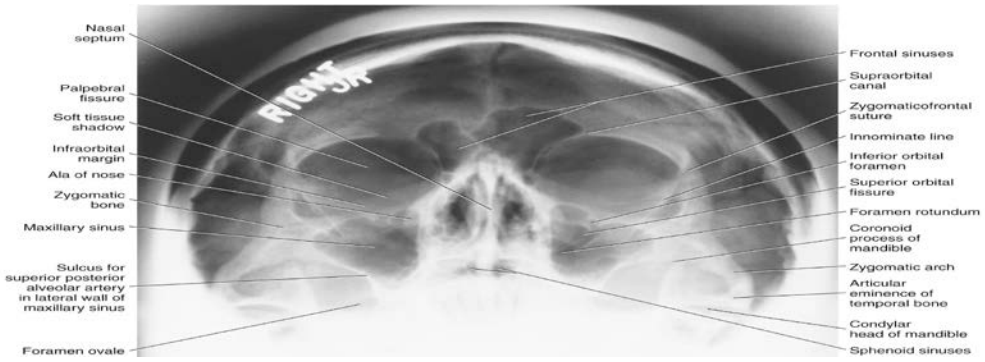
1. Best way to view maxillary sinus? **Water's view** Secondary view PAN

The **Waters projection** is optimal **for visualization of the maxillary sinuses**, especially to compare internal radiopacities, and the frontal sinuses and ethmoid air cells.



(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 27).

3. Lipid solubility and nonionized base. Nonionized is lipid soluble, ionized is water soluble

4. Child has pain? **Osteomyletis**, chronic osteitis

Staph. Aureus is common organism.

Rarely, odontogenic infection may lead to **osteomyelitis**, most commonly involving the mandible. Radiographically, the bone has a 'moth-eaten' appearance. Curettage of the area is required to remove bony sequestra and antibiotics given for at least 6 weeks, dependent on the results of microbiological culture and sensitivity test results.

(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 6).

5. What do you check on bone graft to see if osseous integration worked? **Post**, instant, Pre

6. Extraction sequence

The order in which multiple teeth are extracted deserves some discussion. Maxillary teeth should usually be removed first for several reasons. First, an infiltration anesthetic has a more rapid onset and also disappears more rapidly. This means that the surgeon can begin the surgical procedure sooner after the injections have been given; in addition, surgery should not be delayed because profound anesthesia is lost more quickly in the maxilla. In addition, **maxillary teeth should be removed first because during the extraction process**, debris such as portions of amalgams, fractured crowns, and bone chips may fall into the empty sockets of the lower teeth if the lower surgery is performed first. In addition,

maxillary teeth are removed with a major component of buccal force. Little or no vertical traction force is used in removal of these teeth, as is commonly required with mandibular teeth. A single minor disadvantage for extracting maxillary teeth first is that if hemorrhage is not controlled in the maxilla before mandibular teeth are extracted, the hemorrhage may interfere with visualization during mandibular surgery. Hemorrhage is usually not a major problem because hemostasis should be achieved in one area before the surgeon turns attention to another area of surgery, and the surgical assistant should be able to keep the surgical field free from blood with adequate suction.

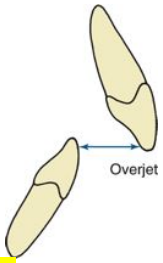
Tooth removal usually begins with extraction of the most posterior teeth first. This allows for the more effective use of dental elevators to luxate and mobilize teeth before the forceps are used to extract the tooth. **The two teeth that are the most difficult to remove, the first molar and canine, should be extracted last.** Removal of the teeth on either side weakens the bony socket on the mesial and distal side of these teeth, and their subsequent extraction is made more straightforward.

Thus, for example, if teeth in the maxillary and mandibular left quadrants are to be extracted, the following order is recommended: **(1) maxillary posterior teeth, leaving the first molar; (2) maxillary anterior teeth, leaving the canine; (3) maxillary first molar; (4) maxillary canine; (5) mandibular posterior teeth, leaving the first molar; (6) mandibular anterior teeth, leaving the canine; (7) mandibular first molar; and (8) mandibular canine.**

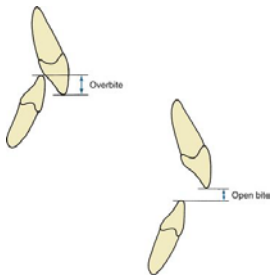
(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 8.3.2).

7. Horizontal overlap **2-4 mm of overjet**

Overjet is defined as **horizontal overlap** of the incisors. Normally, the incisors are in contact, with the upper incisors ahead of the lower by only the thickness of their incisal edges (i.e., **2-3 mm overjet is the normal relationship**). If the lower incisors are in front of the upper incisors, the condition is called *reverse overjet or anterior crossbite*.



Overbite is defined as **vertical overlap** of the incisors. Normally, the lower incisal edges contact the lingual surface of the upper incisors at or above the cingulum (i.e., **normally there is 1 to 2mm overbite**). In open bite, there is no vertical overlap, and the vertical separation of the incisors is measured to quantify its severity.



(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 1.3).

? ??8. Which is harder to anesthesize? Mx molar IRP, chronic

9. Hemisection: cut molar into 2, premolar

Hemisection is the splitting of a two-rooted tooth into two separate portions. This process has been called ***bicuspidization* or *separation*** because it changes the molar into two separate roots. **Hemisection is most likely to be performed on mandibular molars with buccal and lingual class II or III furcation involvements**.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 68.6.2).

10. Mucopolysaccaride is answer Hunter Hurler
11. Undercut
12. 2 questions about reducing max tuberosity –denture wont fit because of undercut

The primary objective of soft tissue **maxillary tuberosity reduction** is **to provide adequate interarch space for proper denture construction in the posterior area and a firm mucosal base of consistent thickness over the alveolar ridge denture-bearing area**. Maxillary tuberosity reduction may require the removal of soft tissue and bone to achieve the desired result. The amount of soft tissue available for reduction can often be determined by evaluating a presurgical panoramic radiograph. If a radiograph is not of the quality necessary to determine soft tissue thickness, this depth can be measured with a sharp probe after local anesthesia is obtained at the time of surgery.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 13.5.1).

13. LED curing vs regular curing? Why is LED curing beter? Range, last longer
LED range 400-499nm or 460-490nm, causes damage of retina of eye, depth of 2mm

Most recently developed are the LED curing units. These units have a number of advantages compared to other curing units, including a **wavelength spectrum emission that is closely matched to camphorquinone**. In addition, these units are **more energy efficient**, allowing them to be battery operated. The diodes have a **life span that is approximately 1,000 times longer than the typical halogen bulb**. While the earlier versions of LED curing units provided inadequate irradiance, the newer generation has overcome this deficiency. **About the only disadvantage to these units is their narrow**

wavelength spectrum, limiting their usefulness in curing any materials that do not use camphorquinone as the photoinitiator.

The practical consequence is that curing depth is limited to **2 to 3 mm** unless excessively long exposure times are used, regardless of lamp intensity.

(Anusavice, Kenneth J.. *Phillips' Science of Dental Materials, 11th Edition*. Saunders Book

(Summitt, James B.. *Fundamentals of Operative Dentistry: A Contemporary Approach, 3rd Edition*. Quintessence Publishing (IL), 012006. 10.9.10).

14. Test for boy/girl-chi square

t-test is statistical difference bwtn 2 median, ex the diffr. Btwn the control group and group receiving the tx.

Chi-square (χ^2) test: the chi-square test measures the association between two categorical variables.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

15. How do you know if it's a non-odontogenic tumor, pain doesn't subside

Non-odontogenic tumo. r toothache can often be differentiated from odontogenic toothache by local provocation. Pulpal and periodontal pains are increased by local provocation of the teeth such as percussion, hot, cold, or biting forces. When toothache pain is not increased by provocation, one should be suspicious of nondental toothache. **Local anesthetic can be very helpful in differentiating true dental pain from pain referred to the teeth**.[104-106] Local anesthetic applied in the region of a true dental toothache will reduce or eliminate the pain. **Local anesthetic at the site of the nonodontogenic toothache often will not reduce the pain since the site of pain is not the true source of pain**.

???Odontogenic tumor relieved by _____=osteoma
Not relieved by aspirin is osteoma, osteoblastoma

(American Academy Of Orofacial Pain, Jeffrey P. Okeson. *Orofacial Pain: Guidelines for Assessment, Diagnosis & Management, 3rd Edition*. Quintessence Publishing (IL), 011996. 7.1.4).

16. Difference between 245 (**inverted cone**) and 330 (**pear shape**) bur 245 longer

17. What turns porcelain green? **Copper or silver**

Porcelain that is baked onto a high –fusing gold alloy may exhibit a green discoloration due most likely to contamination of the metal by **COPPER traces**. (Dental Decks)

Examples of metallic oxides and their respective color contributions to porcelain include iron or nickel oxide (brown), copper oxide (green), titanium oxide (yellowish brown), manganese oxide (lavender), and cobalt oxide (blue). Opacity may be achieved by the addition of cerium oxide, zirconium oxide, titanium oxide, or tin oxide.

(Anusavice, Kenneth J.. *Phillips' Science of Dental Materials, 11th Edition*. Saunders Book Company, 072003. 24.7.4).

18. Referred pain

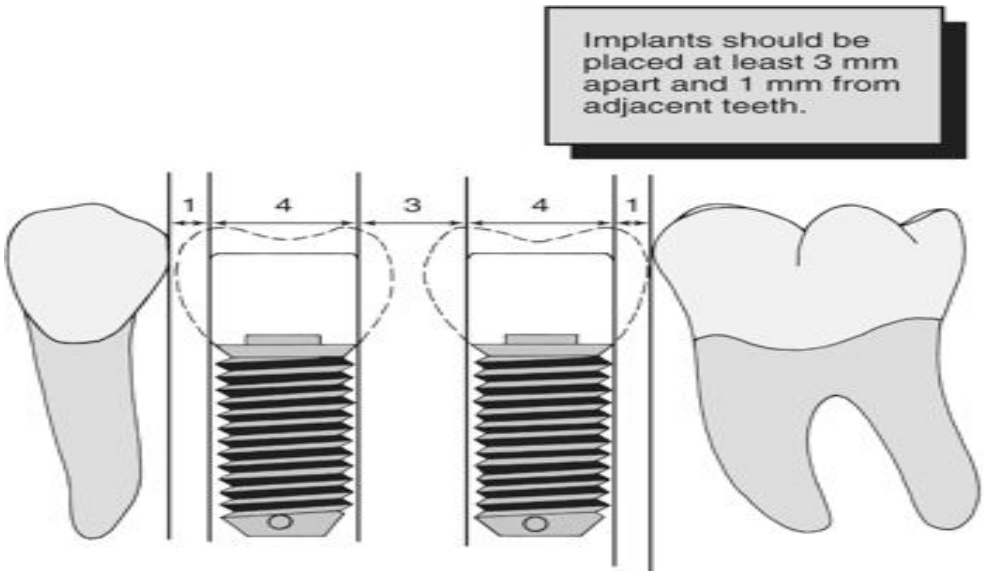
Referred pain: Pain experienced from a site other than the site of the stimulus or tissue damage. Afferent fibers from several sites (possibly some distance from each other) converge on second-order neurons; then central cognitive processes mistake the true site.
(Walton, Richard E.. *Principles and Practice of Endodontics, 3rd Edition*. Saunders Book Company, 012002. 29.2.1).

19. Warfarin, Coumadin, wha. t test do you use? **INR (with in 24hrs presurgery)**
INR of 1=normal

Warfarin can be monitored via PT (Extrinsic pathway) time. **Patients who take warfarin (Coumadin) for anticoagulation must have a current international normalized ratio (INR) determined before any invasive procedure can be performed.** Most dental procedures, including minor surgery, may be performed safely without discontinuation or alteration of the Coumadin dosage, **as long as the INR is within the therapeutic range (3.5 or less)**. Local hemostatic measures generally are adequate to control bleeding and include the use of hemostatic agents in the sockets, suturing, gauze pressure packs, and tranexamic acid or e-aminocaproic acid mouth rinses. More extensive surgical procedures associated with anticipated significant blood loss should be discussed with the patient's physician.

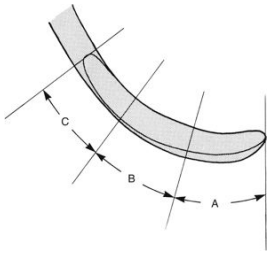
(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 4.4.1.2)..:’

20. **How far you place implants from tooth**? **1mm from adjacent tooth**



Recommended minimum distances (in millimeters) between implants and between implants and natural teeth. (From Rosenstiel SF, Land MF, Fujimoto J: *Contemporary Fixed Prosthodontics*, ed 4, St Louis, Mosby, 2006.)

21. Remove rampant caries from anterior
22. Curretage what part of blade do you use in perio? **Lower third** **(apical 1/3 aka Toe)**



Gracey curette blade divided into three segments: ***A*, the lower one third of the blade**, consisting of the terminal few millimeters adjacent to the toe; *B*, the middle one third; and *C*, the upper one third, which is adjacent to the shank.

If only the middle third of the working end is adapted on a convex surface so that the blade contacts the tooth at a tangent, *the toe or sharp tip will jut out into soft tissue, causing trauma and discomfort. If the instrument is adapted so that only the toe or tip is in contact, the soft tissue can be distended or compressed by the back of the working end, also causing trauma and discomfort.* A curette that is improperly adapted in this manner can be particularly damaging because the toe can gouge or groove the root surface. Only the **lower third** or half of the Gracey blade is in contact

with the tooth during instrumentation. **Concentrate on using the lower third of the cutting edge for calculus removal.**

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 51.2.6.1).

23. Pregnant lady? Lay right side up, what is artery are you protecting?

During late pregnancy, a phenomenon known as supine hypotensive syndrome may occur that manifests as an abrupt fall in blood pressure, bradycardia, sweating, nausea, weakness, and air hunger when the patient is in a supine position. Symptoms are caused by impaired venous return to the heart that results from **compression of the inferior vena cava** by the gravid uterus. This leads to decreased blood pressure, reduced cardiac output, and impairment or loss of consciousness. **The remedy for the problem is to roll the patient over onto her left side (*right hip up*),** which lifts the uterus off the **vena cava**. Blood pressure should rapidly return to normal. (Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 18.1.1).

24. If patient is laying backwards and going into syncope what is being smushed?
Abdominal aorta
(couldn't find anything about abdominal aorta being smushed!!)
25. Periapical abcsess vs periapical radiolucency which do you do first? **Endo then perio**
26. Mandibular incisor coming in crowded how do you make space? Interarch distance from **primitive space**
Distal to canine for mandibular arch and mesial to canine for maxillary arch

27. Which do you gain back? Tooth mobility, bone, etc,

28. Neurapraxia

The three types of nerve injuries are (1) neurapraxia, (2) axonotmesis, and (3) neurotmesis .

Neurapraxia, the least severe form of peripheral nerve injury, is a contusion of a nerve in which continuity of the epineurial sheath and the axons is maintained. Blunt trauma or traction (i.e., stretching) of a nerve, inflammation around a nerve, or local ischemia of a nerve can produce a neurapraxia. **Because there has been no loss in axonal continuity, spontaneous full recovery of nerve function usually occurs in a few days or weeks.**

Three types of peripheral nerve injury. **A, Neurapraxia. Injury to nerve causes no loss of continuity of axon or endoneurium**. Example shown is implant placed in inferior alveolar canal, compressing the nerve. **B,** Axonotmesis. Injury to nerve causes loss of axonal continuity but preserves endoneurium. Example shown is overly aggressive retraction of mental nerve. **C,** Neurotmesis. Injury to nerve causes loss of axonal and endoneurium continuity. Example is cutting of inferior alveolar nerve during removal of deeply impacted third molar.

Axonotmesis has occurred when the *continuity of the axons but not the epineurial sheath is disrupted*. Severe blunt trauma, nerve crushing, or extreme traction of a nerve can produce this type of injury. **Because the epineural sheath is still intact, axonal regeneration can (but does not always) occur with a resolution of nerve dysfunction in 2 to 6 months.**

Neurotmesis, **the most severe type of nerve injury**, involves a **complete loss of nerve continuity**. This form of damage can be produced by badly displaced fractures, severance by bullets or knives during an assault, or by iatrogenic transection. **Prognosis for spontaneous recovery of nerves that have undergone neurotmesis is poor**, except if the ends of the affected nerve have somehow been left in approximation and properly oriented.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 4.3.6.1).

29. Key to RCT, cleaning and shaping, why did it fail

Most nonhealing (failures) of root canal treatments is directly or indirectly caused by bacteria somewhere in the root canal system. In general, the most common causes of failure are (1) errors in diagnosis and treatment planning, (2) coronal leakage, (3) lack of knowledge of pulp anatomy, (4**) inadequate débridement and/or disinfection of the root canal system**, (5) inadequate restorative protection, (6) operative errors, (7) obturation deficiencies or errors, and (8) vertical root fracture.

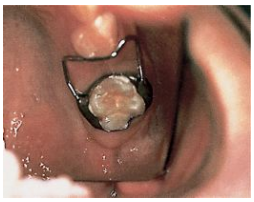
(Walton, Richard E.. *Principles and Practice of Endodontics, 3rd Edition*. Saunders Book Company, 012002. 19.8).

30. Manic depressive not taking medicine what will happen? **Mood swings**

Drug therapy is essential in bipolar disorder for achieving two goals: rapid control of symptoms in acute episodes of mania and depression, and prevention of future episodes or reduction of their severity and frequency. **Mood disorders have a tendency to recur**. Affective episodes may occur spontaneously or may be triggered by adverse events. Individuals with mood disorders and their families must become aware of the early signs and symptoms of affective episodes, so that treatment can be initiated. **These individuals also must be made aware of the need for medication compliance and of the medication's adverse effects and possible complications.**

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 29).

31. **Band and loop** for 1st primary molar



A band and loop space maintainer. The placement of a space maintainer must not compromise the permanent tooth. Bands should be cemented with a luting glass ionomer as a protection against caries and the appliance reviewed regularly. As the premolar erupts, the appliance is removed when there is interference with normal emergence. ***The distal shoe is the appliance of choice when a primary second molar is lost before eruption of the permanent first molar.***

(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 9.4.3.2).

32. 5 year old child having pain what do you give them? Asprin, ibuprofen, codeine, **acetominphen**

Aspirin compounds and non-steroidal antiinflammatory agents are *contraindicated* because about 4% of patients experience wheezing after taking these drugs. **Acetaminophen is recommended.**

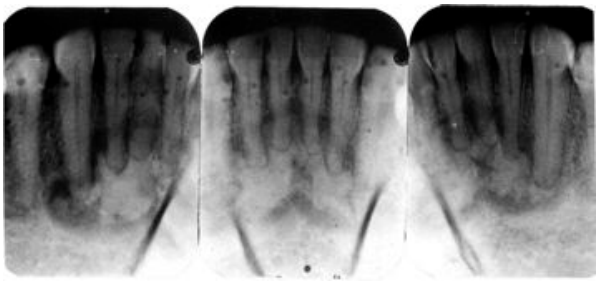
(McDonald, Ralph. *Dentistry for the Child and Adolescent, 8th Edition*. Mosby, 022004. 23.14.1).

33. PCOD

Periapical cemento-osseous dysplasia

1. A reactive process of unknown cause that requires no treatment.
2. Clinical features
   a. **Commonly seen at the apices of one or more mandibular anterior teeth.**
   b. **No symptoms; teeth vital**.
   c. Most frequently seen in **middle-aged women.**
   d. Starts as circumscribed lucency, which gradually becomes opaque.
   e. An exuberant form that may involve the entire jaw is known as florid osseous dysplasia.

Periapical cemento-osseous dysplasia.



34. Which least likely to have hepatitis B? café workers @ hospital, down syndrome, **diabetic**

Hepatitis B virus (HBV)

(1) *Etiology:* the disease is produced by a highly infective virus known as the **Dane particle**. This intact virus consists of an inner core antigen (HBcAg) and an outer coat surface antigen (HBsAg).

(2) *Risk of transmission:* 30% after percutaneous injury from an *infected* patient. As little as 1×10^{-8} mL of blood can transmit the disease.

(3) *Diagnosis:* HBV is diagnosed based on a physical examination, medical history, and blood tests. HBV blood tests include hepatitis B antigens and antibodies, and hepatitis B viral DNA (HBV DNA), which detects genetic material (DNA) from the HBV.

(4) *Prevention:* **a vaccine to immunize recipients against HBV is available**. Three doses are given to confer immunity: an initial dose, followed by a second dose at 1 month, and then a third dose 6 months after the first. Since HBV is highly infectious, all dental personnel should be vaccinated against HBV.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.4).

35. Freeze dried bone: **allograft**

Several clinical studies by Mellonig, Bowers, and co-workers reported bone fill exceeding 50% in 67% of the defects grafted with **freeze-dried bone allograft (FDBA)** and in 78% of the defects grafted with FDBA plus autogenous bone.[129,158,171] *FDBA, however, is considered an osteo-conductive material*, whereas *decalcified FDBA (DFDBA) is considered an osteoinductive graft*. Laboratory studies have found that **DFDBA has a higher osteogenic potential than FDBA and is therefore preferred**. DFDBA in periodontal defects results in significant probing depth reduction, attachment level gain, and osseous regeneration ; the combination of DFDBA and GTR has also proved to be very successful.- However, limitations of the use of DFDBA include the possible, although remote, potential of disease transfer from the cadaver.

FDBA= *osteo-conductive- potential of graft material to serve as a scaffold that favors outside cells to penetrate the graft and form new bone. (Mosby p260)*

DFDBA= *osteoinductive-the ability of the graft to contain molecules that convert neighboring cells into osteoblast. (Mosby p260)*

36. OKC-most likely to reoccur

The ***odontogenic keratocyst (OKC)*** is an important entity to differentiate from other odontogenic cysts because of its potential to be **aggressive**. OKCs can be seen at any age but are most often diagnosed in patients between ages 10 and 40. They occur most commonly in males within the **posterior mandible**. Radiographically, OKCs present as well-defined unilocular or multilocular radiolucencies. *Histologically, the cyst lining consists of a thin layer of parakeratinized or orthokeratinized stratified squamous*

epithelium with a prominent basal cell layer and a corrugated appearance of the epithelial surface. **Treatment requires aggressive and complete removal of the lesion, as recurrence rates for inadequately removed lesions can reach 60%.** Multiple OKCs may occur; these patients should be evaluated for **nevoid basal cell carcinoma syndrome (Gorlin syndrome)**

(Kumar, Vinay. *Robbins & Cotran Pathologic Basis of Disease, 7th Edition*. Saunders Book Company, 082004. 16.1.6).

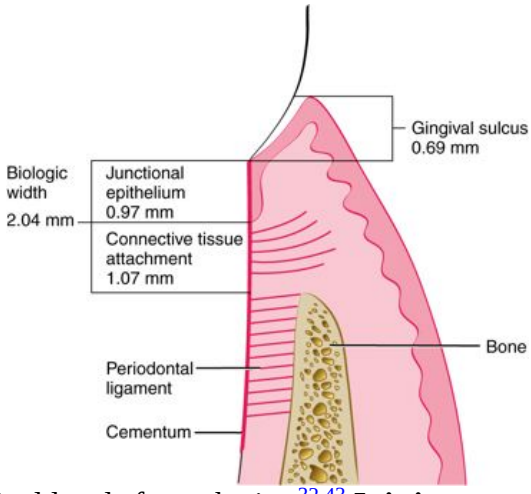
37. Nevoid BC

Nevoid basal cell carcinoma syndrome (Gorlin syndrome) is an autosomal dominant inherited condition that exhibits high penetrance and variable expressivity. The syndrome is caused by mutations in **patched** *(PTCH)*, a tumor suppressor gene that has been mapped to chromosome 9q22.3-q31. Approximately 35% to 50% of affected patients represent new mutations. The chief components are **multiple basal cell carcinomas of the skin odontogenic keratocysts(postr mandibule)** , **intracranial calcification (calcification of falx cerebri and frontal bossing)** , and **rib and vertebral anomalies**. Many other anomalies have been reported in these patients and probably also represent manifestations of the syndrome. The prevalence of Gorlin syndrome is estimated to be about 1 in 60,000.

(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 15.1.7).

38. #8 Reduce @ gingival-need crown lengthening

Surgical crown-lengthening procedures are performed to provide retention form to allow for proper tooth preparation, impression procedures,[21] and placement of restorative margins



and to adjust gingival levels for esthetics.[32,43] **It is important that crown-lengthening surgery is done in such a manner that the biologic width is preserved. The *biologic width* is defined as the physiologic dimension of the junctional epithelium and connective tissue attachment**. This measurement has been found to be relatively constant at **approximately 2 mm** (±30%).[10] The healthy gingival sulcus has shown an average depth of 0.69 mm.[19] It has been the orized that infringement on the biologic width by the placement of a restoration within its zone may result in gingival inflammation,

The biologic width has been estimated to be about 2 mm. Efforts should be made to preserve its integrity.

pocket formation, and alveolar bone loss. **Consequently, it is recommended that there be at least 3.0 mm between the gingival margin and bone crest**.[12,38,39,41] **This allows for adequate biologic width when the restoration is placed 0.5 mm within the gingival sulcus**.

Surgical crown lengthening may include the removal of soft tissue or both soft tissue and alveolar bone. **Reduction of soft tissue alone is indicated if there is adequate attached gingiva and more than 3 mm of tissue coronal to the bone crest**. This may be accomplished by either gingivectomy or flap technique. **Inadequate attached gingiva and less than 3 mm of soft tissue require a flap procedure and bone recontouring**. In the case of caries or tooth fracture, to ensure margin placement on sound tooth structure and retention form, the surgery should provide at least 4 mm from the apical extent of the caries or fracture to the bone crest.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 71.4.3).

39. Material least to do impression with-irreverisble hydrocolloid, polyether

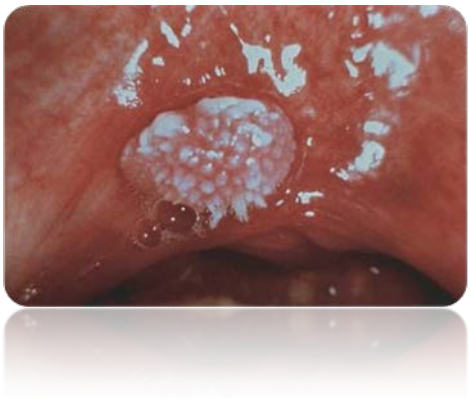
40. H2 histamine-gastric reflux

H_2 histamine receptor blockers inhibit the action of histamine on the parietal cell of the stomach. H2 treat Zollinger-Ellision Syndrome, GERD, acid reflux. Examples are Cimetidine(Tagament), Ranitidine(Zantac), and Famotidine(Pepcid) and Nizatidine(Axid), Omeprazole (Prilosec) and Lansoprazole(Prevacid)

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 8.6.4).

41. Hue, value, chroma which is in 100ths? HUE

42. Papilloma



(Langlais, Robert P.. *Color Atlas of Common Oral Diseases, 3rd Edition*. Lippincott Williams & Wilkins, 012003. 10.3.5).

The squamous papilloma is a **soft, painless, usually pedunculated, exophytic nodule with numerous fingerlike surface projections that impart a "cauliflower" or wartlike appearance**

(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 10.1.1).

43. Apexification-when do u use-nonvital want to close apex

Apexification is a method of treatment for immature permanent teeth in which root growth and development ceased **due to pulp necrosis**. Its purpose is to allow the formation of an apical barrier. Apexification is most often performed in incisors that lost vitality after a traumatic injury. It may also be indicated in nonvital immature teeth after carious exposures, and in certain anatomic variations such as dens invaginatus.

When a diagnosis of irreversible pulpitis, pulp necrosis, or acute or chronic apical periodontitis has been established, treatment should be planned. The most important consideration is whether the tooth can be restored to function and aesthetics. The apexification procedure can be done in young patients with short roots. However, because of the long duration of the treatment, patients' and parents' compliance is required. Apexification is a predictable procedure, and an apical barrier will be formed in 74% to

100% of cases.[75] The most common complication is cervical crown or root fracture because the cervical portion of the tooth is very thin and may fracture easily.[22]

Apexification is traditionally performed using a **calcium hydroxide** dressing that disinfects the root canal and induces apical closure. The high pH and low solubility of calcium hydroxide keeps its antimicrobial effect for a long period.[28] Siqueira and Lopes discussed the mechanisms of its antimicrobial activity in detail.[76] Calcium hydroxide assists in the debridement of the root canal, as it increases the dissolution of necrotic tissue when used alone or in combination with sodium hypochlorite.[37] Apexification requires multiple visits and could take a year or more[52] to achieve a complete apical barrier that would allow root canal filling using gutta-percha and sealer. The time needed for apexification depends on the stage of root development and the status of the periapical tissue.

Root-end resection (periradicular surgery or apicoectomy)

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition.* Mosby, 042005. 33.4.1).

44. Apicoectomy-when do you do it-ant get to apex

1. Indications

a. Persistent or enlarging periradicular pathosis following nonsurgical endodontic treatment.

b. Nonsurgical endodontics is unfeasible when:

(1) A marked overextension of obturating materials is interfering with healing.

(2) Biopsy is necessary.

(3) Access for root-end preparation and root-end filling is necessary.

(4) When the apical portion of the root canal system with periradicular pathosis cannot be cleaned, shaped, and obturated.

(Mosby. *Mosby's Review for the NBDE, Part II.* Mosby, 042007. 1.2.2).

45. Calcified canal what do you do-**refer**
46. When is it ok to do a temporary fixing on patient? Emergency
47. Incidence 100/1000

***Incidence**:* indicates the number of new cases that will occur within a population over a period of time (e.g., the incidence of people dying of oral cancer is 10% per year in men aged 55 to 59 in our community).

Incidence = Number of new cases of the disease / Total number of people at risk

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

48. Principle of tell show do:

the great majority of children require minimal management efforts other than providing information on what is going to happen (e.g., **tell, show, and do**). An important caveat is that every child responds to his or her environment with an individualized style.

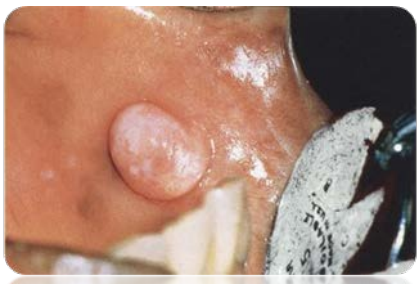
(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition.* Mosby, 042005. 6.7).

49. How do you get a child acting out to act favorably? Let them watch another child behaving

Many practitioners have long used modeling strategies by letting the younger child watch "big sister" through the appointment if they perceive a positive relationship between a confident sibling and the fearful child. A simple variation of the same strategy involves scheduling an unrelated fearful child to watch another child patient during his appointment.

(Weinstein, Philip. *Treating Fearful Dental Patients: A Patient Management Handbook, 2nd Edition*. University of Washington, Continuing Dental E, 091995. 10.3.2).

50. Fibroma



(Langlais, Robert P.. *Color Atlas of Common Oral Diseases, 3rd Edition*. Lippincott Williams & Wilkins, 012003. 10.2.7).

51. Cancer translocation **p53 gene**

52. Greatest degree of linear coefficient of expansion? **Resin** (Composite resin is 2.5x greater than tooth structure when subjected to extreme changes in temp than other materials. Direct Gold is similar to tooth but higher and Amalgam is 2x that of tooth)

53. Calcification sequence? **7mos-3yrs (Primary-**14 wks (CI), 15 wks (1stM), 16 wks(LI), 17 wks (C), 18 wks (2nd Molar) all these weeks are in utero. And the sequence is A-B -D-C-E- **Permanent-** Birth(1stM), 6 months(anterior teeth except max LI), 12 months (Max LI), 18 months (1st PM), 24 months (2nd PM), 30 months (2nd M)- Mosby pg 176
54. **Class 3**- cleft palate and cleft lip
55. Sickle cell-trauma, infection-thrombocytopenia (also and

Patients with sickle cell anemia produce hemoglobin S instead of the normal hemoglobin A. Hemoglobin S has a decreased oxygen-carrying capacity. Decreased oxygen tension causes the sickling of cells. **These patients are susceptible to recurrent acute infections, which result in an "aplastic crisis" caused by decreased red blood cell production and in subsequent joint and abdominal pain with fever.** Over time there is a progressive deterioration of cardiac, pulmonary, and renal function.

(McDonald, Ralph. *Dentistry for the Child and Adolescent, 8th Edition*. Mosby, 022004. 24.3).

56. Thyrotoxic crisis

thyrotoxic patients are usually treated with agents that block thyroid hormone synthesis and release, with a thyroidectomy, or both. However, patients left untreated or incompletely treated can develop a thyrotoxic crisis, caused by the sudden release of large quantities of preformed thyroid hormones. Early symptoms of a **thyrotoxic crisis** *include restlessness, nausea, and abdominal cramps. Later symptoms are a high fever, diaphoresis, tachycardia, and, eventually, cardiac decompensation.* The patient becomes stuporous and hypotensive, with death resulting if no intervention occurs due to Cardiac Heart Failure and pulmonary edema.

(Peterson, Larry J.. *Contemporary Oral and Maxillofacial Surgery, 4th Edition*. Mosby Elsevier Health Science, 122002. 6.3.5.3).

7. Sequence for nausea , vomiting

58. Periostat and doxycycline. What does it do:

Subantimicrobial tetracycline (Periostat) is useful in treating moderate to severe chronic periodontitis. **The active ingredient in Periostat is *doxycycline hyclate***. In concert with scaling and root planing, Mohammad et al.[38] have shown this treatment to be effective in institutionalized older adults. Periostat is contraindicated for those patients with an allergy to tetracycline.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 45.6.1.1).

59. Bevel for occlusal on a crown? **structural integrity**
Beveling provides structural integrity (you'll have more metal in that area). That is the need for the bevel to be placed on the functional cusp.

60. Closed panel go to specialist which would allow you to go to another dentist but reimburse you-HMO,PPO, etc

In the closed model, also known as the Exclusive Provider Organization, the beneficiaries have a limited choice of offices where they can go to obtain dental care. If they go to offices not included in the panel, they receive no benefits. This model is often used in a D-HMO or PPO plan.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.6).

61. Increase mucus from obstruction

Cystic fibrosis

a. Transmission: caused by a genetic mutation (nucleotide deletion) on chromosome 7, resulting in **abnormal chloride channels.**

b. *The most common hereditary disease in Caucasians.*

c. Genetic transmission: autosomal recessive.

d. **Affects all exocrine glands**. Organs affected include lungs, pancreas, salivary glands, and intestines. **Thick secretions or mucous plugs are seen to obstruct the pulmonary airways and intestinal tracts.**

e. Is ultimately fatal.

f. Diagnostic test: sweat test—**sweat contains increased amounts of chloride**.

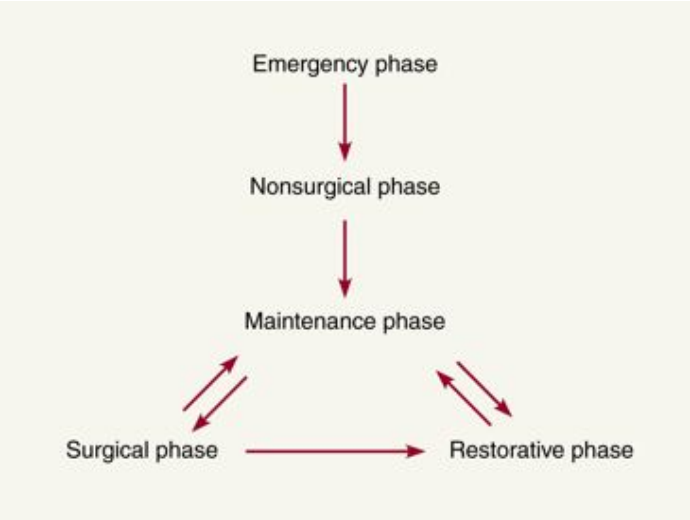
(Mosby. *Mosby's Review for the NBDE, Part I*. C.V. Mosby, 072006. 3.4.2).

62. Patient has increase in salivation how does it affect denture? **No affect**, problem seating, soft tissue reline, differing salivation

saliva lubricates the oral tissues and increases denture comfort.

(Zarb, George. *Prosthodontic Treatment for Edentulous Patients: Complete Dentures and Implant-Supported Prostheses, 12th Edition*. Mosby, 092003. 6.8).

63. Emergency phase, perio, reeval, fixed, maintenance



(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 41.1.3).

64. How many canals in primary 2nd molar

Mandibular first molars: 3
Mandibular second molars: 4
Maxillary first molars: 3
Maxillary second molars: 3

65. Denture for 19years- relieve pain denture and have white spot what do you do

Relieve the denture in the area of the lesion and reevaluate in 1 week.

66. Patient has successful treatment for gum disease but still keeps poor oral hygiene. What kind of study? Incomplete

67. Null hypothesis

the **null hypothesis,** which is the hypothesis that there is no real (true) difference between means or proportions of the groups being compared or that there is **no real association between two continuous variables.**

(Jekel, James F.. *Epidemiology, Biostatistics and Preventive Medicine, 2nd Edition*. W.B. Saunders Company, 092001. 10.2.2).

68. Amoxicillin and clonavonic acid is combined to keep from degrading beta lactam ring and forms AUGMENTIN

Amoxicillin is a bactericidal, semisynthetic penicillin that is effective against both gram-positive and gram-negative microorganisms. It is susceptible to penicillinase (β-

lactamase). Amoxicillin combined with **clavulanate potassium (Augmentin)** is resistant to a number of penicillinases.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 7.7).

69. How long do you take patient off of Coumadin before surgery? **2-3 days**

The INR is used to gauge the anticoagulant action of warfarin. Most physicians will allow the INR to drop to about 2.0 during the perioperative period, which usually allows sufficient coagulation for safe surgery. **Patients should stop taking warfarin 2 or 3 days before the planned surgery**. On the morning of surgery, the INR value should be checked; if it is between 2 and 3 INR, routine oral surgery can be performed. If the PT is still greater than 3 INR, surgery should be delayed until the PT approaches 3 INR. Surgical wounds should be dressed with thrombogenic substances, and the patient should be given instruction in promoting clot retention. Warfarin therapy can be resumed the day of surgery

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 1.3.6.2).

Warfarin and Coumadin are oral anticoagulants that inhibit the biosynthesis of the vitamin K–dependent coagulation proteins (factors VII, IX, and X and prothrombin). These drugs are bound to **albumin**, metabolized by hydroxylation by the liver, and excreted in the urine. The PT is used to monitor warfarin therapy because it measures three of the vitamin K–dependent coagulation proteins: factors VII and X, and prothrombin. The PT is particularly sensitive to factor VII deficiency. Therapeutic anticoagulation with warfarin takes 4 to 5 days.[1]

Level of anticoagulation and need for altering dosage to avoid excessive bleeding

PTR (1.5 to 2.0) or INR (2.0 to 3.0): Dosage does not need to be altered

PTR (2.0 to 2.5) or INR (2.5 to 3.5): Dosage may be altered

PTR (2.5 or >) or INR (3.5 or >): Delay invasive procedure until dosage decreased

Decision is made to alter dosage of anticoagulation medication

Physician will reduce patient's dosage

Affect of reduced dosage takes 3 to 5 days

Dental appointment needs to be scheduled within 2 days once desired reduction in PTR or INR has been confirmed

For patients taking **more than 325 mg of aspirin per day, aspirin may need to be discontinued 7 to 10 days before surgical therapy**

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 44.10.1).

(Little, James W.. *Dental Management of the Medically Compromised Patient, 6th Edition*. Mosby, 042002. 21.6.5.5.1).

70. Benzodiazepine affects gaba (Note: Benzo are minor tranquilizers that are used to relieve anxiety and induce sleep, skeletal mm. relaxant. It depresses the limbic system and inhibits the neurons GABA0(gamma amnio butyric acid) on the chloride channels.)
71. Albuterol –asthma (is an expiratory wheezing- is treated by inhaler albuterol which is a b2 adrenergic agonist other examples are metaproterenolo and salmeterol. It is also tx by theophylline or the leukotriene called montelukast. In an office if inhaler is not available one gcan use epinephrine to treat anaphylactic shock.) mosby pg 300-301
72. If patient wants to last for 8 hours which is long acting drug? Aspirin, ibuprofen, acetominaphine, n-something

Diflunisal is 3 to 4 fold more potent than aspirin as an analgesic and an anti-inflammatory agent, but has no anti-pyretic properties.(p.504 lippincott pharmacology)

Diflunisal (DOLOBID) is a difluorophenyl derivative of salicylic acid; it is not converted to salicylic acid *in vivo*. Diflunisal is more potent than aspirin in antiinflammatory tests in animals and appears to be a competitive inhibitor of cyclooxygenase. However, it is largely devoid of antipyretic effects, perhaps because of poor penetration into the CNS. The drug has been used primarily as an analgesic in the treatment of osteoarthritis and musculoskeletal strains or sprains; in these circumstances **it is about three to four times more potent than aspirin**. The usual initial dose is 500 to 1000 mg, followed by 250 to 500 mg every 8 to 12 hours. For rheumatoid arthritis or osteoarthritis, 250 to 500 mg is administered twice daily; maintenance dosage should not exceed 1.5 g per day. ***Diflunisal does not produce auditory side effects and appears to cause fewer and less intense gastrointestinal and antiplatelet effects than does aspirin***.

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 29.2.4.4).

73. Glass ionomer placed on rampant caries
74. Epulis fissuratum-inflamed tissue in ridge area to put denture back in it is due to ill fitting denture in the buccal flange area. It is flappy(hyperplastic) tissue on the ridge area. Tx. Will be to adjust the denture border and use tissue conditioner. Mosby pg 322
75. Why do you take denture out at night

Patients should be told that dentures must be left out of the mouth at night to provide needed rest from the stresses they create on the residual ridges. Failure to allow the tissues of the basal seat to rest may be a contributing factor in the

development of serious oral lesions, such as inflammatory papillary hyperplasia, or may increase the opportunity for microbial infections, such as candidiasis. When dentures are left out of the mouth, they should be placed in a container filled with water to prevent drying and possible dimensional changes of the denture base material.

(Zarb, George. *Prosthodontic Treatment for Edentulous Patients: Complete Dentures and Implant-Supported Prostheses, 12th Edition*. Mosby, 092003. 4.2.1.7).

76. **Ectodermal dysplasia**

Hereditary ectodermal dysplasia

1. An X-linked recessive condition that results in partial or complete anodontia.

2. Patients also have hypoplasia of other ectodermal structures, including hair, sweat glands, and nails.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 4.1.19).

77. Ameloblastoma-**dentigerous cysts**
Ameloblastoma most likely develop in the wall of a dentigerous cyst(Mosby pg 118-119. IT is a benign but aggressive odontogenic tumor with high recurrence.Cystic variant is less aggressive and less likely to occur. The solid type occurs in adults 40 years old. Common location-mandibular molar ramus. It is unilocular or multiocular radioluceny. 3 variants of solid type1. Follicular 2. Plexiform 3.desmoplastic- favor anterior maxilla TX. Enucleation with curettage

78. Process of PCN-not wide range
79. Periostat n doxycycline inhibits what? **collagenase**

Subantimicrobial tetracycline (Periostat) is useful in treating moderate to severe chronic periodontitis. **The active ingredient in Periostat is *doxycycline hyclate***. In concert with scaling and root planing, Mohammad et al.[38] have shown this treatment to be effective in institutionalized older adults. Periostat is contraindicated for those patients with an allergy to tetracycline. The semisynthetic compounds (e.g., **doxycycline**) **were more effective than tetracycline in reducing excessive collagenase activity in the gingival crevicular fluid (GCF) of chronic periodontitis patients.**

80. How do you clean furcation after perio surgery? Floss, toothbrush, water

Subgingival irrigation performed with an oral irrigator using chlorhexidine diluted to one-third strength, performed regularly at home and after scaling, root planing, and in-office irrigation therapy, has produced significant gingival improvement compared with controls. **Subgingival irrigation** with specialized tips for deep pockets and **furcation** areas is effective when used daily as part of the home care routine. Use chorahexadine. The best view of bone defect is with a flap reflection.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 50.8.2).

81. What type of reinforcement is smiling and praising a child

Positive reinforcement (i.e. 'behaviour shaping') at every stage of the treatment process is recommended, to indicate to the child that he is making successful steps in the process of receiving treatment. The frequent use of praise during a child's appointment — when the child performs an appropriate behaviour — is essential.

(Humphris, Gerry. *Behavioural Sciences for Dentistry*. Churchill Livingstone, 022000. 9.10).

82. ANUG comes with **spirochetes**

Acute necrotizing ulcerative gingivitis (ANUG)

1. Characteristics
   a. Painful, bleeding gingival tissues.
   b. Blunting of interproximal papillae.
   c. Pseudomembrane on the marginal gingiva. Sloughing off
   d. Fetid breath.
   e. High fever.
2. **Caused by fusiform bacilli (spirochetes),** Prevotella intermedia and other anaerobes.
3. Most common in teenagers and young adults.
4. Responds well to debridement, oxidizing mouth rinses, and antibiotics.

ANUG(gingiva only, low grade fever) must be distinguish form acute herpes infection (ulcer on mucosa and gingival , high fever)

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 5.2.7).

also Prevotella intermedia are seen in high levels in necrotizing disease pg. 243 Mosby

83. Pic of white spongy nevus

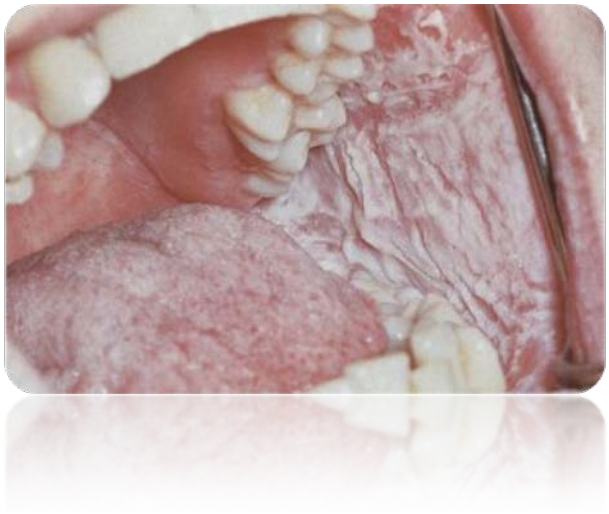
White sponge nevus: of buccal mucosa.

