Sheet no :12

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Today we will discusses some cases to reach true diagnosis ;

The doctor refuses to give us the slide so l try my best to explain this lecture .

Lets start with very basic simple case

Case 1 :

A 35 years old pt female presented with complaint pain of lower right quadrant every time she eats or drinks something cold , pain started a few weeks ago but seems to be getting worse , she can't locate which tooth hurts most but it's in LRQ.

Medication : fit

Dx : several long standing moderately deep restoration in her posterior teeth ,

-poorly localized pain >>it indicate it's pulpal pain but we don't know if it's reversible or irreversible .

The x-ray are not really useful in pulpal pain ,they might give u a hint for what might be the cause .

-Few weeks >>very important >>why ??

Acute pain is easy to diagnosis .

-problem start when we have chronic pain (3-4years ) this is difficult usually is not related to teeth .

-next step : pulpal test :

We test the 6>> typical sever lingering pain , it was tenderness upon percussion >> indicate acute apical periodontitis ,so that straight forward .

Dx : irreversible pulpitis and acute per apical periodontitis .

Tx : RCT for LR6,

No need for antibiotics because there is no infection .

\* the problem that happen in our clinic is that some students come with x-ray and ask the doctor ..Is this pt need RCT ??

This is totally wrong , we have to listen to the pt and take full history and examination then diagnose .

Diagnose :is what the pt problem is .

Clinical finding :is the things that u find it during your examination .

Case 2 :

29 years old male enter your practice carrying a cup of ice water

he said" I have a terrible tooth ache for the last few days it hart when ever l eat or drink something hot ,, last night l tried to eat hot soup and the pain was worse , if l sip ice water >> the pain get relief ,,but as soon as I stop drinking the ice , the teeth ache com back "

-pt unsure of location of pain .

Medically :fit

DHx : deep restoration placed in teeth 6,7 in the last year.

-pt suffering from palpal pain ,in advance stage of irreversible pulpitis .

\*the bacterial infection will cause degeneration of pulpal tissue and protein that will produce gases in the pulp ,consequently ,these gases will expand and press on nerve fiber that are still vital in pulp .

There for upon placing some thing cold >>this gases shrink>> so the pressure on vital nerve will decrease in that confined space of the pulp .

- in x-ray :

No thing ,not confirmative ,u should listen to the pt .

-both teeth tender to percussion .

Cold test :

We do hot test by hot water ( u isolate each tooth separately by rabber dam and u rinse with warm water .

It's time consuming but it's the last resort .

\*so pt in pain now so use cold test and see when the pain disappear ,,

Result :

Cold test on 7 >>nothing

Cold test on 6 >>pain disappear

So Dx: irreversible pulpitis and acute apical periodontitis on lower 6 .

Clinical finding :necrotic pulp with acute apical periodotitis on 7 (this is true but it's not the cause of symptoms ,so RCT to 7 will not relief the pain .

Case 3 :

23 years old female,

Cc : pain upon chewing in URQ that started a few days ago following placement of composite restoration ,temperature change don't affect pain .

Medication :oral contraceptive pills .

DHx :good OH, regular tender .

\*pain upon chewing mean it's not pulpal problem .

\*OCP>> can't use antibiotics because interaction with OCP.

PA Rx -ray : not show any thing .

\*this symptoms may caused by high filling composite .

Dx: acute apical periodontitis .

Rx: occlusal adjustment and NSAID ( to relief pain ) .

Case 4 :

52 years old male ,

Cc: suffering from intermediate pain for a period of time in upper right quadrant .

MHx : control hypertension ,type 2 DM (u make sure the pt has breakfast and medication because stress in clinic may cause hypoglycemic shock to that pt ).

-in upper right 4 serves as an abutment for a 3 unit fixed –fixed bridge ,

3 has a distal amalgam restoration ,3and 4 equally tender to percussion palpation of the buccal vestibule revealed tenderness and a mild swelling between the two teeth .

X-ray :radiolucency >>necrotic pulp and chronic per apical periodontitis .

Cold test :

Normal response on UR 4 .

Negative response on UR3.>> that indicate defective amalgam on 3 and large apical radiolucency related to canine (lamina dura not clear )

Dx: necrotic pulp and acute apical abscess of UR 3.

Tx:

RCT to UR3 and antibiotics (depend on systemic involvement ).

Case 5:

30 years old pt ,

Cc : pain upon chewing in LRQ that started a couple of weeks ago ,pain is sharp ,quick ,last for few second not affected by change in temperature . DHx : good OH ,fair amalgam restoration in 6 and 7 lower right .

Medically : fit and well .

\* examination 6 and 7 are slightly tender (this happen a lot and not indicate any thing )

So pulp test doing :

-On 7 negative response .

-on 6 positive response .

- probing depth >>normal >>no pocket .

x- ray :on 7 there is large periapical lesion and necrotic pulp .

So pain on chewing usually mean a problem with the periapical tissue .

\* Bite test :

\* in fact :

The pain is felt instantly after the pt stop biting .

The are two response to the bite test:

1. Upon biting the pt feel pain .>> inform us if there is apical periodontitis (chronic apical ,abscess ,high filling ).
2. Upon biting no pain is felt .>> inform crack and upon biting the crack closes and upon relieving the bit ,the crack re opens; stimulating the pressure increase and the toxins and irritant will re enter the pulp causing pain .

