Treatment Planning Board (EXAMPLE)

Patient: M(r,s) X, (Axium Number)
Student: YOUR NAME, GRU College of Dental Medicine

Patient introduction: M(r, s). X is a 64 year old Caucasian (fe)male from _____, Georgia.
Chief Concerns: *(State the patient's concerns as closely as possible in their own words. They can have as many concerns as they express, but they should focus on answering the questions "Why has the patient presented for treatment* **now***?)* "I want to get new partials and fix this broken crown" patient indicates #10.

History of Present Illness: *(This should describe the* ***history of the Chief Concerns****. If they are just concerned about large generalities that will be answered in other sections, no need to repeat here)*
Ms. X states that her grandson accidentally bumped her #8 with his head approximately 4 months ago and she has also chipped the existing crown on #10. When prompted, she admits #8 has also become more sensitive over the past few weeks, first to cold, then to pressure. Her existing maxillary and mandibular partials were fabricated at approximately 10 years ago at a private dentist in her home town. She has been satisfied with them, but they "seem much looser than they were when they were new."

Medical History: *(Review medical history in general, focusing on what will give a reader a clear picture of this patient's pertinent data. Review major surgery, asking if they had any trouble with anesthesia, and record the answer positive or negative. List all medications, what the patient is taking them for, and the dental implications.).*
Ms. X describes her general health as excellent. Her last physical was in December of 2007. She has been diagnosed with restless leg syndrome which occurs when sitting for long periods of time and is on medication for the condition. She also takes estrogen replacement. She does not use tobacco or alcohol, and has no reported allergies and no bleeding or heart problems. Ms. X had a hysterectomy in 1995 with no complications.

Medication:	**Pt taking for:**	**Dental implications:**
Ogen (Estropipate) 125mg	Estrogen replacement	None
Requip (Ropinirole) 0.5mg	Restless leg syndrome	Xerostomia or increased salivation

Review of Systems: Today blood pressure is _____ and pulse is _____. *(Take the BP, pulse)*

Dental History: *(Ascertain the patient's awareness of and interest in previous dental disease and treatment. Document existing dental treatment and evaluate patient's history with existing endodontic therapy and appliances.)* Ms. X has been visiting her local dentist approximately every year until two years ago when he retired. She did not like the other dentist who was approximately an hour away, and a friend recommended she visit the dental school. She values her remaining teeth and approximately 10 years ago committed to significant endo and fixed treatment. She states she tends to avoid many foods because of difficulty chewing.

- Extractions/Missing: 1-3, 7, 13-16, 17-19, 21, 30-32. *(Attempt to determine when and why teeth were lost. Caries? Periodontal disease?)* Teeth were lost when the patient was in her teens and

early 20's. She states she "used to just drink soda all day long and my family couldn't afford to go to the dentist so they just pulled them." No teeth have been lost in the past 20+ years.

- Direct Restorations: 23 and 27 DL composite
- Indirect Restoration: PFM FPD 4-6, 8-9 (with 7 cantilevered), PFM crown 10, 20, 22, 28, 29. Treatment completed approximately 10 years ago. Current partials are loose when pressure applied to edentulous area, especially the mandibular RPD.
- Endodontically treated: *(Evaluate radiographically and clinically with percussion and palpation. Obtain a history to determine if patient has a history of pain to pressure, movement, or any sinus tract, purulence)*. NSRCT 28, 29. Pt remembers treatment completed approximately 10 years ago and denies any pain with biting, movement, or pressure.
- Esthetic Concerns: *(Evaluate the patient's smile line and lightly mark it on the study casts. Photos are strongly encouraged if any anterior restorations are contemplated. Note any existing margins and determine, tactfully, if patient would be interested in having restorations replaced. Always consider feasibility of vital bleaching since once restorations are done, the shade cannot be matched. However, if patient already has a number of direct restorations, consider that they will not change shade and may look worse if teeth are bleached. Patient must be advised of these options.)* Although the existing PFM crowns have unesthetic exposed margins, the patient's smile line does not expose them, and she is not interested in replacing them due to finances. However, they are a full two shades lighter than the uncrowned #11, 12 (B3 vs B1) and the patient is very interested in bleaching those two teeth to even the shades. She is resigned to the appearance of the existing RPD clasps and is not interested in placement of implants.
- Previous Removable History*: (if appropriate, ask if they have ever worn any appliances in the past, what kind, and how they did with them. In this case, it was covered in the History of Present Illness, so no need to repeat it here.)*

Dental Examination:

