TG Page 275

Denture hygiene

Dentures should be regularly cleaned twice a day to remove food particles and plaque. Advise patients to remove dentures from the mouth and clean them with warm water, mild soap and a toothbrush, denture brush or soft nail brush. Avoid cleaning dentures with hot water, toothpaste, kitchen detergents, laundry bleaches, methylated spirits, antiseptics or abrasives (unless instructed to by a dental practitioner). Patients should clean their gums and remaining teeth with a soft toothbrush and toothpaste.

SBQ 10- Ortho case

8 year old Jason arrives at your clinic with his mom. His mom is extremely concerned and complains of a gap between his upper front teeth and forwardly positioned upper teeth. On examination he has unerupted upper canines and premolars and deficient chin.

I. His mother wants you to start treatment using wires and clips as she has seen on her neighbor's child right now. How will you manage her?

A. Agree with her and start fixed Orthodontic treatment for space closure

B. Refuse treatment

C. Refer her to Orthodontist

D. Take an OPG and explain that spacing is normal at this age

Ans D

Ref-Handbook of orthodontics-Martyn and Andrew -page 145

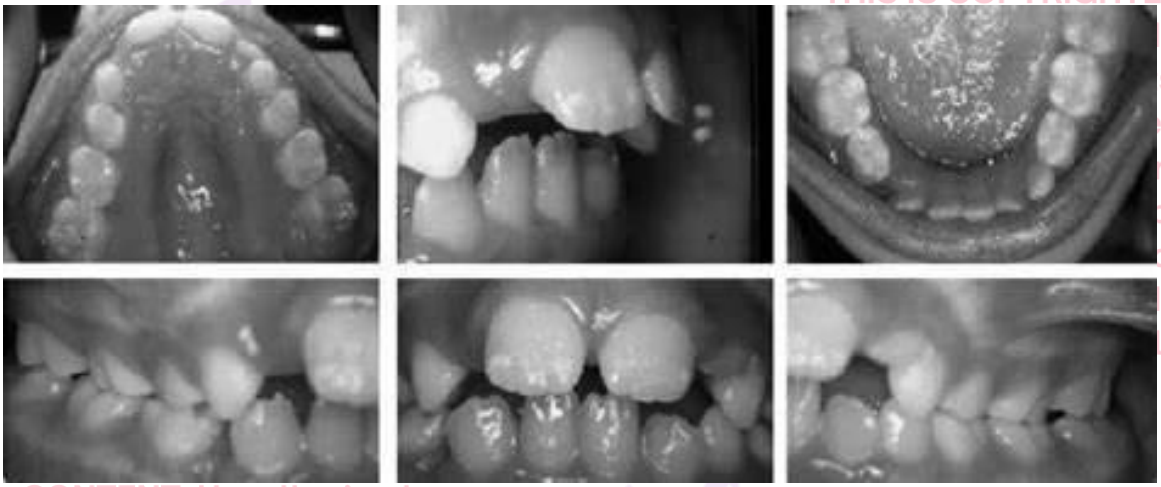
As permanent canines and premolars erupt at the age of 10-12 years old,first we have to take a radiograph to check the condition of the permanent teeth.

Radiographs

Radiographs are usually required prior to orthodontic treatment to assess:

- Presence or absence of permanent teeth;
- Root morphology of permanent teeth;
- Presence and extent of dental disease;
- Presence of supernumerary teeth;
- Position of ectopic teeth; and
- Relationship of the dentition to the dental bases and their relationship to the cranial base.

II. What is the patient's current malocclusion?



A. Class III

B. Class II Div I

C. Class II Div 2

D. Class I mod 2

Ans B

Ref-Ortho hand book by Martyn and Andrew Page 3

Distobuccal cusp of the upper 1st molar is in the buccal groove of the lower first molar,and upper anterior teeth are proclined.

- Class II—the relations of the dental arches are abnormal, with all the mandibular teeth occluding distal to normal. Angle recognized two subdivisions under class II:
  - Class II division 1—upper incisors are protruding;

III. Patient had his E extracted one month ago due to extensive caries. What type of Orthodontic treatment should his dentist have started at that time?

A. Preventive

B. Interceptive

C. Corrective

D. Surgical

Ans B

Ref-Cameron Page 409

'Interceptive orthodontics' implies that corrective measures may be necessary to intercept a potential irregularity from progressing into a more severe malocclusion.

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IV. What is the ideal time of treatment for the patient's skeletal malocclusion?

A. Right now

B. After 1 year

C. During pubertal growth spurt

D. After completion of growth

E. Pre pubertal stage

Ans C

Ref-Handbook of orthodontics, Martyn and Andrew Page 182

Treatment to correct a class II skeletal base relationship is most effective during the adolescent growth spurt. In females, this will generally occur earlier than in males and is poorly correlated with dental age. Therefore, this type of treatment should often be started earlier in females than males.

V. What kind of appliance should be given to the patient for the correction of his malocclusion?

A. Removable appliance

B. Fixed appliance

C. Functional appliance

D. Orthopedic appliance

E. Clear aligner

Ans C

Ref-Handbook of orthodontics-Martyn and Andrew Page185

In a young patient with a class II skeletal discrepancy, utilizing growth with a functional appliance can facilitate treatment, which is not possible in an older patient or adult, where growth potential either is poor or has disappeared. In

Functional appliances/myofunctional appliances

These are removable or fixed appliances that either utilize, eliminate or guide the forces arising from muscle function and altering the position of mandible, causing stretching of the facial soft tissue, to produce a combination of dental and skeletal changes. They are most frequently used for correction of anteroposterior jaw relationship in class II malocclusion, however, class III malocclusion can be treated occasionally.

Orthopaedic appliances generally use teeth as "handles" to transmit forces to the underlying skeletal structures. These appliances produce intermittent forces of very high magnitude. Such heavy forces when directed to the basal bone via teeth tend to alter the magnitude & direction of the jaws by modifying the pattern of bone apposition at periosteal sutures and growth sites. The followings are the basic principles of using orthopaedic appliances effectively:

Examples of

Functional appliances-Bionator, twin block

Orthopedic appliances- head gear, chin cup

SBQ 11 ortho case

22 yo Mohan arrives at your clinic complaining of bad breath. He is concerned about his oral hygiene and says he brushes twice daily using 1500 ppm toothpaste. He is also concerned about the appearance of his face and teeth. Examination reveals severe upper and lower anterior crowding.

I. What is the cause of a patient's halitosis? IG

A. Systemic condition

B. Lack of brushing

C. Poor oral hygiene habits

D. Irregular teeth leading to food lodgement and plaque deposits

Ans D

Though the patient tries to maintain good oral hygiene by brushing twice, Irregular teeth facilitate food lodging and prevent proper accessibility of cleaning aids.

Option A ruled out as there is no mention of systemic condition in the history

option B and c are ruled out as the patient is brushing 2 times a day.

Ref-TG Page 125

Intraoral causes

- poor oral hygiene (eg food particles between the teeth, on the tongue and around the gums)

II. You performed scaling and root planing. What is your next step? TE

A. Prescribe chlorhexidine mouthwash

B. Motivate patient for Orthodontic correction of his crowded teeth

C. Refer to medical practitioner for evaluation of halitosis

D. Prescribe 5000ppm toothpaste

Ans B

Main cause of halitosis(crowding) should be addressed,so the patient should be referred to an orthodontist.

Option A is ruled out as CHX mouthwash does not reduce the halitosis, unless the oral hygiene is maintained and prolonged use of CHX for more than 2 weeks is not recommended.

Option C-Reference to medical practitioner is done only after managing intra oral causes does not reduce the halitosis.

Option D is used in high caries risk,but not for halitosis.

III. You referred the patient to an orthodontist. What is an essential instruction upon starting fixed Orthodontic treatment in such a patient? PH

A. Brush after every meal

B. Use of orthodontic brushes twice daily

C. Avoid sugary foods

D. Avoid hard and sticky foods for 1 week

E. Have plenty of fruits

Ans B

Ref-Prevention and caries risk management in teenage and ortho patients page s38

control.[18] A powered brush provides important benefits over a manual toothbrush, but even more so when special orthodontic heads are used, since the bristle patterns and bristle materials have been optimised for use around orthodontic appliances.[19] If a powered brush is recommended, an appropriate dedicated orthodontic brush head should be used, since these have been found to outperform regular brush heads.[20]

The role of orthodontist in maintaining oral health-British orthodontic society

For patients aged 7 years and over, and adults, the following is recommended:

- Brush at least twice a day with fluoridated toothpaste. Brush last thing at night and at least on one other occasion.
- Use fluoridated toothpaste with 1350-1500ppm fluoride.
- Spit out after brushing and do not rinse to maintain fluoride concentration.
- Reduce the amount and frequency of sugary food and drinks.
- Professional application of fluoride varnish (2.26% NaF) twice a year.
- Patients with increased caries risk should use a fluoride mouthrinse (0.05% NaF) daily at a different time to brushing.
- For patients aged 12 years and over, interdental plaque control is recommended using an interdental or single-tufted brush where there is sufficient space between teeth to allow use of these brushes. For small spaces between teeth, use of dental floss or tape is recommended.

Option A-Rinsing after every meal is recommended not brushing

IV. After 2 years mohan came to you complaining of white spots on his teeth. What should have been prescribed post Orthodontic treatment to address this issue? TE

A. Fluoride toothpaste

B. Fluoride varnish

C. Cpp Acp tooth mousse + Fluoride toothpaste

D. Enamel Polishing

E. APF gel

Ans C

Ref-TG Page 69

Emerging evidence suggests casein phosphopeptide–amorphous calcium phosphate (CPP-ACP) in combination with fluoride can reverse dental caries in the early stages of the disease (noncavitated lesions). CPP-ACP

Option A-In addition to fluoride ,CPP-ACP will promote remineralisation by providing a source of calcium and phosphorus.

Option B,E-is to be professionally applied and not to be prescribed.

Option D-enamel polishing does not cause remineralisation ,it is relatively invasive

V. You want to classify Mohan's malocclusion. Which x ray will help you? IG

A. Lateral cephalogram

B. Opg

C. PA cephalogram

D. Lateral skull radiograph

E. CBCT

Ans A

Ref-Cameron Page 415

- Lateral cephalogram – this is useful to assess skeletal discrepancy when treatment is to be started. Tracing of the film and subsequent cephalometric analysis will aid diagnosis and treatment planning. This film can also be used as a baseline to monitor future growth.

Option B-OPG is used for overall analysis of dentition not useful for classification of malocclusion

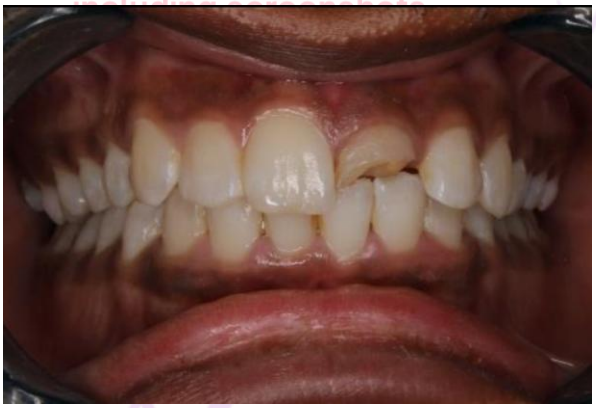
Option C-For transverse discrepancies and asymmetry

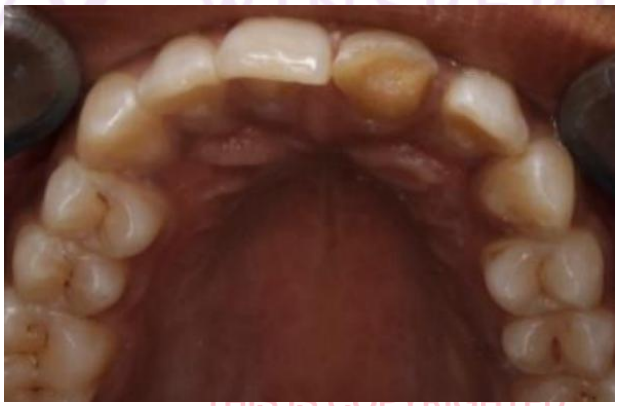
Option D- For injuries to skull

Option E- useful for evaluation of exact location of the impacted or supernumerary teeth

SBQ 12- Crown lengthening

21 year old Harish reported with dislodged restoration irt 21. He had undergone root canal treatment about 2 years ago, following trauma to his front teeth. He is disappointed with his previous restoration as it has been dislodged twice and is keen on getting a long term solution to his problem . On intra oral examination you identify numerous teeth with dental caries and a probing pocket depth of 4mm irt 21.





1.What investigation will you do further? IG

A Pulp sensibility

B Percussion

C IOPA

D Probing

Ans C

IOPA is needed prior to restoration to evaluate the success of the root canal treatment,check periodontal status of the tooth

Option A-pulp sensibility is not useful in root canal treated teeth

Option B- Percussion not first line of investigation,and patient did not complain of pain on biting

Option D-Probing is already done

Ref-Odell case 65 Page 365

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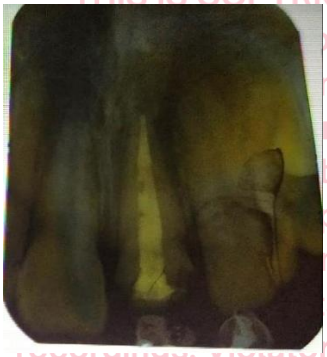
Periapical radiographs, ideally taken by using the paralleling technique and a beam aiming device, are required to:

- Assess presence and quality of any root fillings and the status of the periradicular tissues
- Aid identification of the source of the sinus
- Detect or exclude caries
- Help eliminate root fracture as a cause. This is difficult as the fracture line would have to be in the line of the x-ray beam (bucco-palatally) to be visible and even then might be superimposed on the root canal or root filling
- Confirm the alveolar bone levels.



