Contents

Videos

Video 1: Step-by-step extraction of a right maxillary lateral incisor using periotomes and forceps. The video demonstrates proper patient positioning, surgical armamentarium, patient comfort and safety devices, administration of local anesthesia, extraction of the tooth, and suturing the site.

Video 2: Step-by-step extraction of a left maxillary central incisor using periotomes, elevator, and forceps. The video demonstrates proper patient positioning, surgical armamentarium, patient comfort and safety devices, administration of local anesthesia, extraction of the tooth, and suturing the site.

Video 3: Suturing techniques. This 5-minute video demonstrates surgical armamentarium and three commonly used suturing techniques: interrupted suture, continuous suture, and figure-8 suture.

Video 4: Time out procedure. This 1-minute video demonstrates the performance of a time out procedure to verify the correct patient, correct procedure, and correct site for a live patient.

1 New Patient Visit

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Consultation Visit—New Patient Script

One of the greatest sources of anxiety and confusion for preclinical and new-to-clinic dental students is *What should I say to the patient*? Learning *what* to say and *how* to say it to patients is an important skill worthy of development. Of course, it takes time to get the words, rhythm, and the delivery correct, but doing so may help the practitioner appear friendly, amicable, and thorough while instilling confidence in the listening patient. But importantly, this must occur within a short period of time.

Over the years, many generations of students and young practitioners have found it immensely helpful to have some *scripts*—well-practiced guidelines—as far as what to say, how to say, and what level of depth to delve into when first interacting with patients. Good practitioners work at fine-tuning their delivery when it comes to greeting a new patient, discussing their findings/diagnoses, presenting the treatment plan, and then closing out the visit.

This is meant to be a starting point for new practitioners or those with high anxiety about the first few times when they have a patient in their chair.

Example: The following might be a sample consultation *script* to use as a guideline when meeting a new patient "Ms. Jones" who has a painful, nonrestorable mandibular molar that requires removal.

"Good morning, Ms. Jones, my name is (student) Doctor_____. Tell me what brings you in today. I understand that you have a broken molar causing you pain, and that you would like to have it removed. Is that correct? We are more than happy to get that taken care of for you. First, let me ask you a couple of questions. Do you have any medical conditions or concerns that you are currently being treated for, such as diabetes or asthma? Do you have any problems with your heart or with high blood pressure? Do you get pains in your chest or lose your breath when walking or doing any form of activity, or even from just sitting? Have you had any issues with bleeding in the past? Are you currently taking any prescription or nonprescription medications? Do you have any allergies to any medications—penicillin, codeine, or dental numbing medicine? Do you smoke? If so, how much and for how many years? Do you drink alcohol? Do you use any other recreational drugs—marijuana, cocaine, or heroin? It is important for us to know these things because some of our medications or treatments might interact with certain drugs or chemicals. Have you had any surgeries in the past? Have you ever had any problems with anesthesia that you know of or were told about? Have you ever had any problems with local anesthesia in a dental office? What we will do right now is take a look at your radiograph(s), talk about what we see and what we can offer you, and then we'll leave any decision-making up to you. Okay?"

When reviewing diagnostic material such as a panoramic radiograph, a thorough, verbal description in terms understandable to the patient is helpful. You can say something like the following (while using your hands or a pointer to describe as you speak).

"In the radiograph(s), these teeth up here (indicating with a pointer) are your top teeth; these are your bottom teeth. This is your right side; this is your left side. Let us zoom in on the bad molar causing your pain. This tooth is missing tooth structure and has a deep cavity, or a hole, that we can see in this dark area of the tooth. Notice how it appears very different in color from the other surrounding teeth.

Because of how much tooth structure is missing, we are not able to fix that with our dental techniques. The only treatment we can offer you is removal or extraction. Most patients do well with these procedures with local anesthesia—where we give you some numbing medicine in the area so you do not feel any pain. You will feel pressure as I am working, but there will be no discomfort or pain. You might even hear some funny noises as we are working, but that is normal, as well. We might have to make a small incision in the gums. If we do, it will only be as long as the tooth from front to back, so it will not be very big. But that will allow us better access to the entire tooth so we can work more quickly and get you back on your way. Once we get the tooth out, we will put in some dissolvable stitches to close the gums. This also helps with the healing process. The procedure will take about 10 to 20 minutes once you are numb and comfortable. And after we are done you will be ready to go home.

