Inland Empire Perio Study Club

Patient Name: Dell Foster

Case Presentation By: Rob Hardwick

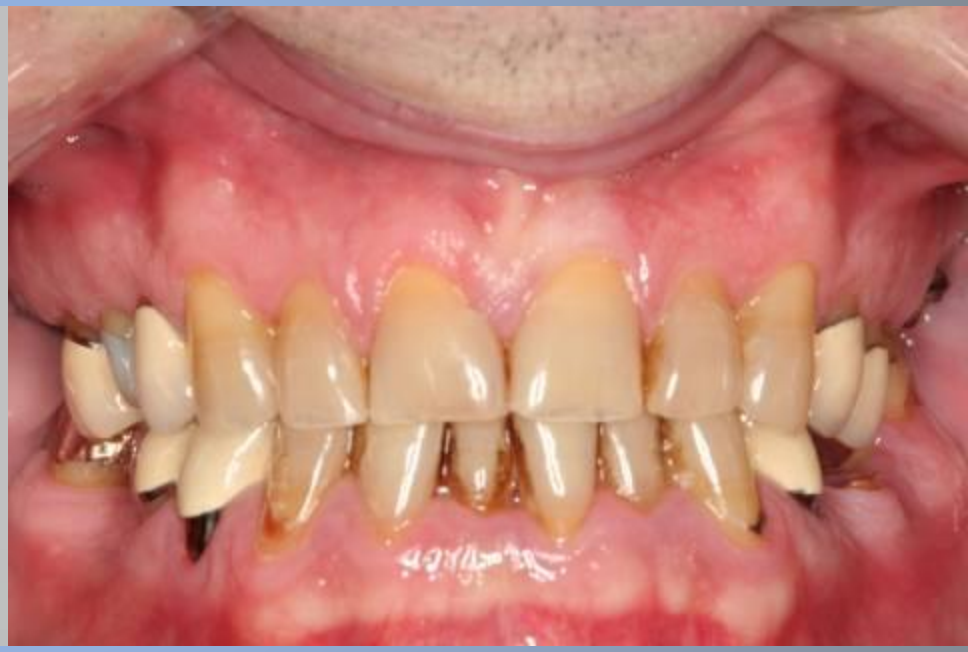
Personal History: Dell Foster, 50 year old male. Dell was born in Tacoma, WA, where he was adopted as a young child. He attended grade school in Yakima and high school in north Seattle. In 1987 he received a BA in accounting at City University in Belleview, WA. He was married and moved to Spokane for 3 years and then to Las Vegas for thirteen years. Recently he has moved to Colville. He is divorced and has one child twenty-two years old. His adoptive grandmother, Mrs. Foster, was my first grade teacher in Colville in 1956.

Medical History:

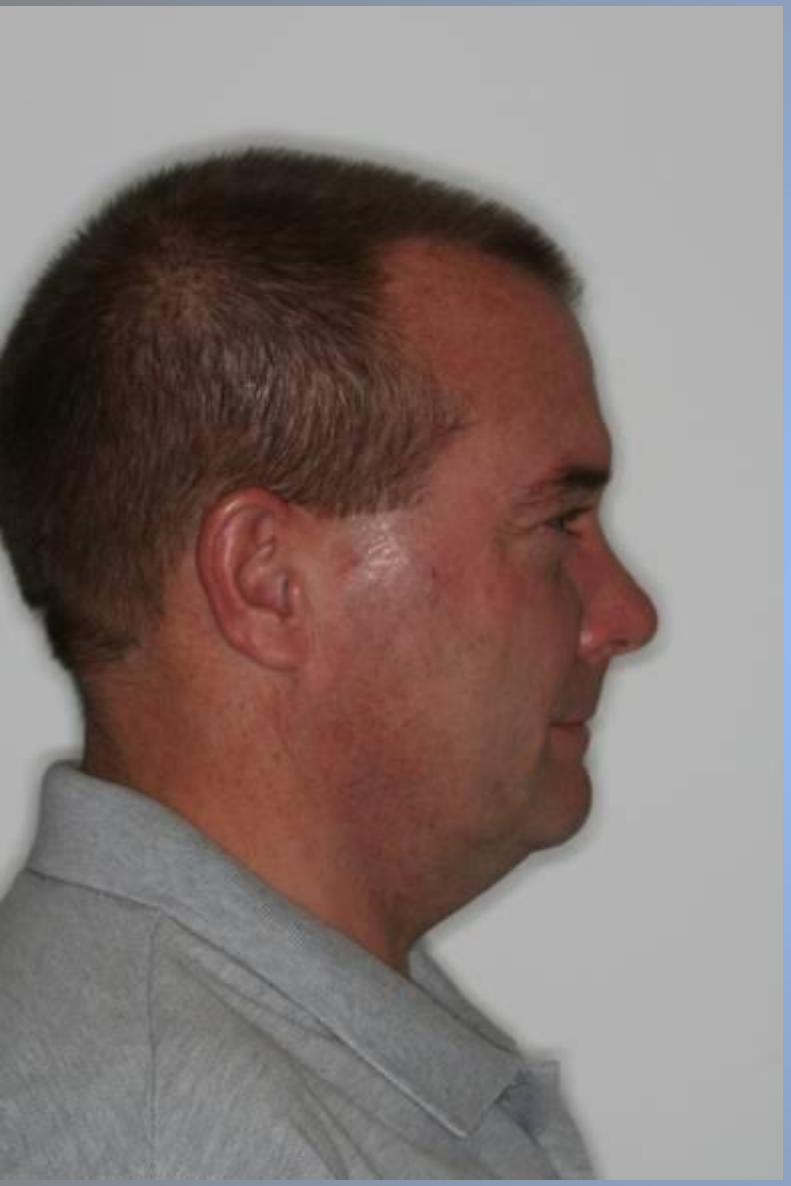
1) Allergies to animals, nuts and environment.
2) Smokes one pack per day.
3) He enjoys good health.

Chief Complaint:

1) Hot and cold sensitivity in upper right.
2) Lack of teeth and difficulty chewing.
3) Appearance not a concern.



Recession and Attachment Loss: #'s 27 and 28- buccal.
Gingival Margin Discrepancy: Lower anteriors and bicuspids due to crowding, decay and recession.
Left Posterior Bite Collapse and Uneven Occlusal Plane.



Profile

Dell has an acceptable profile and does not appear to have lost vertical dimention.

Home Care:

1) No flossing.
2) Brushes once a day.
3) Eats average American diet

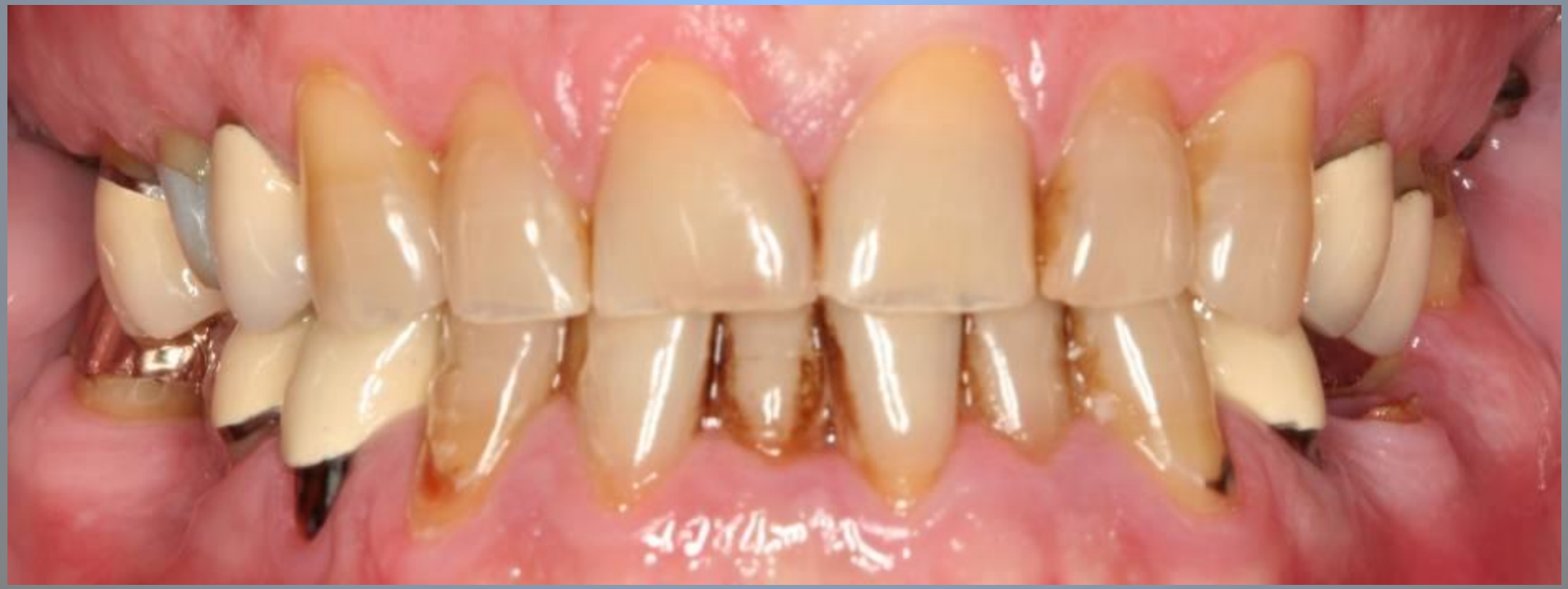
Family Dental History:

His sister has her natural teeth as do his adoptive parents who are in their eighties.

Dental History:

Dell had routine dental care from childhood through college. This included one year of ortho in college. After college he stopped seeing the dentist for routine care until 1981 when he had dental coverage for about 5 years. During that time he had many crowns done.

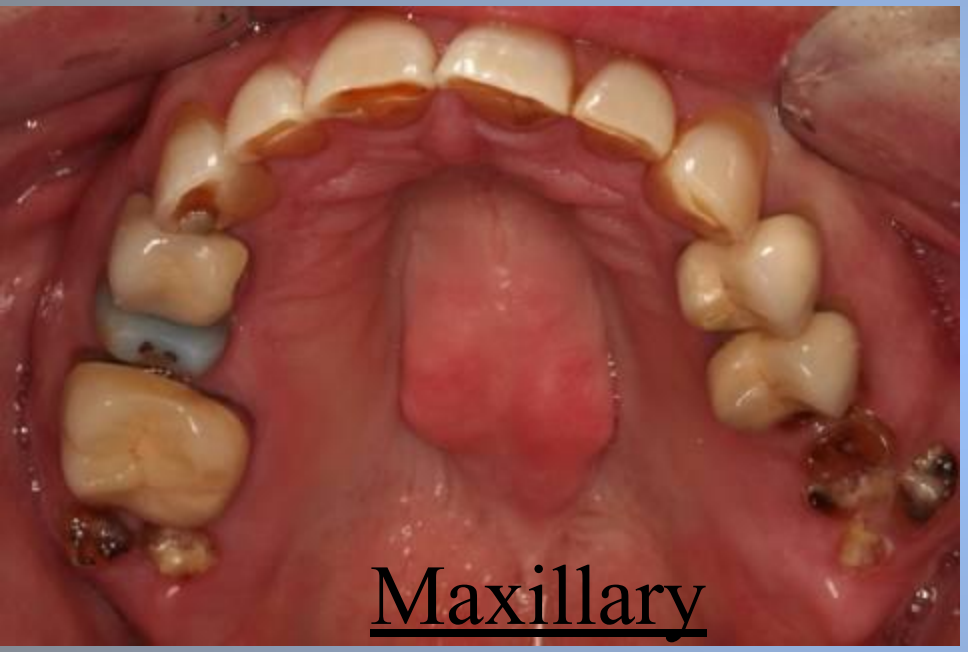
In the last ten years Dell's dental treatment has been limited to emergency care only. Dell has never had an accident which required dental care. No dentist has ever talked to Dell about gum disease, and what he is aware of has come from the media.

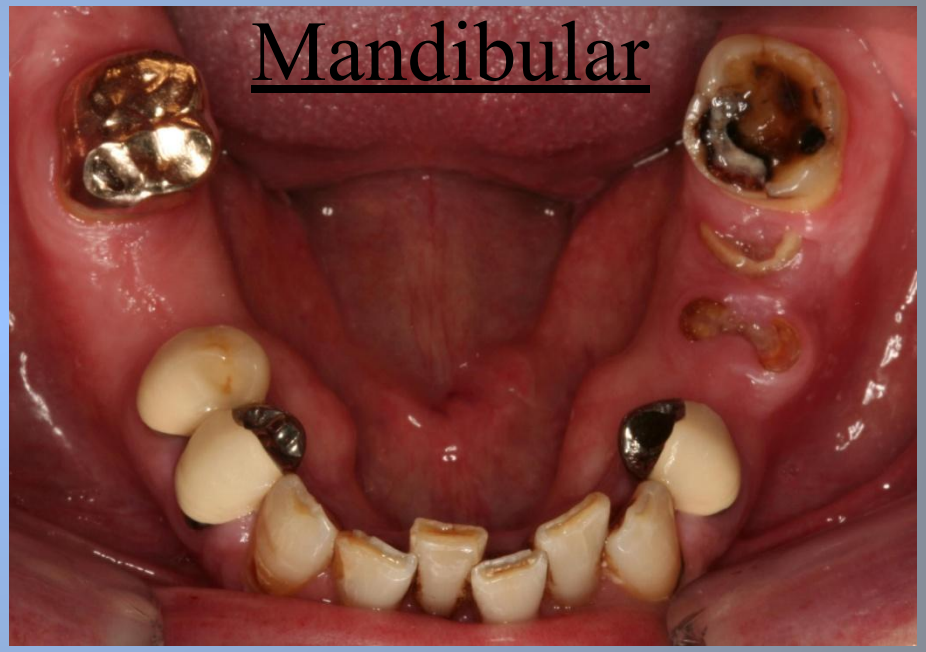


Hopeless root tips #'s 2, 14, 15, and 19. An endo with post buildup was placed on #4 as an emergency treatment.

Heavy Incisal-Lingual Wear: On maxillary anteriors.

Excessive Wear: On occlusal of #'s 18 and 31.





Large palatal exostosis and bilateral tori. Heavy wear on lower anteriors.

Poor Contacts : #'s 5 and 6 , #'s 6and7, #'s 12 and 13. Poor contacts on #'s 22, 23, 24, 25 and 26 due to crowding.

Open Contacts: #'s 10 and 11.