2 What is the fault in this radiograph? IG

A Prolonged exposure to developer

B Prolonged exposure to fixer

C Improper rinsing after developing

D Insufficient rinsing after fixing

Ans – D

Ref-White and pharroah page 68,74

Light Radiographs (Fig. 6-12)	*Dark Radiographs* (Fig. 6-14)
PROCESSING ERRORS	PROCESSING ERRORS
Underdevelopment (temperature too low; time too short; thermometer inaccurate)	Overdevelopment (temperature too high; time too long)
Depleted developer solution	Developer concentration too high
Diluted or contaminated developer	Inadequate fixation
Excessive fixation	Accidental exposure to light
	Improper safelighting

WASHING

After fixing, the processed film is washed in a sufficient flow of water for an adequate time to ensure removal of all thiosulfate ions and silver thiosulfate complexes. Washing efficiency declines rapidly when the water temperature falls below 60° F. Any silver compound or thiosulfate that remains because of improper washing discolors and causes stains, which are most apparent in the radiopaque (light) areas.

3.How to avoid cross contamination while making an intra oral radiograph ? TE

A remove the glove , position the tube and operate the x ray controls

B Use gloved hand to position the tube and operate the control and then clean all the contaminated surface of radiography equipment at the end of the day

C Use gloved hands but operate the x ray controls through a barrier that is changed at the end of each appointment

D Remove the glove , wear a new pair of glove position the tube and operate the x ray controls

Ans C

Ref-ICG Page 69

- use gloved hands but operate the x-ray controls through a barrier that is changed at the end of each appointment. These controls then need cleaning before the barrier is replaced.

Option A-did not mention about cleaning after each patient

Option B-cleaning should be done at the end of the appointment not at the end of the day.

Option D-after removing gloves hand hygiene should be performed.

4. What could have not contributed to repeated fracture of restoration? IG

A Traumatic Bite

B Poor retention of composite

C Polymerisation shrinkage of composite

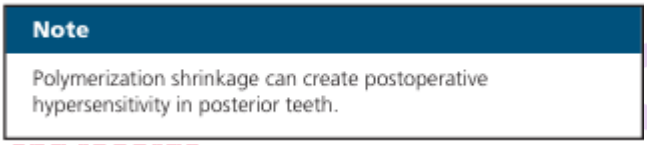
D lack of enamel for bonding

Ans C

All of the options can cause fracture of restoration and or dislodgement

Polymerisation shrinkage causes marginal leakage not fracture.

Ref-Mount and Hume Page 174



5. What is the best way to manage 21? DM

A Crown lengthening + Composite core + crown

B Composite core + crown

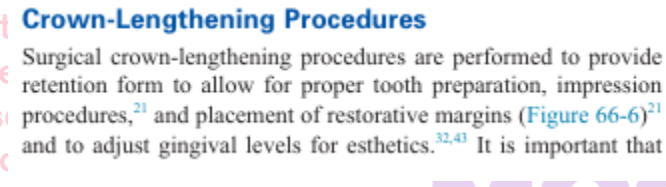
C Gic core + crown

D Post + composite core + crown

Ans A

Ref-Carranza 12th edition,chapter 66,page 651e1

Distal side of the tooth 21 is devoid of ferrule,so crown lengthening is needed to create a ferrule for placing the restorative margins.



Crown-Lengthening Procedures

Surgical crown-lengthening procedures are performed to provide retention form to allow for proper tooth preparation, impression procedures,[21] and placement of restorative margins (Figure 66-6)[21] and to adjust gingival levels for esthetics.[32,43] It is important that

Option C-GIC-is not a permanent core material.

Option D-enough tooth structure is there for retaining the core.

SBQ 13- Perio management

A 50-year-old Caucasian female reported having discomfort and pressure when chewing on her mandibular left molar about 1 month previously, which had lasted for several days. At the time that she presented to the periodontal clinic, the pain and pressure had disappeared. The patient has significant medical problems which includes gastric ulcer and was treated for breast cancer 4 years previously. She had been hospitalized for a hip fracture and got it replaced with a joint prosthesis

1.A pulp test of tooth 36 revealed no response to thermal stimulation and no response to an electrical test.The patient was asked to occlude on a bite stick (Tooth Sleuth). No pain was elicited. Primary occlusal trauma was seen on the same tooth . She is also a severe bruxer. Which of the following can be ruled out from differential diagnosis after the above mentioned investigations? DM

A Cracked tooth

B Trauma from occlusion

C Pulp necrosis

D Periapical cyst or granuloma

Ans : A

Ref-Diagnostic and treatment preferences for cracked posterior teeth-recent article folder

As the patient did not have pain on biting a tooth slooth, crack tooth can be ruled out.

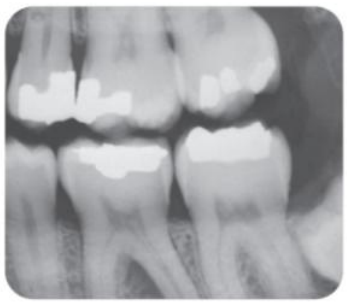
Regarding the aids used for diagnosing cracked teeth, pain on biting replicators such as FracFinder® or Tooth Slooth® were the most popular, while pain on biting was the most frequent symptom that made the respondents suspect a crack in tooth. Of note is

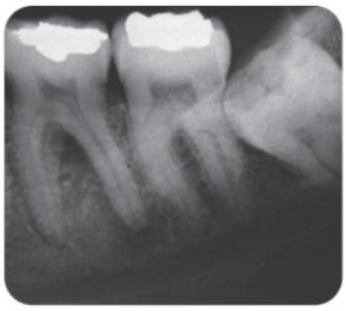
Option B was ruled out as It was mentioned in the history that occlusal trauma was seen.

Option C- is ruled out as there is no response to thermal stimulation and electrical test.

Option D-Necrotic pulp can cause periapical cyst or granuloma.

2. Periodontal chart on 36 revealed probing depth of
   3 10 3
   3 2 3
   And radiograph was given





What is your diagnosis ? DM
A Primary endodontic lesion with secondary periodontal lesion
B Primary endodontic lesion and Primary periodontal lesion
C Primary periodontal lesion with secondary endodontic lesion
D Vertical root fracture
Ans A

Ref-Endo -perio juncture -ADJ article

Here the infection most likely spread from necrotic pulp to the periodontal tissues via the accessory canals in the furcation region and secondarily involved the periodontal tissue causing secondary perio infection.

Primary endodontic with secondary periodontal

If a primary endodontic infection is left untreated, continued suppuration can sometimes lead to the supporting periodontal tissues becoming secondarily involved, eventually resulting in a periodontal defect which becomes involved with plaque and possibly calculus.[51] Once the periodontal tissues have become secondarily involved, both periodontal and endodontic treatment are required, as the periodontal condition is

Option B and C are ruled out as Patient did not have Periodontitis mentioned in the initial history- so it is not a primary periodontal lesion.

Option D is ruled out as Vertical root fracture is not possible diagnosis as the tooth is not root canal treated,nor having post present.

3.Which is not involved in Phase 1 therapy in this patient ? DM

A Oral prophylaxis

B Periodontal surgical therapy for 36

C Endodontic therapy for 36

D Occlusal guard for maxilla

Ans B

Ref-Carranza 12th edition page 480: Phase 1 therapy includes non-surgical procedures.

is required in phase I therapy. The following list of elements makes up phase I therapy:

1. Complete removal of calculus (see Chapters 46 and 47)
2. Correction or replacement of poorly fitting restorations and prosthetic devices (see Chapter 67)
3. Restoration or temporization of carious lesions
4. Orthodontic tooth movement (see Chapter 51)
5. Treatment of food impaction areas
6. Treatment of occlusal trauma (see Chapter 50)
7. Extraction of hopeless teeth
8. Possible use of antimicrobial agents including necessary plaque sampling and sensitivity testing (see Chapters 8 and 48)

4 How long does it take for the periodontal pocket to resolve TE

A 4 weeks after surgery

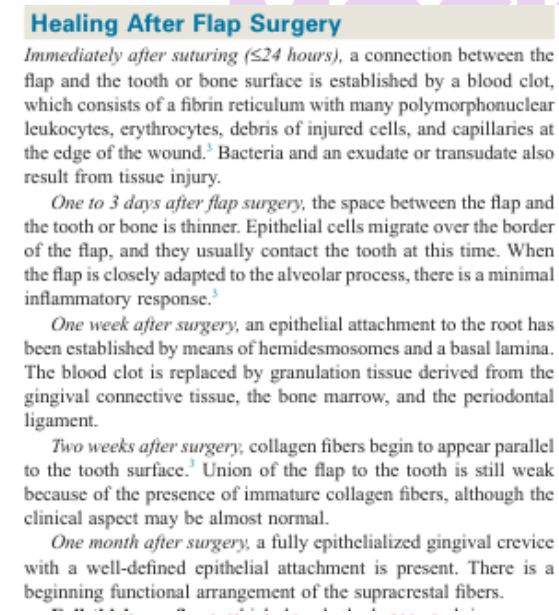
B 2 months

C 3-6 months

D 12 months

Ans A

Ref-Carranza 12th edition ,page 586



Healing After Flap Surgery

Immediately after suturing (≤24 hours), a connection between the flap and the tooth or bone surface is established by a blood clot, which consists of a fibrin reticulum with many polymorphonuclear leukocytes, erythrocytes, debris of injured cells, and capillaries at the edge of the wound.[3] Bacteria and an exudate or transudate also result from tissue injury.

One to 3 days after flap surgery, the space between the flap and the tooth or bone is thinner. Epithelial cells migrate over the border of the flap, and they usually contact the tooth at this time. When the flap is closely adapted to the alveolar process, there is a minimal inflammatory response.[3]

One week after surgery, an epithelial attachment to the root has been established by means of hemidesmosomes and a basal lamina. The blood clot is replaced by granulation tissue derived from the gingival connective tissue, the bone marrow, and the periodontal ligament.

Two weeks after surgery, collagen fibers begin to appear parallel to the tooth surface.[3] Union of the flap to the tooth is still weak because of the presence of immature collagen fibers, although the clinical aspect may be almost normal.

One month after surgery, a fully epithelialized gingival crevice with a well-defined epithelial attachment is present. There is a beginning functional arrangement of the supracrestal fibers.

5. Which pain killer must be avoided in this patient TE

A Celecoxib

B Paracetamol

C Oxycodone

D Tramadol

Ans A

Ref-TG Page 46

As the patient has significant gastric ulcers,NSAIDS are contraindicated.

Box 8. Patients who should not be prescribed an NSAID by a dentist

- patients with severe **kidney impairment** (eGFR of less than 30 mL/min)
- patients with severe **heart failure**
- patients with an active **gastrointestinal ulcer** or **gastrointestinal bleeding**
- patients with **bleeding disorders**
- patients taking **corticosteroids** or **anticoagulants**
- patients with **multiple risk factors** for increased NSAID toxicity (eg elderly patients with a history of gastrointestinal bleeding)

eGFR = estimated glomerular filtration rate; NSAID = nonsteroidal anti-inflammatory drug

6. Which surgical antibiotic prophylaxis is needed before performing phase 1 therapy ? TE

A amoxicillin 2 g intramuscularly, 30 minutes before the procedure

B amoxicillin 2 g intravenously, within the 60 minutes before the procedure

C cefalexin 2 g orally, 60 minutes before the procedure

D There is no need

Ans D

Ref-TG Page 190,191

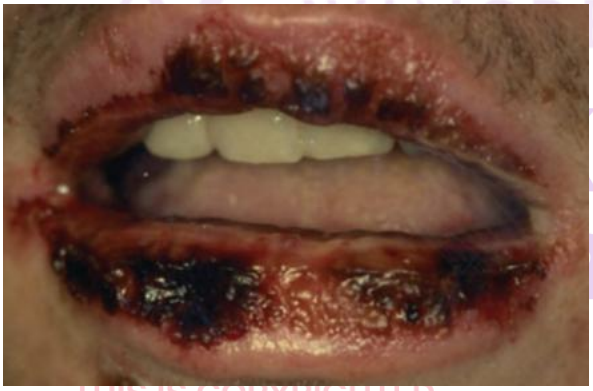
There is no indication for surgical antibiotic prophylaxis for phase 1 therapy and also for joint prosthesis.

Surgical antibiotic prophylaxis is rarely indicated for dental procedures.

Only give surgical antibiotic prophylaxis to patients with a pre-existing joint prosthesis or breast implant if prophylaxis is indicated for the procedure.

SBQ 14- Viral disease EM

A 27-year-old male presented with a painful mouth owing to ulcers associated with bleeding for 2 weeks. History revealed fever and body pains 2 weeks ago, following which he noticed vesicles on the bilateral buccal mucosa and labial mucosa. The vesicles subsequently ruptured leaving ulcerated areas associated with severe pain and bleeding on mastication, making it difficult to consume both solid and liquid foods. Five days after the inception of oral lesions, he developed cutaneous lesions on the upper and lower extremities, which were preceded by itching. On examination, the floor of ulcers was covered by pseudomembrane, surrounded by erythematous halo with irregular margins and a nonindurated base with bleeding on provocation.