- Head and Neck Exam-Within normal limits *or note any findings, including bony excrescences like tori*
- TMD Exam- *List maximum stretch opening, passive opening, right and left lateral movements and protrusive movements. Note any findings in range of motion, pain, tenderness, joint sounds*
  The TMD screening exam showed that Ms. X has a maximum stretch opening of 57 mm with a passive stretch of approximately 2 mm. The patient had 10 mm maximum right lateral movement, 5mm maximum left lateral movement, and 7 mm maximum protrusive movement. There were asymptomatic joint sounds present for the right joint and no joint sounds present in the left TMJ upon opening and closing. There was no discomfort during opening or closing. The patient's mandibular direction during opening was deflected to the left. No pain was present upon palpation.
- Occlusal exam: Skeletal Class I occlusion. *Note any occlusal findings that are outside of normal occlusion: uneven occlusal plane, supraerupted or tipped teeth, teeth out of arch alignment, open bite or deep bite, crossbite, fremitus or mobility from occlusion. Mounted casts are usually advised.*
  At the occlusion screening exam, it was determined that CR equals MI. Vertical overlap = 2mm, Horizontal Overlap = 2 mm, IOD 2-4mm.
    - Right- group function with non-working contacts on 12-20

    - Left- group function with no non-working contacts.
    - Protrusive- immediate posterior disclusion
- Caries: *(List teeth with caries and location)* Secondary caries was noted on 20 under crown margins.
- Pulp status. *(Consider testing the pulpal status of teeth with crowns, deep restorations, unexpected discoloration, or any history of trauma with Endo-Ice, as well as a comparison tooth (usually the contralateral tooth. If you are considering teeth as abutments for fixed or removable appliances, consider pulp testing them as well)* Endo Ice test gave normal response on, #9, 20, 22, 7, 28, but no response on #8. Percussion normal on all listed teeth except #8 which is sensitive to percussion and palpation. *(There is no need to test all teeth in the quadrant unless you are evaluating referred pain.)*
- Periodontal findings:
    - Probing depths recorded in Axium. *No attachment loss > 4 mm or* Noted attachment loss 4-5 mm #20, 27, 28.
    - Gingival Index ____ Plaque Index ____ *Record the most recent data*
    - Other Periodontal information: *(Consider any teeth that might be abutment teeth for FPD or RPD- note areas of inadequate zone of attached gingiva, frenum pull or other periodontal consideration associated with restorative care.)*
- Caries Risk Assessment Findings: *(Evaluate findings of CRA form and determine, if patient has current active caries, what is the source of the caries, what you have already advised the patient, and how they have responded to your counseling.)* Patient's diet and oral hygiene habits are not caries promoting. Patient is exposed to three fluoride exposures per day. However, as patient is now caries active, will continue to monitor patient for possible dry mouth from medications.
- Radiographs: *(Review key findings from radiographic interpretation)* Patient presents with TMJ joint, nasal cavity, and maxillary sinus within normal limits as well as normal trabecular densities in the maxilla and the mandible. Generalized mild horizontal bone loss with localized moderate to severe horizontal bone loss in mandibular was seen. Generalized mild horizontal bone loss was seen in maxillary arch. No caries present. Radiograph #8 shows possible periapical radiolucency.

Diagnostic Summary: *(Start with your risk assessment of the three major disease processes, then sum up the patient's overall diagnoses by category [MOREPOOOPE]. All treatment should be justified by this diagnostic summary.)*

- Risk Assessment:
    - Oral Cancer- Low to moderate. Patient is 64 years old, but does not use tobacco or alcohol.
    - Caries- Mod Risk with current active root caries
    - Periodontal Disease- Mod Risk
- Restorative- *(You have already listed specific teeth above, so no need to redo that here. This is an overview of disease processes.)* Root caries, attrition (generalized)
- Endodontic- #8 Non-vital pulp, periapical abscess without sinus
- Periodontal- Generalized Moderate Chronic Periodontitis with Localized Severe Chronic Periodontitis, gingival recession leaving inadequate zone of attached gingiva for RPD clasp.
- Prosthodontics- No posterior support, Partial edentulism maxillary and mandibular (Kennedy Class I on mandibular and maxillary)
- Esthetic- Discolored teeth (post eruptive)

Treatment Overview*: (A statement of your general plan of treatment taking into account the findings and the patient's situation (health, desires, and financial resources). This is to help those who read the treatment plan know what direction you chose and why at the major decision points of the case. Examples: Prosthetics- Implant vs. Fixed vs. Removable, Perio- conservative vs surgical therapy. Identify any "key teeth" – those teeth with diagnostic decisions on which future decisions hinge- and identify alternative treatment plans will be based on decisions on those teeth. Make sure all of your diagnoses are addressed in the treatment overview. Textbook "Treatment Planning in Dentistry" by Stefanac and Nesbit has many helpful sections that will answer real-world questions.*

The primary objective is to satisfy the patient's chief complaint: "Want to get new partials and fix this broken crown." As #8 is non-vital, it will be referred to Endo for non-surgical root canal treatment through the existing crown. Periodontal therapy will be started with scaling and root planing in lower quadrants per perio plan. Caries on crown margin #20 will be repaired if possible. Phase 3 plan consists of remaking lower partial denture.