Dx: cracked tooth LR6.

Clinical finding :

No pulpal involvement yet ,so no need to RCT.

It's chronic periapical periodontitis because associated with radiolucency and the pain is dull but in acute apical periodontitis we don’t see any thing in x-ray .

Case6:

Mohammed 42 years old ,pain on chewing ,problem in LRQ , started a few months ,

The pain was bearable and kept under control using simple analgesics ,,

Two days ago the pain had become sever and analgesics not help him .

Medically :HIV ( no treatment received ) .

DHx:

Irregular attending ,poor OH , heavy restored dentition .

\*\*every dentist must welcome every pt into clinic ,it's not acceptable ethically to refuse treating a pt because he /she is HIV positive ..

\*\* no extra percussion should be taken by the dentist when treated HIV pt because it is necessary to be caution with all pt entering your clinic and treat them all as HIV pt .

- palpation percussion :LR6.

-pocket probing :LR6=12mm mesially and buccally .

Pulp test :positive response to EC.

Dx:

It 's not a pulpal problem >>we don't need RCT. >> totally periodontal problem .

Pt suffering from an acute periodontal abscess on LR6.

R x : sub gingival debridement and root planning ,

U may describe antibiotics if there is systemic involvement (CD4 is above 400 ).

Tx:

Nothing to do with this tooth just take it out .

\*\* what 's the difference between generalized bone loss and loss around the tooth 8 mm all around and between pocket probing that normal then sudden drops ??

The narrow isolated pocket could be :

1)fracture .

2)sinus tract : rinse to gingival sulcus ,may be seen clinically as narrow isolated pocket, there is no periodontal damage , it's a sinus tract that is an endodontic problem .>> if u manage the endo problem ,the pocket will disappear.

3)could be some thing palatogingival groove ( it's a groove extend all the way to the apex , u get narrow isolated pocket .

Case 7:

39 years old female ,constant dull pain in her lower jaw ( right and left )

Started two years ago in upper jaw but now seems to be felt in lower .

-she take analgesics but they don't help her ..

Medically :

Amitriptyline ( tricyclic anti-depressant ).

DHx : goo OH ,multiple restoration have been provided recently ,regular tender .

In X-ray :

All teeth with very good quality RCT .

What happened in this case is When ever the pt said I need RCT, the dentist do it without any diagnosis !! ,, so the dentist is just a very good endodontic technician !!

\*\* any odontogenic pain can be referred like :

if it's a problem in upper ,it will referred to lower but it never cross the midline because each side of arch is innervated separately ,

when the pain is cross the midline this will be so suspicious .

the non-odontogenic tooth ache is often difficult to diagnose .

DDx:

Chronic idiopathic facial pain ( atypical facial pain ) >>it associated with stressed (depressant ) pt .

Tx:

Referral to a specialist , he may give her antidepressant .anticonvulsant ,pain killer .

Atypical facial pain mean :

If we are honest with our selves ,it's the way that we reach the Dx by excluding every thing else that we know,

We tell the pt we don't know what the pain is ( if we are honest ) but we are not , we need confidence of our pt ( we know what they have ).

Case 8:

53 years old female ,

Sever sharp pain in the right side of her face started few weeks ago , pain is sporadic , last for a few second ,,

\*U need to ask pt about severity ( how much sever ).

\_And between the episodes , there is no pain at all >> not constant type of pain , she is fine until this come again , she dosen't use pain killer , because pain lasts few second only .

\* pain kick off upon eating and brushing .

Medically :

She take aspirin, prosthetic hip joint ( antibiotic needed);

Unlike the British guideline ,American school believe in significance of prescribing antibiotics for those pt because high risk of developing infective endocarditis , British school believe that ,the risk of dying from antibiotics complication is higher than the risk of dying from IE .

DHx:

Irregular tender, recent RCT on LL6.

\* palpation of labial vestibule between 4and 5 (trigger zone ) is very pain full ( RT side) ,as soon as the area is touched ,the symptoms manifest .

\* percussion :LR 1-7 no TTP

\*probing depth is normal .

\*pulp test : normal response .

\* X-ray : tiny cavity which is trigeminal neuralgia .

Dx :

Neuropathic pain /trigeminal neuralgia .

\*we are not asked to diagnose trigeminal neuralgia but we shouldn't do RCT because we couldn't diagnosis the case .

Clinical finding :

Generalized tooth surface loss , mesial occlusal cavity on lower right 6 .

Tx : referral to a neurologist .

If your pt on anticoagulant ,you should know about bleeding tendency by PT( prothrombin time ) /INR ( international normalized ratio)

\*INR: is a single test u need to know about bleeding tendency , prothrombin time lower than 3 is safe ( limit to target )

\*don’t ask your pt to stop any coagulant drug , Because no matter how bleeding is severe >> rarely become life threating , if bleeding happen send pt to hospital and they will control it , but if the pt get coagulation basically recurrent thrombosis , then it is life threating .

\* if your pt on warfarin DON’T give him ID block because the bleeding in parapharyngeal space may cause a large hematoma that can obstruct the air way .

\* no ID block even thought you do aspiration.