1. What is your diagnosis ? DM

A Severe form of herpetic gingivostomatitis

B Mucous membrane pemphigoid

C Pemphigus

D Erythema Multiforme

Ans D

Intra oral and labial ulcers associated with bleeding and cutaneous lesions with erythematous halo are suggestive of erythema multiforme

Option A-ulcers are more generalised,not associated with bleeding and involve gingiva.

Option B–MM pemphigoid does not have systemic symptoms like fever and body pains.

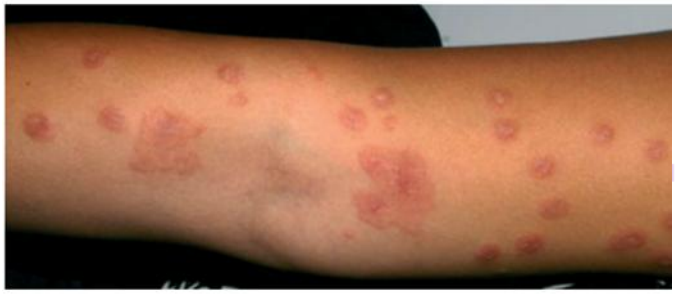
Option C-white radiating Wickham's striae are seen bilaterally on buccal mucosa and doesn't have systemic symptoms

Ref-oral mucosal diseases article in oral medicine folder -Page 29,30

ERYTHEMA MULTIFORME

Erythema multiforme (EM) is part of a spectrum of complex, immune-mediated, reactive, muco-cutaneous disorders that often presents with oral, especially, labial mucosal erythema, blistering and ulceration.[25,26] This spectrum encompasses a range of four clinical conditions (Table 2) that overlap in regards to their clinical features and suspected aetiology and pathogenesis: (1) EM minor with predominantly cutaneous involvement with the appearance of the classic "target lesions" and infre-quently, only mild oral mucosal involvement; (2) EM major with cutaneous and mucosal involvement of at least one other site, apart from the oral mucosa (Figs 2a

2. What are these lesions seen on the arm ? DM



A Kopliks spot

B Target lesions

C nikolsky sign

D Psoriasis

Ans B

Ref-oral mucosal diseases article in oral medicine folder -Page 29,30

cutaneous lesions with erythematous halo are suggestive of “Target lesions” of EM

(Table 2) that overlap in regards to their clinical features and suspected aetiology and pathogenesis: (1) EM minor with predominantly cutaneous involvement with the appearance of the classic “target lesions” and infre- quently, only mild oral mucosal involvement; (2) EM

3 While he undergoes his medical treatment , the patient is prone to which of the following while performing dental procedure? DM

A Risk of bleeding

B Adrenal insufficiency

C poor wound healing

D Anaphylaxis

Ans B

Ref-TG Page 163,oral mucosal diseases article page 31

Systemic steroids are used for the management of erythema multiforme which makes the patient more prone for adrenal insufficiency.

The long-term use of therapeutic doses of corticosteroids can cause adrenocortical suppression and subsequent dependence on exogenous corticosteroid therapy. The dose and duration of treatment likely to cause clinically relevant adrenocortical suppression is not clear and varies significantly between patients. Oral prednisolone at a dose of 10 mg or more daily (or the equivalent dose of another corticosteroid) for more than 3 weeks could be expected to cause adrenocortical suppression. A high dose of an inhaled, topical or intra-articular corticosteroid can also cause adrenocortical suppression.

4.In the cleaning and processing area, these were kept in the cupboard. What is this and what is it used for ? PH

A Helix text for hollow loads

B Bowie dick's test for air removal and steam penetration

C Vacuum test used for leak detection

D Soil test for instrument washer

Ans A

Ref-ICG Page 51

How the PCD test works

A strip with Class 2 chemical indicators is used at the end of a PCD to demonstrate the extent of steam penetration into the hollow load device, via its narrow lumen. For small steam sterilisers, the level of challenge (what was previously called a 'hollow load of type A') is explained in ISO 11140-6:2022 in its Annex E as being based on a 'reference hollow device'. Section 4.3.1.2 describes a reference hollow load device where the tubing is PTFE or FEP with an internal diameter of 2 mm and a length of 1500 mm. This creates a specific challenge to air removal and steam penetration when used in an empty chamber in type B cycle steam sterilisers.

5.In relation to gloves used, which of the following statements is true ? TE

A nitrile gloves tend to tear easily as they are thinner than latex glove

B 'bare below the elbow' mandates the use of gloves that cover only hands and not covering the wrist

C A glove labeled 'Powder-free' will have trace amounts of residual former-release powder.

D Glove box must have a separation distance of 1 meter in front of the patient

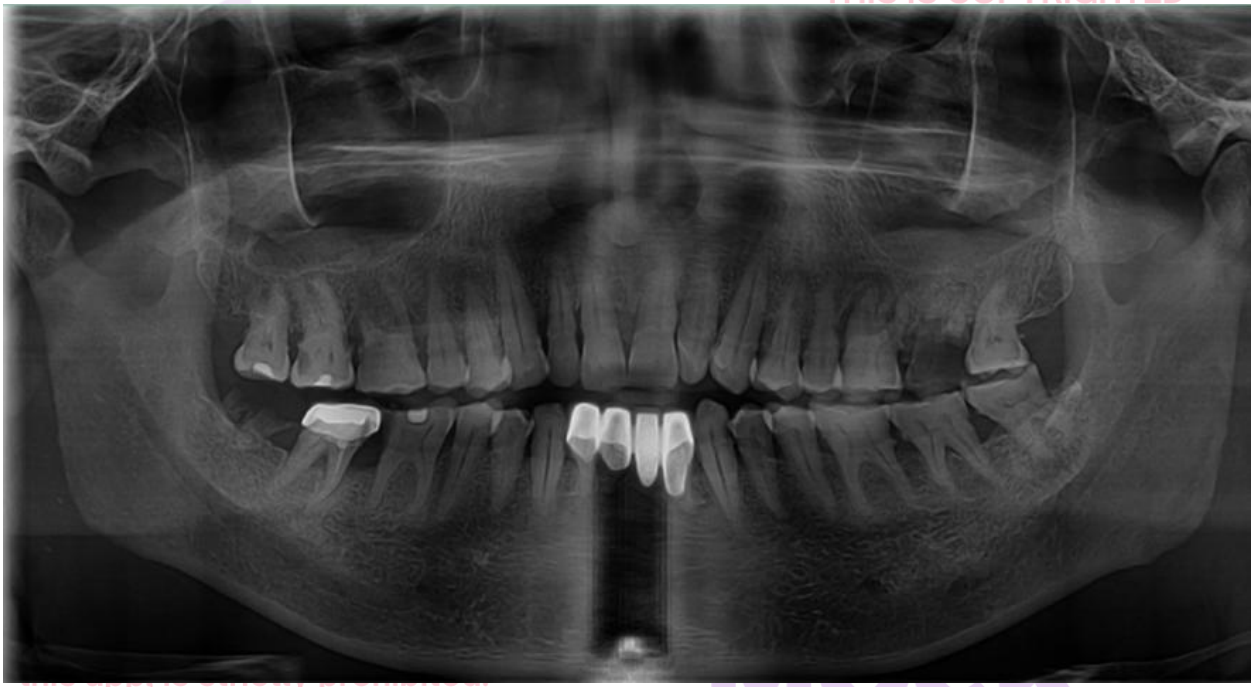
Ans C

Ref-ICG Page 20

A glove that is labelled as being 'powder-free' will have trace amounts of residual former-release powder (2 mg or less per glove) and no intentionally added donning powder. Powder-free gloves are recommended because they reduce occupational allergy to latex in HCWs via both respiratory and contact routes.

SBQ 15- Periodontal Abscess

A 69 year old diabetic patient visits with a complaint of recurrent dull aching pain and swelling in the left upper back teeth region for the past few months. The pain is intermittent with phases of exacerbation and remission. Usually patients resort to using over the counter medication for management of pain. But now the patient is not able to eat on that side and says food gets lodged on the same side. Intra oral examination revealed grossly decayed 27, severe recession up to apex of the palatal root of 26 and probing depth of 8 mm on 3 sites on the buccal , root stumps in relation to 48, grade 3 mobile 47. You ordered an OPG



1 What is your diagnosis in relation to 26? DM

A Periapical periodontitis

B Periodontal abscess

C Chronic periapical abscess

D Chronic alveolar abscess

Ans B

Ref-TG Page 75

Recurrent dull aching pain and swelling associated with food impaction, in a diabetic patient suggestive of a provisional diagnosis of periodontal abscess.

Option A- apical periodontitis is ruled out as the tooth26 is not having decay and there is no pain on biting.

Option C,D -are same and ruled out as there is no endodontic involvement or sinus tract formation.

2 How will you manage 26? DM

A Root canal therapy

B Extraction

C Localized scaling and root planing

D coronally positioned flap

Ans B

According to the given history, 26 has recurrent abscess, bone loss and palatal recession till apex and multiple deep pockets of 8mm ,all of which indicate the poor prognosis for 26 and requires extraction.

3. Patient says that he is about to travel abroad next week and that he prefers to get the treatment done there. What does the Australian dental association not suggest regarding overseas dental treatment? PH

A. Australian residents should only seek dental care in Australia.

B. Australian residents should seek the advice of an Australian dentist before embarking on overseas dental treatment.

C. Australian residents should not seek treatment overseas due to the inability to provide supportive maintenance dental visits

D. The indemnity shall be provided only for 5 years after the provision of treatment elsewhere

E.The overseas treating practitioner must follow proper infection prevention and control standards

Ans: D

Ref-Overseas elective dental treatment position statement -Health promotion folder

2.4. Promoters of health services in overseas countries should be required to indemnify consumers for all adverse outcomes caused by such treatment. This indemnity should not be time limited as adverse outcomes may not become apparent for a number of years after the provision of treatment.

4. After extraction of 26 and 27 you plan to place two implants of 4mm diameter, what is the mesiodistal width needed? DM

A 11mm

B 12mm

C 13mm

D 14mm

Ans D

Ref-Carranza 12th edition Page 698

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required over the mandibular nerve). This dimension is desired to maintain at least 1.0 to 1.5 mm of bone around all surfaces of the implant after preparation and placement.

nterdental Space

dentulous spaces need to be measured to determine whether enough space exists for the placement and restoration with one or more implant crowns. The minimal space requirements for the placement of one, two, or more implants are illustrated diagrammatically in Figure 72-9. The minimal mesial-distal space for an implant placed between two teeth is 7 mm. The minimal mesial-distal space required for the placement of two standard-diameter implants (4.0-mm diameter) between teeth is 14 mm

5. If cement retained implant crowns are to be given, what is the minimum vertical restorative space required? DM

A 7mm

B 8mm

C 9mm

D 10mm

Ans 7mm

Ref-Carranza 12th edition Page 698

Interocclusal Space

The restoration consists of the abutment, the abutment screw, and the crown (it may also include a screw to secure the crown to the abutment if it is not cemented). This restorative "stack" is the total of all the components used to attach the crown to the implant. The dimensions of the restorative stack vary slightly depending on the type of abutment and the implant-restorative interface (i.e., internal or external connection). The minimum amount of interocclusal space required for the restorative "stack" on an external hex-type implant is 7 mm.

SBQ 16- Antibiotic

A 45 year old female patient reports to you saying she has severe pain and swelling of the right side of the face . She has also been feeling feverish and unwell since yesterday. She said that there has been some swelling of the gingiva around the tooth in upper jaw a week ago and she has been unable to bite her teeth together for a few days. Today, she awoke to find the facial swelling; she feels unwell and has difficulty eating and opening her mouth

1.What will you do next ? IG

A IOPA and vitality test

B Refer to hospital

C Conduct clinical examination

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D Start with antibiotics

Ans B

Ref-TG Page 84

> Arrange urgent transfer of patients with a spreading infection with severe or systemic features to a hospital that has an oral and maxillofacial surgeon or another appropriate expert.

Option A,C- patient is having difficulty opening the mouth and also severe features are present so cannot delay referral

Option D- IV antibiotics are needed ,which are to be done in hospital setting

2. Patient was given IV antibiotics while samples were given for culture sensitivity , this antimicrobial therapy is called ? TE

A Prophylactic antimicrobial therapy

B Empirical antimicrobial therapy

C Directed antimicrobial therapy

D Surgical antimicrobial therapy

Ans B

Ref-TG Page 16

When antibiotics are given based on clinical presentation and expected antibiotic susceptibility, without knowing the causative organism-it is known as empirical antimicrobial therapy.

> **Empirical antimicrobial therapy** is used to treat an established infection when the pathogen has not been identified. Antimicrobial choice is based on the clinical presentation and the expected antimicrobial susceptibility of the most likely or important pathogen(s).

3. Which of the following is the antibiotic of choice? TE

A Benzylpenicillin 4- hourly plus metronidazole 500 mg 12-hourly intravenously

B Amoxicillin+clavulanate intravenously 4 hourly

C Cefazolin 2 g intravenously 4 hourly

D Metronidazole 500 mg 12 hourly

Ans A

Ref-TG Page 85

1 benzylpenicillin intravenously

patients requiring intensive care support: 2.4 g (child: 50 mg/kg up to 2.4 g) 4-hourly

patients not requiring intensive care support: 1.8 g (child: 50 mg/kg up to 1.8 g) 4-hourly

PLUS

metronidazole 500 mg (child: 12.5 mg/kg up to 500 mg) intravenously, 12-hourly

Option B and C - are given 6hrly not 4hrly

Option C and D-are given in combination not individually

4 When will you shift to oral medication ? TE

A Based on the results of cultures and susceptibility testing

B fever resolved or improving and patient is able to swallow the medicines orally

C After 24 hours

D After 48 hours

Ans B

Ref-TG Page 18,86

Switch to oral therapy once swelling and trismus subside (and the patient can swallow) and purulent discharge from the drains slows. If results of susceptibility testing are not available for oral continuation therapy, use the appropriate regimen on p 83

Box 3. Guidance for intravenous to oral switch

It is often appropriate to switch a patient's therapy from the intravenous to oral route when all of the following apply [NB1]:

- clinical improvement
- fever resolved or improving
- no unexplained haemodynamic instability
- tolerating oral intake with no concerns about malabsorption
- a suitable oral antimicrobial with the same or similar spectrum, or an oral formulation of the same drug, is available. For children, a suitable paediatric formulation is available.