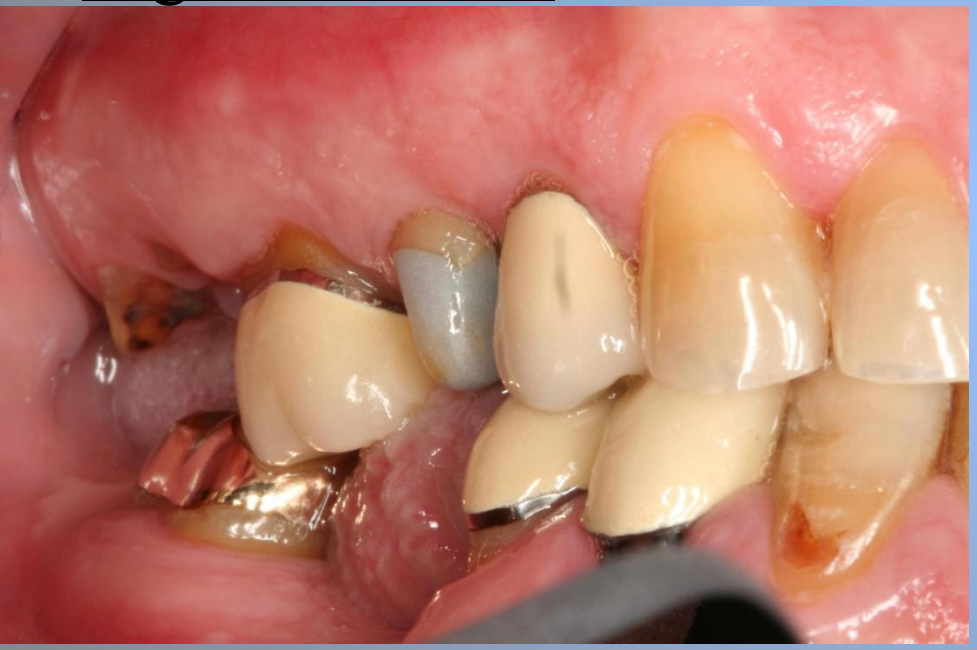
Arch Form: Is incomplete on upper and broken and incomplete on lower.

Decayed Teeth:

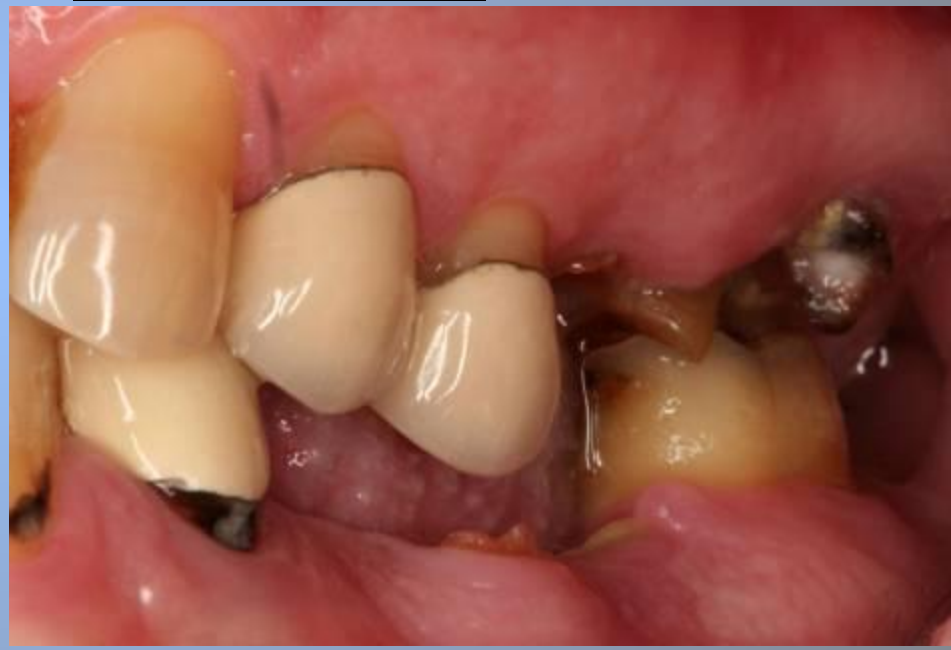
Many multiple areas of rampant decay resulting in loss of function and poor posterior bite support .

Super-erupted Teeth #’s 13 and 18.

Right Posterior in Occlusion



Left Posterior in Occlusion



Home Care History:

1) No flossing. 2) Brushes once a day. 3) Eats average American diet. He is demonstrating motivation to change for the better.

Occlusion

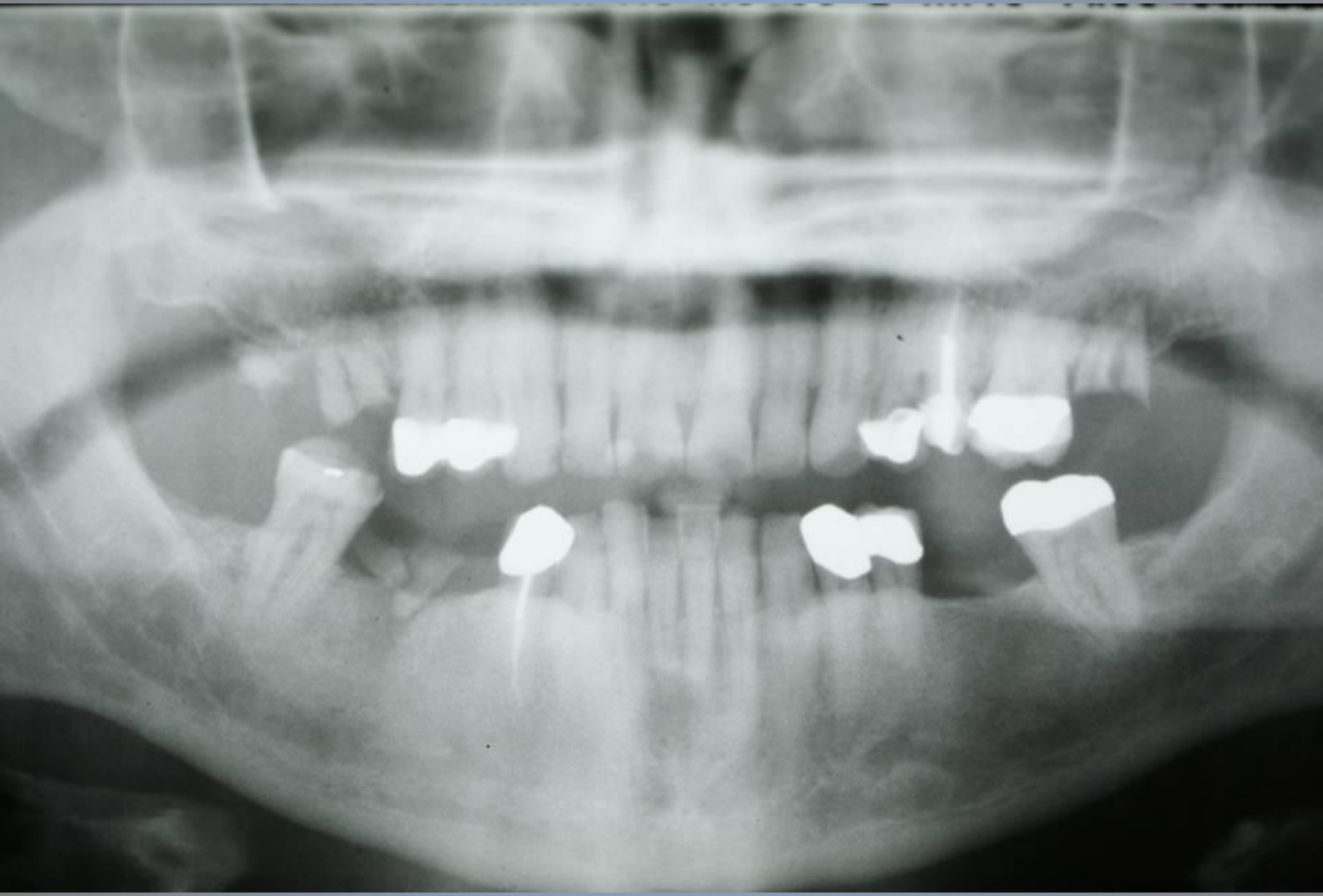
Class I: with crowding in lower anteriors.

- Right and left posterior bite collapse in molars.
- #13 super-erupted 1 to 2 mm.
- #18 super-erupted 3mm.

Excursions:

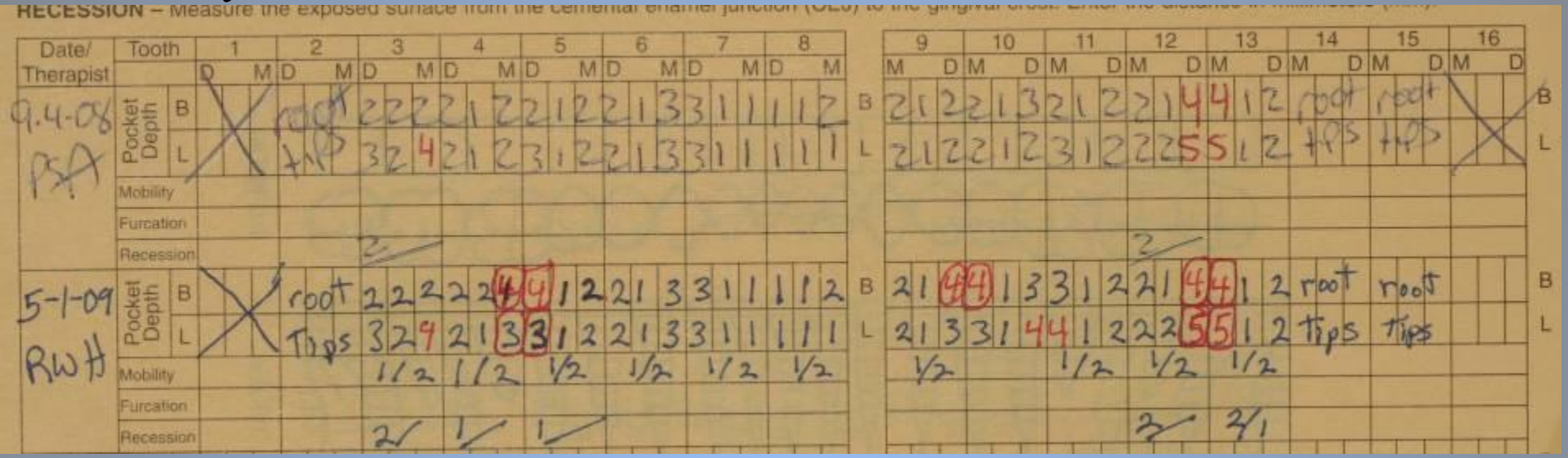
- Right working on #’s 5, 6.
- Left working on #’s 11, 12.
- Protrusive on #’s 7, 8, 9, 10.
- Protrusive interference on #’s 3, 31.
- Parafunction: Heavy wear areas and wear facets are present in anterior and posterior teeth. Patient is not aware of parafunctional grinding or clenching.

Pano 11/13/08

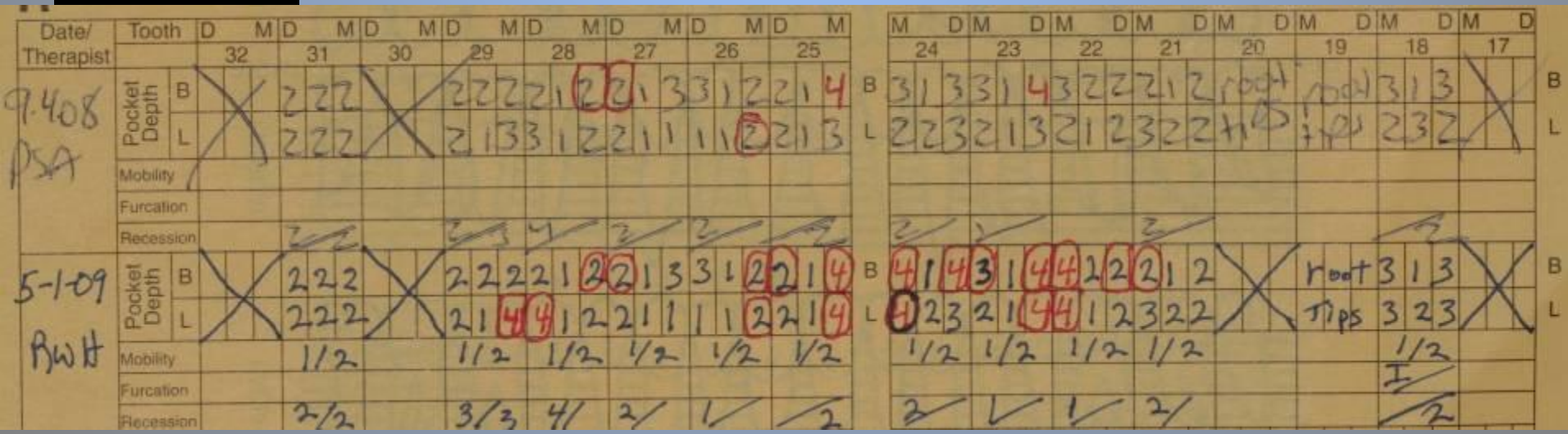


These probes were done by my hygienist first on 9/4/08 and then by me on 5/1/09. There is a moderate difference especially in bleeding probably due to technique and expectations.

Maxillary

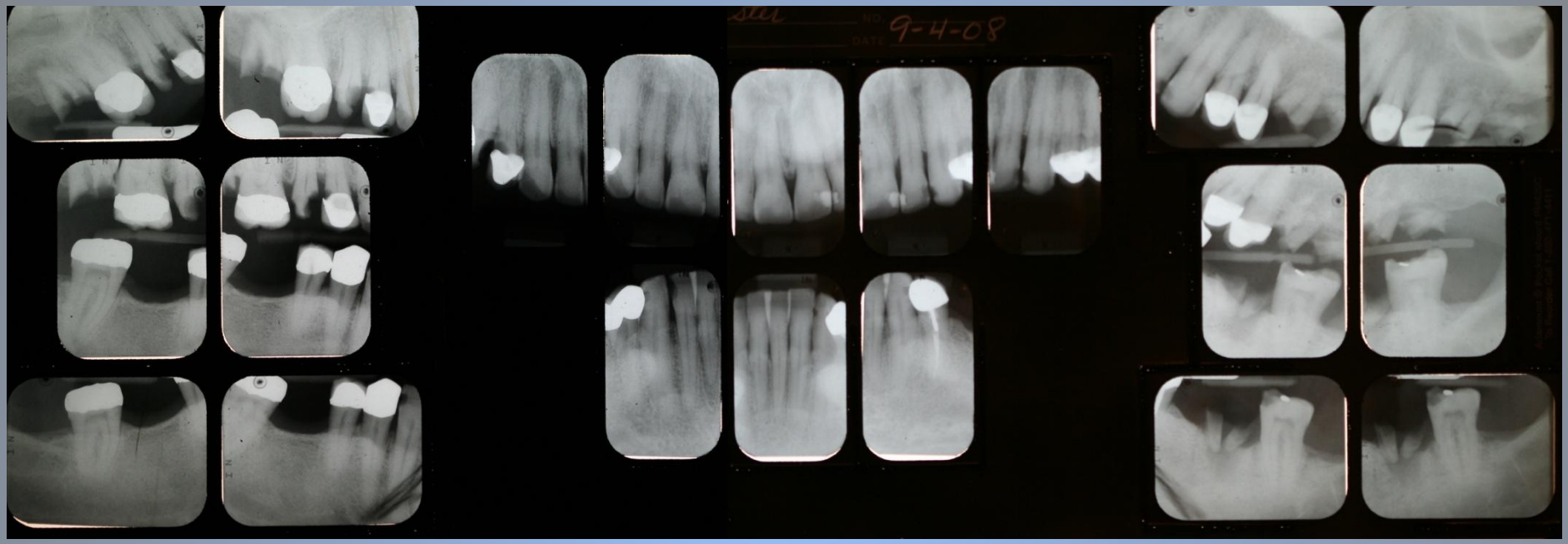


Mandibular



The radiographs were taken on 9/4/08.