Then comes your recovery phase. It is normal and expected for some swelling to occur. It takes about 3 days for this swelling to reach its peak before it starts to get better. There also is a possibility of bruising in the area. Bruising typically lasts longer than swelling, but it will go away. There are no diet restrictions or activity restrictions. You can eat and drink whatever is comfortable for you, but perhaps it will be wise to stay away from sharper-edged foods, such as chips, for a few days. And lastly, we will be giving you two or three medication prescriptions to take during your recovery. One is a pain medication such as acetaminophen (Tylenol®). Take it if you need it. One is a medicated mouthwash. It is like a topical antibiotic and helps the gum tissue and the socket heal more quickly. And the last one is something like Motrin®or Advil®that helps minimize your swelling and contributes to pain relief.

Let me discuss with you the risks of the procedure. The main risks of any tooth removal procedure are some minor discomfort, swelling, and bleeding or oozing following surgery. These are all normal and expected. There is a low risk of infection, but these are rare. There is also a small possibility that additional surgery may be needed if the site fails to heal properly. It is unlikely, but adjacent teeth or nerve structures can be bruised, bumped, or nicked during the process of completing our work. We will make every effort to avoid this, but it is possible. There is also a chance that we may decide to leave a small piece of the tooth or root behind if attempting to remove it places important structures, such as nerves, at

Charts and Charting

- Most attorneys say that if something is not written in the chart, it did not happen.
- Document every encounter with patients.
- If you call a patient, document it in the chart.
- If you see a patient, document the progress notes in the chart.
- If you are scheduled to see a patient, and he/she fails to show, document it.

Comprehensive Oral Evaluation—History and Physical Examination

- A thorough medical history and complete head and neck physical examination should be performed for every *new* patient and on yearly or semiannual reevaluation visits.
- It should include the following items:
  - Identification [ID] (*age, race, gender*).
  - Chief complaint [CC] (*why is the patient here?*).
  - History of the present illness [HPI] (*how long has the problem been going on?*).
  - Past medical history [PMH] (include primary care physician's name and phone number, current illnesses, and past illnesses or hospitalizations).
  - Past surgical history (PSH).
  - Social history (Soc).
    - *Tobacco use*: pack years = packs per day × number of years smoked.
    - *Alcohol use* (type, amount, frequency).
    - *Recreational drug use* (specify the drug and route).
  - Medications [Meds] (*prescription and nonprescription*).
  - Allergies (ALL).
  - American Society of Anesthesiologists' (ASA) status.

Physical Exam

- Vital signs.
  - Blood pressure (BP).
  - Heart rate (HR).
  - Temperature (T).
  - Respiratory rate (RR).
- General.
  - Height.
  - Weight.
  - Body mass index (BMI).

- Facial skin.
  - Visible rashes.
  - Lesions.
  - Scars.
  - Tattoos.
- Oral cavity.
  - Occlusion and dental condition.
  - Also evaluate the following for presence of any abnormalities:
    - Tongue.
    - Floor of mouth.
    - Buccal mucosa/vestibule.
    - Lips.
    - Hard/soft palate.
    - Tonsils.
    - Oropharynx.
- Neck.
  - Lymphadenopathy (LAD).
  - Thyroid size.
  - Jugular venous distention (JVD).

Radiographic Findings

- Any abnormalities seen on radiographs (see Chapter 5, Essentials of Dental Radiographic Analysis and Interpretation).

Assessment

- Diagnoses or a list of issues.

Plan

- Suggested course of treatment action.

Comprehensive Oral Evaluation on New Patient—Sample Note

Meticulous record-keeping and note-taking is essential for successful dental practice. Undocumented discussions are not considered in a court of law.

A complete sample consultation note for a new patient exam should be written in a manner similar to the following:

ID/CC: A 42-year-old female presents for removal of her symptomatic, fractured, carious, nonrestorable tooth number 19.

HPI: Patient reports that this tooth broke about 2 months ago while eating popcorn. She has been having intermittent pain ever since.

PMH: Hypothyroidism, iron-deficiency anemia.

PSH: Gallbladder removal 3 years prior—no anesthetic complications.

Soc: Half pack per day cigarette use × 10 years (five pack year history); occasional beer drinker; no hard liquor; smokes marijuana five times per week.

Meds: Levothyroxine, iron supplement.

ALL: Penicillin—rash.

ASA: 2

Exam: BP: 115/75 (right arm, sitting); HR: 68; T: 98.7; RR: 15.

Height: 5′1″.

Weight: 115 lb.

BMI: 21.7.

Extraoral/facial skin: No visible rashes, lesions, scars, or tattoos; maximum interincisal opening of 35 mm, cranial nerves V2 and V3 grossly intact bilaterally, right temporomandibular joint (TMJ) reciprocal click with no pain.

Oral cavity: Class 1 molar/canine relationship with some anterior dental crowding/malpositioning; right anterior dorsum of tongue with 5 mm firm fibroma-like lesion; buccal mucosa with linea alba noted bilaterally; vestibule, lips, hard/soft palate, tonsils, and oropharynx with no apparent lesions or ulcerations; tooth number 19 is fractured with exposed pulp and missing coronal tooth structure—nonrestorable.