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5 Which of the following non-antibiotic has cross reactivity with Antibiotic sulfonamides? TE

A sulfamethoxazole

B sulfadiazine

C sulfasalazine

D dapsone

Ans C

Ref-TG Page 35

sulfonamides. (The exception is sulfasalazine, a nonantibiotic sulfonamide that is structurally similar to sulfonamide antibiotics; avoid sulfasalazine in patients with antibiotic sulfonamide allergy, and vice versa.)

SBQ 17- Infant candidiasis

A mother of a 5 month old baby reports at your dental clinic in New South Wales, complaining that the baby refuses to take feed for the past few days. She wants to know if this is related to teething pain and how she can take care of it

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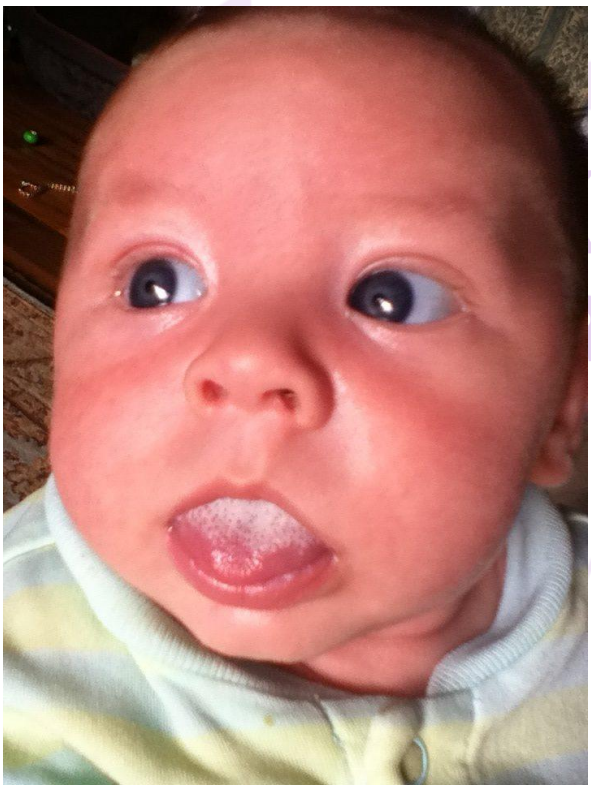


1.What is the white patch on the tongue ? DM

A Improper oral hygiene

B Oral thrush

C Geographic tongue

D Oral mucositis

Ans B

Ref-TG-Page 114

Candida species are a commensal organism of the oral cavity. Oral candidiasis is an opportunistic infection that is uncommon in healthy individuals; however, it occurs relatively commonly in neonates. Table 10 (below) lists common risk factors for oral candidiasis. Table 11 (p115.7)

2.Which is not a predisposing factor for it ? IG

A Poor bottle hygiene habits

B poor oral hygiene

C immunocompromised

D mouth breathing

Ans D

Ref-TG Page 114

Table 10. Common risk factors for oral candidiasis

Local factors	Systemic factors
dentures	immune compromise (eg poorly controlled diabetes)
salivary gland hypofunction	drugs (eg systemic corticosteroids, antibiotics)
corticosteroid inhalers	
poor oral hygiene	
smoking	

3.How will you manage? TE

A miconazole 2% gel 1.25 mL topically (then swallowed), 4 times daily, after feeding, for 7 to 14 days; continue treatment for at least 7 days after symptoms resolve.

B miconazole 1.2% gel 2.5 mL topically (then swallowed), 4 times daily, after feeding, for 7 to 14 days; continue treatment for at least 7 days after symptoms resolve.

C amphotericin B 10 mg lozenge sucked (then swallowed), 4 times daily, after food, for 7 to 14 days; continue treatment for 2 to 3 days after symptoms resolve

D nystatin 100 000 units/mL suspension 3ml, 4 times daily, after feeding, for 7 to 14 days; continue treatment for 2 to 3 days after symptoms resolve

Ans A

Treat oral candidiasis in **neonates and children younger than 2 years** with a topical antifungal. In infants, apply the dose in the front of the mouth to avoid choking. Use:

1. nystatin 100 000 units/mL suspension 1 mL topically (then swallowed), 4 times daily, after feeding, for 7 to 14 days; continue treatment for 2 to 3 days after symptoms resolve*

   OR

2. miconazole 2% gel 1.25 mL topically (then swallowed), 4 times daily, after feeding, for 7 to 14 days; continue treatment for at least 7 days after symptoms resolve.

4.What is incorrect with oral health promotion in this infant ? PH

A Before your child starts getting teeth you can clean their gums using a clean, damp cloth.

B As soon as your child's first teeth appear, clean them using a child-sized soft toothbrush, without toothpaste.

C Tap water should be boiled and cooled for children until they are 12 months of age.

D Teach your baby to drink water from a cup starting at around 12 months of age.

Ans D

Ref-Oral health of babies and toddlers article by Queensland government

Brush teeth as soon as they appear

Clean teeth as soon as they appear in the mouth. This is usually around 6 months of age, but this varies between children.

Use a small, soft toothbrush to gently clean teeth morning and night. For children under 18 months, just wet the toothbrush with water. Don't use toothpaste unless advised by a dental practitioner.

You can also use a damp washcloth or gauze wrapped around your finger if your baby won't accept a toothbrush.

Drinks for babies (birth to 12 months)

Breastmilk or infant formula is the baby's main drink until they are 12 months of age. Babies younger than 12 months are not able to drink cow's milk.

Babies fed on breastmilk do not need any extra drinks. Breastmilk is all the food and drink they need for around the first 6 months.

Babies fed on formula can be fed cooled boiled tap water if extra fluid is needed.

From 6 months, small amounts of cooled boiled water can be given to babies as well as breastmilk or formula.

Try to introduce a cup from 6 months and stop using a bottle from 12 months.

Choose healthy foods low in sugar for older babies and toddlers. Tooth-friendly foods do not contain added sugars and honey. Visit the Growing good habits website (https://growinggoodhabits.hw.qld.gov.au/) for more information on introducing first foods.

5. What is Child Dental Benefit Schedule (CDBS) PH

A All children (under 21 years of age) who are NSW residents are eligible for free public dental services

B All children from 0–17 years of age can access up to $1,132 for oral health care over two calendar years.

C All children are eligible for free public dental service until pre-school

D All children from 0–13 years of age can access up to $2,095 for oral health care over three calendar years.

Ans B

Ref-CDBS article

What is the CDBS?

The CDBS is a program for eligible children that provides up to $1,132 in benefits (the benefit cap) over a relevant two calendar year period for basic dental services.

Which children are eligible for dental services?

A child is eligible if they are:

- eligible for Medicare, and
- aged 0-17 years at any point in the calendar year, and

SBQ 18- Replacement resorption

A 13 year old female patient reports to you with her father for management of broken teeth in the upper front jaw region. She had a fall 5 years ago and tooth had been asymptomatic. She is now interested in getting her smile corrected. On examination you noticed Ellis class 2 fracture irt 11 and 21. Dental caries i.r.t 16,26,27,36 and 36. Pt has a thumb sucking habit.

1. You performed EPT in relation to 11 and it gave no response when compared to 21,22 and 12. What is the pulp status in relation to 11? DM

A Pulp necrosis

B Pulp is vital

C Pulp is still healing

D Ept is inconclusive in traumatic injuries

Ans A

Ref-Trauma guidelines article

Since the trauma took place 5yrs back and the current non-responsiveness of the tooth to the EPT indicates necrosis of the tooth.

5 | PULP STATUS EVALUATION: SENSIBILITY AND VITALITY TESTING

5.1 | Sensibility tests

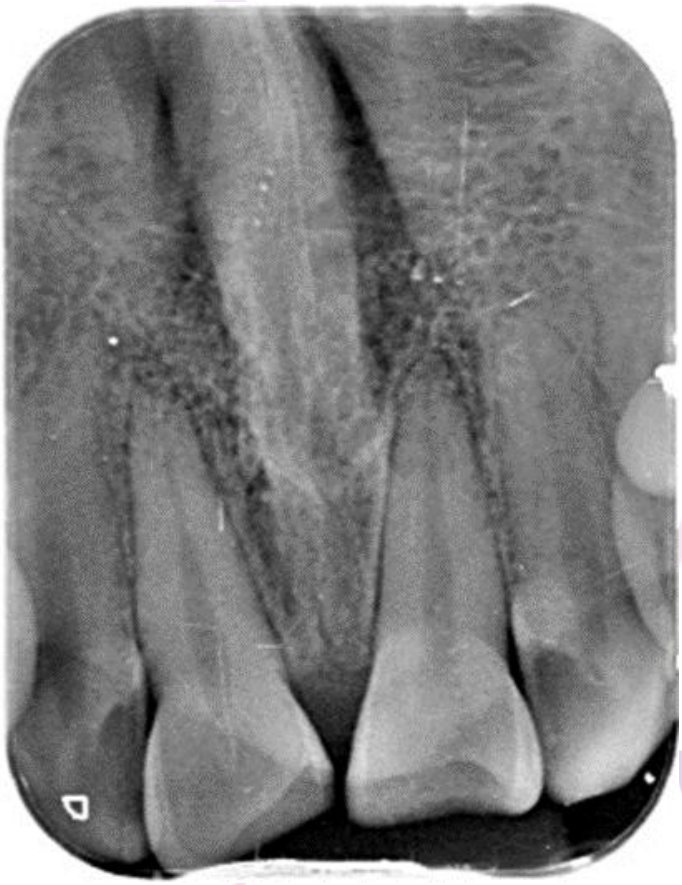
Sensibility testing refers to tests (cold test and electric pulp test) used to determine the condition of the pulp. It is important to un-

Ref-Endo disease classification article

Pulp necrosis

A necrotic pulp should be suspected when the tooth does not respond to pulp sensibility tests. However, this will not always be the case since teeth with pulp canal calcification, previous root fillings or pulpotomies will also not respond to pulp sensibility tests. Likewise, some teeth or patients just do not respond to such tests for no apparent reason. When pulp necrosis is present, the history may reveal past trauma, previous episodes of pain or history of restorations and caries. Radiographically, a tooth with a necrotic pulp may have signs (such as untreated caries, an extensive restoration, previous pulp capping) or there may be no such signs (e.g., following trauma). Trauma to a tooth

2. What radiographic change is seen in 11 that has been induced by trauma? IG



A External replacement resorption

B External cervical resorption

C Inflammatory apical resorption

D Pulp necrosis

Ans A

Ref-tooth resorption -a clinical classification article page 276

Resorption is noted at the apex of the teeth and that area is replaced with bone.

6.3 | External replacement resorption

External replacement resorption is the process where cementum and dentin are resorbed and replaced by bone (Figure 8). The term "replacement" is used as it describes the nature of this resorption.

3. How will you manage 11 ? TE

A Resin Composite restoration

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B RCT and ceramic crown

C RCT + composite restoration

D GIC restoration

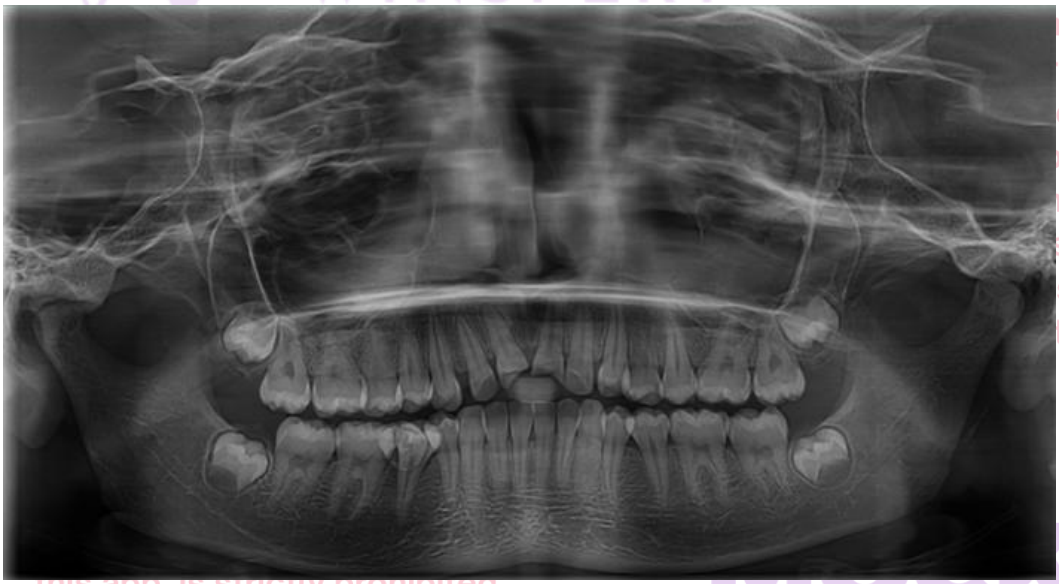
Ans C

Ref-Walton and trauma guidelines

As the pulp is necrosed-RCT is needed and enough tooth structure is present therefore it doesn't need full coverage restoration,it can be restored with composite.