The lesions of white sponge nevus usually **appear at birth or in early childhood**, but sometimes the condition develops during adolescence. **Symmetrical, thickened, white, corrugated or velvety, diffuse plaques affect the buccal mucosa bilaterally in most instances**. Other common intraoral sites of involvement include the ventral tongue, labial mucosa, soft palate, alveolar mucosa, and floor of the mouth, although the extent of involvement can vary from patient to patient. Extraoral mucosal sites, such as the nasal,

esophageal, laryngeal, and anogenital mucosa, appear to be less commonly affected. Patients are usually asymptomatic.

TREATMENT AND PROGNOSIS

Because this is a benign condition, **no treatment is necessary. The prognosis is good.**



(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 16.2.1).

84. Periodontitis and doxycycline (inhibit collgenase in clavicular fluid)

Effective against broad spectrum of microorganisms; used systemically and applied locally (subgingivally). Doxycycline has the same spectrum of activity as minocycline and may be equally as effective.[18] Because doxycycline can be given only once daily (qd), however, patients may be more compliant. Compliance is also favored because its absorption from the gastrointestinal (GI) tract is only slightly altered by calcium, metal ions, or antacids, as is absorption of other tetracyclines. **The mechanism of action is by suppression of the activity of collagenase, particularly that produced by polymorphonuclear leukocytes (PMNs).**

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 52.2.1).

85. Patient has hip replacement a year ago what kind of treatment can you render?
Antib iotic Prohphylaxis
"Given the potential adverse outcomes and costs of treating an infected joint replacement , the AAOS recommends that clinicians consider antibiotic prophylaxis for all total joint replacement patients prior to any invasive procedure that may cause bacteremia" (dental drug booklet p.79) Kaplan pg 292. Premedication fo knee and hip

replacement is sometimes advised. They are more likely to be premedicated if recent years (0-2 years) and the AHA antibiotic regimens are often used. However if in doubt, send for medical consult.

86. What can you not give a patient with a heart condition

Drug considerations:

- For patients taking digitalis (CHF), **avoid epinephrine** ; if considered essential, use cautiously (maximum 0.036 mg epinephrine or 0.20 mg levonordefrin); **avoid gag reflex; avoid erythromycin and clarithromycin, which may increase the absorption of digitalis and lead to toxicity.**

- For patients with NYHA class III and IV congestive heart failure, avoid use of vasoconstrictors; if use is considered essential, discuss with physician.

- **Avoid epinephrine-impregnated retraction cord**. (use retraction chord with **aluminum potassium sulfate instead)**

- Schedule short, stress-free appointments.

- Use semisupine or upright chair position.

- Watch for orthostatic hypotension, make position or chair changes slowly, and assist patient into and out of chair.

- **Avoid the use of nonsteroidal antiinflammatory drugs (NSAIDs).**

- **Watch for signs of digitalis toxicity (i.e., tachycardia, hypersalivation, visual disturbances, etc.).**

- Nitrous oxide/oxygen sedation may be used with a minimum of 30% oxygen.

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 6.4.1.1).

87. Contraindication for implant-myocardial infarct, **smoking**, bone loss

Or Adolesant

The implant team should advise potential implant patients of the detrimental effects that smoking has on their oral and systemic health. Complications must be discussed and highlighted in the informed consent. Patients should be encouraged to start a smoking cessation program before implant treatment. **Smoking is not an absolute contraindication; however, the risks and possible morbidity on the respective procedures must be evaluated.** Note: Relative contraindications are ppl who have uncontrolled diabetes and smokers. ABSOLUTE CONTRAINDICATIONS: mental or physcho disorders, under age 16, ppl who are too critical, one cant please.

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 20.7.1.4).

88. How long do you splint with avulsion. **7-10 days**, bony fracture 2-8 weeks

(not sure where they got 2-8 weeks… bony fracture should be **3-4 weeks in children** !!!)

Splinting of avulsed teeth

- Composite resin and nylon fibre (0.6 mm diameter) such as fishing line (20 kg breaking strain) *or*
- orthodontic brackets with arch wire (0.014" (0.4 mm)).
- Orthodontic appliances are particularly useful as the time taken to apply the brackets is half that to set composite resin.
- *Splints should be flexible to allow normal physiological movement of the tooth*. This helps to reduce the development of ankylosis; however, if there is a bone or root fracture present, then a rigid splint must be used so that there is no movement of the teeth and bony segments.
- **Splints should generally stay in place for 7–10 days** if there are no complicating factors such as alveolar or root fractures. The occlusion may need to be relieved when the degree of overbite or luxation is such that the tooth receives unwanted masticatory force. This can be achieved by minimal removal of enamel, or construction of an upper removable appliance, or placement of composite resin on the molars to open the bite. Some physiological movement is necessary.

Close reduction with plastic tooth (with fingers).

Dento-alveolar fractures

With luxation of teeth, the alveolar plate can be fractured or deformed. Use firm finger pressure on the buccal and lingual plates to reposition. It should be remembered that alveolar fractures can occur without significant dental involvement. **These alveolar fractures should be splinted for 3–4 weeks in children (6–8 weeks in adults).** Luxated or avulsed teeth usually result in alveolar bone fracture and/or displacement. Firm pressure is needed to realign bony fragments. Splinting will be required for 3–4 weeks. Dental Secrets pg 242. Splinting times for root and alveolar fractures used to be 2-4 months but recent studies have shown splinting for 3 weeks is sufficient.

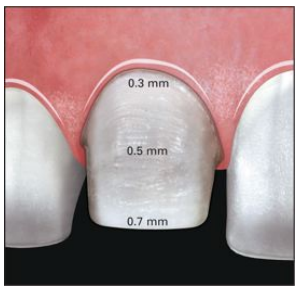
(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 5.16.4).

89. Why is core better than another-lets out fibers

90. Ppm in water-1

1 ppm = 1 gm/L

91. How much do you take off facial for veneer? .**5-1mm Note Cervical is 0.3 mm,**



Facial is 0.5 mm and incisal is .7mm-1mm

Average facial reduction for enamel-bonded veneer. (Illustrations for chapter 16 by John Bonfardeci, Studio Giovanni.)

(Summitt, James B.. *Fundamentals of Operative Dentistry: A Contemporary Approach, 3rd Edition*. Quintessence Publishing (IL), 012006. 16.3.1.1).

92. Capping-2mm for caoh2 (Liners are 0.5 mm and bases are 2-4 mm)

93. Pics of chronic osteitis, myleits, bells palsy, gingival hyperplasia

94. Child with asthma-inspire vs **expire**

Childhood asthma is an extremely common condition throughout the world. Children with acute asthma present with varying severity and often have increased work of breathing. **Expiratory wheezing** and a prolonged expiratory phase, caused by reversible broncho-spasm, can be heard without the stethoscope and are apparent on auscultation.

Stridor is inpirtory asthma

(Bickley, Lynn S.. *Bates' Guide to Physical Examination and History Taking, 9th Edition*. Lippincott Williams & Wilkins, 122005. 18.6.10).

95. Contraindication for diazepam-diabetic, **pregnancy**, etc
(Tetracycline, Benzodiazepine, and Barbiturates AVOID AVOID AVOID during pregnancy)
Can give tyenol , codeine, proxyfine (darvon),

96. Child with gum disease-chronic, acute herpetic gingivitis Mosby pg 193. Primary is seen in children less than 6 years old. Viral , bleed tendor gingfiva, oral mucosa , less that 5yr,

97. Ging recession 5-6mm on #4 & 20, Hemoglobin of 12. Wht do you do? **Treat**, refer to dr, scaling n root planning

Hemoglobin (male)

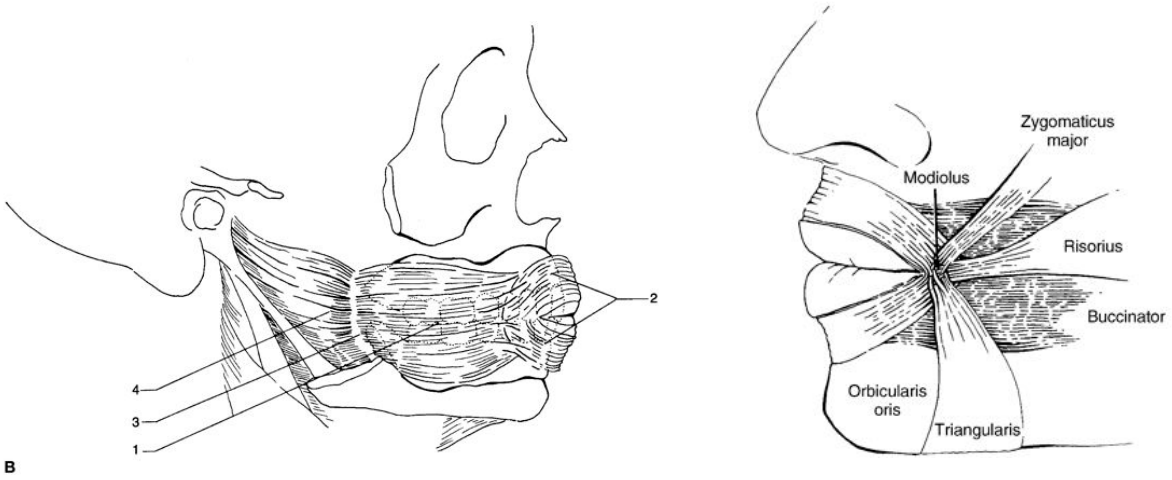
13.5-17.5 g/dL

Hemoglobin (female)

12.3-15.3 g/dL

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 1.4).

98. What muscle covers denture? **Buccinators**, masseter, lat & med pterygoid



Functional unit of the **buccinator**. This muscle ***(1)*** and the orbicularis oris muscle *(2)* depend on the position of the upper denture for their proper action. *(3)* is the pterygomandibular raphe, and *(4)* is the superior constrictor of the pharynx.

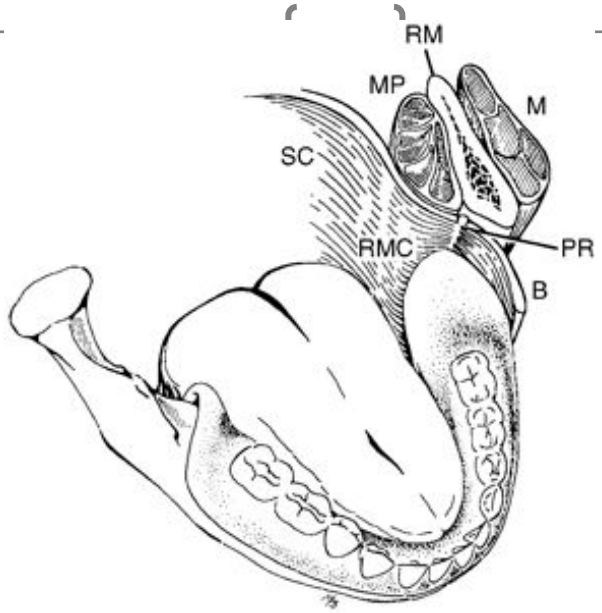
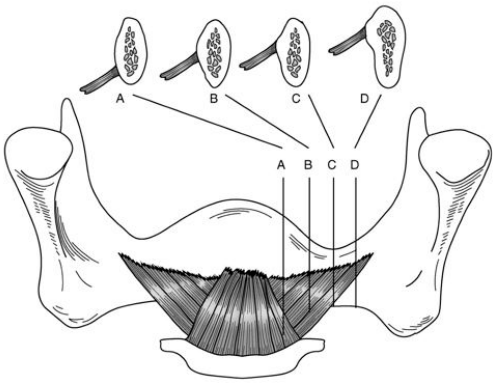


Diagram shows the relationship of the medial pterygoid muscle to the superior constrictor muscle. *B*, Buccinator muscle; *M*, masseter muscle; *MP*, medial pterygoid muscle; *PR*, pterygomandibular raphe; *RM*, ramus of the mandible; *RMC*, posterolateral portion of the retromylohyoid curtain formed by the mucous membrane covering the superior constrictor muscle *(SC)*.

(Zarb, George. *Prosthodontic Treatment for Edentulous Patients: Complete Dentures and Implant-Supported Prostheses, 12th Edition*. Mosby, 092003. 18.3.1.2).

99. What provides lingual retention? **Mylohyoid**



Relationships of the mylohyoid muscle in various regions. The letters with prime signs denote cross sections of the designated areas. *A*, Canine region. *B*, Premolar region. *C*, First molar. *D*, Third molar. At point *D*, notice that the mylohyoid ridge approaches the level of the alveolar crest. The angle of the posterior lingual flange in

the molar region is affected by this muscle; anteriorly, only the length of the flange is affected.

The posterior part of the mylohyoid muscle in the molar region affects the lingual impression border in swallowing and in moving the tongue. During swallowing, the mylohyoid muscles contract, raising the floor of the mouth. During impression taking, it is very easy to carry the impression material into the undercut below the mylohyoid ridge because the mylohyoid muscle is a thin sheet of fibers that, in a relaxed state, will not resist the impression material. *Extension of the lingual flange under the mylohyoid ridge cannot be tolerated in function because it will interfere with the action of the mylohyoid muscle when it contracts, and this will displace the denture, causing soreness.* **For the denture to be successful, the flange must be made parallel to the mylohyoid muscle when it is contracted.**

Fortunately, in this posterior region, the lingual flange can go beyond the mylohyoid muscle's attachment to the mandible because the mucolingual fold is not in this area. Thus the impression may depart from the stress-bearing area of the lingual surface of the ridge, moving away from the body of the mandible to be suspended under the tongue in soft tissue on both sides of the mouth, thereby reaching the mucolingual fold of soft tissue for a border seal. The distance that these lingual borders can be away from the bony areas will depend on the functional movements of the floor of the mouth and by the amount that the residual ridge has resorbed.

An extension of the lingual flange well beyond the palpable position of the mylohyoid ridge, but not into the undercut, has other advantages. The lack of direct pressure on the sharp edge of the ridge will eliminate a possible source of discomfort. If the impression is made with pressure on or slightly over this ridge, displacement of the denture and soreness are sure to result from lateral and vertical stresses. On the other hand, if the border stops above the mylohyoid ridge, vertical forces will cause soreness, and the border seal will be easily broken. **If the flange is properly shaped and extended, it will provide border seal and guide the tongue to rest on top of the flange.**

(Zarb, George. *Prosthodontic Treatment for Edentulous Patients: Complete Dentures and Implant-Supported Prostheses, 12th Edition*. Mosby, 092003. 14.3.4.1).

100. Neurofibromatosis- **axiallary freckling, café- au-late, lesch nodules**

Neurofibromatosis Type I (von Recklinghausen Disease)

Neurofibromatosis, type I. Multiple cutaneous neurofibromas are noted on the face and trunk.

(Rubin, Emanuel Rubin. *Rubin's Pathology: Clinicopathologic Foundations of Medicine, 4th Edition*. Lippincott Williams & Wilkins, 042004.). Mosby pg 113

Neurofibromatosis type I (NF1) is characterized by ***(1) disfiguring neurofibromas, (2) areas of dark pigmentation of the skin (café au lait spots), and (3) pigmented lesions of the iris (Lisch nodules).*** It is one of the more common autosomal dominant disorders, affecting 1 in 3500 persons of all races.

- **Café au lait spots:** Although normal persons may exhibit occasional light brown patches on the skin, more than 95% of persons affected by NF1 display six or more such lesions. These are over 5 mm before puberty and greater than 1.5 cm thereafter. Café au lait spots tend to be ovoid, with the longer axis oriented in the direction of a cutaneous nerve. Numerous freckles, particularly in the axilla, are also common.

- **Lisch nodules:** More than 90% of persons with NF1 display pigmented nodules of the iris, which consist of masses of melanocytes. These raised lesions are believed to be hamartomas.

- **Skeletal lesions:** A number of bone lesions occur frequently in NF1. These include malformations of the sphenoid bone and thinning of the cortex of the long bones, with bowing and pseudarthrosis of the tibia, bone cysts, and scoliosis.

- **Mental status:** Mild intellectual impairment is frequent in patients with NF1, but severe retardation is not part of the syndrome.

- **Leukemia:** The risk of malignant myeloid disorders in children with NF1 is 200 to 500 times the normal risk. In some patients, both alleles of the NF1 gene are inactivated in the leukemic cells.

(Rubin, Emanuel Rubin. *Rubin's Pathology: Clinicopathologic Foundations of Medicine, 4th Edition*. Lippincott Williams & Wilkins, 042004. 6.5.8.4.1).

101. Most impacted tooth? **Mx k9 (Note. Mosby pg 177 what is the most congenitally missing tooth 3rd molars, mand 2pm, Max LI, max 2PM)**

102. Least likely to graft? Mn 1st premolar (thinnest tissue around this tooth), Mx k9 ??????
Thiniest Mand. 1pm –ca, thicket max 2pm and Mand Ci
Facial Max LI, Mandibular central and maxillary 2 premolar: **widest keratinized gingival**
Facial of Mand. C, Mandibular first premolar, and lingual surfaces adjacent to mand. Incisors and canines and MB of Max 1st Molar and Mand. 3rd Molar: **narrowest keratinized gingival**

I would think that the least likely area would be mand central or maxillary 2 pre-molar if that's an answer choice !

103. Purpose of hex implant :

in an internal **hex implant**, the *antirotational feature* of the abutment is designed within the implant body. As a result, the implant body is lower in profile and easier to cover with soft tissue during surgery. In addition, *the antirotational feature* is often deeper within the body compared with external hex implants.

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 11.4.6).

104. Push on rest seat it comes up? Base doesn't come up bc of resin Need indirect retention, could

105. 2nd to s. mutan-L. bacillus

106. RCT done on a big RL a year ago, assymptomatic and bigger 2 years later? Necrotic or actinomyces ???

107. Pt gets a injection few days later have lateral bilateral swelling tongue-**ludwigs angina Sublingual, submental, submand**

108. **Base metal** vs noble metal-single crown-3 unit Base metal Bridge , Crown high nobal metal.

Boney wall defect which is better for graft . = # 3 walled defect

109. Papillon le fever (Pt. has palmar/plantar keratosis, floating teeth on xray, severe periodontitis and erythematous gingival

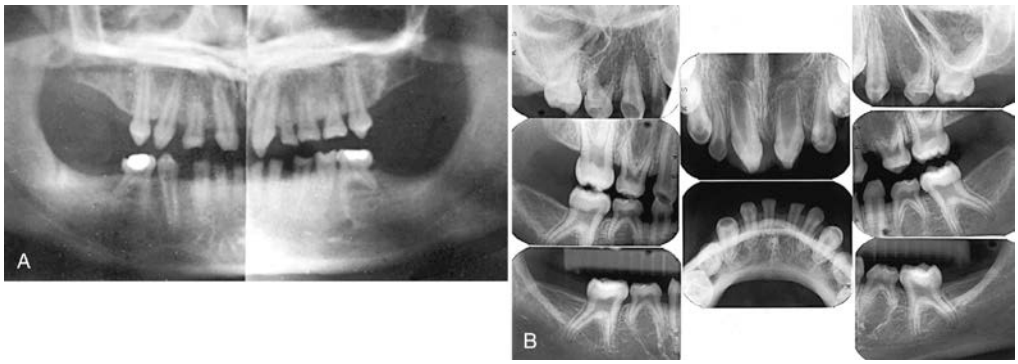
In most cases, the dermatologic manifestations become clinically evident in the first 3 years of life. Diffuse transgredient (first occurs on the palms and soles and then spreads to the dorsa of the hands and feet) **palmarplantar keratosis** develops, with occasional reports of diffuse follicular hyperkeratosis and keratosis on the elbows and knees. The oral manifestations consist of **dramatically advanced periodontitis** that is seen in both the deciduous and permanent dentitions and develops soon after the eruption of the teeth. Extensive hyperplastic and hemorrhagic gingivitis is seen. A rapid loss of attachment occurs, with the teeth soon lacking osseous support and radiographically appearing to float in the soft tissue). Without aggressive therapy, the loss of the dentition is inevitable.

(Neville, Brad W.. *Oral & Maxillofacial Pathology, 2nd Edition*. Saunders Book Company, 012002. 4.10).

110. Oligiodontia-**ectodermal dysplasia**

Anodontia or oligodontia may occur in patients with ectodermal dysplasia. This genetically inherited autosomal dominant disorder results in the absence of at least two ectodermally derived structures such as sweat glands, hair, skin, nails, and teeth.

ectodermal dysplasia



(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 19.1.2).

<vbk:978-0-323-04983-2#outline(19.1.2)>uart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 19.1.1.11).

111. Collimation-tube Circular to rectangular 48%

A **collimator** is a **metallic barrier with an aperture in the middle used to reduce the size of the x-ray beam and thereby the volume of irradiated tissue**. Round and rectangular collimators are most frequently used in dentistry. Dental x-ray beams are usually collimated to a circle Use of collimation also improves image quality. When an x-ray beam is directed at a patient, the hard and soft tissues absorb about 90% of the photons and about 10% pass through the patient and reach the film.

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 1.5.5).

112. Erosion of Teeth – bullemia on max lingual s

Patients with bulimia may present with **severe erosion of the lingual and occlusal surfaces** of the teeth Severe erosion can cause increased tooth sensitivity to touch and to cold temperature. Dental caries may be more prevalent in these patients. The amount of saliva produced may be decreased. Patients often report dry mouth. Those with poor oral hygiene have increased periodontal disease. The parotid gland may become enlarged, and patients with anorexia nervosa may have decreased salivary flow, dry mouth, atrophic mucosa, and an enlarged parotid gland.[3]

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 28.3.4.6).

113. Patient gets 25% home bleaching. Wrong its 10% but 2nd part is true

The current home bleaching technique, employing a custom-fit tray containing 10% carbamide peroxide solution, was first used by Klusmier in the late 1960s.[6] **In-office bleaching materials are usually supplied in concentrations of 35% hydrogen peroxide, although some concentrations may be as high as 50%.** The caustic nature of 35% to 50% hydrogen peroxide mandates that the soft tissues be isolated from any possible contact with the bleaching material. Note in Endo: Intracoronal bleaching is with sodium perborate (walking bleach).Superoxol used to be used with contained 30% hydrogen peroxide but the complication was external cervical resorption bc irritation diffuses through tubules to cementum and PDL. Heat combined with it may cause necrosis of cementum and PDL. Mosby pg. 27

(Summitt, James B.. *Fundamentals of Operative Dentistry: A Contemporary Approach, 2nd Edition*. Quintessence Publishing (IL), 012001. 15).

114. What goes into cavernous sinus from upper lip? Infection
Subcutaneous tissue

Cavernous sinus thrombosis may also occur as the result of superior spread of odontogenic infection via a hematogenous route. Bacteria may travel from the maxilla posteriorly via the pterygoid plexus and **emissary veins** or anteriorly via the **angular vein** and inferior or superior **ophthalmic veins** to the cavernous sinus. The veins of the face and orbit lack valves, which permits blood to flow in either direction. Thus bacteria can travel via the venous drainage system and contaminate the cavernous sinus, which results in thrombosis. Cavernous sinus thrombosis is an unusual occurrence that is rarely the result of an infected tooth.

(Peterson, Larry J.. *Contemporary Oral and Maxillofacial Surgery, 4th Edition*. Mosby Elsevier Health Science, 122002. 21.1.2).

115. URI-**no NO2** **Upper Respiratory Infect (Empzema or COPD no Nitrous)**
116. In posterior composite why do you have to redo-occlusal-**wear**
117. Periosteum- atthced vis sharpeys fibers (stick to bone and cementum) , cementum, alveolar bone, or all 3
118. Symphisis-intraocciptal, **sphenoocciptal**, which bone forms last(Notes others are intersphenoid-first, sphenoethmoid-second, and sphenoocipital-last mosb pg 146)

Endochondral bone formation occurs at the extremities of all long bones, vertebrae, and ribs and at the articular extremity of the mandible and base of the skull. Early in embryonic development a condensation of mesenchymal cells occurs. Cartilage cells differentiate from these mesenchymal cells, and a perichondrium forms around the periphery, giving rise to a cartilage model that eventually is replaced by bone. Intramembranous bone formation was first recognized when early anatomists observed that the fontanelles of fetal and newborn

skulls were filled with a connective tissue membrane that was replaced gradually by bone during development and growth of the skull. In intramembranous bone formation, bone develops directly within the soft connective tissue. The mesenchymal cells proliferate and condense. This sequence of events occurs at multiple sites within each bone of the cranial vault, maxilla, body of the mandible, and midshaft of long bones.

(Nanci, Antonio. *Oral Histology: Development, Structure, and Function, 7th Edition.* Mosby, 092007. 6.3.3).

119. Vertical root fracture- taking bite registration? Doesn't interfere with bite class3 (Note: J-shaped lesion on xray. It can be the sequelae of cementation of post or excessive condensation. Poor Prognosis. Pain upon biting.)

120. Pt with denture and need to increase VDO what do you do?**remount**

121. Calcification sequence (Primary teeth it is A(14 weeks), D(15 weeks), B(16 weeks), C (17 weeks) E (18 weeks) all are in utero. Permanent teeth 1st Molars (Birth), All anterior teeth except max LI (6 months), Max LI (12months), 1st PM (18 months) 2nd PM (24 months) 2M(30 months) Mosby pg 176

122. Nonworking-bull working-lubl LBCUp Ma

123. Transillumination-vertical fracture will not see crays lines (Cracked tooth syndrome is visible upon transillumination and VRF is often confirmed via visualization) Mosby pg 9, 10,19 Dental Secrets pg. 122. Diagnosis 1.)transillumination with fiberoptic light. 2.) Peristent periodontal defects in otherwise healthly teeth 3.) wedging and staining of defect. 4. Radiographs rarely show VRF but do show a RL defect laterlly from sulcus to apex.

124. Minor connector connects to

The primary function of a **minor connector** is to join the remaining components of a removable partial denture to the major connector. **Minor connectors also are responsible for distribution of applied forces to the supporting teeth and oral tissues**. Therefore, rigidity is an essential characteristic of all minor connectors. The broad distribution of forces prevents any one tooth or any one portion of an edentulous ridge from bearing a destructive amount of stress. In contrast, bending or deformation of a minor connector may result in stress concentration and damage to the supporting teeth and soft tissues.

Types of minor connectors

There are four categories of minor connectors. They may be described as follows:

1. Minor connectors that join clasp assemblies to major connectors
2. Minor connectors that join indirect retainers or auxiliary rests to major connectors
3. Minor connectors that join denture bases to major connectors
4. Minor connectors that serve as approach arms for vertical projection or bar-type clasps

(Phoenix, Rodney D.. *Stewart's Clinical Removable Partial Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 012003. 2.2).

125. Last number on instrument Width,Acut angle, Length, A- blade angle

Operative cutting instrument formulas. (e.g., 10-8.5-8-14). **The first number** indicates the ***width of the blade*** **or primary cutting edge in tenths of a millimeter** (0.1 mm). **The second number** of a four-number code indicates the ***primary cutting edge angle***, measured from a line parallel to the long axis of the instrument handle in clockwise centigrades. The angle is expressed as a percent of 360 degrees. The instrument is positioned so that this number always exceeds 50. If the edge is locally perpendicular to the blade, then this number is normally omitted, resulting in a three-number code. **The third number** (second number of a three-number code) indicates the ***blade length*** in millimeters. **The fourth number** (third number of a three-number code) indicates the ***blade angle***, relative to the long axis of the handle in clockwise centigrade. For these measurements, the instrument is positioned so that this number is always 50 or less.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 2.3.1).

126. Seizure-gv diazepam (doesn't not treat vomiting emetis) Tx. anexity , muscle relax spasm , insomnia

If convulsions occur, patients should be protected from hurting themselves. Basic life-support measures are instituted as needed and venous access gained, if possible, for administration of anticonvulsants. Medical assistance should be obtained. If venous access is available, **diazepam should be slowly titrated until the seizure activity stops (5 to 25 mg is the usual effective range)**. Vital signs should be checked frequently.In emergency cases for status epileptics lorazapam or diazepam can be given but preferably diazepam since lorazapam has to be refridgerated.

(Peterson, Larry J.. *Contemporary Oral and Maxillofacial Surgery, 4th Edition*. Mosby Elsevier Health Science, 122002. 7.3.4.5).

127. To far superior and anterior dentures-what sounds

The labiodental sounds *f* and *v* are made between the upper incisors and the labiolingual center to the posterior third of the lower lip. **If the upper anterior teeth are too short (set too high up), the *v* sound will be more like an *f*. If they are too long (set too far down), the *f* will sound more like *v* . Mosby pg 323. Linguoalveolar sounds are s, z, sh, ch. They help determine the vertical overlap and length. Linguodental is this that those, b,m, p sounds are strictly lip. If whistling sound occurs, it is indicative that the posterior dental arch form is too narrow.**

(Zarb, George. *Prosthodontic Treatment for Edentulous Patients: Complete Dentures and Implant-Supported Prostheses, 12th Edition*. Mosby, 092003. 19).

128. If you did a DO what axioline angle is not there Mesial facial Line angle (included distal facial,

129. If you fall and break incisor which class is it due to? Class 2 div 1

130. Indirect vs direct onlay while child is waiting

131. Only reason to remove cusp-**decay**

132. Large structure in mouth appears on xray-radiolucent

133. Support area for max and mand denture

Maxilla: residual ridge primary, rugea secondary

Mandible: buccal shelf primary secondary alveolar ridge

134. Cleidocranial dysplasia-**supernumary teeth, membranous clavicle, flat bones**

135. Nitrates vs nitrites what do they do

Mosby p 298, decreace cardiac rate and force, prephreial vascular resistance , dialate coronary bld vessile

the nitro **vasodilators relax most smooth muscle**, including that in arteries and veins. Low concentrations of nitroglycerin produce dilation of the veins that predominates over that of arterioles. Venodilation results in decreased left and right ventricular chamber size and end-diastolic pressures but little change in systemic vascular resistance. Systemic arterial pressure may fall slightly, and heart rate is unchanged or slightly increased reflexly. Pulmonary vascular resistance and cardiac output both are slightly reduced. Nitrites is for urine and Nitrates is for cardio

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 34.1.3.1.1).

136. Nausea and vomiting from opoid receptor poisoning? **Chemoreceptor trigger zone – medulla oblongata , br stm**

137. Xerostomia can cause what? Prilocaprine Tx and Sjo Cevelatimine

Tissues may be dry, pale, or red and atrophic. The tongue may be devoid of papillae and may be atrophic, fissured, and inflamed. **Multiple carious lesions** may be present, especially at the gingival margin and on exposed root surfaces.

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 31.3.8.2).

<vbk:978-0-323-04535-3#outline(31.3.8.2)>

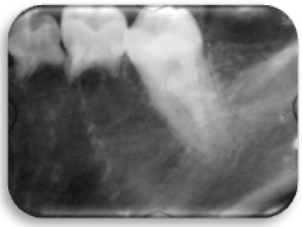
138. PCN(cidal) and tetracycline (static) cancels each other out S

139. Obliterate pulps-**dental dysplasia and dentinogenesis imperfect pp 123 mosbys**

Dentin Dysplasia

Dentin dysplasia represents another group of inherited dentin disorders resulting in characteristic features involving the circumpulpal dentin and root morphology. The roots tend to be short and sharply constricted. Primary teeth have obliterated pulps. Both

primary and permanent dentitions demonstrate multiple periapical radiolucencies and absent pulp chambers. Cascading tubule patterns result from blockage of normal dentin tubules by calcified masses.



Dentinal dysplasia type 1. Note rootless primary teeth.

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition*. Mosby, 042005. 3.4.2.2).

140. Child heart failure-resp dysplasia

Bronchopulmonary dysplasia is a chronic lung disease usually resulting from the occurrence during infancy of respiratory distress syndrome that requires prolonged ventilation with a high concentration of inspired oxygen. About 20% of infants with bronchopulmonary dysplasia die within the first year of life. **The major causes of death are cor pulmonale, respiratory infections, and sudden death.**

(McDonald, Ralph. *Dentistry for the Child and Adolescent, 8th Edition*. Mosby, 022004. 23.14.2).

141. Which does not contribute to oral cancer-**HIV**, tobacco, alcohol, HBV

142. Hyperocclusion

143. Reason for not doing a inlay

144. Indirect vs direct adv of dir dentinal bonding, adv indir strength of restoration.

145. Sodium hyperchlorite is not chelating agent- **dissolve organic matter**

146. EDTA is chelating agent- **dissolve inorganic matter, remove smear layer.**

147. Combination syndrome- decrease VDO, increase interocclusal distance flabby max ridge, resorption of rid

148. Extraction sequence for molar-3,2,1-1,2,3-1,3,2-2,1,3 Max ext

149. Increasing spatulation does what to setting expansion: **increase**

Summary of Effect of Manipulative Variables on Properties of Gypsum Products

Manipulative Variable	Setting Time	Consistency	Setting Expansion	Compressive Strength
Increase water/ powder ratio	Increase	Increase	Decrease	Decrease
Increase rate of spatulation	Decrease	Decrease	Increase	No effect
Increase temperature of mixing water from 23° to 30° C	Decrease	Decrease	Increase	No effect

(Powers, John M. Powers. *Craig's Restorative Dental Materials, 12th Edition*. C.V. Mosby, 022006.).

150. Increase water to powder ratio does what: **increase setting time, decrease setting expansion, decrease compressive strength**

151. Die plaster Beta vs die stone Alpha (Note die plaster can either be Type 1 Gypsum product for Impression Plaster which is not used or Type 2 which is plaster used for ortho molds. Type III gypsum is yellow stone used for diagnostic casts and Type IV gypsum is die stone used to give more accuracy for RPD and crowns and implants. It is harder.)

152. Why do teeth shift after braces removed? **Supercrestal fibers**

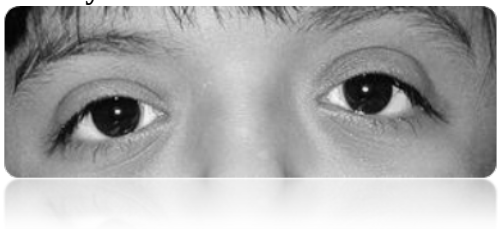
153. Tx mentally challenged patient with consistency or flattery

154. PIC-white spng nevus (bilateral , cleido cranial dysp, ging hyperplasia, COT

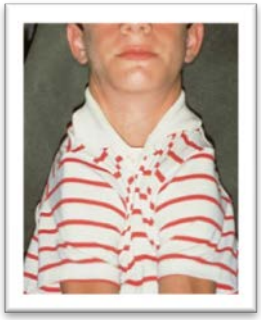
155. Hypertolerism

Hypertelorism. Space out eyes

Minor anomalies that affect the eyes and ocular region include widely spaced eyes (hypertelorism) –**seen in Apert's syndrome**



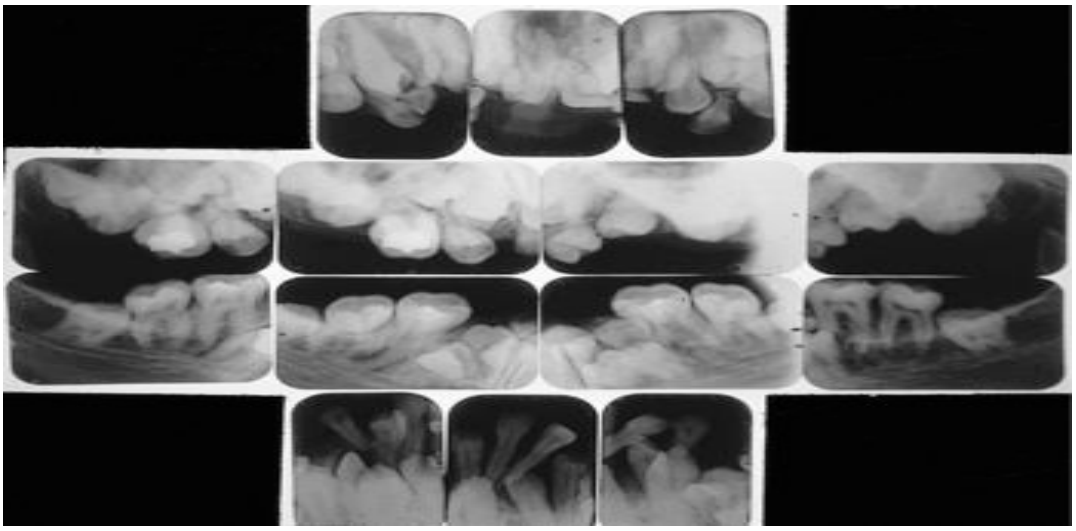
Cleidocranial dysplasia in a patient able to approximate his shoulders because of hypoplastic clavicles.



The head is large and brachycephalic. Patients have pronounced frontal, parietal, and occipital bossing. The facial bones and paranasal sinuses are hypoplastic, giving the face a small and short appearance. The nose is broad based, with a depressed nasal bridge. Ocular hypertelorism is often present. The entire skeleton may be affected, with defects of the pelvis, long bones, and fingers. Hemivertebrae and posterior wedging of the thoracic vertebrae may contribute to the development of kyphoscoliosis and pulmonary complications.

Maxillary hypoplasia gives the mandible a relatively prognathic appearance, although some patients may show variable mandibular prognathism because of an increased length of the mandible in conjunction with a short cranial base. The palate is narrow and highly arched, and there is an increased incidence of submucosal clefts and complete or partial clefts of the palate involving the hard and soft tissues. Nonunion of the symphysis of the mandible is seen.

Cleidocranial dysplasia
showing unerupted and supernumerary teeth.



(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition*. Mosby, 042005. 16.4.1).

156. Why is 3 degree burn vs 1 degree burn less painful

First-degree (superficial) burns

First-degree burns affect only the epidermis, or outer layer of skin. The burn site is red, painful, dry, and with no blisters. Mild sunburn is an example. Long-term tissue damage is rare and usually consists of an increase or decrease in the skin color.

Second-degree (partial thickness) burns

Second-degree burns involve the epidermis and part of the dermis layer of skin. The burn site appears red, blistered, and may be swollen and painful.

Third-degree (full thickness) burns

Third-degree burns destroy the epidermis and dermis. Third-degree burns may also damage the underlying bones, muscles, and tendons. The burn site appears white or charred. There is no sensation in the area since the nerve endings are destroyed.

157. Arcon vs non arcon articulator (pg. 319 mosby)

(MMC) Arcon- where the condyles are attached to the lower member of the articulator and the fossae are attached to the upper member. More accurate for fabricating fixed restorations, especially when an interocclusal record is used to mount mandibular cast. Nonarcon has upper and lower members rigidly attached. Provide easier control in setting teeth for complete and partial dentures. Both are semiadjustable and use a facebow.

1. Guy has problem with a tooth and has a hole drilled thru the O of MOD composite and the pain is relieved. What caused it? **polymerization shrinkage**

2. Primary mandibular 2nd molar has how many canals? : **4**
3. Patient removes denture and it's red, also taking ampicillin what's the reason? **Candidiasis**,
4. Radiolucency below 1 molar of a 18 yr old? Salivary gland occlusion, OKC
5. Which division is likely to break incisors? **Class 2 div 1**
6. Neuropraxia question-nothing severed, perioneum intact, can get it from stretching.
7. What happens if you over titrate amalgam? Increase creep
8. Sialolith commonly found? **Submandibular gland-wharton's duct**

Most pathologies found in parotid gld

> It is believed that the higher rate of sialolith formation in the **submandibular gland** is due to (1) the torturous course of **Wharton's duct**, (2) higher calcium and phosphate levels, and (3) the dependent position of the submandibular glands, which leave them prone to stasis.

(Greenberg, Martin S.. *Burket's Oral Medicine: Diagnosis and Treatment, 10th Edition*. B.C. Decker, 012003. 9.3.5).

9. Reason for mucocele on lip? Obstruction**,** minor salivary gland by mucus plug, **trauma**

> The mucocele constitutes the most common nodular swelling of the lower lip. These swellings are asymptomatic, soft, fluctuant, bluish-gray, and usually less than 1 cm in diameter. Enlargement coincident with meals may be an occasional finding. The most common location is the lower lip midway between the midline and commissure, but other locations include the buccal mucosa, palate, floor of the mouth, and ventral tongue. Children and young adults are most frequently affected. **Trauma is the etiologic agent.**

(Langlais, Robert P.. *Color Atlas of Common Oral Diseases, 3rd Edition*. Lippincott Williams & Wilkins, 012003. 8.5.1).

10. What is the best way to view Maxillary sinus? **Water's/ 2ndary PAN**
11. What is best way to view TMJ? **MRI**
12. When you move to right what nonworking cusp lingual interfere with non working movement

Non working interference- inner aspect of facial cusp of lower teeth. Lingual incline of buccal cusp

Working interference- inner aspect of lingual cusp of upper teeth buccal in of the maxillary .

13. What do you Tx ANUG with? **Antibiotics, chlorhexidine rinse**

> *Treatment of ANUG* includes evaluation of the medical history, **application of topical anesthetic** followed by **gently swabbing the necrotic lesions** to remove the pseudomembrane, and **removal of local factors** such as calculus (often with ultrasonics unless contraindicated by the medical history). **Systemic antibiotics should be prescribed only if there is evidence of lymphadenopathy and/or fever**. The patient should be instructed to avoid alcohol and tobacco, **rinse with chlorhexidine**, get adequate rest, gently remove bacterial plaque, and to take an analgesic as needed for pain. They should return in 1 to 2 days for re-evaluation and further debridement. Approximately 5 days later they should be seen for re-evaluation, further counseling

regarding diet, rest, and tobacco use, reinforcement of oral hygiene instruction (including chlorhexidine rinses), and periodontal evaluation.

Sialendentitis, saugage(mucous extravasion/ retention phenomenum) like cells in Wharthins Duct/ parotid gland. (Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 7.7)

14. Common periodontal disease in school age disease? **Gingivitis** **IgG**

15. Tetracycline vs penicillin (Tetracyclines are used in adjunct therapy to treat ppl with Perio issues. They enter the gingival crevicular fluid. They are broad spectrum and they inhibit the 30 S Ribodome. They cause intrinsic staining in teeth and pregnant women should not take this drug. Penicillin is a broad spectrum antibiotic. It inhibits cell wall synthesis. Often times ppl become allegic.)
16. Methotextrate metronidazole (Methotextrate I an antineoplastic drug that targets dihydrofolate reductase. Metronidazole is an antifungal drug. It is used in tx of people who have perio. It is usually combined with amoxicillin. Don't take alcohol while taking this drug. It is indicated for ppl who have clostridium difficule, fusobacterium and bacteriodes. It is contraindicated in pregnancy, alcohol or disulfram use. Mosby pg 307-309
17. Metronidazole is a drug of choice for ANUG and cause disulfarim affect(nausea, vomiting, flushing of the skin, tachycardia, and shortness of breath). Rarely causes stevens- Johnson syndrome (true or false) Steven Johnson, Erythemia M is due to drug; TEN, EM, self limiting mucosal oral lesion.
18. Patient got 25% bleaching and has increased sensitivity. True or false (1st part is false because home bleaching is 10%)
19. Home care patient responsibility is to brush teeth and remove bacteria and remove subplaque. True then **false.**
20. Highest % of caries population-**hispanic children**
21. What do you see first the **donors epithelium** or recipients epithelium?
22. Glucose in kids what is most important? **Quantity**, time, composition , consistency
23. What do you see in freeze-dried bone? Osseous conductive material
Cadavor , Value is BMP bone morphogenic protein,
24. What is freeze dried bone? **Allograft**
25. What is malignant? Pagets b/c it is at risk of developing osteosarcoma but is benign. ***Fibrous dysplasia*** Mosby pg 120. It is more common in maxilla. Affects children. Radiographic appearance is diffuse opacity(ground glass). 2 syndromes: 1.) McCune-albright- polystotic, café au lait spots, endocriopathies. 2.) Jaffe-lichenstein- polystotic and café au a lait spots. , ***paget's*** (Mosby pg. 121- Osteitis deformasns. Pt. complaint "Hat/denture doesn't fit anymore." Older group. A progressive metabolic disturbance of many bones, usually spine femour, cranium, pelvis and sternium. Symmetrical enlargement, dentures become too tight, and diastemas and hypercementosis appears. Bone fragility. Paget's disease has the increase tendency to develop malignant bone neoplasms (per book pg 105 Oral Path) and Per Dr. Gibson Paget's has the tendency to develop into osteosarcoma. **central giant cell granuloma** (Mosby pg 120) a tumor that exhibits undpredictable clinical behavior, some are aggressive and have recurrence. RL

sometimes loculated and in teenages in the mandibular anterior is favored. Composed of fibroblast and and MNGC. Tx is excision Calcitonin is a medical management that can be used for large lesions???

26. Pic of gingival hyperplasia, caused by what? **Phenytoin(Dilantin)- anti-convulsant, Dilatizam- Calcium Channel Blocker, Nifedipine(Procardia)- calcium channel blocker, Verampil- calcium channel blocker and cyclosporine- used in immune graft host reponse**

27. Grand mal(tonic-clonic) seizure drug of choice? **Dilantin**(**phenytoin**)

Status epilepticus-**diazepam** absence seizure (petit Mal)- Ethosuximide or valproic acid (also used to treat manic depressive illness and has more adverse effects than ethosuximide. Mosby pg 285

The medical management of epilepsy usually is based on long-term drug therapy. **Phenytoin (Dilantin), carbamazepine (Tegretol), and valproic acid** are considered first-line treatments.

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 27.1.4).

28. If you need to increase VDO on mounted cast how do you do it? Remount
29. What is contraindicated when treating a sickle cell Patient? **Salicyclates, barbiturates, vasoconstrictors**

Dental Management of the Patient With Sickle Cell Anemia

1. Confirm with patient's physician that the condition is stable.
2. Arrange short appointments.
3. **Avoid long and complicated procedures.**
4. Maintain good dental repair.
5. Institute aggressive preventive dental care.
   a. Oral hygiene instruction
   b. Diet control
   c. Toothbrushing and flossing
   d. Fluoride gel application
6. **Avoid oral infection; treat aggressively when present**.
7. Use pulse oximeter, maintain O_2 saturation above 95%.

8. **Use local anesthetic without epinephrine for routine dental care. For surgical procedures, use 1:100,000 epinephrine in local anesthetic.**

9. **Avoid barbiturates and strong narcotics; sedation may be attained with diazepam (Valium).**

10. Use prophylactic antibiotics for major surgical procedures.

11. **Avoid liberal use of salicylates; control pain with acetaminophen and codeine.**

12. Use nitrous oxide–oxygen with greater than 50% oxygen, high flow rate, and good ventilation.

30. Fenestration-

Isolated areas in which the root is denuded of bone and the root surface is covered only by periosteum and overlying gingiva are termed ***fenestrations***. In these areas the marginal bone is intact. When the denuded areas extend through the marginal bone, the defect is called a ***dehiscence***

Dehiscence on the canine and fenestration of the first premolar.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 5.3.7).

31. 6 questions about furcations.