Abscessed Teeth: #'s 4 and 5 have endo abscesses due to deep decay into the pulp. #21 has a suspicious widening of the PDL at the apex.

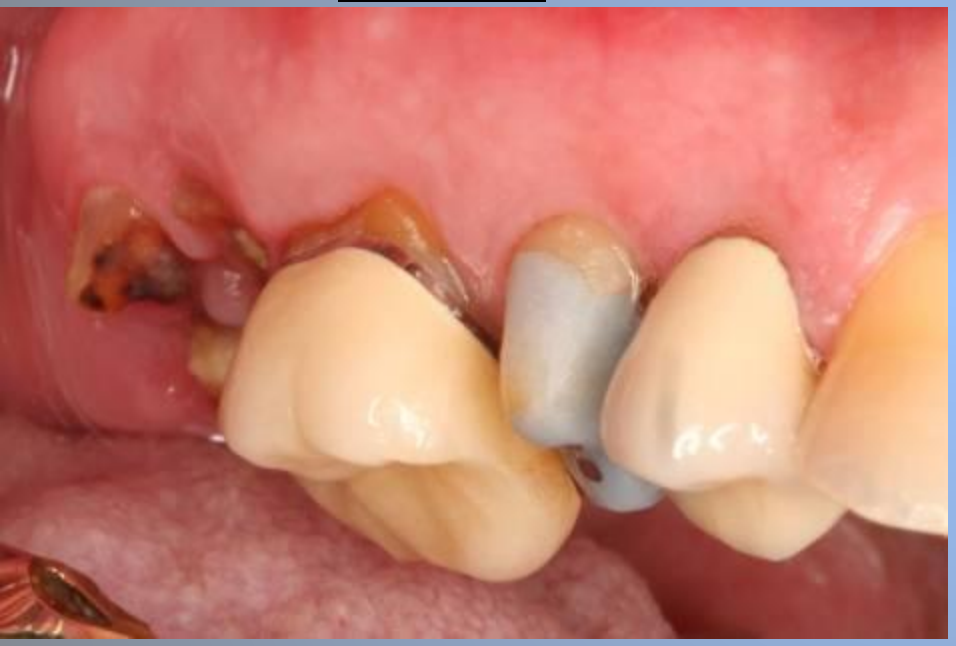


Dell has no significant tooth mobility and minmal furcation involvement.

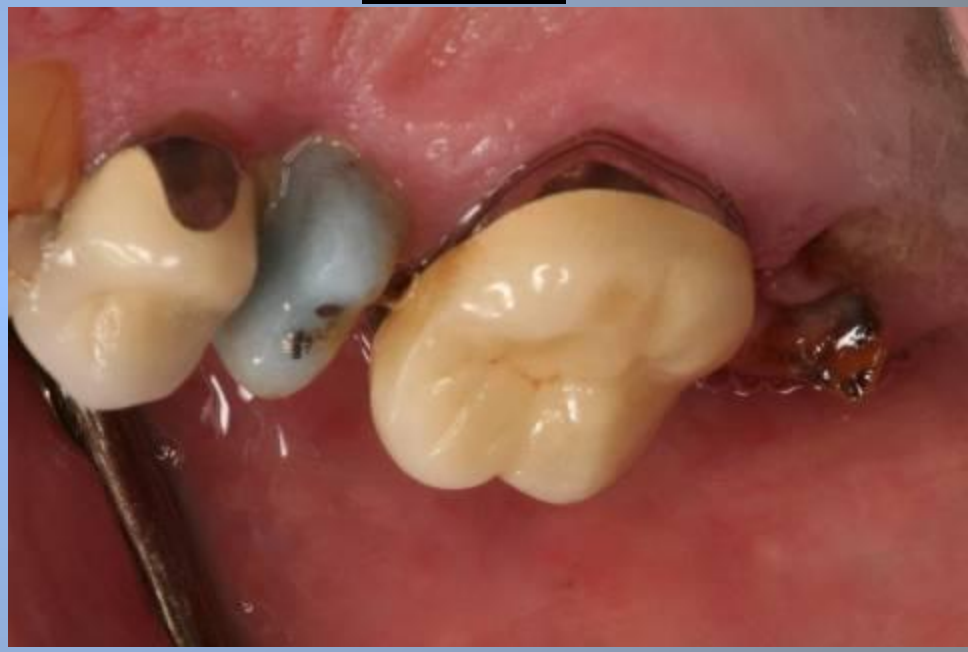
The lower anteriors and the upper right and left bicuspids have moderate bone loss. #10 has radiographic mesial and distal vertical bone loss but its recession and probes are minimal. Teeth #'s 3, 13, 18 and 31 are super-erupted. There are abscessed root tips which contribute to the gingival inflammation and general periodontal problem. The decay of #'s 4 and 5 are creating a biological width violation for restoration.

Upper Right Posterior

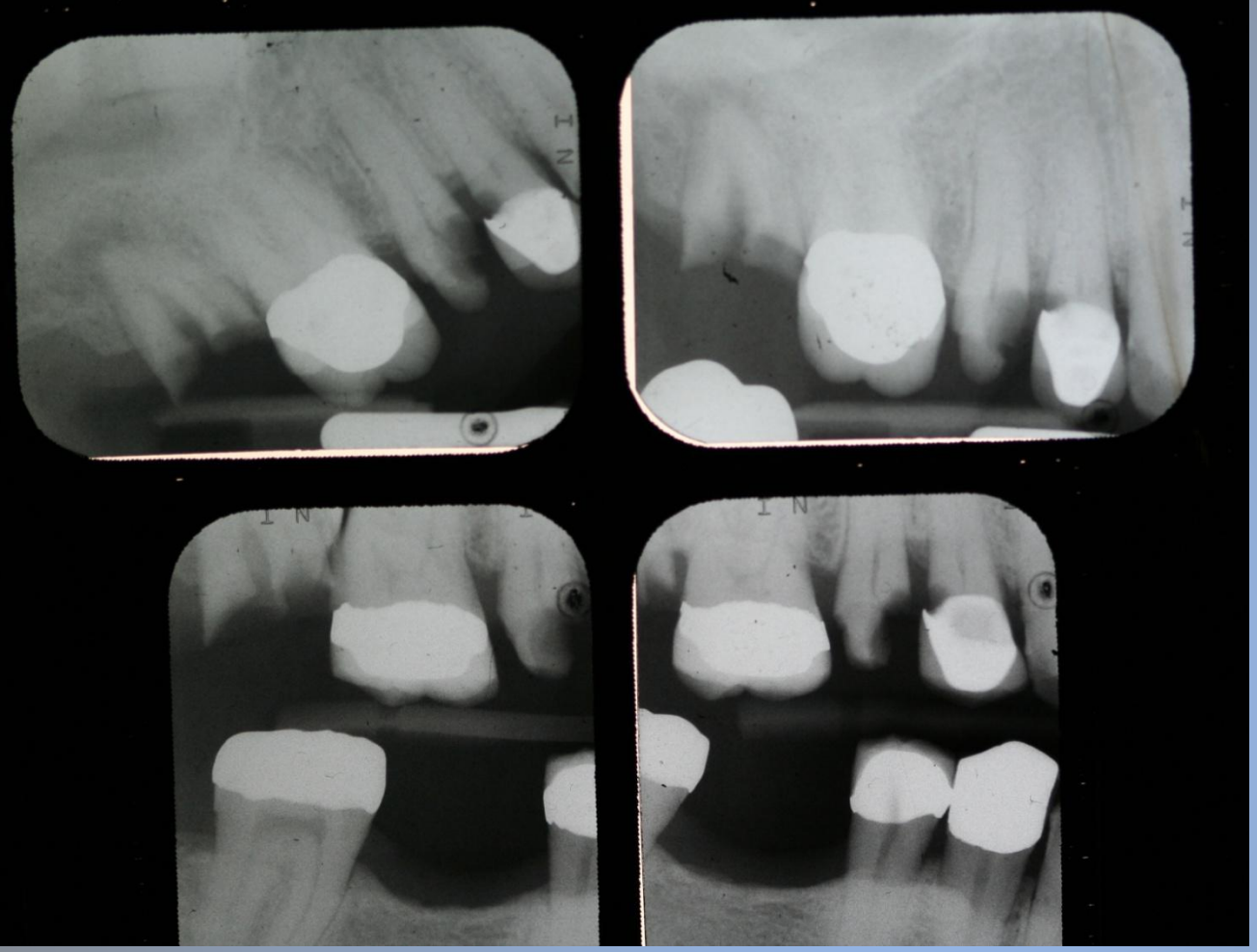
Buccal



Palatal



Root tips of #2 and emergency endo buildup on #4. There is adequate attached gingiva. The papilla appear blunted.



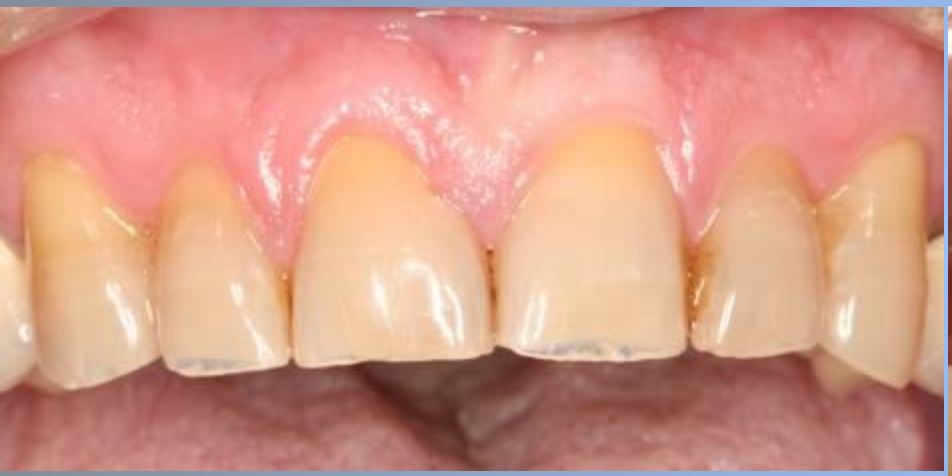
Upper Right Posterior

#’s 4 and 5 have vertical bone loss between them and there is bleeding upon probing. The furca on #3 appears to be sound.

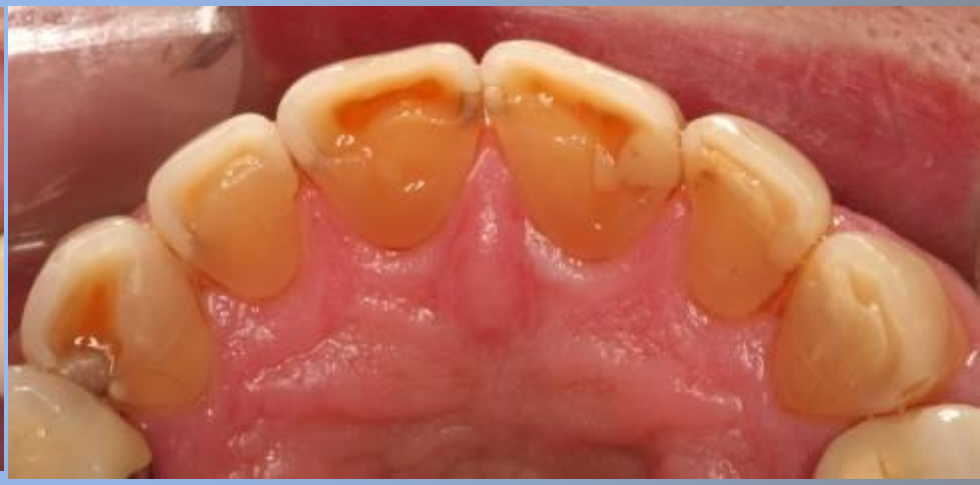
Tooth		1		2		3		4		5		6
		D	M	D	M	D	M	D	M	D	M	D
Pocket Depth	B			root		2	2	2	4	4	1	2
	L			Tips		3	2	4	2	1	3	3
Mobility						1/2		1/2		1/2		1/
Furcation												
Recession						2/		1/		1/		

