Basic Instrumentation

- Periotomes
- Luxators
- Elevators
- Handpieces
Periotomes

Should always be used around all erupted teeth when possible. 

ESPECIALLY erupted third molars.
Luxators
Cannot be used like an elevator. The tips will break.
Baby Cryers

Karl Schumacher #21 and #22
Avoiding a Very Preventable Surgical Complication

by Jay B. Reznick, DMD, MD

From Dental Town August 2010
Risks associated with use of a high speed air turbine drill during a dental extraction

- Subcutaneous emphysema of face, neck, chest
- Pneumomediastinum
- Facial Infection/Cellulitis
- Thoracic infections/mediastinal abscess
- Descending necrotizing mediastinitis
- Visual disturbance, visual loss
- Fatal air embolism
- Cardiac arrhythmia, Cardiac arrest
- Death
Surgical Burs

• 699
• 701
• 702*
• 703
• 8 Round
Traumatic forceps 88 cowhorn picture of model
chlordane (BAK) as a surface coating may reduce the capacity of biofilm formation. BAK is a cationic detergent that expresses a high affinity to membrane proteins and is widely used in oral disinfectant mouthwashes. It is important to note that although this study shows promise in reducing biofilm formation, it does not eliminate its formation. Therefore, prudent timing of removal of a temporary restoration and replacement with a definitive one remains crucial.

Endodontic therapy is a viable and successful option to save a natural tooth. Research has demonstrated that the coronal seal, both temporary and permanent, is one of the most crucial factors in achieving a successful treatment outcome. There are many alternatives for temporary restorations, and correct placement is important to ensure the long-term success of treatment.

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ATRAUMATIC EXTRACTION
Physics Forceps
...in my opinion, socket preservation should be standard of care.”

“...all dentists should accomplish this simple technique of socket grafting.”

“...especially important in areas of the mouth where shrinkage of bone and soft tissue will not allow implant placement.”
Dr Christensen’s Summary

• To answer your question, socket grafting is not yet the “standard of care” but in my opinion, it certainly should be, at least in the smile zone.

• I suggest all dentists should do the simple technique of socket grafting where shrinkage should not allow adequate implant placement or would lead to an unsightly pontic.
Without Grafting

• Soft tissue infiltration
• 30-60% potential bone loss in 2-3 years
• Loss of height and width of ridge
• May predispose the need for later grafting
• The overhead cost of grafting material and related products is high. If it is cost prohibitive for the patient and the whole idea is to keep epithilium from invading the socket at least a $10 collagen plug and gel foam sutured into place will minimize soft tissue infiltration.
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* In Development

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Why you need good x-rays
Look What Happened At the Dentist’s Office
Coronectomy is an effective strategy for treating impacted third molars in close proximity to the inferior alveolar nerve


Stacy Ceisler, DDS, PhD

Systematic review conclusion. Coronectomy of an impacted mandibular third molar with a high risk of experiencing nerve injury is less likely to cause damage to the inferior alveolar nerve than is complete extraction of the third molar.

Critical summary assessment. Evidence suggests that coronectomy is a good option for patients at risk of experiencing inferior alveolar nerve injury but is technique sensitive and not without complications.

Evidence quality rating. Good

Clinical question. Among patients at high risk of experiencing inferior alveolar nerve injury due to removal of an impacted mandibular third molar, does coronectomy decrease risk of nerve injury or other complications such as infection in comparison with complete removal of the tooth?

Review methods. The authors independently and in duplicate assessed the 38 studies identified through a systematic review. The authors included in the review only studies involving defined high risk of nerve injury as measured by means of radiography. The authors identified 38 studies with their search strategies, however, only four met all inclusion criteria. Of the four studies included in the meta-analysis, two were randomized controlled clinical trials and two were case series with no randomization.

Main results. Frequency of nerve injury among those undergoing complete removal of the impacted third molar varied among the four studies; however, results from all studies demonstrated a strongly protective effect for those undergoing coronectomy. For example, pooled results from the four studies demonstrated only two nerve injuries for the coronectomy group (total of 401 mandibular third molars) as compared with 42 reported events for the complete-removal group (total of 549 mandibular third molars). Thus, risk of nerve injury was significantly reduced for patients who underwent coronectomy as compared with complete removal of teeth structures (RR, 0.11; 95% CI, 0.03-0.44).
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FIGURE 14-43  Penetration Site for VA Nerve Blocks. The penetration site for VA nerve blocks is indicated by the needle.
3. In cases in which the OAC had persisted for some time and an organized fistula had developed between the maxillary sinus and oral cavity, the fistula was excised and inverted as an inner layer, followed by the expansion of the \( \text{BFP} \) as described.

4. When the \( \text{BFP} \) was used to close large defects after tumor resection, maximal mobilization of the flap was done, and the whole accessible \( \text{BFP} \) was engaged.

**Results**

The \( \text{BFP} \) for closure of an OAC was successfully engaged in 161 patients at our department. The maximal defect size was \( 56 \times 42 \text{ mm} \) after tumor resection. The surgical procedure was performed using local anesthesia in 107 patients and with the patient under general anesthesia in 54 patients. In 12 patients (7.5%), closure of the OAC was insufficient, and a second operation was necessary. Of these 12 patients, 3 had had large defects after tumor resection and 6 had had a chronic and complicating recurrent OAC after other attempts at closure. Excluding all severe and complicating cases, such as tumor-related defects or previously treated cases, the overall success rate for the closure of OAC was nearly 98%. The details of the evaluated complications are listed in Table 3.

The typical clinical course of the exposed \( \text{BFP} \) in the oral cavity was as follows (Figs 7-11). The surface turned from the typical fatty yellow to a paler yellow/white color after 3 to 4 days. Usually the surfaces became a lighter and lighter red after 1 week, and strong granulation was visible until the complete coverage of the fatty surface by newly formed re-epithelialized mucosa. The sometimes initially voluminous tissue showed continuous shrinkage and reached the normal mucosal level after 3 to 4 weeks. The depth of the vestibular sulcus increased continuously in almost all cases, and prosthetic rehabilitation was feasible in all cases. The 8 patients with pain persisting longer than 2 weeks or a limited mouth opening had a delayed healing progress, but were all 8 were free of any limitations at the end of the follow-up period. Mouth opening exercises and analgesics were prescribed to these patients.
been documented for reconstruction of the palatal region, buccal mucosa, closure of oronasal fistulas, coverage of the surface of bone grafts, and reconstruction after post-traumatic defects in the maxillary region. Since its first description in 1752 by Hister and in 1802 by Bichat, its potential clinical applications was hidden for almost 2 centuries. Today, the term "boule de Bichat" is still common in French reports, and within the German nomenclature the sole name "Bichat" is widely used to describe the BFP. Anatomically, it consists of a central body and 4 processes—the buccal, pterygoid, superficial, and deep temporal process. The buccal and deep temporal branches of the maxillary artery, transverse facial branches of the superficial temporal artery, and branches of the facial artery provide the blood supply. Each process has its own capsule and is anchored to the surrounding structures by ligaments. The possible function of the BFP include the prevention of negative pressure in newborns while suckling, separating the masticator muscles from one another and from the adjacent bony structures, enhancement of intermuscular motion, and the protection of neurovascular bundles. The buccal process is located superficially within the cheek and is partially responsible for the cheek contour. The BFP seems to
Trust in Providence.

"Preach the Gospel at all times, and when necessary use words."

-St. Francis of Assisi