32. What do you do with probe if furcation is wide and narrow, narrow, wide? **Probe or cant probe? Grade 1 probe goes less than 1/3, G2 probe goes more than 1mm(do GTR n graft), G3 probe goes straight thru, G4**

Grade I is incipient bone loss, **grade II** is partial bone loss (cul-de-sac), and **grade III** is total bone loss with through-and-through opening of the furcation. **Grade IV** is similar to grade III, but with gingival recession exposing the furcation to view.

Ci Tx SRP.Cii Tx GTR,

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 28.5.8).

33. What do you do for a furcation that you can see through? T or F. Tunneling, GTR membrane?

Class I: Early Defects

Incipient or early furcation defects (class I) are amenable to conservative periodontal therapy. Because the pocket is suprabony and has not entered the furcation, oral hygiene, scaling, and root planing are effective.[15] Any thick overhanging margins of restorations, facial grooves, or CEPs should be eliminated by odontoplasty, recontouring, or replacement. The resolution of inflammation and subsequent repair of the periodontal ligament and bone are usually sufficient to restore periodontal health.

Class II

Once a horizontal component to the furcation has developed (class II), therapy becomes more complicated. **Shallow horizontal involvement without significant vertical bone loss usually responds favorably to localized flap procedures with odontoplasty and osteoplasty. Isolated deep class II furcations may respond to flap procedures with osteoplasty and odontoplasty**. This reduces the dome of the furcation and alters gingival contours to facilitate the patient's plaque removal.

Classes II to IV: Advanced Defects

The development of a significant horizontal component to one or more furcations of a multirooted tooth (late class II, class III or IV[13]) or the development of a deep vertical component to the furca poses additional problems. **Nonsurgical treatment is usually ineffective because the ability to instrument the tooth surfaces adequately is compromised.[30,36] Periodontal surgery, endodontic therapy, and restoration of the tooth may be required to retain the tooth.**

34. 8 year old Central incisor canal is constricted but has apical RL what do you do? **Refer**
35. What is worst if doing a RCT? Insufficient obturation, **insufficient cleaning and shaping**,
36. In RCT was is plastic (fiber) post good to use? Same strength as dentin, better strength then steel, same strength as steel, when cemented you can view on xray, Bonds to dentin, esthetics, easy to remove.
37. RCT done and years have RL below what caused this? **actinomyces**
38. Xray of woman who had molar extracted, now has infection, what caused this? Osteomyletis, **residual cyst**

> A residual cyst is a cyst that remains after incomplete removal of the original cyst. The term *residual* is used most often for a *radicular cyst* that may be left behind, **most commonly after extraction of a tooth.**

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 21.3.7).

39. C factor(configuration factor)- composite ratio for bonded to unbounded

The **C-factor** is related to the cavity preparation geometry and is represented by **the ratio of bonded to nonbonded surface areas**. Residual polymerization stress increases directly with this ratio. Worst cfactor is cl 1, rating grade 5

(Anusavice, Kenneth J.. *Phillips' Science of Dental Materials, 11th Edition*. Saunders Book Company, 072003. 18.4.10).

40. Bilateral split osteotomy what nerve do you worry about severing? **Inferior alveolar**
41. Cleft palate/lip- **class 3**
42. Main reason for redoing anterior composite-**discolored or esthestics**
43. Fluoride- how much do we use in community water **0.7-1.2 ppm**

AGE	< 0.3	0.3–0.6	> 0.6
Birth–6 months	None	None	None
6 months–3 years	0.25 mg	None	None
3–6 years	0.50 mg	0.25 mg	None
6–16 years	1.0 mg	0.50 mg	None

Temporate hotter (drinking more H2O more fluoride ingesting 1.2)

44. 5yr old has .28 fluoride how much do you supplement: **0.5**

Fluoride Supplementation Schedule Fluoride Ion Level (ppm)

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007.).

45. What is true and not true about fluoride?
46. What is helpful in senior citizens????? Medicare
47. **When you transilluminate tooth what does the light go thru? Thru fracture but not crays line. Dx vertical fracture.** Transillumination is the clinical practice of shining light through hard or soft tissue as a diagnostic aid, to disclose or emphasize internal defects.
48. Flabby tissue for a denture what do you do first? Epuilis fisratura and excise.

Flabby ridges provide poor support for the denture, and it could be argued that the tissue **should be removed surgically to improve the stability of the denture and to minimize alveolar ridge resorption**. However, in a situation with extreme atrophy of the maxillary alveolar ridge, flabby ridges should not be totally removed because the vestibular area would be eliminated. Indeed the resilient ridge may provide some retention for the denture.

(Zarb, George. *Prosthodontic Treatment for Edentulous Patients: Complete Dentures and Implant-Supported Prostheses, 12th Edition*. Mosby, 092003. 4.2.2).

49. Most likely to cause candidiases? **Inadequate Vertical dimension of occlusion** (loss of intermaxillary space), excessive interocclusal distance
50. Glass ionomer benefits besides fluoride? Used as cement, covalent bond, resist to fracture polyaryclic acid form ionic bond to enamel and dentin
51. Pic of white spongy nevus
52. Benefit of methadone vs morphine? Withdrawal less severe, used 2 detox morphine addicts Methadone is used to relieve moderate to severe pain that has not been relieved by non-narcotic pain relievers. It also is used to prevent withdrawal symptoms in patients who were addicted to opiate drugs and are enrolled in treatment programs in order to stop taking or continue not taking the drugs. Methadone is in a class of medications called opiate (narcotic) analgesics. Methadone works to treat pain by changing the way the brain and nervous system respond to pain. It also works as a substitute for opiate drugs of abuse by producing similar effects and preventing withdrawal symptoms in people who have stopped using these drugs

53. Purpose of plaque index? Show the patient their cleaning ability

> An interproximal plaque index is used to measure interproximal toothbrush **cleaning efficiency**.

(Harris, Norman O.. *Primary Preventive Dentistry, 6th Edition*. Prentice Hall, 082003. 5.4.1).

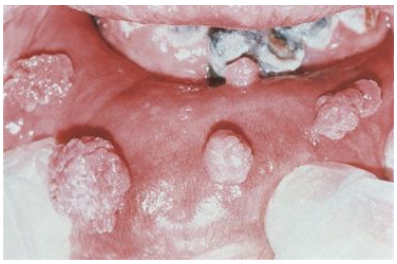
54. Synchondrosis what is last to fuse? Sphenooccipital (starts in teens ends @ 20), intraoccipital (frontal ethmoid/sphenoethmoid might be 1st) spheno-ethmoid second

> **At approximately 16 years of age the sphenooccipital synchondrosis fuses**, thus joining the basiocciput and the body of the sphenoid.

(Liebgott, Bernard. *The Anatomical Basis of Dentistry, 2nd Edition*. Mosby, 012001. 6.3.1.3.4).

55. Cauliflower like lesion on lip

Condyloma acuminata: on labial mucosa.



> **Condyloma acuminata** are usually small and pink to dirty gray. The surface may be flat but is more often pebbly and resembles a **cauliflower.** HPV 6 & 11

(Langlais, Robert P.. *Color Atlas of Common Oral Diseases, 3rd Edition*. Lippincott Williams & Wilkins, 012003. 10.3.4).

(Langlais, Robert P.. *Color Atlas of Common Oral Diseases, 3rd Edition*. Lippincott Williams & Wilkins, 012003. 10.3.5).

56. Naloxlone/ narcan antidote for opiods overdose

antidote for benzo over dose is flumazenil (I think fentanyl is used with benzo for preop sedation

Fentanyl is an opioid reversed by naloxone and flumazenil reverses benzodiazepine

57. Start vomiting after because it triggers chemoreceptor zone

> The central component of the vomiting response is due to stimulation of the emetic **chemoreceptor trigger zone** in the area postrema of the medulla oblongata

> Nausea and vomiting in the postoperative period continue to be a significant problem following general anesthesia and are caused by an action of anesthetics on the chemoreceptor trigger zone and the brainstem vomiting center, which are modulated by serotonin, histamine, ACh muscarinic, and dopamine receptors. The 5-HT_3serotonin receptor antagonist ondansetron (*see* Chapter 38) is very effective in suppressing nausea and vomiting. Common treatment also includes droperidol, metaclopromide, dexamethasone, and avoidance of N_2O. The use of propofol as an induction agent and the nonsteroidal antiinflammatory drug ketorolac as a substitute for opioids may decrease the incidence and severity of postoperative nausea and vomiting.

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 10.4.2.1.2).

58. Chemo causes thrombocytopenia and sickle cell

> Myelosuppression—as manifested by leukopenia, neutropenia, thrombocytopenia, and anemia—is a common sequela of several forms of cancer chemotherapy. **Within 2 weeks of the beginning of chemotherapy administration, the white blood cell count falls to an extremely low level.** The effect of myelosuppression in the oral cavity is marginal gingivitis. Mild infections may develop, and bleeding from the gingiva is common. If the neutropenia is severe and prolonged, severe infections may develop. The microorganisms involved in these infections may be overgrowths of the usual oral flora, especially fungi; however, other microorganisms may be causative. Thrombocytopenia can be significant, and spontaneous bleeding may occur. This is especially common in the oral cavity after oral hygiene measures. Recovery from myelosuppression is usually complete 3 weeks after cessation of chemotherapy

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 18.2.2).

59. Dental office matches benefits of other offices but patient can choose dentist-PPO, HMO, closed or open panel

60. Patient has to go to specific dentist in this plan-**hmo**,ppo,closed or open panel

> PPOs differ from HMOs in that they are fee-for-service plans, so in **PPOs a beneficiary can go to any participating provider** for any covered service, because payment is made only when care is provided

"Open panel" dental plans. Like a PPO

Some dental plans will permit any dentist who so chooses to participate as a provider of dental services for the plan. In these cases the dental plan is said to employ an "open panel" of provider dentists. This type of dental plan is nice in the sense that your current dentist, or else the dentist you would like to utilize, can provide your dental treatment.

"Closed panel" dental plans. Like HMO

Some dental plans dictate that the dentist providing your dental treatment must be one approved by the dental insurance company

. This type of situation is termed a "closed panel" of dentists.

The concept of a closed panel plan has to do with the fact that the dental insurance company has negotiated a contract with its network of provider dentists. In return for receiving patient referrals from the dental insurance company the participating dentist has agreed to discount their fees. Utilizing a closed panel is one way a dental insurance company can reduce their costs.

(Burt, Brian A.. *Dentistry, Dental Practice, and the Community, 6th Edition*. Saunders Book Company, 032005. 7.8.3).

61. How does collimation work? A device capable of collimating radiation, as a long narrow tube in which strongly absorbing or reflecting walls permit only radiation traveling parallel to the tube axis to traverse the entire length. Reduce from circu
62. What muscle does the denture cover? **Buccinator**
63. EDTA chelating agent inorganic material , smear layer remove
64. Sodium in RCT what does it NOT do? Not a chelating agent organic material
65. Antipsychotic drugs act on which receptors? Multi receptors but mostly **dopamine**

> Radioligand-binding and autoradiographic assays for **dopamine receptor** subtypes have been used to define more precisely the mechanism of action of antipsychotic agents. Estimated clinical potencies of most antipsychotic drugs correlate well with their relative potencies *in vitro* to inhibit binding of radioligands to **D_2-dopamine receptors**. (Mosby pg 281.- Anti-psychotics block dopamine receptors in the mesiolimbic and mesocortical pathways.

(Brunton, Laurence. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 11th Edition*. McGraw-Hill Professional Publishing, 092005. 18.2.2.2).

66. Nitrate(NO3) vs nitrites(NO2) mechanism of action? **Nitrates increase O2 supply by vasodilating action on smooth muscle in coronary arteries.**

> These agents are prodrugs that are sources of nitric oxide (NO). NO activates the soluble isoform of guanylyl cyclase, thereby *increasing intracellular levels of cyclic GMP. In turn, this promotes the dephosphorylation of the myosin light chain and the reduction of cystolic* (Ca^{2+}) and **leads to the relaxation of smooth muscle cells in a broad range of tissues**. **The NO-dependent relaxation of vascular smooth muscle leads to vasodilation;** NO-mediated guanylyl cyclase activation inhibits platelet aggregation and relaxes smooth muscle in the bronchi and gastrointestinal

(Brunton, Laurence. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 11th Edition*. McGraw-Hill Professional Publishing, 092005. 31.2).

67. How do you treat dry sockets? **Surgical dressing, and analgesic**
68. If patient has excess saliva-realign, no affect, helps with retention(I think reline) The more saliva the better it adds with retention to create the seal. For example in clinics when you insert patients maxillary denture. You tell them to close and swallow so that you can seal the peripheral borders and suction. The less saliva the worse.
69. Why do you place a functional cusp bevel? Retention & resistance, **structural integrity**,

> As part of the occlusal reduction, a wide bevel should be placed on the functional cusps of posterior teeth to **provide structural durability in this critical area**. Failure to place a functional cusp bevel can result in thin, weak areas in the restoration

(Shillingburg, Herbert T.. *Fundamentals of Tooth Preparation: For Cast Metal and Porcelain Restorations*. Quintessence Publishing (IL), 011987. 1.3.2).

70. Which patient is more likely to have thrombocytopenia- chemotherapy, **taking oral contraceptive**??? Thrombocytopenia -Thrombocytopenia is any disorder in which there is an abnormally low amount of platelets. Platelets are parts of the blood that help blood to clot. This condition is sometimes associated with abnormal bleeding. Disorders that involve low production in the bone marrow include: Aplastic anemia Cancer in the bone marrow, Cirrhosis (chronic liver disease), Folate deficiency, Infections in the bone marrow (very rare), Myelodysplasia, Vitamin B12 deficiency Board Busters pg 214. – results in multiple bruises, petechiae, hemorrhage into the tissue. Maybe caused by heparin(warfarin) therapy. Oral manifestations are severe/profuse gingival hemorrhage and palatal petechiae.

71. Patient has small cavity @ what point do you interfere with decay? ½ way thru enamel, seen on xray, **seen in dentin or cavitated**
72. What do you see in thyroid storm exspect? High temperature, sweating, rapid heartbeats, or weight loss. Thyroid storm is a life-threatening condition that develops in cases of untreated thyrotoxicosis (hyperthyroidism).**Causes, incidence, and risk factors** Thyroid storm results from untreated hyperthyroidism. It is usually brought on by a stress such as trauma or infection.**Symptoms**

Symptoms are severe and may include:

- Agitation
- Change in alertness (consciousness)

- Confusion
- Diarrhea
- Fever
- Pounding heart (tachycardia)
- Restlessness
- Shaking
- Sweating

Signs and tests

- The top number in a blood pressure reading may be high
- Increased heart rate

Blood tests are done to evaluate thyroid function.

73. What is a minor connector? Connects things to major connector
74. What is the rest seat connected to if that is connected to major connector? Minor connector
75. Least congenitally missing tooth? 3m-mand-**2pm-lat incisor**
Most: 3rd molar→mand 2 bicuspid→max lateral (least)
76. Erution sequence/ calc seq Look at Mosby pg 176
77. When is 1st sign of calcification (4months in utero) which is about 14 weeks and the first tooth would be the primary central incisor Mosby pg 176
The crown of all primary begins to calcify 4-6 months in utero
78. Fractured mandible how long is appropriate to keep in closed reduction? 4weeks, **6 weeks**, 9 weeks, 12 weeks(4-6 weeks) (2 weeks deciduous)

> Once the closed reduction had been achieved, maxillomandibular wires replace the elastics and are maintained for **6 weeks**.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 24.3.1).
79. Irreversible hydrocolloid is not used in fixed (Note irreversible hydrocolloid is alginate and is used for preliminary impressions. Must be poured immediately and goes from gel to sol.)
80. How do you increase working time with irreversible hydrocolloid? Increase spatulation, **increase cold water**, increase hot water

81. Which stone and how do you make it set up faster? **Slurry water**, hot water, cold water
82. If you cut a DO what axiolineangle is not there? No distal wall
83. Flap surgery wide gap in between how do you clean interproximal furaction? **Interproximal brush,** water pick, floss
84. Guy on recall for perio has mesial on #4 distl on #20 with 6mm perio pockets what do you do? Surgery, scaling(6-7mm for 3-4month recall), etc
85. 10 yr old with gap what do you do? Take away frenum, ortho, **wait for Mx k9 eruption**

86. What isn't seen on xray gingival cyst or **nasiolabial cyst**
87. Supragingival plaque is more gram negative or **positive**
Supragingival plaque is more **gram positive (Note:) Major organic components of plaque biofilm are polysaccharides, proteins, glycoproteins, lipids. The major inorganic component of plaque is calcium and phosphorous.) – Mosby pg 242**

> **Supragingival plaque (More gram positive)**
>
> **saliva is the main source of inorganic component** .Supragingival is either tooth-associated or outer layer. **Tooth-associated** is composed primarily of **gram -positive cocci and short rods**. **Mature outer surface of plaque** is gram-negative rods and filaments and spirochetes.
>
> **Subgingival**
>
> **Subgingival plaque is mainly derived from gingival crevicular fluid. tooth associated** is **gram negative rods** and ***Tissue associated*** is **gram negative rods and cocci, filaments, flagellated rods and spirochetes.**

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 10.8).
88. Key features of cleidocranial dysplasia. **Retain primary dentition longer.** Autosomal dominant condition manifested by many alterations, especially of teeth and bones. The most distinctive features include: delayed tooth eruption, supernumerary teeth, hypoplastic aplastic clavicles, cranial bossing, and hypertelorism. (Mosby pg 123)
89. After 10 years % of people with successful implants? (5 year 95 Mn 90 Mx) so **80-90%**

> The implant and related prosthesis can attain a **10-year survival of more than 90%.**

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 1.7).
90. Alvused teeth best prognosis? Something to do with time and what its stored in(best in 15-30minutes, hanks solution, or milk,saline,saliva) Note viaspan is also a good solution and as long as the tooth is replaced in less than a hour
91. Test for prevelance of incidence investigating oral cancer in a nursing home pts what kind of study is this?
92. T test vs chi square (The t-test assesses whether the means of two groups are *statistically* different from each other. Chi square- test measures the association between two categorical variables. MOSBY pg 214)
93. INR determines **PT measure warfarin dose**, liver damage, vit k status
94. Kid wheezes with inspiration(vocal cord obstruction) ?? laryngospasm. Tx is with succinylcholine
95. Common dental office problem? Asthma hyperventilation, **syncope (Note: tx for syncope would be inhaled ammonia)**
96. Patient needs to be medicated for 8 hrs what do you give them? Aspirin, ibuprofen(4-8), acetaminophen, **naproxene(12**)

Diflunisal (dolobid 8-12 hrs) Effectiveness of diflunisal is similar to other NSAIDs, but the duration of

action is twelve hours or more Though diflunisal has an onset time of 1 hour, and maximum analgesia at 2 to 3 hours. Diflunisal is in a class of medications called NSAIDs. It works by stopping the body's production of a substance that causes pain, fever, and inflammation.

97. H2 histamine receptor is for gastric acid reduction(Mosby pg 293-294- examples are cimetidine, ranitidine, famotidine, nizatidine. Omeprazole (Prilosec) and lanzsoprazole (prevacid)
98. Most likely to reoccur **OKC**
99. What do you use to cool bone when place a implant? Air, **irrigated solution**

> Bone cell survival is very susceptible to heat. Eriksson has demonstrated that in rabbit, bone temperature as low as 3° C above normal (40° C) can cause bone cell necrosis.[49] Therefore a conscious effort is made to control temperature elevation every time a rotary instrument is placed in contact with bone. At least **50 mL/min of cooled irrigation, such as sterile physiologic saline, is used as a profuse irrigant and is a critical element to reduce heat.**[35-37,50] ***Distilled water should not be used*, as rapid cell death may occur in this medium.**[51] **Intravenous dextrose solution (D_5W) also may be used, with the clinical advantage of decreasing hand piece breakdown occurring from the effects of the salt in a saline solution, although the surgical gloves often feel sticky near the conclusion of the surgery.** The irrigant also acts as a lubricant and removes bone particles from the implant osteotomy site. Without irrigation, drill temperatures above 100° C are reached within seconds during the osteotomy,[52] and consistent temperatures above 47° C are measured several millimeters away from the implant osteotomy. The temperatures of the irrigant can also affect the bone temperature.[36,39] Copious irrigation is suggested, especially in D1 bone.

(Misch, Carl E.. *Contemporary Implant Dentistry*, *3rd Edition*. Mosby, 122007. 29.2.1.3).

100. Maximum amount of nitrous? **70%**
101. 100th in hue, value, chroma? ???Brightness, hue is measured in 100th i.e 100th, 200th, 300th not 344, 546 etc
102. Gardner syndrome- osteomas, polyps that turn into adenocarcinomas, supernumary teeth (Mosby pg 123- autosomal dominant disorder, consists of intestinal polyposis, osteomas, skin lesions, impacted permanent and supernumerary teeth and odontomas. Intestinal polyps have a very high rate of malignant conversion to colorectal carcinoma.
103. Tell show do is for who-child
104. 2yr ol acting up what do you do-get down to their level and talk to them
105. Same question-show them another child behaving which is an example of modeling
106. LED cure light why is it more beneficial than halogen and know the range. 430-490 shorter curing time
107. Permanent teeth vs primary teeth-higher pulp horns, pulp chamber is bigger in primary teeth
108. Pt has Mn molar extracted 3 days later have pain- alveolar osteitis (dry socket)

> Dry socket or alveolar osteitis is delayed healing but is not associated with an infection. This postoperative complication causes moderate to severe pain but is without the usual signs and symptoms of infection, such as fever, swelling, and erythema. The term *dry*

socket describes the appearance of the tooth extraction socket when the pain begins. In the usual clinical course, **pain develops on the third or fourth day after removal of the tooth**.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 11.9.3).

109. Infection on lip can cause cavernous sinus thrombosis thru infection travelling. **Cavernous sinus thrombosis** (CST) is the formation of a blood clot within the cavernous sinus, a cavity at the base of the brain which drains deoxygenated blood from the brain back to the heart. The cause is usually from a spreading infection in the nose, sinuses, ears, or teeth. *Staphylococcus aureus* and *Streptococcus* are often the associated bacteria. Cavernous sinus thrombosis symptoms include; decrease or loss of vision, chemosis, exophthalmos (bulging eyes), headaches, and paralysis of the cranial nerves which course through the cavernous sinus. This infection is life-threatening and requires immediate treatment, which usually includes antibiotics and sometimes surgical drainage. Cranial nerves 3, 4, 5, 6, are affected.

110. Autistic child-likes affection, needy, **repeat things over and over**

111. Patient with heart attack-answer is heart attack?

112. Ameloblastoma form from dentigerous cysts

113. What do you have with seizures-hyper…(hyperventilation, hyperthyroidism, **hyperexcitable nerves**) (Note: tx of seizures: grand mal- phenytonin (Dilantin), absence seizures (petit mal) (ethosuxmide and valproic acid) prophylaxis for partial seizures- Carbamazepine which also treats trigeminal neuralgia

114. What does cusp reduction do? Retention, **resistance**(conserve tooth struct and gives rigidity)

115. Unbundling and beneficence definitions-bene promotes wellbeing of others, unbundling is charging separately ie.post and core

116. Waive copay-**price fixing**

117. Pic of compound odontoma

118. Alpha agonist acts on?(**adrenergic**, epinephrine, SNS)

119. What can you get back? Tooth mobility

120. % of people that get fluoridation? **67-70**

In 1992, when the last *Fluoridation Census* was published, approximately *135 million Americans* were consuming fluoridated water while an *additional 10 million* were drinking water with optimal levels of *naturally occurring fluoride*, equating to 57% of the entire population or 62% of those who are served by *centralized piped-water systems*.[7–8] (see Table 8-2). **As of 2000, the percentage of the population receiving optimally fluoridated water through public water systems has risen to 65.8%** and 26 states achieved the Healthy People 2000 goal of 75% of the population served by community water fluoridation[8] (see Figure 8-2). From 1992 to 2000, 28 cities adopted fluoridation, with an estimated 8,295,552 million people added to the Fluoridation Census.

(Harris, Norman O.. *Primary Preventive Dentistry, 6th Edition*. Prentice Hall, 082003. 8.2).

121. Treat external resorption with what? **RCT**, CAOH2

Root canal treatment is therefore recommended routinely for replanted teeth with closed apexes to prevent the occurrence of inflammatory resorption.

(Torabinejad, Mahmoud. *Endodontics: Principles and Practice, 4th Edition*. Saunders Book Company, 032008. 10).

122. Apexification-nonvital tooth

123. Indirect vs direct on child

124. Pt on antidepressant what is your greatest concern? **Epinephrine** or time in chair These patients are usually taking MAOI which may potentiate the effect of the Epi by inhibiting the re-uptake.

125. Pt is emergency remove decay that is medium to deep but not pulpal exposure so you temp it what are the indication for that? Emergency

126. Order of treatment perio not endo related, order of Tx endo not perio related.

127. Pt has Mn molar cracked? Best description? Stabbing pain, **pain upon releasing bite is Cracked Tooth Syndrome. Use transillumination for diagnosis. Prognosis depends on how severe. Crack is in a M-D dimension. Note: Pain upon biting is a sign of Vertical Root Fracture. It is diagnosed by transillumination. It is in a F-L dimension. Poor prognosis. Tx is Extraction.On radiograph if can see lesion it is a J-shaped lesion.**

128. 40 yr old pt has 32 teeth with deep fissures what do you do? Sealant, amalgam, **observe**

129. 1st molar decay what do you do? MOD & DO, MO & DO (what the hell !!!)

130. Hex implant prevents **rotation**

131. What is the initiator of caries? S. mutans not option so L. bac

132. Don't give a pregnant woman what? **Diazepam**, (Other drugs cannot be given: warfin, NSAIDS, methotrexate, merpidine, nitrous oxide, barbituates, Phenergan, prophyphene tetracycline, carbamezapine, choloral hydrate, morphine, diphenhydramine, hydrocholoride, cortiocosteroids, chlorodiazepine. DRUGS THAT CAN BE GIVEN- Tylenol, Tylenol #3, codeine

133. 5 year old child extraction what do you give them? **Acetaminophen**

134. Braces move due to **supracreseptal fibers**

135. Ortho Tx does…..pulpal response, **decrease blood to PDL, widened PDL Mosby pp156-157. Root resorption during otho tooth movement is a potential side effect of orhto therapy. As the PDL experiences hyalinzation in specific stress areas of compression the adjacent cementum shows signs of resorption by clastic cells.. Heavy forces applied to a tooth can cause pain as soon as the PDL is initially compressed.**

136. Important with successful RCT what is the least likely to happen-**regen of dentin**, regen of cementum, regen of alveolar bone

The purpose of the pulp is dentin formation, and if your RCT was performed well there should no longer be any vital pulp tissue in the canal. So… no pulp tissue, no dentin regeneration.

137. Prescribed opioid analgesic physical signs-headache, irritability, hypo… (**nausea, vomiting, drowsiness, itching, constipation, respiratory depression)**

138. IV antibiotic has tachycardia and other problems 1st thing you do is what? **Epinephrine, stop antibiotic** (if serious cardioversion, admin adenosine, stable refer,ECG)

Agree, sounds like an anaphylactic response: you already have an IV line so just give 3 ml of 1:10,000 epinephrine

139. All effects the success of implant except-remaining teeth

140. Epitomizes dental fear-chair

141. Causes sudden mobility- **secondary traumatic occlusion**

142. Mandibular lateral incisor eruption where do you get space- **primate space**

primate space, is located **mesial to the maxillary canine** and **distal to the mandibular canine.**

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition.* Mosby, 042005. 18.4.5.2).

143. Pregnant woman in dental chair- **lay on left side** to prevent from laying on **vena cava**

144. Perio disease time of life theory episodic or random-random burst theory
The "random burst" theory has recently been proposed as an explanation of the pattern of periodontal disease progression. The theory predicts that the progression of bone loss at individual sites is not dependent upon previous bone loss and age.

145. Neurofibromatosis –**freckling(Crowe's sign), lisch nodules(iris freckling), café au lait**, Mosby pg 113. Multiple neurofibromas, malignant transformation of neurofibromas in 5% to 15% of patients.

146. Major complaint from a denture patient-can say certain words**, lack of retention in mandibular denture**

147. Osteoradionecrosis **most associated with mandible**

True because the maxilla is more vascularized than the mandible. Osteoradionecrosis occurs as a result of hypoxia of tissue.

148. Best time to get children to stop children from sucking thumb- primary dentition period

To minimize the risk of habitinduced malocclusion, **such habits should be eliminated by 24 months of age**. Thus given the physiologic and psychological need for sucking in the first year of life, **it is not prudent to recommend elimination of habits prior to 12 months of age.**

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition.* Mosby, 042005. 13.6.5).

149. Device place to prevent thumb-sucking-positive, negative, **adversive**

150. Smiling, praising down syndrome pt-social, positive reinforcement

151. Modeling & shaping questions

152. What model to get child to follow directions

153. Teach child to turn negative thoughts to positive experience-**reshaping**, modeling

154. Drug A has higher efficacy than B? more potent, **smaller dose**

efficacy is that property *intrinsic* to a particular drug that determines how "good" an agonist the drug is. Historically, efficacy has been treated as a proportionality constant that quantifies the extent of functional change imparted to a receptor-mediated response system on binding a drug. Thus**, a drug with high efficacy may be a full agonist eliciting, at some concentration, a full response, whereas a drug with a lower efficacy at the same receptor may not elicit a full response at any dose.**

(Brunton, Laurence. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 11th Edition*. McGraw-Hill Professional Publishing, 092005. 1.2.2.2).

155. When do you do maintenance phase in perio?After phase II therapy
Phase 1- Nonsurgical

Phase 2- Surgical

Phase 3- Restorative

Phase 4- *Maintenance (phase IV therapy).* Periodontal procedures include periodic evaluation of oral hygiene status, presence or absence of local factors, and condition of the periodontium (pocket depths, attachment levels, mobility, occlusion). **This phase actually should begin after the completion of phase II therapy.**

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 7.5).

156. Added to polymethyl methacrylate for? Strength, polymerization, …

157. What size do you do a excision? **(<1 cm in diameter)**

(Regezi, Joseph A.. *Oral Pathology: Clinical Pathologic Correlations, 4th Edition*. Saunders Book Company, 012003. 6.1.6.5).

158. Salivary gland defect

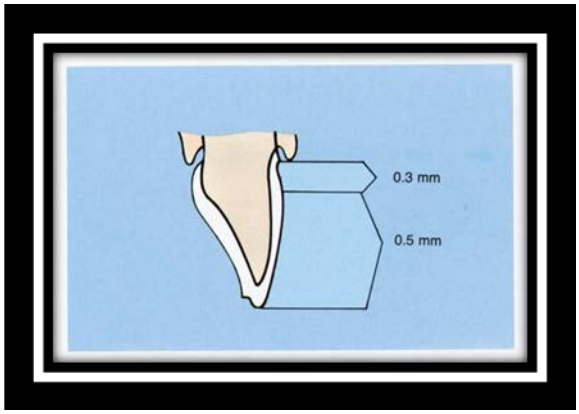
159. Palmar plantar keratosis- Lefevre Papillone (autosomal dominant, palmar and plantar keratosis. Erythematous and associated with aggressive periodontitis, The severe destruction of periodontium results in loss of most primary teeth by the age of 4 and most permanent teeth by age 14. Hyperkeratosis of palms and soles of feet appear in first few years of life.

160. #8 lighter than the rest of teeth what do you do? **Bleach other teeth**, crown

161. What's not on ADA website? Licensing

162. How much do you take off facial view of veneer? **.5 mm (.5mm in the middle, .3 mm in the cervical and .7mm and in incisal)**

for a two-shade color shift in all teeth, a 0.3-mm tooth reduction in the cervical one third and a **0.5-mm tooth reduction in the remainder of the facial surface are sufficient**.



(Rufenacht, Claude R.. *Fundamentals of Esthetics*. Quintessence Publishing (IL), 011990. 12.5.1).

163. Regen of periosteum needs- sharpeys fibers, cementum, alveolar bone, **periodontal ligaments**

164. Benefits of PCN except? Cheap, low toxicity, not broad spectrum

Bactericidal with narrow-spectru, safe:low-toxicity, cheap, p.26 d.secrest

165. What will happen if you issue broad spectrum antibiotics-**creates infection**
166. Denture pt with opposing teeth? Mx bone resorption, post tuberosity droops, **Mx anterior resorption (**Combination syndrome)pt. will have a flabby ridge and anterior resorption
167. What cause angular chelitis-**VDO loss (increased interocclusal space and tx will be nystatin or clomatriazole)**
168. Pt has hypoparathyroid disorder can be prevented by giving what?iodine?(**vit d therapy**, calcium, no way to prevent primary) Note: hypothyroidism- myxedema in adults and cretinism in children. Hyperthyroidism is goiter's syndrome. Treatment with hyperthyroidism is iodine.
169. Pt has low alkaline phosphatase what do they have? (magnesium deficiency Symptoms of magnesium deficiency include: hyperexcitability, dizzyness, muscle weakness and fatigue.[1] Severe magnesium deficiency can cause hypocalcemia, low serum potassium levels (hypokalemia), retention of sodium, low circulating levels of parathyroid hormone (PTH), neurological and muscular symptoms (tremor, muscle spasms, tetany), loss of appetite, nausea, vomiting, personality changes [2] and death from heart failure., hemolytic anemia, wilson's disease(too much copper in body). **Elevated levels alkaline phosphatase in Paget's/osteosarcoma ↑**

> **A decrease in serum alkaline phosphatase** and an increase in the urinary excretion of phosphoenolamine are pathognomonic for **hypophosphatasia**.

(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 6.7.6).

170. Periodontal disease in children? Acute periodontitis, **marginal gingivitis**
171. Articaine (septocaine) is metabolized where? **Plasma esterase and liver.**
172. A drug is first passed means? Excreted in urine, **metabolized in liver or intestine**

> Following nonparenteral administration of a drug, a significant portion of the dose may be metabolically **inactivated in either the intestinal epithelium or the liver before it reaches the systemic circulation.** This first-pass metabolism significantly limits the oral availability of highly metabolized drugs.

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 2.5.2).

173. Diagnosis for bullemia A dental exam may show cavities or gum infections (such as gingivitis). The enamel of the teeth may be worn away or pitted because of too much exposure to the acid in vomit.

A physical examination may also show:

- Broken blood vessels in the eyes (from the strain of vomiting)
- Dry mouth
- Pouch-like look to the corners of the mouth due to swollen salivary glands
- Rashes and pimples
- Small cuts and calluses across the tops of the finger joints from forcing oneself to vomit

A chem-20 test may show an electrolyte imbalance (such as hypokalemia) or dehydration.

174. Bullemia is form of erosion

175. Wipe something down and it kills everything but spores-**disinfected (disinfectants should be able to kill Mycobacterium Tuberculosis, which is the benchmark organism. It is the process in which antimicrobial agent destroys germicide or avoids the growths microbiostatic of pathogenic microrganisms. Mosby pg 218**
176. Allergic to amoxicillin give the patient what: **clindamycin 600 mg in adults and 20 mg in children, clarithomycin,/azithromycin 500 mg in adults and 15 mg, cephalexin 2g in adults and 50 mg in children**
177. Identify nasal septum-zygoma
178. Where do you use base metal-**bridge**
179. Where do you use noble metal-**single crown**
180. Premed with endocarditis main concern? If had previous
181. Pt had hip replacement 10 months ago do you premed? **Yes (less than 1 yr pre-medicate)**
182. 30 year old pt has deep fissure least likely to do? Sealant, **amalgam**, observe
183. Most common root fracture- **Mandibular 1st molar**
184. Most successful place to put a implant? **Mandibular anterior**
185. Ectodermal dysplasia

Hereditary ectodermal dysplasia

1. An X-linked recessive condition that results in **partial or complete anodontia**.

2. Patients also have **hypoplasia of other ectodermal structures, including hair, sweat glands, and nails.**

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 4.1.19).

186. Doxycycline does what? Inhibits collagenase it is used in sulcular depth.Tetracycline is a broad spectrum antibiotic inhibits 30 S ribosome. It is can go into gingival crevicular fluid
187. What sound is hard to make if denture is placed to far facially? **"F" and "V" sound**
188. Bony resorption from implant considered successful If you have .1mm of resorption per year? **Yes Note: if have less than 0.02 mm of bone loss per year it is successful. If have greater than .2 mm year it is failure.**
189. How much radiation exposure is considered bad? 4 Gy (acute radiation)?????
190. What is considered safe amount of radiation? **50 mSv of whole body radiation in 1year individuals occupationally exposed in operation of dental xray equipment receive an annual average of 0.2mSV (0.04% of allowable limit)Mosby pg. 129**

Dentists and their staff are occupationally exposed workers and are allowed to receive up to **50 mSv of whole-body radiation exposure per year**

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 3.2.1).

191. If xray goes through something thick what will it look like on xray? Cancer, thickness, no cancer, **radioopaque**, had to penetrate thick structure looks radioopaque
192. Cementing all porcelain or all ceramic crown what resin good to use and what benefits? **Resin cement** -Fracture, fill in margin, **color control**
193. Contraindication with St Johns Wort? Asthma, **warfarin**, pregnancy
194. Replacement resorption- necrotic pulp resorption(?) associated with ankylosis Mosby pg 23 Cause: PDL (nonviable PDL), occurs in about 60% of replanted teeth. Radiographic evidence continuous replacement of lost root with bone. NO RL (loss of cementurm, dentin, PDL and with the ingrowth and fusion of bone to the root defect.) CCL evidence. Irreversible: dental treatment cannot stop progression. Metallic sound on percussion.
195. In a injury this acid is produced and is responsible for what? Prostaglandin??
196. Tooth fused to bone-replacement resorption
197. Porcelain is strongest in what stage? Firing, cooling, stressed I think its cooling
198. Most damaging type of mercury? **Methyl, ethyl (organic)**

Least damaging -inorganic

I think the concepts were basically the same…I can say I saw a good number of my questions somewhere, not in the exact same form but a variation of some sort where you could easily get it wrong if u just looked at remembered questions and didn't seek understanding of the concepts. I also noticed that at least 75% of my case patients had things that were related to topics covered in the JADA(implants more in depth than mosby, bisphosphanates, drug abusers, sjogren's, u name it) that were not covered in enough detail in our study aids for the test. Good Luck and make sure u give as you are receiving if you are reading this.

Know hyper and hypo thyroid really well…each symptom of each and what goes with what.

Animal has caries and feed them cariogenic food via stomach tube what will happen to the caries intraorally? Decrease, **stopped**, increase, increase dramatically

Caries in Rats Fed a Decay-producing Diet Via Normal and Stomach Tube Routes

Group	Methods of Feeding	No. of Rats	Avg. No. of Carious Molars	Avg. No. of Carious Lesions
A	Normal	13	5.0	6.7
B	Stomach tube	13	0	0

(From Kite et al. J Nutr. 1950:42.)28

(Harris, Norman O.. *Primary Preventive Dentistry*, *6th Edition*. Prentice Hall, 082003.).
Extension of retromolar pad in dentures? 1/3,**2/3**. In front

Daily requirement of fat? 10,20,**30**,40(who cares)

What is most common reason children get coronary artery disease? Obesity, diabetes

Oseteogenesis surgery vs ostectomies why is one prefer over the other? Less parasthesia and some more

What are leukotrienes are now being linked to? Asthma the leukotriene is montelukast. Mosby pg 301

> *Leukotrienes* (LTs) are synthesized from arachidonic acid by a different pathway, and they are part of the airway inflammatory response. LTC_4, LTD_4, and LTE_4 may play a role in asthma. These **LTs are 1000 times more potent than histamine as bronchoconstrictors**, they stimulate mucous production, and they increase vascular permeability, which can lead to edema. LTB_4 induces leukocyte chemotaxis, increased vascular permeability, and vasodilation. LTs are removed almost completely by the pulmonary circulation, so their effects are local.

(Johnson, Leonard. *Essential Medical Physiology, 3rd Edition*. Academic Press - Non Elseiver S & T, 092003. 21.5.3).
Know what to do if you fracture the aleveolar bone while extracting….they had place flap to visualize the pieces(which is what you should do) but they also had refer to oral surgeon which is what a general dentist SHOULD do so who knows

Know how to remove mandibular tori. Is was like with osteotome, bur, etc. I said section w bur and use the osteotome

I had the inverted Y question. I put floor of nasal and wall of max sinus

Know how to treat hypo(called insulin shock) and hyperglycemia in pediatric and adult patients…I chose juice, had glucose but u they said IM and u give it via IV and u def don't give more insulin

I had a lot of fear vs anxiety questions…know the diff thoroughly in terms of children.

BOX 7.1 ANXIETY

Anxiety refers to a hypothetical psychological construct which is:

- Anticipatory
- Associated to a specific event (but not always)
- Aversive
- Unpleasant to experience; and
- Takes time to dissipate.

Three components are helpful in explaining anxiety.

1. Physiological and somatic sensations, for example:

- Breathlessness
- Perspiration
- Palpitations
- Feelings of unease.

2. Cognitive features (that is, how changes occur in thinking processes), for example:

- Interference of concentration
- A focusing of attention sometimes known as hypervigilance
- Inability to remember certain events while anxious
- Imagining the worst that could happen.

3. Behavioural reactions, for example:

- Avoidance, i.e. the postponing of a dental appointment, or requesting to have all dental treatment conducted in a single session.
- Escape from the situation which precipitates the anxiety.

BOX 7.2 FEAR

Fear overlaps with the anxiety construct but emphasises a more biological response. Someone who experiences fear will not necessarily be anticipating a negative event, — their response will occur at the moment the unpleasant event (e.g. pain) occurs. In a sense the fear response is a valuable one, in that it produces a protective 'fight or flight' response. That is, the individual who experiences fear (and the physiological reactions can be magnified relative to anxiety), usually in response to a clear unpleasant stimulus, selects whether to engage in defence ('fight') or makes a hasty retreat ('flight'). Either way the fear response can be quickly resolved and dissipated. In this sense fear may be seen more positively as the individual is very often clear what precipitated the fear reaction.

A panic reaction is a special type of fear, sometimes regarded as a 'fear of fear itself'. The individual who suffers a panic reaction is acutely aware of the physiological sensations within his body and certain symptoms he experiences act to trigger a full-blown fear reaction. This experience may well be more common in dental patients than has hitherto been realised and will be discussed later in the chapter.

(Humphris, Gerry. *Behavioural Sciences for Dentistry*. Churchill Livingstone, 022000. 9.1).

Random statistic questions…

How far does floss and toothbrush penetrate sulcus? I put 2-3mm for both and I looked it up before the test and couldn't find a definitive answer but I did see that toothbrush goes up to 3

Know IRM, ZOE, and Glass ionomer…they seemed to like them and know the composition of each one of those materials

What surface is caries most prevalent? Occlusal, **interprox**, facial, lingual

Cutting access prep on Max incis, angle bur distally to avoid what? (this is in dental decks) mesial perforation

Want to gain straight line access…they had many reasons that seemed good access preps but ultimately this is what we want to do

Osteoporosis and bisphosphates…know what happens when on bisphosphanates and get messed up jaw similar to osteoradionecrosis but here its called regular osteonecrosis bcuz ur assuming pt didn't have radiation treatment

Smiling, praising a child? Token reinforcement, social reinforcement (positivie reinforcement)

Know that you will use glass ionomer if you are close to gingival margins

GI over composite due to….fluoride release

Glass ionomer has….polyacrylic acid

IRM is ZOE combined with…… methyl methacrylate

Autistic people have? Heightened perception to sounds, lights, or greater than average intelligence NOTE:

Autistic disorder (also called autism; more recently described as "mindblindedness") is a neurological and developmental disorder that usually appears during the first three years of life. A child with autism appears to live in their own world, showing little interest in others and a lack of social awareness. The focus of an autistic child is a consistent routine and includes an interest in repeating odd and peculiar behaviors. Autistic children often have problems in communication, avoid eye contact and show limited attachment to others.

More than 500,000 people in the US have been diagnosed with some form of autism. Autism can prevent a child from forming relationships with others (in part, due to an inability to interpret facial expressions or emotions). A child with autism may resist cuddling, play alone, be resistant to change and have delayed speech development. Persons with autism tend to exhibit repeated body movements (such as flapping hands or rocking) and have unusual attachments to objects. However, many persons with autism excel consistently on certain mental tasks (i.e., counting, measuring, art, music, memory).

What are the symptoms of autism? The following are the most common symptoms of autism. However, each child may experience symptoms differently. Symptoms may include:

- Does not socially interact well with others, including parents.
  - Shows a lack of interest in, or rejection of, physical contact. Parents describe autistic infants as "unaffectionate." Autistic infants and children are not comforted by physical contact.
  - Avoids making eye contact with others, including parents.
  - Fails to develop friends or interact with other children.
- Does not communicate well with others.
  - Is delayed or does not develop language.
  - Once language is developed, does not use language to communicate with others.
  - Has echolalia (repeats words or phrases repeatedly, like an echo).
- Demonstrates repetitive behaviors.
  - Has repetitive motor movements (such as rocking and hand or finger flapping).
- Is preoccupied, usually with lights, moving objects, or parts of objects.
- Does not like noise.
- Has rituals.
- Requires routines.

Have implant should the emergence profile be from the? 1mm below CEJ of adjacent, 1mm above, **2-4mm below the CEJ**, 2-4mm above

Asked what part of framework resists corrosion? Chromium-cobalt wasn't there together but listed as separate parts. Cobalt, **chromium**, blah blah Note Cobalt is for rigidity and silver turns porecelain green

Epipheseal plate is most similar to what? **Syncodrosis (intersphenoid first, spehenoethmoid second, and sphenoociptal last)**

What don't u take with methotrexate? **Beta-lactam antibiotics**

If you have a patient with an overdenture, what is the treatment for the roots? Fluroide treatment for them
Fluoride + cholrhexidine is more effective than fluoride alone

Know when to biopsy and when not to (vague I know but its prob related to length of lesion and common locations where cancer could be, refer to oral path book)

I had a patient who had like a super furcation on #18 bone loss all around and am impacted #17, they said that these teeth were being sent to be biopsied upon extraction. The question asked why…it was either due to #18 or because of the locsalozed aggression on #18, which is what I chose

Know when to use chlorohexidne rinse vs fluoride treatment in medically compromised patients(unclear I know but I cant remember what the illness was)

Know ***tensile strength*** is the ultimate strength before breaking….***yield strength*** is one before it deforms permanently. They asked me this in relation to why would I choose a metal framework for a patient.

They had a patient and they asked what would give her the best retention for her dentures? Ridge augmentation, implant supported denture….i like both

In a case I had a man with sickle sell…know what special precautions needed to be taken with these patients

I also had a man who was a crackhead…it asked me that since this patient is on cocaine should I not expect him to maintain his
oral health. True or false

Also asked me what drug would I give him for pain…I chose the regular ibuprofen vs Percocet,etc(just didn't seem to give a drug abuser something more to abuse)

I had some SOPS too, ph caries etc

Know about the incisal guidance on the articulator….