Upper Anterior

Buccal



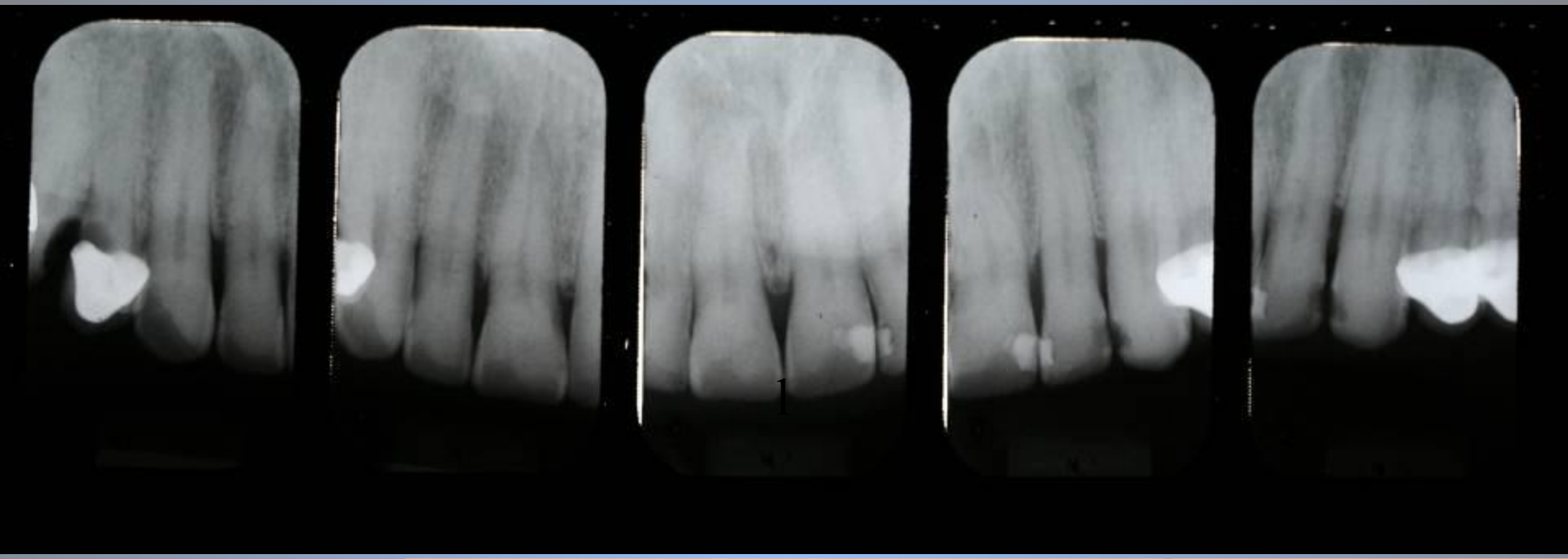
Lingual



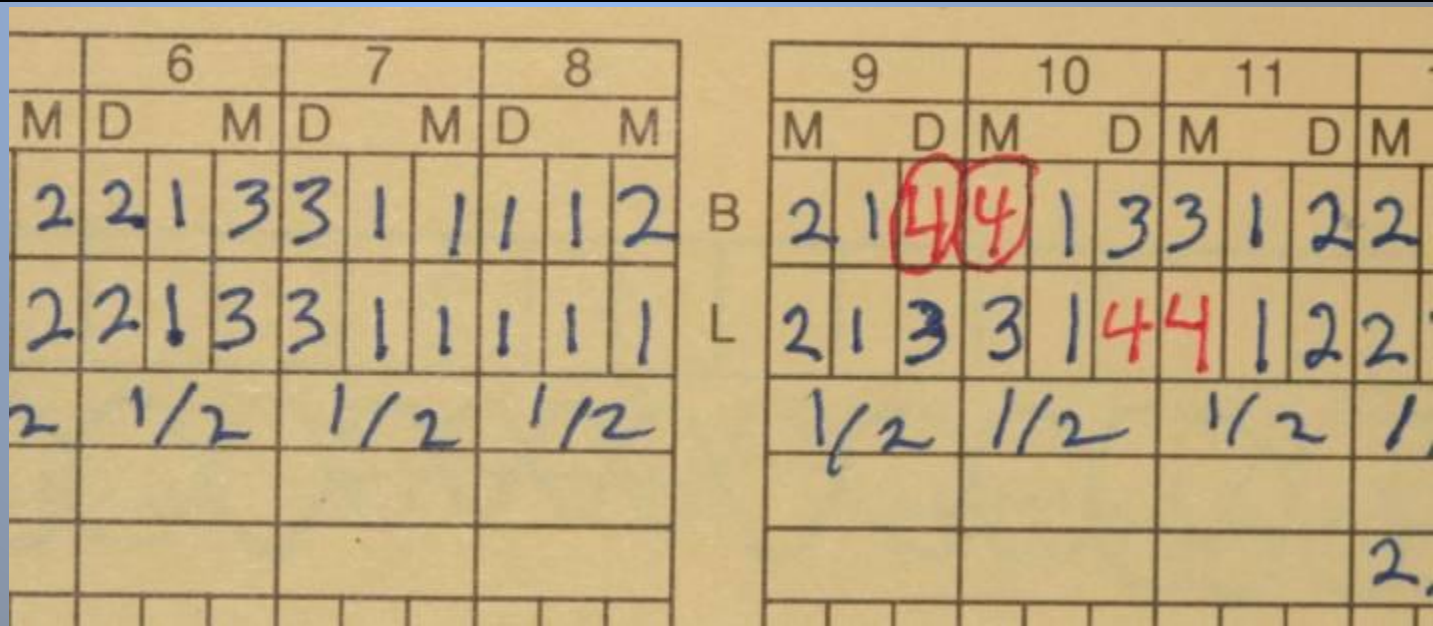
Parafunction:

There is heavy wear with cupping and chipping and decay on the IL's of #'s 6 through 11. This leaves Dell with poor protrusive and canine function. The gingiva appears fibrous and glistening rather then stippled.

Upper Anterior



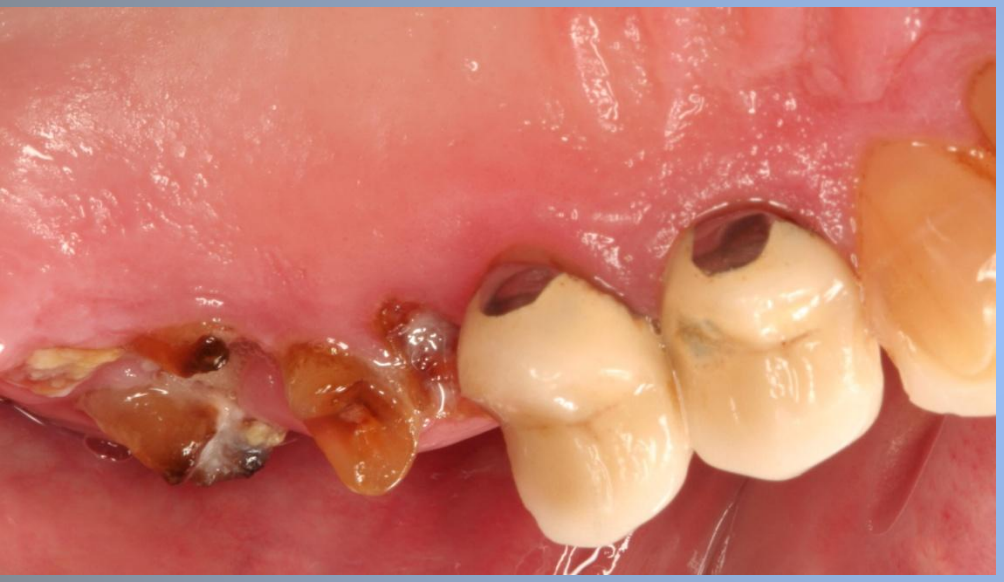
There appears to be vertical bone loss on the mesial and distal of #10. Areas of Decay.



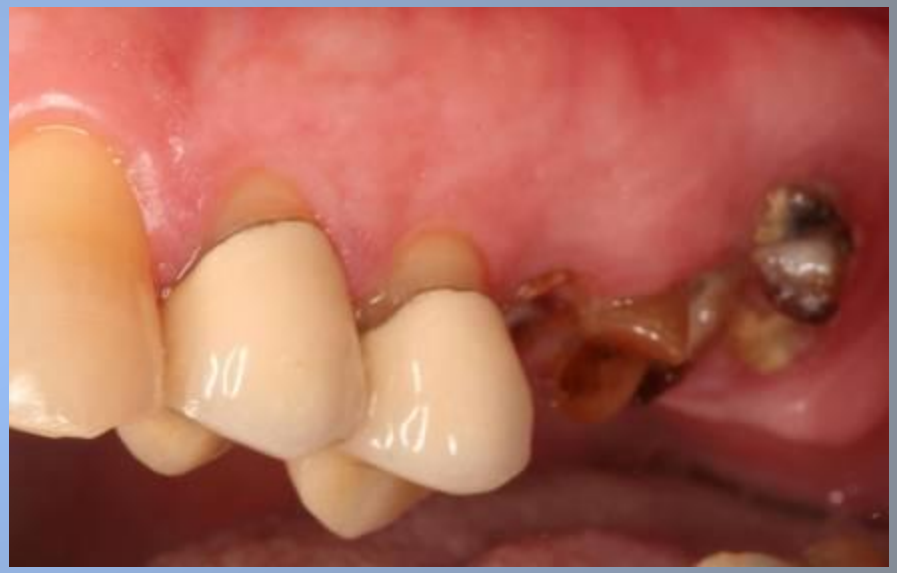
Upper Left Posterior

Super-erupted #13 with marginal ridge discrepancy.

Palatal

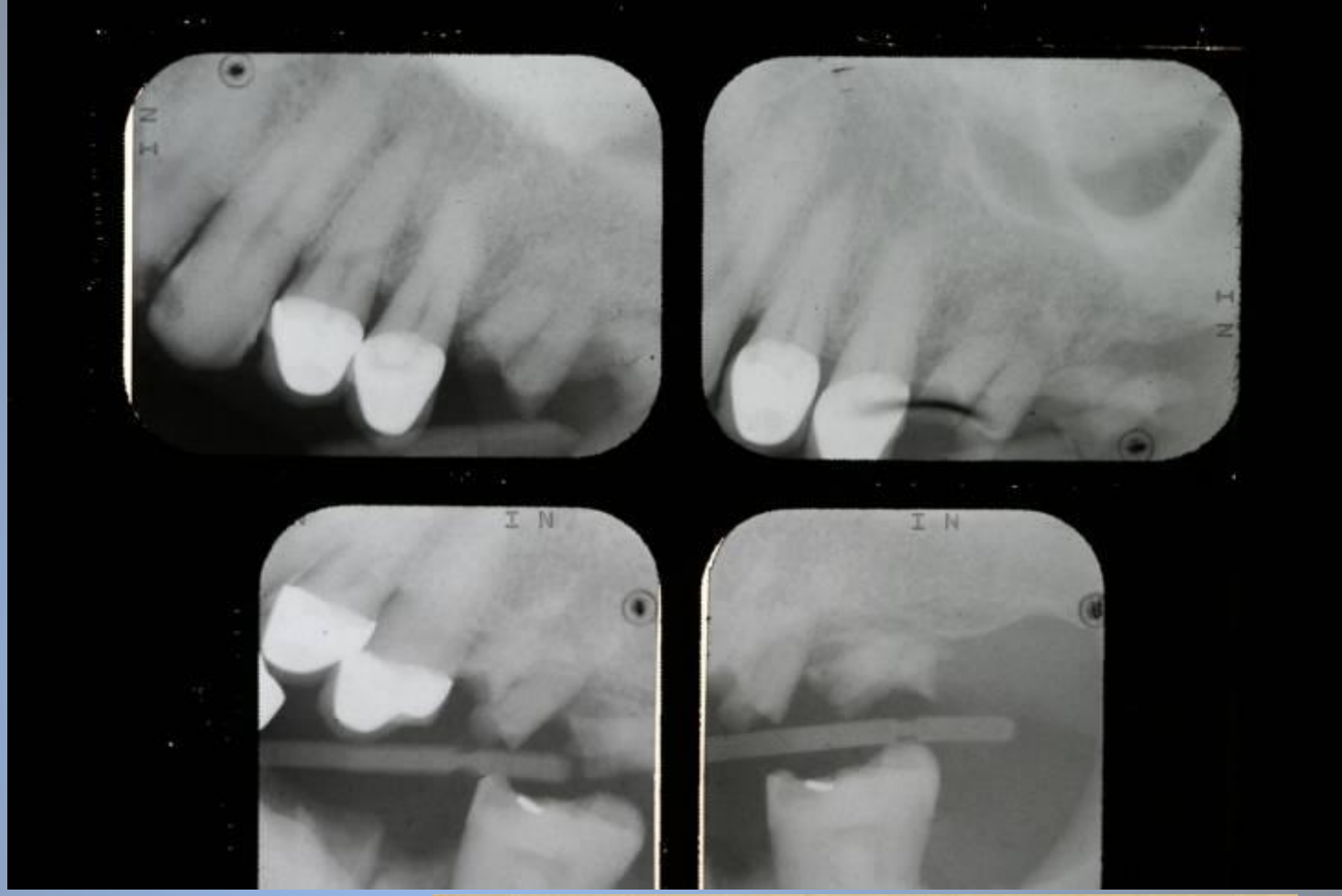


Buccal

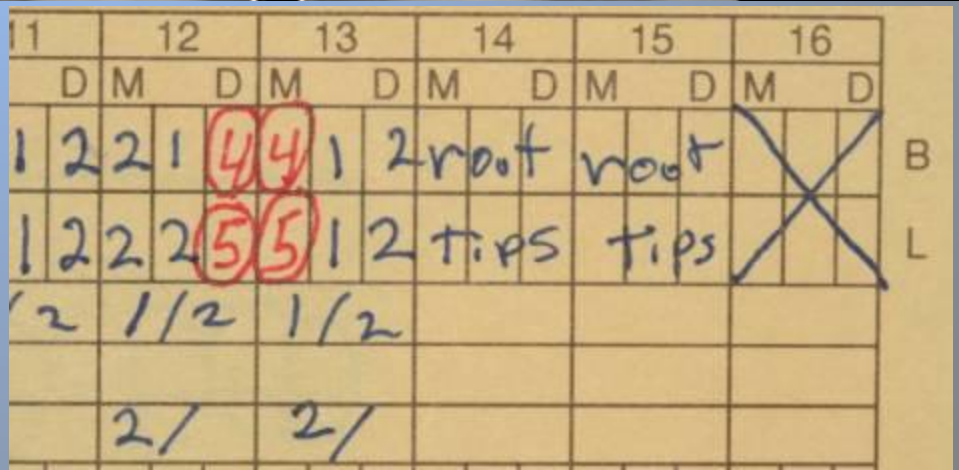


#’s 14 and 15 are just root tips. Red and slightly swollen gingiva on the lingual of #’s 12 and 13 as well as around the root tips.

Upper Left Posterior

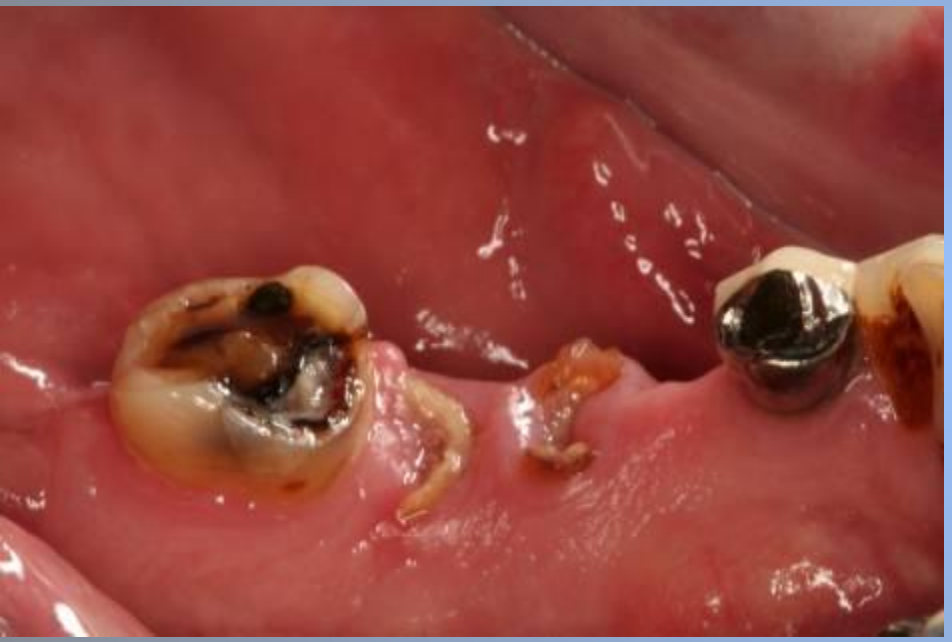


Root tips only on #’s 14 and 15. # 13 is super-erupted with posterior bite collapse.