Neck: Left submandibular LAD—one pea-sized node noted that is freely movable and tender to palpation.

X-rays: Panoramic radiograph shows fractured tooth number 19 with 3 mm periapical radiolucency on mesial root apex.

Assessment: Fractured, carious, nonrestorable tooth number 19.

Plan: Local anesthesia, surgical extraction of tooth number 19, excisional biopsy of periapical lesion with submission to oral pathologist, placement of mineralized allograft to site number 19. Anticipate 45 minutes of chair time.

Risks/benefits/alternatives discussed with patient in detail; all questions were answered to patient's satisfaction; treatment plan and consent forms signed.

Surgical Treatment Note—Sample Note

The 42-year-old female returned to clinic for local anesthesia, removal of nonrestorable, carious tooth number 19, excisional biopsy of periapical lesion, socket allograft; procedure and consent reviewed/signature verified. "Time out" procedure was performed prior to the administration of local anesthetic.

Preop BP: 118/76, P: 78.

Treatment: 1.7 mL of 2% lidocaine with 1:100k epi given as left inferior alveolar nerve (IAN) block; 1.0 mL of 2% lidocaine with 1:100k epi given as left long buccal infiltration; crestal incision on facial surface of tooth number 19 created with number 15 blade; full thickness flap elevated on facial surface of tooth number 19; surgical hand piece used to incompletely section tooth number 19 into mesial and distal roots; Bayonet elevator used to complete sectioning and deliver the distal root; number 190 elevator used to deliver mesial root; curette used to excise mesial root periapical granuloma/cyst which was then placed in formalin, bone file used to smooth facial bone; copious saline irrigation of socket and under facial flap; placed 0.7 mL mineralized allograft to socket number 19; 3-0 chromic gut continuous sutures placed from mesial papilla to distal papilla; hemostasis achieved; patient tolerated very well. Tissue specimen will be submitted to oral pathology laboratory.

Postop BP: 121/82, P: 71.

Prescriptions given: Ibuprofen 600 mg, #12 tabs, 1 tab PO q6h prn pain; acetaminophen 500 mg, #12 tabs, 1 tab PO q6h prn pain; chlorhexidine gluconate 0.12%, 1 bottle, 15 cc PO swish 30 second/spit tid til gone.

Postop instructions sheet given and reviewed verbally with patient.

Next visit: Follow-up in 1 to 2 weeks for postop check, or as needed.

Clinical Pearls

- Make sure to call patients in the evening following a procedure.
- Even if the procedure was not a "big deal" for you to perform, it most certainly is a big deal from the patient's standpoint.
- They will appreciate the call and may have questions about their postop care or prescriptions.

Limited Oral Evaluation—Sample Consultation Note

ID/CC: 18-year-old female presents for evaluation regarding removal of her symptomatic, grossly carious, nonrestorable upper right first molar tooth number 3.

HPI: She reports intermittent pain, swelling, and drainage associated with this tooth.

PMH: Exercise-induced asthma; no hospitalizations or emergency room visits in the last 5 years for asthma-related illness; uses rescue inhaler as needed; typical trigger for asthma attacks includes running more than a block in cold weather; denies history of heart, liver, kidney, bleeding, infectious, or other disorders.

PSH: Appendix removal 3 years ago—no general anesthetic or surgical complications.

Soc: Tobacco/cigarette use—half pack per day × 2 years; denies alcohol use; reports marijuana use 1 to 2 times per week; denies any other recreational drug use.

Meds: Albuterol MDI as needed for asthma/wheezing (1 time per month typically).

ALL: Penicillin—reports getting a rash.

Exam: Well developed, well nourished; head, eyes, ears, and nose exam unremarkable; maximum interincisal opening 35 mm, cranial nerves V2 and V3 intact bilaterally; remaining cranial nerves grossly intact; neck is supple with no masses, thyroid swellings, or LAD noted; full adult dentition; fair oral hygiene; oropharynx clear; grossly carious, fractured, nonrestorable tooth number 3; all other oral hard and soft tissues appear normal.

X-rays: Panoramic radiograph and periapical radiograph reveal a grossly carious, fractured, nonrestorable tooth number 3; also noted are mesially tipped, full bony impacted teeth numbers 17 and 32, along with vertically positioned, partial bony impacted teeth numbers 1 and 16.

Assessment: Grossly carious, fractured, nonrestorable tooth number 3.

Plan: Local anesthesia, surgical extraction of tooth number 3. Anticipate 30 minutes of chair time.

Risks/benefits/alternatives discussed with patient (guardian if a minor) in detail; all questions were answered to patient's satisfaction; treatment plan and consent forms signed.