Horizontal axis of rotation:-- Variability of the position of the horizontal axis of rotation in relationship to the maxillary dental cast.

Condylar inclination/fossa components: -- Variability of the angle of the eminentia, directional guidance of the superior, posterior, and medial walls of the fossa, and ability to simulate laterotrusive movement.

Inter Condylar distance: -- Adjustability of the distance between the vertical axes of rotation.

Bennett angle/Bennett movement:--Adjustability of the angle and capability of simulating sideshift movement.

Incisal guidance:--Adjustability and ability to simulate the anterior guidance of the natural dentition.

Know arcon vs non acron articulates and how they differ in terms of the condyle Mosby pg.319. Acron the condyles are in the lower membrane and the fossa are in the upper membrane. Non-acron the upper and lower are rigidly attached.

Know in terms of the solder that if u want it stronger than make it **wider**

Oral Bisphospanates heavy

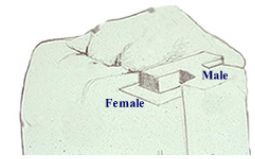
IV Bisphosphonates	Oral Bisphosphonates
Zoledroic acid (zomate)	Fosamax (Aldrenonate)
Pamidronate (Aredia)	Actonel (Risedronate)

	Boniva (ibandronate)

Genial turbercles picture but make sure

Know about a precision attachment…asked what was it used for, key is that it is used for esthetics on people who don't want the clasp showing on their RPD

What is a Precision Attachment?



The Female is attached to crowns or bridgework.
The male is attached to the partial denture

A precision attachment is a precision-machined male and female (key and lock) housing that connects a removable partial denture to fixed bridgework

The female part of the attachment is soldered to fixed crowns or bridgework the male part is attached to the partial denture. The male is machined by the manufacturer to fit the female with such precision that any male out of the box will fit any female with an exact degree of accuracy. All of the precision attachments in a partial denture are positioned so that they are *exactly parallel* to each other.

If taking a palatal graft, know what nerves can be damaged (guessing u should know MC location) Nasopaltine, ant palatine, greater palatine

Get plenty of sleep night before, review remembered question and pics before bed. That's it! 400 questions is a lot to deal with in one day. They make you think. Its not hard, we have been exposed, we have to use what we know. The test is kinda like a final at school. Lots of material lots of 50/50 questions. Lots of "awe man if I only looked at that stuff just a little longer or made myself remember the little facts". Its stuff we *should* know. Its fair straight forward. Broad not too specific. Implants were kinda tricky but we were not taught at school. Sucks to be us…well only for that part. My test was heavy on perio, implants, behavioral mgmt, stats, CD, everything else was about even. Little pharm and OS.

- Bisphosphonate, there is a concern with xrays while on bisphosphonates.
- Frey syndrome-sweat on parotid when you eat

Frey's syndrome (also known as **Baillarger's syndrome**, **Dupuy's syndrome**, **Auriculotemporal syndrome** or **Frey-Baillarger syndrome**) is a food related syndrome which can be congenital or acquired specially after parotid surgery and can persist for life.

> The symptoms of Frey's syndrome are redness and sweating on the cheek area adjacent to the ear. They can appear when the affected person eats, sees, dreams, thinks about or talks about certain kinds of food which produce strong salivation. Observing sweating in the region after eating a lemon wedge may be diagnostic.

- Xrays of nutrient canals, inverted Y around pm and k9 max (max sinus and zygomatic process I think), periapical cyst around max lat, perfectly round cyst on pan right above pm(in mosby),
- Tons of perio from tx planning, to implants (implants were hit heavy), GTP, BMP, furcations, how to treat, if it's a deep c2 furcation what are some acceptable tx (I put resection as least desirable),
- Implant success, what factors will help implant **osseointegrate** and what factors will not let it osseoimtegrate Note Mosby pg 260. Titanium implants have a layer of titanium oxidide on their surface that is responsible for osseointegration.
- What is more stable an single implant of 4mm or **5mm or a double implant ligated together** for a total of 4mm and 5mm (I put double implant ligated for a combo of 4mm because it sounded like it would not be as stable as a single implant being 4mm thick. The other one would be 2 2mm implants ligated together.
- 30% fat allowed for daily value
- What is the most a toothbrush and dental floss can peretrate into sulcus. I put 1mm and 1mm. the other choices were 2-3mm. I thought that was too much
- ID a CT scan. Look at MRI example just to be sure. My picture was of a CT image of the brain and skull.
- Nutrient canals! I had to id 3 of them on pics
- Diabetic patient
- What could precipitate a seizure- **hypoglycemia**, hypokalemia, hypocalcemia, hyponuternia, one other hypo-
- ANUG, NUG,
- Know differences of endo dx hard. I had at least 15 questions
- What Kennedys class does not have mods =(**IV)**
- SS crown prep for pedo, know what you need to do and guides etc (Note: 1.) occlusal reduction 2.) M and D interproximal reduction 3.) Round off sharp edges 4.) select crown 5.) adjust crown by crimping and checking occlusion. 6.) cement with polycarboxylate cement.7.) remove excess cement 8.) check the area again. 9.) Follow up where you will check occlusion and margins as well as gingiva margin.
- What pedo molar are you concerned with likely pulp horn exposure. Distobuccal , mesiobuccal, 1m or 2m (4 choices)
- Pulp tests. What you see to differentiate b/w acute perio abcess and acute periodontitis, how to differentiate b/w chronic and periodontal abscesses
- Know perio and endo abscesses and what pulp test you would do to dx them.
- Tx planning for perio and implants
- Value, hue, chroma-know what they are and what they depict. Ie "saturation" would be mean value. Hue- color chroma is saturation of hue and value is lightness and darkness
- How to change the color. I put bleach the other teeth to match the cown.
- Few operative questions.15max- just the basics, outline, gold, cad/cam, inlay only (the remembered ? are good)

- Oral path like what is this pic most assoc with, know basics like what does each mean and assoc with. Not too in depth, but deffinatley know what it is
- Peutz-jeughers, ewing, langerhans, histiocytosis x(what would you see if a child was take a long time of antibiotics, also pt taking long history of corticosteroids what would they be predisposed too. Also pt is on chemo what are they predisposed to. I put candidiasis cause of opportunistic organism.
- Dude, leavell and Rivera had a combined I would say 60 questions. They are easy, but definitely review. Mosbys has good explanation
- ***Cohort (prospective***- general population is followed through time to see who develops the disease and then various exposure factors that affected the group are evaluated. ***Cohort Retrospective***- used to evaluate the effect that a specific exposure has had on a population., ***Cross-sectional***- a study in which the health conditions of a group ar assumed to be a sample of a particular populatin assessed at one time., ***chi-square***- measures the association btw two categorical variables.It is used when the data is expressed as counts or proportions.Mosby pg 210-214
- Code of Ethics-5questions. Benefiance, **Nonmalfience**- which one does keeping up with skills and knowing when to refer fall under

1. Autonomy- self governance; protect the patients confidentiality- safe guarding patients privacy

1.patient involvement (options on alternatives)

2. confidentiality of patient records

3. Informed consent

2. Non Malificience- do no harm

1. keeping knowledge and skills current
2. knowing when to refer
3. staying up to date with CEs
4. second opinions
5. auxillary personnel
6. personal impairment- use of controlled substances which impair the doctor to practice
7. post-exposure to blood born pathogens- must inform the patient of possible exposure and must provide access to care
8. patient abandonment- must give patient adequate notice and opportunity for patient to go elsewhere
9. dentist should avoid interpersonal relationships with patient

3. Beneficence- DO GOOD

1. Timely delivery of dental care
2. Community service
3. Reporting abuse and neglect

4. Justice- fairness; dentist has duty to treat people fairly without prejudice

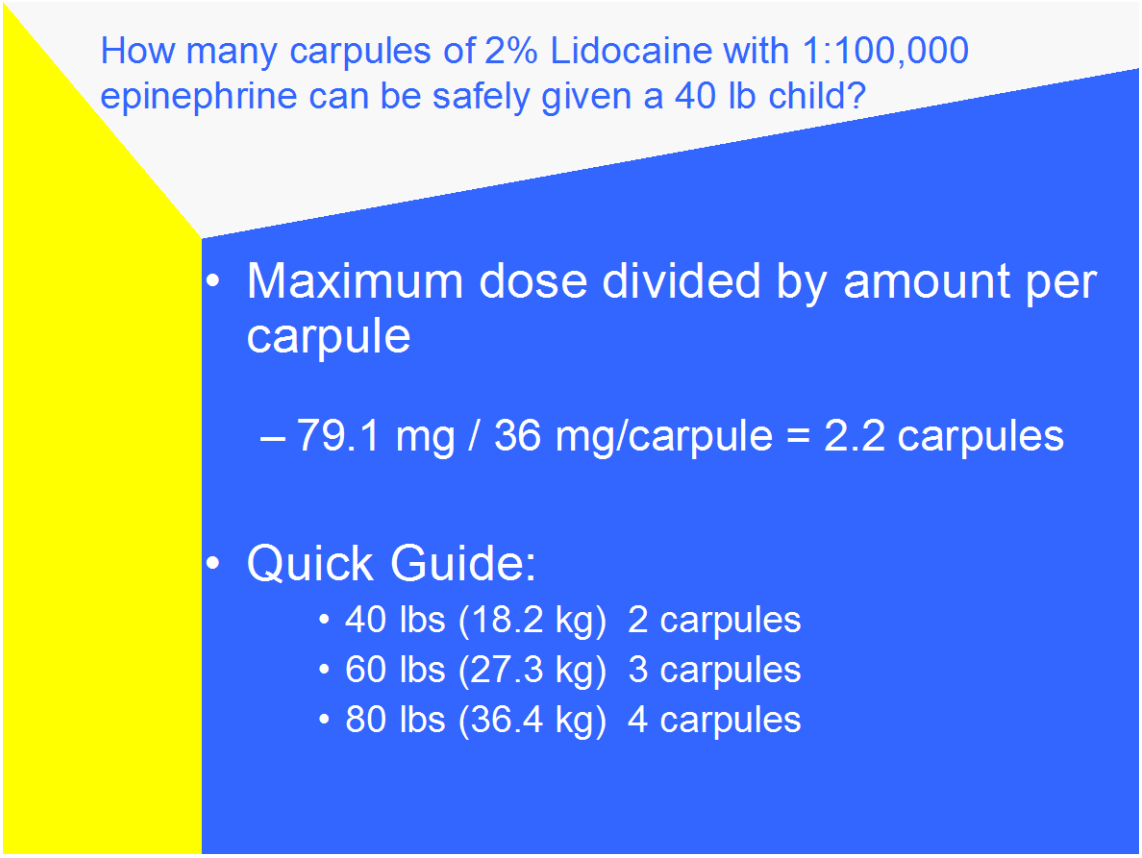
1. Must provide care to patients with blood-borne pathogens
2. Dentist must make arrangements for emergency care for patients of record
3. Justifiable criticism
4. Expert testimony

5. Veracity- truthfulness. Respecting the position of trust

1. Dental amalgam and other restorative materials- removing amalgam from non-allergic patients and replacing with composites because amalgam is “bad” is improper and unethical.

2. Advertising
3. Dentists leaving practice- have up to 1 year to leave previous practitioners name on the practice until complete transition
4. Representation of fees- overbilling, copayment, treatment dates- altering dates for insurance purpose

- I had 3 calculation question, how much MAX carpules lido 3% can you give a 40kg child.
- How many carpules 2% lido 1:100,000 epi can you give chil?



- Had to figure how many grams of anesthetic you could give child. (something knowing that anesth would be 4.4 or something like that. Pedo section in mosby pg 182 states that the MAX RECC. Dose of anesthetic for 2%lidocaine 1:100,000w/ epi, 3% mepivacaine, and 4% prilocaine with 1:200,000 epi is 4.4 mg/kg
- How to tx plan Alzheimer pt, do you do what he would have wanted before end stage or do you just do palliative keeping out of pain and disease (I put that one)
- If an 84 yr old man comes in for new appt with his son. Son had a paper stating a legal guardian (not son) who can make decision. This was weird cause I didn't know if the old man was senile or independent. I put legal guardian must be there, but I think they should have said that the pt is dependent on legal guardian.
- Remembered stuff was good
- Know about denture processing and resins and evaporation and temperatures. They wanted to know something about shirking and leftover resin.

- **F,v, T, C, all sounds**. >---- This is the labiodental sounds.These sound help determine the position of the incisal edges of the maxillary anterior teeth Look in mosby pg 323a
- **S, z, ch, sh, and j** are the lingualveolar sounds. The sound help to determine the vertical length and overlap of the anterior teeth.
- **This, That, Those,** are linguodental sounds. If the tip of the tongue is not visible the teeth are most likely too far anterior except in CLASS II malocclusion. If the tongue sticks out the teeth are too far lingually
- **B,P, M**, sounds are made by the contacts of the lips
- **Lisp, whistle, and what sound** would that be the patient has a narrow palatal vault

- Denture should IDEALLY cover entire or 1/3 or 2/3 retromolar pad. I put entire even though its 2/3 (wasn't a choice) thought 1/3 too little

- Porpanolol what it is and what is it used for? It is the prototype of nonselective B blockers. The effct of B blockers is lower BP, reduce angina, reduce rish afer myocardial infarction, reduce heart rate and force, antiarrhythmic effect, cause hypoglycemia in diabetics, and lower intraocular pressure. Mosby pg 277- 278

- Pharm was basic, what do you give as antidote for overdose of sedative (not naloxone)- I think it was diphenhydramine. Something dr Williams said a couple times in class Note sedative drugs are benzodiazapiene- antidote is flumanazil, and barbituates don't quote un quote have one. Naloxone is the antidote to opiods.

- Preg pt hypotension- **lay on left side, right hip in air. To protect crushing Inferior Vena Cava.**

- Pt with moderate emphysema, stops often to catch breath- position least tolerate- I put horizontal recline

- Composites- basic stuff pros cons contra, indications

- What was added to zinc oxide eugenol to make IRM- Poly methy mecrylate

- Glass ionomer mixed with polyacrylic acid to form a cemen of glass particles surrounded by a matrix of fluoride elements. Dental Secrets pg 158 #109

- Have your articulator and want to adjust the VDO and condylar incline, where is the pin? On the table, **raised off the table**,

- Arcon vs nonarcon- which one will let you do something with mounting casts?? Look at mosbys for explanationpg 319. The Acron is used to mount mandibular cast.

The condyles are in the lower membrane and the fossa are in the upper membrane. Nonarcon provide easier control for seeting teeth for completed and partial dentures

- Open impression technique. Whats its used for and the adv for doing so. I put something like better detail
- CD pt with "abused" tissues. You want to make new dentures, what do you do first. I put surgically remove "abused" tissues.
- Space you are concerned with extraction on 3 molar max. I put infratemporal fossa. Though max sinus was too anterior

Impacted maxillary third molars are occasionally displaced into the maxillary sinus (from which they are removed via a Caldwell-Luc approach). But if displacement occurs, it is more commonly into the infratemporal space. During elevation of the tooth, the elevator may force the tooth posteriorly through the periosteum into the infratemporal fossa. The tooth is usually lateral to the lateral pterygoid plate and inferior to the lateral pterygoid muscle. I

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 11.3.2).

- Infection from PM goes into **buccal space**
- If trying to take max impression and access buccal space, what muscle would be in the way. I put masseter, maybe obicularis oris. Other choices were med and **lat ptyerygoid**
- Pedo mgmt- sedations, behavioral mgmt
- Implant osseointegration Note Length of time it takes implants to osseointegrate within the arches- mandibular anterior -4 months, mandibular posterior- 5 months, max anterior and posterior is 6 months
- Main cell type in Established lesion (mast, tcell etc)- PLASMA CELLS

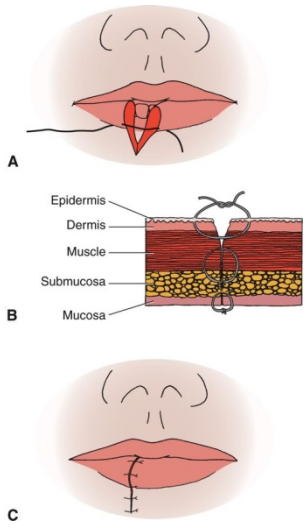
Over time, the *established lesion* evolves, characterized by a predominance of **plasma cells** and **B lymphocytes** and probably in conjunction with the creation of a small gingival pocket lined with a pocket epithelium.[47] The B cells found in the established lesion are predominantly of the immunoglobulin G1 (IgG1) and G3 (IgG3) subclasses.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 21.4).

- Where do you put a suture for a laceration on the lip to inside of mouth first? I put line the lip up then proceed

If a patient has a laceration of the tongue or lip that involves muscle, resorbable sutures should be placed to close the muscle layer or layers, after which the mucosa is sutured. Minor salivary gland tissue protruding into a wound can be judiciously trimmed to allow for a more favorable closure.

In lacerations extending through the entire thickness of the lip, a triple-layered closure is necessary (Fig. 23-4). If the laceration involves the vermilion border, **the first suture placed should be at the mucocutaneous junction**. **Perfect alignment of this junction of skin and mucosa is imperative, or it can result in a noticeable deformity that can be seen from a distance.**



(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 23.1.3.4).

- Pt comes in with pain, what do you do first? Remove pain, comp tx plan and exam, adv carious lesions. Also was comp tx plan first then remove pain. But I put remove pain first cause that's what we were taught in school, soooooo I hope they are right..lol
- What can cause hypoglycemia and thyroid issues. Read up on thyroid storm and what you will see

- If a pt is hypothyroid they will feel cold to touch or hypotension. I put cold to touch. Note: Hypothryoidism is assoicted with Hashmito's disease. In children its cretinism and in adults its myxedema. For dental care for the myxedema patient, it is important not to prescribe opiates for palliative tx bc the patient may be unusually sensitive and die from normal doses of opiates. (Dental Secrets pg 33)Symptoms include constipation, cold to touch, depression, fatigue, heavier menstrual periods, joint or muscle pain, paleness or dry skin, thin brittle hair or fingernails, weakness, or unintentional weight gain. Hyperthyroidism is associated with Hyperthyroidism is associated with Grave's disease. The symptoms in the patient is difficulty concentrating, fatigue, frequent bowel movements, Goiter(enlarged thyroid) heat, weight loss, restlessness.

- INR values and when it is ok to do oral surgery- 3 or less Being more sensitive to cold

- Pt on warfarin, when can you do OS- **2 or 3 days**

The INR is used to gauge the anticoagulant action of warfarin. Most physicians will allow the INR to drop to about 2.0 during the perioperative period, which usually allows sufficient coagulation for safe surgery. **Patients should stop taking warfarin 2 or 3 days before the planned surgery**. On the morning of surgery, the INR value should be checked; if it is between 2 and 3 INR, routine oral surgery can be performed. If the PT is still greater than 3 INR, surgery should be delayed until the PT approaches 3 INR. Surgical wounds should be dressed with thrombogenic substances, and the patient should be given instruction in promoting clot retention. Warfarin therapy can be resumed the day of surgery

- Fluoride does what to bacteria, what to tooth structure, and anything to collagen? I don't think it does anything to collagen as far as reinforcement

Fluoride works primarily by topical effects to prevent and reverse the caries process, whether in enamel, cementum, or dentin. Low concentrations of topical fluoride inhibit demineralization, enhance remineralization, and inhibit the enzyme activity in bacteria by acidifying the cells.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 50.9).

- Leave a small carious lesion in by accident and place a sealant over it. What will happen? **Arrest decay** or continue lesion.

- Primary Endo infection (Mosby pg 16) strict anerobes predominant. Gram (-) anaerobic- Porphyromonas species and Bacteriodes melaninogeica are most common. Gram (+) anaerobic Actinomyces is gram on root caries

- Where to place a gingival margin for ant max incisor pfm. At the crest of gingiva or between **gingival crest and alveolar crest**. I put the latter because it was the only one that hinted at subgingival finish line. Mosby pg 331 states margins should ideally be placed supragingival or at the gingival crest whenever possible for maintenance care, ease of preparation and impression. The fixed book states on pg 244 Subgingival margins may be indicated for esthetic reasons, particularly when the patient has a high lip line and when the use of a metal collar labial margin is contemplated.

- Pic of nicotine stomatits or denture stomatits
- Steven Johnson syndrome is a severe form of EM with extensive involvement of the mucos membrane of the oral cavity, eyes,genitalia, and occaisionaly upper GI and Respiratory tract. Typical Target Lesions may be seen on the skin (dental secrets pg 55) EM- Mosby pg 108 it is a self-limiting hypesensitivity rxn that affects skin/mucosa. IT is caused by 1.) herpes simplex virus 2.) mycoplasma pneumonia 3.) medications. Pt has targetoid lesions and oral ulcerations. It has a minor form which is associated secondary to herpes hypersensitivity and Major form is Steven Johnson syndrome which is ofter triggerd by drugs and 3.Toxic epidermal necrolysis which is seen in older

patients for tx in hospital burn unit., pemphigoid mosby pg 110 – autoimmune disease. autoantibodies **attack the jxn btw epithelium and connective tissue** leading to the formation of subepitheial bulla. Oral lesions usually present as desquamative gingivitis. Tx is steroid. Histology has suprabasilar vesicle without acantholyis (Board Buster pg 246) Pemphigus (BB pg 246) autoimmune. Autoantibodies attack **desmosomal** plaque of the epithelial cells leading to acantholysis and supraepithelial bulla. Positive nokolsky sign. Tx with corticosteroids or other immunosuppressive drugs.

1. Xerostomia can lead to = **lymphoma**
2. Most congenitally impacted tooth: **max canine**
3. Most congenitally missing tooth: **max third, mand 3m man Pm , max li , max 2pm, Primary li , Most impacted mand 1st primary**
4. Know how to treat ANUG

The use of antibiotics varies widely in the management of ANUG but dental prophylaxis is almost always prescribed. A typical clinical treatment includes: *(1)* dental scaling and prohylaxis with local anesthesia, *(2)* chlorhexidine rinses, *(3)* metronidazole or tetracyline, *(4)* adequate sleep, and *(5)* reduced smoking. Typically pain symptoms subside within 48 hours of treatment.

(American Academy Of Orofacial Pain, Jeffrey P. Okeson. *Orofacial Pain: Guidelines for Assessment, Diagnosis & Management, 3rd Edition*. Quintessence Publishing (IL), 011996. 7.2.1).

5. Signs of neurofibratosis

Syndrome of neurofibromatosis 1

(a) **Multiple neurofibromas**.

(b) Six or more **café-au-lait** macules (each > 1.5 cm diameter).

(c) **Axillary freckling (Crowe's sign), and iris freckling (Lisch spots**).

(d) Malignant transformation of neurofibromas in 5% to 15% of patients.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 4.1.7).

6. Found on floor of mouth, bluish swelling- **ranula**
7. When to use base metal=bridge vs. `high metal=single unit crown (Fixed book pages 599-609- Concept : An alloy with a higher modulus of elasticity has greater stiffness or rigidity for elastic deformation. For the fabrication of a long-span FDP, an alloy with a relatively high modulus of elasticity to reduce the amont of bending deflection under loading is preferred, because excessive flexure can cause fracture of brittle porcelain. One benefit of predominatly based alloy is their value of modulus of elasticity are much higher than those of noble metal alloys. Therefore it is used for long span FPD. The difference btw high noble and noble alloy is the cost. Either or is used for single crown.

** Green discoloration of a crown is due to silver but some green discoloration has been seemed to be eliminated by substituting potassium ions for sodium ions s. The larger potassium ions impede the diffuson of silver into the porcelain.

** FYI High noble has 60% noble metal content and > 40% gold
Noble metal has 25% noble metal content and no gold
Predominantly base has <25% noble metal content and no gold

Fixed Book pg 606

8. Affects **basement membrane** = **pemphigoid**

Mucous membrane pemphigoid

1. An autoimmune disease of mucous membranes; antibodies directed against basement membrane antigens (Laminin 5, BP180, others).

2. Clinical features

a. Affects older adults, typically over the age of 50 years.

b. Presents as multiple, painful ulcers preceded by bullae which form below the epithelium at the basement membrane.

c. Oral lesions may be found in any region, especially and sometimes exclusively in the attached gingival; ocular lesions can lead to blindness if untreated.

d. **Positive Nikolsky** sign may be present.

e. Persistent disease.

3. Patients are managed with corticosteroids

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 4.1.4).

9. Primary 2nd molar lost and 2nd premolar 1/3 root formed how is it effected:
You need 2/3 of the root formed for eruption through bone and ¾ through gingival.

10. Main complication during RCT- **ledge formation, perforation, instrument separation, vertical root fracture**

11. IgG does what: **seen in pemphigoid/pemphigus**

*Neutrophils then migrate through the endothelium (**diapedesis**) and ingest the bacteria. **IgG and C3b are opsonins, which enhance ingestion of the bacteria**. There are receptors for the heavy chain of IgG and for C3b on the surface of the neutrophils*

(Levinson, Warren. *Medical Microbiology & Immunology, 8th Edition*. McGraw-Hill Medical Publishing, 062004. 8.3.1).

12. How do u treat external resorption

When the cause of external root resorption is known, the treatment is usually to remove the etiologic factors. This may mean cessation of excessive mechanical forces, removal of an adjacent impacted tooth, or eradication of a cyst, tumor, or source of inflammation. If the area of resorption is broad and on an accessible surface of the root (such as at the cervical location), curettage of the defect and the placement of a restoration usually stops the process.

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 5th Edition*. Mosby, 122003. 22.2.4.2.5).

13. Which of the following is a schedule II drug
Oxycodone + acetaminophen (**Percocet, Tylox**) schedule 2
Oxycodone + aspirin (**Percodan**) schedule 2
Hydrocodone –III
Codeine/ acetaminophen/propoxyphene-III

Schedule I Controlled Substances

Substances in this schedule have a high potential for abuse, have no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of the drug or other substance under medical supervision.

Some examples of substances listed in schedule I are: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ("ecstasy").

Schedule II Controlled Substances

Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.

Examples of single entity schedule II narcotics include morphine and opium. Other schedule II narcotic substances and their common name brand products include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®), and fentanyl (Sublimaze® or Duragesic®).

Examples of schedule II stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®). Other schedule II substances include: cocaine, amobarbital, glutethimide, and pentobarbital.

Schedule III Controlled Substances

Substances in this schedule have a potential for abuse less than substances in schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

Examples of schedule III narcotics include combination products containing less than 15 milligrams of hydrocodone per dosage unit (Vicodin®) and products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with codeine®). Also included are buprenorphine products (Suboxone® and Subutex®) used to treat opioid addiction. -narcotics Examples of schedule III non include benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as oxandrolone (Oxandrin®).

Schedule IV Controlled Substances

Substances in this schedule have a low potential for abuse relative to substances in schedule III.

An example of a schedule IV narcotic is propoxyphene (Darvon® and Darvocet-N 100®).

Other schedule IV substances include: alprazolam (Xanax®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

Schedule V Controlled Substances

Substances in this schedule have a low potential for abuse relative to substances listed in schedule IV and consist primarily of preparations containing limited quantities of certain narcotics. These are generally used for antitussive, antidiarrheal, and analgesic purposes.

Examples include cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC® and Phenergan with Codeine®).

14. Transdermal patch: fentanyl (opiod)

> Transdermal fentanyl patches are approved for use with sustained pain. The opioid permeates the skin, and a “depot” is established in the stratum corneum layer.

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 24.11.1.8).

15. Widending of pdl space: **osteosarcoma and scleroderma**
16. Reason for dual cured resin

> Systems used to cement restorations often use both photo- and chemical-initiation (dual curing) because **it is often difficult to expose regions of the material to sufficient light to reach the maximum degree of conversion and thus maximum strength. With these dual-curing materials, maximum degrees of conversion of 80% have been reported.**

(Powers, John M. Powers. *Craig's Restorative Dental Materials, 12th Edition*. C.V. Mosby, 022006. 7.2.1.1).

17. Facial, lingual , mesial defect, is it horizontal, angular, crater or **hemiseptal** and how do u treat bone graft
18. lesion on tongue the same exact lesion on palate what is it? Candadiasis, syphilis, lichen planus
19. elementary school fluorid program, how often and what do u give them

> Numerous studies have demonstrated that dental caries can be reduced by approximately 25% to 28% by rinsing **daily** or weekly in school with dilute solutions of fluoride. **Rinsing weekly with a 0.2% neutral sodium fluoride (NaF) solution requires fewer supplies and less time than daily rinsing with a 0.05% NaF solution**

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.2).

20. Caucasian with cleft lip=1/700
21. why does composite fail in primary teeth

> (1) Placement of composite resin is highly technique sensitive, and the final restoration is very negatively affected by any moisture contamination. If a **dry field cannot be maintained,** resin-based composite is probably the worst choice of restorative material.

However, a resin-modified ionomer can tolerate some moisture and might be used as an aesthetic material in such a situation. (

Because primary enamel is approximately one half the thickness of permanent enamel, retention gained solely from acid etching will be similarly reduced, and therefore it is still prudent to include some minor mechanical retention in the preparations.

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition.* Mosby, 042005. 21.4.5.2).

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition*. Mosby, 042005. 21.4.5.2).

22. construction overdenture what is least concern

23. pt taking corticosteroid, u give epi what is ur concern= hypertentions

Diseases of the adrenal cortex may cause adrenal insufficiency. Symptoms of primary adrenal insufficiency include weakness, weight loss, fatigue, and hyperpigmentation of skin and mucous membranes. However, the most common cause of adrenal insufficiency is chronic therapeutic corticosteroid administration (secondary adrenal insufficiency). Often, **patients who regularly take corticosteroids have moon facies, buffalo humps, and thin, translucent skin.** Their inability to increase endogenous corticosteroid levels in response to physiologic stress may cause them to become *hypotensive*, syncopal, nauseated, and feverish during complex, prolonged surgery.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 1.3.5.2).

24. NUG= interdental papilla (Blounting

The necrotizing periodontal diseases. The clinical appearance of the necrotizing diseases is unique among the periodontal diseases because of the characteristic ulceration and necrosis of the marginal gingival. This may be covered by a **yellowish white or grayish slough or pseudomembrane and have blunting of the papillae, bleeding on provocation or spontaneous bleeding, pain, and fetid breath**. The disease may present as ***necrotizing ulcerative gingivitis* (*NUG*; no attachment loss) or *necrotizing ulcerative periodontitis* (*NUP*; with attachment and bone loss)**. Predisposing factors may be stress, smoking, and immunosuppression such as seen with human immunodeficiency virus (HIV) infection.

Treatment for both NUG and NUP consists of débridement of necrotic soft and hard tissue, antibiotic therapy with metronidazole or tetracycline (500 mg four times a day) for a week, and a follow-up with scaling and débridement

(Greenberg, Martin S.. *Burket's Oral Medicine: Diagnosis and Treatment, 10th Edition*. B.C. Decker, 012003. 20.3.2.5.3.1).

25. Post palatal seal, know all considerations

26. Most common tooth for dry socket: **mandibular third molars**

> The occurrence of a dry socket after a routine tooth extraction is rare (2% of extractions), but it is frequent after the removal of impacted mandibular third molars (20% of extractions in some series).

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 11.9.3).

27. How does LA work

> **The *membrane expansion theory*** states that local anesthetic molecules diffuse to hydrophobic regions of excitable membranes, producing a general disturbance of the bulk membrane structure, expanding some critical region(s) in the membrane, and preventing an increase in the permeability to sodium ions.
>
> The ***specific receptor theory*, the most favored today**, proposes that local anesthetics act by **binding to specific receptors on the sodium channel**.[24] The action of the drug is direct, not mediated by some change in the general properties of the cell membrane. Both biochemical and electrophysiological studies have indicated that a specific receptor site for local anesthetic agents exists in the sodium channel either on its external surface or on the internal axoplasmic surface.[25,26] **Once the local anesthetic has gained access to the receptors, permeability to sodium ions is decreased or eliminated and nerve conduction is interrupted.**

(Malamed, Stanley. *Handbook of Local Anesthesia, 5th Edition*. Mosby, 072004. 1.3.1).

28. What dosen't require premedication –refer to 1997 prophylaxis guidelines
29. With institutionalized elderly patient what is not concern

> Many institutionalized persons have poor oral health.[71] It is often conjectured that this is because residents of institutions are likely to have more severe disabilities than those who are disabled but live in the community, or **that the oral care of institutionalized populations is of poorer quality than those not institutionalized.** A recent study examined the oral-hygiene habits, gingival bleeding, food diaries, and oral microorganisms of moderately or severely mentally retarded adults before and up to 21 months after relocating into the community from an institutional setting.[72] Of the oral-health parameters measured, none worsened and some improved, demonstrating that **the institutional environment does place the compromised patient at greater risk for poor oral health.**
>
> **Even the totally disabled or comatose patient who is no longer taking food by mouth but is being nourished via a gastric tube or intravenous line is subject to intra-oral plaque and calculus accumulation and should have daily oral-hygiene procedures performed. Ironically, it has been shown that, although plaque accumulates at about the same rate in tube-fed and normally fed patients, calculus accumulates faster in tube-fed patients.**

(Harris, Norman O.. *Primary Preventive Dentistry, 6th Edition*. Prentice Hall, 082003. 20.10).

30. Pic looked like mucocele and asked what can cause it caused by traumatic severance of salivary excretory duct. It is common in lower lip and buccal mucosa. It is often bluish in color

31. Minimum Distance between implants = **3 mm**

32. Minimum distance between implant and nerve = **1mm (implant to adjacent tooth) 2mm from implant to all vital nerves except for mental nerve which is 5 mm and all bony structures (1 mm- ie buccal plate, lingual plate, maxillary sinus) and AVOID MIDLINE**

33. Best flap for esthetics: **papilla preserving flap**

Anterior: #1) papilla preserving flap #2) sulcular incision flap #3) modified widman
Posterior: #1) papilla preserving flap#2) sulcular incision flap #3) modified widman

Therapy for Moderate to Severe Periodontitis in Anterior Sector

The ***papilla preservation flap*** can be used for both purposes and also offers a better postoperative result, with less recession and reduced soft tissue crater formation interproximally. [14]***The papilla preservation flap is the first choice when a surgical approach is needed*.**

When the teeth are too close interproximally, the papilla preservation technique may not be feasible, and a technique that splits the papilla must be used. **The *sulcular incision flap* offers good esthetic results and is the next choice.**

When esthetics are not the primary consideration, the *modified Widman flap* can be chosen. This technique uses an internal bevel incision about 1 to 2 mm from the gingival margin without thinning the flap and may result in some minor recession.

Infrequently, bone contouring may be needed despite the resultant root exposure. The technique of choice is the *apically displaced flap with bone contouring*.

Therapy for Moderate to Severe Periodontitis in Posterior Area

Treatment for premolars and molars usually poses no esthetic problem but frequently involves difficult accessibility. Bone defects occur more often in the posterior than the anterior sector, and root morphologic features, particularly in relation to furcations, may offer unsurmountable problems for instrumentation in a close field. Therefore, surgery is frequently indicated in the posterior region.

The purpose of surgery in the posterior area is either enhanced accessibility or the need for definitive pocket reduction requiring osseous surgery. Accessibility can be obtained by either the undisplaced or the apically displaced flap.

Most patients with moderate to severe periodontitis have developed osseous defects that require some degree of osseous remodeling or reconstructive procedures. **When osseous defects amenable to reconstruction are present, the *papilla preservation flap is the***

> ***technique of choice*** **because it better protects the interproximal areas** where defects are frequently present. ***Second and third choices are the sulcular flap and the modified Widman flap,*** **maintaining as much of the papilla as possible**.
>
> When osseous defects with no possibility of reconstruction are present, such as interdental craters, the technique of choice is the *flap with osseous contouring*.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 59.6.2.4).

34. Syphilis mistaken for = **scc**
35. Associated with k9=**AOT**

> **Adenomatoid odontogenic tumors** are frequently asymptomatic and are discovered during the course of a routine radiographic examination or when films are made to determine why a tooth has not erupted. Larger lesions cause a painless expansion of the bone. In about 75% of cases, **the tumor appears as a circumscribed, unilocular radiolucency that involves the crown of an unerupted tooth, most often a canine**. This follicular type of adenomatoid odontogenic tumor may be impossible to differentiate radiographically from the more common dentigerous cyst. The radiolucency associated with the follicular type of adenomatoid odontogenic tumor sometimes extends apically along the root past the cementoenamel junction. This feature may help to distinguish an adenomatoid odontogenic tumor from a dentigerous cyst

(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 15.3.4.1).

36. How to treat class 3 furcation

Isolated deep class II furcations may respond to flap procedures with osteoplasty and odontoplasty

37. Narcotics to u give pregnant lady: **propoxyphene/talwin** (both are group C), however, **Acetaminophen** is the drug of choice for pregnant pts.

> Ideally, no drug should be administered during pregnancy, especially during the first trimester. However, adhering to this rule is sometimes impossible. Most of the commonly used drugs in dental practice can be given during pregnancy with relative safety, although a few exceptions are notable.
>
> **The analgesic of choice during pregnancy is acetaminophen (category B).** Aspirin and nonsteroidal anti-inflammatory drugs convey risks for constriction of the ductus arteriosus, as well as for postpartum hemorrhage and delayed labor (see Table 18-3).[39,40] The risk of these adverse events increases when agents are administered during the third trimester. Risk also is more closely associated with prolonged administration, high dosage, and selectively potent anti-inflammatory drugs, such as ***indomethacin.***
>
> **Prolonged or high doses of opioids are associated with congenital abnormalities and respiratory depression.[41,42] For this reason, opioid-containing drugs should generally be avoided.**

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 18.2.4.1).

38. How do u test for acute periradicular periodontitis: **percussion**

> Application of **pressure by fingertip or tapping with the butt end of a mirror handle can cause marked to excruciating pain**. "Thickening" of periodontal ligament (PDL) space may be a radiographic feature of AAP

(Walton, Richard E.. *Principles and Practice of Endodontics, 3rd Edition*. Saunders Book Company, 012002. 3.6.1.2).

39. Pulp test on tooth with incomplete apex

> **Thermal testing is widely used with open apices** but may be complicated by a lack of neural development or by an exaggerated response caused by apprehension in a young patient. No response to repeated thermal testing, as compared to a positive response in the contralateral control tooth, may indicate the presence of a necrotic pulp; this can be confirmed by other tests. A problem (with an open or closed apex) after a luxation injury is that nerves may be damaged while the blood supply remains intact, and, therefore, the pulp is healthy but unresponsive.

(Walton, Richard E.. *Principles and Practice of Endodontics, 3rd Edition*. Saunders Book Company, 012002. 22.3.2.3).

40. Comp on post tooth what surface wears 1st –**occlusal**

41. All treat angina except

Nitrates, beta-blockers, calcium channel blockers, platelet aggregation inhibitors (aspirin/plavix) are used to treat angina

The problem with angina is insufficient o2 to meet demands to the myocardium

Nitroglycerin; (admin. Sublingual) increase oxygen supply to the heart by direct vasodilation of smooth muscle

Propanolol: reduce oxygen demand by inhibiting chronotropic demands

Calcium channel blocker: deacrease o2 demands byreducing afterload

42. Scar on lip looks like mucocele do u want to biopsy, smear, **excision,** incision

43. Indication of class ii inlay

> The indications for an inlay are virtually the same as for an amalgam restoration. The inlay simply replaces missing tooth structure without doing anything to reinforce that which remains.[3] If the tooth requires protection from occlusal forces, the protection must be gained by the use of some other type of restoration that incorporates a veneer of casting alloy over the occlusal surface.[4] Inlays tend to wedge cusps apart,[5] and a lone-standing unsupported cusp is at risk of fracture.

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 12).

44. Palatal grooves most commonly found on which teeth? Molar, **max incisior**, canine, pm

45. Implant heat temp = 37 degrees celcius

> Bone cell survival is very susceptible to heat. Eriksson has demonstrated that in rabbit, bone temperature **as low as 3° C above normal (40° C) can cause bone cell necrosis**.[49] Therefore a conscious effort is made to control temperature elevation every time a rotary instrument is placed in contact with bone. At least **50 mL/min of cooled irrigation**, such as sterile **physiologic saline**, is used as a profuse irrigant and is a critical element to reduce heat.[35-37,50] *Distilled water should not be used*, as rapid cell death may occur in this medium.[51] **Intravenous dextrose solution (D_5W) also may be used**, with the clinical advantage of decreasing hand piece breakdown occurring from the effects of the salt in a saline solution, although the surgical gloves often feel sticky near the conclusion of the surgery

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 29.2.1.3).

46. Most likely cause for implant failure? **Heat**, fracture, bone (or mobility)
47. Which antibiotic is used to treat infection from hospital **vancomycin (fyi asprigilloss ass wit nosicommal infe)**
48. Palmar and platar pitting = Nevoid basil cell Papillon–Lefèvre syndrome- (periodontitis is also associated)
49. #30 has swelling facial to it, pulp test r normal , what is emergency tx? **Incise and Drain**, curretage, debride canals
50. chelating agent = edta and inorganic
51. xray 4yr old u don't see 2nd pm do you **refer** to pedo, close space , maintain space
52. concern of child with trauma, condylar hyper, facial asymmetry
53. bulimia= erosion of teeth (max lingual)
54. calcifacation seq: **A-B-D-C-E in primary teeth and they occur in utero in the following weeks 14-15-16-17-18**
55. most prev disease= cleft lip/palate congent ial disorder most prevalient
56. with acromegaly = overgrowth of mandibular Ciii
57. when rpd continues to break? Occlusal trauma, **poor design**

> Failure of an occlusal rest rarely results from a structural defect in the metal and rarely if ever is caused by accidental distortion. Therefore **the blame for such failure must often be assumed by the dentist for not having provided sufficient space for the rest during mouth preparations.**

(Carr, Alan B.. *McCracken's Removable Partial Prosthodontics, 11th Edition*. Mosby, 072004. 22.2).

58. least material used in fixed impressions: irreversible hydrcolloid
59. cause allergic rxn with penicillin = **cefelexin (1st generation cephalosporin pg 307- Mosby)**
60. how to u measure interarch distance

> measuring arch perimeter from the **mesial of one first molar to the other**, over the contact points of posterior teeth and incisal edge of anteriors.

(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 6.5.1.2.1).

61. HMO(aka capitation) = usual customary fee
62. What is synchondriasis related to

> Histologically, a **synchondrosis** looks like a two-sided **epiphyseal plate**

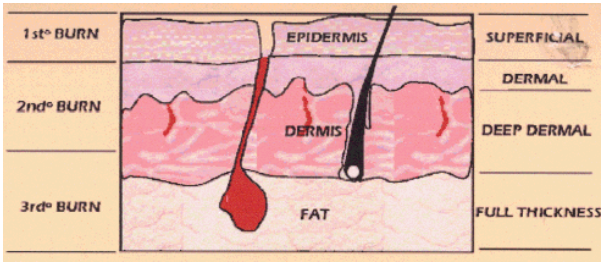
(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 2.6.2).

63. Purpose of crown lengthening

> There are circumstances in which it may be desirable to have a longer clinical crown on a tooth than is present. The lengthened tooth that results from this surgery should afford better retention for any crown placed on it, with margin placement in an area of the tooth more accessible for cleaning. If the band of attached gingiva is too narrow, it must be made wider with a graft or an alternative restoration must be made for the tooth.

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 16.2.10).

64. Person with missing teeth associated with = ectodermal dysplasia,
65. Recapping of needle = one handed , scoop tech,
66. Y when pt has 3rd degree burn doesen't hurt but 1st degree burn does



Probably because the nerve endings are completely destroy in a 3rd degree burn which involves the epidermis and dermis. Second degree would be more painful because if oly the epidermis is destroy it will allow the nerve endings to come in contact with "outside environment" resulting in great pain…

67. Pregnant patient = left side up
68. Sufonylureas , how it works

Sulfonylureas cause hypoglycemia by stimulating insulin release from pancreatic β cells. Sulfonylureas are a class of antidiabetic drugs that are used in the management of diabetes mellitus type 2. MOA: close potassium channels in cell membranes. Stimulate release of insulin from pancresas and increase the sensitivity of target organs to insulin.
Examples: tolbutamide, acetohexamide,tolazmide,chlorpropamide,glyburide,glipizide, and glimepiride.
Adverse effects: hypoglycemia, GI upset, vertigo and edema,sodium retention. Mosby pg 302
Onset &Duration of action in the various types of insulins is the difference .
Sulfoneria are indicated for type II

(Brunton, Laurence. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 11th Edition*. McGraw-Hill Professional Publishing, 092005. 60.2.1.1).

69. Which is contraindicated for RCT tx- **nonrestorable tooth**
70. Pain to ear= man molars
71. MOD rest, pain on eating = crack tooth syndrome
72. Porcelain turn green = silver Ag Arguntum
73. Allergy to metal = nickel which is seen in RPD. Females more prone to having allergy
74. Test tooth with crown on it- **percussion**

> When other tests are inconclusive or cannot be used and a necrotic pulp is suspected, **dentin stimulation with a *test cavity*** is helpful. For example, a tooth with a porcelain-fused-to-metal crown often cannot be tested accurately by standard thermal or electrical tests. After careful subjective examination and an explanation of the nature of the test to the patient, preparation **without anesthesia is done with a small, sharp bur. With a vital pulp, the surface of the restoration or the enamel can be penetrated without too much discomfort. If the pulp is vital, there will be a sudden sensation of pain when dentin is reached. In contrast, if discomfort or pain is absent, the pulp is probably necrotic; an access preparation has already been started and the procedure may be continued**.

(Torabinejad, Mahmoud. *Endodontics: Principles and Practice, 4th Edition*. Saunders Book Company, 032008. 5.3.4.5.1).

75. Purpose of dowel

> **A post usually made of metal that is fitted into a prepared root canal of a tooth. A dowel is combined with an artificial crown or core to provide the retention and resistance for a crown**

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 13.5.1).

76. Most common reason to redo compo resto: **probably shade !!** or anterior esthetics
77. Pfm, discoloration around margin- **cement polymerization**
78. Question about headlighting

> **any obtrusive bulge areas must be flattened to avoid "headlight" show-through of the underlying tooth color or opaque-bonding resin**.

79. What is used in crosslinking with benzomethyl-acrylate: methyl methacrylate(monomer) use PMMA (KiM)

80. Some led light wont cure resin because it outside range of light? **True** or not true

> Most recently developed are the LED curing units. These units have a number of advantages compared to other curing units, including a **wavelength spectrum emission that is closely matched to camphorquinone**. In addition, these units are **more energy efficient**, allowing them to be battery operated. The diodes have a **life span that is approximately 1,000 times longer than the typical halogen bulb**. While the earlier versions of LED curing units provided inadequate irradiance, the newer generation has

overcome this deficiency. **About the only disadvantage to these units is their narrow wavelength spectrum**, limiting their usefulness in curing any materials that do not use camphorquinone as the photoinitiator.