Lower Left Posterior

Lingual



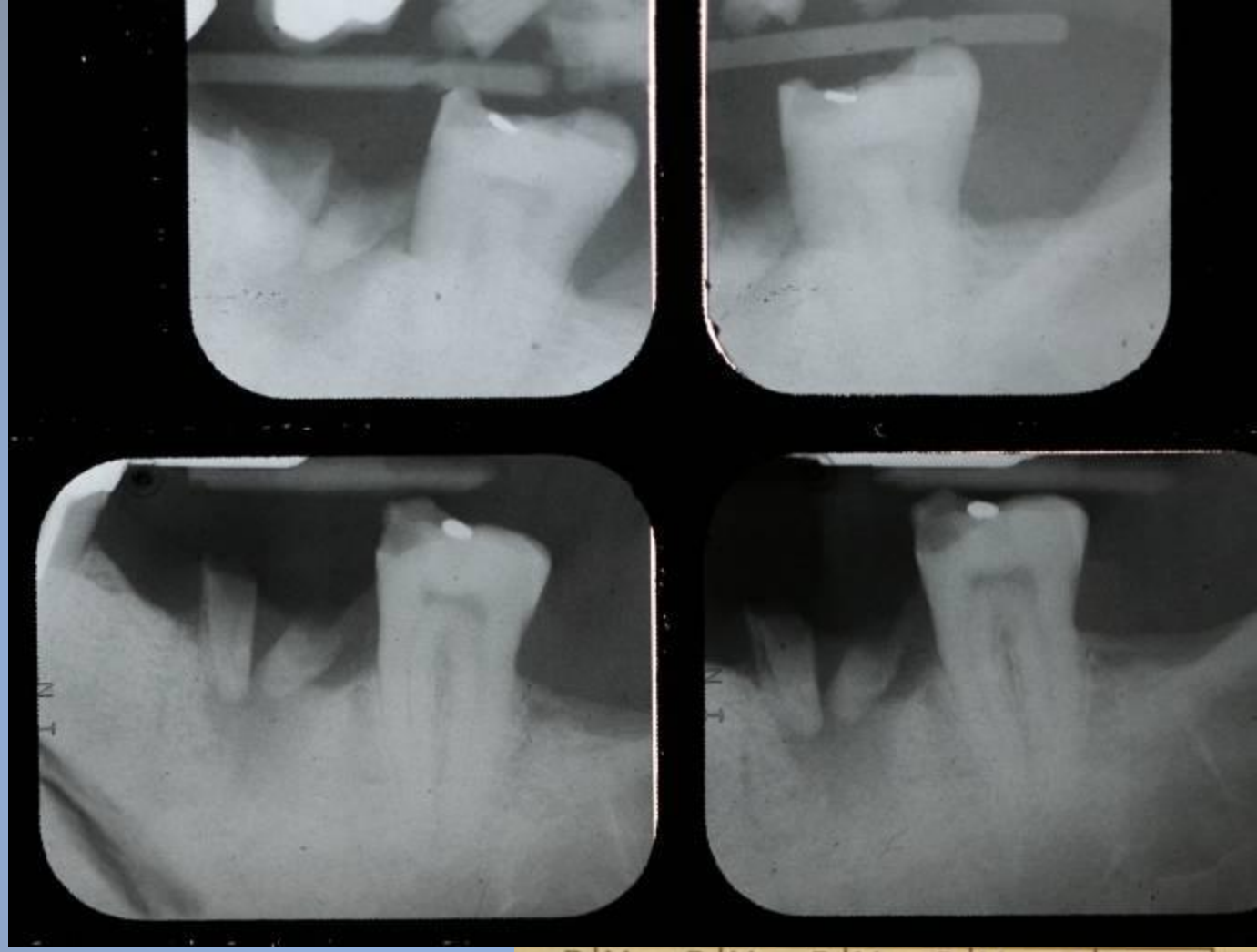
Decayed #18,
root tips #19.

Tori

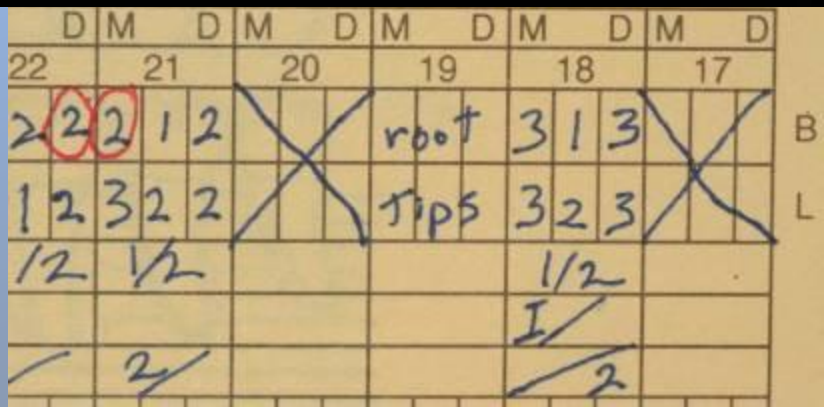
Buccal

Smooth gingiva.

Lower Left Posterior



#18 has extensive occlusal decay. It also has a class I buccal furca. #19 is abscessed root tips. #20 is missing and #21 is on the anterior films.

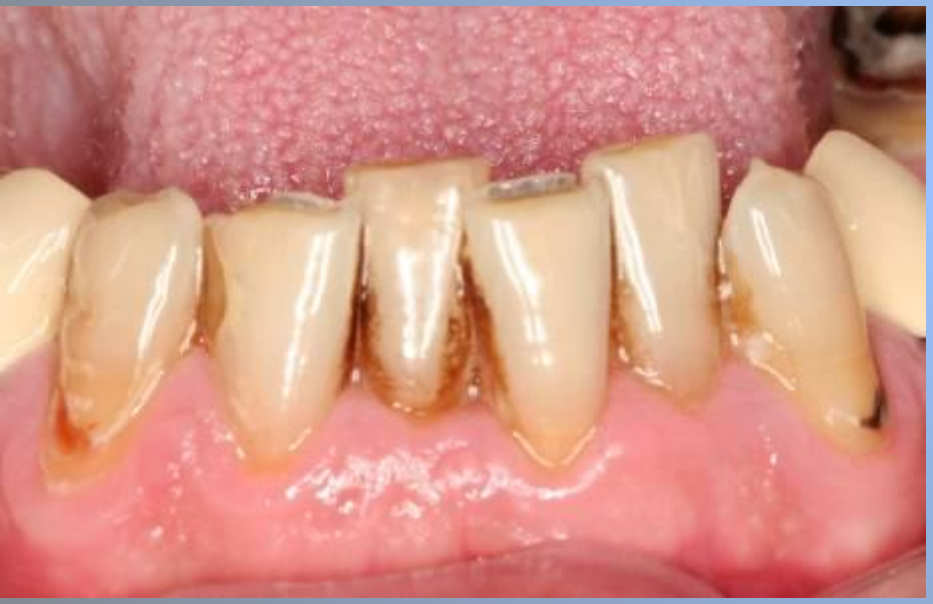


Lower Anterior

Buccal

Lingual

Recession : 2mm on buccal of #'s 24, 27 and 2mm on lingual of # 25.



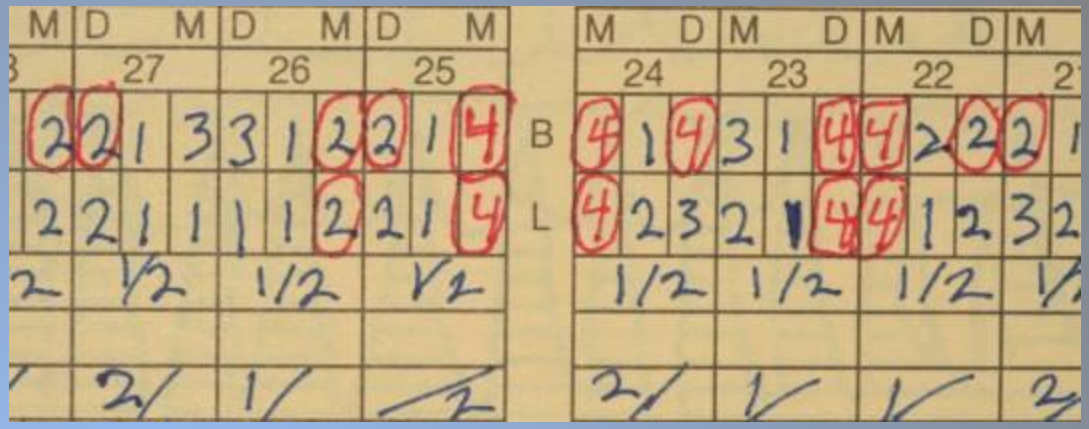
Calculus: Obvious supragingival calculus present on buccal and lingual of lower anterior teeth.

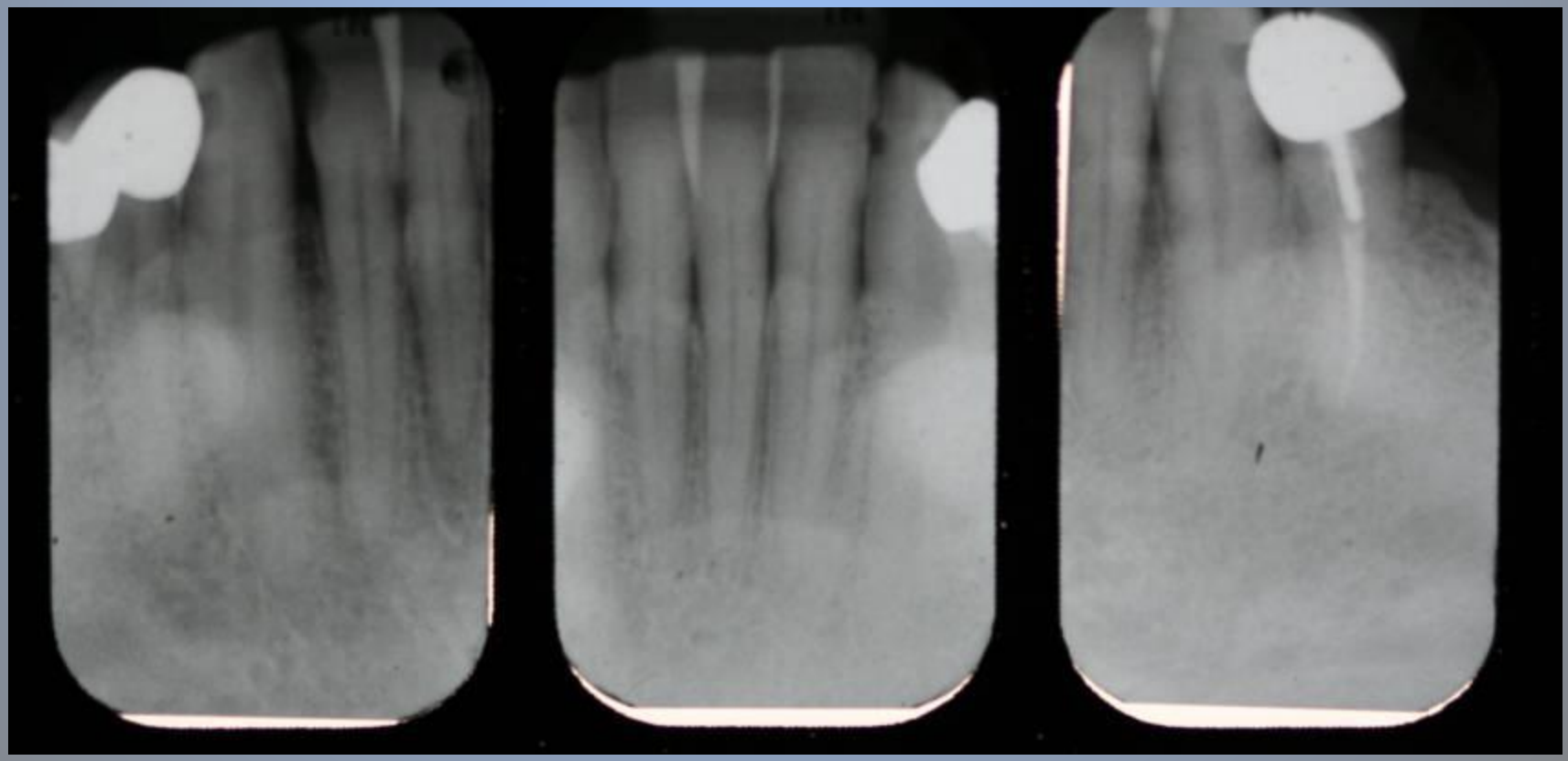
Incisal Wear: Excessive wear on lower anteriors.

Gingiva: Smooth and fiberous.

Lower Anteriors

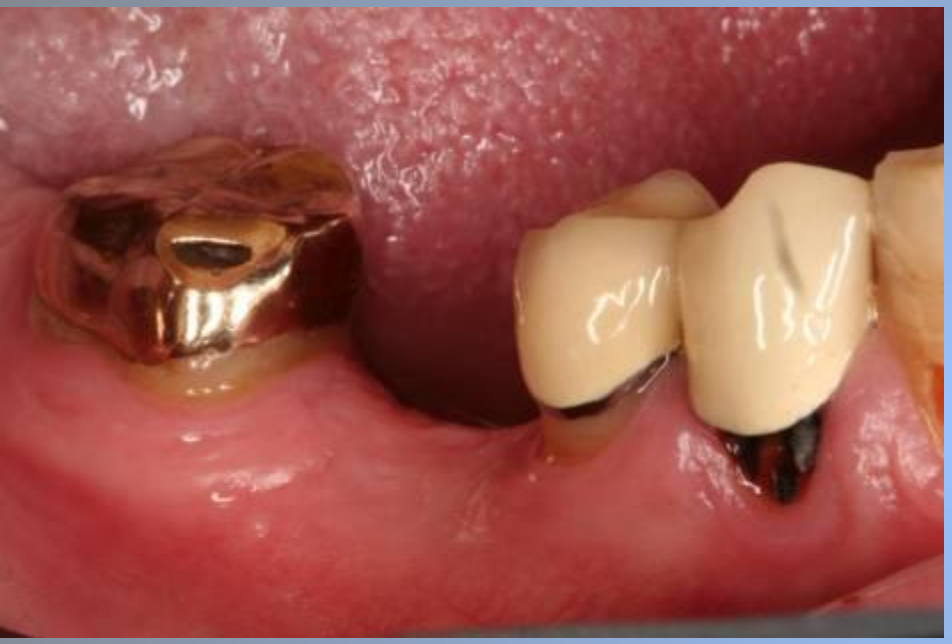
Horizontal bone loss and suspicious widening of the PDL on #21. The tori are noticeably blocking some of the root areas.