Treatment
• If the tooth fragment is available and intact, it can be bonded back on to the tooth. The fragment should be rehydrated by soaking in water or saline for 20 min before bonding • Cover the exposed dentin with glass-ionomer or use a bonding agent and composite resin • If the exposed dentin is within 0.5 mm of the pulp (pink but no bleeding), place a calcium hydroxide lining and cover with a material such as glass-ionomer

4.What is the white radio-opaque structure seen in the OPG on the apices of the maxillary teeth IG



A Floor of antrum

B Hard palate

C Palatoglossal air space

D Artifact

Ans B

Ref-White and pharoah page 181

the floor. If the chin is tipped too high, the occlusal plane on the radiograph appears flat or inverted, and the image of the mandible is distorted (Fig. 11-12, *A*). In addition, a radiopaque shadow of the hard palate is superimposed on the roots of the maxillary teeth. If the chin

5. In order to perform the procedure the consent is taken from PH

A Child

B Both child and parent

C Parent

D Legal guardian

Ans C

The patient is 13 yrs old ,so they need consent of parents

4.1. **Minors**

(d) In the case of young children, dentists must obtain the consent of the child's parent or legal guardian for the dental procedure.

(e) The parent or guardian's consent must be given on the basis of the same information as would normally be required if consent were being obtained from an adult.

SBQ 19-

An indigenous patient who is undergoing therapy for tuberculosis calls you complaining of spontaneous pain in his left lower back teeth region. It awakens him during sleep. He is in his quarantine period.

1.What will you advise this patient for pain management ? TE

A ibuprofen 400 mg orally, 6-8 hourly and paracetamol 1000 mg orally, 4-6 hourly

B Ibuprofen 500mg alone orally, 12 hourly

C Celecoxib 100mg, 6-8 hourly

D Paracetamol 2000 mg, 4-6 hourly

Ans A

According to ICG, Since the patient is having an active TB infection, and doesn't not have severe paiN or emergency.The treatment should be deferred.

There is no contraindication for prescribing Ibuprofen or paracetamol in this patient

Ref-TG Page 137,138

Combining analgesics from different classes can result in enhanced pain management, or synergistic analgesia (eg combining ibuprofen and paracetamol provides greater pain relief than either drug alone).

If adjunctive analgesia is required for **mild to moderate acute nociceptive dental pain** (for indications, see p.131), use:

ibuprofen 400 mg orally, 6- to 8-hourly for the shortest duration possible and no more than 5 days without review

PLUS

paracetamol 1000 mg orally, 4- to 6-hourly (to a maximum of 4 g in 24 hours) for the shortest duration possible.

2.In a couple of days the patient reports to you with facial swelling. While performing an examination of such a patient what precaution is important? TE

A use of surgical mask

B Use of P2/N95 mask

C pre procedural mouth rinse with ozonated water

D attending to her as first patient of the day

Ans B

Use of Particulate filtration respirators(PFR) like P2 N95 masks is mandatory to treat these patients as a part of transmission based precautions as TB is an air borne infection.

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Airborne precautions, which include the use of surgical PFRs, are designed to reduce the likelihood of transmission of microorganisms that remain infectious over time and distance which remain suspended in the air for longer periods of time due to their small size (less than 5 microns). These agents may be inhaled by susceptible individuals who have not had face-to-face contact with (or been in the same room as) the infectious individual. Infectious agents for which airborne precautions are indicated include measles, chickenpox (varicella), and *Mycobacterium tuberculosis*, as well as novel respiratory pathogens such as H5N1 influenza, avian influenza, SARS-CoV-2 (the virus responsible for COVID-19) and certain other coronavirus infections.

3. Which of the following is not a consideration when using a P2/N95 mask : TE

A masks should not be touched while being worn

B masks should be changed when they become moist

C masks can be reapplied after they have been removed as it has been fit tested

D masks should not be left dangling around the neck

E hand hygiene should be performed upon touching or disposing of a used mask

Ans C

Ref-ICG Page 22

Masks are never reapplied when they have been removed.

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Mask Musts	Mask Must Nots
Be put on after performing hand hygiene. Note that further hand hygiene is then needed before donning gloves.	Be touched by the hands while being worn, other than to remove it completely using the strings / loops.
Be fitted and worn according to the instructions for use – this means using both tie strings where the mask has two ties and adapting the mask to the bridge of the nose.	Be lowered to expose the nose.
Cover both the nose and mouth, and, where possible, be folded out to fully cover the chin and upper neck.	Be worn around the neck.
Be changed when soiled or wet.	Be worn for extended periods of time (e.g. more than the manufacturer's recommended duration).
Be removed by touching the strings and loops only.	Be removed by touching the front of the mask.

4.You provided active dental treatment and prescribed antibiotics. The patient requests you to clean his teeth as well. How do you educate the patient on when he can undertake this treatment ? PH

A Tell him that treatment should be deferred until he is no longer infectious and has reached the end of any mandatory quarantine period

B Tell him that he can be treated after his course of medications are completed

C Tell him that he can be treated now, but you will schedule an appointment at the end of the day

D Refer to a specialist

Ans A

Ref-ICG Page 76

Tuberculosis is spread by droplets, or by direct contact.
Tuberculosis has been transmitted as a result of dental procedures.
Patients with these diseases should have their dental treatment deferred until they are no longer infectious and have reached the end of any mandatory quarantine period.

5. How will you sterilize the diagnostic instrument (mouth mirror and tweezers) used for examination? TE

A consider them as critical items and follow the corresponding protocols

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B they are semicritical items and will follow a routine sterilization protocol

C they must undergo a dual cycle of sterilization

D They must be sterilized separately

Ans B

Ref-ICG Page36

Semi-critical RMDs

These come into contact with intact mucosa, or non-intact skin.

Examples of semi-critical RMDs: mouth mirrors, restorative instruments, dental tweezers and probes, metal impression trays.

- These RMDs must be cleaned to remove soil and organic material as soon as possible after use, following the manufacturer's advice for reprocessing.
- They are to be sterilised using steam or using another approved method (e.g. low-temperature hydrogen peroxide gas plasma sterilisation).

6. After his treatment for TB was completed and his medical doctor told him he no longer had active TB infection .How will you manage his gum disease? DM

BPE score

110

101

A Supra gingival scaling and root planing

B Supragingival scaling alone

C Plaque and gingivitis charting and oral hygiene demonstration

D Supragingival scaling and oral hygiene instruction

Ans C

Score 1 of BPE indicates that there is plaque and Bleeding on probing,,pocket depths of less than 3.5mm

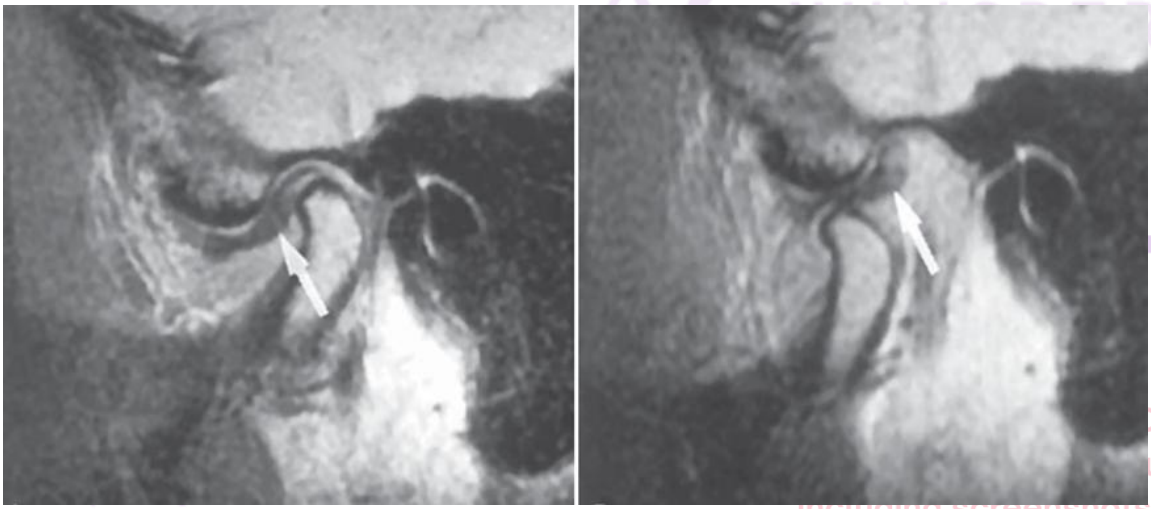
Probing depth	Observation	BPE Score
Black band completely visible	No probing depths >3.5 mm, no calculus/ overhangs, no bleeding after probing	0
Black band completely visible	No probing depths >3.5 mm, no calculus/ overhangs, but bleeding after probing	1

BPE Score	Guidance on Further Assessment and Treatment
0	Periodontal treatment is not required
1	Plaque and gingivitis charting and oral hygiene demonstration.

SBQ 20- TMJ

A patient reports to you saying that his previous dentist made a diagnosis of TMD , after he visited him for a routine dental check up. The patient is worried and wants a second opinion from you. He says that he has no joint pain or discomfort.

1 What does his MRI depict? IG



A Anterior disc displacement with reduction

B Anterior disc displacement without reduction

C Closed lock

D Normal open and closed position of TMJ

Ans A

Normally articular disc and condyle move together,

In this x-ray,the disc is present anterior to the condyle and upon mouth opening, the disc went posterior to the disc and the condyle is able to come forward-so it is anterior disc displacement with reduction.

Ref-Odell Case 8 Page 48

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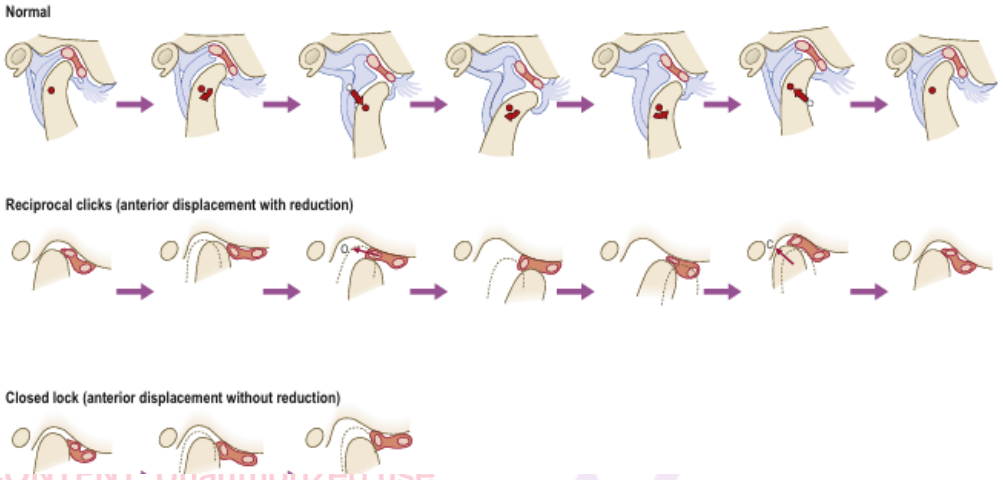

2 How will you manage this ? DM

A Anterior repositioning splint

B Mandibular advancement splint

C Patient education and reassurance

D Stress management

And – C

Ref-TG Page 145

Since the patient is asymptomatic and history didn't mention any stress inflicting the patient. Conservative management is educating and reassuring the patient.

Management of temporomandibular disorders

The aim of temporomandibular disorder management is to control the patient's symptoms rather than achieve a cure. Treatment goals should be tailored to the specific diagnosis, and may include reducing pain and adverse loading, restoring mandibular function and resuming normal daily activities.

Management strategies are conservative and can include:

- patient education and reassurance
- jaw rest, using strategies such as dietary modification to minimise chewing (eg eating only soft foods)
- avoidance of extreme jaw movements (eg yawning, chewing gum, singing)
- massage and application of warm packs to the temporomandibular joints and cheeks several times per day. Cold packs can be useful in the presence of redness and swelling

3 Patient is disappointed with the conduct of the previous dentist as he has unnecessarily made him undergo diagnostics like MRI? PH

A Explain the patient the importance of MRI for assessing the TMJ diseases

B Tell the patient MRI is a very safe diagnostic imaging modality and is routinely performed

C Tell the patient the previous dentist is at fault and encourage him to raise a complaint

D Explain the patient that MRI was absolutely not needed in his case

Ans A

Ref-Odell case 8 page 49

disc can be seen.

Magnetic resonance imaging (MRI) is probably the most useful investigation for this case because it will show the position of the disc as well as the surrounding structures. Scanning can be performed with functional movement to produce a series of dynamic images. Common indications for MRI include severe pain or clinically abnormal locking, previous TMJ surgery or any anatomical abnormalities unclear on the DPT. Furthermore, extensive MRI scanning may be undertaken if other diseases are suspected. MRI images from this patient are shown in

Option B-MRI is not routinely performed

Option C- we should not encourage the patient to complain about a colleague.

Option D- MRI is not absolutely unnecessary as there is disc displacement

4 Patient reports to you after a few months saying that the jaw hurts and she has difficulty chewing. How will you manage now ? DM

A Michigan splint

B Anterior repositioning splint

C Mandibular orthopedic repositioning appliance

D Mandibular advancement splint

Ans B

As there is a disc related problem(disc displacement),anterior repositioning splint is required.