The practical consequence is that curing depth is limited to **2 to 3 mm** unless excessively long exposure times are used, regardless of lamp intensity.

81. Patient taking albuterol must have: **asthma (B2 receptor)**
82. Disadvantage of polyether: **hard (high modulus of elasticity = high rigidity)**

The impression material exhibits accuracy on par with, or somewhat superior to, that of other elastomers. It has **excellent dimensional stability even when pouring is delayed for prolonged periods of time.** [48,50,74] **It is accurate when poured 1 week after removal from the mouth**. [62] Polyether has an affinity for water, making it **hydrophilic (advantage)**. *Impressions should not be stored in a humidor or moist environment*. **The material is stiff, and undercuts must be blocked out**. Its resistance to tearing upon removal is roughly equal to that of silicone and less than that of polysulfide. [73] It is somewhat brittle.

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 17.7).

83. What do u do to close diasterma

The best approach, however, is to do nothing until the permanent canines erupt (unless crowding or the appearance of the teeth becomes a major issue). If the diastema does not close spontaneously at that time, an appliance can be used to move the teeth together, and a frenectomy should be considered then if there is excessive tissue bunched up in the midline. Early frenectomy should be avoided.

A small but unesthetic diastema (2 mm or less) can be closed in the early mixed dentition by tipping the central incisors together. A maxillary removable appliance with clasps, fingersprings, and possibly an anterior bow will successfully complete this type of treatment.

A diastema greater than 2 mm is unlikely to close spontaneously. In most instances, closing a large unesthetic diastema requires ***bodily repositioning*** of the central incisors to maintain proper inclinations of the teeth. Mesial root movement also provides more space for the eruption of the lateral incisors and canines. When the situation demands bodily mesiodistal movement, **an anterior segmental archwire** from central to central incisor or the classic 2 × 4 appliance can be quite satisfactory. Initial alignment of the incisors with a flexible wire is required. Then a stiffer archwire can be employed as the teeth slide together (18 mil round or 16 × 22 mil steel are good choices during the space closure). The force to move the incisors together can be provided by an elastomeric chain tying these teeth together, or by a coil spring compressed over the archwire between the first molar and lateral incisors. The diastema closure is more predictable if only mesiodistal movement is required. If protruding incisors are to be retracted as the space closes, careful attention to the posterior anchorage is required.

There are two possible orthodontic techniques: a partial fixed appliance, typically with bonded brackets on the maxillary incisors and a bonded tube on the first molars for additional anchorage control; or a sequence of clear aligners. With a fixed appliance, initial alignment is carried out using a light wire such as 16 mil A-NiTi or 17.5 mil braided steel. This wire is replaced, after the teeth are aligned, with a 16 or 18 mil round steel wire along which the teeth are repositioned using elastomeric modules or coil springs. There is always a tendency for the space to reopen after any degree of diastema closure. Bonding a flexible wire on the lingual of the incisors as a semi-permanent retainer is recommended.

(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 12.6.1.2).

84. Trisomy 21 associated with **midface deformity**
85. Which is associated with dentigenesis imperfecta = obliteration of pulp, bulbous crown, cervical constriction, osteogenesis imperfecta, blue sclera
86. Said they have disease but they really don't = false positive

Munchausen syndrome by proxy is a condition in which a person, usually a parent, presents factitious symptoms and illnesses in a child, which may result in extensive testing and/or hospitalizations.

Examples of emotional abuse include denial of affection, isolation, extreme threats, and corruption. A parent who knowingly and willingly does not seek care for a child who has pain, infection, or inadequate function is guilty of neglect.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 10.11.5).

87. Class V on k9 how do u bevel incisal and cervical margin

88. Osteogenesis linked to DI- true
89. How soon after bleaching can u do a restoration: 2-**3 weeks + is optimal**
3 or more weeks d.secrets p.168 (One wK)
90. Which antibiotics treats anaerobic bacteria
Metronidazole or clindamycin are both effective for aneorobes
91. What do u use if patient is taking Coumadin (warfarin)
Must have a **PT** test done or an **INR** (more common now) 24 hrs before surgery and value is 2-3
92. Most common cause of cardiac failure in kids- **respiratory disease**
93. X ray used to diagnose horizontal x-ray if hortizontal bone loss BW
94. Antifungal used to treat HIV induced candidiasis

Systemic therapy includes the use of any one of these three: **ketoconazole, itraconazole, and fluconazole.** Fluconazole and amphotericin B may be used intravenously for the treatment of the resistant lesions of CMC and systemic candidiasis. **Fluconazole** therapy for oral candidiasis associated with HIV infection often results in the development of resistance to fluconazole. Itraconazole can be substituted for fluconazole in resistant patients, but **fluconazole is still the mainstay of therapy for HIV-associated candidiasis**.

(Greenberg, Martin S.. *Burket's Oral Medicine: Diagnosis and Treatment, 10th Edition*. B.C. Decker, 012003. 5.3.2.8).

95. Widening of pdl- Related to disease
Osteosarcoma and **scleroderma, ortho** all have widening of PDL
96. How to evaluate primary tooth for endo
Make sure the **apex is closed** ! usually occurs 3 years after the eruption..
97. Disease ask with hand deformation
Rheumatoid arthritis, usually presents as pain in the joint at the end of the day and have + anti-rheumatoid factor.
98. What is 3 wall defect called: *intrabony defect*

> The three-wall vertical defect was originally called an ***infrabony defect***.* This defect appears most frequently on the mesial aspects of second and third maxillary and mandibular molars. The one-wall vertical defect is also called a ***hemiseptum.*** The 2-wall defect is a **crater** and the four wall defect is a **trophe/molt**

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 28.5.3).

99. Stridor = COPD / laryngospasm it is wheezing in inspiratory air and treated with succynlcholine

> Audible ***stridor*****,** a high-pitched wheeze, is an ominous sign of airway obstruction in the larynx or trachea.

(Bickley, Lynn S.. *Bates' Guide to Physical Examination and History Taking, 9th Edition*. Lippincott Williams & Wilkins, 122005. 7.4.2).
100. Kvp causes: kvp controls the **quality** of the film and increases the penetration, density **↑mA, KvP, exposure time-↑density and a decrease in filtration and object to source distance causes increase in density**
101. Mode of action of NSAIDS inhibit COX

> Aspirin and NSAIDs inhibit the COX enzymes and prostaglandin production; Aspirin covalently modifies COX-1 and COX-2, **irreversibly inhibiting cyclooxygenase activity.** This is an important distinction from all the NSAIDs because the duration of aspirin's effects is related to the turnover rate of cyclooxygenases in different target tissues. The duration of effect of nonaspirin NSAIDs, which competitively inhibit the active sites of the COX enzymes, relates more directly to the time course of drug disposition. The importance of enzyme turnover in relief from aspirin action is most notable in platelets, which, being anucleate, have a markedly limited capacity for protein synthesis. Thus, the consequences of inhibition of platelet COX-1 (COX-2 is expressed only in megakaryocytes) last for the lifetime of the platelet. Inhibition of platelet COX-1–dependent TXA_2 formation therefore is cumulative with repeated doses of aspirin (at least as low as 30 mg/day) and **takes roughly 8 to 12 days—the platelet turnover time—to recover once therapy has been stopped.**

(Brunton, Laurence. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 11th Edition*. McGraw-Hill Professional Publishing, 092005. 26.2.1).

102. Bleeding time is involved with: **von willebrand's diease**
103. Tx benzo overdose- **Flumazenile**
104. # one disorder in America -Cardiovascular disease (adult)or obesity(children) !!!
105. what KvP causes quality
106. mode of action of NSAIDS

NSAIDs) inhibit both cyclooxygenase-1 (COX-1; constitutive) and cyclooxygenase-2 (COX-2; induced in settings of inflammation) activities, and thereby synthesis of prostaglandins and thromboxane. The inhibition of COX-2 is thought to mediate, at least in part, the antipyretic, analgesic, and antiinflammatory action of NSAIDs, but the simultaneous inhibition of COX-1 results in unwanted side effects, particularly those leading to gastric ulcers, that result from decreased prostaglandin formation.

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 29).

107. Which bur gives u smoothest surface = diamond, **straight fissure**, cross-cut (roughest)

(Shillingburg, Herbert T.. *Fundamentals of Tooth Preparation: For Cast Metal and Porcelain Restorations*. Quintessence Publishing (IL), 011987. 9).

108. advantage of an indirect restoration over amalgam-**Less polymerization shrinkage, better proximal contact, less marginal leakage, increased flexure and tensile strength**
109. kid with open and flared ant teeth, what class- **Class 2 division 1**
110. last sensation to disappear with LA- 1)Pain 2) temp 3) touch 4) **proprioception 5)motor**
111. opioids act on which receptor: **mu receptor** (analgesia)
Three opioid receptor types, μ, δ, and κ,.
112. pt given anesthesia has inflammation, y is anesthesia not as effective
Not enough free base due to low (*too much H+*) ph in the inflamed tissue **Not enough free base**
113. pt develops burn in corner of mouth and b/c of it pt develops angular chelitis
114. syneresis- sweating (humidity hot you sweat)
imbibitions –swelling (when you inbide drink)

1. Palatogingival grooves contributing to periodontal disease most commonly associated/found on which maxillary teeth? **Incisors**, Canines, PMs, Ms
2. School-wide fluoridation? ***Weekly rinsing w/ NaF 0.2%* /0.05% NaF daily**

The major difference is that the recommended concentration for school water fluoridation is 4.5 times the concentration of fluoride recommended for community water supplies in the respective geographic area. **The CDC no longer promotes school water fluoridation**. Radike et al observed schoolchildren who rinsed their mouths once each school day for 2

school years with a stannous fluoride mouthrinse containing 250 ppm fluoride (about 0.1% stannous fluoride).[107] There was a significant reduction in dental caries at the end of the first and second school years. Two independent examiners found caries reductions of 33% and 43% in DMFS scores. The anticaries benefit from the stannous fluoride mouthrinse was especially encouraging because the children already were receiving the optimum benefit of water fluoridation.

(McDonald, Ralph. *Dentistry for the Child and Adolescent, 8th Edition*. Mosby, 022004. 10.9.4).

1. You have a patient who is manic-depressive, in the manic state, refuses medication. During treatment you will experience what with the patient?
    a. Rigid OH rituals
    b. Obsessed with facial esthetics
    c. Mood swings/changes during treatment
    d. Can't remember last choice
2. Localized aggressive periodontitis? **1st molars and incisors**

Localized aggressive periodontitis: **At least one first molar and at least one incisor** or second molar and two or fewer canines or premolars had greater than 3 mm of attachment loss.
(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 8.6).

3. Pic of hands on older white female that looked like arthritis, pain in morning esp, positive for antinuclear antibodies (ANA).What does she have? **Rheumatoid arthritis**, SLE, can't remember other choices

The main clinical finding is **inflammation of the small joints of the hands and feet**. Other organs, such as the pleura, pericardium, and skin, can also be involved. Most of the clinical findings are caused by immune complexes that activate complement and, as a consequence, damage tissue. The diagnosis of rheumatoid arthritis is supported by detecting **rheumatoid factors in the serum**.

Treatment of rheumatoid arthritis typically involves aspirin, nonsteroidal anti-inflammatory drugs, immunosuppressive drugs, or corticosteroids.

(Levinson, Warren. *Medical Microbiology & Immunology, 8th Edition*. McGraw-Hill Medical Publishing, 062004. 66.3.5.2).

4. Premature loss of what primary tooth will lead to most rapid loss of space if not maintained? **Primary second molar**

Space regaining is most likely to be needed when primary maxillary or mandibular second molars have been lost prematurely because of decay or, less frequently, because of ectopic eruption of the permanent first molar. **The permanent first molar usually migrates mesially quite rapidly when the primary second molar has been lost, and in the extreme case may totally close the primary second molar extraction**

site. If the primary second molar has been lost prematurely in a single quadrant, up to 3 mm of space may be regained by tipping the molar back distally. If space loss is bilateral, the limit of space regaining is 5-6 mm for the total arch.
(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 7.3.1.2).

5. Gave description of hemiseptum (defects related to how many walls present)

The **three-wall vertical defect** was originally called an *intrabony defect.** This defect appears most frequently on the mesial aspects of second and third maxillary and mandibular molars. The **one-wall vertical** defect is also called a ***hemiseptum.***
(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 28.5.3).

6. Know Drug Schedules…mine asked me to pick the Schedule II drug from a list? Can't remember choices

Aproved by Kim; Schedule II are pure codeine or hydrocodone alone !!

Oxycodone + acetaminophen (Percocet and tylox)	**schedule 2**
Oxycodone + aspirin (percodan)	**schedule 2**
Codeine + acetaminophen (Tylenol 1,2,3)	**schedule 3**
Hydrocodone + acetaminophen (lorcet,loratab, vicodin)	**schedule 3**
Propoxyphene + acetaminophen (Darvocet)	**schedule 4**

7. Codeine Allergy

In most cases, patients truly allergic to one opioid can tolerate an opioid from a structurally different class. For example, patients truly allergic to codeine can usually take fentanyl (Sublimaze), methadone, propoxyphene (Darvon), or meperidine, if appropriate. On the other hand, patients truly allergic to codeine should not be prescribed morphine, hydrocodone, oxycodone (Oxycontin, OxyFast, OxyIR, Roxicodone), or hydromorphone (Dilaudid, Palladone).

8. Question about null hypothesis and mouthwash

A clinical trial to test a preventive agent or treatment regimen begins with a null hypothesis (i.e., **the proposition that there is no difference in disease experience between the test and control groups**). **Reject null hypothesis- no difference, chi square is low** Accept null hypothesis is if the value is high and results are called not statistically significant – Mosby pg 213-214

9. What metal causes a restoration to look green in an RPD framework? **Silver**, chromium, palladium…? **Silver**

10. What does maintenance phase of periodontal surgery seek to accomplish?

Immediately after completion of Phase I therapy, the patient should be placed on the ***maintenance phase*** **(Phase IV) to preserve the results obtained and prevent any further deterioration and recurrence of disease.** While on the maintenance phase, with its periodic checkups and controls, the patient enters into the *surgical phase* (Phase II) and *restorative* (reparative) *phase* (Phase III) of treatment.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 41.1.2).

11. Digitalis and a diuretic? What is the effect: toxicity may occur with **spironolactone** or **hydrochlorothiazide**

> Salicylates may reduce the tubular secretion of canrenone and decrease the diuretic efficacy of spironolactone, and **spironolactone may alter the clearance of digitalis glycosides. Spironolactone is a true antagonist of aldosterone.**

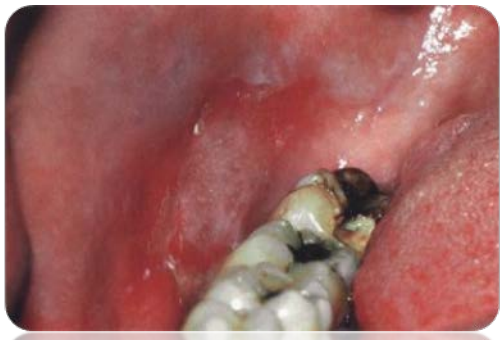
> Drug interactions may occur when loop diuretics are coadministered with: (1) *aminoglycosides* (synergism of ototoxicity caused by both drugs); (2) *anticoagulants* (increased anticoagulant activity); (3) ***digitalis glycosides*** (**increased digitalis-induced arrhythmias)**; (4) *lithium* (increased plasma levels of lithium); (5) *propranolol* (increased plasma levels of propranolol); (6) *sulfonylureas* (hyperglycemia); (7) *cisplatin* (increased risk of diureticinduced ototoxicity); (8) *NSAIDs* (blunted diuretic response; salicylate toxity when given with high doses of salicylates); (9) *probenecid* (blunted diuretic response); (10) ***thiazide diuretics*** (synergism of diuretic activity of both drugs leading to profound diuresis); and (11) *amphotericin B* (increased potential for nephrotoxicity and toxicity and intensification of electrolyte imbalance).

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 31.5.7).

12. Dual-cure resin

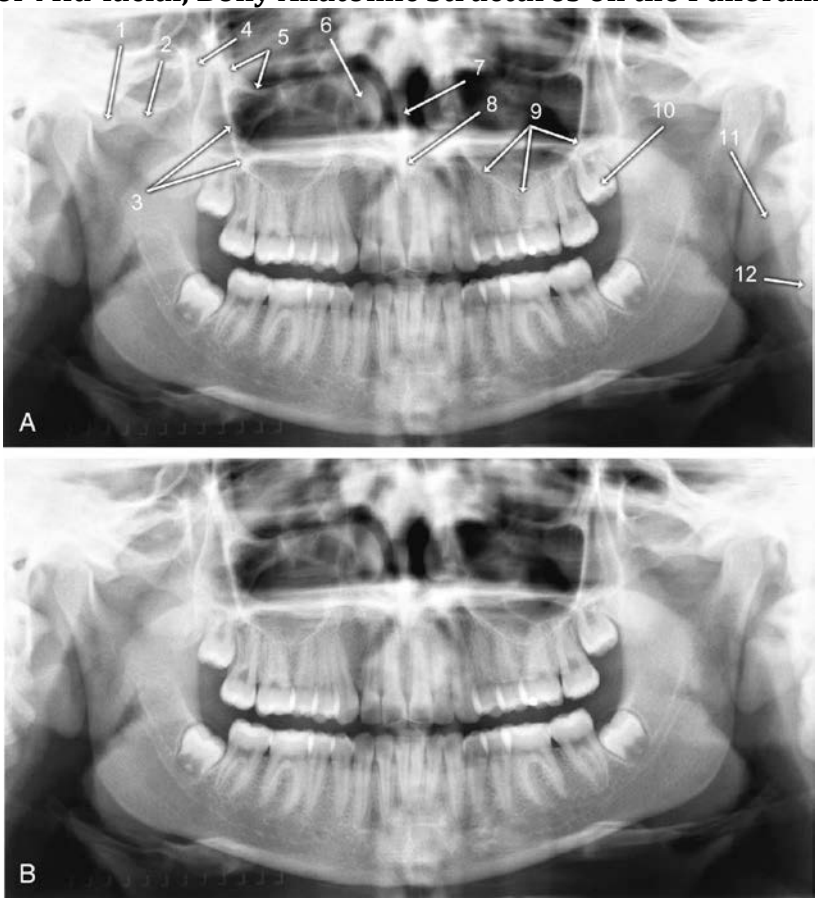
13. Not on my test but need to know difference b/t Arcon and Non-Arcon articulator? Mosby pg 319. Acron is where the condyles are in lower membrane and fossa in the upper and is used to mount the mandibular cast and non-acron is for to provide easier control of setting teeth for complete and partial dentures
14. Pic of Erosive Lichen Planus

Erosive lichen planus: of buccal mucosa.*



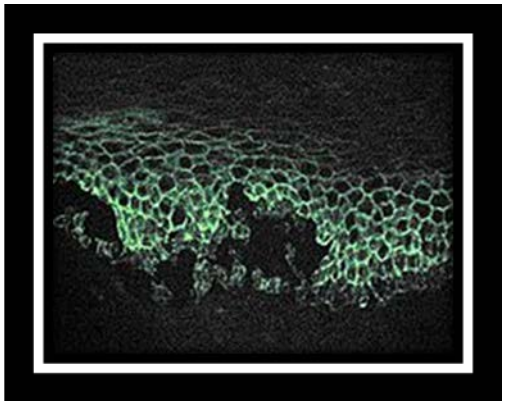
15. Know how to ID anatomical structures on radiograph…exs: lateral fossa, nasal fossa, zygomatic process

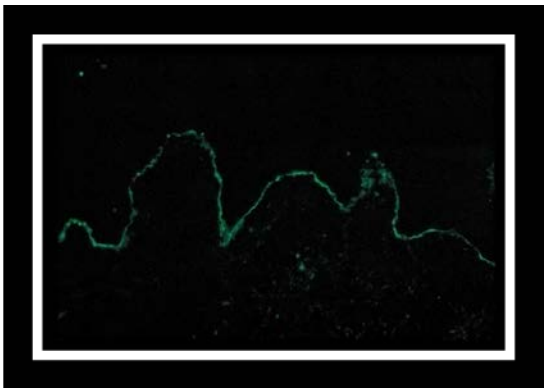
Maxillary, or Mid-facial, Bony Anatomic Structures on the Panoramic Image.



The labeled **(A)** and unlabeled **(B)** images are duplicates of the same patient. *1,* Articular tubercle, temporal bone. *2,* Zygoma. *3,* Zygomatic process of maxilla. *4,* Pterygomaxillary fissure. *5,* Floor of orbit. *6,* Anterior aspect if inferior concha. *7,* Nasal septum. *8,* Anterior nasal spine. *9,* Floor of maxillary sinus. *10,* Maxillary left third molar (developing). *11,* Ear lobe. *12,* Cervical vertebral body.

16. Pemphigus vs Pemphigoid? Where does the split occur with each? Spilt occus at suprabasilar cleft but In pemphigus it is with acantholysis and pemphigoid its not.





Pemphigus	Pemphigoid
IgG against desmosome (above Basal cell)	hemi desmosome against

17. Cross-over study? Can't remember choices

    Certain types of trial use a ***crossover* design**, in which subjects serve as their own controls. Each subject receives an active treatment for a specific time and a placebo (or no treatment) during a control period. **Crossover designs are useful in short-term trials (weeks or months, rather than years) for preventing reversible conditions like gingivitis or calculus accumulation but are *unsuitable for caries prevention trials because the time needed for new lesions to develop is too long*.**
    (Burt, Brian A.. *Dentistry, Dental Practice, and the Community, 6th Edition*. Saunders Book Company, 032005. 13.3.3).
18. Pain to ear from? Mandibular molars
19. Occlusion…know it! Can't remember specific questions
20. Acetaminophen and Aspirin? How are they similar? **Both are antipyretic and analgesic**
    (They differ in that acetaminophen is not anti-inflammatory, no GI ulcers, no clotting disturbance, and does not cause reye's syndrome)
21. Cracked tooth with no pulpal involvement? What is the definitive treatment
    Bad prognosis…

    Directional percussion is also advocated. Percussion that separates the crack may cause pain. Opposite-direction percussion usually is asymptomatic.

    If the fracture appears to be incomplete (not terminating on a root surface), the tooth is restored to bind the fractured segments (barrel-stave effect) and also to protect the cusps. For a permanent restoration, a full crown is preferred, although an onlay with bevels may suffice. *Posts and internally wedging foundations are to be avoided*. Acid-etch dentin bonding resins or bonded amalgams may help to provide a foundation for the crown to prevent crack propagation, although this approach is unproven.[31]

    The overall prognosis depends on the situation but is always questionable at best. The patient is informed about the possible outcomes and the unpredictability of duration of treatment. The fracture may continue to grow with eventually devastating consequences, requiring tooth extraction or additional treatments (Figure 28-13). Furthermore, the patient should be informed that cracks may be present in other teeth as well and could manifest in the future.

(Walton, Richard E.. *Principles and Practice of Endodontics, 3rd Edition*. Saunders Book Company, 012002. 28.6.7).

22. 76 y.o. man wants dentures replaced after 19 years…white lesion small on vestibular area…he didn't know it was there? What do you do? Biopsy, relieve denture and follow-up, can't remember other choices…

a lesion that is associated with the periphery of illfitting dentures,[7] the so-called **epulis fissuratum**, in which the growth is often split by the edge of the denture, one part of the lesion lying under the denture and the other part lying between the lip or cheek and the outer denture surface. This lesion may extend the full length of one side of the denture. Many such hyperplastic growths will become less edematous and inflamed following the removal of the associated chronic irritant, but they rarely resolve entirely. In the preparation of the mouth to receive dentures, **these lesions are excised to prevent further irritation and to ensure a soft-tissue seal for the denture periphery**. (Greenberg, Martin S.. *Burket's Oral Medicine: Diagnosis and Treatment, 10th Edition*. B.C. Decker, 012003. 7.2.1.1).

23. Pregnant woman…put on left side so right hip is up IVC
24. Pregnant woman with syncopal episode? What could be compressed if placed in wrong position? Aortic valve, fetus, **Inferior vena cava**
25. HMO…aka capitation
26. Know how to determine rate of attachment loss (????)

27. **Attachment loss is the measure from the CEJ to the base of the periodontal pocket.** With the free gingival margin 2 mm apical to the CEJ and the probing pocket depth measurement 6 mm, there has been 8 mm loss of attachment.
28. External bevel incision made where

internal bevel incision is made at least 3 mm coronal to the mucogingival junction, including the creation of new interdental papillae.

Student Doctor real quick??'s
When do you bevel occlusal rim?? VDO in length is correct
Government base dental on funds on ? need, demand, cost
Tarodontism , the pulp move s? Occlusal
Most common failure of the Ca RCT ? Cleaning and shaping
Most coming problem of teeth whn prepping? Heat
Found in crevecular fluid? Lymphocytes
To give dx of chronic periodontitis which surfaces need to be counted? 30 or more Answer is 40
Why is epinephrine contraindicated in Multiple scarosis Pt? B/c they are taking MAOI's with endogenous epinephrine.
Aspiration is not needed in ? Anerysmal bone cyst, simple bone cyst, traumatic bone cyst,
Site specific characteristic is associate with ? Recurrent Herpes b/c always in V3 and b/c all others can show up anywhere , histoplasmosis
New root attachment is from what ? Pathonomoic or Iatrogenic ???? (may be talking about long jxnl epithelium but what cause it to form? Did you create it when SRP.
Aspirin acts on the what pathway? Extrinsic pathway (heparIn – IV-Intrinsic)
Ideal age for treating malocclusion ? 5-10, 10-14, or at any again depending on the condition

29. Why are inorganic pyrophosphates put in toothpaste?: **abrasive for tartar control**

Colloidal binding agent. This agent acts as a **carrier for the more active ingredients**. Sodium alginate or methylcellulose will thicken the vehicle and prevent separation of the components in the tube during storage.

- ***Humectants***. An example is **glycerin**, which is **used to stabilize the composition and reduce water loss** by evaporation.
- ***Preservatives***. Preservatives are used to **inhibit bacterial growth within the material.**
- ***Flavoring agents***. Peppermint, wintergreen, and cinnamon **are added to enhance consumer appeal and to combat oral malodors**.
- ***Abrasives***. Abrasives are incorporated into all pastes **to aid in the removal of heavy plaque, adhered stains, and calculus deposits**. **Calcium pyrophosphate**, dicalcium phosphate, calcium carbonate, hydrated silica, and sodium bicarbonate are used in varying amounts to obtain this effect.
- ***Detergents***. An example is **sodium lauryl sulfate**, which is used to reduce surface tension and enhance the removal of debris from the tooth surface.
- ***Therapeutic agents***. Therapeutic agents are added to most toothpastes marketed in North America and Europe. The use of **stannous fluorides** **has been demonstrated to be effective in the uptake of the fluoride ion and improved resistance of fluorapatite to acid demineralization** in the initiation of carious lesions.
- ***Other chemicals***. Minor miscellaneous ingredients are included to reduce tube corrosion, stabilize viscosity, and provide pleasing coloration. Minor amounts of peroxides are included in some pastes, with marketing claims that they will remove innate discolorations and improve esthetics.

30. Most common reason for anterior composites to be replaced? **Shade**
31. Most common reason for posterior composites to be replaced? **Microleakage**
32. Patient had conservative MOD composite done and now has sensitivity..why? **microleakage**
33. Modified Widman flap
    Perio book pg 937- facilitates instrumentation but does not attempt to reduce pocket depth. It does not intend to remove the pocket wall but it does eliminate the pocket linining. Dental secretsbook pg 110. It is known as an open or flap curettage. Sulcular or submarginal incisions are made initially and full thickness flaps are elevated for debridement, scaling, and rooth planning and flap is closed with sutures.
    1) Pockets where the base are located coronal to the mucogingival junction
    2) Where there is little or no thickness of marginal bone
    3) Shallow to moderate pocket depth
    4) When esthetics is important

34. Allograft question? FDB (osteoconductive) and DFDB(osseoinductive)
35. How far from vital nerves must implants be placed? **2 mm**, 4 mm, 5 mm? except mental nerve which is 5 mm (1mm is correct but if not answer)

36. Tetracyline and periodontal disease?
    Subantimicrobial tetracycline (Periostat) is useful in treating moderate to severe chronic periodontitis. The active ingredient in Periostat is *doxycycline hyclate*. In concert with scaling and root planing, Mohammad et al.[38] have shown this treatment to be effective in institutionalized older adults. Periostat is contraindicated for those patients with an allergy to tetracycline.

    (Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 45.6.1.1).

37. MC complaint about NSAIDS?
38. Aspirin? **Irreversible action on platelets (Ibuprofen is reversible action)**
39. Look at what for patient on coumadin? **INR**, PTT, PT, Ivy bleeding time
40. In regards to institutionalized elderly patients and dental care? Their care is worse than those non-institutionalized
41. Chancre of syphilis most likely resemebles? Herpes, **SCC**?

- Patient with bifid ribs most like to have what else? OKCs (**Nevoid Basal cell carcinoma or Gorlin syndrome)** Multiple basal cell carcinomas of the skin
- Odontogenic keratocyst: Seen in 75% of patients and is the most common finding. There are usually multiple lesions found in the mandible. They occur at a young age (19 yrs average).
- Rib and vertebrae anomalies
- Intracranial calcification
- Skeletal abnormalities: bifid ribs, kyphoscoliosis, early calcification of falx cerebri (diagnosed with AP radiograph)
- Distinct faces: frontal and temporoparietal bossing, hypertelorism, and mandibular prognathism

42.

43. Patient with Trisomy 21? Midface deficiency- Down Syndrome
44. Incidence of cleft palate/lip in Causians? **1/700**
    Cleft lip and palate occur in about **1 in 800 white newborns**, 1 in 2000 black newborns, and 1 in 500 Japanese or Navaho Indian newborns
45. C1 esterase deficiency? Neuroangioedema

    Hereditary angioneurotic edema results from inherited deficiency of **C1 esterase** inhibitor, yielding uncontrolled activation of the early components of the complement system (Chapter 2). The resulting urticaria affects the lips, throat, eyelids, genitals, and distal extremities. When the larynx is affected it can be dangerous since airway patency may be compromised.
    (Kumar, Vinay. *Robbins Basic Pathology, 8th Edition*. Saunders Book Company,

46. Most common salivary gland tumor? **Pleomorphic adenoma Mosby pg 115**

The ***pleomorphic adenoma***, or *benign mixed tumor*, is **the most common salivary gland tumor**. The mean age of occurrence is 45 years, with a male-to-female ratio of 3:2. In the major glands **the parotid gland is involved in more than 80% of cases; in the minor glands the most common intraoral site is the palate** (Fig. 20-42). Pleomorphic adenomas are usually slow-growing, painless masses. The histopathologic examination shows two cell types: **(1) the ductal epithelial cell and (2) the myoepithelial cell**, which may differentiate along a variety of cell lines (*pleomorphic* means many forms). A connective tissue capsule exists, which may be

incomplete. **The treatment involves complete surgical excision with a margin of normal uninvolved tissue**. **Parotid lesions are treated with removal of the involved lobe along with the tumor. Recurrence is possible in rare occasions**, as well as a small risk (5%) of malignant transformation to a *carcinoma ex pleomorphic adenoma*.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 20.9.1).

47. Motor branch of Trigeminal nerve exits the skull through? **Foramen ovale**, stylomastoid foramen, superior orbital fissure

Motor Root

The motor root of the trigeminal nerve arises separately from the sensory root, originating in the motor nucleus within the pons and medulla oblongata (Fig. 12-2). Its fibers, forming a small nerve root, travel anteriorly along with, but entirely separate from, the larger sensory root to the region of the semilunar (or gasserian) ganglion. At the semilunar ganglion the motor root passes in a lateral and inferior direction under the ganglion toward the **foramen ovale, through which it leaves the middle cranial fossa** along with the third division of the sensory root, the mandibular nerve (Fig. 12-3 and Fig. 12-4). Just after leaving the skull, the motor root unites with the sensory root of the mandibular division to form a single nerve trunk.

48. Motor fibers of the trigeminal nerve supply the following muscles:
49. 1. Masticatory
50. a. Masseter
51. b. Temporalis
52. c. Pterygoideus medialis
53. d. Pterygoideus lateralis
54. 2. Mylohyoid
55. 3. Anterior belly of the digastric
56. 4. Tensor tympani
57. 5. Tensor veli palatini
58. (Malamed, Stanley. *Handbook of Local Anesthesia, 5th Edition*. Mosby, 072004. 12.1.1).

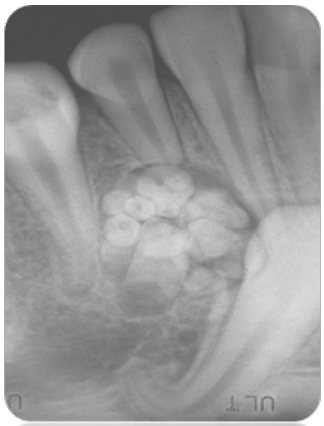
59. Distraction osteogenesis vs. convention osteotomy? Why?

This surgical technique has been developed to increase vertical bone height in the deficient jaw site and contrasts with the more conventional method of bone grafting with or without membranes. Under the proper circumstances, most cells in bone can differentiate into osteogenic or chondrogenic cells needed for repair. Ilizarov[7,8] introduced the process of generating new bone by “stretching,” referred to as ***distraction osteogenesis***. **Other important advantages of distraction osteogenesis are that no second surgical site is needed to harvest bone, and the newly created bone has native bone at the crest, which are thought to withstand forces better than fully regenerated bone**.

One of the most significant disadvantages of the distraction osteogenesis procedure for intraoral application is the unidirectional limitation of current devices.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 78.2.2).

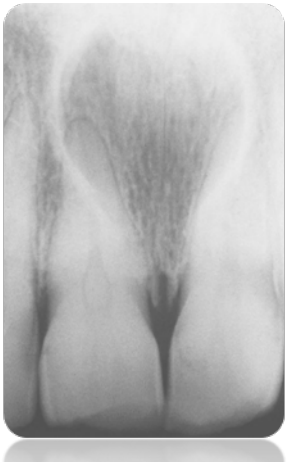
60. Last sensation lost with local anesthesia? #1) pain #2) temp #3)touch #4) proprioception 5)motor
61. X-ray of **compound odontoma**? Toothlets



62. Something sounded like maybe snowflake calcifications (RO areas) in a 10 y.o. girl? **AFO**
    Mosby pg 119 f
    AOT- snowflake calcifications, adolescent females, impacted canines, anterior maxilla
    AFO(ameloblastic fibroma-odontoma- young children, w/wo calcification, assoc w unerupted teeth, posterior mandible
    AF(ameloblastic fibroma)- similar to AFO

63. Description for Nasopalatine duct cyst…b/t centrals

Nasopalatine duct cyst. Well-circumscribed radiolucency between and apical to the roots of the maxillary central incisors.



64. PCOD in female…periapical radiolucencies near mandibular incisors..teeth vital

I had 6 cases with a random number of questions per case.

NO FLUORIDE QUESTIONS

ERUPTION SEQUENCE SEEMED TO BE MORE IMPORTANT THAN AGE ON MY EXAM

THE ONLY L.A. QUESTION AS FAR AS CALCULATION GOES ASKED THE MAX. AMOUNT OF MEPIVACAINE THAT COULD BE GIVEN TO AN ADULT: 5 CARPULES AND KNOW THAT A CHILDS DOSE SHOULD NOT EXCEED AN ADULT SO THE MAX AMOUNT OF MG TO GIVE CHILD OF 2% LIDO WAS EQUAL TO 290 (300 WAS NOT A CHOICE)

Pt. had RA along with other conditions and was taking Methotextrate

Which drug would increase the toxicity of Methotextrate? **Aspirin, PNC**

Examples of Drug-Drug Interactions Important in Dentistry

DENTAL DRUG	INTERACTING DRUG	COMMENTS
Penicillins	Macrolides, tetracyclines, clindamycin	Bacteriostatic drugs reduce the effect of bacteriocidal drugs
Tetracyclines	Oral antacids	Reduced absorption of tetracyclines
Aspirin	Anticoagulants	Increased bleeding tendency
Aspirin	Probenecid	Decreased effect of probenecid
Aspirin	Methotrexate	Increased methotrexate toxicity
Acetaminophen	Alcohol	Increased risk of liver toxicity in chronic alcoholics
Local anesthetics	Cholinesterase inhibitors	Antagonism of cholinesterase inhibitor—reduced effectiveness of the cholinesterase inhibitor in the patient with myasthenia gravis

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007.).

Know antibiotic premedication in the incident that someone is allergic to Amoxicillin (Penicillin)

ASA Classification of a pt. who had a MI within the last year and has had a heart attack

American Society of Anesthesiologists (ASA) Classification of Physical Status

ASA I: A normal, *healthy patient*

ASA II: A patient with *mild systemic disease or significant health risk factor*

ASA III: A patient with *severe systemic disease* that is *not incapacitating*

ASA IV: A patient with *severe systemic disease* that is a *constant threat to life*

ASA V: A *moribund patient who is not expected to survive without the operation*

ASA VI: A declared *brain-dead patient* whose organs are being removed for donor purposes

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 1.2.3).

Child who was a "highly functioning autistic"…how would you treat them (Nitrous, General Anesthesia, Hospital setting, **Tell show do**)

A pt. had a fear of "stroking out" in the dental chair while receiving care…how would you treat them?

Pt. has probing depths recorded and at a future visit the oral hygiene is good but the depths in one quadrant has not improved…what do you do? (SC/RP, **flap surgery**…)

Penicllin and Cephalosporins cross reaction

Pt. allergic to aspirin, which drug would you prescribe for pain? (All choices had aspirin or an aspirin combo, so choose the oddball)- **tylenol**

Child in one case had ectodermal dysplasia

Know the correct responses once a pt. tells you their chief complaint

Down Syndrome pts are not at risk for caries, more periodontal disease

Neurapraxia, axonapraxia, axonotmesis, neurotmesis

Pt. on Warfarin, concerned with :PT, PTT, CBC, **INR**

(warfarin → follows PT the ex patriot goes to WARfarin)

St. John Wort is used to treat: **depression**

Race with highest incidence of caries: **native americans**

NiTi vs. SS endo files

Mouthbreathers and how they present orally as far as the type of occlusion- **ant open bite, pos xbite**

Know SNA and SNB and if the value is + or – which Angles Classification is present

Know definitions of: yield strength, percent elongation, cross-sectional study, cohort study

> The **yield strength** is defined as the stress at which a material exhibits a specified limiting deviation from proportionality of stress to strain.
>
> The deformation that results from the application of a tensile force is ***elongation***
>
> **Modulus of elasticity**

Children with coronary artery disease-**obesity**

Why do you splint teeth: **pt comfort**

Type of incision made to remove a palatal torus: **y incision**

Picture of a pt. with Lichen Planus

Difference btw a gingival margin trimmer and a hatchet

Gingival index: ordinal

Scores and Criteria for the Gingival Index**.**

0: Normal gingiva

1: Mild inflammation—slight change in color, slight edema; no bleeding on probing

2: Moderate inflammation—redness, edema, and glazing; bleeding on probing

3: Severe inflammation—marked redness and edema; ulceration; tendency to spontaneous bleeding

(Burt, Brian A.. *Dentistry, Dental Practice, and the Community, 6th Edition*. Saunders Book

Scale	Description	Example
Nominal	A variable is expressed as categories with no order in terms of one category being greater or less than another category.	Gender is categorised as either female or male. Other nominal scales include various ethnic groupings, or types of dental practices such as urban, suburban or rural.
Ordinal	A scale that comprises at least two categories in which an order is reflected by degree. An ordinal scale is often regarded as a rating that can be ranked. There is an undisputed 'order' to the scale.	An attitude scale is commonly expressed as an ordinal scale. The degree of agreement can be expressed as a three-category scale ranging from disagree, neutral, agree.
Interval	This refers to a scale that has numbers associated upon which mathematical operations can be performed and the magnitude of the values are respected and remain clear. That is, values may be multiplied, subtracted etc., and meaningful data are retained. However there is no zero point.	Examples include the various psychological scales based upon multiple questions summed together. A classic example is the assessment of IQ. There is debate about the acceptance of attitude scales as Interval Scales, notable examples include measures of stress or dental anxiety.
Ratio	Similar to interval scale but a zero point exists.	Celsius scale which has an absolute zero. Income level is another example.

Company, 032005. 16.1.1).

Picture of a pts. Tongue that had unilateral lesion the entire length of the tongue: Herpes zoster

Child has an intruded tooth, what do you do? Monitor/ watch in hopes that they will re-erupt Mosby pg 195

Pt. with multiple neuromas??? **MEN Type III Mosby pg 113. Mucosal neuromas of multiple endocrine neoplasia syndrome MEN III 1.) inherited as autosomal dominant 2.) Syndrome components: a.) oral mucosal neuromas (hamartomas) b.) medullary carcinoma of the thyroid c.) pheochromocytoma of the adrenal gland. Pt has multiple neuromas and Marfarnoid appearance with thickened eyelids. Mutation of RET protooncogene (ORAL PATH NOTES)**

Sjogren associated with **lymphoma. Mosby pg 114. It is a bilateral enlargement of the parotid. Primary sjogren is associated with dry eyes (keratoconjunctivitis sicca) and xerostomia. Secondary Sjogren is dry eyes, dry mouth rheumatoid arthritis and autoimmune disease. Diagnosis is LAB test for autoantibodies (RF-rheumatoid arthritis), ANA- antinuclear antibodies. Patients at risk for developing lymphomas and cervical caries associated with the dry mouth**

Definition of chroma- saturation of hue, value- lightness and darkness and hue- color

Oral Cancer gene**: p53**

Metronidazole and **disulfuram effect – alcohol should not be taken while taking metronidazole for at least 48 hrs. Disulfuram is the antidote to alcohol abuse. It is given to treat chronic alcoholism.**

Consuming ethanol (alcohol) while using metronidazole has long been thought to have a disulfiram-like reaction with effects that can include nausea, vomiting, flushing of the skin, tachycardia (accelerated heart rate), and shortness of breath,[17] however there are studies calling that notion into question.[18] Consumption of alcohol should be avoided by patients during systemic metronidazole therapy and for at least 48 hours after completion of treatment.[3] However, the mechanism of this reaction in the clinical setting has recently been questioned by some authors,[19][20] and a possible central toxic serotonin reaction for the alcohol intolerance suggested.[21]

Systemic antifungal agent: **Ketoconazole**

Ph that caries start **5.5**

Prilocaine and **methmoglobinemia**

Oral Path: ***Lichen Planus***- Mosby pg 109 .IT can also be caused by diuretic (hydroclorothiazide- dental secrets) T- lymphocytes target the basal keratinocytes. Histo: saw tooth patten. 4 types: 1.) reticular- wickam striae (lace like lines) 2.) erosive- ulceration . May have slight elevated risk to malignancy. 3.) erythematous or atrophie- lesions predominately red 4.) plaque- plaque like lesions. Tx: corticosteroids, ***Ectodermal Dysplasia,*** anodontia. Abonormal development of skin, sparse thin hair, no sweat ***Down Syndrome*** – trisomy 21. Midface hypoplasia

Dental material with highest degree of thermal expansion (**Resin**)

Picture of child with #19 and 30 erupted with open apices…know that this is normal based on the childs age (btw 6 and 8)

Internal vs. external bevel and which produces the least discomfort

> **The internal bevel** flap promotes faster healing (stimulates primary healing), controls postoperative bleeding, **minimizes postoperative pain**, and allows the optional use of a periodontal pack. **External bevel heal by secondary intention**

(McDonald, Ralph. *Dentistry for the Child and Adolescent, 8th Edition*. Mosby, 022004. 20.5.3).
LOTS OF PERIO…SO MUCH I DON'T REMEMBER. SORRY

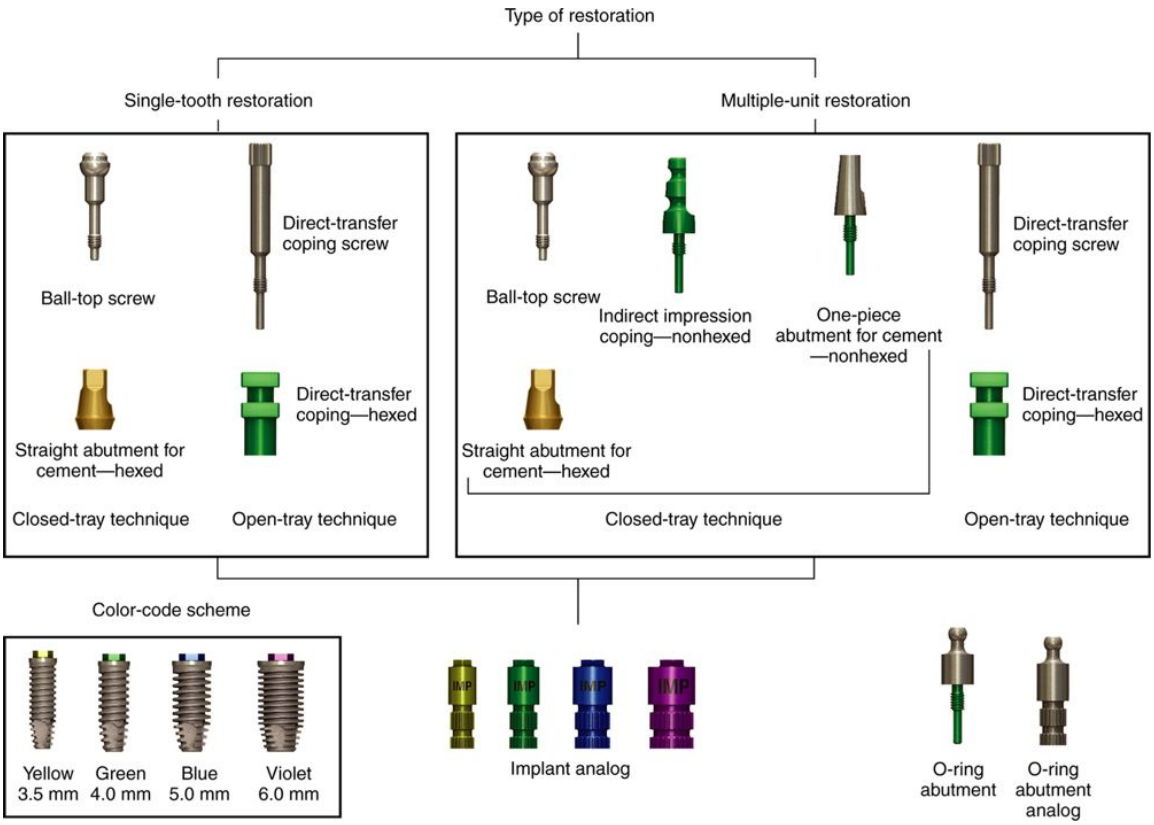
THE CASES ARE VERY SUBJECTIVE, SOMETIMES THE RADIOGRAPHS ARE HORRIBLE AND YOU FIND YOURSELF TRYING TO GUESS OR SEE STUFF THAT REALLY ISNT THERE. I DON'T HAVE A METHOD TO GET THROUGH IT, JUST PRAY.

