*CONS 3*

*Sheet # 2*

*Dr. mohammad rababah*

*Written by : Majdoleen & Hala*

Continuous of cavity preparation ....

$ What is the reasons that lead to cavity preparation :

1. Presence of of caries .
2. Fractured tooth ( you bevel this tooth then you restore it )
3. Poor restoration with recurrent caries
4. If the tooth need RCT then you have to do access cavity and after RCT procedure you have to restore the crown .
5. Preparation for dental prosthesis that need rest seat for example
6. Removing stain for esthatic reasons
7. Trauma
8. Non-Carious lesions including the cervical Non-Carious lesions ( attrition- erosion- abfraction)

So all these things will lead you to decide when to intervene and when not to . NOW we'll talk about the first one which is CARIES

Oral health in jordan is not a priority but for us as dentists it is a priority !!

$ The strong question is when to start removing carious lesions in another words when to convert our work from preventive ( which is the medical phase of dentistry ) to operative work ( the surgical phase ) ?? Every cavity preparation we're doing will remove sound tooth structure with caries so you have to ask yourself does this lesion needs a cavity . If the lesion is ok not painful so the workful neglect\* and improving the oral hygiene might be helpful .

\* workful neglect : is that when the dentist follow up the problem without any intervention ..

At the beginning of dentistry , dentists were removing all caries even if it was a small pit then restoring it with amalgam restoration this concept was known as ( extension for prevention ) in jordan it becomes crown for prevention which is absolutely wrong !!!

# NOTE::

symptoms : what's reported by the pt.

Signs : when you reproduce the pt's complain by electrical/ thermal stimulation or pulp tests .

# any procedure you'll do you have to get an INFORMED CONSENT from the pt itself, it could be signature in surgical procedures or if it was a simple procedure such as class 1 amalgam and the pt confirmed the procedure you should record that in the progress note that the treatment plan was confirmed by the pt and signed by supervisor .

As we said before cavity preparation is more related to the tooth materials than the caries itself so you always have to be as preservative as you can ( biomimetic approach )

For example : if you have class 1 fissure caries on lower 6 , if you're going to do a retentive amalgam restoration you'll remove a huge amount of sound tooth structure . Composite is better choice and s.times a fissure sealant or preventive resin restoration is enough .

# Now , what to eliminate during cavity preparation:

1/ pain

2/ caries

3/undermined enamel

4/ Fractured tooth part which might lead to injuries to the tongue or soft tissue

5/ discoloration of old composite .

6/ premature contact

7/ overhanging restorations .

What we need to preserve? tooth structure , pulp (don't make pulp exposure ) , preserve my and the pt health , functional occlusion integrity (sometimes if the restoration was high it will make problem in occlusion ) , soft tissue, pdl , natural appearance .

what we need to restore? function, appearance , facial and occlusal harmony in completely edentulous pt ( most of completely edentulous pt have over closure 'reduced OVD' so we restore the ovd by simple procedure)

in the past if someone has attrition of his teeth we make crowns for him but now there is new type of composite that can withstand occlusal forces.

-what we need to prevent? pulp exposure , cross infection , iatrogenic dentistry , unsightly restorations.

it is all about diagnosis , we have to know the symptoms.

for example if patient came with carious lesion , when to start? when there is loss of integrity of the enamel ? or when it reaches the dentin

we should deal with that only if he had a symptom , if not we have to encourage the prevention methods(oral hygine).

-we have to know when to make restoration? if there is a lesion and it is subsurface we don't make intervention but we ask the patient to improve his oral hygiene , decrease sugar intake and make flossing.

-things on X-ray are in 2 Dimension so it don't represent the real case 100%

it only represent 60-70 % of the real

so thing that look like it doesn't reach the DEJ it maybe already pass it.-

also we have to differentiate between cervical burnout and caries on radiograph.

for example the digital panoramic x-ray can show amalgam restoration and beneath it there is a caries due to the presence of radiolucency we call this thresholding.

-we don't use the panoramic radiograph to detect caries, rather we use intraoral radiograph (bitewing and periapical )

-if there is involvement of the outer side of the dentin and the pt is high risk to caries we make intervention.

-but if he is low risk patient we can make prevention

we have to look if there is discoloration by drying it with good light , or we can use floss (if it stuck ) this mean it is a dentin lesion.

if enamel lesion we leave it.-

we will talk about the details how to diagnose caries later on

fissurectomy : we open the fissure and we can see the base of the fissure , if there is caries or not , only small opening with small bur we don't need a big cavity then we close it by composite or amalgam , but if there is a minimal caries we close it with fissure sealant.

if there is caries all around the restoration , we remove the restoration

for overhanging restoration we remove part of it.