Option A-is used for bruxism and MPDS.

Option C-it can lead to posterior open bite.

Option D-is used in mandibular sleep apnoea

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5. In one of his follow up visits , the patient asks if he can be given botulinum toxin for management of his disorder. What are the guidelines for this treatment ? PH

A There is no evidence for the use of botulinum toxin to manage the symptoms of temporomandibular disorders

B botulinum toxin is not a cure for temporomandibular disorders, but maybe used as a part of overall management

C Any general dentist can administer botulinum toxin

D Adverse effects associated with inadvertent injection of botulinum toxin into non target tissues are common

Ans B

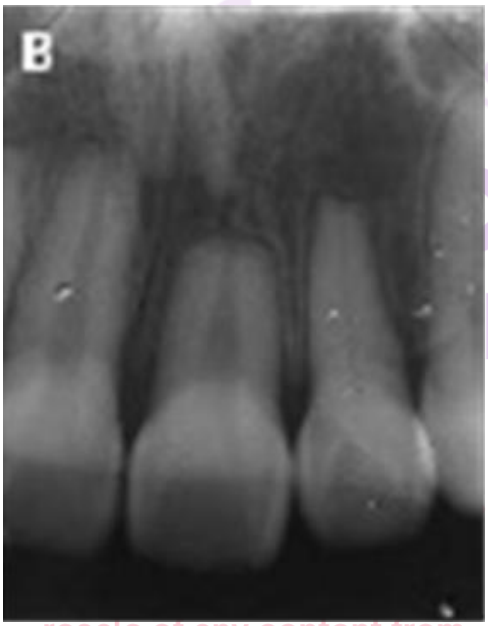
Ref-TG Page 146

There is some evidence for the use of botulinum toxin to manage the symptoms of temporomandibular disorders when conservative measures are inadequate. Ensure patients understand that botulinum toxin is not a cure for temporomandibular disorders, but may be used as part of the overall management strategy. The use of botulinum toxin for temporomandibular disorders is off-label. Dentists require additional training to administer botulinum toxin.* If the recommended doses and protocols are adhered to, the incidence of adverse effects is low. Local complications include stinging during injections, bruising at the site of injection and excessive muscle weakness. Adverse effects associated with inadvertent injection of botulinum toxin into nontarget tissues are rare, but can include alteration in smile and temporary dry mouth. Systemic adverse effects include an influenza-like syndrome that is transient and hypersensitivity reactions.

SBQ-21- External root resorption

Jack, a 17 year old, reports for a routine dental check up along with his mother . He visits his dentist regularly. He had undergone orthodontic treatment about a year ago.His family recently moved to the city where you are practicing. . You performed the oral examination and no significant findings were seen.

1 A section of OPG is shown , what is seen in upper incisors ? IG



A External orthodontic root resorption

B Internal root resorption

C Replacement resorption

D Apical periodontitis

Ans A

Ref-Resorption - clinical classification article

Patient's history states that the patient underwent ortho treatment and no history of any trauma and the x-ray shows resorption of apex of roots 11,21,22-all these indicate the possibility of the condition is external orthodontic root resorption.

6.6 | Orthodontic resorption

Orthodontic resorption is the process by which the apical part of one or more teeth undergo resorption, resulting in shortened roots

Radiographically, the roots appear shortened and blunted with rounded apices. The lamina dura usually appears normal and the PDL space may be normal or it may be widened as a result of the orthodontic tooth movement rather than because of the resorption. There

2.What could have caused this pattern of resorption in this patient ? IG

A trauma

B Orthodontic treatment

C periapical disease

D failure of root apex to close

Ans B

Ref-Resorption - clinical classification article

(Figure 13). The term "orthodontic" is used because the resorption occurs during orthodontic treatment and there is no other aetiology. In some ways, this resorption could be considered to be similar to "pressure resorption" but there are two distinct differences. The first difference is the specific aetiology—that is, the forces that are generated during orthodontic treatment whereas, in contrast, pressure resorption is the result of pressure from an impacted tooth or an adjacent pathological condition such as a tumour or cyst (see above). The second difference is the site of the resorption which is always apical whereas pressure resorption can occur anywhere along the length of the tooth root. Hence, the more specific term of "external orthodontic resorption" is appropriate.

3.The mother is worried looking at short teeth on the x ray, she feels the teeth may shed off. What would you advise her? DM

A Yes this is serious problem that needs immediate treatment

B explain the patient the importance of procedures like apexification to form a calcific barrier at root end

C explain her that resorption will not continue further,but regular monitoring and maintaining oral hygiene is required.

D requires no further management .

Ans C

Ref-root resorption-clinical classification article

If orthodontic resorption is diagnosed after the orthodontic treatment has been completed (e.g. on post-treatment radiographs), then the resorption should not continue since the orthodontic forces are no longer being applied to the tooth/teeth, However, regular monitoring of the tooth/teeth with further radiographs (such as, after 6 months) should be arranged to ensure the resorption has stopped, as well as to assess whether the mobility has reduced, the pulp, periapical and periodontal tissues are healthy, and the patient is maintaining a high level of oral hygiene.

4.What is a patient related factor for this type of resorption? DM

A alveolar bone density

B severity of malocclusion

C tooth-root morphology

D root proximity to cortical bone

E All of the above

Ans E

Ref-Root resorption in orthodontics-review article

Factors related to the patient:
These include genetic factors, chronological age, dental age, gender, ethnic factors, syndromes, psychological stress, increased occlusal force, tooth vitality, type of teeth, dental invaginations, features of dentoalveolar and facial structures, existing root resorption before treatment, proximity of the root to the cortical bone, nutrition, systemic factors (illnesses that cause inflammation, asthma, allergy, etc.), hormonal irregularities, systemic medicine use, metabolic skeletal disorders, parafunctional habits, morphology of teeth/root, developmental abnormalities of roots, properties of cementum mineralization, hypofunction of the periodontium, history of trauma, endodontic treatment, density of the alveolar bone, and type and severity of malocclusion and alcoholism.

5. What is the most damaging orthodontic movement of teeth ? IG

A Extrusion

B Intrusion

C Tipping

D Rotation

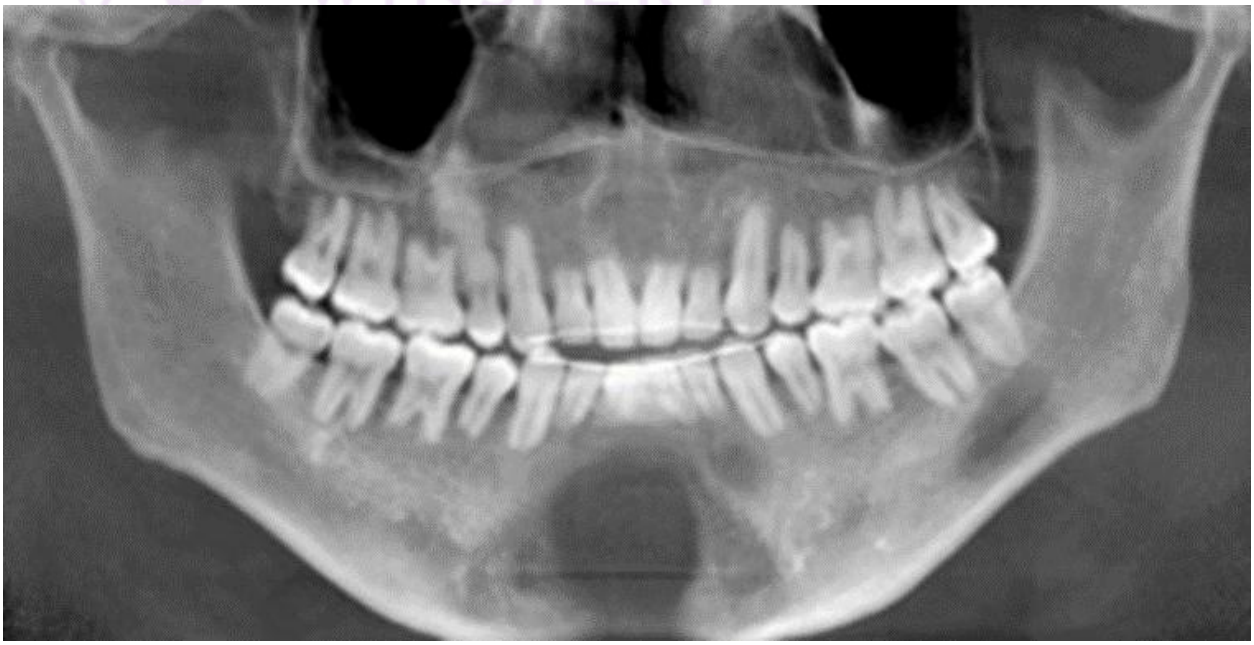
Ans B

Ref-Root resorption in orthodontics-review article

Direction of tooth movement
According to the type of movement, high points of pressure, where the force is intensified, are more prone to root resorption. In intrusive movements, almost all pressure is gathered in the root apex; the risk of resorption markedly increases because of root anatomy (14). When compared with intrusive movements, extrusive movements occur easily, but they also cause root resorption in interdental areas in the cervical third of the root. It has been stated that root resorption occurs four times more during intrusion than during extrusion (15).

The most detrimental orthodontic movement that may induce root resorption is the combination of lingual root movement with intrusion (16). Li et al. (17) evaluated the amount of root resorp-

6. This is an OPG of another patient with a similar condition, what is the cause of the error seen here ?
IG



A patient bit too anteriorly on the rod

B patient bit too posteriorly on the rod

C Patient's head is tipped downwards

D Patient's head is tipped upwards

Ans C

Ref- Langlais textbook-page 76

exaggerated smile appearance of teeth and mandible, is caused by head tipping downwards

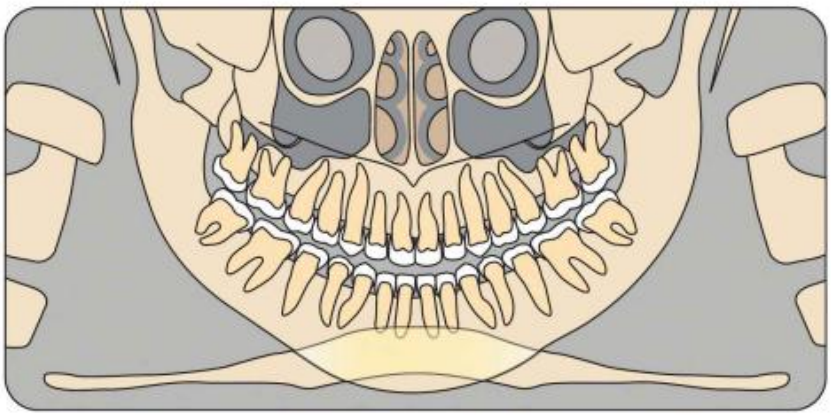


Figure **6-37** Patient's chin tilted too low.

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SBQ-22- LA allergy

Your patient is to have a crown preparation performed on her lower second molar and a very small amalgam placed in an upper premolar on the same side. You have given an infiltration of 1.0 ml lidocaine (lignocaine) 2% with adrenaline (epinephrine) 1:80 000 and used a further 2-ml cartridge to give an inferior dental and lingual nerve block. Having finished injecting, you turn away to prepare some instruments. Almost immediately the patient says she feels uncomfortable. She is clearly apprehensive and is holding her chest complaining of palpitations.

1 What could be the cause of her symptoms?   IG

A Intravascular injection of LA

B vasovagal syncope

C hypersensitivity

D Panic attack

Ans A

Ref-Odell case 37,page 204

The symptoms occurred due to inadvertent injection of LA containing adrenaline intravenously-adrenaline effect

> **Intravascular injection** is the most likely diagnosis, the patient's symptoms being caused by the vasoconstrictor component of the local anaesthetic. The solution contains 1:80 000 adrenaline (epinephrine), which causes tachycardia felt by the patient as palpitations. Intravascular injection is most common after inferior dental blocks and posterior superior dental blocks because of the high vascularity of the injection site.

Syncope has lightheadedness,nausea,anxiety,and tinnitus.

Hypersensitivity appears as urticaria,rashes,and angioedema.

Panic attack can also raise the adrenaline levels ,but it occurs slowly and the stress should be very high

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2. How could this have been best avoided? TE

A Giving the injection at a posterior site

B Using plain Lignocaine

C Good injection technique

D Depositing LA in bolus form

Ans C

Ref-Odell case 37 page 206

◆ How Can the Risk of Intravascular Injection Be Minimized?

Good injection technique is the key to reducing the risks associated with intravascular injection because it ensures that the minimum amount of anaesthetic solution is used. The solution should be injected slowly, thus reducing the risk of injecting a bolus into a vessel. An aspirating technique should always be used, even though it does not always guarantee success; because of the narrow needle diameters used in dentistry, aspiration is relatively poor.

3. If the patient said that his skin turned slate-grey in colour the last time he had a dental injection, which LA agent commonly causes this? IG

A Lignocaine

B Ropivacaine

C Articaine

D Prilocaine

Answ D

Ref-TG Page 204

slate gray color of skin after injecting LA, indicates methemoglobinemia which is commonly caused by prilocaine

> Methaemoglobinaemia is mainly associated with prilocaine (particularly at doses over 600 mg) and benzocaine, but is occasionally reported with lidocaine, articaine and tetracaine. Slate-grey skin discolouration and cyanosis

4. What is the maximum number of cartridges that can be used in this patient, her body weight is 65kg?

TE

A 10

B 12

C 13

D 14

Ans A

Ref-TG Page 207

Patient weight is 65 kg and requires a local anaesthetic for a dental procedure.