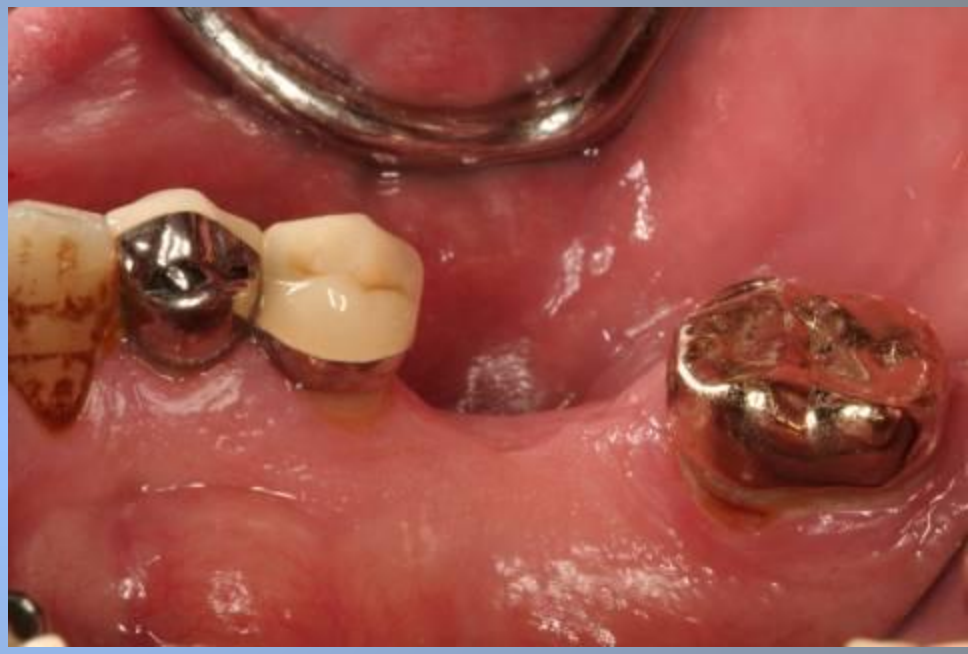


Lower Right Posterior

Buccal



Lingual

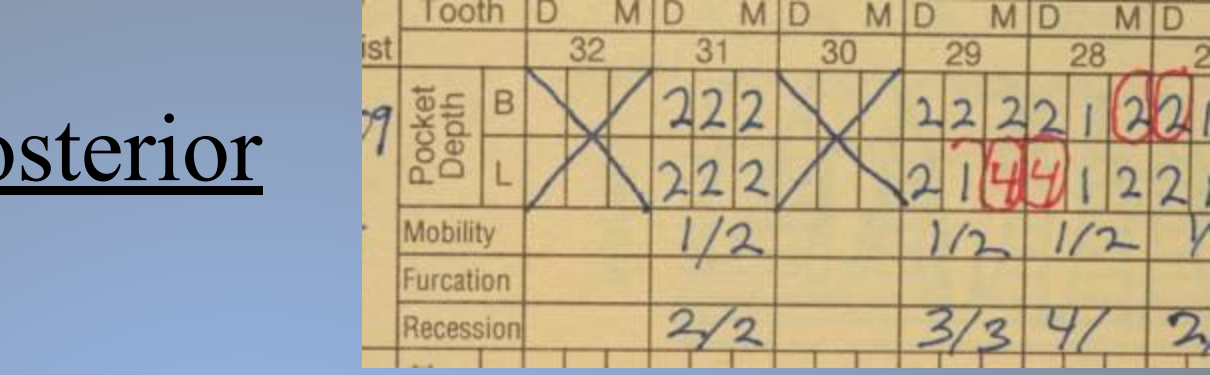


Recession: On the buccal of #28 and on the buccal and lingual of #29. Lingual recession on #31.

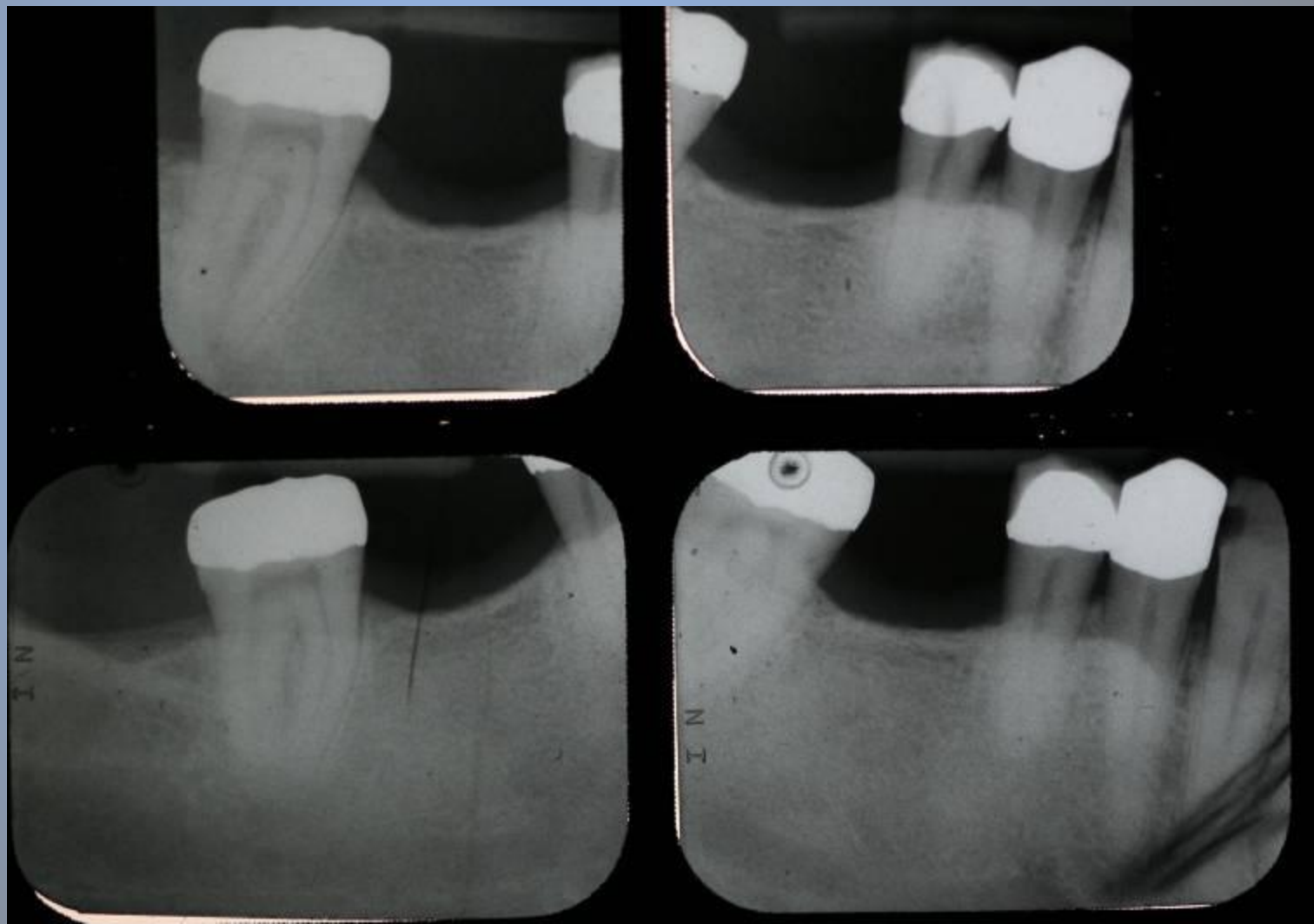
Gingiva: Is smooth and fibrous.

Tori: On lingual of #'s 27, 28, and 29.

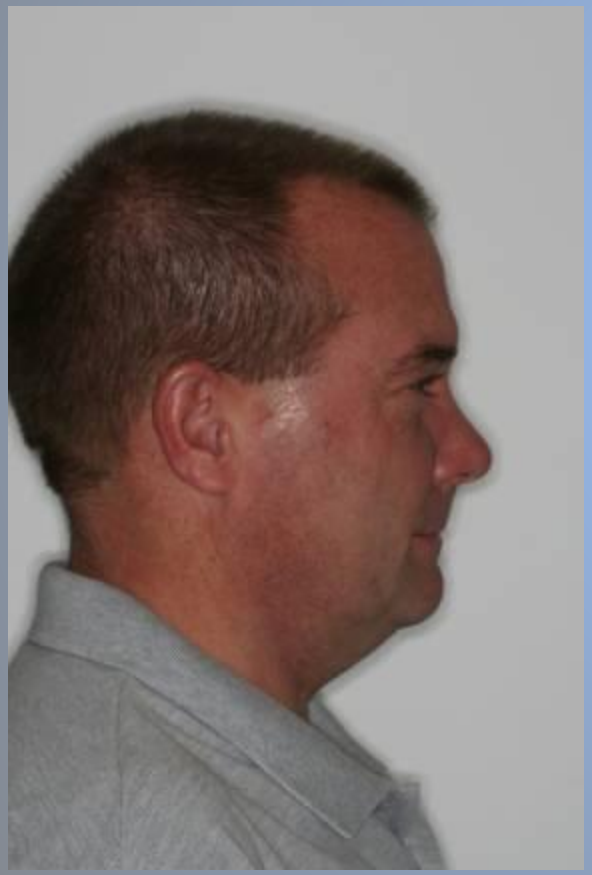
Lower Right Posterior



#31 appears to have good bone levels without furca involvement. There is some radiographic loss of bone on the distal of #29.



TMJ



Occasional popping, no pain or locking of jaw.

After probing each quadrant, note whether or not bleeding has occurred. Indicate the bleeding area by circling the pocket in red.
Move each tooth between two instrument handles in a bucco-lingual direction and attempt to depress each tooth in its socket. Grade each tooth
0 - Movement of less than 0.5mm; 1 - 0.5mm to 1.0mm; 2 - 1.0mm to 2.0mm; 3 - Movement of more that 2.0mm or depressible.
- Probe from the buccal and lingual. Record accordingly: 0 - Normal; 1 - Slight; 2 - Moderate; 3 - Through and through.
- Measure the exposed surface from the cemental enamel junction (CEJ) to the gingival crest. Enter the distance in millimeters (mm).

oth	1	2	3	4	5	6	7	8
	D M	D M	D M	D M	D M	D M	D M	D M
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L	X	Tips	3 2 4	2 1 (3 3)	1 2	2 1	3 3	1 1 1 1
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	9	10	11	12	13	14	15	16
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L	2 1 3	3 1	(4 4) 1	2 2 (5 5)	1 2	Tips	Tips	X
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oth	32	31	30	29	28	27	26	25
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	M D	M D	M D	M D	M D	M D	M D	M D
	24	23	22	21	20	19	18	17
B	(4 1 (4)	3 1	(4 4)	2 (2 2)	1 2	X	root	3 1 3	X
L	(4) 2 3	2 1	(4 4)	1 2	3 2 2	X	Tips	3 2 3	X
	1/2	1/2	1/2	1/2			1/2		
							I/		
	2/	1/	1/	2/			/2		
B									
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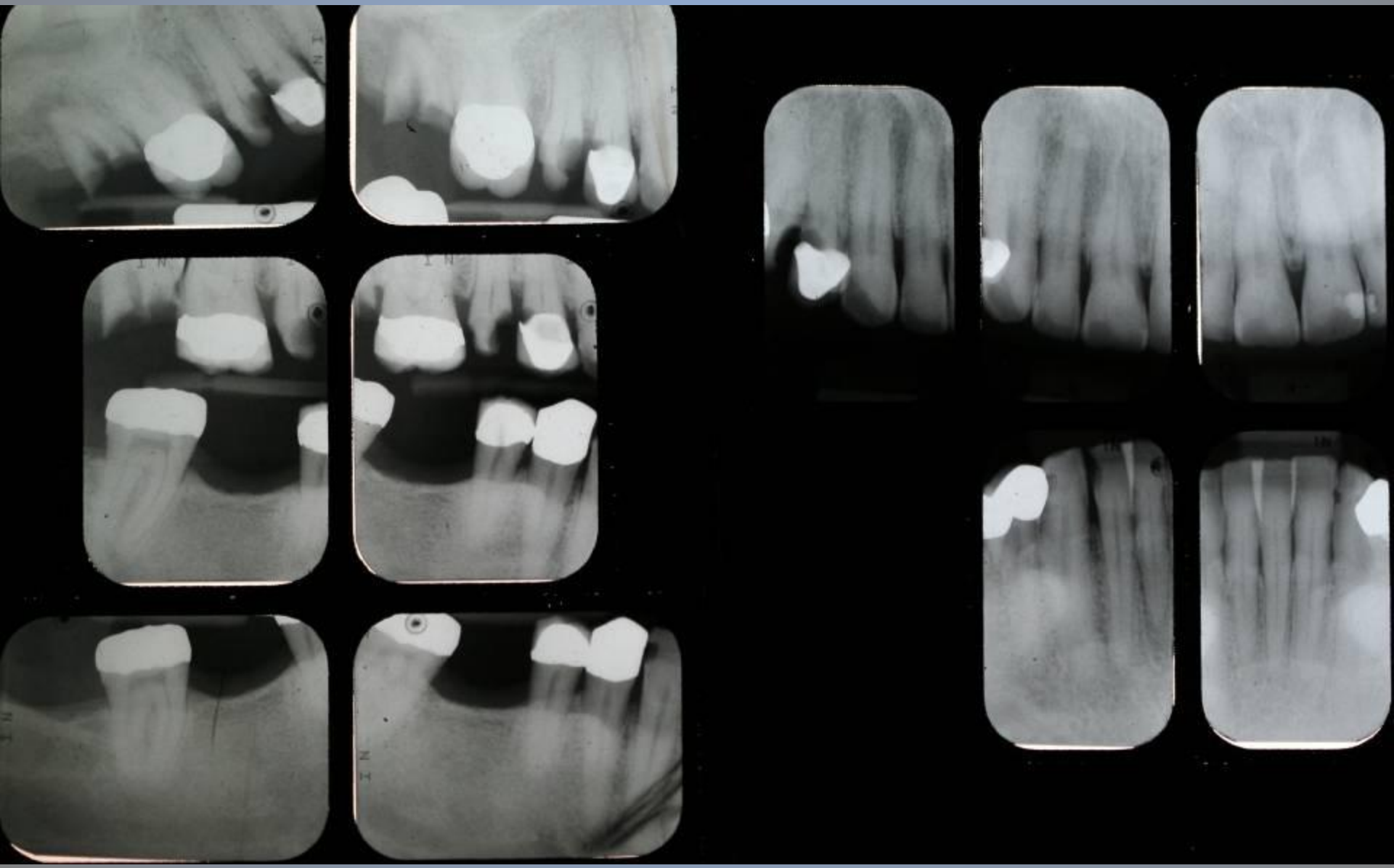
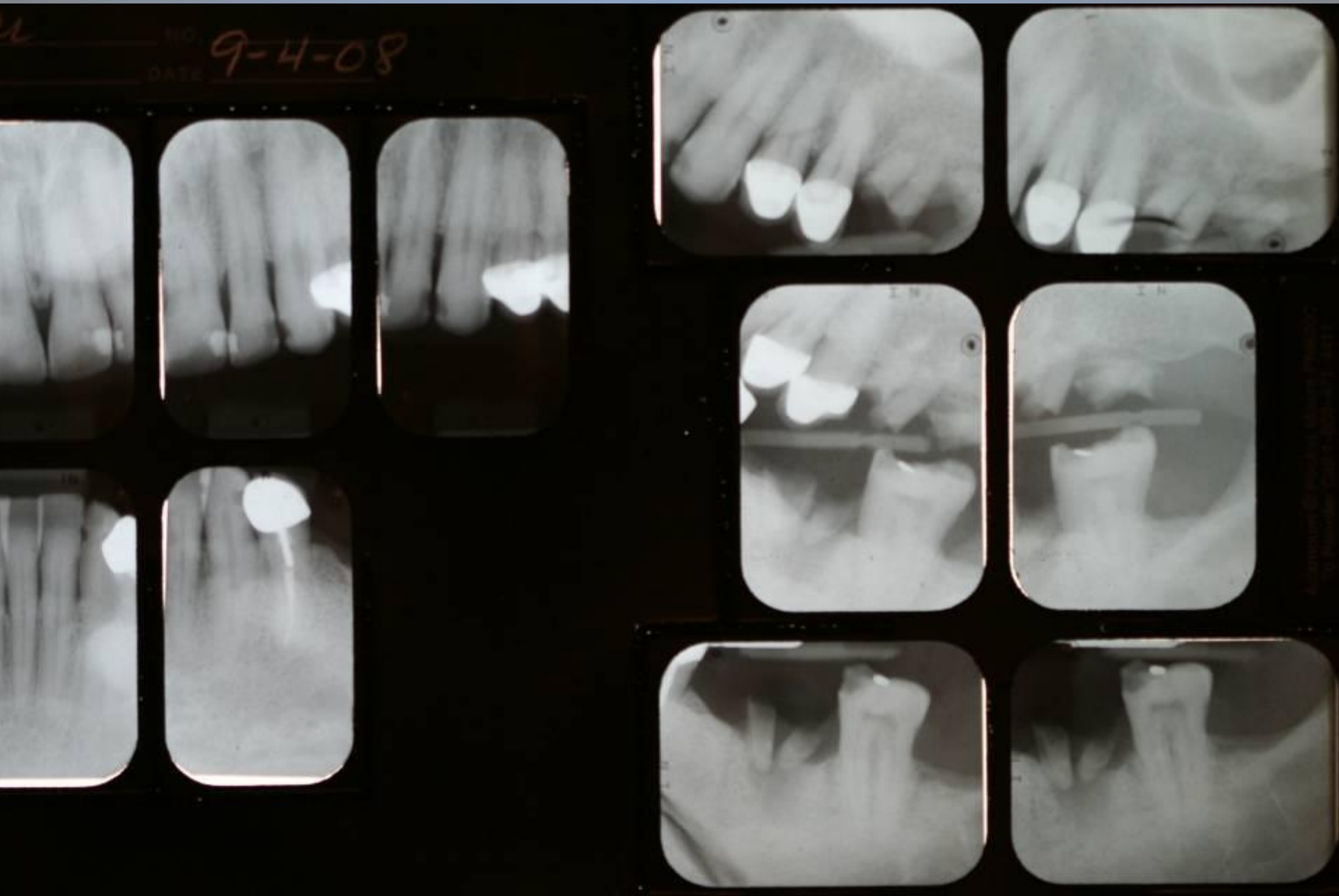
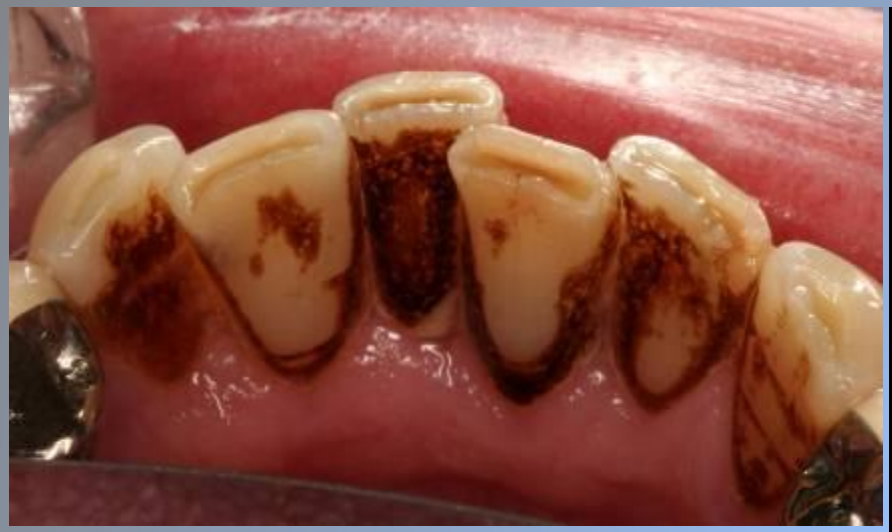
Right Side 9/4/08