- **Previous treatment**. Prior to Treatment Planning Board, the following treatment has already been performed:

  Perio- D0180 evaluation, D1110

  Preventive Plan implemented to date:
  - **Caries:** To address patient's mod risk, patient has been aware that her current medications have probably increased her risk for future caries, and patient has been advised to watch her diet for sources of simple carbohydrates. Recommended use of 1200 ppm toothpaste 3x per day with no rinsing, and use of 0.05% NaF rinse at bedtime, use of xylitol gum 3x per day.
  - **Periodontal:** Oral hygiene instructions focused on sulcular brushing technique in areas of pocketing. Added Proxy-brush dipped in Listerine to areas where interproximals open.
- **Phase 1.** *(Consider all treatment, evaluations needed in order to answer key questions in the treatment plan in addition to urgent care to relieve pain, biopsy suspicious lesions, and meet interim esthetic needs. Examples: determine restorability of a carious tooth, determine direction of perio treatment with D0180, esthetic evaluation if significant anterior restorations are contemplated, determine if an implant is feasible.)*

  Consultations Planned:
  - Endodontic consult. Probable non-vital pulp with periapical inflammation #8.
  - An oral surgery consult will be needed if implants are chosen as a treatment.

  If #10 is deemed not salvageable, treatment options will include inclusion of #10 on RPD, implant, cantilever FPD 11-10. If salvageable endodontically, patient understands the crown will need to be replaced as repair of porcelain is not predictable.

Phase 2. *(In addition to overall disease control, consider how treatment will be sequenced. Make clear those treatments that can occur concurrently and those that must be done sequentially. List direct restorations in the order in which you plan to perform the care, and state why (deepest first, usually; if you deviate from this, give your rationale. List material choices and, briefly, why chosen. For example, "restorations of #x, y, z will be done with composite as they are planned to be prepared for rest seats for RPD" or "#a will be amalgam as it is a large cusp coverage restoration in an unesthetic area which will be in high function.").*

- Deliver vital bleach trays, achieve best shade match. As no treatment is planned on those teeth, other treatment can progress concurrently.

- Actively treat and control the carious disease process. As patient has lost salivary flow, will prescribe 5000ppm Fluoride toothpaste and advise use of xylitol, as well as scrutinizing diet for possible sources of unrecognized simple carbohydrates. Perform direct restoration #20 with RMGI for fluoride release on root surface. Restore access prep #8 with composite.
- Continue treatment of periodontal disease- scaling and root planing will be performed on lower quadrants to remove accessible bacterial plaque/calculus and resolve gingival inflammation. After evaluation of healing and hygiene, will evaluate for connective tissue grafts on #20 & 28 and refer if advisable.

Re-Evaluation prior to corrective phase, a D0003 examination (and D0120 if indicated) will be done where control of caries and periodontal disease will be evaluated with updated CRA, radiographs, periodontal evaluation as indicated. Reinforce to patient that continuation of control of disease processes by patient lifestyle and hygiene activities, will predict success of Phase 3.

Phase 3. *(First, decide if missing teeth need to be replaced- not all do. Patients can do well with first molar occlusion, or if the patient has relatively weak biting force [smaller, older patients] second premolar occlusion. Then your decision is Implant vs Fixed vs Removable.*

Replace missing teeth to provide the patient with increased chewing efficiency, enhanced esthetics and stability of the dental arches. This will be accomplished with removable partial dentures as patient is not interested in implants. Existing crowns appear adequate for support of RPD's.

Maintenance. *(Justify your recall schedule and explain what you will do at each appointment. It is permissible to coordinate caries and perio recalls, however, just determine which the greater risk is and select that regime.)*

- Caries Disease Control: Patient placed on 3-month recall for F varnish placement, review of diet, Rx for 5000 ppm F toothpaste, dental exam. Radiographs every 12 months for remineralization evaluation, caries assessment.
- Periodontal Disease Control: As patient is on a 3 month recall for caries, will also do Prophy q months unless clinical situation justifies modification to q 6 months.
- Prosthetic Maintenance: Every appt will check fit and stability of RPDs. Homecare for RPDs will be reinforced.

Alternative Treatment Options. *(There is seldom only one feasible way to treat a patient. While you have articulated why you have chosen what you think is the best way to treat them, where there are other options you are considering (and there should be!!!), list them and explain your rationale. In the process of developing alternative treatment option fees, feel free to create as many alternative Phase III plans in axiUm as you wish in order to the patient the various pricing option- as long as they are rational, feasible plans. There is no need to print out hard copies, however.)*

Implant supported Mandibular RPD. Although patient states she is not interested in implants, when I mentioned that two implants (a single implant on each mandibular edentulous ridge) could stabilize her lower RPD and increase her chewing efficiency, the patient became somewhat interested in learning more. However, there is some resorption of the residual ridge width even though there is enough length on the pan; she would not be interested in bone grafting. One of the goals of Tx Planning Board is preliminary evaluation of feasibility of implants. If so, she states she "might ask my daughter if she could help me out."

All implant fixed option. Discussed option of replacing missing teeth with single tooth implants to first molar occlusion. Patient does not feel she can afford this option, but consideration will be given, if she

chooses the implant supported option, that placement of implants may be converted to fixed crowns in the future.