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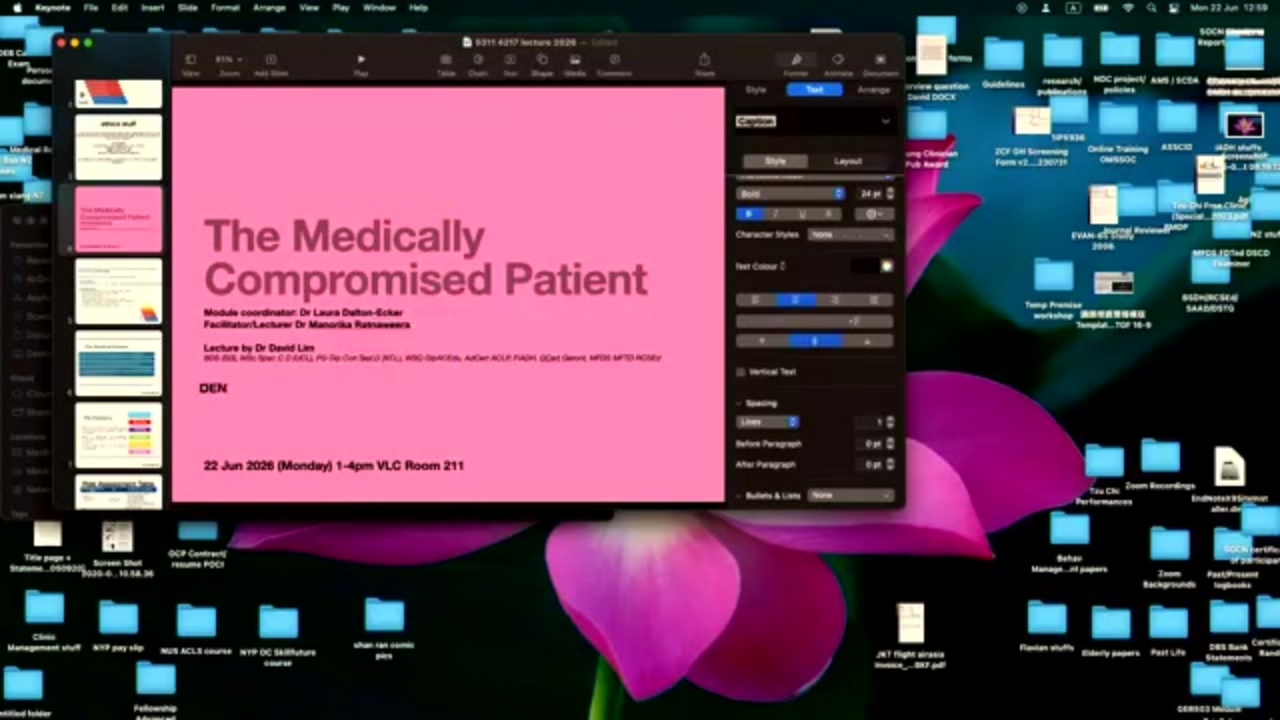
The Medically Compromised Patient

Module coordinator: Dr Laura Dalton-Ecker
Facilitator/Lecturer Dr Manorika Ratnaweera

Lecture by Dr David Lim
BDS (SG), MSc Spec C D (UCL), PG Dip Con Sed D (KCL), WSQ DipACEdu, AdCert ACLP, FIADH, GCert Geront, MFDS MFTD RCSEd

22 Jun 2026 (Monday) 1-4pm VLC Room 211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DENT5311

22 Jun 2026 (Monday) 1-4pm VLC Room 211

DMD3 Tutorial on Monday, June 22 at 1:00-4:00 PM in the VLC (Room 211) covering the topic of **The Medically Compromised Patient.**

What students need to bring and use - papers/pens (brain storm), laptops.

Learning Objective

1. Formulate a medical category - risk assessment - modification table for medically compromised patien

Lesson plan(Gagne 9):

1. Gain Attention, Inform Obj, Prior Knowledge (10min, 1300pm)
2. Present information, provide guidance (10min)
3. Elicit performance (30min)
4. Form up in 6 groups (5-6pax), 25 min to prep 1 question.
5. Use paper/chat GPT/google. create a 8min ppt with 2-3min Q&A
6. All 6 grps present (60min), assess performance
7. Remind to use during Clinics. enhance retention (end ~1500+pm)

The Medical History

- Look at the Systems that are compromised – stable vs unstable
- Look at the medications – dosages, frequency and conditions its used for
- Look at the dental treatment modifications that are required
- Prioritize the medical history in relation to its impact on dental procedure
- Any medical consult requirements?

From Dr Lydia See

The Dentistry

- What is it about the dentistry that is going to impact the overall systemic health of the patient?
- What is it about the overall systemic health that is going to impact on the dentistry?
- Are we doing invasive vs. non-invasive procedures?

Bacteraemia

Bleeding

Healing

Anxiety

Positioning

Consent

From Dr Lydia See

Risk Assessment Table

Medical categories and others	Risk	Modifications / Implications
Respiratory - Severe asthma - inhaler use	Asthmatic attack Poor healing	• Bring inhaler, prophylactic dose • Avoid triggers (cold/dust) • Late morning appointment • Supplementary oxygen? • Drug Px:? steroid use, theophylline may be potentiated by liver enzyme blockers
Cardiac - Valvular repair (patient unsure) - PFO - HTN	MI Stroke, DVT I.E. AB Prophy	confirm cardiac history Warfarin, INR check(therapeutic INR ~2.5), morning appointments, haemostat measures, consent If require AB cover Other related medications e.g. Beta Blocker CCB, ACE Inh etc
Social - Financial constraints - Smoking	Poor attendance Treatment option limits	• Referral for social assistance/ charitable dental service p.r.n. • Smoking cessation
Others - Rheumatoid arthritis - Visual impairment - Anxiety (generalised)	Fall risk	• Barrier free access, fall prevention • Dental Behavioural Support

Clinical Scenario

A 63 year old man came into the clinic with a painful upper right wisdom tooth. It affects his eating and sleeping. He has not seen the dentist for around 10 years due to dental anxiety.

Medical History

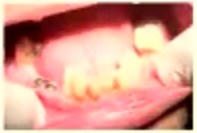
- Asthma. Poorly controlled with exacerbations almost every 2 weeks, and admission to hospital 1-3 times annually. Not all attacks are subdued with salbutamol inhaler. No known triggers, although cold air and dust are reported to possibly worsen it. Does not regularly follow up with physician.
- Mild dental anxiety - mainly to sound of ultrasonic and handpieces
- Rheumatoid arthritis with left knee swollen
- Reduced BMI
- Smokes ~ 5 cigarettes a day now, cut down from ~ 20 sticks a day 20 years ago
- History of cataract surgery on right eye, with some residual visual impairment

Medications

- Salbutamol 200mcg inhaler
- Fluticasone 500mcg with Salmeterol 50mcg inhaler
- Lignosus rhinocerus (traditional Chinese tonic, 虎乳芝)

Dental History

- Uses an acrylic partial upper denture fabricated over 10 years ago that overlays retained
- Brushes once a day only
- Does not clean/brush denture



Social History

- Low socio-economic status
- Works as a security officer with varying shifts in the morning and overnight
- Divorced, lives alone

Oral examination

- Upper left wisdom tooth with caries into pulp
- Poor oral hygiene
- Rampant caries with other retained roots (see **Figure 1.27.1- Picture of caries / retained roots in a patient with severe asthma**)
- Oral candidiasis on upper palate
- Upper denture with dried debris on fitting and smooth surfaces.

What are your treatment considerations briefly? Can you treat the pain today?

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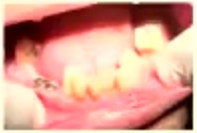

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- Upper denture with dried debris on fitting and smooth surfaces.

What are your treatment considerations briefly? Can you treat the pain today?

- The tooth extraction should be completed today. Despite assessed to be moderate to high risk, attenuating the specific risks and possessing emergency preparedness are key.
- He will require further fillings, extractions and partial dentures in the future. Dental health education is also important.

CHAPTER 16.4: BARIATRIC PATIENTS

Clinical Scenario

A 55 year old female presents to you complaining of pain in an upper left first molar tooth.

Medical History

- Raised BMI of 46.9 kg/m2 (174cm, 142kg)
- Major Depressive Disorder
- Dental anxiety
- Asthma, well controlled and on follow-up
- Hypertension
- Diabetes mellitus
- Hypercholesterolaemia
- Ischaemic heart disease - controlled angina
- Sleep apnoea: Continuous Positive Airway Pressure (CPAP) device used at night
- GORD
- Osteoarthritis
- Generalised musculoskeletal pain

Medications

- Aspirin
- Glyceryl Trinitrate (GTN) inhaler
- Amlodipine
- Atenolol
- Atorvastatin
- Lansoprazole
- Metformin
- Corticosteroid inhaler
- Salbutamol inhaler

Dental History

- Irregular attender, previous visit over 5 years ago
- Snacks on cakes and biscuits between meals with 10 sweetened beverages daily
- Brushes twice a day with fluoridated toothpaste but unable to reach upper posterior teeth
- Dental anxiety associated with injections and drilling sensation / sounds; avoids fillings and prefers dental extractions
- No history of dental sedation or GA for dental treatment

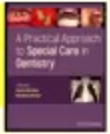
Social History

- Divorced and lives alone
- Has two sons who are married and live separately
- Rarely leaves her home
- No consumption of tobacco, alcohol or recreational drugs
- Requires hospital transport to attend appointments
- Mobility: although able to stand for short periods, using a bariatric wheelchair to attend hospital appointments

Oral examination

- Poor visualisation of the mouth due to extensive adipose tissue intra-orally limiting visual access to the posterior teeth
- Generalised soft deposits and food debris
- Generalised gingival inflammation
- Partially edentate
- Food packing between the UL6 and UL7
- Caries: UL6 distal; tender on palpation; grade 1 mobile
- Generalised tooth surface loss (erosion)

1. Create a Medical Category - Risk Assessment - Modifications table.
2. What additional factors do you have to consider when undertaking a risk assessment of this patient
3. The patient consent to extraction of the carious upper left first molar. How would you modify the delivery of dental treatment?
4. Criteria for referring the Bariatric patients. How is ASA grading for them like?



Clinical Scenario

An 80 year old lady was admitted via a trolley bed from the wards. She was assessed by a physician and has a mobile lower incisor indicated for removal in view of aspiration risk.

Medical History

- Severe Multi-infarct (vascular) dementia - fluctuating consciousness between stupor and hypersomnia. Bedridden. Double incontinence.
- Aspiration pneumonia, hospitalised over 2 incidents over the past 2 months.
- Thromboembolic stroke, Right Middle Cerebral Artery stroke 3 years ago.
- Ischaemic heart disease
- Severe dysphagia- nasogastric tube fed. nil-by-mouth
- History of laryngeal carcinoma in 1994 treated with Conventional radiotherapy (70 Gys 33 Fractions)
- Methicillin-resistant Staphylococcus aureus (MRSA) positive
- Hypertension

Medications

- Omeprazole
- Plavix (clopidogrel)
- Timolol
- Neurobion
- Vitamin D and calcium supplements

1. Create a Medical Category - Risk Assessment - Modifications table.
2. What medical disorders/conditions are associated with end-of-life care?
3. The patient consent to extraction of the carious upper left first molar. How would you modify the delivery of dental treatment?
4. Criteria for referring the Bariatric patients. How is ASA grading for them like?

Dental History

- Has not received oral hygiene assistance at the long-term care facility over the past year
- Nasogastric tube fed for 2 years (nil-by-mouth)
- Constantly grinds and mouth breathes almost entirely

Social History

- Chinese ethnicity
- Stays in a hospice and is bedridden
- Arrived by arranged transport from hospice
- Husband is the main caregiver and next-of-kin

Oral Examination

- Challenging behaviour during examination
- Trismus affecting ability to visualise palatal and lingual surfaces
- Mobile lower right central incisor
- Uncontrolled bruxism and clenching
- Dry secretions on tooth surfaces and palate (Figure 16.6.1 and Figure 16.6.2)

1. What other issues and concerns is end of life care often associated with?

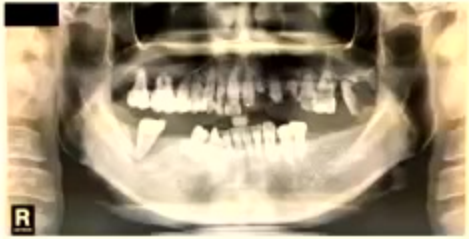
CHAPTER 26. Chronic obstructive pulmonary disease

SECTION I

Clinical Scenario
A 67 year old man turned up at the charity clinic that you volunteer at. He complains of "weakening" and "crumbling" teeth.

Medical History:

- Chronic Obstructive Pulmonary Disease - irregular in medical follow-up
  - FEV1, or forced expiratory volume in 1 sec, was 38% of normal predicted. Recent chest x-rays showed flattened diaphragm.
  - SpO2 is 93% on room air, heart rate 94/min
  - Respiratory rate is 24 per minute and shallow
  - Dry hacking non-productive cough, pitting oedema
- Hypertension ~152/85
- Hyperlipidaemia
- Asthma
- Others: Ex-smoker with 70 pack-year cigarette history, reduced BMI



Medication

- Prednisolone 10mg
- Ipratropium bromide + albuterol sulfate combination inhaler
- Salbutamol inhaler
- Simvastatin
- Enalapril

Dental History

- Brushes once a day with manual toothbrush
- Irregular dental attender
- Does not use interdental brushing aid

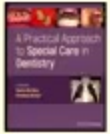
Social History

- Works at the local hawker centre for almost 50 years, exposure to long-term inhalation of smoke (see **Figure 1.26.1**)
- Hokkien-speaking (a type of Mandarin dialect)
- Smoked for 50 years, around 1.5 pack a day. Quit smoking 2 years ago, reportedly due to rising tobacco tax and physician advice
- Receiving social assistance
- Stays with wife, has two married children who visit infrequently

Oral Examination

- Prolonged oral health neglect
- Multiple interproximal caries
- Erosion lesions and root caries

1. Create a Medical Category - Risk Assessment - Modifications table.
2. How do you assess the severity of the patient's COPD
3. What are the treatment options for managing multiple caries & high caries risk?
4. What other factors do you need to consider that can affect treatment success?



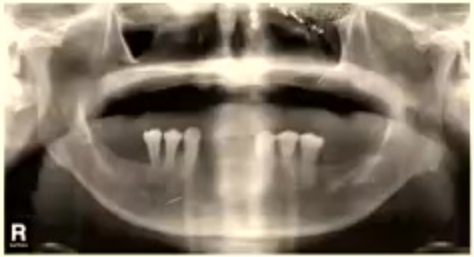
CHAPTER 59. HOMELESSNESS

CLINICAL SCENARIO

You received a referral letter from the local prison service regarding a 64 year old man emplaced on a "Mandatory Aftercare Scheme" for ex-offenders. He has multiple medical conditions, unemployed, and is currently homeless. He is referred to exclude dental causes of recurrent sinusitis.

Medical History

- Hepatitis C on half yearly follow-up
- Latent tuberculosis
- Chronic obstructive pulmonary disease
- Mild asthma
- Chronic sinusitis and allergic rhinitis
- Gastric reflux - undergoing medical follow-up
- Others: renal cyst, benign prostate hypertrophy
- H/O: four surgical repair of oral antral fistula,
- previous injecting drug user, ex-smoker, heavy alcohol use



Medications

- Omeprazole
- Salbutamol inhaler (200mcg)
- Fluticasone inhaler twice daily
- Array of traditional Chinese tonics and herbs

Dental history

- Brushes once a day with hard toothbrush
- No comprehensive dental treatment for over a decade
- Irregular dental attender, visits only when symptoms arise
- Prison dental service provided extractions only
- Mouth breather, daily regurgitation of gastric contents

Social History

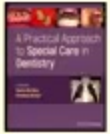
- Ex offender, released from prison 1 month ago
- Staying at the void deck of an estate, and moving to a "Halfway Home" after being picked up by community services
- Unemployed due to medical conditions
- Separated from wife for 20 years, have not contacted daughter over 10 years
- Distant relationship with siblings

Oral Examination

- Edentulous upper jaw with frictional keratosis and traumatised ridge from lower teeth
- Lower teeth with very poor periodontal health
- No obvious sinus tract was seen

Radiographs

1. Create a Medical Category - Risk Assessment - Modifications table.
2. What cross-infectivity steps would you take?
3. What other (non-medical) factors do you need to consider that can affect treatment success?



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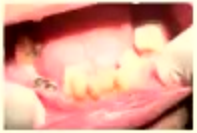

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- Works as a security officer with varying shifts in the morning and overnight
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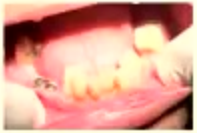

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- He will require further fillings, extractions and partial dentures in the future. Dental health education is also important.

Clinical Scenario

A 63-year-old male came into the clinic with a painful upper right wisdom tooth. It affects his eating and sleeping. He has not seen the dentist for around 10 years due to dental anxiety.

Medical History

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- Lignocaine /frimocaine (traditional Chinese tonic, 舒筋丸)

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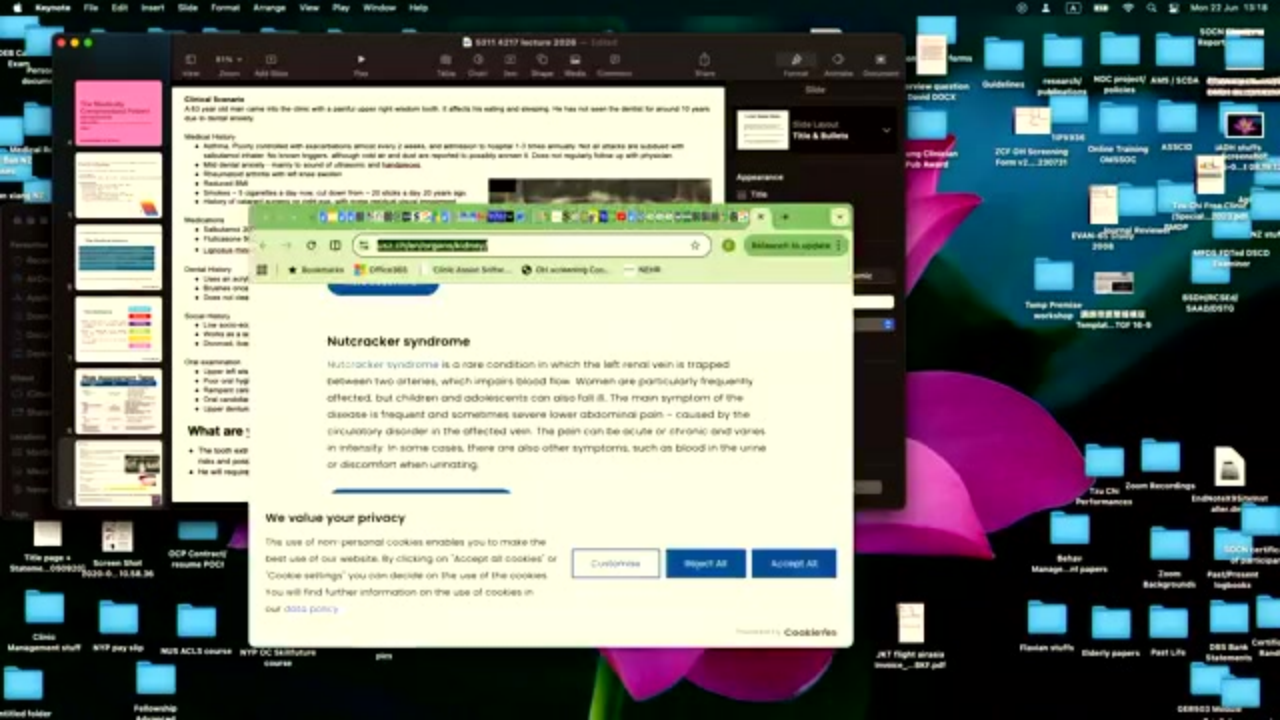
Nutcracker syndrome
Nutcracker syndrome is a rare condition in which the left renal vein is trapped between two arteries, which impairs blood flow. Women are particularly frequently affected, but children and adolescents can also fall ill. The main symptom of the disease is frequent and sometimes severe lower abdominal pain – caused by the circulatory disorder in the affected vein. The pain can be acute or chronic and varies in intensity. In some cases, there are also other symptoms, such as blood in the urine or discomfort when urinating.
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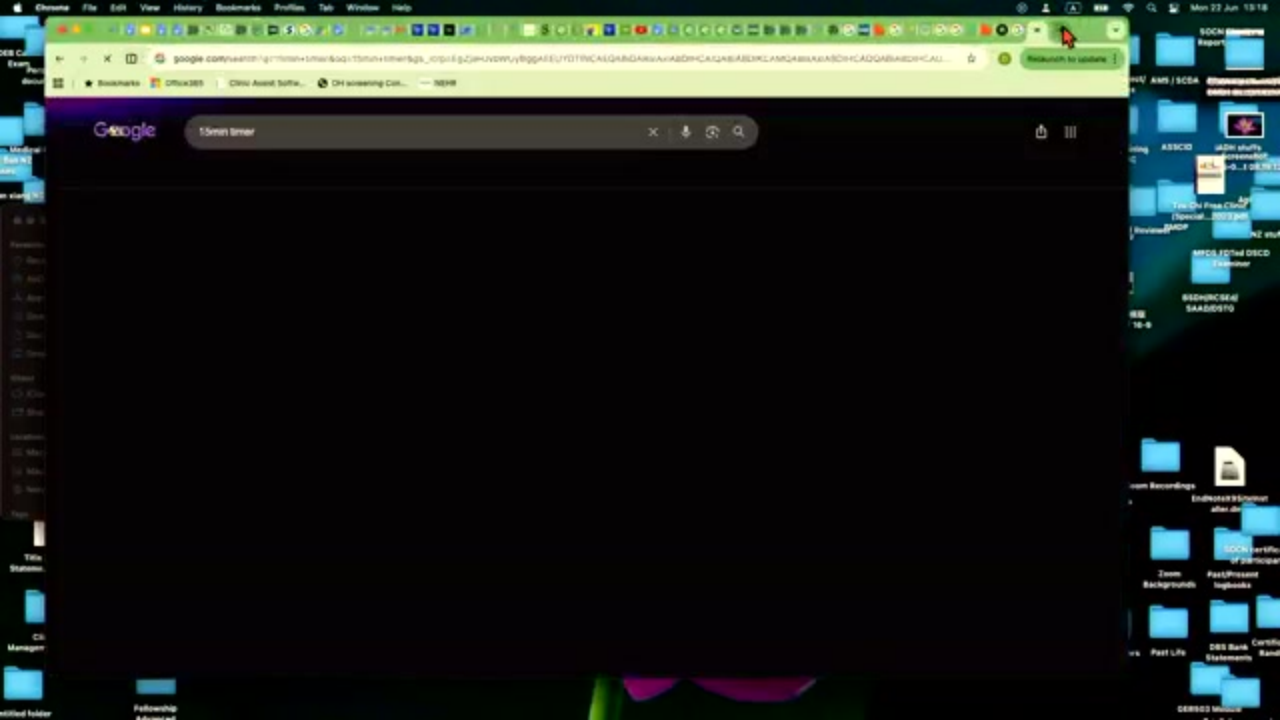
it is often diagnosed by chance. The main causes of chronic kidney disease include high blood pressure and diabetes. Although a complete cure is not possible, the progression of the disease can be slowed down with targeted measures. This includes an adapted diet, blood pressure-lowering medication and good blood sugar control. At an advanced stage, dialysis or a kidney transplant may be necessary.