More to come as I remember…

Open impression tray technique: wtf

(*Basically the open tray technique is used When it is preferable to have the impression coping retained in the impression material to avoid uncertainty in re-seating*).

> An impression is necessary to transfer the position and design of the implant or abutment to a master cast for prosthesis fabrication. A transfer coping is used in traditional prosthetics to position a die in an impression. Most implant manufacturers use the terms *transfer* and *coping* to describe the component used for the final impression. Therefore a transfer coping is used to position an analog in an impression and is defined by the portion of the implant it transfers to the master cast, either the implant body transfer coping or the abutment transfer coping.
>
> *Two basic implant restorative techniques are used to make a master impression, and each uses a different design transfer coping, based on the transfer technique performed*. **An indirect transfer coping** uses an impression material requiring elastic properties. [32] **The indirect transfer coping is screwed into the abutment or implant body and remains in place when a traditional "closed tray" impression is set and removed from the mouth.** The indirect transfer coping is usually slightly tapered to allow ease in removal of the impression and often has flat sides or smooth undercuts to facilitate reorientation in the impression after it is removed.
>
> A **direct transfer coping** usually consists of a hollow transfer component, often square, and a long central screw to secure it to the abutment or implant body and may be used as a pick-up impression coping. **An "open tray" impression tray is used to permit direct access to the long central screw securing the indirect transfer coping. After the impression material is set, the direct transfer coping screw is unthreaded to allow removal of the impression from the mouth. Direct transfer copings take advantage of impression materials having rigid properties and eliminate the error of permanent deformation because they remain within the impression until the master model is poured and separated**.



An indirect transfer (*far left and center*) is inserted into an implant body or abutment for screw retention, and a closed tray impression is made. The impression is removed, and the transfers are connected to an analog and reinserted into the impression. **A direct impression transfer (*far right*) uses an open tray to make the impression. The direct transfer coping screw must be unthreaded before the impression is removed from the mouth. (*Courtesy BioHorizons, Birmingham, Ala.*)**

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 2.4.3).

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 2.4.2).

Type of radiograph used to view a midface fracture: **CT scan**

Trauma to the maxilla and midface may require CT or CBCT for a thorough evaluation.

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 15.1.10).

RADIOGRAPHS

TMJ	MRI *gold standard
Maxillary, Frontal Sinuses	Waters view/ Occipito-Mental
Condylar Neck	Townes View
Zygomatic Arch	1. Submental Vertex/Bucket/Jug Handle 2. Waters View
Mid- Facial fractures	1. CT 2. Waters
Horizontal/Verital Bone loss	Vertical Bitewing
Periapical lesions	PA

Listerine and its MOA (Phenol)-

> **The active ingredients in Listerine are *methyl salicylate* and three essential oils (eucalyptol, thymol, and menthol).** Listerine has been shown to be effective in reducing plaque and gingivitis compared with placebo rinses in young healthy adults. Listerine may exacerbate xerostomia because of its high alcohol content, ranging from 21.6% to 26.9%. Listerine is generally contraindicated in patients under treatment for alcoholism who take Antabuse (disulfiram). Listerine may benefit patients who do not tolerate the taste or staining of chlorhexidine and who prefer OTC medicaments that are less expensive and easier to obtain

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 45.6.1.1).

EDTA

Retentive and reciprocal clasps…which goes where, which is stronger

> One finger of metal is termed a *retentive clasp,* while the other is termed a *reciprocal clasp.* The retentive clasp is located in an undercut area of the clinical crown and resists displacement of the prosthesis away from the underlying hard and soft tissues. The reciprocal clasp is located in a non-undercut area and serves as a bracing or stabilizing element for the prosthesis. The resultant assembly is termed an *extracoronal retainer* because the retentive and reciprocal components lie on the external surfaces of an abutment.

(Phoenix, Rodney D.. *Stewart's Clinical Removable Partial Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 012003. 1.1.2).

Hyperbaric O2

> hyperbaric oxygen treatment (60- to 90-minute dives 5 days per week, for a total of 20 to 30 dives before extraction, 10 dives after extraction).

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 26.2.5.2.6).

Space maintainers: Mosby pg 188 1.) **Band and loop**- indicatd withen you have unilateral or bilateral loss of primary 1st molars 2.) **Distal Shoe or acrylic partia**l- indicated when missing 2nd primary molars before the eruption of the permanent 1st molar 3.) **Lingual Holding arch** (mandibular)- used in mixed dentition when missing primary mandibular canines. It prevents lingual movement of incisors following premature canine loss. It also prevents the posterior teeth from moving mesially 4.) **Nance appliance** (maxillary arch)- features an acrylic button to aid in preventing mesial movement of maxillary posterior teeth.

Antidote for Opiods - naloxone

Radiograph of pt with candidiasis

97. Disease ask with hand deformation

> Characteristic limb defects help to distinguish **Apert syndrome** from other craniosynostosis syndromes. Syndactyly of the second, third, and fourth digits of the hands (mitten hands) and feet always is observed

Dental significance

Common relevant features of Apert Syndrome are a high-arched palate, pseudomandibular prognathism (appearing as mandibular prognathism), a narrow palate, and crowding of the teeth.

[edit]

(Neville, Brad W.. *Oral & Maxillofacial Pathology, 2nd Edition*. Saunders Book Company,

98. What is 3 wall defect called infrabony and treated via GTR
99. Stidor = copd or laryngospasm (inspiratory wheezing tx succyinlcholine)

> **Stridor**: a harsh, high-pitched breath sound such as the one often heard on inhalation with an acute laryngeal obstruction.

(Dorland, Newman W.. *Dorland's Illustrated Medical Dictionary, 31st Edition*. Saunders Book Company, 052007.).

<vbk:978-1-4160-2364-7>

100. Kvp causes

> Increasing mA**, kVp**, or exposure time increases the number of photons reaching the film and thus increases the density of radiograph. And it's a decrease in object-source distance and filtration
>
> Note Kvp= quality and mA= quantity

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 4.2.4).
<vbk:978-0-323-02565-2#outline(4.2.4)>

101. Mode of actionof NSAIDS

There has been substantial progress in elucidating the mechanism of action of NSAIDs. Inhibition of cyclooxygenase (COX), the enzyme responsible for the biosynthesis of the prostaglandins and certain related autacoids, generally is thought to be a major facet of the mechanism of NSAIDs

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 29.1).
<vbk:0-07-135469-7#outline(29.1)>

102. Bleeding time is involved with

Platelet inadequacy usually causes easy bruising and is evaluated by a **bleeding time** and platelet count. **Von willibrand disease**

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 1.3.6.1).
<vbk:9780323049030#outline(1.3.6.1)>

103. Tx benzo overdose

The primary indications for the use of **flumazenil** are the management of suspected benzodiazepine overdose and the reversal of sedative effects produced by benzodiazepines administered during either general anesthesia or diagnostic and/or therapeutic procedures. **Flumazenil** is available **only for intravenous administration**

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 18.2.4.3).
<vbk:0-07-135469-7#outline(18.2.4.3)>

104. # one disorder in America

105. what KvP causes (quality)

Increasing mA, **kVp**, or exposure time increases the number of photons reaching the film and thus increases the density of radiograph.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 4.2.4).
<vbk:978-0-323-02565-2#outline(4.2.4)>

106. mode of action of NSAIDS

NSAIDs inhibit both cyclooxygenase-1 (COX-1; constitutive) and cyclooxygenase-2 (COX-2; induced in settings of inflammation) activities, and thereby synthesis of prostaglandins and thromboxane. The inhibition of COX-2 is thought to mediate, at least in part, the antipyretic, analgesic, and antiinflammatory action of NSAIDs, *but the simultaneous inhibition of COX-1 results in unwanted side effects, particularly those leading to gastric ulcers, that result from decreased prostaglandin formation.*

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 29).
<vbk:0-07-135469-7#outline(29)>

107. which bur gives u smoothest surface = diamond, **straight fissure**, cross-cut

108. advantage of an indirect restoration over amalgam Dental secrets pg 153. They exhibit reduced polymerization shrinkage, increased flexural tensile strength, resistance to abrasion and fracture and improved color stability.

> The **indirect technique** offers the advantage of allowing most of the procedure to be done away from the chair. It affords an opportunity for visualization of the restoration and ready access to waxing the margins. Because it allows a technician to fabricate the pattern, the indirect technique has become the most popular means of fabricating cast restorations.

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 19).
<vbk:0-86715-201-X#outline(19)>

109. kid with open and flared ant teeth, what class? Class II Div 1

110. last sensation to disappear with LA Mosby pg 288
Pain --→ Temperature-→ Touch MOTOR

111. opioids act on which receptor ? mu receptor

> **opioids** are the primary analgesics used during the perioperative period. *Fentanyl* (SUBLIMAZE), *sufentanil* (SUFENTA), *alfentanil* (ALFENTA), *remifentanil* (ULTIVA), *meperidine* (DEMEROL), and *morphine* are the major parenteral opioids used in the perioperative period. **The primary analgesic activity of each of these drugs is produced by agonist activity at μ-opioid receptors** (Pasternak, 1993). Their order of potency (relative to morphine) is: sufentanil (1000×) > remifentanil (300×) > fentanyl (100×) > lfentanil (15×) > morphine (1×) > meperidine (0.1×)

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 15.4.2).
<vbk:0-07-135469-7#outline(15.4.2)>

112. pt given anesthesia has inflammation, y is anesthesia not as effective

> Inflammation, infection, or pain (either acute or chronic) usually decreases depth and anticipated duration of anesthesia. Increased vascularity at the site of drug deposition results in a more rapid absorption of the local anesthetic and a decreased duration of anesthesia.

(Malamed, Stanley. *Handbook of Local Anesthesia, 5th Edition*. Mosby, 072004. 4.2).
<vbk:0-323-02449-1#outline(4.2)>

113. pt develops burn in corner of mouth and b/c of it pt develops

114. syneresis----→ process of giving off water to the aire causes shrinkage i.e humidity

imbibition-----→ process of taken in water, expanding i.e. swelling

(Powers, John M. Powers. *Craig's Restorative Dental Materials, 12th Edition*. C.V. Mosby, 022006. 2.2.4).
<vbk:0-323-03606-6#outline(2.2.4)>

- Bisphosphonate, there is a concern with xrays while on bisphosphonates. Xrays can be taken. There Is a concern with the IV bisphosphonates Zomate (zolendroic acid) and Aredia (Pamidronate). It can lead to osteoradionecrosis of the jaw. These patients must be treated with hyperbaric oxygen therapy prior to dentoalveolar procedure. Mosby pg 78. Bisphosphonate is the breakdown of hypocellular, hypovascular and hypoxic tissuse (Dental secrets 58)
- Frey syndrome-sweat on parotid when you eat

Frey's syndrome is a relatively common complication of parotidectomy. This syndrome presents as gustatory sweating. When regenerating postganglionic secretory parasympathetic fibers from the parotid gland become mixed with the postganglionic sympathetic fibers to the sweat glands, a condition in which a patient will flush or sweat with salivary stimulation results. **Minor's starch-iodine test can be used to demonstrate the area of gustatory sweating**. Frey's syndrome can occur in as many as 30 to 60% of patients who have undergone parotidectomy. **The treatment of this disorder consists of the topical application of antiperspirants or anticholinergics. Botulinum toxin injections have been used to treat Frey's syndrome.**

(Greenberg, Martin S.. *Burket's Oral Medicine: Diagnosis and Treatment, 10th Edition*. B.C. Decker, 012003. 9.6.3.1).
<vbk:1-55009-186-7#outline(9.6.3.1)>

- Xrays of nutrient canals, inverted Y around pm and k9 max (max sinus and zygomatic process I think), periapical cyst around max lat, perfectly round cyst on pan right above pm(in mosby),
- Tons of perio from tx planning, to implants (implants were hit heavy), GTP, BMP, furcations, how to treat, if it's a deep c2 furcation what are some acceptable tx (I put resection as least desirable),

ultrasonic scalers were equal to hand scalers in reducing the bacteria in **class I** furcations but more effective in **class II and III furcations**.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 54.3.4).
<vbk:1-4160-2400-X#outline(54.3.4)>

- Implant success, what factors will help implant **osseointegrate** and what factors will not let it osseoimtegrate

For the evaluation of **implant success**, **immobility** and **radiographic evidence** of bone adjacent to the implant body are the two most accurate diagnostic aids in evaluating success. Follow-up or recall radiographs should be taken after 1 year of functional loading and yearly for the first 3 years.

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 3.15.6). <vbk:9780323043731#outline(3.15.6)>

- What is more stable an single implant of 4mm or 5mm or a double implant ligated together for a total of 4mm and 5mm (I put double implant ligated for a combo of 4mm because it sounded like it would not be as stable as a single implant being 4mm thick. The other one would be 2 2mm implants ligated together.
- 30% fat allowed for daily value
- What is the most a toothbrush and dental floss can peretrate into sulcus. I put 1mm and 1mm. the other choices were 2-3mm. I thought that was too much

(I think the answer is 2-3 mm, until the floss or the tooth brush reaches the depth of the biological width).

- ID a CT scan. Look at MRI example just to be sure. My picture was of a CT image of the brain and skull.

Cat scans are a specialized type of x-ray. The patient lies down on a couch which slides into a large circular opening. The x-ray tube rotates around the patient and a computer collects the results. These results are translated into images that look like a "slice" of the person. MRI is a completely different animal! Unlike CT it uses magnets and radio waves to create the images. No x-rays are used in an MRI scanner.

	CT Scan	MRI	
Radiation exposure:	Moderate - high radiation	None	
Principal used for imaging:	Uses X-rays for imaging	Uses magnets and radio waves to create the images.	
Time taken for complete scan:	Usually completed within 5 minutes	Scanning typically run for about 30 minutes.	
Details of soft tissues:	**Less detailed compared to MRI**	**Much higher detail in the soft tissues**	

- Nutrient canals! I had to id 3 of them on pics
- Diabetic patient- HBA 1C levels- if 8% then good glycemic control if onver 10% poor control. early morning appointments that are short(means high glucose, low insulin) . Pt should have eaten and taken medicine. The most common diabeteic emergency in dental office is hypoglycemia, when the blood glucose level drops below 60 mg/dL. If patient goes into insulin shock and conscious give 15mg of carbohydrate (orange juice, candy, 3-4 teaspoon of sugar etc) If unconscious, give 50 mL of dextrose

in 50% concentration or 1 mg IV or IM of glucagon. These patients have the tendency to have xerostomia and adverse affects in perio.

- What could precipitate a seizure- hypoglycemia, hypokalemia, hypocalcemia, hyponuternia, one other hypo-

common causes include **hypoglycemia**, drug withdrawal, infection, and febrile illness (e.g., meningitis, encephalitis). Specific triggers of seizures (e.g., **odors, bright lights**) should be identified and avoided. Some medications used to control seizures may affect dental treatment because of drug actions or adverse effects. For example, gingival hyperplasia is a well-known adverse effect of **diphenylhydantoin**. TX of seizures ASAP could be injection via IV of diazepam or phentobarbittal

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 1.1.4.2).

<vbk:978-0-323-04535-3#outline(1.1.4.2)>

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 27.1.2.2).

<vbk:978-0-323-04535-3#outline(27.1.2.2)>

- ANUG, NUG, - Mosby pg 240- necrotic ulceration of the marginal gingival tissues, bleeding upon proing, pain, fetid breath. May sometimes be accompanied ith fever, malaise, and lymphadenopathy
- Know differences of endo dx hard. I had at least 15 questions
- What Kennedys class does not have mods =(**IV**) Mosby pg 327
- SS crown prep for pedo, know what you need to do and guides etc
- What pedo molar are you concerned with likely pulp horn exposure. Distobuccal , **mesiobuccal**, **1m** or 2m (4 choices)
- Pulp tests. What you see to differentiate b/w acute perio abcess and acute periodontitis, how to differentiate b/w chronic and periodontal abscesses

periodontal abscess formation associated with pain, swelling, pus exudate, pocket formation, and tooth mobility. A more chronic response may also occur without pain and involves the sudden appearance of a pocket with bleeding on **probing** or exudation of pus. Also, please note that a **periodontal abscess will be EPT "positive"** as opposed to **periapical abscess which will be EPT "negative".**

(Torabinejad, Mahmoud. *Endodontics: Principles and Practice, 4th Edition*. Saunders Book Company, 032008. 6.8.3.1.5).

<vbk:1-4160-3851-5#outline(6.8.3.1.5)>

- Know perio and endo abscesses and what pulp test you would do to dx them.

Probing helps in differentiating endodontic from periodontal disease. For example, a periodontal abscess can simulate an acute apical abscess. However, with a localized **periodontal abscess**, the pulp is usually vital. In contrast, an **acute apical abscess** is

related to an unresponsive (necrotic) pulp. These abscesses occasionally communicate with the sulcus and have a deep probing defect.

(Walton, Richard E.. *Principles and Practice of Endodontics, 3rd Edition*. Saunders Book Company, 012002. 17.7.4).

<vbk:0-7216-9160-9#outline(17.7.4)>

- Tx planning for perio and implants
- Value, hue, chroma-know what they are and what they depict.

The three characteristics of color are ***hue***, ***chroma***, and ***value***. [24] To facilitate communication with ceramists, the dentist should be thoroughly familiar with these terms and their definitions. ***Hue*** is that quality which distinguishes one color from another. It is the name of a color, such as red, blue, or yellow. **Hue** may be a primary color or a combination of colors. ***Chroma*** is the saturation, intensity, or strength of a hue. For example, a red and a pink may be of the same hue. The red has a high chroma, while the pink, which is actually a weak red, has a low chroma. *Value*, or brightness, is the relative amount of lightness or darkness in a hue. **Value is the most important color characteristic in shade matching**.

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 23.2).

<vbk:0-86715-201-X#outline(23.2)>

- How to change the color. I put bleach the other teeth to match the cown.
- Few operative questions.15max- just the basics, outline, gold, cad/cam, inlay only (the remembered ? are good)
- Oral path like what is this pic most assoc with, know basics like what does each mean and assoc with. Not too in depth, but deffinatley know what it is
- **Peutz-jeughers-** freckle like lesions on the hands, perioral skin and oral mucosa and intestinal polyps that may become malignant, **Ewing**- Mosby pg 122. I is a rare round cell malignant RL in children. Aggressiv multimodality therapy fair prognosis., **langerhans,histiocytosis x-** mosby pg 121. Radiographic shows punched out lesions and or lucencies around ooth rooths (floating teeth). Histo- eosinophils are mixed in with the cells. Prognosis is very good if localized if not fatal. Tx is excision, low dose radiationor chemotherapy. 3 different classifications 1.) eosinophilic granuloma- chronic form with solitary or multiple bone lesions 2.) Hand-Schuler Christian disease – chronic disseminated form with a triad (bone lesions, exophthalmos, and diabetes insipidous and 3.) Letterer- siewe disease- acute disseminated form (bone, skin and internal organs) (what would you see if a child was take a long time of antibiotics, also pt taking long history of corticosteroids what would they be predisposed too. Also pt is on chemo what are they predisposed to. I put **candidiasis** cause of opportunistic organism.
- Dude, leavell and Rivera had a combined I would say 60 questions. They are easy, but definitely review. Mosbys has good explanation
- Cohort, x-sectional, chi-square- mosbypg 210-214
- Code of Ethics-5questions. Benefiance, Nonmalfience- which one does keeping up with skills and knowing when to refer fall under (benefiance)

- I had 3 calculation question, how much MAX carpules lido 3% can you give a 40kg child. Mosby pg 182

40 kg x 4.4 mg/kg lido = 176 mg
3% x 10 x 1.8 = 54 mg/cartridge
176mg/54 mg/cartridge = 3.25 cartidges

- How many carpules 2% lido 1:100,000 epi can you give child

A 20 kg child (approximately 5 years old) can tolerate a maximum dose of 2% lidocaine (lidocaine) with vasoconstrictor of:

7 mg/kg × 20 kg = 140 mg. Equivalent of 3 carpules (6.6 ml).

(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 1.10.1.1).
<vbk:0-7234-3186-8#outline(1.10.1.1)>

- Had to figure how many grams of anesthetic you could give child. (something knowing that anesth would be 4.4 or something like that. Pedo section in mosby
- How to tx plan Alzheimer pt, do you do what he would have wanted before end stage or do you just do palliative keeping out of pain and disease (I put that one)
- If an 84 yr old man comes in for new appt with his son. Son had a paper stating a legal guardian (not son) who can make decision. This was weird cause I didn't know if the old man was senile or independent. I put legal guardian must be there, but I think they should have said that the pt is dependent on legal guardian.
- Remembered stuff was good
- Know about denture processing and resins and evaporation and temperatures. They wanted to know something about shirking and leftover resin.

In general, heat-activated acrylic resins are polymerized by placing the flasks in a constant **temperature water bath at 74°C (165°F) for 8 hours or longer with or without a 2- to 3-hour terminal boil at 100°C**. A shorter cycle involves processing the resin at 74°C for approximately 2 hours then boiling at 100°C for 1 hour or longer.

Rapid-cure type resins have been recently introduced in the market. The resins are polymerized by rapidly heating the packed dough in boiling water for 20 minutes. The materials are hybrid acrylics, in which activation of the polymerization reaction is carried out through both chemical and heat activators, allowing rapid polymerization without porosity.

It should be noted, however, that **processing at temperatures that are too low or for shorter times increases the residual monomer content in the processed denture base. Excess residual monomer in the polymerized resin base could lead to tissue irritation, sensitivity, or even allergic reactions in some patients.** The plasticizing effects of excess monomer could also adversely affect the properties and dimensional stability of the denture. Fortunately, allergies to residual monomer are relatively rare, and

most patients are well able to tolerate the 0.2% to 0.5% of residual monomer that often remains, even in a properly polymerized base.

After the polymerization procedure, the denture flasks are cooled slowly to room temperature to allow adequate release of internal stresses and thus minimize warpage of the bases. Deflasking then follows and should be done carefully to avoid fracture or flexing of the dentures.

(Zarb, George. *Prosthodontic Treatment for Edentulous Patients: Complete Dentures and Implant-Supported Prostheses, 12th Edition*. Mosby, 092003. 12.1.4.1).

<vbk:0-323-02296-0#outline(12.1.4.1)>

- F,v, T, C, all sounds. Look in mosby and what they are for. Lisp, whistle, and what sound would that be
- Denture should IDEALLY cover entire or 1/3 retromolar pad. I put entire even though its 2/3 (wasn't a choice) thought 1/3 too little
- Porpanolol what it is and what is it used for

Propanolol is a B-adrenergic blocker (Blocks B1 and B2) used to treat Hypertension (decrease cardiac output and rennin secretion) Angina pectoris (decrease heart rate and contractility, which result in decrease O2 consumption) MI (decrease mortality)

- Pharm was basic, what do you give as antidote for overdose of sedative

The primary indications for the use of **flumazenil** are the management of suspected benzodiazepine overdose and the reversal of **sedative "effects"** produced by benzodiazepines. Naloxone is for Opioids overdose.

*****No reversal agent exists for sedative and barbiturate overdose.*****

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 31.1.3.2.7.3).

<vbk:978-0-323-04535-3#outline(31.1.3.2.7.3)>

- Preg pt hypotension- lay on left side

During late pregnancy, a phenomenon known as supine hypotensive syndrome may occur that manifests as an abrupt fall in blood pressure, bradycardia, sweating, nausea, weakness, and air hunger when the patient is in a supine position.[1,3] Symptoms are caused by impaired venous return to the heart that results from **compression of the inferior vena** cava by the gravid uterus. This leads to decreased blood pressure, reduced cardiac output, and impairment or loss of consciousness. **The remedy for the problem is to roll the patient over onto her left side**, which lifts the uterus off the vena cava. Blood pressure should rapidly return to normal.

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 18.1.1).

- Pt with moderate emphysema, stops often to catch breath- position least tolerate- I put horizontal recline

Dental Management of the Patient With , Chronic obstructive pulmonary disease

Review history for evidence of concurrent heart disease; take appropriate precautions if heart disease is present.

- Avoid treating if upper respiratory infection is present.
- **Treat in upright chair position**.
- Use local anesthetic as usual.
- Avoid use of rubber dam in severe disease.
- Use pulse oximetry to monitor oxygen saturation.
- Use low-flow (2 to 3 L/min) supplemental oxygen when oxygen saturation drops below 95%; it may become necessary when oxygen saturation drops below 91%.
- **Avoid nitrous oxide/oxygen inhalation sedation with severe COPD and emphysema.**
- **Consider low-dose oral diazepam or other benzodiazepine; these may cause oral dryness.**
- **Avoid use of barbiturates, narcotics, antihistamines, and anticholinergics**.
- Supplemental steroids may be needed if patient is taking steroids and an invasive procedure is planned.
- **Avoid erythromycin, macrolide antibiotics, and ciprofloxacin for patients taking theophylline**.
- Do not use outpatient general anesthesia.

COPD, Chronic obstructive pulmonary disease.

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 7.1.5.1.1).

<vbk:978-0-323-04535-3#outline(7.1.5.1.1)>

- Composites- basic stuff pros cons contra, indications
- What was added to zinc oxide eugenol to make IRM- **polymethyl methacrylate**

Intermediate restorative material (IRM) is a zinc oxide and eugenol cement that has been reinforced for increased strength. It is used as an intermediate base beneath a metallic restoration and also as a temporary restoration.

Composition. (1) **Powder**. The powder is composed of 80 **percent zinc oxide and 20 percent polymethyl methacrylate** (the powder used for acrylic resin). (2) **Liquid**. The liquid is **99 percent eugenol** and **1 percent acetic acid**.

- Glass ionomer mixed with polyacrylic something.

Glass ionomer is composed of:
Powder: Fluoro alumino-silicate glass
Liquid: polyacrylic acid
Source: Dental Decks Operative

- Have your articulator and want to adjust the VDO and condylar incline, where is the pin? On the table, raised off the table,

Off the table.. can't explain it…

---

1. How many miligrams of epinephrine do you give an adult in anaphylactic shock? **0.3 mg**

Prevalence: indicates what proportion of a given population is affected by a condition at a given point in time. It is expressed as percentage and ranges from 0% to 100%, (e.g., the prevalence of periodontal disease among 100,000 adolescents was 5%).

Prevalence = Number of people with the disease/Total number of people at risk

Incidence: indicates the number of new cases that will occur within a population over a period of time. (i.e. the incidence of ppl dying of oral cancer is 10% per year in men aged 55 to 59 in our community)

Incidence: # of new cases of the disease/ total # of ppl at risk

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

1. Most repeated value: **mode**
2. In one liter you have 1 ppm fluoride, how many mg? 1
3. Metronidazole is an antibiotic and antiparasitic.
4. Metronizadole should not be given to alcoholics.
5. Temporal arteritis patient is not given steroids on time what would happen? **Blindness**
6. Which of the following is a characteristic of benzodiazapene? **Increasing frequency of opening of the associated chloride ion channel a**
7. The hardest cement to wash away is: **resin;**
8. **easiest cement to wash is zinc phosphate**

Which metal causes allergic reaction? Nickel

Nickel allergy is a relatively common problem, occurring in 10% to 20% of females.

(Powers, John M. Powers. *Craig's Restorative Dental Materials, 12th Edition*. C.V. Mosby, 022006. 5.3.2).

9. Angle ANB used for relationship of maxilla to mandible
10. During asthma attack, if inhaler does not work what do you give? **Epinephrine**

Administer fast-acting bronchodilator (Note: Corticosteroids have delayed onset of action), oxygen, and, if needed, **subcutaneous 0.3 to 0.5 mL of epinephrine (1:1000**) (Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 7.2.5.1.1).

11. A five year old is prescribed tetracycline for infection, which tooth is affected? Canines
12. Intrusion of a primary tooth, what would you do? Let it re-erupt.
13. The edgewise appliance is best for achieving:

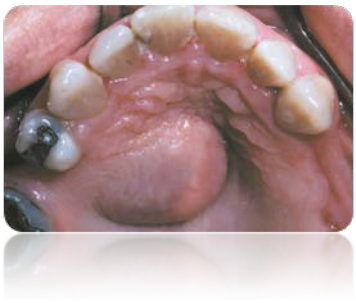
The principle of the **edgewise appliance**, control of tooth movement via rectangular arch-wires in a rectangular slot, remains the basis of contemporary fixed appliance therapy

14. What makes space for eruption of molars? Resporption in anterior and apposition of ramus in posterior.
15. Overlap is the vertical relationship of maxillary to mandibular incisors
16. Underexposed radiograph, what went wrong? **Not enough exposure time**
    Light films: Underexposed/image not dense enough) incorrect miliamperage (too low) or exposure too short; incorrect focal film distance; cone too far from patient's face, film placed backwards. (Dental decks radiology technique)
17. Which xray would be better to determine bone level? **Bitewings**
18. A patient comes in, complains of denture not fitting; bone thick and dense in x ray; **paget's disease**
19. Photograph of palate with ulceration in hard palate, present for several days; **salivary gland tumor**

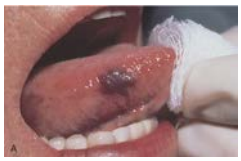
The **palate is the most common site for minor gland mixed tumors**, accounting for approximately 50% of intraoral examples. This is followed by the upper lip (27%) and buccal mucosa (17%). Palatal tumors almost always are found on the posterior lateral aspect of the palate, presenting as smooth-surfaced, dome-shaped masses. **If the tumor is traumatized, then secondary ulceration may occur.** Because of the tightly bound nature of the hard palate mucosa, tumors in this location are not movable, although those in the lip or buccal mucosa frequently are mobile. The pleomorphic adenoma is typically a well-circumscribed, encapsulated tumor However, the capsule may be incomplete or show infiltration by tumor cells. This lack of complete encapsulation is more common for minor gland tumors,

Pleomorphic adenoma.

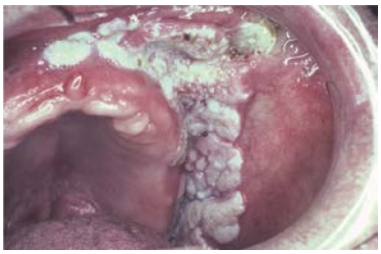
Firm mass of the hard palate lateral to the midline.



(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 11.13.2.1).

20. Picture of lateral border of tongue being blue? Hemangioma 

    (Kumar, Vinay. *Robbins Basic Pathology, 8th Edition*. Saunders Book Company, 052007. 10.11.1.1.2).
21. Vericuous carcinoma what does it look like? **Wart looking, cauliflower appearance. Etiology: tobacco and human papillomavirus (subtypes 16 & 18) Tx surgical excision and has good prognosis Mosby pg 111**



(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 10.27.1).

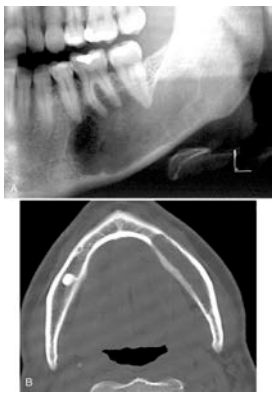
22. All of these have antiplatelet properties except? **Acetominophen**
23. Ginseng is contraindicated in a person taking **aspirin**
24. Hemophilia A: which test would you perform? **PTT**
    Best test for hemophilia (25-36 sec) OS dental decks
25. How long should aspirin be stopped before treatment? **1 week**

The best screening test for aspirin effect is the PFA-100. Although aspirin affects platelets and the coagulation process through its effects on platelet release, this does not usually lead to a significant bleeding pro-blem unless the PFA-100 is greatly prolonged. If surgery must be performed under emergency conditions, and the PFA-100 is greatly prolonged, DDAVP can be used to shorten the PFA-100. This should be done in consultation with the patient's physician or hematologist. **On a less urgent basis, with approval from the physician,**

aspirin may be discontinued for <u>3 days</u>; this allows for arrival of a sufficient number of new platelets into the circulation.

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 25.6.7.4).

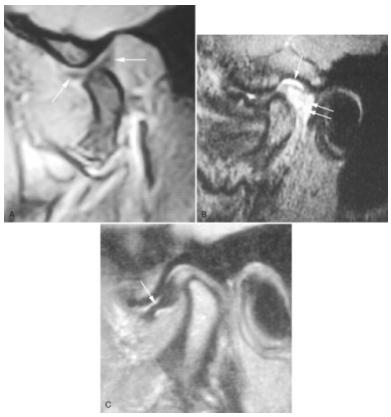
26. Which of the following has the least effect on platelet aggregation? **Naproxe**n
27. You give naloxone for which of the following? **Fentanyl overdose**
28. The duration of action of talbutal, a short acting benzodiazopene, is short because of **redistribution**
29. Which of the following is a true cyst? **Dermoid cyst** (staphne, aneurismal, traumatic bone cyst are not true cysts)
30. Traumatic bone cyst will have a scalloped appearance in between roots of teeth.



(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 21.5.5).

31. When you are taking an xray, which technique will show the maxillary sinus below the roots of the maxillary teeth? **Bisecting angle**
32. Which radiographic technique will you use to see the relationship of the disc in the fossa? MRI? **MRI** gold standard for visualization of TMJ (Dr. Ross's notes… oh sorry Dr. EDMON's notes !!)

Because of its excellent soft tissue contrast resolution, **MRI** is useful in evaluating soft tissue conditions, for instance, the position and integrity of the disk in the TMJ



(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 13.3.3).

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 13.2.10).

33. During Endo treatment of mandibular molar with three canals (mesiobuccal, mesilingual, distobuccal) if file is put into the mesiolingual canal and you move the cone mesially, in which order will you see the canals? **Mesiolingual, mesiobuccal, and distobuccal**
34. Common disorder among elderly? **Depression**

Depression is common among elderly people. Lack of motivation and lethargy are features which will compromise oral health through lack of oral hygiene, though strategies can be adopted to improve such situations. Dementia may influence treatment planning at the mid to later stages of this degenerative disease, but detailed assessments can be undertaken to determine the level of intervention when treatment is indicated.

(Humphris, Gerry. *Behavioural Sciences for Dentistry*. Churchill Livingstone, 022000. 7.2.4.4).

1. Dementia is long term memory or short term memory loss? **Short term**
2. Nightguards do which of the following? Stop grinding or **distribute forces evenly**
3. The cool slab for mixing zinc phosphate does which of the following? **Allows you to incorporate more powder**

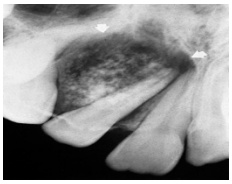
The manner in which the reaction between the **zinc phosphate cement** powder and liquid is permitted to occur determines to a large extent the working characteristics and properties of the cement mass. **Incorporate the proper amount of powder into the liquid slowly on a cool slab (about 21° C) to attain the desired consistency of cement.** A properly cooled, thick glass slab will dissipate the heat of the reaction. Should a rapid reaction occur, ample working time would not be available for proper manipulation of the cement before hardening or setting occurs. The mixing slab temperature should be low

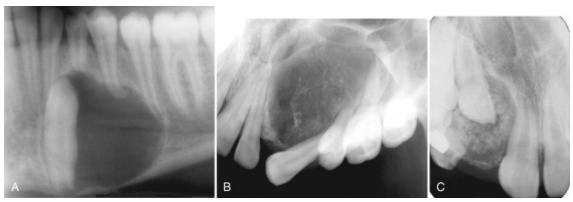
enough to effectively cool the cement mass but must not be below the dew point. A temperature of 18° to 24° C is indicated when room humidity permits.
The amount of powder that can be incorporated into a given quantity of liquid greatly determines the properties of the mixed mass of cement. Because an increase in the ratio of powder to liquid generally provides more desirable properties, incorporate as much powder as possible to obtain a particular consistency.
(Powers, John M. Powers. *Craig's Restorative Dental Materials, 12th Edition*. C.V. Mosby, 022006. 20.3.4.3).

4. Extrinsic staining on a crown could be accomplished by all of these except? **Increasing the value**.
5. Which of these would be least affected by radiation? **Nerve**
   Least affected: **mature bone, muscle, and nerve**
   ***Most affected*: small lymphocytes, bone marrow, reproductive cells, immature bone cells**
   Dental decks, radiology
6. Where would you find the fluoride applied topically? **On outer surface of enamel**
7. Smooth surface carious lesion found apical to contact point
8. Pits and fissure cavity have apex of triangle pointing to outer surface of tooth
9. Dietary analysis done to determine amount and type of **carbohydrate ingestion/sugar intake**.
10. Which bacteria is responsible for the progression of decay? Lactobacillis
11. At what ph is tooth surface demineralized? 5.5
12. Nitrous-oxide would not be administered to someone with nasal congestion
13. When would you extract a third molar? When there is unrestorable decay
14. A 14 year old girl with erupted canine has radiolucenies has **AOT** (adenomatoid odontogenic tumor)

    At least 75% of adenomatoid odontogenic tumors occur in the maxilla. The incisor-canine-premolar region, especially the cuspid region, is the usual area involved in both jaws. It occurs more commonly in the maxilla. This tumor may have a follicular relationship with an impacted tooth; however, often it does not attach at the cementoenamel junction but surrounds a greater part of the tooth, most often a canine.

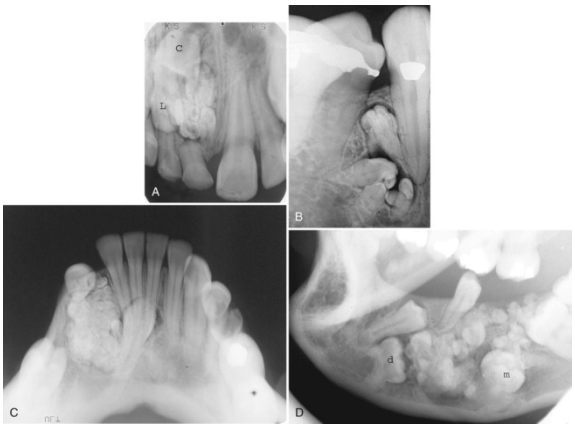
    (Courtesy R. Howell, DDS, Morgantown, W.V.)





    (White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 22.7.4.21.1).
15. Odontoma xray shows little teeth in lower mandible; its **odontoma**

Several examples of compound odontomas; note the numerous internal components and the radiolucent capsule. **A,**

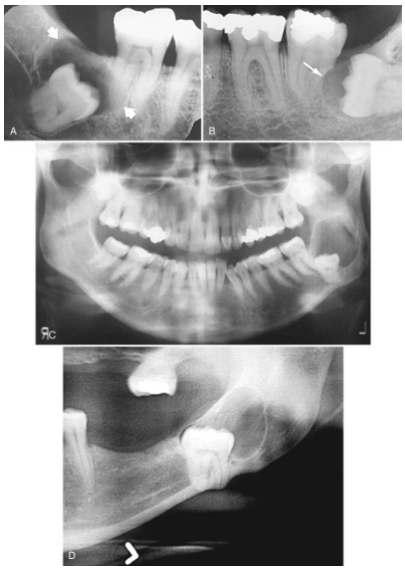


An example in the anterior maxilla that has interfered with the eruption of the central incisor *(C)* and the lateral incisor *(L)*. **B,** Within the mandible. **C,** Within the anterior mandible interfering with the eruption of the cuspid. **D,** Within the mandible interfering with the eruption of the first premolar, deciduous molar *(d),* and the first molar *(m)*.

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 22.7.4.4.3).

16. Xray showing impacted third molar with cyst on occlusal: it's a **dentigerous cyst**

Dentigerous cysts.A, A cyst surrounds the crown of a third molar *(arrows)*. **B,** The cyst has caused resorption of the distal root of the second molar *(arrow)*. **C,** A cyst that involves the ramus of the mandible. **D**, A dentigerous cyst that is expanding

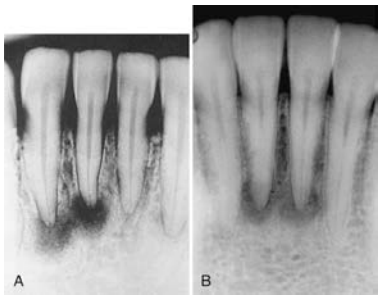


distally from the involved third molar.

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 21.3.15.1).

17. Periapical cemento osseuous dysplasia PCOD shown on xray; discussed **black women**

PCD is a common bone dysplasia that typically occurs in middle age; the mean age is 39 years. It occurs *nine times more often in females than in males* and **almost three times more often in blacks than in whites**. It also frequently is seen in Asians. The involved *teeth are vital, and the patient usually has no history of pain or sensitivity*. The lesions usually come to light as an incidental finding during a periapical or panoramic radiographic examination made for other purposes. The lesions can become quite large, causing a notable expansion of the alveolar process, and may continue to enlarge slowly.



(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 24.1.2.4.3).

18. By which method is plaque not removed? **Water irrigation**
19. How long will it take for plaque to mature? **24-36 hours**
20. When a pediatric patient is shown another child in office who is behaving well, it is an example of **modeling**
21. Prilocaine calculation, 600 mg max, 4%, 1.8 mL; how many carpules before overdose? 40 x 1.8= 72mg= 600/72 = 8 carpules
22. A patient needs premedication is allergic to penicillin give them **clindamycin 600 mg** 1 hour before
    Or: cephalexin 2g (adult), 50mg/kg (child)
    Azithromycin or Clarithromycin 500mg (adult), 15 mg/kg (child)
23. Which of these conditions does not need premedication? **Mitral valve prolapse *without* regurgitation.**
24. A patient comes in and you do a MOD composite. He comes in later complaining of pain, you remove occusal composite replace and pain goes away. What was causing the pain? **Polymerization shrinkage**

There is evidence that restorative materials may not bond to enamel or dentin with sufficient strength to resist the forces of contraction during polymerization, wear, or thermal cycling. If a bond does not form, or debonding occurs, bacteria, food debris, or saliva may be drawn into the gap between the restoration and the tooth by capillary

action. This effect has been termed ***microleakage***. The importance of microleakage in pulpal irritation has been extensively studied.
(Powers, John M. Powers. *Craig's Restorative Dental Materials, 12th Edition*. C.V. Mosby, 022006. 5.3.1.1).

25. Carpel Tunnel syndrome is result of repetitive movements.

    Pain and numbness on the ventral surface of the first three digits of the hand (but not in the palm), especially at night, suggest median nerve compression in the carpal tunnel, which lies between the carpal bones dorsally and a ventral band of more superficial fascia, the *flexor retinaculum*. **Onset often related to repetitive motion with wrists flexed (e.g., keyboard use, mail-sorting), pregnancy, rheumatoid arthritis, diabetes, hypothyroidism**
    Thenar atrophy may also be present.
    (Bickley, Lynn S.. *Bates' Guide to Physical Examination and History Taking, 9th Edition*. Lippincott Williams & Wilkins, 122005. 15.4.43.1).
26. Complications of sagital osteotomy, what is complication? **Paresthesia of lip**.
27. Worst situation to place implant? **Adolescent**
28. *Nitriglycerin and Epinephrine are physiologic antagonists*
    (**epinephrine and histamine are physiologic antagonist**, not sure about nitro and epi)
29. When you are waxing an rpd, you wax on the refractory cast

    In removable partial denture fabrication, a **cast made from refractory material** serves as the foundation for waxing and casting procedures.
    (Phoenix, Rodney D.. *Stewart's Clinical Removable Partial Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 012003. 10.6.6.3).
30. The purpose of the tissue stops in bilateral distal extension rpd? **To prevent tilting while packing resin into the rpd.** It stabizes the rpd

The cast stop *(arrow)* projects from the tissue surface of the minor connector to contact the dental cast.
The importance of cast stops As previously noted, relief is provided beneath minor connectors of open construction and mesh construction. This relief provides space between the minor connector and the underlying master cast (or residual ridge). This space permits resin to encircle the minor connector and provides a mechanism for attachment of the denture base to the framework. While this method works quite well for tooth-supported removable partial dentures, it must be modified for distal extension applications. *In a distal extension prosthesis, the use of relief produces a minor connector that is supported at only one end. As a result, the minor connector may bend when a load is applied.* ***Since considerable force is applied during the packing and***

***processing of acrylic resin, the probability of bending is increased during these procedures. To prevent bending, a small area at the free end of the minor connector should contact the master cast. This portion of the minor connector is termed a cast stop*.**

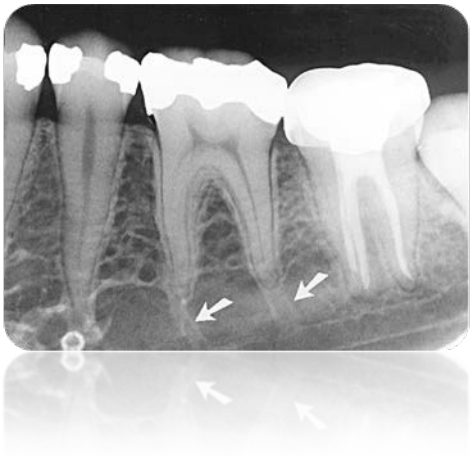
31. In order to prevent vertical root fractures when doing post and core what do you do? **Prevent fracture via appropriate canal prep and balanced pressure of condensation forces**

32. Transillumation helps you diagnose cracked tooth syndrome
33. A patient with a post and core and crown comes back in three days with pain on biting. What is diagnosis? Vertical root fracture.
34. The tooth *least* likely to have two canals? Maxillary central
35. Sodium hypochlorite when used in endo does which of the following? Kills bacteria, removes organic substances. It is a nonchelating agent.

    Copious irrigation with sodium hypochlorite is performed throughout instrumentation to reduce amounts of necrotic tissue and bacteria.
    Torabinejad, Mahmoud. *Endodontics: Principles and Practice*, *4th Edition*. Saunders Book Company, 032008. 9.10.4.2).

36. Lidocaine toxicity treated with? Diazepam
    Interesting question…actually if the lidocaine toxicity creates an epileptic procedure than yes diazepam is the agent of choice for status epilepticus. However, they recently created "Oraverse" which is "phentolamine mesylate" which can be used for reversal of soft tissue anesthesia.