Lidocaine 2% (that is 20 mg/mL) with adrenaline (epinephrine) 1:80 000 (12.5 micrograms/mL) is used . To,Calculate the maximum dose in milligrams based on the patient's weight maximum safe single dose of lidocaine with adrenaline is 7 mg/kg

7 mg/kg x 65 kg = 455 mg

Use the concentration of solution (mg,/mL) to convert the calculated dose to volume

455 mg ÷ 20 mg/mL = 22.75 mL

To Convert the calculated volume to number of 2.2 mL dental cartridges

1 cartridge=2.2ml

therefore 22.75ml makes 10 cartridges

22.75ml/2.2ml=10.3

Therefore, the total volume administered must not exceed 22.7.5 mL or 10 cartridges containing 2.2 mL each

SBQ 23- Bleeding post op

Sebastine, an african male reports to your oral surgery oriented dental practice complaining of cheek bite in the right cheek region. Medication history reveals that the patient is taking clopidogrel and rosuvastatin. Your examination revealed a severely broken 48, that is impinging on the right cheek and causing injury.

1.Which of the following could not be a possible risk factor for him ? DM

A abnormal kidney or liver function

B prior stroke

C history of bleeding

D labile INR

Ans D

As the patient is on clopidogrel which has an antiplatelet effect and INR is not used to test its antithrombotic activity, therefore labile INR(poor anticoagulant control) could not be a risk factor for him.

Box 18. Important patient-related factors that increase the risk of prolonged bleeding from an oral or dental procedure in patients taking antithrombotic drugs

Patients with multiple risk factors have an additive risk of prolonged bleeding. Risk factors include:

- elevated blood pressure
- abnormal kidney or liver function
- prior stroke
- history of bleeding (particularly if this occurred with a similar procedure)
- pre-existing bleeding disorder
- poor anticoagulant control (eg labile INR)
- older age or frailty
- other drugs that predispose to bleeding [NB1], including NSAIDs (eg nonprescribed NSAIDs, low-dose aspirin)
- hazardous alcohol consumption.

2.He wants to undergo the surgery under Sedation? What is the precaution he must undertake ? DM

A You can have a light meal on the day of your appointment, but do not have anything to eat or drink within 2 hours of your appointment.

B Do not drink alcohol or use illicit or recreational drugs 48 hours before your appointment.

C If you are having an oral medicine for anxiolytics, it will need to be taken at the dental clinic approximately 2 hours before your treatment starts.

D Avoid medicines if he has been taking any.

Ans A

Ref-TG Page 216

Before the appointment

You can have a light meal on the day of your appointment, but do not have anything to eat or drink within 2 hours of your appointment.

Do not drink alcohol or use illicit or recreational drugs on the day of your appointment.

If you are taking other medicines, take them at the usual times unless otherwise advised.

If you are having an oral medicine for anxiolysis, it will need to be taken at the dental clinic approximately 1 hour before your treatment starts.

Wear loose-fitting clothes, and do not wear jewellery. Remove contact lenses.

Let your dentist know if you are unwell on the day of your appointment, because it may affect your treatment.

3.You have decided to extract 48, what is to be done ? DM

A Proceed with extraction

B Refer to GP

C refer to oral surgeon

D smoothen the sharp edge

Ans A

Ref-TG 157,162

As the patient is on single anti platelet drug with no patient related risk factors, single tooth extraction is a low risk procedure ,so extraction can be performed.

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Patients taking a single antiplatelet drug undergoing an oral or dental procedure

This advice applies to patients taking a single antiplatelet drug (eg clopidogrel, prasugrel, ticagrelor, aspirin, dipyridamole) and not taking an anticoagulant.

Temporary interruption of single antiplatelet therapy is **not** required for the following oral and dental procedures:

- procedures that are unlikely to cause prolonged bleeding (see Table 16; p.157)
- procedures with a lower risk of prolonged bleeding (see Table 16; p.157).

Oral and dental procedures that are unlikely to cause prolonged bleeding
examination and diagnostic procedures (eg periodontal examination, impressions)
restorative treatments (eg restorations, root canal therapy)
orthodontic treatment
Oral and dental procedures that are likely to cause prolonged bleeding
Lower risk of prolonged bleeding
extraction of a small number of teeth (eg 1 to 3 teeth) that are not adjacent
periodontal procedures (eg subgingival debridement)
incision and drainage of swellings
limited or small soft tissue biopsies

4.The broken tip of the root has to be removed by an open method . How will you proceed? DM

A Advise the patient to stop the medication

B Defer the treatment for 2 weeks

C Consult general practitioner for a risk of bleeding

D leave the root and observe

Ans C

Ref-TG Page 157,162

As the root tip is to be removed by an open method which includes mucoperiosteal flap elevation - it is a high risk procedure,so general practitioner should be consulted for the probability of excessive bleeding.

Higher risk of prolonged bleeding [NB2]
extraction of a large number of teeth (eg 4 or more teeth) or extraction of adjacent teeth that creates a large wound
any procedure where a mucoperiosteal flap is used (eg surgical extractions, implant placement, periapical surgery, periodontal surgery)
extensive soft tissue biopsies
hard tissue biopsies

Consult the clinician managing the antiplatelet drug to determine if temporary interruption of single antiplatelet therapy is required for the following oral and dental procedures:

- procedures with a higher risk of prolonged bleeding (see Table 16; p.157).

5. When can a broken root tip be left in situ ? DM

A Its vital and only less than 5 mm is left

B It is nonvital

C

D Always

Ans A

Ref-Contemporary exodontia ADJ article in oral surgery folder page S13

the patient through much less pressure. What happens if a root tip fractures? Firstly consider leaving it there if it is vital, less than 5 mm and in proximity to a vital structure such as a nerve. If you can, remove it through a small boney window thus maintaining alveolar bone height (Fig. 6).

SBQ 24- Bone disorder and dental management

A 73-year-old woman was referred by her oncologist for assessment of exposed bone in her left mandible. She underwent extraction of her carious mobile lower left canine and lower left second premolar under local anesthesia 6 months previously. Prophylactic antibiotics were administered before extraction. Exposed bone was present since her extractions and she was managed conservatively with chlorhexidine

mouthwash and oral co-amoxiclav. Her medical history included a diagnosis of osteoporosis and left breast cancer . She underwent a left mastectomy and adjuvant chemotherapy, which included zoledronic acid intravenously to reduce her risk of osteoporosis-induced fractures.

1.Which of the following is not an antiresorptive drug ? IG

A Alendronate

B Denosumab

C Ibandronic acid

D Bevacizumab

Ans D

Ref-TG Page 164

Bevacizumab is an antiangiogenic drug

drugs include bisphosphonates and denosumab. Antiangiogenic drugs (eg bevacizumab, sunitinib) interfere with the formation of new blood vessels, and are used in the treatment of some malignancies.

2.Patient is diagnosed to have MRONJ. Risk of developing MRONJ is highest in which of the following situations ? DM

A A patient receiving bisphosphonate for osteoporosis

B A patient receiving bisphosphonate for non cancer indications for 2 years

C A patient been diagnosed with medication-related osteonecrosis of the jaw in the past

D A patient receiving bisphosphonate for non cancer indications for 3 years

Ans C

Ref-TG Page 169

Previous history of MRONJ is a highest risk factor for re-occurrence of MRONJ.

Option A is ruled out as the risk of MRONJ is more when patient is receiving bisphosphonate for cancer

Options B and D are ruled out as the time duration is 4 yrs for non-cancer causes.

3 Management of this patient's condition includes all except ? DM

A Reduce the plaque load in mouth

B pre- and post-procedural triclosan mouthwash.

C Do not debride non healing wounds.

D None of the above

Ans B

Box 21. Management advice for patients at risk of medication-related osteonecrosis of the jaw undergoing a bone-invasive dental procedure

- Inform the patient of the risk of medication-related osteonecrosis of the jaw and obtain consent for the procedure.
- See advice on drug holidays and scheduling of procedures (p.172).
- Do not use antibiotic prophylaxis to reduce the risk of medication-related osteonecrosis of the jaw—there is insufficient evidence to support this practice. However, an active infection should be treated.
- Ensure optimal oral hygiene before and after the procedure.
- Reduce the plaque load with mechanical debridement and pre- and post-procedural chlorhexidine mouthwash.
- Minimise trauma and periosteum stripping, and close any mucosal flaps that are raised with sutures.
- Monitor the oral wound until it heals—healing may be slow.
- Do not debride nonhealing wounds.
- Refer to a specialist if bone is still visible at 8 weeks.

4 What is a drug holiday ? TE

A Temporary discontinuation of antiresorptive therapy

B alternating antiresorptive drug

C Alternating antiresorptive and antiangiogenic drug

D timing the dental procedure to coincide with high serum concentration of drug

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Ans A

Ref-TG Page 172

Drug holidays and scheduling of procedures

If a bone-invasive dental procedure cannot be avoided but is not urgent, temporary discontinuation of antiresorptive therapy (a 'drug holiday'), or timing the procedure to coincide with a low serum drug concentration, have been suggested to reduce the risk of medication-related osteonecrosis of the jaw. These practices are based on extrapolation of the drug pharmacokinetics in the serum and on bone physiology; however, outcome

5 Which of the following stages of MRONJ is asymptomatic? IG

A Stage 0

B Stage 1

C Stage 2

D Stage 3

Ans B

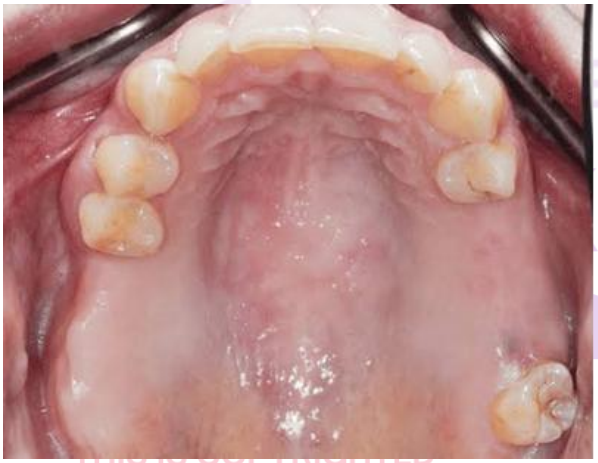
Ref-TG Page 165

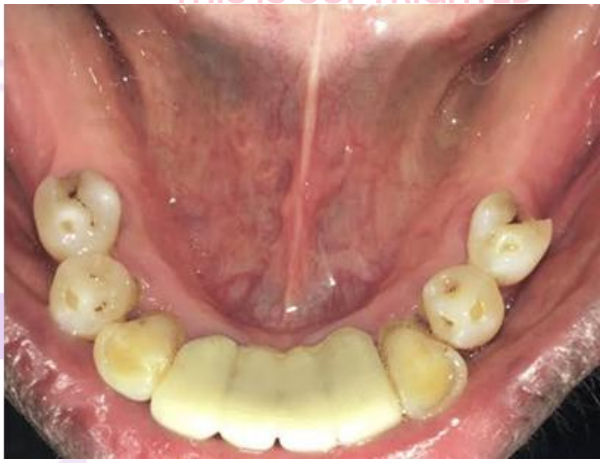
Stage 1 [NB1]	asymptomatic exposed bone no inflammation or infection

SBQ 25- Partial denture

A patient reports to you for rehabilitation of his missing teeth in upper and lower jaw region, the intra oral images are given

1.What is the Kennedy classification ? DM





A upper class 4 mod 1 and lower class 2

B upper class 1 mod 1 and lower class 2

C upper class 2 mod 1 and lower class 1

D upper class 2 and lower class 2

Ans C

Ref- Prostho HOT notes RPD page 19

Upper denture is class 2 with additional edentulous space is modification 1

Lower bilateral posterior edentulous space-class 1

1) Class I: Bilateral edentulous area located posterior to natural teeth

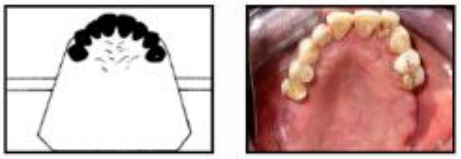


Fig: Kennedy Class I arches (Source-internet and Mc' cracken)

2) Class II: A Unilateral edentulous area located posterior to natural teeth

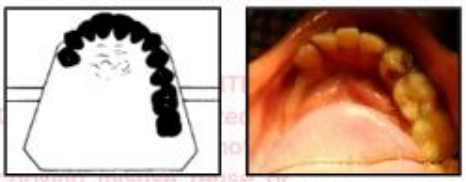


Fig: Kennedy Class II arches (Source-Internet, Mc' cracken)

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2. How will you disinfect the Impression TE

A Rinse thoroughly ,apply a diluted detergent and rinse again

B use sodium hypochlorite solution for 3 to 15 minutes,

C thorough rinsing is sufficient

D low-level chemical disinfection

Ans A

Ref-ICG Page71

4. Impressions

To remove contamination from impressions, thoroughly rinse them with cold running water to remove saliva and traces of blood. Then apply a diluted detergent. This can be done by immersion in a solution of detergent or by spraying the diluted detergent onto the impression (e.g. in a plastic bag). The detergent will have a surfactant action which assists in removing the remaining microorganisms from the impression. Thorough rinsing is then undertaken to remove the detergent. This second rinsing step must continue until all visible contamination is removed. Once this is completed, the impression is deemed to be decontaminated.