Chronic renal insufficiency (kidney weakness, kidney failure)

In the case of renal insufficiency, the kidneys only work to a limited extent and can no longer filter the blood sufficiently to excrete metabolic waste products. Doctors distinguish between an acute and a chronic form. While acute kidney failure occurs suddenly, kidney function deteriorates gradually over a longer period of time in chronic kidney disease (CKD). In Switzerland, an estimated 10% of the adult population is affected.

> Chronic kidney failure treatment
> Treatment for acute renal insufficiency

Adrenal hypofunction (Addison's disease)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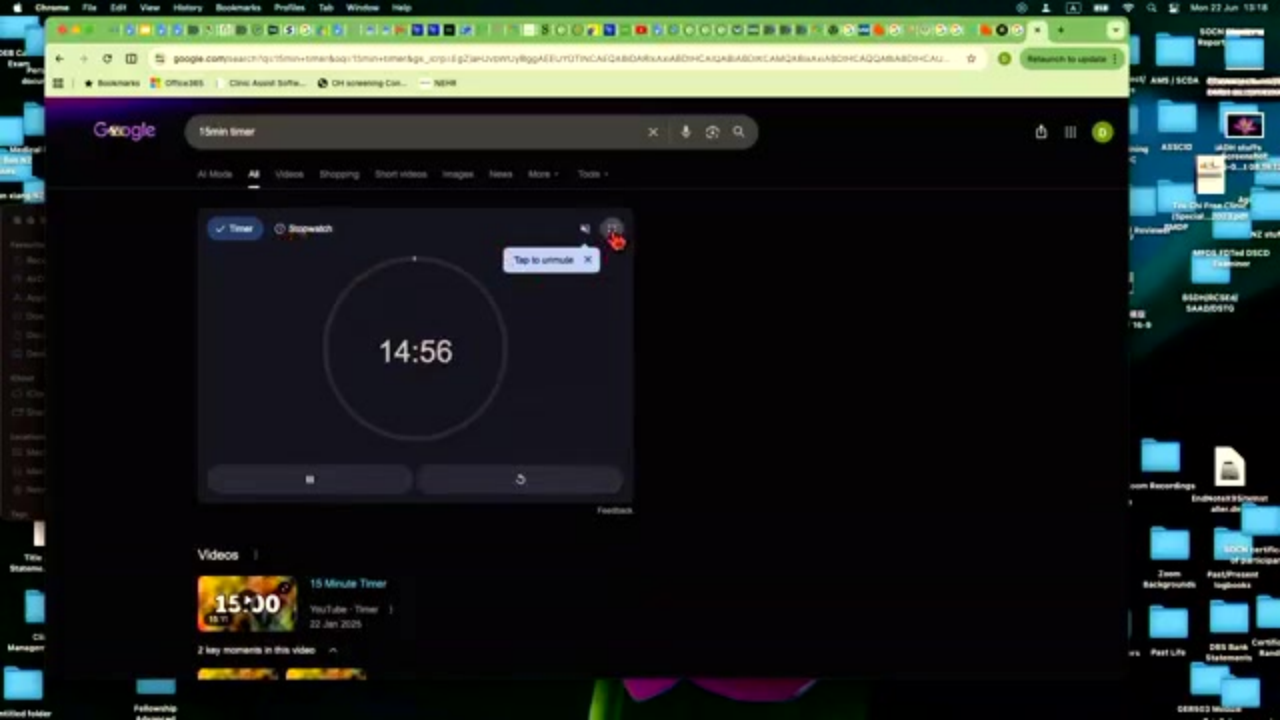
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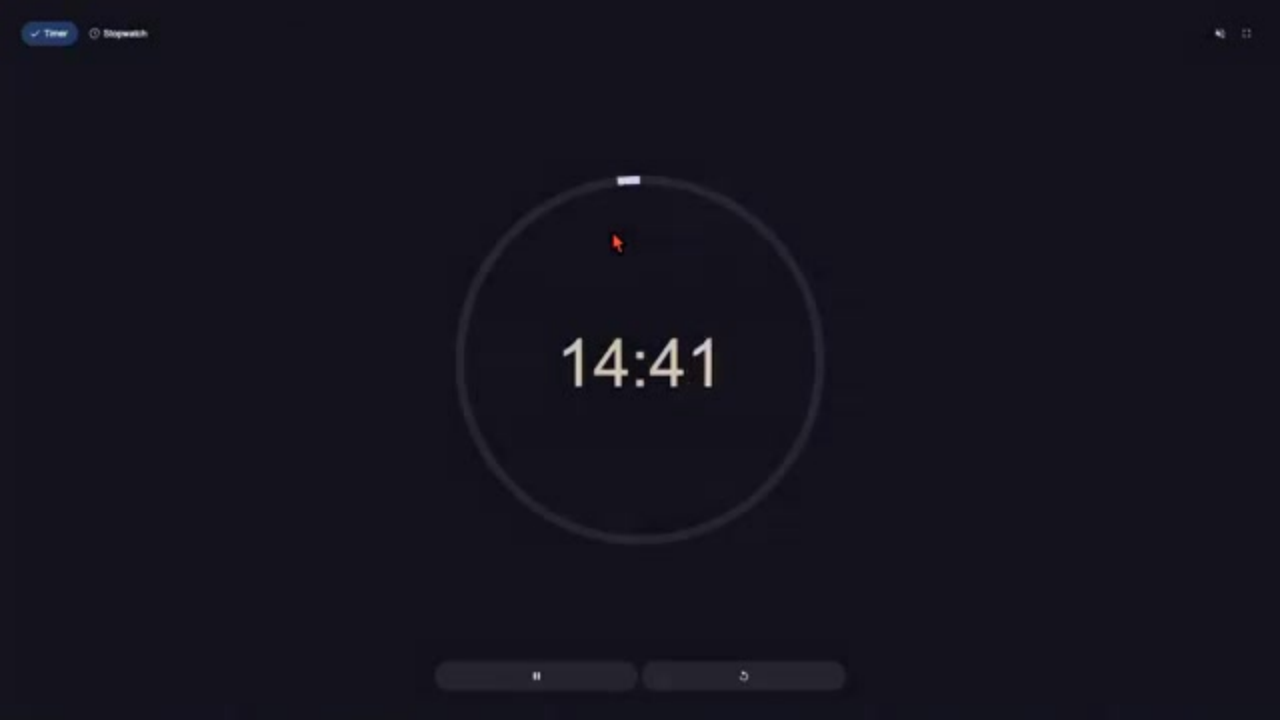
2 key moments in this video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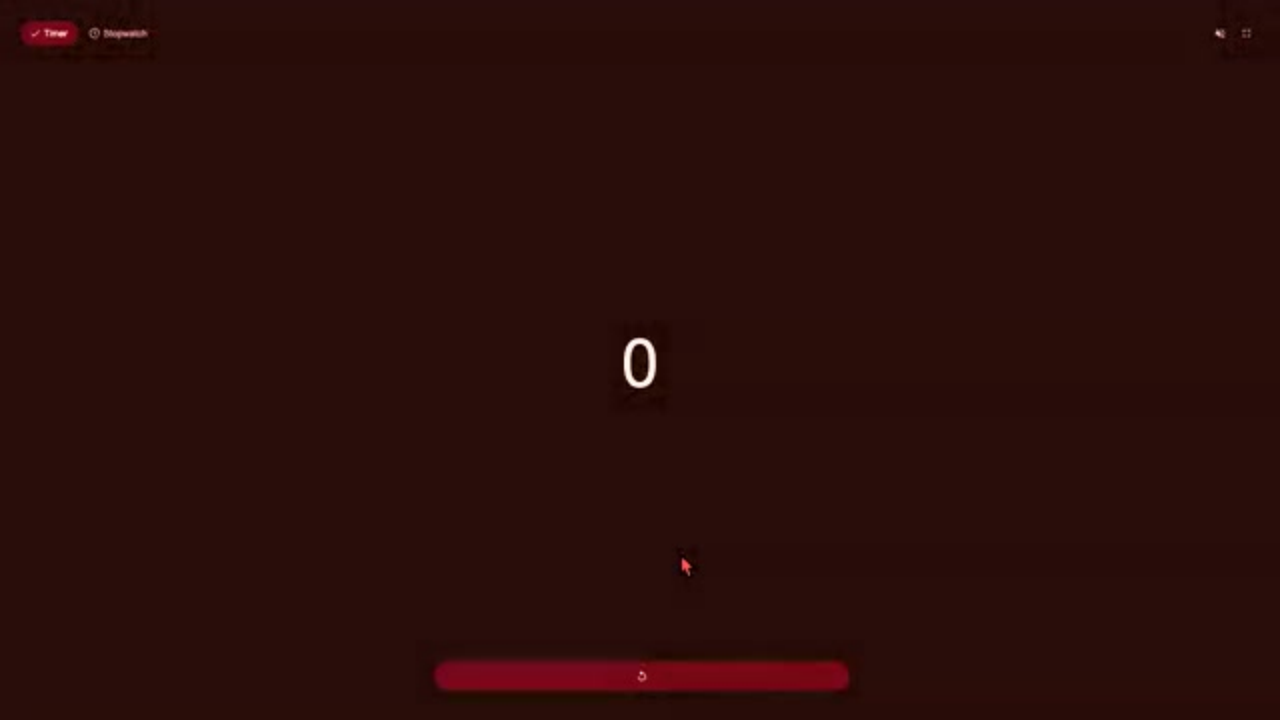
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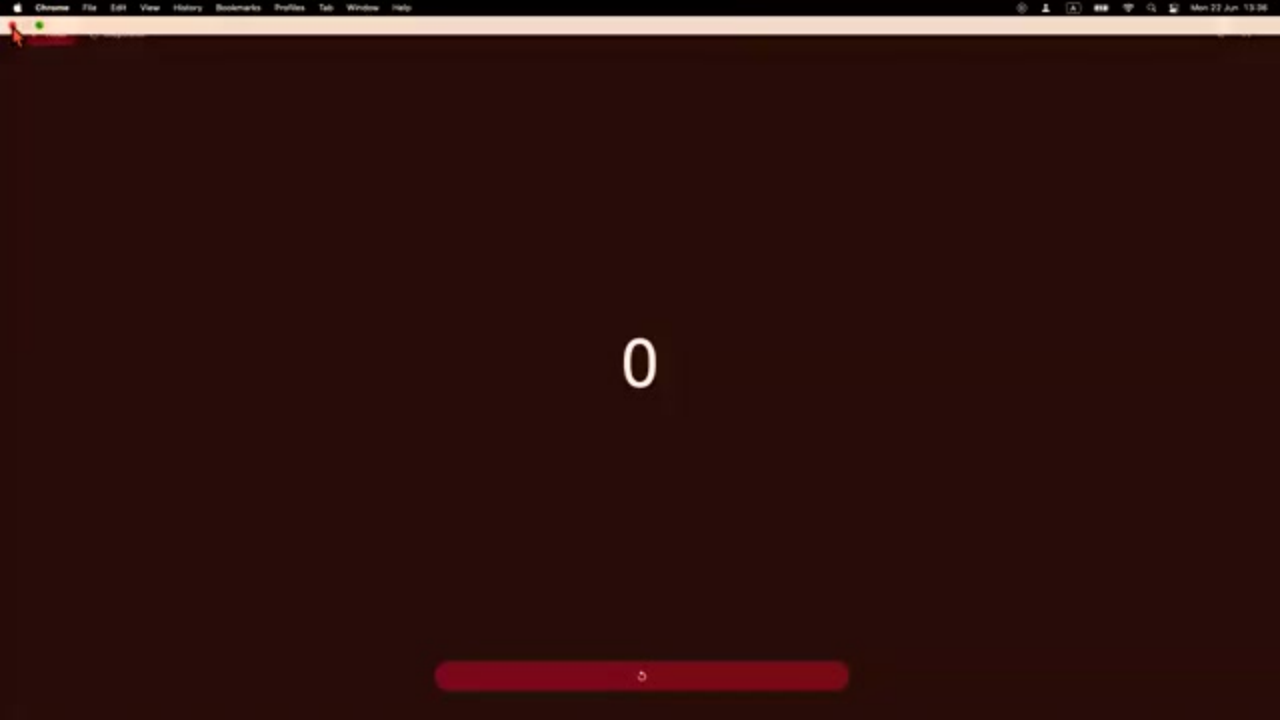
Extron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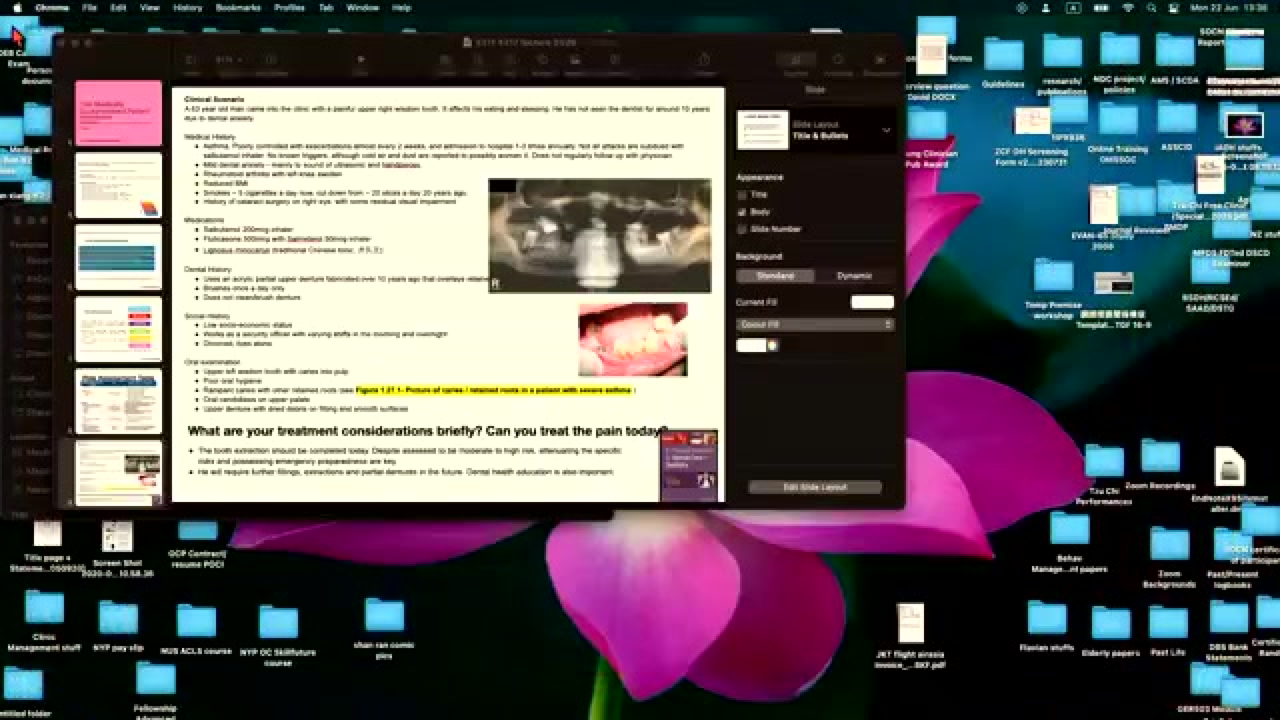
Clinical Scenario
Medical History
Medications
Dental History
Social History
Oral examination
What are your treatment considerations briefly? Can you treat the pain today?

Extron

Medical Categories and Others	Risk	Modifications and Implications
Respiratory • *Severe poorly controlled asthma with frequent exacerbations (every 2 weeks)* • *Admission to hospital 1-3 times a year* • *Salbutamol and steroid inhaler use*	• Acute asthma attack during treatment • Respiratory compromise • Delayed healing/increased infection risk from inhaled steroids	• Confirm current asthma control and last exacerbation • Bring salbutamol inhaler to appointment • Avoid triggers (cold air, dust, aerosols where possible) • Stress reduction protocol • Short morning or late-morning appointment • Monitor breathing throughout tx • Have emergency oxygen and asthma management kit available
Dental Anxiety	• Stress-induced asthma exacerbation • Poor cooperation • Avoidance of future treatment	• Tell-show-do behaviour • Good communication and reassurance • Consider
Rheumatoid Arthritis	• Reduced mobility • Difficulty maintaining oral hygiene • TMJ involvement possible	• Assess ability to perform oral hygiene • Consider modified oral hygiene aids (electric toothbrush) • comfortable chair positioning and support
Smoking (5 cigarettes a day)	• Delayed healing • Increased dry socket risk • Increased periodontal disease and caries risk	• Smoking cessation advice • Advise no smoking for at least 24-48 h post-extraction • Discuss impact on oral disease progression

Page 1 - Add page title

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Page 2 - Add page title

Changes seen

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Medical Categories and others	Risk	Modifications and Implications
Reduced BMI/ possible poor nutrition	• Reduced healing capacity • Inceased frailty	• Assess nutritional status • Provide postoperative dietary advice
Visual impairment	• Increased falls risk • Difficulty understanding written instructions	• Assist with mobility around clinic • Provide verbal and written snstructions in accessible format
Oral Candidiasis	• Oral discomfort • Ongoing fungal infection	• Treat oral candidiasis (eg, Miconazole) • Reinforce inhaler mouth rinsing after use • Dental hygiene instruction
Poor Oral Hygiene	• High caries risk • Periodontal disease progression • Recurrent infections	• Oral hygiene instructions • Denture cleaning education • Preventative programme(Fluoride, recalls)
Rampant caries and retained roots	• Multiple infection source • Future pain and abscess formation	• Comprehensive treatment plan required • Prioritise pain relief and infection control • Staged extractions/restorative care
Upper denture >10 years old with debris formation	• Denture stomatitis • Poor function and hygiene	• Denture assessment • Professional cleaning and possible replacement/reline

Medical Categories and others	Risk	Modifications and Implications
Social Factors • Low socioeconomic staus • Shift worker • Lives alone	• Irregular attendance • Financial barriers • Reduced postoperative support	• Prioritise urgent care today • Consider public dental services/[ayment options • Flexible appointment scheduling • Clear postoperative instructions
Emergency Extraction Today	• Moderate-high medical risk due to poorly controlled asthma	• Pain is affecting eating and sleeping, so extraction indicated today • Ensure asthma status stable on day of treatment • Emergency equipment available • Minimise stress and treatment time

Extron

Complex Geriatric & Special Care Dentistry

Strategic Risk Assessment and Palliative Modifications

Clinical Case Review

Respiratory & Neurological Risk

Respiratory

Risks: Recurrent aspiration pneumonia, severe dysphagia, nil by mouth (NG tube), reduced reserve.
Modifications: Semi-upright positioning, high-volume suction, gauze airway protection, avoid sedation.