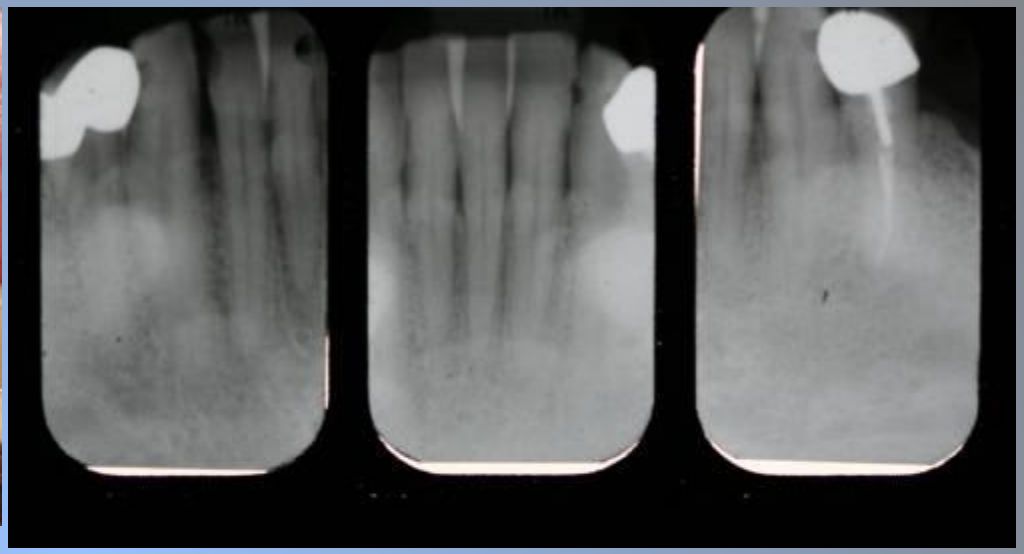


Left Side 9/4/08



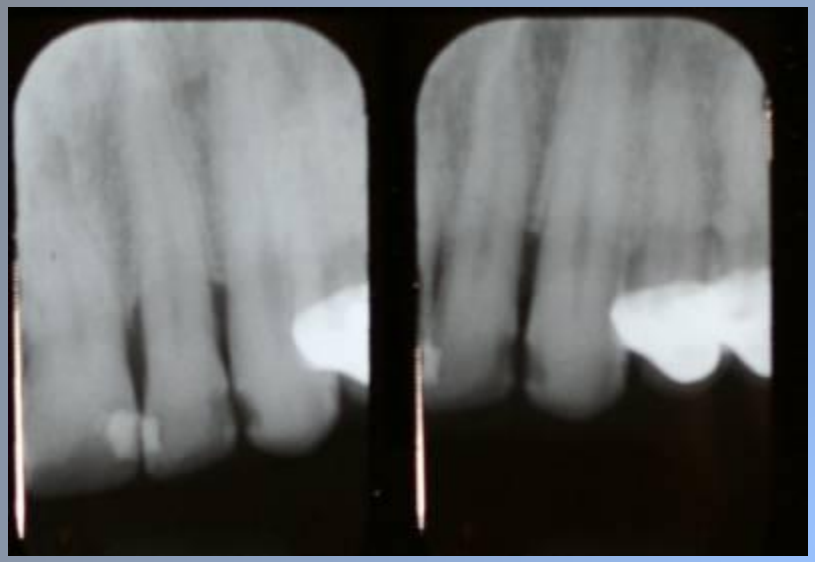
Diagnosis of Perio

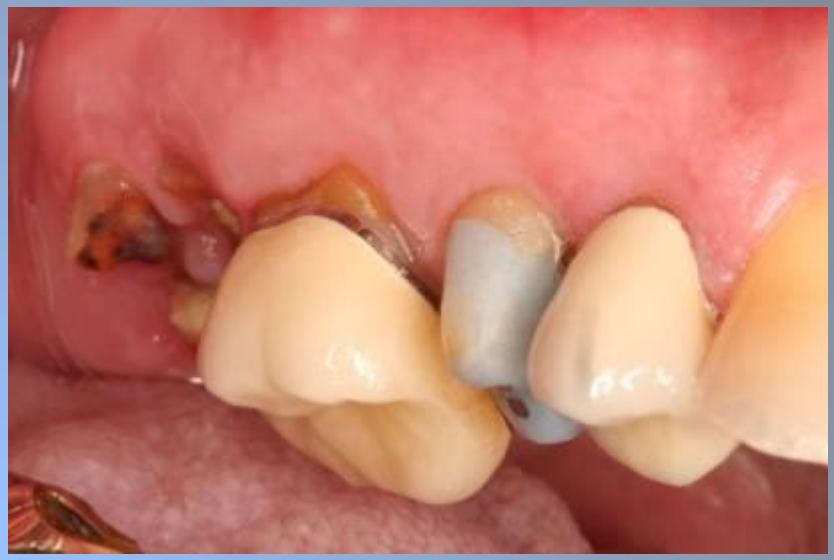




There is marginal gingival inflamation with glossy fibrous tissue and blunted papilla throughout the dentition. There is heavy calculus on the upper and especially on the lower anterior teeth. There is a lack of stippling with multiple areas of bleeding upon probing. The lower anteriors and the upper right and left bicuspids have moderate peridontitis. There is moderate periodontitis with attachment loss in the area of #'s 27, 28 and 29.

Diagnosis of Perio





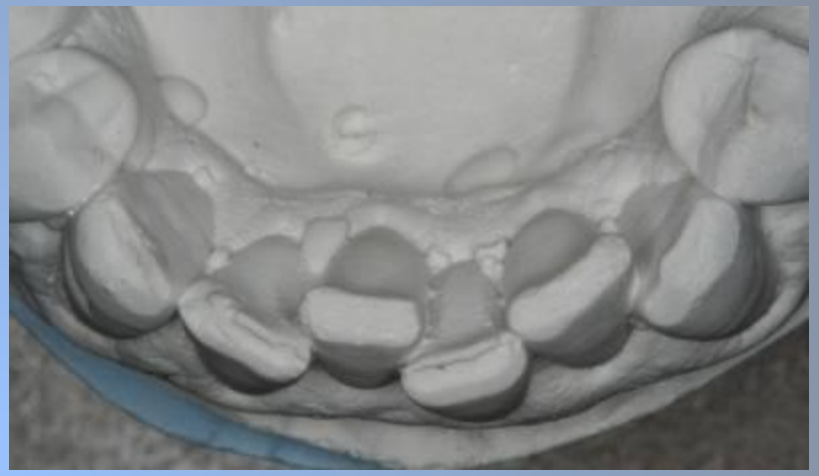
#10 is diagnosed for vertical radiographic bone loss but the recession and probes are minimal. There are abscessed root tips which contribute to the gingival inflammation and general perio-dontal problem. The decay of #'s 4 and 5 are creating a biological width violation for restoration. Dell seems to have a fairly good natural resistance to perio in light of the lack of dental care over the last ten years. I would diagnose the bone quality of the remaining teeth to be good considering the lack of tooth

Diagnosis of Occlusion

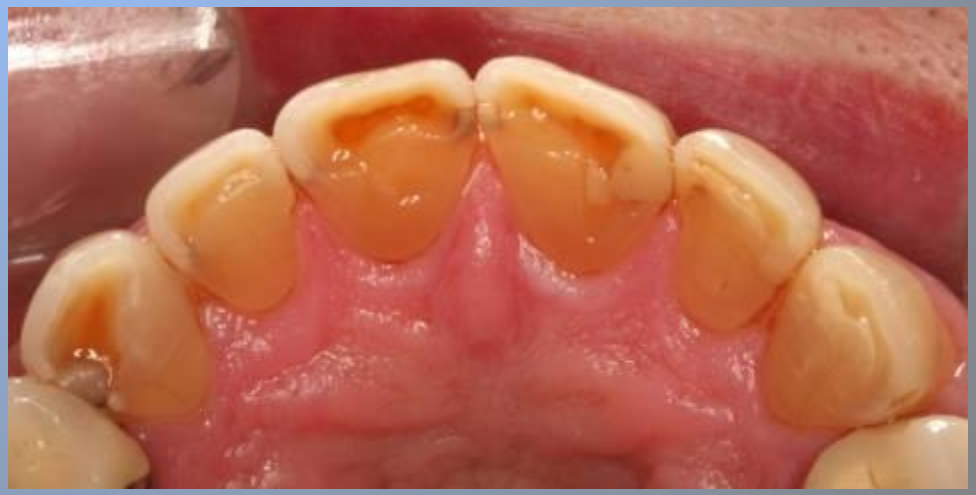
Class I Angle's Malocclusion with tendency toward type III. There is minimal posterior bite support, and patient has difficulty with chewing. **Right working-** Group function with #'s 5 and 6 working against #'s 27, 28 and 29. **Left working-** Group function with #'s 4 and 5 working against #'s 21 and 22. **Protrusive-** Poor function due to heavy wear of upper anteriors.

Diagnosis of Occlusion

- Class I malocclusion with tendency toward a class III indicated by the crowded lower anteriors. This would be confirmed with cephlametric.



- The upper anteriors have heavy lingual wear along with crowded lower anteriors leaving poor opportunity for protective anterior guidance. This patient has bruxism and/or clenching creating his obvious occlusal wear.

