Global Ceram•X Case Contest 2008/2009

In the Dentsply Global Ceram•X Case Contest three UK students came out on top and were put forward to the global final. In this issue we take a look at Barts and The London, Queen Mary’s School of Medicine and Dentistry (UK) student Reena Wadia’s presentation.

Introduction to the case
A 59-year-old female patient presented with large fractures of her maxillary right (UR1) and left (UL1), central incisors. These were a result of a traumatic fall and necessitated restorations for aesthetic and functional reasons.

The UR1 responded normally to sensibility testing and therefore considered to be vital; the UR1 had been treated endodontically, clinically, and aesthetically unsatisfactorily. This case was restored using Ceram•XTM duo; advanced nano- ceramic technology.

Material and method
Ceram•XTM duo (Shade E3 and D2), Nupro® prophylaxis paste (Dentsply DeTrey), 36%, phosphoric acid (DeTrey® Conditioner 56, Dentsply DeTrey), Prime&Bond®NT (Dentsply DeTrey), Enhance and PoGoTM (Dentsply DeTrey), unfilled resin.

Direct adhesive bonding followed by natural layering technique. Ceram•XTM duo shade E3 used to give enamel-like translucency and shade D2 used to replace the lost dentine giving the correct opacity and chroma. Final polishing for superior surface gloss and smoothness.

Discussion and conclusion
A very aesthetically-pleasing, ‘life-like’ result was achieved. This material also has excellent handling and placement properties and is understood to have good longevity. This is thus an attractive option especially for anterior restorations. Ceram•XTM duo certainly brings a smile to both the patient and dentist.

Under-treatment & Supervised Neglect

A highly aesthetically-pleasing result, with the restorations showing natural and harmonious integration into the surrounding dentition.

Step 1- Study models & wax-up
Alginate impressions were taken and an interproximal position registration was recorded. Thereafter, study models were mounted on a semi-adjustable articulator. A diagnostic wax-up was completed to aid fabrication of a silicone putty matrix.

Step 2- Shade selection & isolation
The teeth were cleaned with Nupro® prophylaxis paste. Shades were chosen prior to isolation, to avoid possible interference in chroma and opacity evaluation due to tissue dehydration. Using the Ceram•XTM shade guide in natural light, E1 (enamel) and D2 (dentin) were selected and agreed by the patient. A rubber dam was then placed to isolate the working field.

Step 3- Etch & adhesive
Prime&Bond®NT was applied as a final thin coat to reduce the chance of microleakage. A layer of unfilled resin was then applied as a final thin coat to reduce the chance of microleakage.

Step 4- Silicone putty matrix
Silicone putty matrix was used to fix the patient and dentures. This matrix was used to put in the silicone putty matrix.

Step 5- First enamel layer
The ‘enamel’ composite was applied directly onto the silicone matrix, which was then placed up against the teeth. This allowed the patient to feel the teeth. The ‘enamel’ composite was then put in the silicone putty matrix.

Step 6- Dentine core
Dentine core of the restorations was created. This was cured using 36%, phosphoric acid and PoGoTM. The ‘enamel’ composite was applied as a final thin coat to reduce the chance of microleakage.

Step 7- Final enamel layer
Excess material was removed and the restoration was then fixed to the teeth. The final polishing of the restoration was obtained using disc-shaped Enhance and PoGoTM finishing instruments. After removal of the rubber dam, the restoration was marked and adjusted. The matrix was then removed and the restoration was then fixed to the teeth using a mixture of adhesive and PoGoTM finishing instruments.

Step 8- Shaping & polishing
Excess material was then removed and the restoration was then fixed to the teeth. The final polishing of the restoration was obtained using disc-shaped Enhance and PoGoTM finishing instruments. After removal of the rubber dam, the restoration was marked and adjusted. The matrix was then removed and the restoration was then fixed to the teeth using a mixture of adhesive and PoGoTM finishing instruments.

Step 9- Silicone putty matrix
Silicone putty matrix was used to fix the patient and dentures. This matrix was used to put in the silicone putty matrix.