Neuro-Cognitive

Risks: Severe dementia, fluctuating consciousness, challenging behavior, capacity issues.
Modifications: Consent from substitute decision maker,, keep treatment short/simple, mouth props (cautious), nursing support.

Cardiovascular & Bleeding Management

Cardiac

Risk: MI/Stroke.

Modification: use stress-reduction, limit adrenaline, and confirm medical stability with physician.

Antiplatelet

Clopidogrel (Plavix): Do not stop for simple extraction.

Modification: use local haemostatic measures (sutures, TXA).

Infectious

MRSA Positive: Risk: Cross infection, possible wound infection.

Modification: Strict contact precautions, treat at end of list, coordinate with ward infection control.

Radiation History & ORN Risk

History: 70 Gy for Laryngeal Carcinoma

- **Osteoradionecrosis (ORN):** Life-long risk in irradiated bone field.
- **Liaison Required:** Consult Oncology to map radiation field/maxilla dose.
- **Extraction Protocol:** Atraumatic, smooth bone edges, primary closure, close post-op review.
- **Supportive Care:** High fluoride and dry-mouth lubricants for radiation caries.

Frailty & Dependency Factors

Hospice / End-of-Life

Focus on **Comfort and Dignity**. Avoid elective complex care. Bedside treatment on trolley if safest.

Nutrition Dependence

Nasogastric tube fed.

Risk: Aspiration of debris, candida,

Modifications: assisted toothbrushing, moisturizing gels, avoiding rinses if swallowing is unsafe.

Palliative Care Dentistry

1. Common End-of-Life Medical Profiles

Category	Conditions / Malignancies	Oral Complications
Neurological	Dementia, Parkinson's, Stroke, MND	Xerostomia, Candidiasis
Malignancy	Advanced Cancer, Head & Neck Cancers	Mucositis, Radiation Caries
Cardio-Resp	Heart Failure, COPD, Aspiration Pneumonia	Dysphagia complications
Frailty	Functional dependency, Bedbound, Cachexia	Poor oral hygiene access

Strategic Decision: UL6 Extraction?

#1

Clinical Rationale for Palliation

The Question: Is extraction justified in a bedridden, hospice patient with 70 Gy radiotherapy history?

The Answer: Only if it causes pain, infection, or trauma. If asymptomatic, prioritize prevention to avoid ORN risk.

Critical Check: ORN risk assessment vs. immediate palliative benefit. Liaison with Oncology is non-negotiable.

Procedural Modifications

1

Capacity
Consent from husband/Next-of-Kin

2

Oncology
Confirm radiation dose to maxilla

3

Delivery
Atraumatic, sutures, TXA gauze

4

Post-Op
Bedside follow-up, carer instructions

Bariatric Management Criteria

When to Refer?

- ✓ **Weight Limit:** Patient exceeds standard dental chair safety load.
- ✓ **Transfer:** Requires hoist or multi-staff hospital transfer.
- ✓ **Airway:** Obstructive Sleep Apnoea (OSA) or inability to lie supine.
- ✓ **Comorbidities:** ASA III or IV status requiring specialist monitoring.

ASA Physical Status: Obesity

ASA Grade	Obesity-Related Definition	Functional Status
ASA II	BMI 30–39.9 (Class I/II)	Well-controlled, no functional limits
ASA III	BMI ≥ 40 (Morbid Obesity)	Functional limitations from systemic disease
ASA IV	Severe Obesity with life-threatening disease	Constant threat to life (e.g., severe OSA, sepsis)

**Note: Obesity alone is rarely ASA IV without secondary unstable systemic failure.*

Why this patient is ASA IV

Life-Threatening Risks:

- Recurrent Aspiration Pneumonia (2 hosp. in 2 mos)
- Fluctuating consciousness & vascular dementia
- Nil-by-mouth with severe dysphagia
- Advanced hospice frailty

Questions?

Thank you for your attention.

Extron

Clinical Scenario
An 80 year old lady was admitted via a trolley bed from the wards. She was assessed by a physician and has a mobile lower incisor indicated for removal in view of aspiration risk.

Medical History

- Severe Multi-infarct (vascular) dementia - fluctuating consciousness between stupor and hypersomnia. Bedridden. Double incontinence
- Aspiration pneumonia, hospitalised over 2 incidents over the past 2 months.
- Thromboembolic stroke, Right Middle Cerebral Artery stroke 3 years ago
- Ischaemic heart disease
- Severe dysphagia- nasogastric tube fed, nil-by-mouth
- History of laryngeal carcinoma in 1994 treated with Conventional radiotherapy (70 Gys 33 Fractions)
- Methicillin-resistant Staphylococcus aureus (MRSA) positive
- Hypertension

Medications

- Omeprazole
- Plavix (clopidogrel)
- Tenolol
- Neurobion
- Vitamin D and calcium supplements

1. Create a Medical Category – Risk Assessment- Modifications table.
2. What medical disorders/conditions are associated with end of life care?
3. The patient consent to extraction of the carious upper left third molar. How would you modify the delivery of dental treatment?
4. Criteria for referring the Bariatric patients. How is ASA grading for them like?

Dental History

- Has not received oral hygiene assistance at the long-term care facility over the past year
- Nasogastric tube fed for 2 years (nil-by-mouth)
- Constantly grinds and mouth breathes almost entirely

Social History

- Chinese ethnicity
- Stays in a hospice and is bedridden
- Arrived by arranged transport from hospice
- Husband is the main caregiver and next-of-kin

Oral Examination

- Challenging behaviour during examination
- Trismus affecting ability to visualise palatal and lingual surfaces
- Mobile lower right central incisor
- Uncontrolled bruxism and clenching
- Dry secretions on tooth surfaces and palate (Figure 16.8.1 and Figure 16.8.2)

5. What other issues and concerns is end of life care often associated with?

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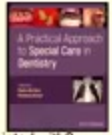

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Extron

CDP WORKSHOP 1 · CASE 5

Chapter 59 — Homelessness

Managing a medically complex, socially vulnerable patient: risk assessment, cross-infection control & treatment-planning factors.

64-yr-old man

ex-offender, recently released

Homeless

void deck → Halfway Home

Medically complex

HCV, latent TB, COPD, GORD

Referred

exclude dental cause of sinusitis

BACKGROUND

Patient Snapshot

Medical history

- Hepatitis C (6-monthly follow-up)
- Latent tuberculosis
- COPD + mild asthma (mouth breather)
- Chronic sinusitis / allergic rhinitis
- GORD with daily regurgitation
- Renal cyst; benign prostate hypertrophy
- ×4 repairs of oral-antral fistula
- Ex-IVDU, ex-smoker, heavy alcohol use

Medications

- Omeprazole (PPI)
- Salbutamol inhaler 200 mcg
- Fluticasone inhaler (ICS) BD
- Array of Chinese herbs & tonics

Social & dental

- Released from prison 1 month ago
- Unemployed; no income; no fixed address
- Socially isolated — no family contact
- Brushes once daily, hard brush
- Irregular, symptom-driven attender
- Edentulous upper jaw; poor lower perio

QUESTION 1

Medical Risk Assessment · Infective & Respiratory

Medical factor	Risk assessment	Modifications
Hepatitis C	Bloodborne virus → cross-infection via aerosols/sharps (needlestick ~1–3%). Chronic fibrosis → impaired drug metabolism & bleeding risk; lifelong HCC monitoring.	Standard precautions for ALL patients; rigorous sharps/PPE. Avoid NSAIDs, cap paracetamol. Liaise GP/hepatologist re LFTs & bleeding before surgery.
Latent tuberculosis	Latent TB is non-infectious — risk is reactivation, not chairside spread. Airborne droplet nuclei matter only in active disease.	Standard precautions only. Confirm status with GP; defer elective care & refer if reactivation signs. Watch isoniazid/rifampicin hepatotoxicity.
COPD / mild asthma (mouth breather)	Reduced respiratory reserve; supine position & rubber dam may compromise breathing. Bronchospasm if anxious. Mouth-breathing + xerostomia → caries.	Treat upright/semi-supine; patient brings salbutamol every visit. Short appointments; minimise aerosols. Avoid NSAIDs; have acute-attack first aid ready.

QUESTION 1

Medical Risk Assessment · GI, Renal, Liver & Bleeding

Medical factor	Risk assessment	Modifications
GORD + daily regurgitation	Gastric acid (pH ~1) → dental erosion (palatal/occlusal); ongoing acid challenge; supine reflux during treatment	Fluoride & sensitivity control; raise chair head. Do NOT brush immediately after reflux. Avoid NSAIDs. Reinforce reflux control with GP.
Renal cyst / BPH	Cyst usually benign — confirm function. Many drugs renally cleared; nephrotoxins worsen function. BPH: anticholinergics → urinary retention.	Confirm eGFR with GP. Avoid NSAIDs/nephrotoxins & dose-adjust renally-cleared drugs. Avoid anticholinergic load
Heavy alcohol / liver	Limited hepatic reserve: impaired metabolism, prolonged bleeding (↓clotting factors), DILI & disulfiram-reaction risk.	Avoid all NSAIDs; paracetamol ≤2–3 g/day. Avoid metronidazole. Check FBC/coag before surgery; opioids sparingly.
Bleeding risk (liver + renal)	Liver → ↓clotting factors; renal/uraemia → platelet dysfunction. Combined → prolonged, unpredictable bleeding.	Recent FBC/platelets + INR before surgery. Local haemostasis (sutures, Surgicel, pressure). Stage extensive surgery.

QUESTION 1

Cross-Cutting Prescribing Rule

⚠ Avoid ALL NSAIDs in this patient.

Triply contraindicated by liver disease (GI/variceal bleeding, hepatorenal risk), GORD (mucosal ulceration) and asthma (NERD/bronchospasm) — and nephrotoxic given the renal cyst.

Analgesia	Antibiotics	Bleeding work-up	Always liaise
Paracetamol is first choice — but cap at ≈ 2–3 g/day (cirrhosis, alcohol, likely malnutrition).	Avoid metronidazole — disulfiram-like reaction + hepatotoxicity.	Screen herbal bleeding risk (ginkgo/garlic/ginger); check FBC + coagulation before any surgery.	Consult GP/specialist before prescribing any hepatically- or renally-cleared drug; plan local haemostasis.

QUESTION 2

Cross-Infection Control Steps

Standard precautions are the baseline for **every** patient — HCV, latent TB and IVDU history reinforce, but do not change, routine practice.

Measure	Key actions
Standard precautions	Treat every patient as a potential carrier; don't "flag" — many carriers are undetected.
PPE	Gloves, mask, eye protection, gown; full barrier for aerosol/surgical work; change torn gloves + hand hygiene.
Hand hygiene	Single most important measure; perform at all critical moments; no jewellery, nail polish or artificial nails.
Aseptic technique	Five principles; risk-assess standard vs surgical; protect key parts/sites with non-touch technique.
Instrument sterilisation	Validated reprocessing; collect only instruments needed; use single-use disposables where available.
Surfaces & waterlines	Disinfect chair/surfaces between every patient; flush waterlines to reduce biofilm.
Sharps & post-exposure	Never recap by hand; dispose to sharps bin. Needlestick → first aid, notify tutor, CAMS report, baseline bloods.
HBV vaccination	Mandatory for dental workers (confirm seroconversion). No HCV vaccine → rely on precautions & sharps safety.
Aerosol / TB control	Rubber dam + high-volume suction; respiratory hygiene. Latent TB non-infectious — defer only if ACTIVE TB suspected.
Waste & reporting	Clinical waste in clinical area only; report all incidents via CAMS and notify supervisor.

QUESTION 2

Key Distinctions to Flag

Latent TB ≠ Active TB

Latent infection is **non-infectious** — no airborne spread.

Airborne isolation and deferral of aerosol-generating care are **not required** for this patient...

...unless reactivation to active disease is suspected (chronic cough, weight loss, night sweats) → defer & refer.

QUESTION 3

Non-Medical Factors Affecting Success

Factor	What it means for the treatment plan
Housing instability	No fixed address breaks the recall chain; appliances lost/unstored → defer definitive prosthetics, single-visit stabilisation, label dentures.
Finances / unemployment	Any out-of-pocket cost is a hard barrier; can't afford OH tools → establish concession eligibility, durable low-cost options, supply starter aids.
Access & attendance	Symptom-driven, irregular; transport a barrier → plan as if each visit is the last; pain/infection first; opportunistic prevention.
Social isolation	No network for reminders, transport or aftercare → liaise with Halfway Home / community team as surrogate support.
Motivation & low dental IQ	Once-daily hard-brush → prevention-first, intensive OHI, CAMBRA; downgrade prognosis where maintenance uncertain.
Diet & behavioural risk	Alcohol + ex-smoking (oral-cancer/perio), erosion, xerostomia → aggressive caries/erosion prevention, cancer surveillance, cessation support.
Mental health / post-release	High depression & relapse risk reduces engagement → short predictable visits, build trust, screen & refer, coordinate care.
Communication & literacy	May not understand condition or consent → plain language, teach-back, visual aids; involve support staff in reinforcement.

BOTTOM LINE FOR THE PLAN

A realistic, phased, prevention-first plan

Social reality → **guarded prognosis**. Match the achievable plan to the patient, not the ideal textbook plan.

1 Relieve

Pain & acute infection control first

2 Stabilise

Arrest caries & periodontal disease

3 Prevent

Intensive OHI, fluoride, CAMBRA

4 Reassess

Review engagement before definitive care

Defer definitive prosthetics until he is housed, stable and demonstrating maintenance — sequence: **relieve → stabilise → prevent → reassess.**

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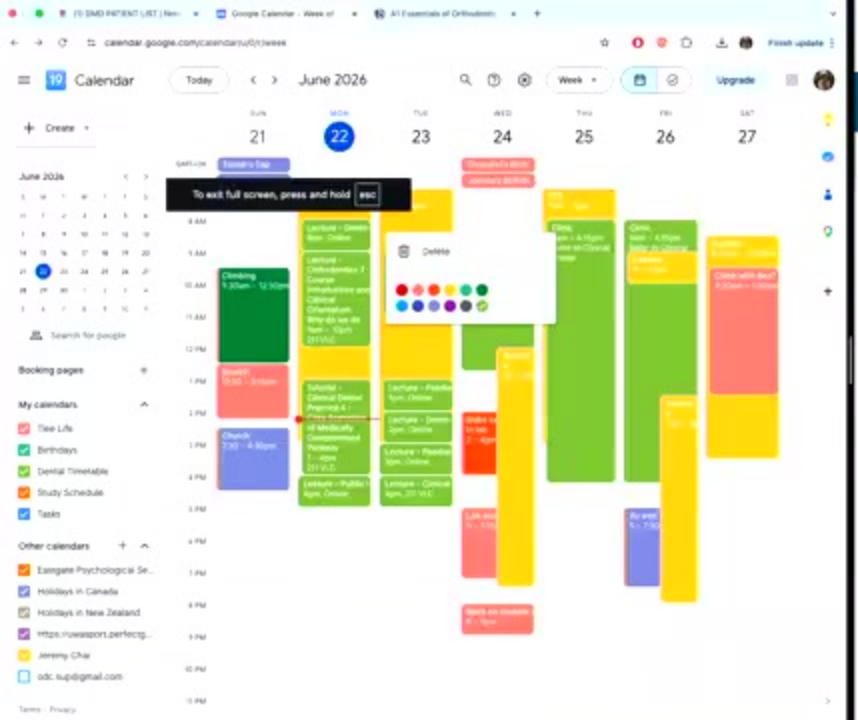
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Dental Timetable
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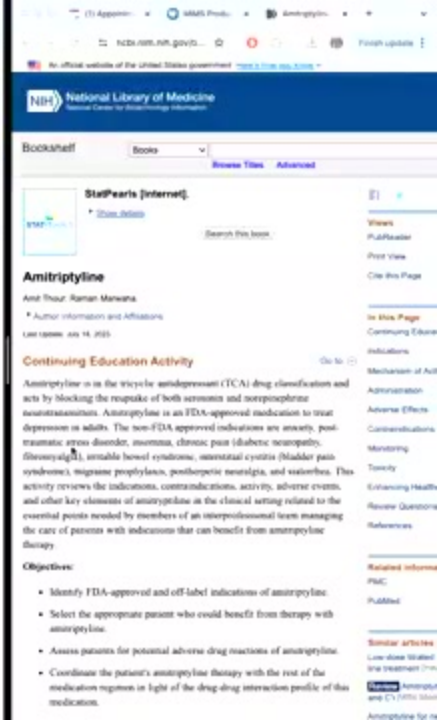
Jeremy Chai
odc.sup@gmail.com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Amitriptyline
Amit Thour; Raman Marwaha.
Author Information and Affiliations
Continuing Education Activity
Amitriptyline is the tricyclic antidepressant (TCA) drug classification and acts by blocking the reuptake of both serotonin and norepinephrine neurotransmitters. Amitriptyline is an FDA-approved medication to treat depression in adults. The non-FDA approved indications are anxiety, post-traumatic stress disorder, insomnia, chronic pain (diabetic neuropathy, fibromyalgia), irritable bowel syndrome, interstitial cystitis (bladder pain syndrome), migraine prophylaxis, postherpetic neuralgia, and sialorrhea. This activity reviews the indications, contraindications, activity, adverse events, and other key elements of amitriptyline in the clinical setting related to the essential points needed by members of an interprofessional team managing the care of patients with indications that can benefit from amitriptyline therapy.
Objectives:
Identify FDA-approved and off-label indications of amitriptyline.
Select the appropriate patient who could benefit from therapy with amitriptyline.
Assess patients for potential adverse drug reactions of amitriptyline.
Coordinate the patient's amitriptyline therapy with the rest of the medication regimen in light of the drug-drug interaction profile of this medication.

Patient Background

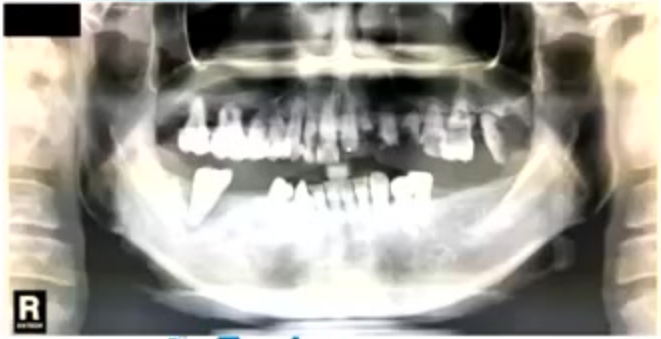
Dental History
- Brushes once a day with manual toothbrush
- Irregular dental attender
- Does not use interdental brushing aid

Oral Examination
- Prolonged oral health neglect
- Multiple interproximal caries
- Erosion lesions and root caries

Social History
- Works at the local hawker centre for almost 50 years, exposure to long-term inhalation of smoke
- Hokkien-speaking (a type of Mandarin dialect)
- Smoked for 50 years, around 1.5 pack a day. Quit smoking 2 years ago, reportedly due to rising tobacco tax and physician advice
- Receiving social assistance
- Stays with wife, has two married children who visit infrequently

Medically compromised

67 year old patient, complaining of weakening and crumbling teeth



Patient Background

Dental History
- Brushes once a day with manual toothbrush
- Irregular dental attender
- Does not use interdental brushing aid

Oral Examination
- Prolonged oral health neglect
- Multiple interproximal caries
- Erosion lesions and root caries

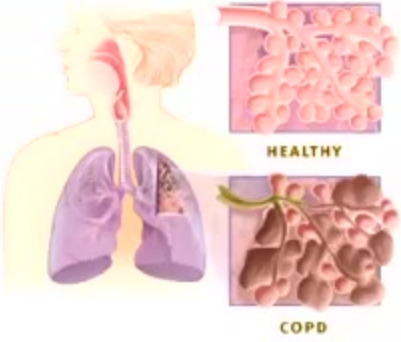
Social History
- Works at the local hawker centre for almost 50 years, exposure to long-term inhalation of smoke
- Hokkien-speaking (a type of Mandarin dialect)
- Smoked for 50 years, around 1.5 pack a day. Quit smoking 2 years ago, reportedly due to rising tobacco tax and physician advice
- Receiving social assistance
- Stays with wife, has two married children who visit infrequently

01 Medical Risk Assessment

Medical Categories and others	Risk	Modifications/ Implication
Respiratory (COPD + asthma, ex-smoker)	Asthma Attack Poor Healing Oral Candidosis Periodontal disease Dry mouth Caries	Remind patient to bring inhaler Avoid triggers Short + morning appointment Discretion with RD More upright position during appointment Risk and spit with water after inhaler use Have emergency oxygen management kit available
CVD (hypertension, hyperlipidaemia)	Hypertensive crisis Risk of stroke or heart attack	Ensure BP is controlled Ensure emergency kit is available
Reduced BMI	Nutritional deficiencies can lead to oral manifestations	Diet analysis Weight history (inquire if sudden weight loss associated with underlying medical conditions) Blood tests
Social: Financial constraints and social barriers	Poor attendance Limited treatment option	Charitable dental service prn

How are we assessing the COPD risk?

a. Spirometry test (FEV1) patient 38% of normal predicted
b. Chest X-ray (flattened diaphragm)
c. Oxygen saturation (<91% unstable, >95% stable) patient has 93%
d. Respiratory rate (depth and rate/min)



What are the treatment options for managing multiple caries and high caries risk?