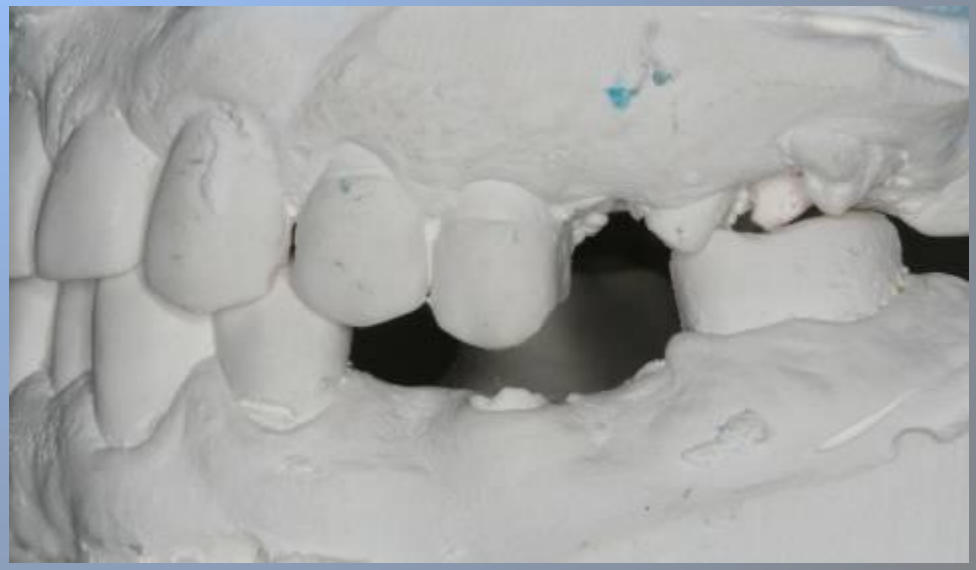


Diagnosis of Occlusion

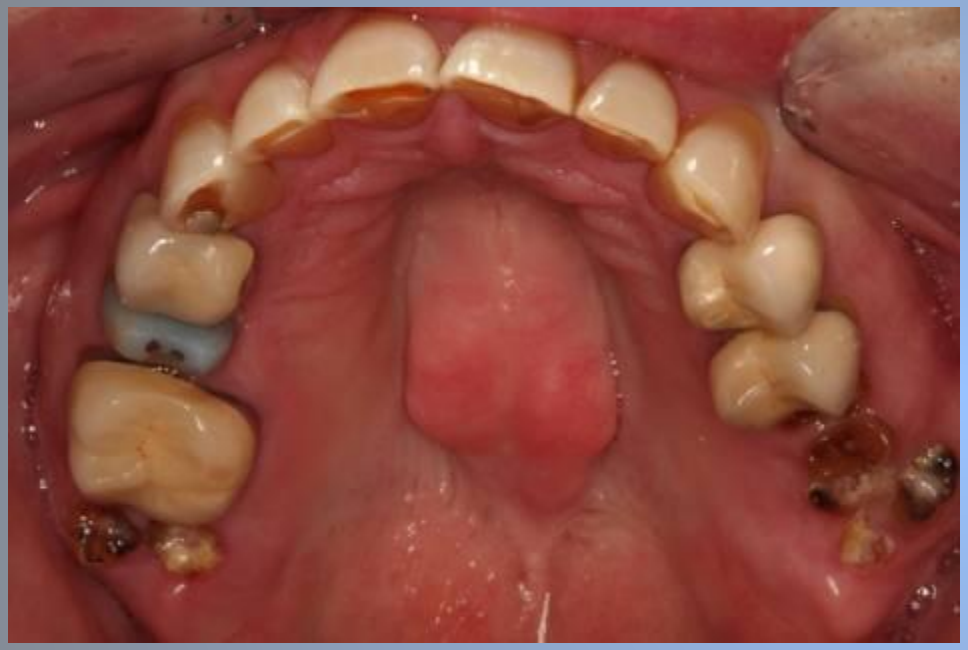
- Super-erupted posteriors #’s 3, 13,18 and 31 due to decayed and missing teeth resulting in protrusive interference on #’s 3 and 31. There is a lack of adequate posterior bite support and occlusal area for vertical stops and reasonable chewing function. The upper and lower arches are unlevel.

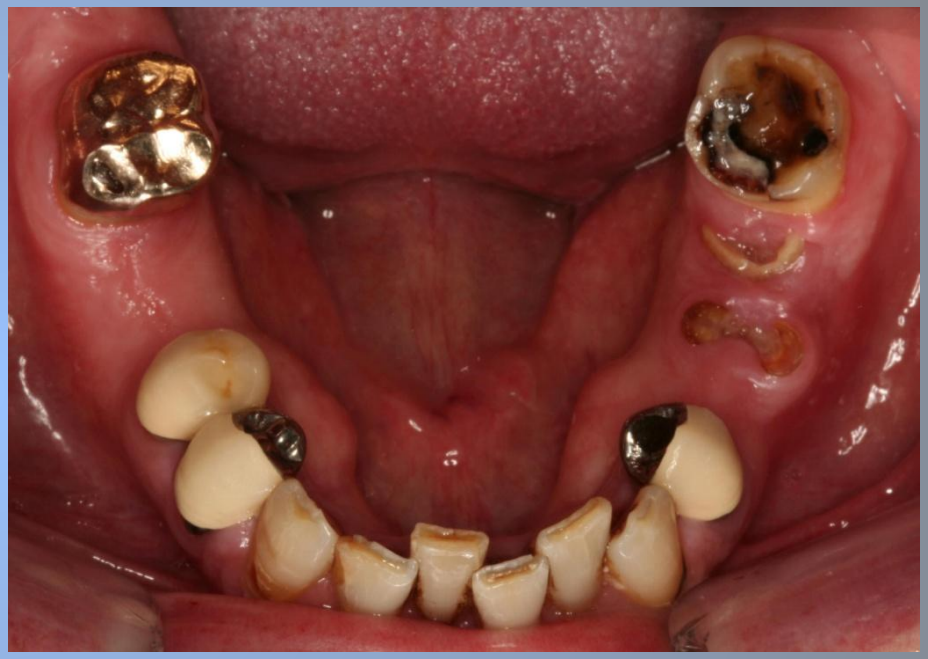
Right

Left



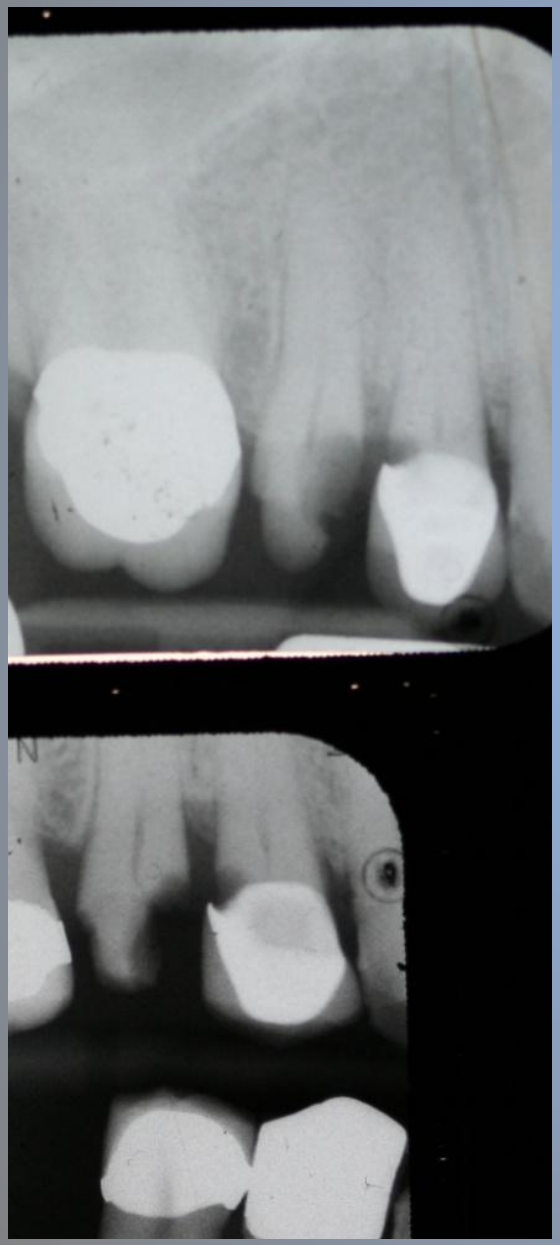
Diagnosis for Restorative



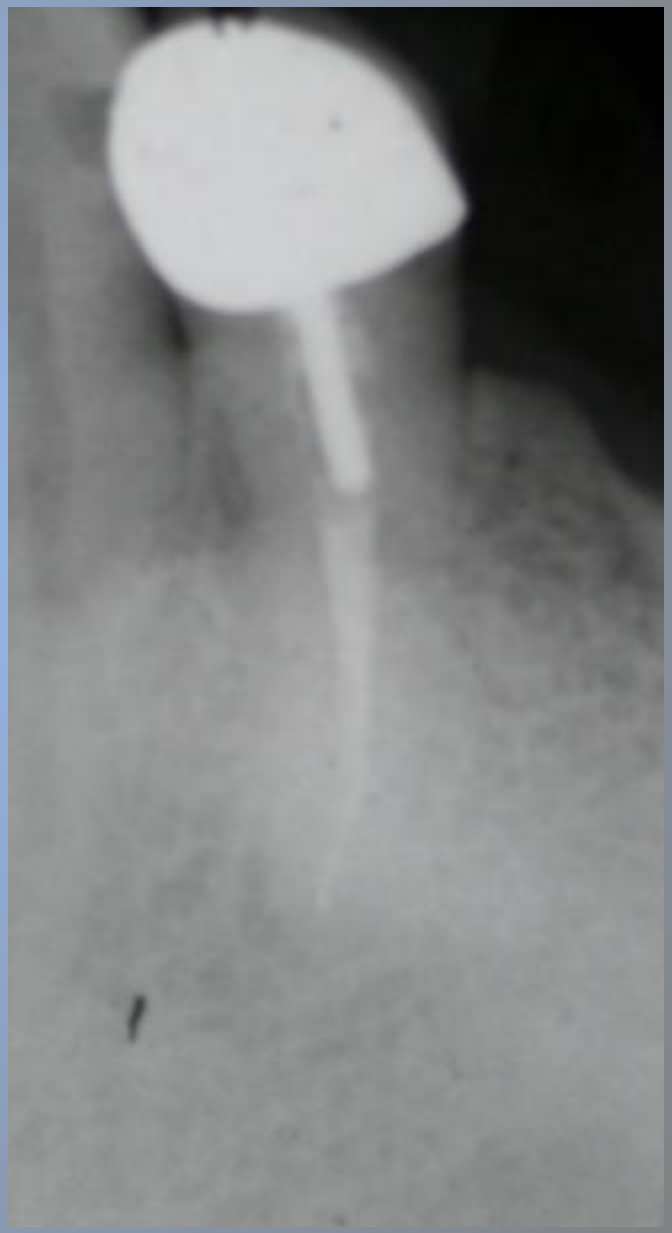


- There are multiple decayed and missing teeth. Most existing restorations are failing with recurrent decay and need to be replaced. There is heavy wear on the arches and they are uneven. Patient is in need of protective night guard to minimize parafunctional destruction.

Diagnosis for Endo



There is decay into the pulp creating irreversible pulpitis on #’s 4 and 5. The endo on #28 is questionable.



Diagnosis of TMJ

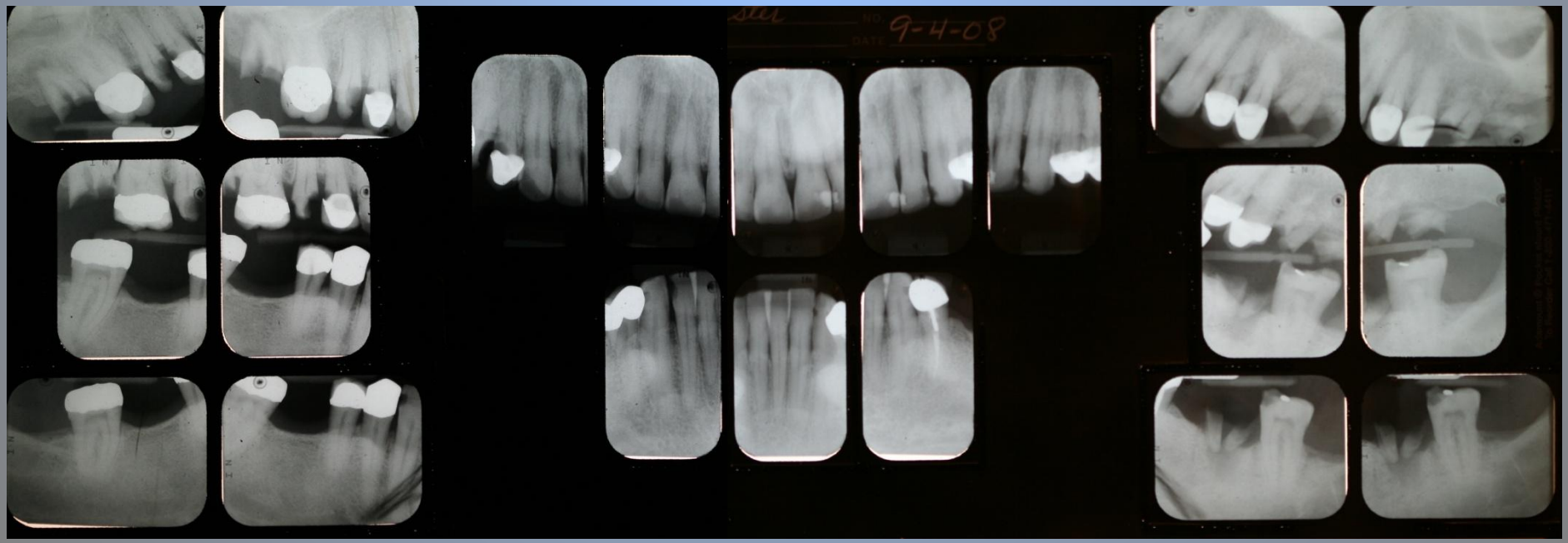
Minor TMD symptoms of occasional soft tissue popping which are probably related to a stretched posterior ligament and a disc which fails to properly translate with the condyle. He has no pain or locking of the jaw.

Treatment Plan:

Phase I Disease Control:

1) Oral home care instruction and coaching.
2) Extract hopeless teeth #'s 2, 14, 15 and 19.
3) Four quads scaling and root planning.
4) Do endo on #'s 4 and 5. Endo consult to evaluate #21.
5) Restore decayed teeth with provisional restorations or composite.
6) Restore worn anterior teeth with direct bond composite.

Re-evaluate Phase I Treatment:



Phase II Definitive Perio Treatment:

Osseous surgery and in lower anterior and osseous surgery in upper R + L posterior with crown lengthening on #'s 4 and 5. Gingival grafting on #'s 27 and 28 with possible root coverage. Evaluation and possible grafting in anticipation of placing implants at #'s 14, 19, 20 and 30.

Re-evaluate Phase II Treatment and Ongoing Perio Maintenance:

Phase III Treatment Consult:

Ortho consult and treatment plan to align lower anteriors and level arches by intruding super-erupted teeth as much as possible.

Consider treatment plan to place implants #'s 14, 19, 20 and 30 in order to aid with ortho treatment.

Phase III Treatment:

Initiate ortho and place implants at #'s 14, 19, 20 and 30. Use integrated implants to aid in ortho treatment. Complete ortho treatment.

Re-evaluate Phase III Treatment and Ongoing Perio Maintenance:

Phase IV Treatment:
Modify composits and provisional restorations including those on implants to establish an ideal occlusal plane with adequate posterior anatomy and centric stops, but without bite interferences. The anteriors would be restored to create anterior guidance for protrusive and right and left working function.
Re-evaluate Phase IV Treatment and Ongoing Perio Maintenance:

Phase V Treatment:
Place upper and lower full mouth definitive restorations using the Phase IV dentition as a model. The goal of the occlusion on the permanent restorations would be to have simultaneous, even contacts on all the teeth in centric relation, as well as protected posterior teeth through anterior coupling. The case should have interference-free excursive movements in right lateral, left lateral and protrusive. The successful aesthetic result of the provisionals should be completely transferred to the permanent restorations.

Re-evaluate Phase V Treatment and Ongoing Perio Maintenance:

Place Patient in Permanent Recare System:

- **Help !**