The emotive phrase “superficial neglect” is often used to describe a situation where a patient’s oral health has been deteriorating due to disinterest/apathy or for a variety of other reasons. Whatever the cir-

The Patient’s Response
On the one hand, there will be cases where the patient has repeatedly declined the dentist’s recommendations for certain treatment, or perhaps a referral. This may be on grounds of cost, inconvenience, disinterest/apathy or for a variety of other reasons. Whatever the cir-

Fig. 1
Fig. 2
Fig. 3

The record should describe the condition of the dental tissues at the time of the initial examination. In cases where things remain less than perfect or continue to deteriorate, the reasons for this should also be clearly documented.

Whether or not the dentist had identified the relevant problems that existed in the patient’s mouth (for example, definitive or fractured restorations, periodontal disease, uncontrolled cavities, tooth tissue loss through erosion, abrasion, attrition or fracture, hard or soft tissue pathology, etc.).

Whether or not the dentist had identified any relevant risk factors that might be contributing to the patient’s deteriorating oral health (for example, oral hygiene, diet, smoking, bruxism or parafunction).

Whether or not the dentist had informed the patient about his or her oral condition, and communicated effectively with the patient about what was being done and why, or what the patient could do to help, control or improve the situation.

Whether or not the dentist had explained the available treatment options to the patient, which in some circumstances might include the possibility of a referral for specialist advice or treatment.
circumstances, it is important to record the recommendations that were made (and the patient’s response) very clearly in the notes at the time.

Similarly, it is important to record in an easy and every appoint-
ment that the patient fails to attend or cancels at the last minute. Reception and administrative staff should be encouraged to amplify clinical notes to reflect what has been agreed with the patient. For example, “Patient rang to cancel appointment. Offered to rebook, but patient prefers to contact us when more convenient.”

With most (although not all) computerised records and appoint-
ment systems, it is relatively easy to record the fact that a patient can-
cels an appointment scheduled several days or weeks after the booking has been made. This helps to establish a more complete record of the patient’s attendance pattern, and this can become very impor-
tant if allegations of supervised neglect or excessive treatment de-
lays are made at a later date.

Where manual (paper) records are being used, however, it would be much more unusual for a receptionist to retrieve the patient’s notes, specifically in order to record the fact that the next appointment, a week or two later, had been can-
celled by the patient. In the absence of this record, the appointment book itself can sometimes become a valu-
able additional record—although many receptionists prefer to canc-
elate appointments compli-
tely, in order to indicate availabil-
ity and to legibly insert a new name.

At some stage in their career, most practitioners will have had pa-
tients who seem to stagger from one crisis to another, and whose treatment never really feels to be under the practitioner’s control. These patients often present with so many unexpected emergency problems in between their sched-
uled review appointments, that one course of treatment seems to merge seamlessly into the next. There is a danger that the patient’s treatment is approached in a reactive “patch and mend” fashion, rather than a more proactive “what’s happening here, and why?” fashion.

Assessing the Situation

In such cases it is important to stand back from time to time and to make the effort to take a more detailed overview of the patient’s oral health, approaching this in the same logical fashion as one might approach a patient who you were treating for the first time. If the records can demonstrate that this was done, then it becomes much easier to defend subsequent allegations of under-treatment or “supervised neglect”.

The records sometimes tell the story of a patient who was at one stage being treated very diligently and attentively by a practitioner, but gradually this picture changes to one in which medical histories are not being updated, periodontal health is not being monitored, x-rays are not being taken, and so on.

A periodontal problem or a si-
ness over a root apex is “treated” with a prescription for antibiotics, but with no other details recorded in the notes, and no arrangements made for follow-up. Worse still, the records simply mention that a prescription was given, with no explanation of why this was being done.

Many factors can contribute to a greater or lesser extent in the “supervised neglect” of a patient: • A dentist who is under stress for reasons unrelated to dentistry (perhaps financial worries, or domestic/personal problems) may be distracted by these out-
side pressures and become less attentive in the treatment of pa-

tients.