- Fillings (direct vs indirect)
- Neutrafluor 5000ppm
- Diet modification (erosion lesions)
- Saliva analysis
- Oral Hygiene Instruction (increasing to brushing 2/day)
- Chlorhexidine mouthrinse (intermittent use to avoid staining)

What other factors do you need to consider that can affect treatment success?

1. Patient motivation and oral hygiene maintenance
2. Language barrier: potentially having a translator
3. Financial barriers: requires social assistance
4. Previous smoker: Encourage continuation of smoking cessation -> can impact periodontal treatment success

Extron

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CHAPTER 28: Chronic obstructive pulmonary disease
SECTION:
Clinical Scenario
A 67 year old man turned up at the charity clinic that you volunteer at. He complains of "weakening" and "crumbling" teeth.
Medical History
Chronic Obstructive Pulmonary Disease - Irregular in medical follow-up
FEV1: at formal expiratory volume in 1 sec, was 78% of normal predicted. Recent chest x-rays showed flattened diaphragm.
SpO2 is 91% on room air. Heart rate 94/min
Respiratory rate is 24 per minute and shallow.
Dry hacking non-productive cough, jutting sedatina.
Hypertension: +152/88
Hypercholesterol
Asthma
Others: Ex-smoker with 70 pack-year cigarette history, reduced BMI
Medication
Prednisolone 10mg
Ipratropium bromide + albuterol sulfate combination inhaler
Salbutamol inhaler
Simvastatin
Enalapril
Dental History
Brushes once a day with manual toothbrush
Irregular dental attendee
Does not use interdental brushing aid
Social History
Works at the local hawker centre for almost 30 years, exposure to long-term inhalation of smoke (see Figure 1.28.1)
Hokkien-speaking, ex-type of Mandarin dialects
Smoked for 50 years, around 1.5 packs a day. Quit smoking 2 years ago, reportedly due to rising tobacco tax and physician advice
Reasoning social assistance
Stays with wife, has two married children who visit infrequently
Oral Examination
Prolonged oral health neglect
Multiple interproximal caries
Erosion lesions and root caries.
1. Create a Medical Category - Risk Assessment - Modifications table.
2. How do you assess the severity of the patient's COPD
3. What are the treatment options for managing multiple caries & root caries?
4. What other factors do you need to consider that can affect treatment success?
R

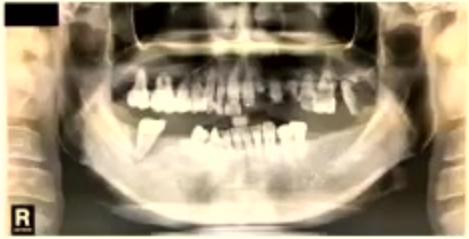
CHAPTER 26. Chronic obstructive pulmonary disease

SECTION I

Clinical Scenario
A 67 year old man turned up at the charity clinic that you volunteer at. He complains of "weakening" and "crumbling" teeth.

Medical History:

- Chronic Obstructive Pulmonary Disease - irregular in medical follow-up
  - FEV1, or forced expiratory volume in 1 sec, was 38% of normal predicted. Recent chest x-rays showed flattened diaphragm.
  - SpO2 is 93% on room air, heart rate 94/min
  - Respiratory rate is 24 per minute and shallow
  - Dry hacking non-productive cough, pitting oedema
- Hypertension ~152/85
- Hyperlipidaemia
- Asthma
- Others: Ex-smoker with 70 pack-year cigarette history, reduced BMI



Medication

- Prednisolone 10mg
- Ipratropium bromide + albuterol sulfate combination inhaler
- Salbutamol inhaler
- Simvastatin
- Enalapril

Dental History

- Brushes once a day with manual toothbrush
- Irregular dental attender
- Does not use interdental brushing aid

Social History

- Works at the local hawker centre for almost 50 years, exposure to long-term inhalation of smoke (see **Figure 1.26.1**)
- Hokkien-speaking (a type of Mandarin dialect)
- Smoked for 50 years, around 1.5 pack a day. Quit smoking 2 years ago, reportedly due to rising tobacco tax and physician advice
- Receiving social assistance
- Stays with wife, has two married children who visit infrequently

Oral Examination

- Prolonged oral health neglect
- Multiple interproximal caries
- Erosion lesions and root caries

1. Create a Medical Category - Risk Assessment - Modifications table.
2. How do you assess the severity of the patient's COPD
3. What are the treatment options for managing multiple caries & high caries risk?
4. What other factors do you need to consider that can affect treatment success?

Extron

Category	Main risks for dental care	Dental modifications
Raised BMI / reduced mobility	Difficult positioning, limited access, airway risk, fatigue, chair weight limit	Check bariatric chair/equipment, allow longer appointments, treat semi-upright, use extra assistance/retraction
OSA on CPAP	Airway obstruction, higher sedation/opioid risk, worse when supine	Avoid/minimise sedation and opioids, treat more upright, bring CPAP if hospital/GA care needed
Asthma	Stress/anxiety may trigger attack	Confirm control, ensure salbutamol inhaler available, avoid triggers, stress reduction
Hypertension	Stress/pain may raise BP	Check BP, use profound LA, reduce stress, limit adrenaline if unstable
Ischaemic heart disease / angina	Stress may precipitate angina	Short morning appointments, profound LA, keep GTN available, avoid excessive adrenaline
Diabetes mellitus	Hypoglycaemia, infection risk, delayed healing	Morning appointments, ensure patient has eaten and taken meds, check control if known, review healing
Aspirin use	Increased bleeding/oozing	Usually continue aspirin, use local haemostatic measures (pressure, sutures, pack)
Major depression / dental anxiety	Avoidance, poor attendance, preference for extraction	Empathetic communication, staged care, explain options clearly, consider anxiolysis if appropriate
GORD + erosion	Reflux risk when supine, ongoing tooth wear	Treat more upright, avoid prolonged supine position, reinforce erosion prevention
Osteoarthritis / musculoskeletal pain	Transfer difficulty, discomfort lying flat/opening long	Use positioning aids, give breaks, keep appointments shorter

Additional Risk Factors and Dental Modifications

Category	Key risk	Modification
 **Osteoarthritis / musculoskeletal pain**	Transfer difficulty, lying flat, prolonged opening	Positioning aids, breaks, shorter appointments
 **Poor diet**	Very high caries and erosion risk	Diet advice, fluoride 5000 ppm if indicated, prevention first
 **Poor posterior access**	Plaque retention, caries, gingival inflammation	Electric/long-handled brush, interdental aids, fluoride, frequent recalls
 **Social / transport issues**	Attendance and follow-up difficulties, limited post-op support	Coordinate appointments and transport, clear post-op plan, consider hospital/community setting

What additional factors do you have to consider when undertaking a risk assessment of this patient

Chair and access safety

- Patient weighs **142 kg**
- Confirm dental chair weight limit
- Ensure safe transfer from bariatric wheelchair.
- Consider whether the clinic has enough space and staff support.

Airway and positioning

Because of **obesity + sleep apnoea + asthma + GERD**, avoid fully supine positioning if uncomfortable or unsafe. Risks:

- Airway obstruction
- Breathlessness
- Reflux
- Reduced tolerance of long procedures

Sedation risk

She has dental anxiety, but sedation is not straightforward. Obesity and OSA increase risk of:

- Airway obstruction
- Hypoventilation
- Respiratory depression
- Opioid/sedative complications

So avoid casual oral benzodiazepines or opioid-heavy analgesia. If sedation/GA is required, this is likely a **hospital/specialist setting** decision.

Cardiovascular risk

She has:

- Hypertension
- Ischaemic heart disease
- Angina
- Aspirin
- Beta-blocker/amlodipine

You need:

- BP check
- GTN available
- Stress reduction
- Profound LA
- Avoid excessive adrenaline
- Monitor symptoms

Diabetes and infection/healing

Diabetes increases risk of:

- Infection
- Delayed healing
- Periodontal disease
- Post-op complications

Check control. If possible, ensure she has eaten, and arrange review.

Social risk

She lives alone, rarely leaves home and requires hospital transport. So:

- Make sure she can attend review.
- Give very clear written post-op instructions.
- Consider whether she needs someone at home after extraction.
- Avoid treatment plans that depend on frequent attendance unless realistic.

The patient consents to extraction of the carious upper left first molar. How would you modify the delivery of dental treatment?

- Evaluate suitability as a bariatric patient
  - Ability to maintain airway during procedure
  - Ability to access intraoral site
  - Bariatric dental chair, positioning, and short appointment length
  - Evaluate BP, HR and RR
  - Patient is not suitable for day surgery under GA due to BMI>40, and OSA.
  - First line would be extraction under LA and can do oral sedation.
    - Can treatment be delayed until risk factors mitigated?
- Risk of delayed haemostasis from warfarin use
- Local anaesthetic considerations
  - Ability to achieve profound anaesthesia
  - Use of vasoconstrictor
    - Adrenaline can cause excitatory CNS effects and worsen dental anxiety
    - Caution for use in patients with uncontrolled angina
- Local aerosol control
  - Manage triggers for asthma, consider additional HVAC ventilation
  - Prepare emergency oxygen and asthma inhaler
- Glycaemic control
  - Assess BGL before procedure and monitor patient vital signs during
- Confirm carer/hospital transport availability after procedure
- Post-extraction review
  - High risk of delayed/impaired healing
  - Reinforce positive OH behaviours at home, use modified techniques to improve access when brushing and cleaning interproximally

Criteria for referring the bariatric patients. How is ASA grading for them like?

- Weight/BMI exceeds dental chair or equipment limits or hoisting required
- Immobility / cannot transfer to or be safely positioned in a standard chair
- ASA III–IV or unstable/complex medical history
- Sedation or GA indicated but high-risk (e.g. OSA) → needs anaesthetist/hospital
- Difficult airway, severe anxiety needing advanced behavioural/pharmacological management
- Surgery environment can't accommodate access, manual handling, or emergency response

ASA grading criteria - patient falling under ASA III

ASA grade	Meaning	Bariatric relevance
ASA I	Healthy patient	Not applicable here.
ASA II	Mild systemic disease	Obesity BMI 30–40 without major systemic complications may fit here.
ASA III	Severe systemic disease, not immediately life-threatening	**Most appropriate for this patient**: BMI 46.9 plus controlled angina, hypertension, diabetes, OSA on CPAP, asthma.
ASA IV	Severe systemic disease that is a constant threat to life	If she had unstable angina, uncontrolled hypertension, poorly controlled diabetes with complications, severe uncontrolled asthma, or severe OSA/respiratory compromise.
ASA V	Moribund patient not expected to survive without operation	Not relevant for routine dental treatment.

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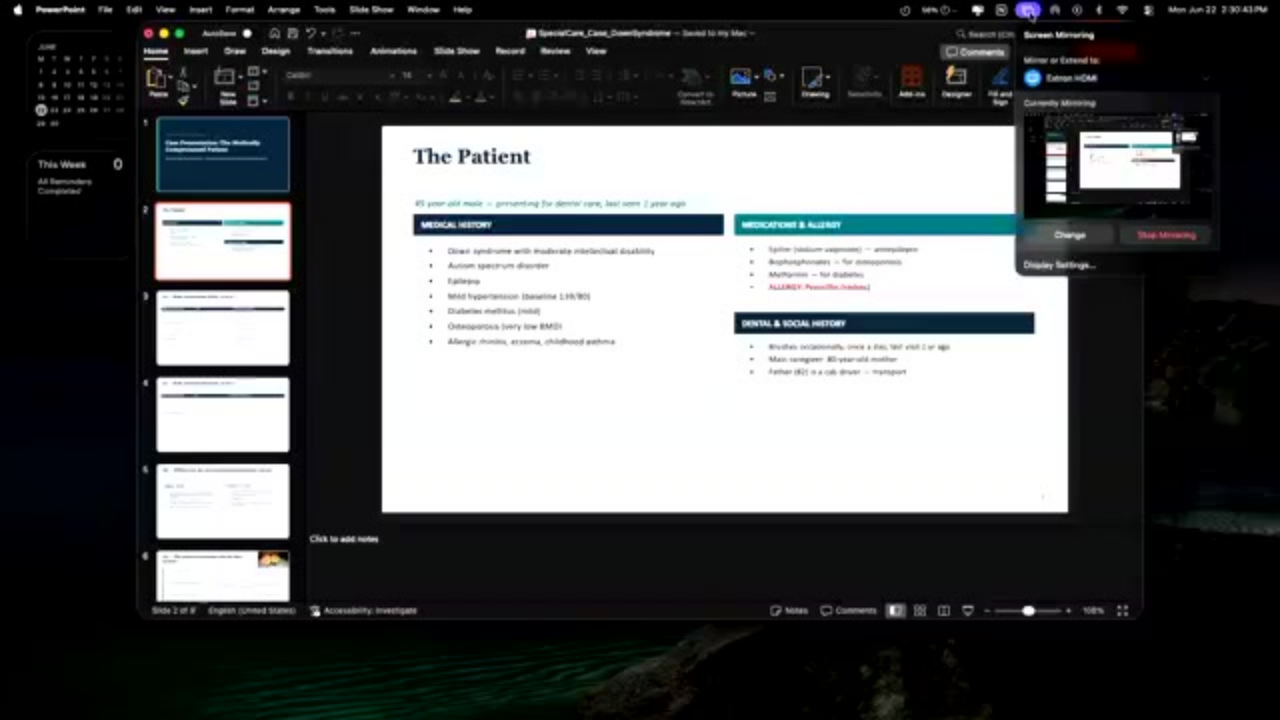
The Patient
MEDICAL HISTORY
MEDICATIONS & ALLERGY
DENTAL & SOCIAL HISTORY
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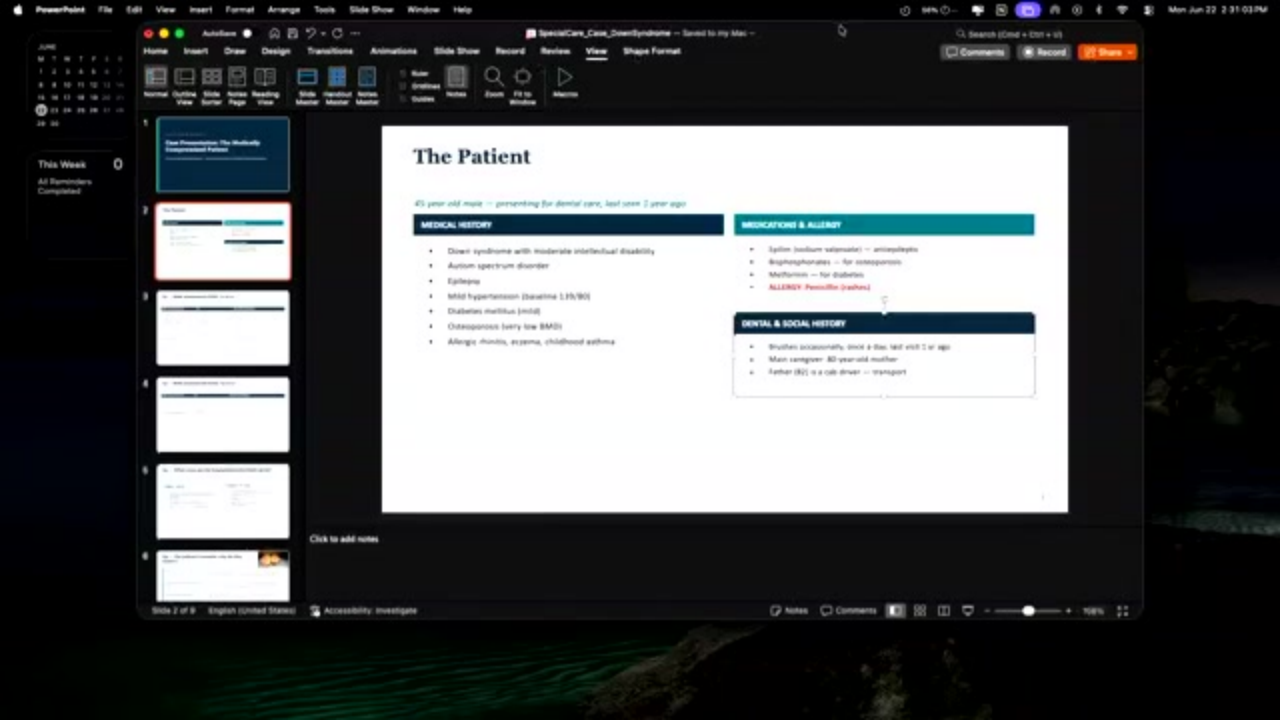

The Patient
45 year old male — presenting for dental care, last seen 1 year ago
MEDICAL HISTORY
Down syndrome with moderate intellectual disability
Autism spectrum disorder
Epilepsy
Mild hypertension (baseline 135/80)
Diabetes mellitus (mild)
Osteoporosis (very low BMD)
Allergic rhinitis, eczema, childhood asthma
MEDICATIONS & ALLERGY
Epilim (sodium valproate) — antiepileptic
Bisphosphonates — for osteoporosis
Metformin — for diabetes
ALLERGY: Penicillin (rashes)
DENTAL & SOCIAL HISTORY
Brushes occasionally, once a day, last visit 1 yr ago
Main caregiver: 80 year-old mother
Father (82) is a cab driver — transport
Click to add notes

The Patient

45 year-old male — presenting for dental care, last seen 1 year ago

MEDICAL HISTORY

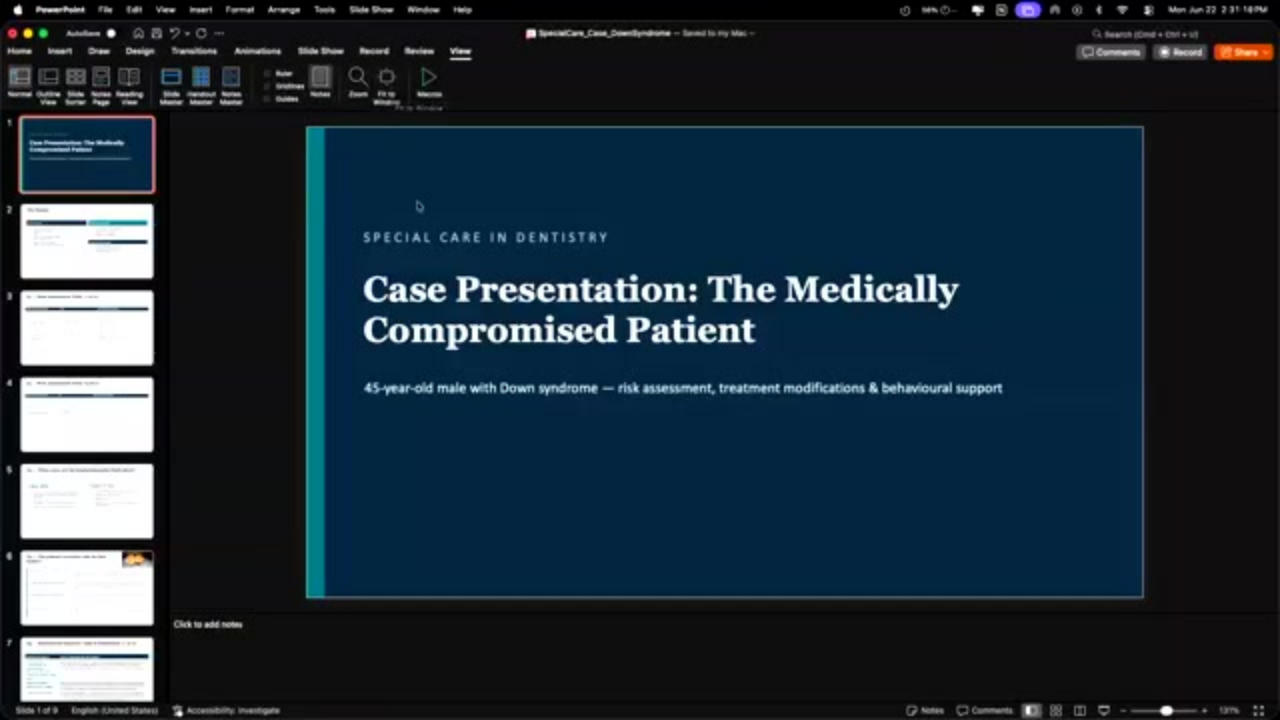
- Down syndrome with moderate intellectual disability
- Autism spectrum disorder
- Epilepsy
- Mild hypertension (baseline 139/80)
- Diabetes mellitus (mild)
- Osteoporosis (very low BMD)
- Allergic rhinitis, eczema, childhood asthma