37. Patient needs a procedure. He goes to doctor for work up. Which of the following values will indicate the need for more lab tests? **Hematocrit of 25** normal is (Male: 40.7-50.3% Female: 36.1-44.3
38. X ray of mandible with dense bone showing vertical radioluncies. What are they? Nutrient canals



(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 10.2.6.11).

39. Glossoptosis, cleft palate, and micrognathia? **Pierre-robin syndrome**
40. Status epilepticus give them? **Diazepam**

Continuous or repeated seizures without periods of recovery between them are known as ***status epilepticus***. This problem warrants notification of outside emergency assistance because it is the most common type of seizure disorder to cause mortality. Therapy includes instituting measures already described for self-limiting seizures; in addition, administration of a **benzodiazepine is indicated**. **Injectable water-insoluble benzodiazepines such as diazepam must be given IV to allow predictability of results, which may be difficult in the patient having seizures if venous access is not already available.** Injectable water-soluble benzodiazepines such as midazolam provide a better alternative, because IM injection will give a more rapid response. Intravenous lorazepam (0.05-0.1 mg/kg) 4 to 8 mg, or **10 mg diazepam**, is generally effective in controlling it. *Lorazepam is preferred by many experts because it is more efficacious and lasts longer than diazepam.*
(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 2.3.4.3).

41. A child who is having frequent seizures is most likely taking a medication that causes gingival hyperplasia in 50% of people. **Phenytoin (dilantin)**

42. Adrenal insuffiency has symptom of hypoglycemia (not hypertension)

Primary adrenal insufficiency (Addison's disease) produces signs and symptoms that relate to a deficiency of aldosterone and cortisol. The most common complaints are weakness, fatigue, and abnormal pigmentation of the skin and mucous membranes. Hypotension, anorexia, and weight loss are additional common findings. If a patient with Addison's disease is challenged by stress (e.g., illness, infection, surgery), an adrenal crisis may be precipitated. This medical emergency manifests as severe exacerbation of the patient's condition, including sunken eyes, profuse sweating, **hypotension**, weak pulse, cyanosis, nausea, vomiting, weakness, headache, dehydration, fever, dyspnea, myalgias, arthralgia, hyponatremia, and eosinophilia. If not treated rapidly, the patient may develop hypothermia, severe hypotension, **hypoglycemia**, and circulatory collapse that can result in death.[2]

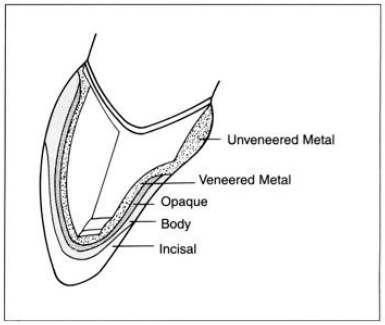
43. Secondary hyperparathyroidisn is a result of **renal failure, chronic renal disease**
44. Which drug causes capillary dilation? **Histamine**
45. Which of the following restorative materials has the closest thermal coefficient of expansion with real teeth? **Direct gold**, Amalgam, composite microfilled, dental acrylic plastics
    Increasing values of coefficient of thermal expansion:
    Porclain→human teeth→dental amalgam→ unfilled acrylic plastics
46. Class II smooth caries lesion is most likely a result of plaque accumulation
47. A new restoration is done on a patient, he comes back complaining of sharp shooting pain when the teeth are in contact. (Unless more information is needed to say type of restorative material,

I would go with hyperocclusion. This is due to: ***galvanic response***- a gold filling placed immediately next to a silver, amalgam filling can cause a sharp pain (galvanic shock) to occur. The interaction between the metals and saliva causes an electric current to occur - it's a rare occurrence, ***hyperocclusion*** premature tooth contact during oral cavity closure. In these cases, the bite appears normal immediately following the procedure, but over the course of a few days following the procedure, the tooth begins to develop bite tenderness and may contact first when the patient closes together.

48. All of the following except: the enamel hatchet can be used for gingival bevel
49. Which of the following ***is not*** a function of opaque porcelain? **Opaque porcelain is used on the incisal and provides translucency**

Opaque porcelain **conceals the metal underneath, initiates the development of the shade, and plays an important role in the development of the bond between the ceramic and the metal. Mosby pg 335 state it must mask the dark oxide color and provide porcelain-metal bod. Bond strength depends on good wetting of the metal surface. Masking must be accomplished with the minimum thickness of opaque about 0.1 mm leaving maximum space to develop a natural appearance with body and incisal porcelains.**

Layers of a metal-ceramic restoration.



2. *Dentin*, or *body*, *porcelain* makes up the bulk of the restoration, providing most of the color, or shade.
3. *Enamel*, or *incisal*, *porcelain* imparts translucency to the restoration.

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 25).

50. Which tooth is most likely to be extracted if affected by periodontal involvement? **Mandibular pre-molar**
51. Which antibiotic prevents collagen break down? **Doxycycline**

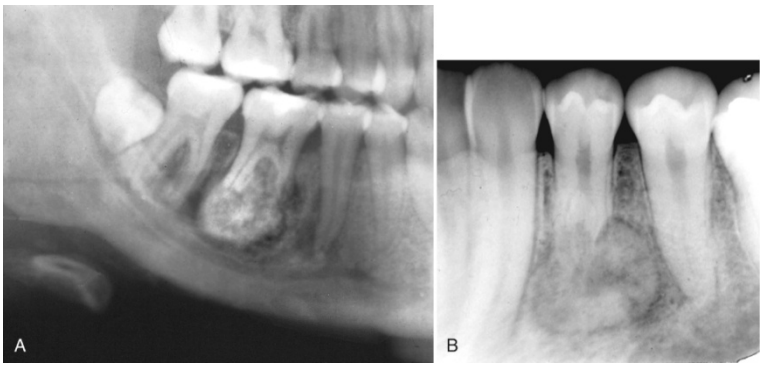
Subantimicrobial tetracycline (Periostat) is useful in treating moderate to severe chronic periodontitis. **The active ingredient in Periostat is *doxycycline hyclate*.** In concert with scaling and root planing, Mohammad et al.[38] have shown this treatment to be effective in institutionalized older adults. Periostat is contraindicated for those patients with an allergy to tetracycline. The semisynthetic compounds (e.g., **doxycycline**) **were more**

effective than tetracycline in reducing excessive collagenase activity in the gingival crevicular fluid (GCF) of chronic periodontitis patients.

52. How is the junctional epithelium attached to the tooth? **Hemidesmosome**
53. Government spends more money in dental care through- Medicare, Medicaid, grants, HMOs
54. From the **free gingival margin to the mucogingival junction measures** keratinized gingiva.
55. If you get punched in right side, the left condyle will break- **true**
56. If you get punched on right side, you will break left condyle and right body of mandible-**true**
57. Pain in the auricular area is referred from ipsilateral mandibular tooth-**true**
58. HIV viral load of 100,000 T-cell count of 30 means you have a high viral load and are succeptible to infections.
59. Rate of epithelial junction regeneration after periodontal surgery is 0.5-1.0 mm, **5-14 days**
60. Emphysema is **rupture of the terminus alveoli**. Deficiency with alpha 1 antitrypsin. Majority is caused by smoking
61. Wheezing is asthma is result of bronchial constriction and air squeezing through. Expiratory air
62. Most common side effect of antihypertensive drugs is **orthostatic hypotension**.
63. Pregnant women with hypotension should be treated with? left lateral tilt positioning
64. Intrapulpal injection… needs prophylaxis
65. Osteoporosis in xray appears with hypocalcification of osteocytes
66. Anesthetizing an infected area best done by block. In mandible IANB
67. Radiograph of calcification around molar: identify as cementoblastoma

Cementoblastoma

A, A portion of a panoramic radiograph showing a large, bulbous, radiopaque mass attached to the roots of the mandibular right first molar. A radiolucent band can be seen surrounding the mass, and root resorption of the molar roots has occurred. **B,** A periapical radiograph of a lesion associated with a bicuspid. (Courtesy B. Pynn, Canada.)

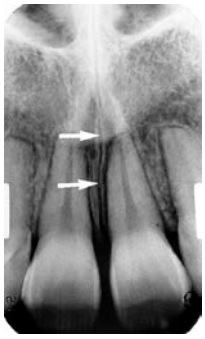


(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition.* Mosby, 092008. 22.7.5.14).

68. Huge radiolucency of skull, pain in back and in mandible? Multiple myeloma Mosby pg 116
69. Hypertensive patients should have K^+levels checked regularly if treated with hydrochlorothiazides

70. New born with white spots on alveolar ridge: bohn's nodule
71. White lesion on mid palate of infant: Epstein pearls
72. Intermaxillary suture pointed to on radiograph

The intermaxillary suture



73. Serial ceph used to track progress of growth
74. Arch analysis used to predict size of unerupted canine and premolar
75. Maxillary central incisor erupts ectopically; should correct as soon as possible.
76. Mandibular canine erupts facially to rest of teeth- likely to lead to… space insufficiency

In the lower arch, however, the canines often erupt before the first premolars, which causes the canines to be displaced facially. To avoid this result, the lower primary first molar should be extracted when there is ½ to ⅔ root formation of the first premolar. This usually will speed up the premolar eruption and cause it to enter the arch before the canine. The result is easy access for extraction of the first premolar before the canine erupts

(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 12.6.5.5).

77. Unfavorable eruption sequence; mandibular second molar before mandibular second premolar
78. Intesifying screens in pan helps to reduce radiation to patient (exposure time)

Contemporary **intensifying screens** used in extraoral radiography use the rare earth elements gadolinium and lanthanum. These rare earth phosphors emit green light on interaction with x rays. Compared with the older calcium tungstate screens, rare earth screens **decrease patient exposure** by as much as 55% in panoramic and cephalometric radiography.
(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 3.3.2.2).

79. Lots of jurisprudence questions/ vocab
80. Patient standing in corner of room with arms crossed what should you say? You look like you're stressed can you tell me what is wrong.
81. Look up cross sectional, cohort

Cross-sectional study*:* a study in which the health conditions in a group of people who are, or are assumed to be, a sample of a particular population (a cross section) is assessed at *one time*. Consider the hypothesis that drinking alcohol increases the risk of

developing oral cancer. If researchers chose to conduct a cross-sectional study to explore this hypothesis, they might examine a group of men who drink alcohol and then compare the occurrence of oral cancer among men who are not alcohol drinkers. The researchers could then determine whether there is an association between the presence of oral cancer and alcohol. Although this study is relatively quick and inexpensive, its potential to contribute to a judgment of causation is limited because it cannot determine whether the outcome (in this case, oral cancer) occurred before the men started drinking, or if it developed as a result of some other cause (e.g., metastasis).

b. *Case control study:* people with a condition ("cases") are compared with people without it ("controls") but who are similar in other characteristics. Hypothesized causal exposures are then sought in the past medical records of the participants. If the researchers had chosen to conduct a case control study to explore the same hypothesis, subjects would have been split into two groups— those with oral cancer and those without it, based on examinations. To search for an association with alcohol drinking, a history before the occurrence of oral cancer would be sought (e.g., through past medical records). Thus, the case control study could establish a temporal relationship between the exposure and disease of interest, in this case a history of alcohol drinking before the appearance of oral cancer.

Cohort study

(1) ***Prospective cohort study****:* a general population is followed through time to see who develops the disease, and then the various exposure factors that affected the group are evaluated. In this case the investigator chooses or defines a sample of subjects who do not yet have the outcome of interest, such as oral cancer. She measures risk factors in each subject (such as habits) that may predict the subsequent outcome. She follows these subjects with periodic surveys or examinations to detect the outcome (s) of interest. Following the group over a period of time, the investigator describes the prevalence of outcomes (such as oral cancer) in the cohort. She then compares the prevalence of the disease in men who drink alcohol with the prevalence of men who do not drink.
(2) ***Retrospective cohort study****:* used to evaluate the effect that a specific exposure has had on a population (e.g., occupational hazards). The investigator chooses or defines a sample of subjects who had the outcome of interest. He measures risk factors in each subject that may have predicted the subsequent outcome.
(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

82. Two different methods of learning, traditional, and self-instruction, evaluate results of tests and want to know what is the independent variable. **The method of instruction**.
83. When would you do an elective root canal? **Not enough tooth structure left for crown**,
84. The disadvantage of ceramic veneer over resin veneer is ceramic is **more expensive**
85. The advantage of direct method in inlay onlay over indirect is that the direct has **better bonding to the tooth,**
86. Which has better prognosis? Incomplete cleaning of root canal (bad prognosis)…. Answer **overextension of filling**?
87. A vital tooth will respond to electric pulp test for **2-5 sec**.
88. Thermal test used to distinguish between reversible and irreversible pulpitis.

89. Electric pulp test dintinguishes vital from nonvital teeth.
90. Apex locator **will not** help you locate canal curvature.
91. Patient had root canal two years ago, come back and has radiolucency, asymptomatic what would you do? **Wait and evaluate**
92. Way to distinguish between periodontal and periapical lesion? **Palpation, probing**
93. Acute periapical periodontitis can be determined by **percussion**.
94. In adult population in U.S. which group has highest rate of periodontitis? AA males Native Americans- via website. http://www.raconline.org/pdf/HRSAposter083103.pdf, they have the highest incidence of Periodontal Disease, tobacco use, and edentuolous rate.
95. In the U.S. the population that is most likely to have diabetes? **Black**
96. Worst prognosis for oral cancer in which population? **Black**
97. From 2000-2006 records, the surgeon general determined that the most preventable cause of death in the united states is **smoking**.
98. Lately, we have seen a decrease in **edentulism** in elderly.
99. Miconazole **inhibits ergosterol production** in cell wall
100. Retraction cord epinephrine acts on **alpha 1 receptor**
101. Neurofibromatosis? pedunculated noducles in skin and mouth, freckling(Crowe's sign), lisch spots(iris freckling) café au lait pigmentation and multiple neurofibromas Mosby g 113
102. Mech of action of chlorhexidine? **The mechanism of action is membrane disruption**

> Chlorhexidine is considered the most effective antiplaque and antigingivitis agent.[1-4,35] **Its antibacterial action can be explained by disruption of bacterial cell membrane by the chlorhexidine molecules, increasing its permeability and resulting in cell lysis and death.**[3]
> (Newman, Michael G.. *Carranza's Clinical Periodontology*, *10th Edition*. Saunders Book Company, 072006. 19.5.2.1).

103. How does chlorhexidine prevent gingivitis? **Reducing bacterial counts in mouth**
104. Complication of extracting molar? **Perforate sinus, damage tuberosity**
105. Ideal pontic? **Passive contact on edentulous ridge**. Mosby pg 3320 Mucosa pontics should be concave and passively contact the ridge
106. A young child under nitrous starts snoring, what do you do? **Remove rubber damn and check position of pharynx.**
107. Nitrous purpose? **To calm anxious patients**.
108. A patient is whimpering during procedure but not resisting. What do you do? **Continue treatment or sedate or tell patient to stop whinpering??**
109. Different cultures, people have diffent perception of pain.
110. What would you not see in bell's palsy? **Hypersalivation**
111. Parkinson's disease all of the following *except* **hyperactive gag reflex**.
112. Mech of action of *carbidopa*, **inhibits the enzymatic breakdown of Levodopa in systemic circulation.**
113. Down syndrome child recently adopted, before adoption lived in foster home; which one these would not be a behavior of the child? **Aggressive**
114. *Trisomy 21* has cleft palate, cardiac abnormality, class III, perio problems **but not rampant caries**.
115. Tricyclic antidepressant not characterized by immediate effect. (they need time to become effective).
116. Cerebral palsy- most are intellectually normal, enamel hypoplasia
117. Decreased oxygenation to brain will result in **vaso-vagal syncope**

118. Most common side effect of nitrous oxide therapy? **Nausea**
119. What happens if you remove oxygen before end of nitrous oxide? **Diffusion hypoxia**
120. patient with odontogenic infection, no allergies, first dose give **1 g of amoxicillin then 500 mg every 6 hrs for 7-10 days. Note that Penicllin V is often preferred drug of choice Mosby pg 95**
121. If you have to change the condylar inclination from 20 to 45 degrees, what adjustment will you make to the teeth? **Increase curve of spee**
122. Widman flap, multiple questions
123. Perio operation in posterior area, what makes operation hard? **External oblique ridge**.
124. Which of the following is not a characteristic of ANUG? Characteristics are **Necrosis / punched out interdental papilla, psuedomembrane margin, bleeding, redness, fetid odor**
125. Bleeding on probing indication of **gingivitis.**

1. Had to Identify Nasoplataine duct cyst(cyst between maxillary CI)

2. Pic of Erosive Lichen Planus(Person skin had been bleeding for 3 months, Pemphgoid and guis were not choices) erosive kind has ulceration 109

3. HMO is (Usuary, Customery, Capatiation, ... I choose Capatiation. Dentist paid a fix amount

4. Government base dental funds off (**need**, demand, cost,..)

5. Which of the following can be delivered via. transdermal patch, **fentanyl** does have a transdermal patch, use for cancer patients

6. I had the question on Empress and Zirconia Crowns (**Zirconia is the strongest.** Empress got crystalline reinforced glass, imparts strength to the ceramic

7. Had a question on a reverse 3/4 crown; most **frequently used on buccal mandibular molar**

8. 55 y.o patient widening PDL space mandibular resportion on the inferior border (I put Sclerosing Sclerdoma) immunologically mediated condition, dense collagen deposition, female predilection, raynaud phenomenon (fingertip turn blue), microstomia, diffuse widening of the PDL, acroosteolystis (resorption of terminal phalanges, claw like)

9. Reason for dual cured resin(didn't know answer). To deal with problems of incomplete curing with VLC due to the thickness of restorations and filler particles scattering light, manufacturers have developed composite resins that are dual cured which combined self curing and visible light curing.

> One way to overcome limits on curing depth and some of the other problems associated with light curing is to combine chemical curing and visible-light curing components in the same resin. So-called **dual-cure resins** are commercially available and consist of two light-curable pastes, one containing benzoyl peroxide (BP) and the other containing an aromatic tertiary amine. When these two pastes are mixed and then exposed to light, light curing is promoted by the amine/CQ combination and chemical curing is promoted by the amine/BP interaction. Dual-cure materials are

intended for any situation that does not allow sufficient light penetration to produce adequate monomer conversion, for example, cementation of bulky ceramic inlays. Like the chemically cured resins, air inhibition and porosity are problems with dual-cure resins.

(Anusavice, Kenneth J.. *Phillips' Science of Dental Materials, 11th Edition.* Saunders Book Company, 072003. 18.4.7).

10. Advantage of using metal frame work all except..(**high flexibility**). Low density(weight), high modulus of elasticity(stiffness), low material cost, and resitance to corrosion)

11. Pic of 14 y..o boy right mand expansion and RCT #30 and pain still present tooth was super erupted, Question asked what could it be Osteosarcoma, **Fibrous Dysplasia**, etc.... I put FD because of age of patient cant remember other choices

Fibrous dysplasia Mosby pg 120. - uncommon, entire half jaw usually in max. affect children, stop growing after puberty, X-ray is diffuse opacity (ground glass). 2 types monostotic or polystotic. The polystotic are associated with syndromes , 1.)McCune- Albright syndrome----→ polystotic, café au lait pigmentation, and endocrinopathies. 2.) Jaffe Lichenstein -----→polystotic, café au lait

Osteosarcoma Mosby pg 122- , new bone is formed(osteoid). Cause unknown. CCL features, pain, swelling, and paresthesia are typically present. PDL invasion results in widening. Mean age of 35 years old but range btw 10 to 85. Manidble more affected than maxilla. Tx. With resection and neoadjuvant chemotherapy anor adjuvant chemotherapy. 5 year survival rate from 25 to 40 % and Prognosis better for mandibular than maxilla (im chosing this bc pt had RCT so possible widening of PDL and the expansion could be from the sunburst appearance osteosarcoma gives expansile lesion)

12. Young patient mand trauma what happens during growth something like that (**condylar hyperplasia**, normal growth)

13. Which mixture is a schedule 2 I put Perocet but they had Hydro + ace

Scheduled Drugs		
Schedule	**Common Drugs**	**Definition**
schedule I	HEROIN, LSD, mescaline, methylenedioxymethamphetamine (MDMA), methaqualone, racemoramide, tilidine, trimeperidine	no accepted medical use high risk for abuse unsafe for use
schedule II	amobarbital, AMPHETAMINE, COCAINE, codeine, glutethimide, hydrocodone, hydromorphone, levorphanol, meperidine, METHADONE, methylphenidate, morphine, oxycodone, oxymorphone, pentobarbital	limited medical use high risk for abuse high risk for physical or psychological dependence
schedule III	amobarbital, amphetamine, anabolic steroids, BUPRENORPHINE, chlorphentermine, codeine compounds, GLUTETHIMIDE, hydrocodone compounds, phenmetrazine	accepted medical use moderate risk for abuse moderate risk for physical or psychological

		dependence
schedule IV	BENZODIAZEPINES, CHLORAL HYDRATE, meprobamate, paraldehyde, pemoline, pentazocine, phenobarbital, propoxyphene compounds, zolpidem	accepted medical use low risk for abuse low risk for physical or psychological dependence
schedule V	codeine COUGH preparations, dihydrocodeine, diphenoxylate	accepted medical use negligible risk for abuse negligible risk for physical dependence, low risk for psychological dependence

14. Have patient who has perio abscess and chronic periodontitis after ER treatment what do you do OHI, **SRP**

15.Which one will not tell pulpal status (thermal, **EPT**, Dental stimulus Percussion)

16. How do you treat 3-walled defect(A.k.a. infrabony)- **guided tissue regeneration**

17. Diagnostic test that always give good results something like that I put **Reliability(Mosby pg 214- is equal to the repeatability and reproducibility fo a test. A reliable test would produce very similar results wehne used to measure a variable at different times.**

18. Had Senstitivity question- **true positives. Patient with the disease who are correctly classified as having the disease**

19. What metal is the target of x-ray made of (Lead, copper, **Tungsten**)

20. Move x-ray from 12in to 4in (3X, 6X, **9X**, 12X)

21. What is the main difference in different insulin prep: **Onset of Action**, Mode of Action Mosby pg 303

22. Stridor/laryngospasm= inspiratory wheezing. Tx succinylcholine

23. Aids patient with Candadisis how do you treat- **Flucanazole and amphotericin B**

24. 3rd molar classification- **mandibular(Distoangular, vertical, horizontal, mesioangular**) in order from hardest to easiet

25. Desenstitztion Mosby pg 228- exposing patient to items from a collaboratively constructed hierarchy of slowly increasing anxiety provoking stimuli while using relaxation skills

26.. Pre-comptemplation Mosby pg 224. An individual is not considering a behavior change. Contemplation- an individual begins to consider a behavior change preparing to take steps to change often expresses a desire to change. Action- an individual is engaged in taking action toward behavior

changed(often requires support for his or her efforts). 4.) maintenance- and individual attempts to maintain a changed behavior.

27. Pregnant women has syncope epioside in the supine position what do you do? Put her on left side right hip up

What do leukotrienes to? Cause Asthma example of leukotriene receptor antagonist is montelukast Mosby pg 301

Highest rate to get autoimmune disease?

Children with coronary artery disease…obesity

What does chemo cause? **thrombocytopenia**

What causes perio disease? **plaque**

What cause seizures? Mosby pg 284. They are caused by inappropriate and excessive activity of motor neurons in the CNS.

Patient with pain after post/core? **Root fracture**

Contraindication for methotrexate?aspirin, pcn

Patient with Sjorgen Syndrome can develop? **lymphoma**

Pic. Of nicotine stomatitis

Highest prevalence for perio disease: **AA males**

Highest prevalence for caries in children: **hispanics**

A patient with retruded tongue, what does that cause? **obstruction**

Reason for splinting a tooth: **comfort**

If you do the outline form and there is still decay what to you do – **use a large round bur and remove from the periphery, *use large round bur and go into the deepest area*, use small round bur and remove from periphery, or use small round bur and go into the deep area.**

Comparing girl and boy what do you use – **Chi test**- Measures the association between 2 categorical values

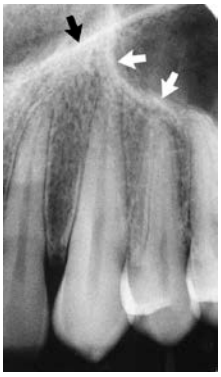
Gemination – with one canal. Mosby pg 178 it is the division of a single tooth bud resulting in a bifid crown.SINGLE PULP CHAMBER

Drug contraindicated for preg. Women PER DR. WILLIAMS NOT. CANNOT GIVE WARFIN, NSAIDS, METHOTREXATE, PENTAZOCINE(TALWIN), PHENOBARBITAL, MERPIDINE, NITROUS, BARBITUATES, PHENERGAN, PROPOXYPHENE, TETRACYCLINE, CARBAMEZAPINE,CHLORAL HYDRATE, CHOLORDIAZEPINE, CORTICOSTERIODS, DIAZAPAM, MORPHINE, DIPHENHYDRAINE AND HYDROCHOLORIDE. ,,,, CAN GIVE TYLENOL, PROPOFOL, AND CODEINE

Inverted Y on xray across the molars and PM

> Consequently, on periapical radiographs of the canine, the floors of the sinus and nasal cavity are often superimposed and may be seen crossing one another, forming an inverted Y in the area.

> The anterior border of the maxillary sinus *(white arrows)* crosses the floor of the nasal fossa *(black arrow)*.



Bright RO image on the chin of a pan…

Earlobe

Hey, here's some Q's I remembered. Hope it helps. Be blessed!

1. How long after bleaching can u do a restoration? **3 weeks or more** (dental secrets p.168Q171)

Recent bleaching procedure : **Wait 1 week after bleaching**

(Powers, John M. Powers. *Craig's Restorative Dental Materials, 12th Edition*. C.V. Mosby, 022006. 10.4.3.1.1).

2. # 29 has an MOD onlay restoration, patient in pain and tooth responsive to NOTHING...whats the pulpal and periapical dx? **Necrotic pulp**
3. C1 esterase deficiency-->**angioedema of lips**
4. What kind of epithelium will be @ a new graft site? (epi from graft site? epi from new site?, **connective tissue from graft site**? or connective tissue from new site?)

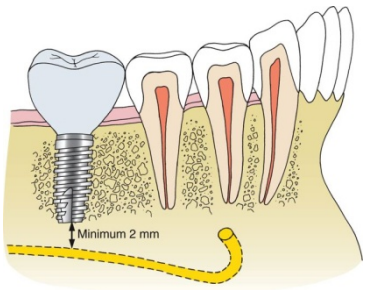
> The success of the graft depends on survival of the **connective tissue**. Sloughing of the epithelium occurs in most cases, but the extent to which the **connective tissue withstands the transfer *to the new location*** determines the fate of the graft

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 69.5.1.1.3).

5. 6 y.o. bit lip one day, now it's a non-ulcerative lesion. What is it?
6. Why recapitulate?

> Recapitulation is important regardless of the technique selected and is *accomplished by taking a small file to the corrected working length to loosen accumulated debris and then flushing it with 1 to 2 ml of irrigant.* Recapitulation is performed between each successive enlarging instrument regardless of the cleaning and shaping technique.

(Torabinejad, Mahmoud. *Endodontics: Principles and Practice, 4th Edition*. Saunders Book Company, 032008. 15.12.13).
7. Implants should be how many mm from nerves? **2 mm (minimum)** from the nerve EXCEPT MENTAL NERVE AND ITS 5MM



8. Opioids act on same receptor as?

Most of the clinically used opioids are relatively selective for **μ receptors (analgesia)**, reflecting their similarity to morphine

Drugs such as *nalbuphine* and *butorphanol* are competitive μ-receptor antagonists but exert their analgesic actions by acting as agonists at K receptors

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 24.8).

9. Penicillin cross allergy with... **cephalosporin**

10. Main reason to redo RCT's? (missed lateral canals?, extruded gutta percha?) **reinfection**

11. # 18 (opercule)in a young patient with pain. WWYD?

excision of the surrounding soft tissue, or **operculectomy**, has been advocated as a method for preventing pericoronitis without removal of the impacted tooth, it is painful and is usually ineffective. The soft tissue excess tends to recur because it drapes over the impacted tooth and causes regrowth of the operculum. The gingival pocket on the distal also remains deep after operculectomy. The overwhelming majority of cases of pericoronitis can be prevented only by extraction of the tooth.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 9.1.3).

12. Mouth wash A vs Mouth wash B--> null hypothesis (just know definition)

13. If a null hypothesis is rejected, how is it stated?

If the observed probability is less than or equal to .05 (5%), the null hypothesis is rejected (i.e., the observed outcome is judged to be incompatible with the notion of "no difference" or "no effect") and the alternative hypothesis is adopted. In this case, the results are said to be "statistically significant." If the observed probability is greater than 0.05 (5%), the decision is to accept the null hypothesis, and the results are called "not statistically significant" or simply NS—the notation often used in tables.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

14. Teenager with proximal decay that will undermine all cusps. What restoration will u do on it?

15. Fluoride commonly used in elementary schools today? **Fluoride mouth rinse: weekly with .02% (neutral sodium fluoride) NaF** p. 208 mosby

16. How to determine fluorosis in a patient? (two teeth? **full mouth must have it**? age?...)

Normal:

The enamel represents the usual translucent semivitriform type of structure. The surface is smooth, glossy, and usually of a pale creamy white color.

Questionable:

The enamel discloses slight aberrations from the translucency of normal enamel, ranging from a few white flecks to occasional white spots. This classification is utilized in those instances in which a definite diagnosis of the mildest form of fluorosis is not warranted and a classification of "normal" not justified.

Very mild:

Small, opaque, paper-white areas scattered irregularly over the tooth but not involving as much as approximately 25% of the tooth surface. Frequently included in this classification are teeth showing no more than about 1-2 mm of white opacity at the tip of the summit of the cusps of the bicuspids or second molars.

Mild:

The white opaque areas in the enamel of the teeth are more extensive but do not involve as much as 50% of the tooth.

Moderate:

All enamel surfaces of the teeth are affected, and surfaces subject to attrition show marked wear. Brown stain is frequently a disfiguring feature.

Severe:

Includes teeth formerly classified as "moderately severe" and "severe." All enamel surfaces are affected and hypoplasia is so marked that the general form of the tooth may be altered. The major diagnostic sign of this classification is the discrete or confluent pitting. Brown stains are widespread and teeth often present a corroded appearance.

(Burt, Brian A.. *Dentistry, Dental Practice, and the Community, 6th Edition*. Saunders Book Company, 032005. 17.2.1).

17. Plaque score? For us or the **patient**
18. Undercuts in anterior and big tuberosities, which do u eliminate? **tuberosity**

19. Which is the least important, hue, value or chroma? Hue I think…

The three characteristics of color are *hue*, *chroma*, and *value*. [24] To facilitate communication with ceramists, the dentist should be thoroughly familiar with these terms and their definitions. *Hue* is that quality which distinguishes one color from another. It is the name of a color, such as red, blue, or yellow. **Hue** may be a primary color or a combination of colors. ***Chroma*** is the saturation, intensity,

or strength of a hue. For example, a red and a pink may be of the same hue. The red has a high chroma, while the pink, which is actually a weak red, has a low chroma

Value, or brightness, is the relative amount of lightness or darkness in a hue. **Value is the most important color characteristic in shade matching**. If it is not possible to achieve a close match with a shade guide, a lighter shade should be selected since it can be stained more easily to a lower value. It is impossible to stain a tooth to obtain a lighter shade (higher value) without producing opacity. If major changes are attempted in the hue or chroma, there will be an accompanying decrease in value.

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 23.2).

20. X-ray's and something about humans versus things in nature...how are the levels determined??

21. Best way to tx external resorption?

Luxated teeth in which the pulps become necrotic are indicated for root canal therapy. Often in luxated teeth, there has been damage to the root cementum. If the pulps become infected, external resorption is stimulated by the presence of bacteria in the pulp space. **To arrest any ongoing resorption and to prevent additional resorption, it is important that the root canal treatment includes all efforts to disinfect the root canal system. It has been recommended that calcium hydroxide be placed in the canal for up to 2 weeks to aid in disinfection before filling the root canals**

(Torabinejad, Mahmoud. *Endodontics: Principles and Practice, 4th Edition*. Saunders Book Company, 032008. 10.3.6.3).

22. Which fracture produces paresthesia?

Probably body.. anything nwhich will affect inf.alv nerve

23. Difference b/w trough, dehesecience, hemiseptum

TROUGH IS 4 WALL DEFECT

When the denuded areas extend through the marginal bone, the defect is called a *dehiscence*

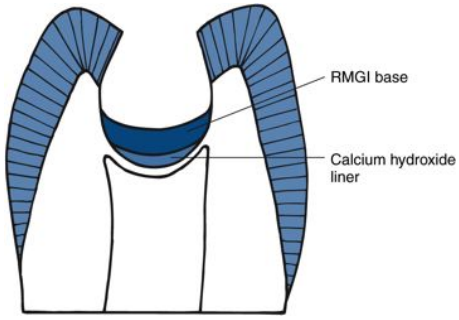
The one-wall vertical defect is also called a *hemiseptum.*

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 28.5.3).

24. Thickness of CaOH2 in a deep prep should be?

Removal of remaining infected dentin is accomplished in the same manner as described previously for the conservative preparation. If a pulp exposure occurs, the operator must decide whether to apply a direct pulp cap of calcium hydroxide to the exposure or to treat the tooth endodontically. **For pulpal protection in very deep carious excavations (where the remaining dentin thickness is judged to be <0.5 mm and a pulpal exposure is suspected), a thin layer (i.e., 0.5-0.75 mm) of a calcium hydroxide liner may be placed.** The calcium hydroxide liner may stimulate secondary dentin formation in an area where a micro-exposure is suspected. If used, it is placed with the same instrument using the same technique as described for the RMGI liner. The calcium hydroxide liner should be placed only over the deepest portion of the excavation (nearest the pulp). A thin base of RMGI should be used to cover the calcium hydroxide.[31] The entire dentin surface should not be covered (Fig. 17-28). The RMGI liner is recommended to cover the calcium hydroxide to resist the forces of condensation and to seal the deeply excavated area.[19] Usually no secondary resistance or retention form features are necessary for extensive Class I amalgam preparations. Primary resistance form was obtained by extending the outline of the tooth preparation to include only undermined and defective tooth structure, while preparing strong enamel walls and allowing strong cuspal areas to remain. If the excavation of caries has removed most (or all) of the flat pulpal floor that was initially prepared, secondary resistance form may be indicated. If so, the dentist establishes flat seats in dentin (0.2 mm inside the DEJ, at the pulpal wall level) that are equally spaced around the periphery of the excavation. Primary retention was obtained by the occlusal convergence of the enamel walls; secondary retention form may result from undercut areas that are occasionally left in dentin (and that are not covered by a liner) after removal of infected dentin. The external walls of the preparation are finished as described previously.

Placement of calcium hydroxide liner and RMGI base.



(Roberson, Theodore. *Sturdevant's Art and Science of Operative Dentistry, 5th Edition*. C.V. Mosby, 042006. 17.6.2.2.2).

25. Medicare...is it a federal program? yes

Since dental insurance is generally provided as an employee benefit, the elderly typically do not have this benefit. According to the 1989 NHIS[26], 50% of the 35 to 54 year, 37% of the 55 to 64 years and 15% of the 65+ population had private dental insurance. **Dental benefits are not included in Medicare**, and very few states provide dental service to adults through the Medicaid program. In 1990, nearly 75% of edentulous persons 35+ years did not have private dental insurance compared to about half of the dentate population.

(Harris, Norman O.. *Primary Preventive Dentistry, 6th Edition*. Prentice Hall, 082003. 21.9).

Medicaid is a program established in 1965 to provide health insurance to low-income populations. **It is jointly funded by the federal and state governments, includes dental services for children, and covers one in every four children in the United States.** Medicaid's Early and Periodic Screening Diagnostic, and Treatment program requires comprehensive children's health and dental services to be provided by all states. Because Medicaid is an entitlement program, enrollment must be offered to eligible children without regard to the fiscal impact on the state. Many barriers exist that deter children from receiving dental services through Medicaid, including low reimbursement rates to dentists, cumbersome claims processing, and real or perceived poor health behaviors by recipients.

(McDonald, Ralph. *Dentistry for the Child and Adolescent, 8th Edition*. Mosby, 022004. 30.5.2.1).

26. I had the avulsed tooth transport medium question twice..Hank's solution
27. Last sensation to leave with local anesthesia

sympathetic function→pain→temp→touch→ deep pressure(proprioceptio)→**motor function**
28. IgG

Opsonization refers to the coating of particles, such as bacteria, with host proteins that facilitate phagocytosis. For example, a bacterial cell may be coated with molecules derived from complement components(e.g., iC3b) for which the neutrophil has receptors (CR3). Similarly, bacterial cells may be coated with specific antibody that fixes complement and results in surface deposition of C3b that is recognized by the CR3 neutrophil receptor when converted to iC3b. **Specific antibody of the immunoglobulin G (IgG) isotype also facilitates phagocytosis directly by binding with the neutrophil Fc receptor and appears to be essential for phagocytosis of certain periodontal pathogens**.

Patients with periodontitis often exhibit very high serum titers of IgG to specific periodontal pathogens. Although B cells are directly responsible for antibody production, T cells are required to regulate the isotype switch from immunoglobulin M (IgM) to IgG. Antigen-presenting cells (APCs) such as the peripheral dendritic cells (e.g., Langerhans cells, macrophages, B cells) are abundant within the gingival tissues[135] and can transport antigen to regional lymph nodes, thus promoting the production of serum IgG antibody. Local immunoglobulin production also has been documented within the gingiva, and the gingival tissues are impregnated with very high levels of immunoglobulins.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 13.2.2).

> *The main **functions of antibodies** are to **neutralize bacterial toxins and viruses, opsonize bacteria**, **activate complement** to form a membrane-attack complex that can kill bacteria, and **interfere with attachment to mucosal surfaces**. IgG is the main opsonizing antibody, IgG and IgM activate complement, and IgA interferes with attachment to the mucosa.*

(Levinson, Warren. *Medical Microbiology & Immunology, 8th Edition*. McGraw-Hill Medical Publishing, 062004. 8.3.1).

29. Issues with waiting period and insurance policy
30. Acryodinia definition

Acrodynia (pink disease)

Mercury toxicity causes alveolar destruction and sequestration. Extremely rare now, although in the past it was not uncommon with the use of teething powders containing mercury.

(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 6.7.10).

On day two, most of my full mouth x-rays were shitty, clinical pics were okay, cephlograms and pans were okay.

Remembered questions Dec 2009

I took first 400 hundred today. I will continue to add as I remember. I do remember more, But I need to look over a few case studies for tomorrow. Good luck!! I had a lot of repeats.

1. what drug is contraindicated w/ nursing mother? Meperidine (ok), codeine(ok), propoxyphene(ok)..tylenol(ok) TETRACYCLINE, CYCLOSPORINE, METHOTREXATE, ARE SOME I FOUND THAT SHOULD NOT BE TAKEN.

2. description on fluctuant mass on midline floor of mouth? Ranula, **dermoid cyst**, lymphoepithelial cyst…I chose dermoid cyst

3. At what age would a kid get ameologenisis imperfecta(hypoplatic type) on Max Central incisor? Ages range from months to years **(perm-6mos/ prim-3-4mos utero)**

Amelogenesis imperfect occurs at birth !!!

4. fusion/germination.

Fusion

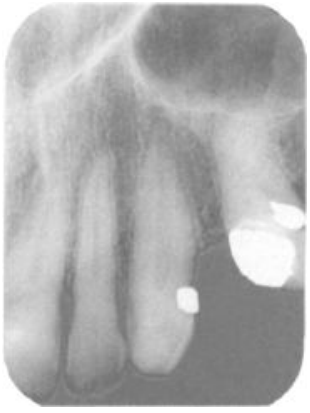
Joining of two teeth of the normal series or a normal tooth and a supernumerary tooth by pulp and dentine. Two canals are usually present. The tooth has arisen from two tooth germs and so the number of teeth in the **dentition is normally reduced by one unit**. *If, however, the normal tooth is fused to a supernumerary, the number of teeth in the arch will be normal*. This fusion is assumed to occur between normal and supernumerary teeth because of the close proximity of the tooth buds.

Gemination

Budding of a second tooth from a single tooth germ. Usually one root canal is present.

(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 7.6.4.2).

5. xray with inverted Y, ID the parts: inf border nasal cavity, **ant border max sinus**



The **inverted Y** is prominently seen in the canine film. The more-anterior arm of the Y with its superior extension consists of the floor of the nasal cavity (fossa), whereas the more-posterior curved arm is the anterolateral wall of the maxillary sinus. The **soft tissue outline of the nasal mucosa** is delineated superiorly by a thin radiolucent line representing an airspace between the nasal turbinate and nasal mucosa. In this example, the **gingiva** is seen at the **crest of the alveolar ridge** in the edentulous area.

(Langlais, Robert P.. *Color Atlas of Common Oral Diseases, 3rd Edition*. Lippincott Williams & Wilkins, 012003. 1.4.3).

<vbk:0-7817-3385-5#outline(1.4.3)>

6. xray of median palatal suture. See pg 336 in Principles of dental imaging

7. opiods contraindicated with **hypothyroidism**..

8. pt with existing crown, lighter than rest of other ant, what to do u do. I chose bleach

9. The advantages of NiTi files over SS files except. **strength**

10. advantage of placing direct composite resin vs indirect

11.which has less discomfort with healing. Internal or external bevel. **internal**

12. which 3 types of margins used for all ceramic crown. **Butt joint**, **shoulder**, **bevel**, chamfer, knife edge….

13. if doing study on male/female with or without cancer what test do u use. T-test, **Chi-square**…

14. cholinergic and anticholinergic The parasympathetic nervous system, which uses acetylcholine almost exclusively to send its messages, is said to be almost entirely cholinergic. (Causes increase in Saliva, lacrimation, urination, diarrhea) Anticholinergics are a class of medications that inhibit parasympathetic nerve impulses by selectively blocking the binding of the neurotransmitter acetylcholine to its receptor in nerve cells.

15. reason for applying dressing after surgery it is a protective obtudent to the gingiva tissue

16. reason for splinting mobile teeth. To provide comfort to patient and function

17. what is best xray to view midface fractures: saggital, waters, pan, **ct scan**

18. st johns wart : **tx depression** and know drug contraindications with aspirin

19. purpose of keyway when prep for post and core. **Antirotation**

20. purpose in casting ring liner. **Allow for expansion**

21. what is sign of ***ectodermal dysplasia*** x-linked recessive. Partial or complete Anodontia. Sparse thin hair, dry scaly skin, decreased sweating, abnormalities with ectoderm developments (nails, hair, skin)

22. listed symptoms of gardners syndrome and u had to choose what was missing. ***Gardner's syndrome***,----→ autosomal dominant, odontomas, osteomas, skin lesions, supernumerary teeth, impacted permanent teeth, intestinal polyposis,(which have very high rate of malignant conversion to colorectal carcinoma)

23. x ray of toothlets: compound odontom

24. what if pain after post and core: root fracture

25.showed picture of CT scan. Had to know that is what it was

26. showed picture of nikolsy sign and said no mucosal or skin leasions present. Pemphigus – multiple painful ulcers preceded by bullae which form within epitheilium. oral lesions precede skin lesion in about half lesions. Heal with no scarring/Pemphigoid heal with scarring . Mucosal and cutaneous involvement. presents as multiple painful ulcers preceded by bullae which form below epithelium oral lesions that my be found in any region in attached gingival and ocular lesions can lead to blinidness (Semblaspharon)Mosby pg 110

27. picture of mucocele (description mosby pg 113- submucosaal nodule of saliva often bluish in color due to escape due to escape from duct of salivary gland. Common in lower lip.

28. sjogren associated with lymphoma. Also sjogren is dry eyes, (keratoconjunctivitis sicca) dry mouth (xerostomia) rheumatoid arthritis. Complication with cervical caries. Mosby pg 114

29. picture on nicotine stomatitis

30. described neurofibromatosis and you had to choose other features: **cafe au lait, multiple neurofibomas, axillary freckling and lisch nodules mosby pg 113**

31.described pt with multiple neuromas. Only one made since to me was MEN (multiple endocrine neoplasia syndrome) MEN III- mosby pg 113 multiple neuromas, syndrome components (oral mucosa neuromas (hamartomas), medullary carcinoma of the thyroid, and pheochromocytoma of the adrenal gland)

32. if push on lesion it blanches: hemangioma

33. describe kid with ulcerative colitis- rectal bleeding

34. if have acromegaly what will be malocclusion class. III

35. how far to extend mand denture base… cover entire retromolar pad

36. if max tuberosity in the way, decrease it.

37. which kennedy class has no mods.. 4

38.. use glass ionomer to tx rampant class 5 decay

39. highest prevalence of perio. black males

40. highest for caries: I chose Hispanic

41. patient consent: I chose falls under autonomy

42. dentist knowledge and skills current/know own limitation: nonmaleficence

43. if loose max primary 2nd molar too soon what will be dent maloccl classon that side : I chose class II bcuz max 1st molar will drift mesially

44. 12 month old knee to knee: head on drs lap with parent and dr facing each other

45. retruded tongue. Bad speech, **cant control lower denture**, difficult swallowing

46. pt had SCRP but still have gen 5-6mm pocket with bop, perio surgery

47. insurance fraud: charging for something ur gonna do a next visit, cuz pt insurance is about to run out or something like that

48. area most prone to develop caries on a class II composite: gingival

49. kid with incisor intruded: leave alone and let re-erupt

50. how to treat maxillar retrognathia: Lefort I osteomy

51. disulfaram:used for alcohol abuse

1. Know the glucose values HBa1C should be 7-9 fasting gluc. 70-130

2 how to treat a dry socket - place medicated obtudent- benzocaine (irrigation by dentist or oral surgeon, placement of medication and pain meds)

3 chiantix(Varenicline)- prescribe for somking cessation

4 Gensing and St Johns Wort avoid asp and St. John wort treats depressive

5 How to treat Prepubertal Periodontitis-- Antibiotics

6 Preg woman lying supine what vessel is smushed--IVC and Abdominal aorta were listed

7PCOD Complex odontoma Bells palsy Basal cell carcinoma AI

PCOD – non-odontogenic tumor in black females, uniquadrant, apex of lower incisors, RL/RO lesions. Teeth are vital

Complex odontoma – most common odontogenic tumor, unerupted or missing teeth, younger age, asymptomatic, purely RO, posterior, poorly developed dental hard tissue

Bells palsy – facial paralysis involving CN VII, Merkelson-rosenthal syndrome, Sarcoidosis (heerforts syndrome)

Basal cell carcinoma – mosby pg 112. most common skin cancer usually in sun damaged skin, rare in oral cavity, usually presents as nonhealing indurated chronic ulcer does not metastasize

Amelogenesis imperfecta – developmental alterations in the structure of enamel in the absence of systemic disorder.