Option B -is for patients with MRSA

3 What clasp is not indicated in distal extension case? TE

A Ring clasp

B Reverse circlet clasp

C I bar clasp

D Circumferential clasp

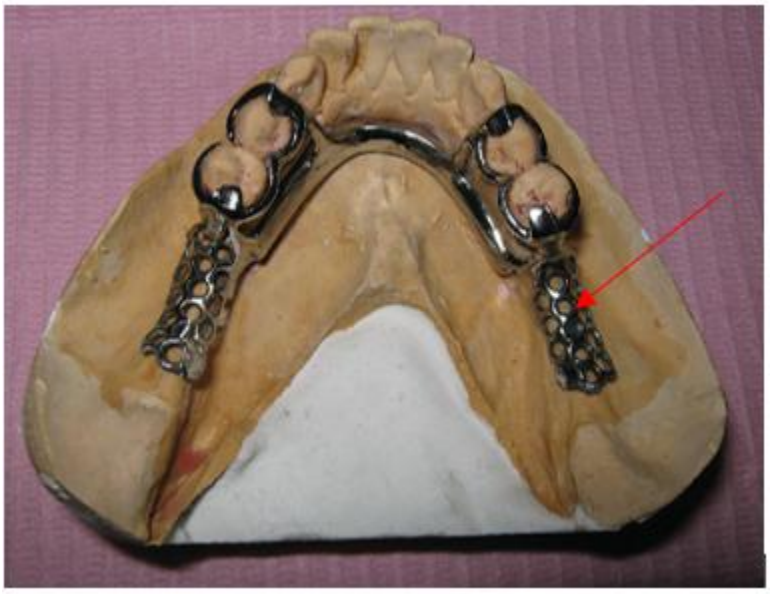
Ans A

Ring clasp is used in the case of tilted molars

Ref-Prostho hot notes RPD-page 32

2. Ring Clasp
   - It is a form of circumferential clap which encircles nearly all of a tooth from its point of origin.
   - It is usually used with mesially and lingually tilted mandibular molars (with a mesiolingual undercut) or mesially and buccally tilted maxillary molars (with a mesiobuccal undercut)
   - For this clasp assembly to be used undercut should be present on the same side of the rest seat that is adjacent to edentulous space.

4 What is this part of Cast partial denture called ? IG



A major connector

B minor connector

C indirect retainer

D direct retainer

Ans B

Ref-Prostho hot notes RPD-paGE 23

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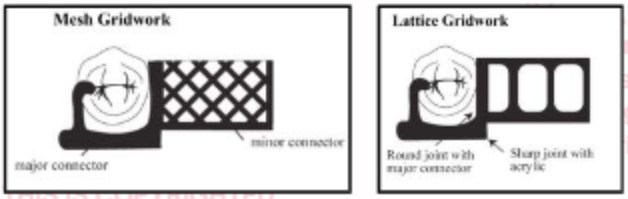
Basic types of minor connectors are:

b) Gridwork minor connectors that connect the denture base and teeth to the major connector.



5.What is providing the indirect retention in this design of metal framework ? DM

A Lingual plate

B multiple circlet clasp

C rests on first premolars

D rest seat on first premolars

Ans C

Rest on first premolars are auxiliary rests placed at a place perpendicular to the fulcrum line,which provides indirect retention

Ref-Prostho hot notes RPD page 23

4) **Indirect Retainer:** A unit of a Class I or II partial denture that prevents or resists movement or rotation of the base(s) away from the residual ridge.
Indirect retainers usually take the form of rests, and they are placed away from the fulcrum line.
Indirect retainers should be placed as far as possible from the distal extension base to gain the best possible leverage advantage against lifting of the distal extension base.
The most commonly used indirect retainer is an auxiliary occlusal rest located on an occlusal surface and as far away from the distal extension base as possible.

- The fulcrum line on a Class I partial denture as passes through the rest areas of the most posterior abutment on either side of the arch.

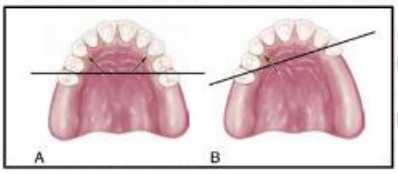


Fig: Class I partially edentulous arch with fulcrum line.
(arrows indicate the most advantageous position of indirect retainers)

SBQ 26- OAF

1. You are about to extract the right upper first permanent molar in a patient who has a large maxillary sinus. What should you warn the patient about prior to the extraction? DM

A Possibility of an oronasal fistula

B Possibility of an oronasal communication

C Possible pain following the extraction

D Possibility of a nose bleed following the extraction

Ans C

Ref-Odell page 101

Formation of oro antral communication and/or fistula can lead to sinusitis which can cause pain,so patients should be warned about pain.

Sinusitis Secondary To Oroantral Fistula. An oroantral communication itself causes little or no discomfort but usually induces a degree of sinusitis. The nature and distribution of pain and presence of nasal discharge are typical of sinusitis. This seems the most likely diagnosis. Fistula formation is most commonly associated with the extraction of maxillary first and second molars.

Options of A,B,D are ruled out as there is a possibility of oro-antral communication not oro-nasal communication.

2. You have just repaired an oroantral communication following removal of an upper molar. What would you include in the post-operative management? TE

A Antibiotics

B Advice to the patient about not blowing their nose

C Nose drops

D Inhalations

E Referral to an ENT department

Ans B

Ref-Odell case 18 page 105

A suitable antral regime would be:
- an absolute ban on blowing the nose for 48 hours
- sneeze allowing pressure to escape through the mouth
- nasal decongestant (e.g. ephedrine nasal spray 0.5%)
- decongestant inhalant.

3.What is the most preferred flap for closure of OAC TE

A Palatal advancement flap

B Buccal advancement flap

C submucosal palatal island flap

D pedicled grafts from the tongue

Ans B

How Will You Close the Defect?

The buccal mucoperiosteal flap with advancement (buccal advancement flap) is the most commonly used technique, and it has more than a 90% success rate. The technique is shown in Fig. 18.4. After excising the fistula, as above, proceed as follows:

4.Which is the ideal extra oral radiographic method to view the maxillary sinus ? IG

A Water's view

B Towne's view

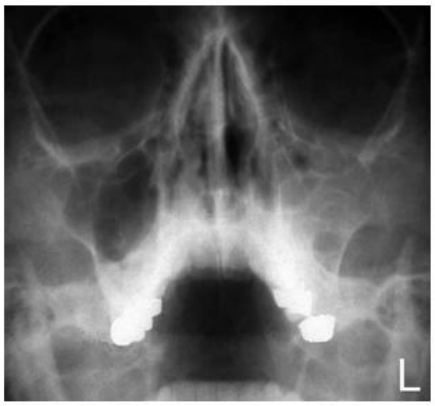
C Reverse towne's view

D Anterior posterior view

Ans A

Ref-Odell case 18 page 102

occipito mental view is also called as water's view



• **Fig. 18.3** Part of the occipito-mental view.

Radiographs of antrum, usually a panoramic tomograph or standard occipito-mental view is sufficient. However, it is difficult to

SBQ 27- instrument injury Hep B

You are extracting a difficult tooth and have used a luxator to loosen the tooth prior to elevation. While transferring the luxator to the bracket table, you drop it. The luxator impales itself in your foot.

1.While making a record of the incident it must include all except ? PH

A how the incident occurred

B gauge of the needle

C type of exposure

D time the injury occurred

E None of the above

Ans E

Ref-ICG Page 82

All are important to document after body fluid exposure incident

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A full record of the incident must be made, including details of:

- who was injured;
- how the incident occurred;
- type of exposure;
- presence of visible blood on the device causing the injury;
- whether a solid sharp object, hollow bore object or needle was involved;
- gauge of the needle;
- time the injury occurred;
- what action was taken;

2.Which if the following is not a part of first aid? DM

A Stop work immediately, regardless of the situation

B Allow the wound to bleed and clean it thoroughly with a soap and lukewarm water

C Do not apply disinfectants as some are irritants and retard healing

D Squeeze the wound immediately

Ans D

Ref-ICG Page 82

- Allow the wound to bleed and clean it thoroughly with a soap and lukewarm water wash. There is no benefit in squeezing the wound. Do not apply disinfectants as some are irritants and retard healing.

3. The source individual should be tested for? TE

A HIV antibody

B HBsAg

C HCV antibody

D All of the above

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Ans D

Ref-ICG Page 83

The source individual should be tested for:

- HIV antibody;
- HBsAg; and
- HCV antibody.

4. The baseline test reported that the source is negative for any blood borne virus. This can be a false negative as the source may be in the window period. What is the duration of the window period for HIV ? IG

A 1 month

B 2 months

C 3 months

D 6 months

Ans C

Ref-Odell Page 83

The window period causes a FALSE NEGATIVE test result. The patient may be infectious, but this is undetectable by testing. Usually, the window period for HIV is up to three months but it can, very rarely, be longer. The use of polymerase chain reaction (PCR) testing for HIV/viral RNA can identify 90% of infections within four weeks, significantly reducing this window period. The window period is six months for HBV and HCV.

5. Dental practitioners who perform exposure prone procedures undergo testing for antibodies to Hepatitis B, Hepatitis C, and HIV? PH

A at least once every three years.

B At least once every year

C Twice every three year

D every year

Ans : A

Ref-ICG Page 15

- Dental practitioners who perform EPPs undergo testing for antibodies to hepatitis B, hepatitis C, and HIV at least once every three years, and after an occupational BBFE.

SBQ 28- swallowed object /injury

While fitting a metal ceramic bridge in the upper right back teeth region for your patient, the bridge slipped from your hand and fell into the patient's throat.

1 Patient is conscious and you see signs of airway obstruction. What will you do? TE

A reassure the patient

B call 000

C check effectiveness of coughing

D give back blows

Ans B

Ref-TG Page 259

If the patient is conscious with signs of airway obstruction (see Table 26; p.257):

- Call 000.
- Reassure the patient and encourage them to relax, breathe deeply and try to dislodge the object by coughing.
- If coughing is ineffective, give up to 5 back blows between the shoulder blades using the heel of the hand (checking for effectiveness between each blow).
- If back blows are unsuccessful, give up to 5 chest thrusts delivered at the same compression point as for CPR (checking for effectiveness between each chest thrust).
- Continue to alternate between back blows and chest thrusts until the obstruction is relieved or assistance arrives.

2 Which of the following indicates complete obstruction of the airway ? IG

A there will not be any attempts to breathe

B no breathing sound

C air emits from nose , but not mouth

D all of the above

Ans B

Ref-TG Page 257

Signs of complete airway obstruction
there may be attempts to breathe
no breathing sounds
air does not emit from nose or mouth

3 If the patient went unconscious then? TE

A call 000

B start CPR

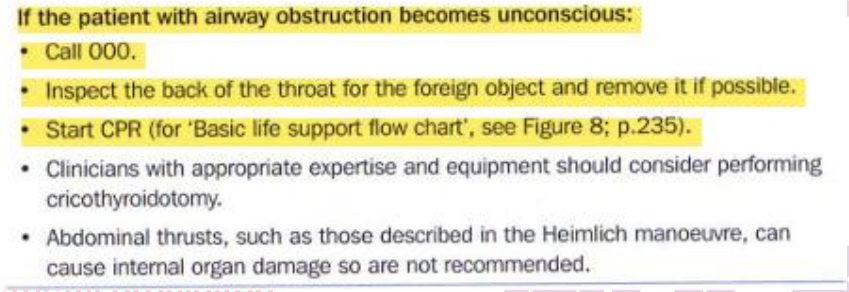
C lie the patient flat

D perform heimlich manoeuvre

Ans B

Ref-TG Page 259

As an emergency was called initially when the patient was conscious and having signs of airway obstruction,now the patient slipped into unconsciousness,so we have to start CPR before emergency services arrive.



If the patient with airway obstruction becomes unconscious:

- Call 000.
- Inspect the back of the throat for the foreign object and remove it if possible.
- Start CPR (for 'Basic life support flow chart', see Figure 8; p.235).
- Clinicians with appropriate expertise and equipment should consider performing cricothyroidotomy.
- Abdominal thrusts, such as those described in the Heimlich manoeuvre, can cause internal organ damage so are not recommended.

4 While performing CPR, how many compressions are given per minute ? TE

A 70-100 times

B 100 - 120 times

C 30-50 times

D 120- 150 times

Ans B

Ref-American heart association

1. For healthcare providers and those trained: conventional CPR using chest compressions and mouth-to-mouth breathing at a ratio of 30:2 compressions-to-breaths. In adult victims of cardiac arrest, it is reasonable for rescuers to perform chest compressions at a rate of 100 to 120/min and to a depth of at least 2 inches (5 cm) for an average adult, while avoiding excessive chest compression depths (greater than 2.4 inches [6 cm]).

5 How could you have prevented this ? DM

A patient should have been placed in supine position

B by using rubber dam

C using low volume suction tip

D tilting the patient's head downward , so object falls into floor of the mouth

Ans B

Ref-TG Page 58

Box 47. Preventive measures to minimise the risk of inhaled or swallowed objects

If possible, use a rubber dam for procedures with a high risk of inhaling or swallowing a foreign object.

If the procedure precludes the use of a rubber dam, other precautions include:

- ensuring a careful and unrushed approach
- having the patient reclined rather than supine
- having instruments and facilities available that can be used to retrieve an object from the oropharynx
- tying dental floss to any object that can be dropped (if appropriate)
- placing gauze across the back of the tongue to trap small items (eg crowns) that may be dropped
- rotating the patient's head so that a dropped object will fall to the side of the mouth
- using high-volume suction.