MEDICATIONS & ALLERGY

- Epilim (sodium valproate) — antiepileptic
- Bisphosphonates — for osteoporosis
- Metformin — for diabetes
- **ALLERGY: Penicillin (rashes)**

DENTAL & SOCIAL HISTORY

- Brushes occasionally, once a day; last visit 1 yr ago
- Main caregiver: 80-year-old mother
- Father (82) is a cab driver — transport


SPECIAL CARE IN DENTISTRY
Case Presentation: The Medically Compromised Patient
45-year-old male with Down syndrome — risk assessment, treatment modifications & behavioural support
Click to add notes

SPECIAL CARE IN DENTISTRY

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DENTAL & SOCIAL HISTORY

- Brushes occasionally, once a day; last visit 1 yr ago
- Main caregiver: 80-year-old mother
- Father (82) is a cab driver — transport

Q1 — Risk Assessment Table (1 of 2)

Medical categories and others	Risk	Modifications / Implications
Respiratory – Childhood asthma – Allergic rhinitis / eczema (atopy)	– Asthmatic attack – Poor healing if on steroids – Reduced supine tolerance	– Ask patient to bring inhaler; prophylactic dose pre-op – Avoid triggers (cold air, dust) – Late-morning appointments; semi-reclined if needed
Cardiovascular – Mild hypertension (139/80) – Down syndrome — congenital heart disease risk	– Stress-induced BP rise – Possible infective endocarditis (if cardiac defect) – Drug interactions	– Confirm cardiac history – Stress / anxiety reduction; monitor BP – Assess need for IE antibiotic prophylaxis – Review polypharmacy interactions
Endocrine / Metabolic – Diabetes mellitus (mild) – On metformin	– Hypoglycaemia (main acute risk) – Increased infection risk – Poor wound healing; periodontal disease	– Morning appointments; ensure patient has eaten – Avoid clashing with insulin peak / missed meals – Check HbA1c (<7% = routine care); manage hypo promptly
Bone / Musculoskeletal – Osteoporosis (very low BMD) – On bisphosphonates	– MRONJ after bone-manipulating procedures – Delayed healing	– Confirm drug, route & duration – MRONJ-specific informed consent – Prevention-led; avoid extractions (endo preferred) – Atraumatic, sequential surgery; liaise physician re drug holiday

Q1 — Risk Assessment Table (2 of 2)

Medical categories and others	Risk	Modifications / Implications
Neurological & Cognitive – Down syndrome – Moderate intellectual disability – Autism spectrum disorder – Epilepsy (sodium valproate)	– Variable co-operation; challenging behaviour – Seizures (stress, curing light, vibration) – Atlantoaxial instability – Communication & capacity limits – Valproate → thrombocytopenia / bleeding	– Behavioural support & desensitisation; same dentist/time/room – Treat in seizure-controlled phase; avoid triggers; team trained for seizures – Prevent neck hyperextension – Capacity assessment → best-interest decision with caregivers – Check clotting before surgery
Social – Caregivers: mother 80 (main), father 82 – Brushing once/day; last visit 1 yr ago	– Poor attendance – Poor daily oral care – Limited support at home	– Caregiver oral-hygiene training & support – Flexible scheduling; domiciliary / transport option – Strong prevention focus; 3-monthly recall
Others (Allergy) – Penicillin allergy (rash)	– Allergic reaction – Complicates antibiotic cover — incl. MRONJ prophylaxis (normally amoxicillin)	– Flag clearly in records – Use non-penicillin alternative (e.g. clindamycin)

Q2 — What route are the bisphosphonates likely given?

Most likely ORAL (per os) for osteoporosis

ORAL (PO)

- Osteoporosis is treated with low-potency oral bisphosphonates
- Typical agents: alendronate (e.g. 70 mg weekly), risedronate, ibandronate
- Taken as a daily, weekly or monthly tablet
- Low MRONJ risk: ~0.001–0.01% in osteoporosis patients
- Risk rises after ≥5 years of use or with extra risk factors

Compare: IV route

- Intravenous bisphosphonates (zoledronate, pamidronate, IV ibandronate) are used mainly in cancer / bone metastases — and sometimes annually for osteoporosis
- High-potency / IV use carries a much higher MRONJ risk: ~7% in oncology patients
- MRONJ risk depends on drug type & potency, ROUTE, duration and the underlying disease

Q3 — The patient's toenails: why do they matter?

An incidental finding that flags whole-patient risks for dental care

Sign of overall self-care / neglect	Thickened, discoloured, overgrown nails suggest limited daily personal care — consistent with brushing only once a day and reliance on elderly caregivers. Predicts poor oral hygiene → reinforces prevention and caregiver training.
Possible fungal infection / poor glycaemic control	Yellow, dystrophic nails (onychomycosis) point to impaired immunity and/or poorly controlled diabetes → higher infection risk and delayed healing, which compounds extraction-healing and MRONJ risk.
Peripheral vascular / healing concern	Nail changes can signal poor peripheral circulation and delayed wound healing — relevant to surgical procedures and recovery.
Prompt to liaise & screen	Triggers liaison with the GP about diabetes control and foot care before invasive treatment, and a check for oral candidiasis given likely immunocompromise.

Q4 — Behavioural supports: risks & limitations (1 of 2)

From least to most restrictive — tailored to this patient

Behavioural support	Risks / limitations for THIS patient
Communication, acclimatisation & desensitisation (tell–show–do, social stories, pictograms, visual timer)	Least restrictive and first-line — but time-consuming and needs multiple visits; autism brings resistance to change; depends heavily on elderly caregivers; possible pain insensitivity can mask problems; may not achieve cooperation for invasive treatment.
Inhalation sedation (nitrous oxide / oxygen)	Nasal hood often fits poorly due to mid-face hypoplasia in Down syndrome; may be rejected by an autistic patient (facial contact); textbook advises caution/avoidance of nitrous oxide in epilepsy; still requires nasal breathing and some cooperation.
Conscious / IV sedation	Response is unpredictable — a paradoxical reaction can occur in autism/intellectual disability; must assess cardiac disease, respiratory function, hypotonia and OSA risk; cannulation needs cooperation; capacity / best-interests required.

Q4 — Behavioural supports: risks & limitations (2 of 2)

Behavioural support	Risks / limitations for THIS patient
Clinical holding	Only with consent or a best-interests decision (patient lacks capacity); must be least-restrictive, by trained staff and documented; can escalate distress/trauma; must avoid neck hyperextension (atlantoaxial instability); suitable only for short, safe procedures.
General anaesthesia	Highest-risk option: difficult intubation (mid-face hypoplasia), atlantoaxial instability on positioning, cardiac & respiratory comorbidity, diabetes/fasting management and epilepsy anaesthetic-agent cautions; needs a hospital setting and a best-interests decision — but allows comprehensive treatment in one visit, reducing repeat exposure.

Extron

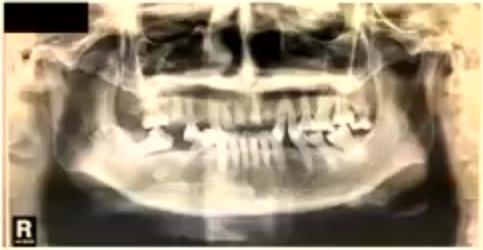
45 y.o. male

MH:
- Down's syndrome
- Moderate intellectual disability
- Autism spectrum disorder
- Epilepsy
- Allergic Rhinitis
- Eczema
- childhood asthma
- mild HTN (baseline 139/80)
- Diabetes mellitus Mild
- Osteoporosis (very low BMD)

MED: Epilim, Bisphosphonates, metformin
Drug Allergy: Penicillin (Rashes)

DH:
- occasional Toothbrushing once a day
- last visit 1 year ago

SH:
- 80 year old mum is main caregiver
- 82 year old dad cab driver



1. Create a Medical Category - Risk Assessment - Modifications table.
2. What type of drug route would bisphosphonates likely be?
3. You saw the patient's toenail whilst having dental treatment - how do you think this can affect our dental treatment delivery?
4. Consider different types of behavioural supports, could you list the risk/limitations of each based on pat

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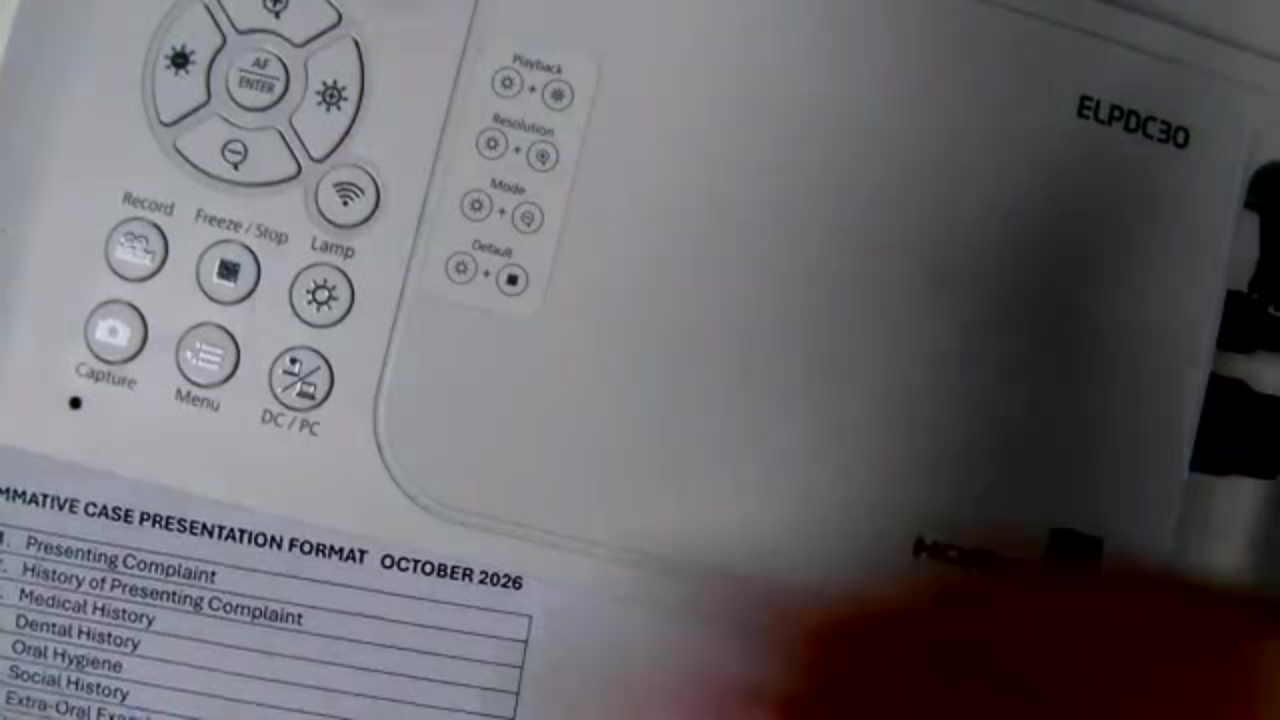
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Presenting Complaint
History of Presenting Complaint
Medical History
Dental History
Oral Hygiene
Social History

ELPDC30

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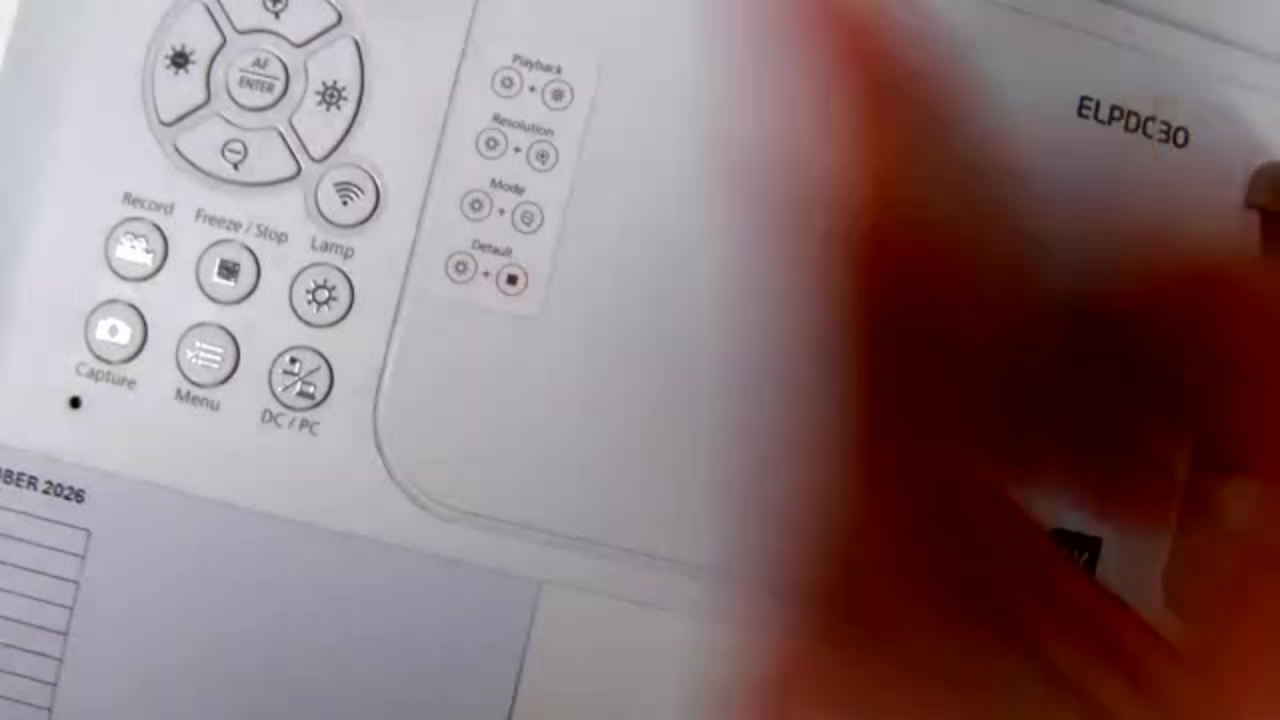
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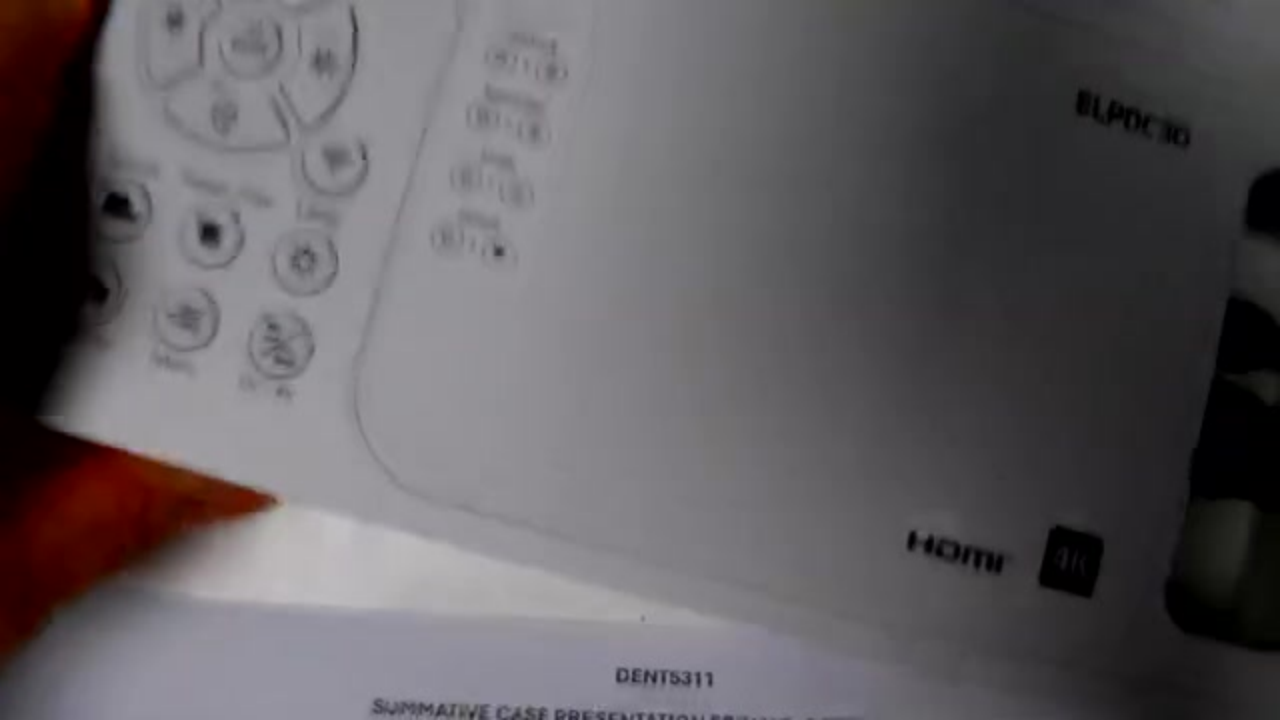

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SUMMATIVE CASE PRESENTATION


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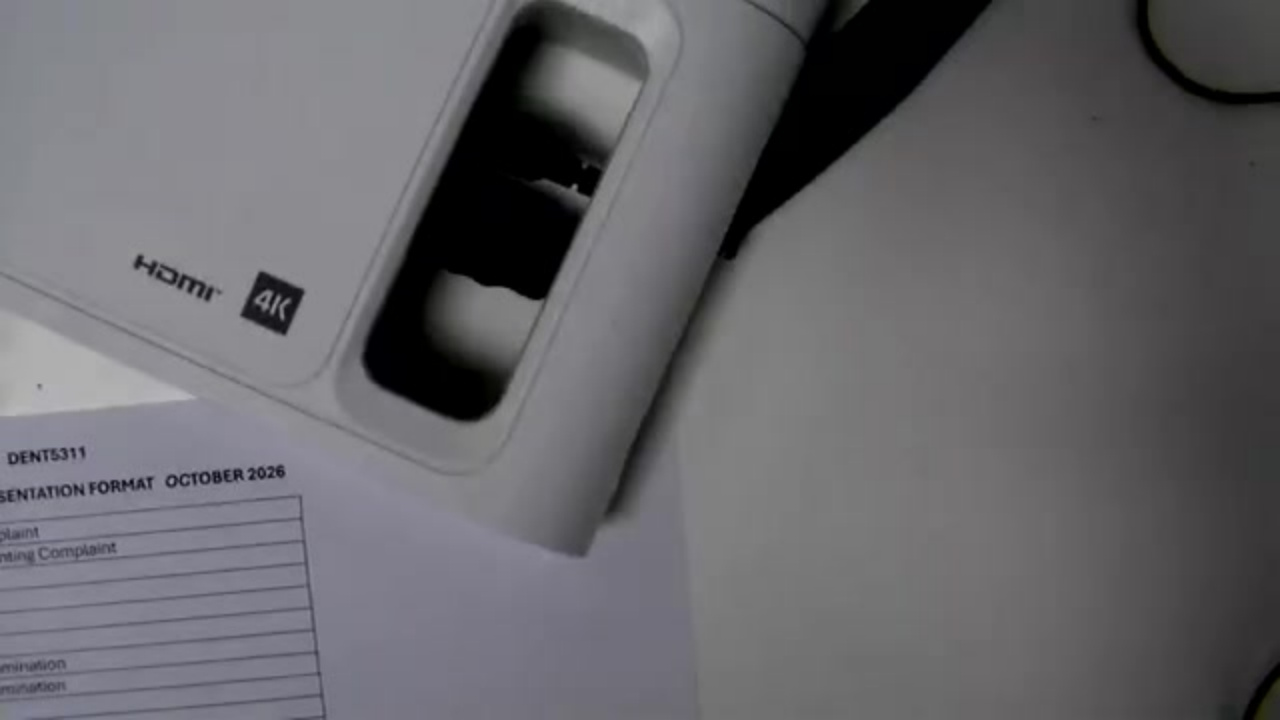
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SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
4. Dental History
5. Oral Hygiene
6. Social History
7. Extra-Oral Examination
8. Intra-Oral Examination
9. Occlusion
10. Dental Prosthesis
11. Tooth Charting
12. Periodontal Charting
13. Radiographs
14. Caries Risk Assessment
-Diet Assessment
-Plaque Score
-Saliva Assessment
15. Periodontal Risk Assessment