• Other dentists are unwell physically or mentally, and may not al-
ways realise this at the time; in one instance the explanation was no more complex than that the practitioner in question had not realised the extent to which his eyesight had deteriorated.

• Sometimes dentists are simply too busy, perhaps having been unable to replace a nurse or associate, and “supervised neg-
lect” becomes a response to hav-
ing to turn to too many patients in too little time.

A significant number of the “multiple” cases of “supervised neglect”, tend to involve practition-
ers who are nearing retirement, which is a particular concern, since a large number of the practitioner’s patients will shortly be seen by a second dentist. This is often the means by which “supervised neg-
lect” has been occurring on a wide scale, over an ex-
tended period of time, there have been many instances where this has created a nightmare situation (financially and logically) for (any dentist) who takes over the care of the patients within the same prac-
tice. The worst scenario arises when such a dentist has taken over a “rolling” list of capititation patients, and finds a significant number of them needing extensive treatment in return for minimal capitation payments.

When a dentist is treating the patient within a capitation payment system, “supervised neglect” can arise for slightly different reasons. Very occasionally, a dentist appears to have no interest in, or awareness of, the patient’s capitation payments, while carry-

ing out a normal range of treatment for patients who are paying fees on an item of service basis. Clearly, it is difficult to justify and defend the ethics of such an approach; it is de-
liberate abuse of the capitation re-
muneration system and it is impor-
tant to appreciate that it is the indi-

cidual dentist, not the payment sys-
tem, who is responsible for abuse of this kind.

Assumptions

When a patient actively de-

cides that treatment has not been rec-
mended, the situation be-

comes quite clear-cut. A feature of “supervised neglect” cases, how-

ever, is sometimes an assumption on the part of the treating clinician that the patient “doesn’t inter-
est” in a certain treatment op-
tion, or that some old and dis-
coloured restoration “didn’t worry them”. When there is no confirmation of this in the records, it is easy for a patient to respond along the lines of how did you know—you never asked me.

To avoid this situation it is sen-
sible either to make, or not make, a specific treatment recommenda-
tion, to discuss the options with the patient and to record the outcome of these conversations clearly in the clinical notes. This becomes partic-
ularly important when treating pa-
tients with whom you have a less-than-
formal relationship—perhaps pro-

fessional colleagues, staff, friends or family members. The worst scenario is clearly the situations where conver-
sations that should take place, might not occur.

Summary

All dentists have a duty of care to exercise a reasonable standard of skill and competence when treating each patient under their care. Fail-
ing to provide necessary treatment is one way in which this duty of care can be breached; recommending or providing unnecessary treatment falls at the other extreme, but is still a breach of a clinician’s duty of care.

Regular and effective commu-

nication with patients about their oral condition, and about what treatment is (and isn’t) being pro-
posed, and why, is a valuable pro-

tection against an allegation of un-
der-treatment. Full and meticulous records based upon appropriate in-
vestigations are equally invalu-
able. These two strategies, coupled with an up-to-date awareness of current thinking in diagnosis and treatment planning, will avoid the majority of problems in this area.

About the author

Various studies have shown that dentists are likely to look more critically at restorations placed by others, than they are in situations where they placed the restorations in question them-

selves—particularly in a regu-

larly-attending patient that they have been treating for many years. One will often observe an old restoration with less-than-optimal margins, surface defects or discoloration. A clinician, who has observed these same restorations over several years with little or no deterioration, and no other signs or symptoms, is well placed to appreciate that the situation is stable.

A clinician seeing this patient for the first time might take the decision to replace the restora-
tions immediately. Whether or not this is seen by the patient as indicative of any fault on the part of the previous dentist, will often depend heavily upon the way in which the second dentist de-

scribes the situation.

The above situation can look somewhat different when this is not an isolated restoration, but one of many such restorations in the same mouth. In this situation there is just one patient out of hundreds where the same situation is en-
countered. Seen through one eye this is supervised neglect; seen through another pair of eyes, this is prudent, care-
tious, minimum-intervention treatment.

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