DENT5311

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
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DENT5311

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

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10. Dental Prosthesis
11. Tooth Charting

SUMMATIVE CASE PRESENTA[redacted]

1. Presenting Complaint
2. History of Presenting Complaint
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4. Dental History
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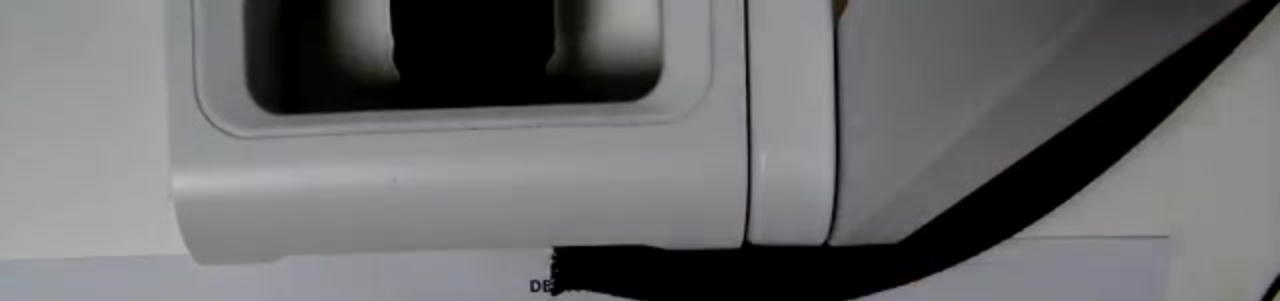
11. Tooth Charting
12. Periodontal Charting
13. Radiographs
14. Caries Risk Assessment
-Diet Assessment
-Plaque Score
-Saliva Assessment
15. Periodontal Risk Assessment
16. Prognosis



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SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
4. Dental History
5. Oral Hygiene
6. Social History
7. Extra-Oral Examination
8. Intra-Oral Examination
9. Occlusion
10. Dental Prosthesis
11. Tooth Charting
12. Periodontal Charting
13. Radiographs
14. Caries Risk Assessment
-Diet Assessment
-Plaque Score
-Saliva Assessment
15. Periodontal Risk Assessment

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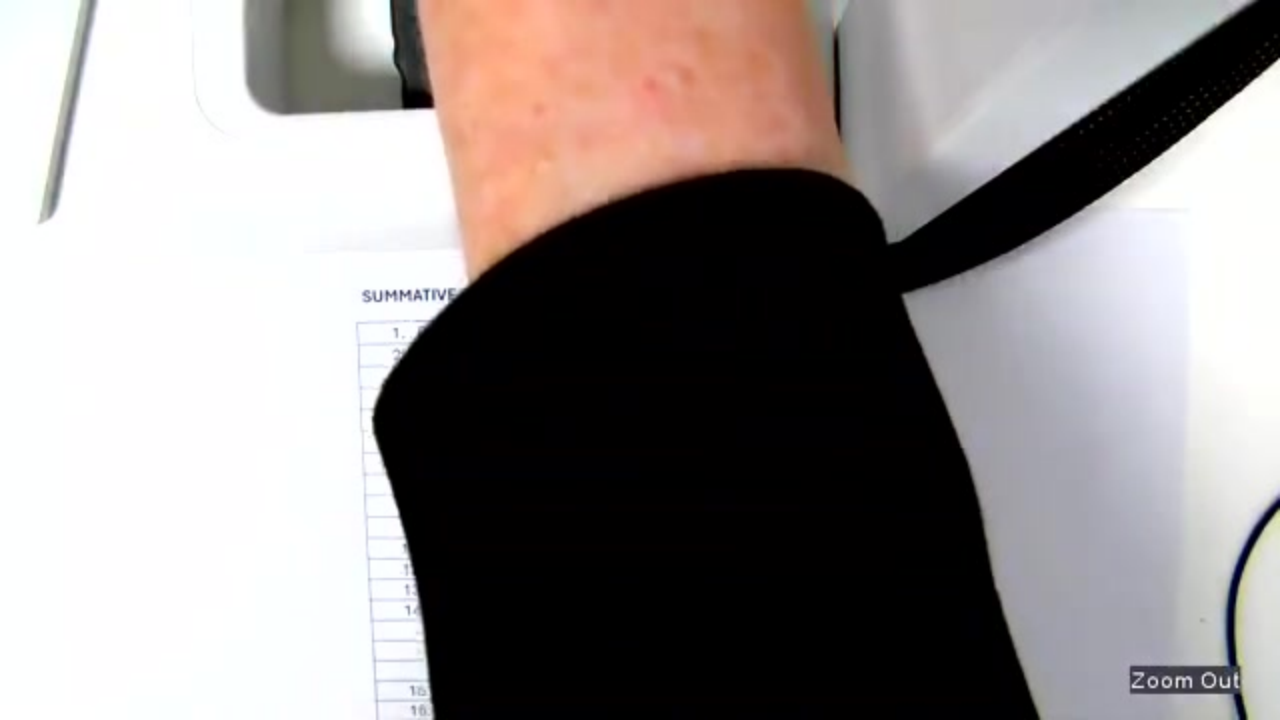
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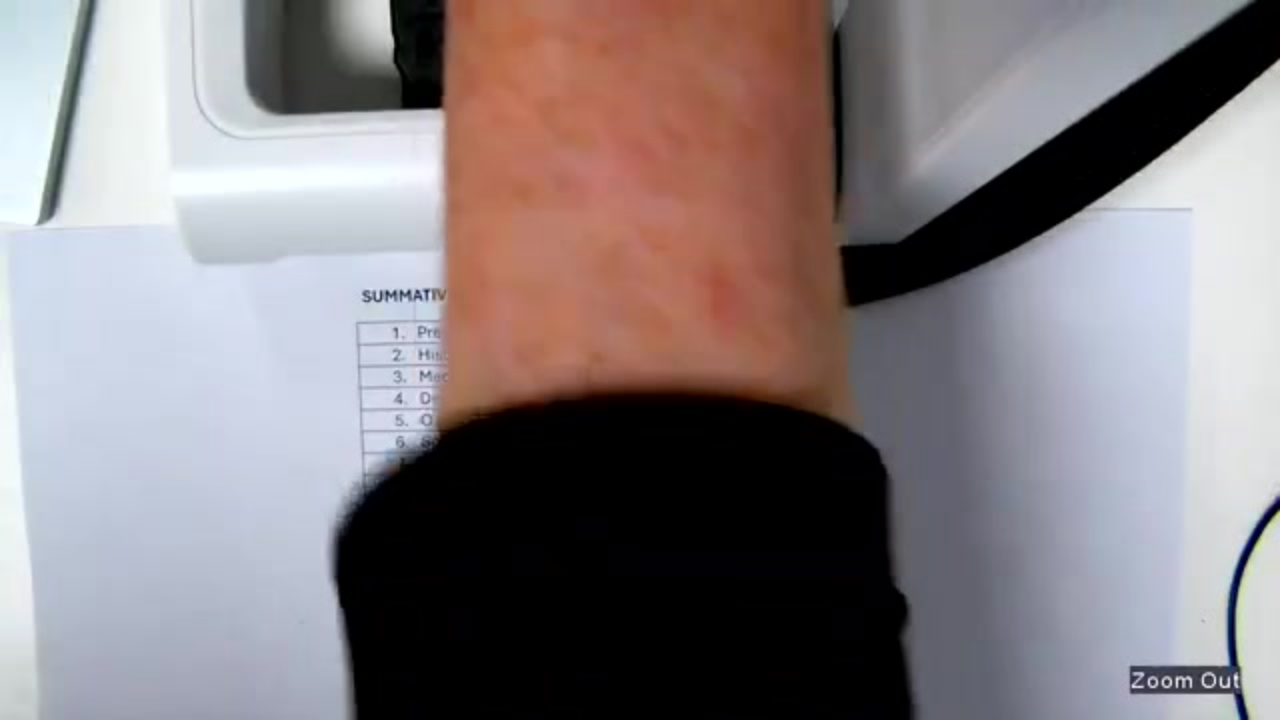
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17. Problem List
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    -Host-related
    -Pathology
    -Morphology
18. Diagnoses

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DENTS311

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint

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SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
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5. Oral Hygiene
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7. Extra-Oral Examination

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19. Treatment Options
20. Management Plans (Timeline)
21. Reflection
22. References

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SUMMATIVE CASE PRESENTATION FORMAT OCTO

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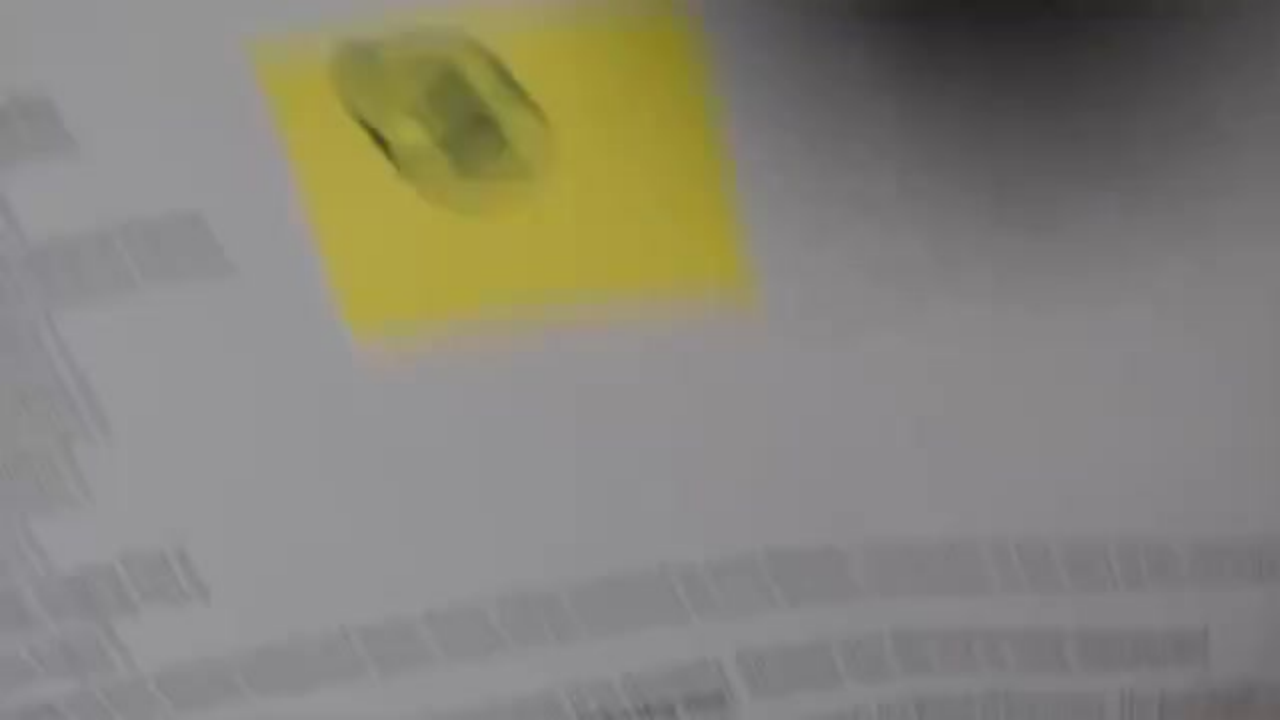

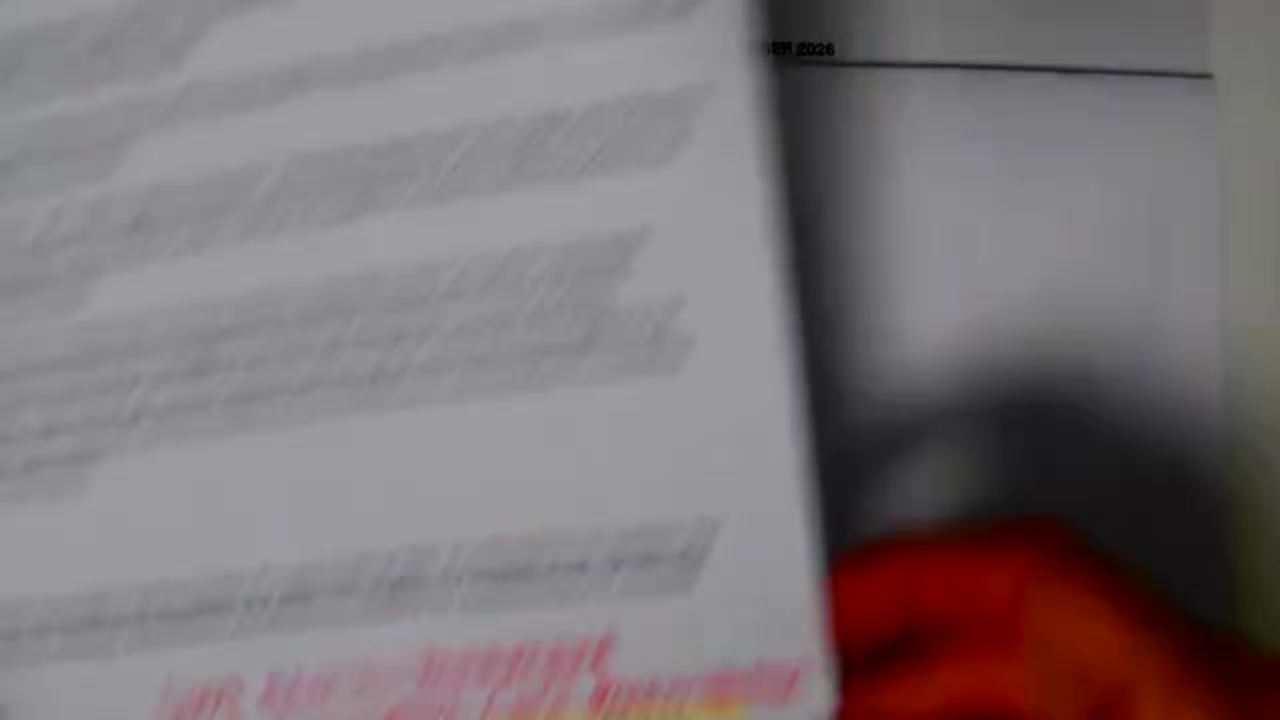

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SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

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ssment overview

erall unit and each module individually must be passed at a pass mark of 50%. If a Module is not passed, the
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ments.

	Unit Weighting
cal Dental Practice (CDP4)	40%
to-alveolar and Maxillofacial Trauma (TRAUMA)	10%
lic Health Dentistry 1 (PHD1)	10%

30% Clinic - Pebblepad
10% Summative Case Presentation

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Portfolio is Formative P/F

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Portfolio is Formative P/F

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Unit Weighting

- Dental Practice (COP4) 40%
- alveolar and Maxillofacial Trauma (TRAUMA) 10%
- Health Dentistry 1 (PHD1) 10%

30% Clinic - Portfolio

10% Summative Case Presentation

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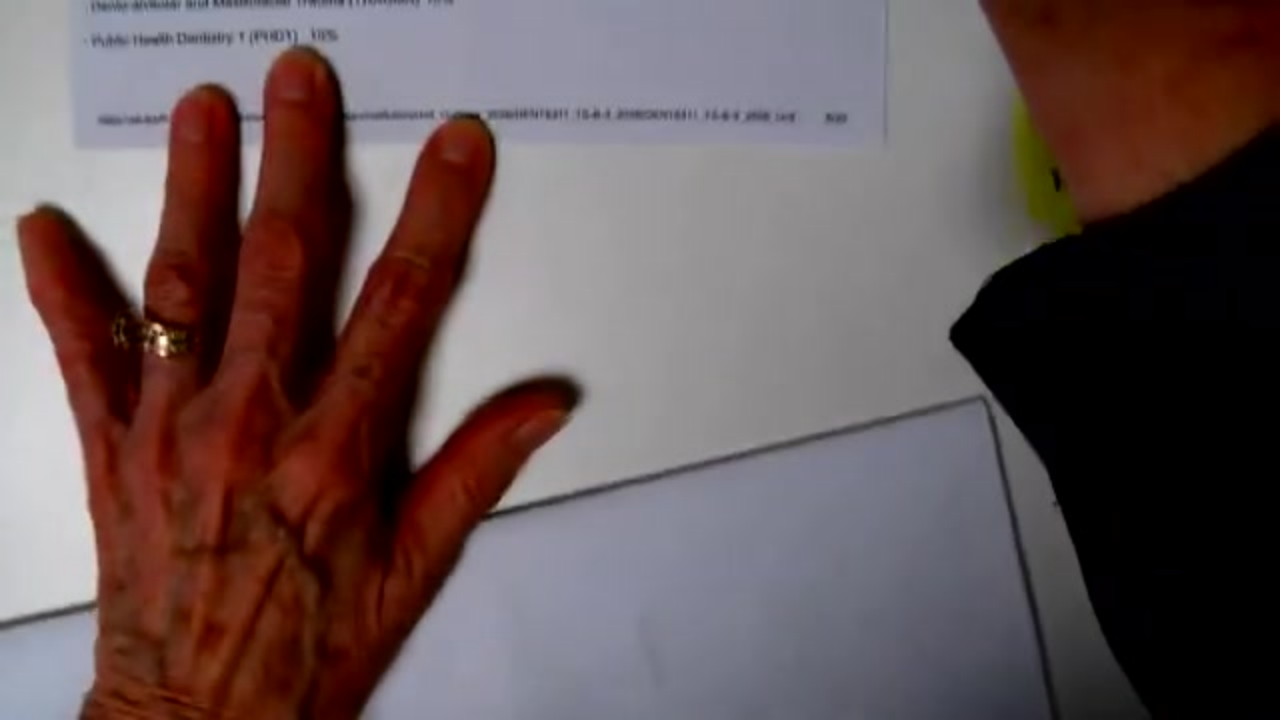
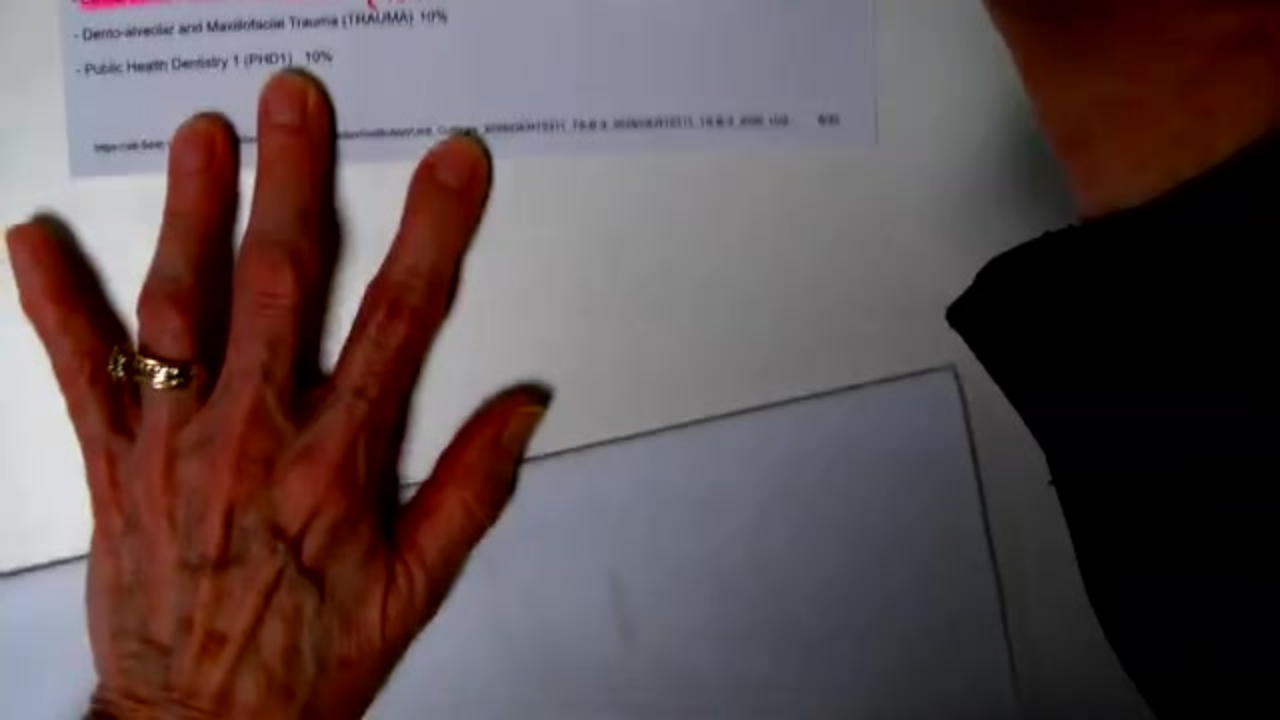



- Dento-alveolar and Maxillofacial Trauma (TRAUMA) 10%
- Public Health Dentistry 1 (PHD1) 10%

1. Assessment overview

The overall unit and each module individually must be passed at a pass mark of 50%. If a Module is not passed, the Board of Examiners will assess the individual assessments and determine eligibility for supplementary or remedial assessments.

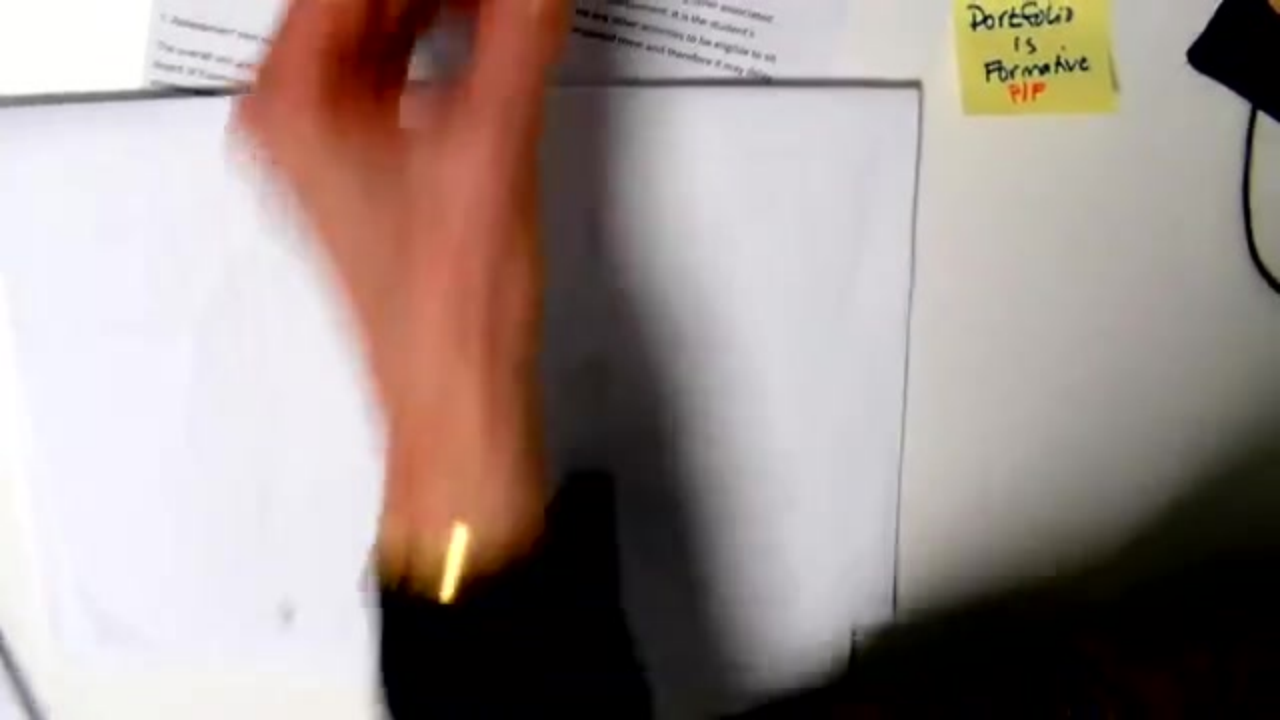
Module	Unit Weighting
- Clinical Dental Practice (CDP4)	40%
- Dento-alveolar and Maxillofacial Trauma (TRAUMA)	10%
- Public Health Dentistry 1 (PHD1)	10%

{ 30% Clinic - Pebblepad
{ 10% Summative Case Presentation

1. Assessment overview

1. Assessment overview

1. Assessment overview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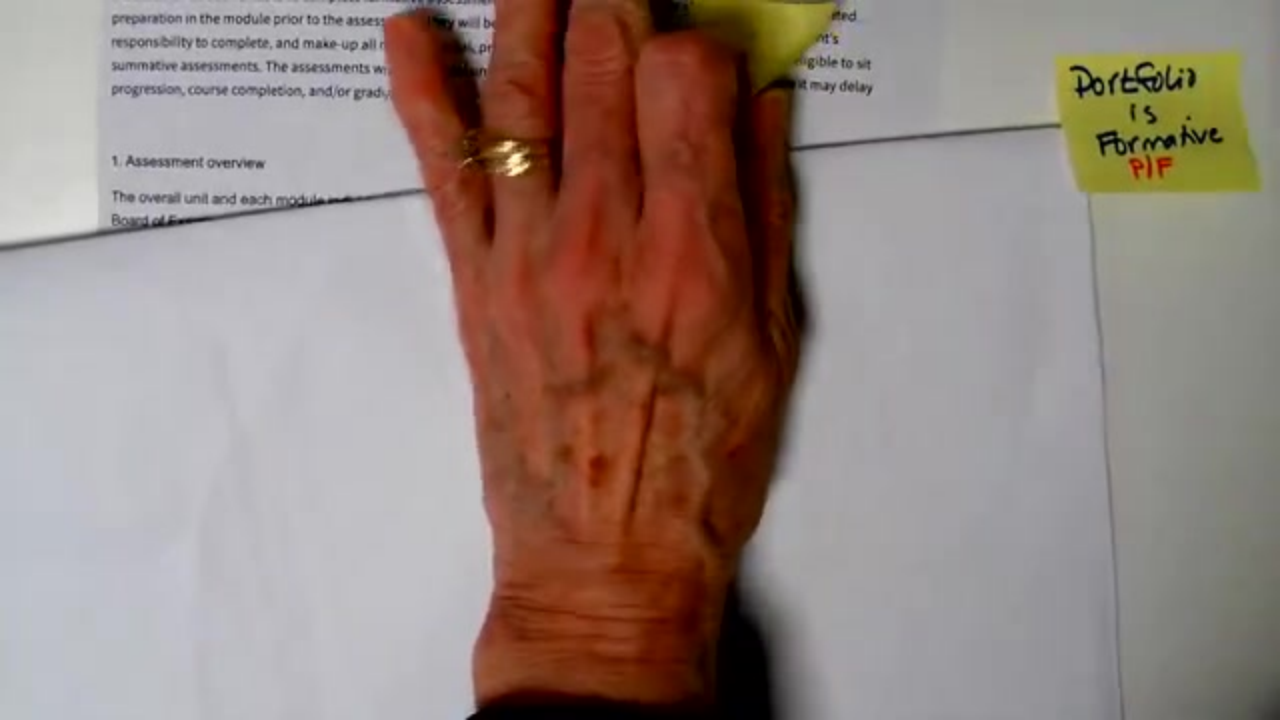
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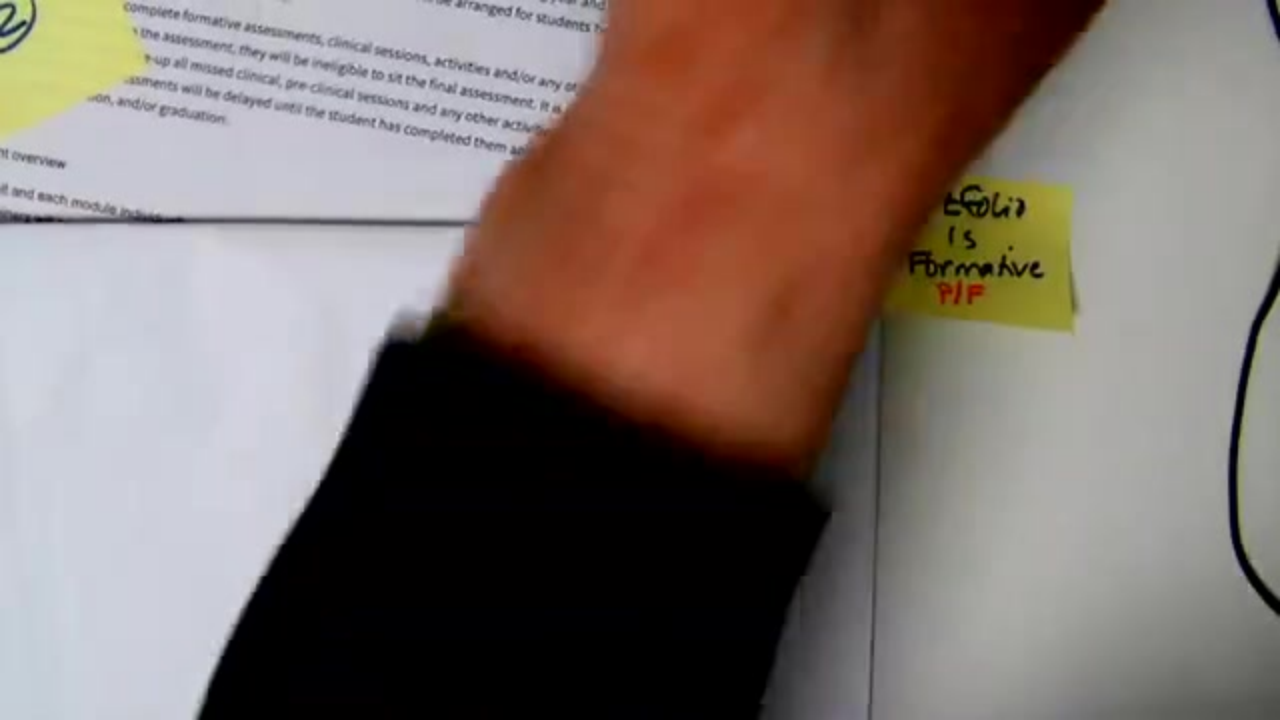
complete formative assessments, clinical sessions, activities and/or any
the assessment, they will be ineligible to sit the final assessment. It
-up all missed clinical, pre-clinical sessions and any other
assments will be delayed until the student has completed them
on, and/or graduation.
nt overview
ll and each module
Is
Formative
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* Cases of unsatisfactory results in failed components

decide if the student can be granted a Supplementary assessment.

Students who fail one or more Modules in DENTS311 will need to defer Semester 1 of the following year and repeat all Modules in DENTS311 if they wish to continue in the DMD program (a remediation plan must be arranged for students before students can attend clinical sessions after an extended approved leave).

If a student has been unable to complete formative assessments, clinical sessions, activities and/or any other associated preparation in the module prior to the assessment, they will be ineligible to sit the final assessment. It is the student's responsibility to complete, and make-up all missed clinical, pre-clinical sessions and any other activities to be eligible to sit summative assessments. The assessments will be delayed until the student has completed them and therefore it may delay progression, course completion, and/or graduation.

1. Assessment overview

The overall unit and each module individually must be passed at a

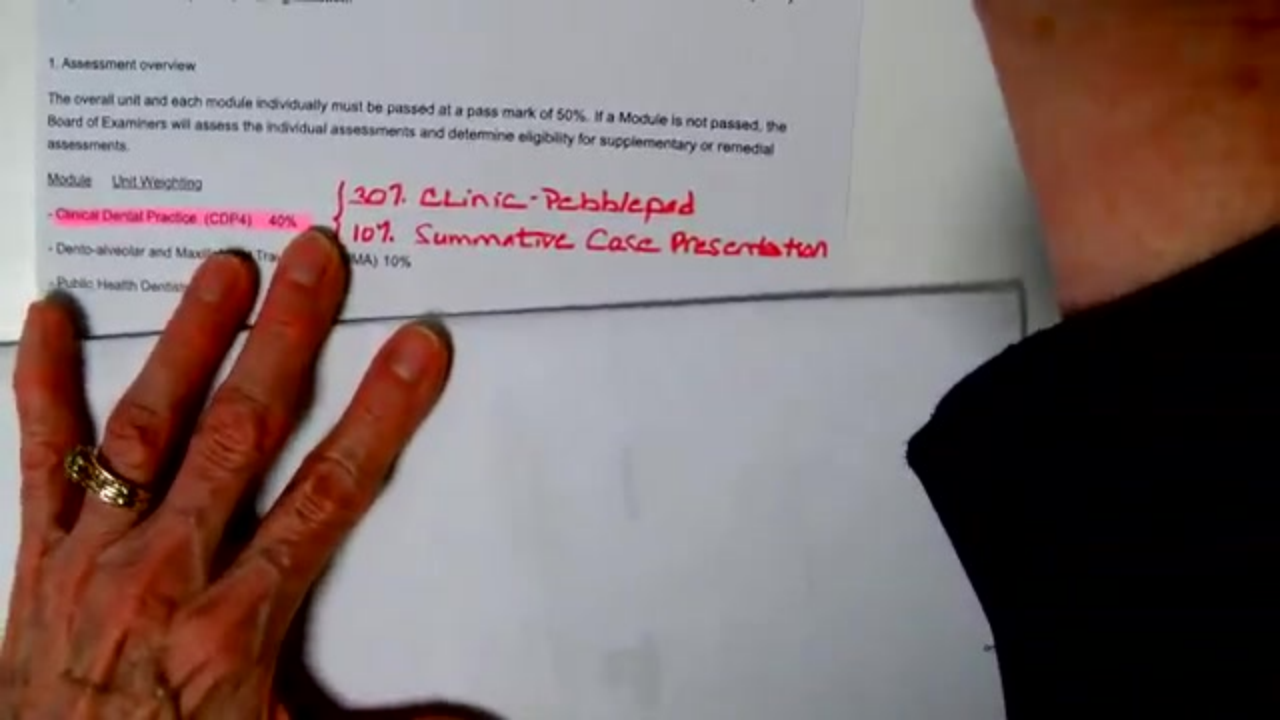
Board of Examiners

1. Assessment overview

The overall unit and each module individually must be passed at a pass mark of 50%. If a Module is not passed, the Board of Examiners will assess the individual assessments and determine eligibility for supplementary or remedial assessments

Module	Unit Weighting
- Clinical Dental Practice (CDP4)	40%
- Dento-alveolar and Maxillofacial Trauma (TRAUMA)	10%
- Public Health Dentistry 1 (PHD1)	10%

30% Clinic - Pebblepad
10% Summative Case Presentation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Unit Weighting
- Clinical Dental Practice (CDP4) 40%
30% Clinic - Pebbleped
10% Summative Case Presentation
- Public Health Dentist
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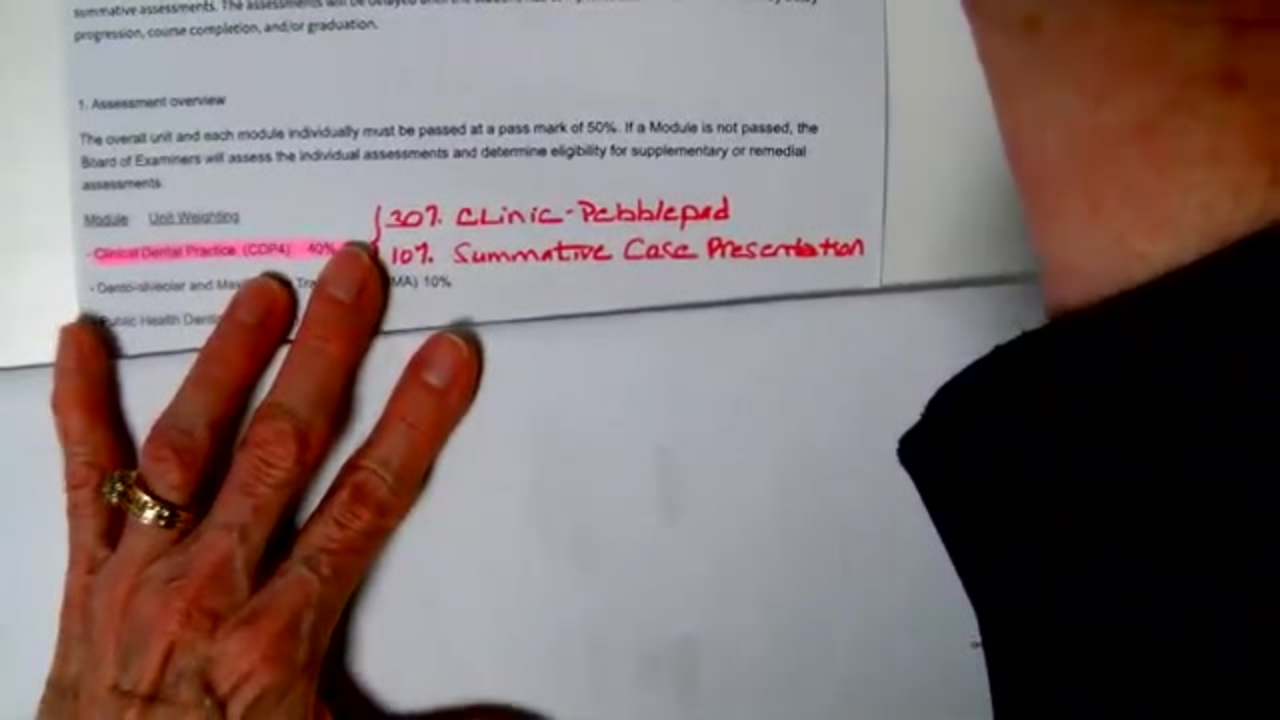
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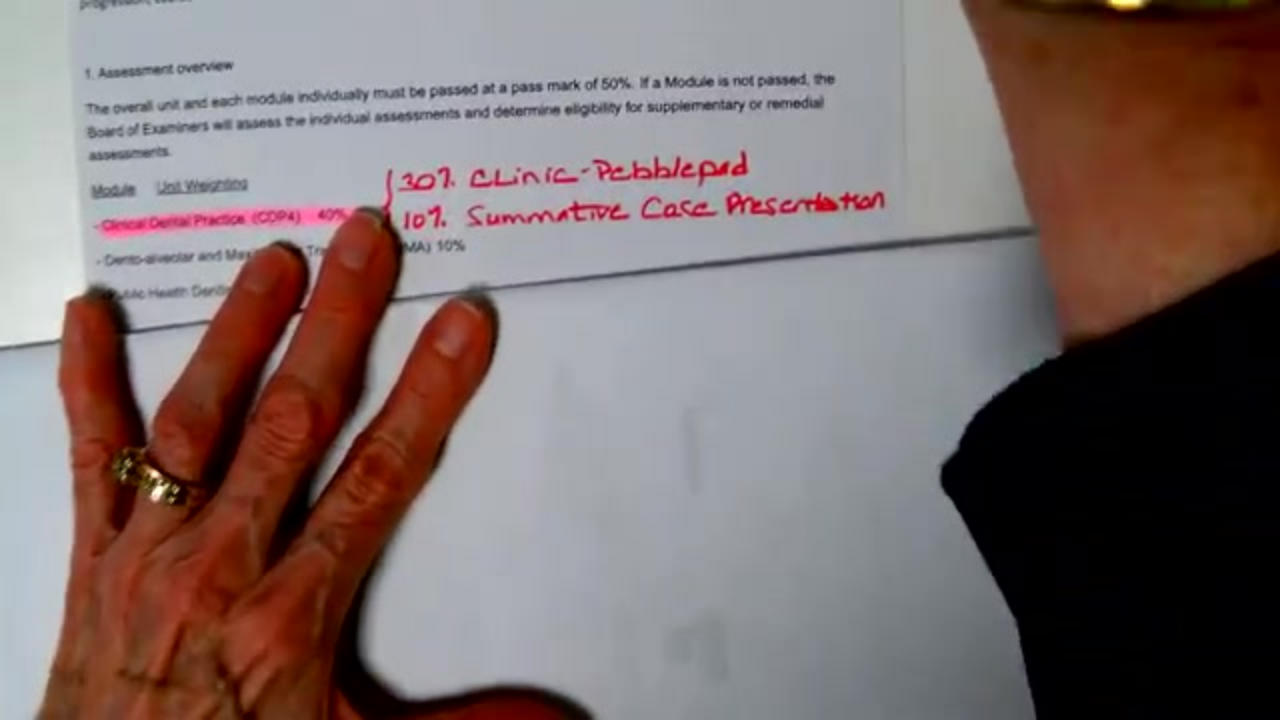
Module
Unit Weighting
Clinical Dental Practice (CDP4)
40%
Dento-alveolar and Ma
Tre
MA) 10%
Public Health Dentis
30% Clinic - Pebbled pad
10% Summative Case Presentation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Module
Unit Weighting
- Clinical Dental Practice (CDP4) 40%
30% Clinic - Pebblepad
10% Summative Case Presentation
MA) 10%

progression, course completion, and/or graduation.

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The overall unit and each module individually must be passed at a pass mark of 50%. If a Module is not passed, the Board of Examiners will assess the individual assessments and determine eligibility for supplementary or remedial assessments.

Module	Unit Weighting
- Clinical Dental Practice (CDP4)	40%
- Dento-alveolar and Maxillofacial Trauma (TRAUMA)	10%
- Public Health Dentistry 1 (PHD1)	10%

30% Clinic - Pebblepad
10% Summative Case Presentation

progression, course completion, and/or graduation.

1. Assessment overview

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Board of Examiners will assess the individual assessments and determine eligibility for supplementary or remedia
assessments.

Module	Unit Weighting
- Clinical Dental Practice (CDPN)	40%
- Dento-alveolar and Maxillofacial Trauma (TRAUMA)	10%
- Public Health Dentistry 1 (PHD1)	10%

30% Clinic - Pebbleped
10% Summative Case Presen

progression, course completion, and/or graduation.

1. Assessment overview

The overall unit and each module individually must be passed at a pass mark of 50%. If a Module is not passed, the Board of Examiners will assess the individual assessments and determine eligibility for supplementary or remedial assessments.

Module Unit Weighting

130% Clinic - Pebbleped

progression, course completion, and/or graduation.

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Module	Unit Weighting
- Clinical Dental Practice (CDP4)	40%
- Dento-alveolar and Maxillofacial Trauma (TRAUMA)	10%

30% Clinic - Pebblepad
10% Summative Case Presentation

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Module	Unit Weighting
- Clinical Dental Practice (CDP4)	40%

30% Clinic - Pebblepad
10% Summative Case Presentation

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0% Clinic-Pebbleped
10% Summative Case Presentation

progression, course completion, and/or graduation.

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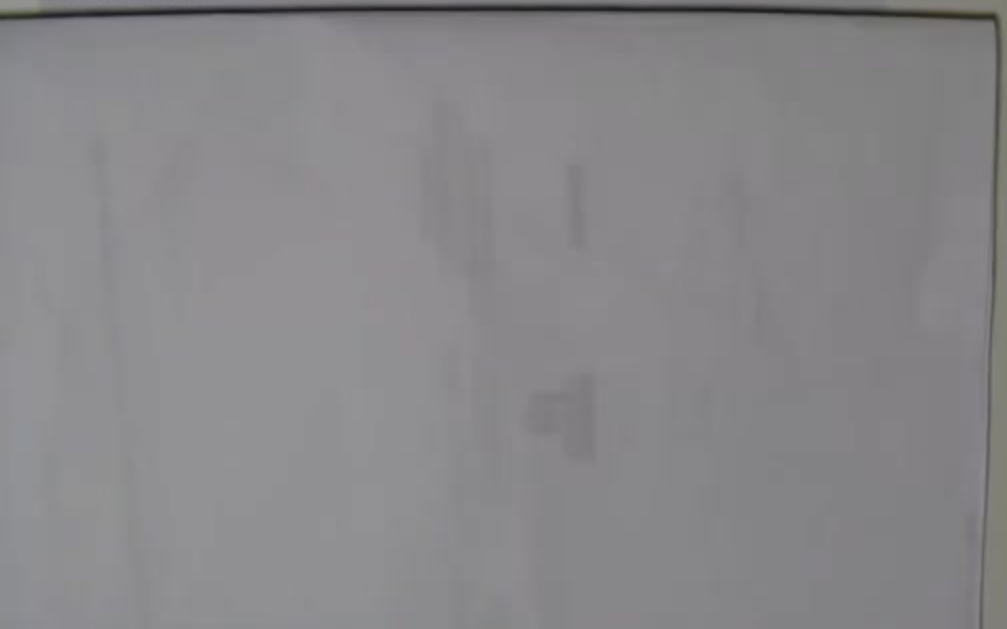
progression, course completion, and/or graduation.

1. Assessment overview



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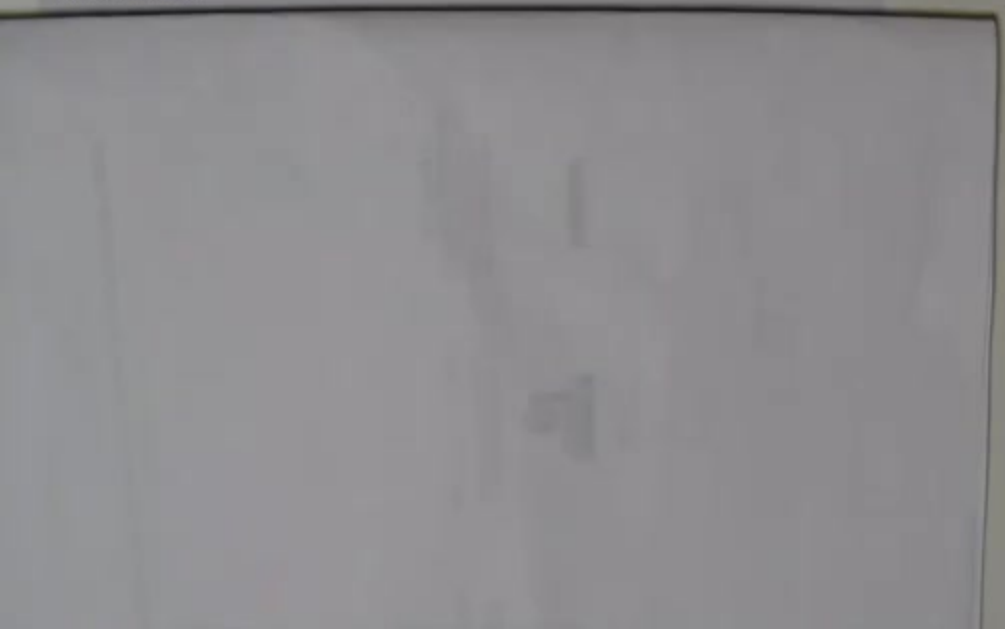
progression, course completion, and/or graduation.

1. Assessment overview



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1. Assessment overview

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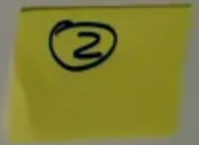

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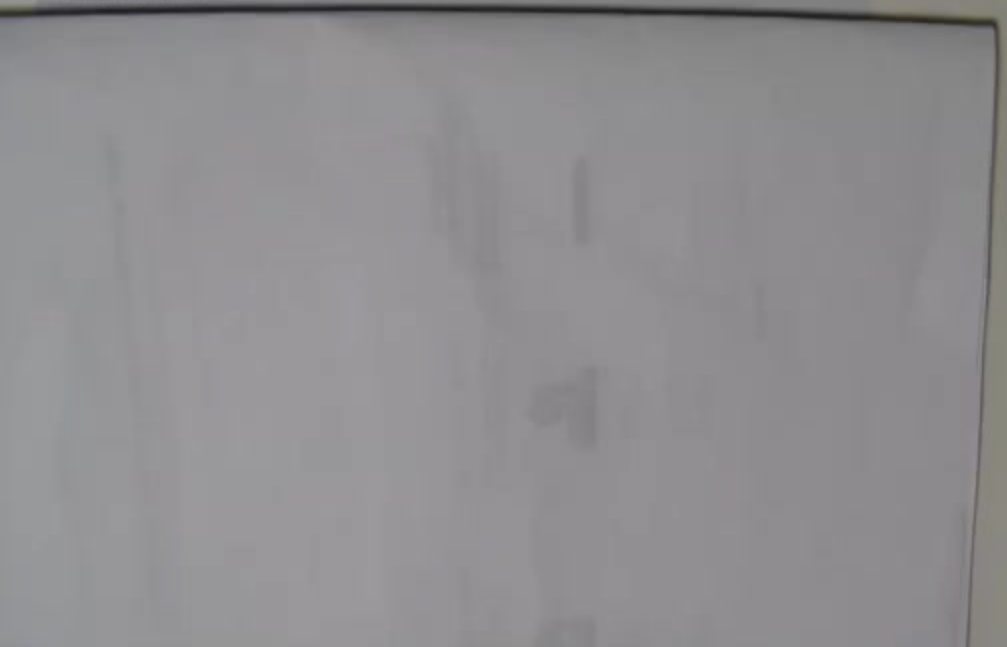

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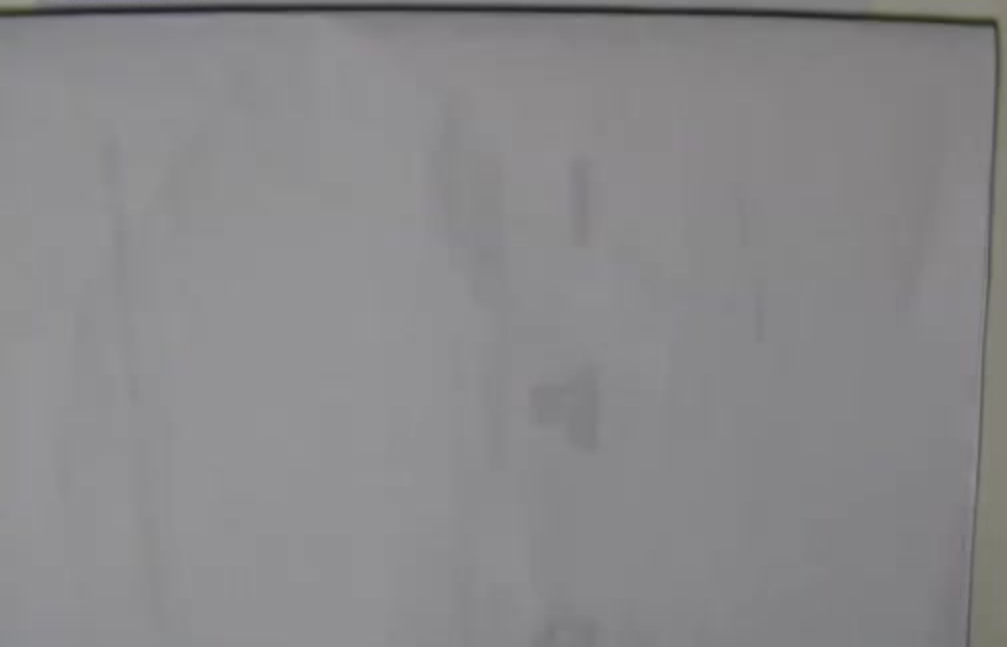
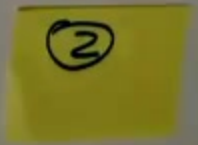
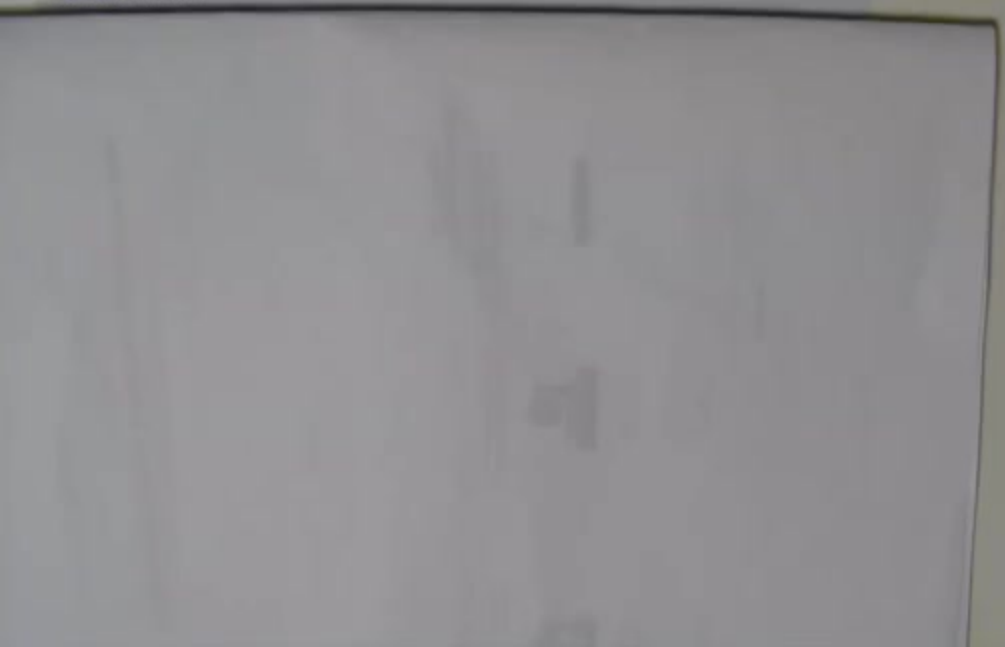




1. Assessment overview



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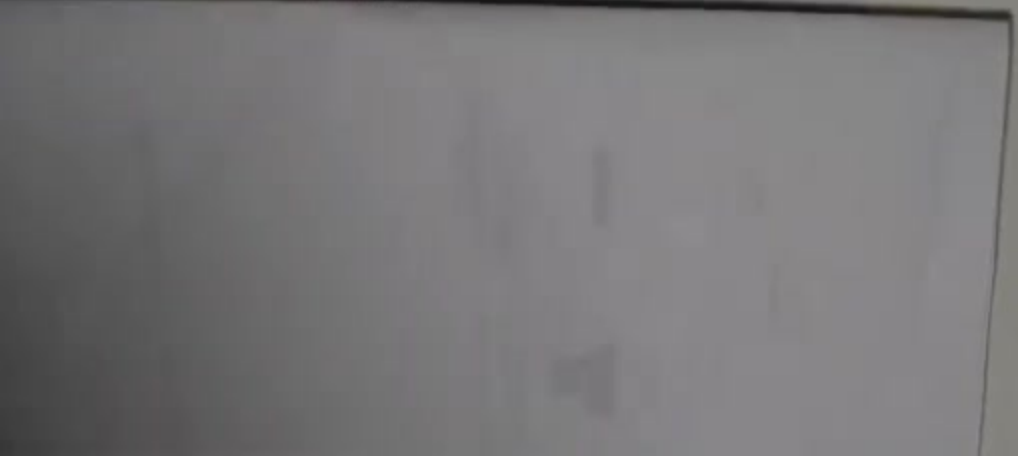
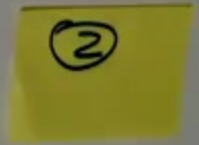
The overall unit and each module individually must be passed at a pass mark of 50%. If a Module is not passed, the Board of Examiners will assess the individual assessments and determine eligibility for supplementary or remedial assessments.

Module	Unit Weighting
Clinical Dental Practice (CDP4)	40%
Dento-alveolar and Maxillofacial Trauma (TRAUMA)	10%

30% Clinic - Pebblepad
10% Summative Case Prescription





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Module	Unit Weighting
- Clinical Dental Practice (CDP4)	40%

30% Clinic-Pebblepad
10% Summative Case Presentation

(2)

1. Assessment overview

The overall unit and each module individually must be passed at a pass mark of 50%. If a Module is not passed, the Board of Examiners will assess the individual assessments and determine eligibility for supplementary or remedial assessments.

Module	Unit Weighting
General Dental Practice (CDP4)	40%
Oral and Maxillofacial Trauma (TRAUMA)	10%
Public Health Dentistry 1 (PHD1)	10%

30% Clinic - Pebblepad
10% Summative Case Presentation

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1. Presenting
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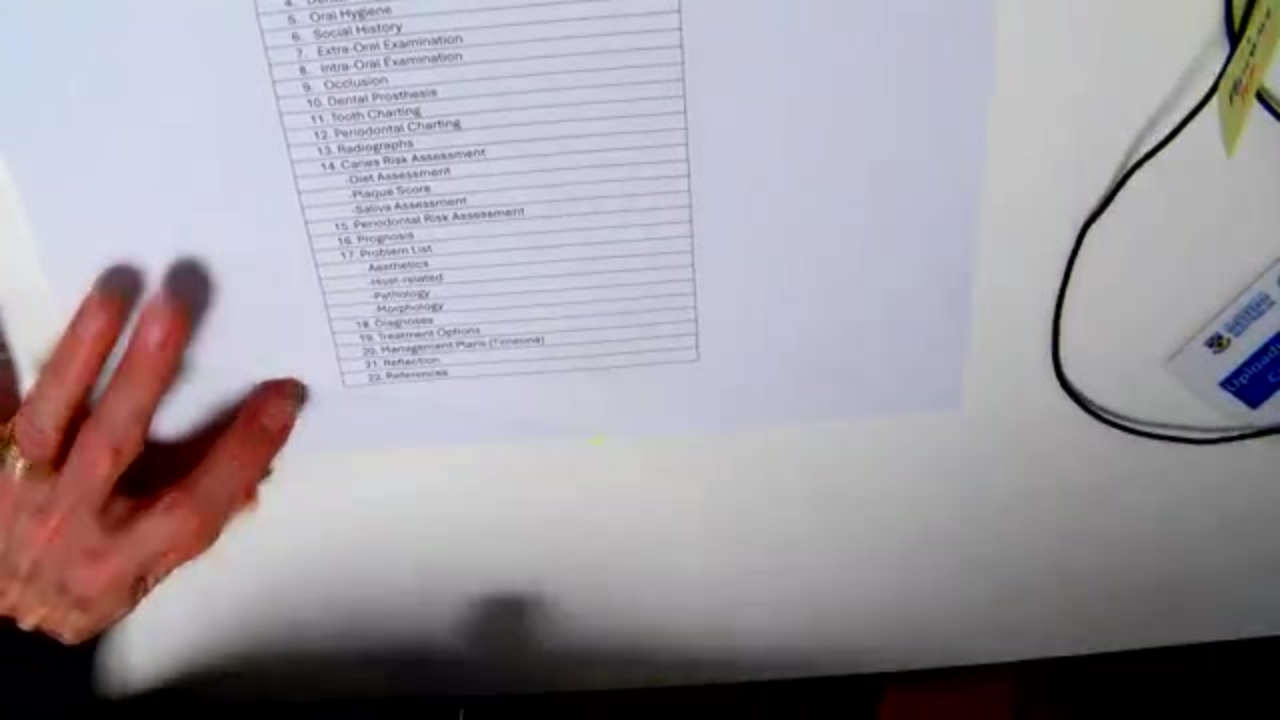
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DENTISTRY

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint

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SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
4. Dental History

DENT5311

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History

DENT5311

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
4. Dental History
5. Oral History

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
4. Dental History
5. Oral Hygiene
6. Social History

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
4. Dental History
5. Oral Hygiene
6. Social History

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
4. Dental History
5. Oral Hygiene
6. Social History
7. Extra-Oral Examination
8. Intra-Oral Examination

SUMMATIVE CASE PRESENTATION FORMAT OCTOBER 2026

1. Presenting Complaint
2. History of Presenting Complaint
3. Medical History
4. Dental History
5. Oral Hygiene
6. Social History
7. Extra-Oral Examination
8. Intra-Oral Examination
9. Occlusion
10. Dental Prosthesis

9. Occlusion
10. Dental Prosthesis
11. Tooth Charting
12. Periodontal Charting

7. Extra-Oral Examination
8. Intra-Oral Examination
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10. Dental Prosthesis
11. Tooth Charting
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11. Tooth Charting
12. Periodontal Charting
13. Radiographs

7. Extra-Oral Examination
8. Intra-Oral Examination
9. Occlusion
10. Dental Prosthesis
11. Tooth Charting
12. Periodontal Charting
13. Radiographs
14. Caries Risk Assessment
-Diet Assessment
-Plaque Score
-Saliva Assessment
15. Periodontal Risk Assessment
16. Prognosis

7. Extra-Oral Examination
8. Intra-Oral Examination
9. Occlusion
10. Dental Prosthesis
11. Tooth Charting
12. Periodontal Charting
13. Radiographs
14. Caries Risk Assessment
-Diet Assessment
-Plaque Score
-Saliva Assessment
15. Periodontal Risk Assessment
16. Prognosis
17. Problem List
-Aesthetics
-Host-related
-Pathology
-Morphology
18. Diagnoses


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SUMMATIVE CASE PRESENTATION NOTES

1. Your **SUMMATIVE** Case Presentations will last 45 minutes
   20 Minutes for you to Present
   25 Minutes for Examiners' Questions
   They will run from Monday, October 12 - Friday, October 16
   -schedules will be provided in late September or early October

2. Arrange your presentation as per the **HEADINGS** on my HO and the LO statements
   The Examiners will expect it to be in that order


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