8What increases in crevicular fliud of a diabetic pt. – **glucose levels**

9 Diazepam- don't give it to **pregnant patients**

10 Which part of the blade contacts the line angle of the tooth when scaling an root planing upper 1/3 **middle 1/3** proximal 1/3

11 Receptors for phenothiazine antipsychotic **dopamine D2 receptors or inhibit 5-HT receptors**

12 Transillumination can show cracks in what instance- **Cracked tooth syndrome vertical root fractures**

13 Shaping - **The process in which the dentist can reshape the tooth by filing or removing some of the enamel. This process is usually not painful and can produce immediate results.**

14 conditioned stimulus - **In classical conditioning, the conditioned stimulus is previously neutral stimulus that, after becoming associated with the unconditioned stimulus, eventually comes to trigger a conditioned response.**

For example, suppose that the smell of food is an unconditioned stimulus and a feeling of hunger is the unconditioned response. Now, imagine that when you smelled your favorite food, you also heard the sound of a whistle. While the whistle is unrelated to the smell of the food, if the sound of the whistle was paired multiple times with the smell, the sound would eventually trigger the conditioned response. In this case, the sound of the whistle is the conditioned stimulus.

15 hurler and hunter syndrome- pt has excess amts of **Mucopolysaccharide mucopolysaccharidosis.**

16 **prevalence** number of ppl with the disease/total number of ppl at risk **incidence** amount of new cases / total of ppl at risk **specificity** ppl who do not have the disease and actually don't have it and **sensitivity** ppl with diseae actually correctly classify as having it

17 what is collimation used for - **a collimator is a device that filters a stream of rays so that only those traveling parallel to a specified direction are allowed through**

18 when to premedicate joint replacements-- when pt is immunocomp and when the replacement occured less than 2yrs ago

19 purpose of hex - **he abutment hex interdigitates with the implant's hex and forms a friction-fit when the abutment is fully seated (pretty much the screw driver)**

20 enamel dysplasia – **aka amelogenesis imperfecta (An autosomal dominant or x-linked disorder in which there is faulty development of the dental enamel owing to agenesis, hypoplasia, or**

hypocalcification of the enamel. It is marked by enamel that is very thin and friable and frequently stained in various shades of brown.)

21 what treats grand mal sz choices were Dilantin(phenytoin) and ethosuximide **DOC valproic acid, then phenytoin and carbamezapine**

22 know calcification sequence in primary and secondary teeth Mosby pg 176

primary: Mx: CI>1M>LI>K9>2M Mn: CI>1M>LI>K9>2M

secondary: Mx: 1M>CI>K9>LI>1PM>2PM>2M>3M

Mn: 1M>CI>LI>K9>1PM>2PM>2M>3M

23neurofibromatosis = **lisch nodules in eye, von recklinghausens, café au lait, axillary freckling**

1. You see a patient that has amalgams and you tell the patient to get them removed and put composite because it is better for the patient. What ethical rule are you breaking? **Veracity**

2. When you over triturate the amalgam how does it affect the amalgam **the reaction of silver alloy with mercury. Undertriturated = low strength Overtriturated = extra low strength, inc. corrosion, dec. setting expansion time, *inc. creep*** Overtrituration results in shorter setting time and increased shrinkage. Undertrituration results in increased expansion, lengthened setting time, and weakened amalgam.

3. Had 2 questions on the SLOB rule. Know that if you move inferiorly and the image follows you then it is on the lingual.

4. Know radiographic appearances for submandabular canal or mandibular canal, know lateral wall of the maxillary sinus, osteoblastoma **(non-odontogenic tumor, painful, doesn't respond to aspirin, RO or mixed, 2-4cm to 10),** odontomas (compound and complex) M**ost common odontogenic tumor, unerupted or missing teeth, purely RO, [compound-anterior, toothlets],[complex-posterior, poorly developed dental hard tissue].** Know clinical pictures of nicotinic stomatitis **(pipe smokers, red dots on palate)**, candidasis, lichen planus **(wickhams striae n stuff)**.

5. Know the distance between 2 implants - **3mm, implant to tooth (1.5mm)**

6. Know what makes an implant biocompatible – **titanium oxide layer that allows for osseointegration**

7. Pain in the ear radiates from → **Mandibular molars**

Forehead region – Mx incisors,

Nasolabial area – Mx canines, PM,

Temporal region – Mx 2PM,

Ear – Mn Molars,

Mental region of Mn – Mn incisors, canines, PM

8. The temperature of an implant drill while working doesn't need to exceed → **40 degrees, to prevent necrosis** (check dental secrets pg 226 number 145) 47 degrees Celsius is necrosis

9. Know how to differentiate between 1st , 2nd and 3rd degree burns (I know random as hell)

- **First-degree burns are usually limited to redness (erythema), a white plaque and minor pain at the site of injury. These burns involve only the epidermis. Most sunburns can be included as first-degree burns.**
- **Second-degree burns manifest as erythema with superficial blistering of the skin, and can involve more or less pain depending on the level of nerve involvement. Second-degree burns involve the superficial (papillary) dermis and may also involve the deep (reticular) dermis layer.**
- **Third-degree burns occur when the epidermis is lost with damage to the subcutaneous tissue. Burn victims will exhibit charring and extreme damage of the epidermis, and sometimes hard eschar will be present. Third-degree burns result in scarring and victims will also exhibit the loss of hair shafts and keratin. These burns may require grafting.**
- **Fourth-degree burns damage muscle, tendon, and ligament tissue, thus result in charring and catastrophic damage of the hypodermis. In some instances the hypodermis tissue may be partially or completely burned away as well as this may result in a condition called compartment syndrome, which threatens both the life and the limb of the patient. Grafting is required if the burn does not prove to be fatal.**

10. What causes a pfm to turn green → silver

11. How do you determine arch length → pm to pm. And nope canine to canine wasn't an option **(mesial of the 1st molar to mesial of the 1st)**

12. Treating a root canal on a maxillary molar and you go through the furcation, what do you do? Repair immediately the ultimate goal is to clean, shape, and obturate as much of the canal as accessible. Avoid using high concentrations of NaOCl bc it may inflame the periodontal tissue. Mosby pg 19 (this what they said showed on test I don't know)Place calcium hydroxide and wait, extract, some other choices.)The material of choice for the repair of a root perforation is Mineral Trioxide Aggregate **(MTA).**

13. Most common salivary gland tumor – **Benign(Pleomorphic Adenoma), Malignant(Mucoepidermoid carcinoma)**

14. Horizontal root fracture in the apical third and what do you do. → Mosby page 21 it has best prognosis

Mid 1/3 -splint and observe **To facilitate pulpal and periodontal ligament healing, the coronal and apical segments were repositioned in as close proximity as possible, and a rigid splint of composite was placed**

15. What nsaid is contraindicated in asthma patients, - **Aspirin**

16. Yes I had those question regarding the pregnant patient and what hip do you place her on, and what is being obstructed. Look at old 09 remembered - **With increase in uterine size with growing fetus, the uterus can partially obstruct the inferior vena cava and aorta when the patient is in a supine position. This will reduce blood pressure and placental perfusion. This may result in fetal distress in the absence of maternal symptoms. Prevention of this is accomplished by elevating the right hip 10- 12 cm. Patient may also feel sweaty, nauseated, weakness, lack of air. Treatment: Place the patient in left lateral decubitus position (Roll patient onto left side).**

17. know about sulfonurea and how its used for diabetes. Know where it works and what it does. **Sulfonylureas bind to an ATP-dependent K^+ (K_{ATP}) channel on the cell membrane of pancreatic beta cells. This inhibits a tonic, hyperpolarizing efflux of potassium, thus causing the electric potential over the membrane to become more positive. This depolarization opens voltage-gated Ca^{2+} channels. The rise in intracellular calcium leads to increased fusion of insulin granulae with the cell membrane, and therefore increased secretion of (pro)insulin. Sulfonylureas are used almost exclusively in diabetes mellitus type 2**

18. How is the face divided vertically → **horizontally 1/3, vertically 1/5**

19. Know what makes a schedule 2 drug –

☐ Schedule I is reserved for drugs or other substances that have no currently accepted medical use and a high potential for abuse. Some Schedule I substances are heroin, LSD, marijuana and methaqualone.

☐ Schedule II is reserved for drugs or other substances that have a currently accepted medical use and a high potential for abuse. Schedule II substances include Actiq®, morphine, methadone and methylphenidate (Ritalin®).Percocet, Percodan

☐ Schedule III is reserved for drugs or other substances that have a currently accepted medical use and a potential for abuse less than drugs or other substances in Schedules I and II. Their use may lead to moderate or low physical dependence or high psychological dependence. Anabolic steroids, codeine and hydrocodone with aspirin or Tylenol®, and some barbiturates are Schedule III substances. Lortab, vicodin

☐ Schedule IV is reserved for drugs or other substances that have a currently accepted medical use and a potential for abuse less than drugs or other substances in Schedules II and III. Their use may lead to limited physical dependence or psychological dependence relative to drugs or other substances in Schedule III. Included in Schedule IV are Ambien®, PROVIGIL®, Darvon®, Sonata®, Valium® and Xanax®.

☐ Schedule V is the classification used for the least dangerous drugs. These drugs or substances have a currently accepted medical use. Their use may lead to limited physical

dependence or psychological dependence relative to drugs or other substances in Schedule IV. Over-the-counter cough medicines with codeine are classified in Schedule V.

20.. Dentists can diagnose bulimia –EROSION ON TEETH. **In many patients with bulimia, such a large amount of the enamel coating dissolves that the underlying layers of the teeth are uncovered. This has unfortunate effects. The teeth become much more sensitive because nerve endings in the underlying layers become exposed. Dental cavities become more numerous because the underlying layers are more sensitive to decay and cavities without the protection of the enamel. Cosmetically, the underlying tooth structure revealed by the loss of the enamel is more yellowish or grayish than healthy white enamel.**

21. Know how to treat anug –Mosby pg 265. Application of LA and gently swab off necrotic lesions to remove pseudomembrane and local factors. Antibiotics only prescribed if lymphadenopathy and fever associated with it. Rinse with cholorhexidine and analgesic for pain. 1-2 day re-evaluation and debridement, 5 day re-evaulation reinforcement of OH. In patients with ANUG, treatment involves antibiotics, NSAIDs, and topical Xylocaine for pain relief. Saline rinses can help to speed resolution, and oral rinses with a hydrogen peroxide 3% solution also may be of benefit**. Metronidazole and Penicillin VK DOC**

22. Most common allergy in dentistry to metal → **nickel**

23. After perio surgery what attaches first> **long junctional epithelium**

24. Odonotoblastic neurons moved by dentinal tubules from→ **mechanical irritation**

25. How do you test a perm tooth with an immature apex → **hot test**

26. How do you test a tooth with a crown on it - **the cavity test is initiated on a suspicious tooth, without anesthetic, and involves drilling a small window through either enamel or a restoration to dentin. The cavity test will stimulate a vital pulp and provoke a painful response when dentin is invaded. In the event of a vital response, a simple restoration is placed. On the contrary, the cavity test will not stimulate a partially necrotic pulp to the same extent as a vital pulp. In this situation, the dentist initiates the access cavity, invades progressively deeper into dentin and often reaches the pulp chamber uneventfully.**

27. What do you place over a tooth that has calcium hydroxide base→ varnish **Cavity varnish is a liner used to seal the dentinal tubules to help prevent microleakage and is placed in a cavity to receive amalgam alloy after any bases have been placed.**

28. What causes porcelain to have brown margins → cement polymerization

29. Common reason for composite failure → review this topic - **The main cause of failure, for most dental resin composites, is the breakdown of the resin matrix and/or the interface between the filler and the resin matrix.**

30. Class 2 decay located >> gingival to the contact **(proximal caries on post. Teeth**)

31. Purpose of dowel **- Use of a metal casting, usually with a post in the pulp or root canal, designed to support and retain an artificial crown.**

32. Most congenitally missing tooth Mn 3rd molars> Mx 3rd M> > mand 2PM>Mx Lat I

33. Most impacted tooth **Mx canine**

34. Between **pemphigoid** and pemphigus(desmosomes) which one affects the basement membrane

35. Know what headlighting of the porcelain is caused by **??????**

36. Know when to do GTR - **• Class II furcations • 2 or 3 wall vertical defects • Recession • Alveolar ridge preservation, • Augment bone in sinus • Augment bone for implant • Sinus perforation after extraction • Augment bone after infection**

37. I HAD TONS OF DR LEAVELL'S STUFF. I'M TALKING ABOUT 10-15 QUESTIONS ON EMPATHY AND APATHY, MODELING, CONDITITIONING etc

Behavior Modification - a form of psychological management that comes about through the education process and is directly influenced by communication.
Classical Conditioning - a form of learning in which the subject establishes a new association between an outside stimulus and a response that is a natural reflex action.
Operant Conditioning – a behavior followed by a particular consequence (reinforcement or punishment) and as a result the frequency of the behavior increases or decreaes

Modeling technique (shown in the photo) involves the modification of behavior by having a patient observe another child who is displaying appropriate behavior.

Systematic desensitization technique involves the gradual presentation of the feared stimulus or procedure, while at the same time working to replace the anxiety with more calm and relaxed behavior.

Empathy - in a medical setting involves the health care provider's appreciation of the patient's emotions and the expression of that awareness to the patient.

Apathy – lack of interest or concern or emotion.

38. I HAD 6 OR 7 QUESTIONS ABOUT DR. RIVERAS STUFF ON SPECIFICITY, SENSITIVITY, VALIDITY etc

Sensitivity – Proportion of truly diseased persons who are identified by a screening test as being diseased.

Specificity – Proportion of truly nondiseased persons who are so identified by a screening test

Validity – Logical truth

39. Legal questions were there. So I have attached a little hand out to go over key facts.

40. Increase kvp what happens → **increase intensity (more energy to reach film, shades of grey are related)**

41. Candida in hiv patient what do you give→ **nystatin, topical clotrimazole, topical nystatin, fluconazole, and topical ketoconazole.**

42. Patient has deep pockets, a lot of calculus and needs ortho. What type of appliance do you give him. Do you give him a **removable appliance**, fixed and do frequent fluoride tx

43. How do you treat periocoronitis **(mild infection-rinse with warm salt water>antibiotics>pain meds) severe infection- extract opposing third molar mosby pg 263**

44. Incidence of cleft lip/palate **Whites 1/700-1000, Asians 1.5x higher then white,**

Blacks 0.4/1000, N. Americans 3.6/1000- highest incidence

45. I didn't have to calculate anything. No local anesthesia, no fluoride supplementation, or eruption sequence questions at all

46. Thiazide diuretics supplement with what → **K (potassium)**

47. Highest incidence of untreated caries in kids → **Hispanics**

48. Xerostomia can lead to→ **infection of salivary gland**, mucocele, tumor in salivary gland

49. Niti over stainless steel file → all except resistance to fracture

50. Angular chelitis caused by → **decreased vdo(increased interocclusal distance)**

51. Mouth breathers all except →These ppl have what is called LONG FACE SYNDROME anterior crossbite, **low mandibular angle** (JUST READ UP ON MOUTH BREATHING) (**We assessed the association between the severity of the obstruction by adenoids/tonsils hyperplasia or the presence of allergic rhinitis and the prevalence of class II malocclusion, anterior open bite and posterior crossbite.)**

52. How do you treat alveolar osteitis(dry socket) – **clean and rinse socket, place dressing, and take NSAIDs**

53. Patient asked about eyes, gloves masks, what don't you say → don't worry we have it under control

54. U do a post and core but the insurance company only pays for 1 → **downcoding**

(down-coding, which is substituting less expensive and less desirable treatment, in an effort to reduce benefit), bundling (having all diff types of insurance with the same company to save money)

ADD ON'S

1. pt that has sjorgen syndrome most likely will develop: Non-hodgkins **lymphoma**

2. what is Multiple Myeloma associated with: amyloid tongue, punched out RL **Systemic amyloidosis is associated with MM**

3. in which racial group is periodontitis most prevelant: black female, **black male**, hispanic f, hispanic m

4. in what group of kids is caries most prevelant: **hispanic**, black, native american, asian

5. radiology id pictures (about 10 questions): arrow on nasal floor, max sinus, earlobe (look at decks)

There was NO Histology!!!!!!

1. All of the following can be used to extract a max. 1st pm except- **23(cowhorn for Mn molars), 286, 150(Mx)**

Mx incisors, canines, bicuspids – 1, 65, 120, 286,150

Mx molars – 53, 88, 210, 286,150

Mn I, C, PM – 151, 203

Mn M – 210, 151, 23

2. Know how to determine based on a cephalograph if the pt has a convex, concave, bimaxillary protrusion profile.

Convex – Class II,

Convcave – Class III

Bimaxillary protrusion – looks like class II but the Mx are really slanted facially

3. If ANB=6 the patient has a **class II malocclusion.**

4. If patient has a class 4 for composite that is discolored, the margins are sealed. What do you do- **use composite tinting**, replace the composite, bleach the tooth,or take off the top layer of composite and place new composite on top. Take off the top layer of composite and place new composite on top. `

5. Difference bt Sensitivity, Specificity, Valicity- several questions

Sensitivity – Proportion of truly diseased persons who are identified by a screening test as being diseased.

Specificity – Proportion of truly nondiseased persons who are so identified by a screening test

Validity – Logical truth

6. If ANB = -3, then the patient has a class III malocclusion

SNA > 84° Mx prognathism, SNB < 78° Mn retrognathism, usually if ANB negative it is class III and if ANB is above 4 it is class II.

Be sure to pay attention to the questions that come with the cases, some ask for angle's classification and some ask for the classification based on the pt's profile

7. Patient is a soccer player with a class II malocclusion, the patient has several cavities and needs a mouthguard, what is the proper sequence to finish their treatment plan and do you have to complete all restorations prior to making the mouthguard. **Yes, do all restoration prior to making the mouthguard.**

8. Know the signs of Post Traumatic Stress Disorder- I know its random

- **Recurring nightmares or thoughts about a traumatic event**
- **Trouble sleeping and eating**
- **Anxiety and fear when exposed to situations that resemble the trauma itself**
- **On edge all the time**
- **Easily startled, overly alert at all times**
- **Depression and sadness**
- **Low energy level**
- **Memory loss, especially of the traumatic event that caused the condition**
- **Inability to focus on work and other daily activities**
- **Difficulty making decisions**
- **Emotionally numb**
- **Withdrawn and disconnected from life and others**
- **Extremely protective and fearful where it comes to the safety of loved ones**
- **Avoidance of people, places, and activities that remind the person of the event**

9. Had a question about FASCIA, yeah I missed that one **NO IDEA**

10. Know the purpose of the re-evaluation phase of periodontal treatment

this period is necessary for the tissues to heal. The patient usually is examined to evaluate the treatment results; the examination is similar to the initial periodontal examination. Clinical findings from the reevaluation examination are compared with those of the initial periodontal examination. Depending on the findings at the reevaluation appointment,

treatment may proceed in several directions: to additional nonsurgical treatment (phase I), to surgical treatment (phase II) or to supportive periodontal care (phase III).

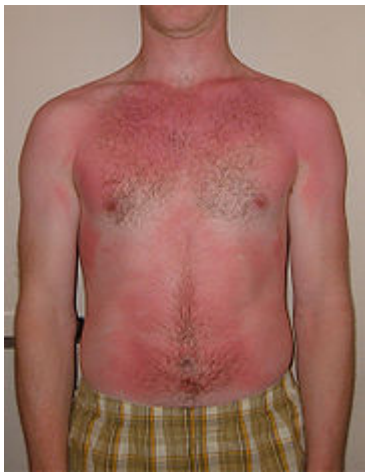
The reevaluation visit of nonsurgical therapy marks the end of phase I (inflammation control, nonsurgical or initial therapy) of periodontal therapy. This stage is perhaps the most important aspect of therapy because it involves determining whether nonsurgical treatment was effective. Is the patient compliant? Is additional reinforcement necessary? Is additional periodontal therapy indicated such as surgeries? How will the prognosis affect the overall restorative plan? Depending on the case, there will be many questions to answer; therefore, communication between the periodontist and the referring general dentist is critical.

11. Know what all is included in the initial phase of periodontal treatment

lab test, med/dent consults>eliminate pain/infection, address chief complaint>prepare tissues for surgery>remove etiological factors by mech means>increase OH> caries control,endo,extractions, ortho, occl adj> antimicrobial therapy>antibiotics>peridex>eval of OH>eval of response to factors listed above

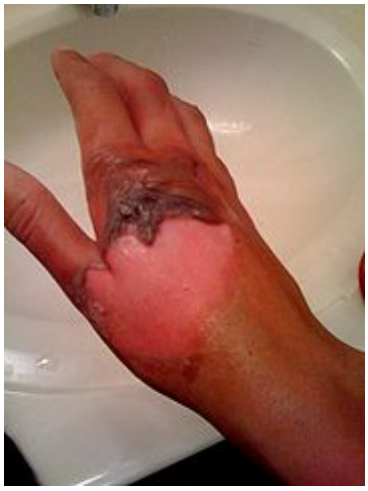
12. 3rd degree burn, consists of a loss of nerve function - **Third-degree burns occur when the epidermis is lost with damage to the subcutaneous tissue. Burn victims will exhibit charring and extreme damage of the epidermis, and sometimes hard eschar will be present. Third-degree burns result in scarring and victims will also exhibit the loss of hair shafts and keratin. These burns may require grafting.**

By degree



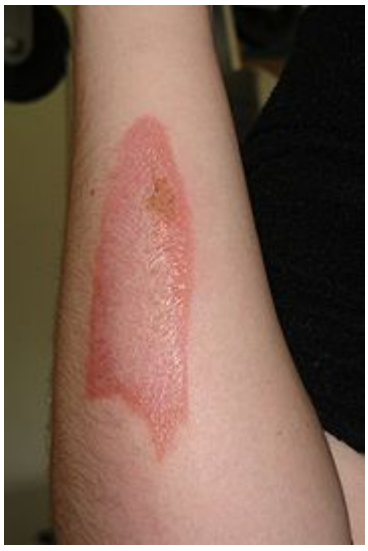
A sunburn is a typical first degree burn.

- **First-degree burns** are usually limited to redness (erythema), a white plaque and minor pain at the site of injury. These burns involve only the epidermis. Most sunburns can be included as first-degree burns.

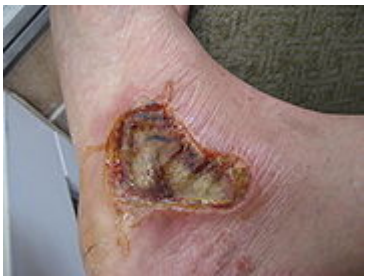


Second-degree burn caused by contact with boiling water

- **Second-degree burns** manifest as erythema with superficial blistering of the skin, and can involve more or less pain depending on the level of nerve involvement. Second-degree burns involve the superficial (papillary) dermis and may also involve the deep (reticular) dermis layer.



Three day old burn caused by kart exhaust.



Eight day old third-degree burn caused by motorcycle muffler.

- **Third-degree burns** occur when the epidermis is lost with damage to the subcutaneous tissue. Burn victims will exhibit charring and extreme damage of the epidermis, and sometimes hard eschar will be present. Third-degree burns result in scarring and victims will also exhibit the loss of hair shafts and keratin. These burns may require grafting.
- **Fourth-degree burns** damage muscle, tendon, and ligament tissue, thus result in charring and catastrophic damage of the hypodermis. In some instances the hypodermis tissue may be partially or completely burned away as well as this may result in a condition called compartment syndrome, which threatens both the life and the limb of the patient. Grafting is required if the burn does not prove to be fatal.

13.What part of the body is the most likely to get a autogenous graft for a bone graft.- **the hip**, can't remember the choices **pelvis or iliac crest**

14. What is NOT covered in the ADA Code of Ethics- Licensing

15. Know about composite tinting

tints are light cured, low viscosity, highly shaded composties used to add esthetic characteristics to restorations.

More important for the entire color stability of a certain material are the internal color changes caused by UV-irradiation or thermal energy. They mainly depend on the system of photo-initiators used in the composite as well as on the applied form and time-span of polymerization [2] and [12]. They are caused by chemical changes in the material's matrices and therefore concern all layers of the material. The fact that they cannot be eliminated by polishing [7] and [13] or post-processing underlines their importance Creative Color Tints are used to impart character to a restoration, such as craze and check lines, occlusal pit and fissure staining, incisal translucency and cervical darkening. The Tints paint on easily and are very translucent and polishable..

16.Pt. presents to the office and complains of a miscolored crown on t#8. You notice that the patient needs perio treatment. The patient only wants the crown replace. WWUD

17. Patient presents for the first appointment. The patient refuses a complete series of xrays. What would you do 1st- **Explain to the patient the importance of the xrays in creating a treatment plan, have the patient sign a waiver, etc.**

6. 12 yo boy has **granulomatous** gingivitis, apthous ulcers, bleeding from rectum: **Ulcerative colitis** Crohn's Disease?

7. radiograph with radiolucency at bottom, didn't say patient had an extraction or anything: benign neoplasm cyst, odontogenic cyst, salivary gland duct cyst...?? **NO IDEA**

8. what opiod should u not give a woman who is breast feeding: **codeine or hydrocodone**

9. which antibiotic has host modulating properties? **Tetracycline's**

the tetracycline antibiotics have been found to inhibit host-derived collagenases and other matrix metalloproteinases by a mechanism independent of the antimicrobial activity of these drugs; this effect may suppress connective tissue breakdown during periodontal disease and during a variety of medical disorders including (but not limited to) noninfected corneal ulcers, serious (sometimes life-threatening) skin-blistering diseases, rheumatoid arthritis and osteoarthritis, systemically--as well as locally--induced bone loss, and perhaps even tumor-induced angiogenesis

10. what blanches when u press on it: **hemangioma** (kaposi's sarcoma DOES NOT BLANCH)

11. Eosinophillic granuloma associated with **langerhans cell histiocytosis**:

12. Whic is most at risk for periodontitis?: smoker, diabetes pt...(probably the diabetes pt) **Diabetes 1 and 2, Smoking is the single major preventable risk factor for periodontal disease.**

13. know definitions about ultimate strength, proportional limit deformation, etc

-Ultimate strength is a material property determined during load/deformation testing of a material or component. It is calculated by using the maximum load along the load/deformation plot and dividing this by the nominal cross-sectional area of the specimen measured in a plane perpendicular to the load. It can be determined for various types of loads (compressive, tensile, torsion, or shear). It is useful for determining the maximum load a product can sustain during a single load cycle.

-proportional limit was defined as the stress at which permanent or plastic deformation occurs

-Stress causes deformation, namely, change in shape of a body. Deformation can range from recoverable elastic deformation, to permanent plastic deformation, and to fracture.

14. differences b/w inlays and onlays, what are the indications for each

15. prep type for inlays or onlays

Inlay – 2mm occlusal reduction, convex walls with 10-15 degree taper, rounded corners and 90 degree at gingival margin

Onlay – 1-2 mm occlusal (cuspal) reduction, 90 degree shoulder (not on occlusal contact), rounded corners and convex walls

16. why only have a plaster index of maxillary teeth?: something about preserving facebow transfer (**internet)**

This procedure orients Mx cast in same relations with opening axis of articular as in original facebow transfer

17. lots of VDO and VDR questions

VDO – the vertical dimension of the face when the teeth are in CO

VDR - ‘ ‘‘ ‘ ‘ ‘ ‘ ‘ ‘ ‘ the mandible is in rest position.

18. scaling and root planing questions

- it leaves a smooth, clean, hard polished root surface

- primary treatment for perio inflammation

- it reduces shallow pockets, bacteria.

19.. denture fabrication procedure and steps **(you should know this thru your own clinical experience)**

20. know definitions of cohort study, etc

Mosby pg 210. Cohort Study Prospective: a general population is followed through time to see who develops the disease and then various exposure factors that affect the group are evaluated.Following the group over a period of time the investigator describe the prevalence of outcomes.

Retrospective Cohort: evaluate the effect that a specific exposure has had on a population(occupational hazards) the investigator chooses or defines a sample of subjects who had the outcome of interest.

A cohort is a group of people who share a common characteristic or experience within a defined period (e.g., are born, leave school, lose their job, are exposed to a drug or a vaccine, etc.). Thus a group of people who were born on a day or in a particular period, say 1948, form a birth cohort.

21. cracked tooth symdrome mostly found in which tooth? 1st **Mandibular Molar, First aid 179**

22. most common odontogenic tumor? **Odontoma**

Most common odotogenic cyst-radicular

Most common non-odotogenic cyst- nasoplatine cyst

23.. postinsertion problems for complete dentures and partials

•Denture base

•Occlusion -

–Interferences - esp. protrusive

•Retention

•Vertical dimension

•Allergies and infections

•Tooth position

24.. major syndromes: triad of symptoms...Review Oral Path **NOTES**

Congenital Syphillis Hucthinson's triad (incisors & mulberry molars, ocular interstitial keratitis CN VIII deafness)

Langherhans cell histiocytosis – Chronic form Triad (exopthalmus, diabetes insipidus, lytic bone defects)

Reiters syndrome Triad (nongonococcal urethritis, arthritis, conjunctivitis)

Pierre-robin triad (Mn micrognathia, cleft palate, glosoptosis)

Pernicous anemia triad (weakness, painful tongue, numbness or tingling of extremeties)

Vit B1 def – Wernicke's encephalopathy (vomiting, nystagmus, mental deterioration)

Crouzon Syndrome (Craniofacial Dysostosis) – premature cranial suture closing Brachycephaly-short, scaphocephaly-boat shaped, trigoncephaly- triangle shaped, Beaten Metal, underdeveloped maxilla. Common features are a narrow/high-arched palate, posterior bilateral crossbite, hypodontia (missing some teeth), and crowding of teeth. Due to maxillary hypoplasia, Crouzon patients generally have a considerable permanent underbite and subsequently cannot chew using their incisors. For this reason, Crouzon patients sometimes eat in an unusual way--eating fried chicken with a fork, for example, or breaking off pieces of a sandwich rather than taking a bite in it.

Treacher Collions Syndrome (Mandibulofacial dysostosis) autosomal dominant, hypoplastic zygomas, narrow face with depressed cheeks, downward slanting palpebral fissures, mandible underdeveloped

Apert's Syndrome- autosomal dominant, acrobrachycephaly (tower skull) ocular proptosis, hypertelorism and downward slanting lateral palpebral fissures . known to have some form of syndactyly- fusion of hands etc Common relevant features of acrocephalosyndactyly are

a high-arched palate, pseudomandibular prognathism (appearing as mandibular prognathism), a narrow palate, and crowding of the teeth.

25. opioid differential questions **(dental decks and tufts review)**

Opiod drugs are used for analgesics, antitussives, antidiarrheals, preanesthetic meds

They raise pain threshold and increase pain tolerance

Morphine- very effective for cancer pain (produces resp depression, euphoria, sedation, dysphoria, analgesia, constipation) used for pulmonary edema

Meperidine – more potent than codeine less potent than morphine can cause seizures, tremors, and muscle spasms contraindicated with MAO inhibitors

Methadone – treat heroin withdrawal used in treating opiod addiciton

Pentazocine Mixed agonist antagonist (also nalbuphine)

26. dental materials

27. cholinergic antagonist, agonists...which ones **increase(agonist)/decrease(antagonist) salivation....etc Antagonist Salivary: Decrease salivation significantly (dry mouth)**
http://www.scribd.com/doc/19341469/13-Cholinergic-Antagonists

28. drug scheduling is based on what properties: efficacy, potencey, **dependency**... **dental deck**

1). **Prevalence**

Prevalence: indicates **what proportion of a given population is affected** by a condition at a given point in time. It is expressed as percentage and ranges from 0% to 100%, (e.g., the prevalence of periodontal disease among 100,000 adolescents was 5%).

Prevalence = Number of people with the disease/Total number of people at risk

2) Incidence

Incidence: indicates **the number of new cases** that will occur within a population over a period of time (e.g., the incidence of people dying of oral cancer is 10% per year in men aged 55 to 59 in our community).

Incidence = Number of new cases of the disease/Total number of people at risk

2). Pt. Takes Estrogen pills: it can **decease osteoporosis**, increase chance of cardiovascular disease, increase chance of clots

> Osteopenia and osteoporosis have been associated with the menopausal patient. *Osteopenia* is a reduction in bone mass caused by an imbalance between bone resorption and formation, favoring resorption and resulting in demineralization and osteoporosis. *Osteoporosis* is a disease characterized by low bone mass and fragility and a consequent increase in fracture risk.[95] In most women, peak bone mass occurs between 20 and 30 years of age, then declines. Menopause accelerates declining bone mass.[93] An estimated 25 million Americans have osteoporosis, 80% of whom are female. Ongoing studies are examining the association of postmenopausal primary osteoporosis with mandibular and maxillary bone mineral density, tooth loss, alveolar ridge atrophy, and clinical periodontal attachment loss. **The effects of hormone replacement therapy (HRT) or estrogen replacement therapy (ERT) on the oral bone and tooth loss also are under investigation. Evidence indicates a probable association between osteoporosis and tooth loss as well as alveolar bone loss.**[37,71,80,81]

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 43.5.1).

3). Know all kinds of radiographs to see TMJ (CT, MRI and so on…)

4). Melanoma- malignant lesions of melanocytes found n the skin especially extremities and head and neck region. Oral Melanomas are raire. .Distinguish from nevus using A= asymmetry B=border irregularity C=color D=diameter >6mm and E=evolving.Oral melanomas are located on the hard palate or maxillary gingiva. Brown/black macule w/ irregular boarders. Diffuse spreading results in nodular appearance.

Melanocytic nevus- mole various types intradermal/intramucosal, junctional, compound, blue, spitz

Stafne bone cyst= RL below mandibular canal

gland salivary tumor= Pleomorphic Adenoma is most common benign and Mucoepidermoid Carcinoma is most common malignant.

5). Which test is best to determine reversible/irreversible pulpitis? **Thermal test**

Reversible pulpitis can be clinically distinguished from a symptomatic irreversible pulpitis in two ways:

(1) *Reversible pulpitis* causes a momentary, **painful response to thermal change** that subsides as soon as the stimulus (usually cold) is removed.

However, symptomatic *irreversible pulpitis* causes a **painful response to thermal change that lingers after the stimulus is removed**.

(2) *Reversible pulpitis* does not involve a complaint of spontaneous (unprovoked) pain.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 1.1.1.1).

6). Small fracture (to dentin) of corner of tooth #8 or 9. What needs to be done: enameloplasty or **composite restoration**?

7). Order of TxPl: Perio, OS, Oper, Ortho,

Preliminary or emergency. Hopeless teeth may be extracted in this phase.

2. ***Nonsurgical (phase I therapy).*** The objective of this phase is to alter or eliminate the microbial etiology and contributing factors to periodontal diseases, leading to reduction in inflammation. This is achieved by **caries control** in patients with rampant caries, **removal of calculus**, **correction of defective restorations**, **treatment of carious lesions, and institution of oral hygiene practices**. It also may **include local or systemic antimicrobial therapy, minor orthodontic tooth movement, occlusal therapy, and provisional splinting and prostheses.** The evaluation phase is designed to determine the effectiveness of treatment provided during phase I therapy. It should occur about 4 weeks after the completion of phase I therapy. This permits time for epithelial and connective tissue healing by the formation of a long junctional epithelium.

3. ***Surgical (phase II therapy).*** This phase includes all surgical therapy, including placement of **implants and endodontic therapy**.

4. ***Restorative (phase III therapy).*** This phase includes placement of **final restorations and fixed and removable prosthetic appliances**, evaluation of the response to these restorations, and periodontal examination.

5. ***Maintenance (phase IV therapy)***. Periodontal procedures include **periodic evaluation of oral hygiene status, presence or absence of local factors**, and condition of the periodontium (pocket depths, attachment levels, mobility, occlusion). *This phase actually should begin after the completion of phase II therapy.*

B. Risk factors, determinants, indicators, and markers for periodontal disease

8). Pedo radiolucency in furcation, what to do? Extraction

In primary teeth, any **radiolucency associated with a nonvital tooth is usually located in the furcation area, not at the apices.** This is because of the presence of accessory canals on the pulpal floor area. Thus, a bitewing film is frequently a useful diagnostic aid, particularly in maxillary molars where the developing premolar obscures the furca in a periapical radiograph.

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition.* Mosby, 042005. 22.2.3).

9). Adult – furcation, what to do? 1). **Hemisection** 2). RCT

Hemisection is most likely to be performed on mandibular molars with buccal and lingual class II or III furcation involvements. As with root resection, molars with advanced bone loss in the interproximal and interradicular zones are not good candidates for hemisection

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 68.6.2).

10). Pulp cap, how much we need to put Ca(OH)2 0.5mm

> Calcium hydroxide liners may provide some thermal insulation to the pulp if used in sufficiently thick layers. **A thickness greater than 0.5 mm is not suggested**. Practically, thermal protection should be provided by the overlying high-strength base or composite restoration.

(Powers, John M. Powers. *Craig's Restorative Dental Materials, 12th Edition*. C.V. Mosby, 022006. 20.7.3.1).

11). Know Apexogenesis/- vital immature tooth used MDTA. The process fof maintaining pulp vitality during pulp treatment to allow continued development of the entire root.

Apexification- non vital immature tooth. Use CaOH2 . ita s method to stimulate the formation of calcified tissue at the open apex of pulples teeth /

Pulpotomy- removal of coronal portion of vital pulp to preserve the vitality of remaining radicular pulp. Performed in pedo patients. Or traumatic exposures after 72 hrs/

Pulpectomy- non vital tooth. Removal of coronal and radicular pulp tissue. Temporay pain relief on teeth with irreversible pulpitis unti nonsurgical endo can be preformed

MOSBY PG 26

12). Dry socket. What is a reason? Not enough blood, **blood-clot fall down**…

> The cause of alveolar osteitis is not absolutely clear, but it appears to result from high levels of fibrinolytic activity in and around the tooth extraction socket. **This fibrinolytic activity results in lysis of the blood clot and subsequent exposure of the bone**.
>
> In the usual clinical course, pain **develops on the third or fourth day after removal of the tooth**. **Almost all dry sockets occur after the removal of lower molars**. On examination the **tooth socket appears to be empty, with a partially or completely lost blood clot, and some bony surfaces of the socket are exposed**. The exposed bone is sensitive and is the source of the pain.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 11.9.3).

13). Petit seizure – Ethosuximide (Zarontin), valproate, lamotrigine, or clonazepam.

Idiopathic seizure disorders are exhibited in many ways, ranging from grand mal seizures, with their frightening display of clonic contortions of the trunk and extremities, to petit mal seizures that may occur with only episodic absences (e.g., blank stare).

Drugs of choice for absence (petit mal) seizures: Ethosuximide (Zarontin), valproate, lamotrigine, or clonazepam.

Drugs of choice for status epilepticus: Lorazepam 4 to 8 mg, or diazepam 10 mg, intravenously.

(Little, James W.. *Dental Management of the Medically Compromised Patient, 7th Edition*. Mosby, 072007. 27.1.4).

14). Be able to separate: Chronic periodontitis/ Supparative chronic periodontitis mosby pg 4

Chronic periradicular periodontitis

a. Chronic periradicular periodontitis is a long-standing, asymptomatic, or mildly symptomatic lesion.

b. It is usually accompanied by radiographically visible apical bone resorption.

c. Bacteria and their endotoxins cascading out into the periradicular region from a necrotic pulp cause extensive demineralization of cancellous and cortical bone.

d. Occasionally, there may be slight tenderness to percussion and/or palpation testing.

e. The diagnosis of chronic apical periodontitis is confirmed by:

(1) **The general absence of symptoms**.

(2) **The radiographic presence of a periradicular radiolucency**.

(3) **The confirmation of pulpal necrosis**.

f. A totally necrotic pulp provides a safe harbor for the primarily anaerobic microorganisms—if there is no vascularity, there are no defense cells.

g. Chronic periradicular periodontitis traditionally has been classified histologically as periradicular granuloma or periradicular cyst. The only accurate way to distinguish them is by histopathological examination.

4. **<u>Suppurative periradicular periodontitis (chronic periradicular abscess)</u>**

a. **It is associated with either a continuously or intermittently draining sinus tract without discomfort.**

b. **The exudate can also drain through the gingival sulcus, mimicking a periodontal lesion with a "pocket."**

c. Pulp tests are negative because of the presence of necrotic pulp.

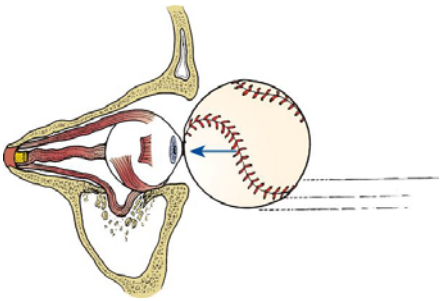
d. Radiographic examination of these lesions shows the presence of bone loss at the periradicular area.

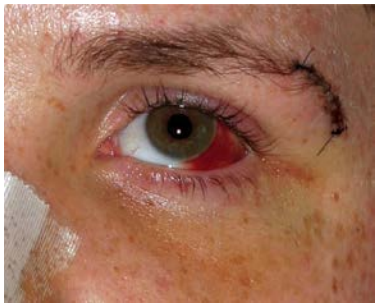
e. Treatment: these sinus tracts resolve spontaneously with nonsurgical endodontic treatment.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 1.1.1.2).

15). Blow out fracture:

Blunt trauma to the eye can result in compression of the globe and subsequent blow-out facture of the orbital floor. The zygomatic arch may also be affected, alone or in combination with other injuries





Blunt-force trauma from a baseball, causing an **orbital floor blow-out fracture**, with bony fragments and orbital contents sagging into the maxillary sinus below.
Periorbital ecchymosis, especially with subconjunctival hemorrhage, is often indicative of orbital rim or zygomatic complex fractures

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 24.1.2).

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 24.3).

16). Calculate half-life of drugs

Equations:

a. $k_e \times t_{1/2} = 0.693$,

where k = the first-order rate constant and $t_{1/2}$ = the half-time.

b. $D = Cp_0 \times Vd$,

where D is the drug dose (single dose), Cp_0 is the plasma concentration at zero time, and Vd is the apparent volume of distribution.

c. $Cl = k_e \times Vd$,

where k_e is the first-order rate constant of elimination, Cl is the clearance, and Vd is the apparent volume of distribution.

d. $t_{1/2} = 0.693 \times Vd/Cl$,

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 8.2.3).

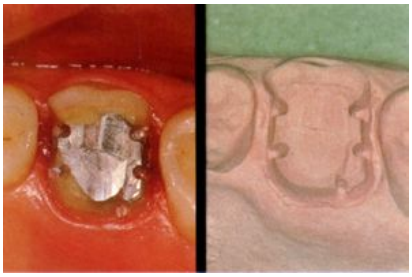
17). Best result is when “short from apex”(0.5-1mm from apex and fill same length) or “at apex”

Working length is established, *slightly short of the radiographic apex*. Instrumentation beyond the apex is not advocated as it may damage the tissue that will ultimately form the barrier.

The objective is to establish the length (distance from the apex) at which canal preparation and subsequent obturation are to be completed. **Optimal length is 1 to 2 mm short of the apex**, although this may vary slightly with different diagnoses.[26] **Procedures may be terminated 0 to 2 mm from the apex if the pulp is necrotic and 0 to 3 mm if the pulp is vital**.

(Walton, Richard E.. *Principles and Practice of Endodontics, 3rd Edition*. Saunders Book Company, 012002. 12.3).

18). If crown-prep is too short, how to prevent rotation – need grove for retention. Where to place it?



A three-quarter crown was used to restore this maxillary first molar after completion of endodontic treatment and placement of an amalgam core *(left)*. Because the tooth had a short clinical crown, multiple grooves were used to enhance retention and resistance. These can be seen in greater detail on the stone cast of the prepared tooth *(right)*.

(Shillingburg, Herbert T.. *Fundamentals of Tooth Preparation: For Cast Metal and Porcelain Restorations*. Quintessence Publishing (IL), 011987. 5.2).

20). If we need to do a bridge and opposing is one tooth is super-erupted. What to do?

Place a crown if >=2mm of supereruption present

> If supraeruption is relatively minor, the occlusal plane may be corrected by carefully recontouring the surfaces of the teeth. If moderate supraeruption has occurred, correction of the occlusal plane may require the placement of cast restorations such as onlays or crowns. If supraeruption is extreme, extraction of the offending teeth may be the only logical solution.

(Phoenix, Rodney D.. *Stewart's Clinical Removable Partial Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 012003. 9).

21). Occlusual caries and Proximal differ?

Occlusal First has it's apex is to the surface, it's base is on DEJ. Second base is on DEJ apex is to the pulp

Proximal First triangle – base is o the surface of tooth, apex is toward DEJ, Second is same- base is on DEJ and apex is toward pulp.

22). Some drug was left for a week, what left was a water /H2O. What drug originaly was left?
Hydrogen Peroxide /H2O2

23). Be able to differentiate on radiograph OKC and dentigerous cyst. Mosby pg 117

Dentigerous cyst is associaled with a RL around crown of impacted tooth. Called eruption cyst if lesion occurs over tooth that has erupted into submucosa. Epithelial lining from reduced enamel epithelium has potential to transform into ameloblastoma. O

OKC- lesions may be CCL aggressive and associated ith Nevoid basal cell carcinoma syndrome/Gorlin Glotz Syndrome (multiple OKC, numerous basal cell carcinoma, skeletal abnormalities frontal bossing, bifid ribs, shortened metacarpals, calcified falx) Lining epithelium is thin and parkeratinized.Epithelium source is rests of dental lamina and tooth vitality Orthokeratinized OKC has lower recurrence rate and is not syndrome associated

24). Be able to identify Verucous carcinoma: smokeless tobacco Mosby pg 111 it is associated with HPV types 16 & 18. Cauliflower appearance.

25). If patient has a cleft lip + palate, what he may have:

Class II malocclusion or Mandibular Retrognatia or **class III?**

26). All kinds of Antibiotics questions

27). Drug against Xerostomia – Pilocarpine and Cevimeline stimulate salivary flow moby pg 279

> **Pilocarpine HCl and cevimeline HCl** are the only systemic sialagogues that are available in the United States.

(Greenberg, Martin S.. *Burket's Oral Medicine: Diagnosis and Treatment, 10th Edition*. B.C. Decker, 012003. 9.4.3.2).

28). Redistribution – short duration of action after a short administration

29). When does a maxillary torus needs a surgery? If it prevocates hyperplasia, potential for malignancy problems, if it interfere with denture?

30). Forcep for maxillary #151, for extraction – is it good? No, 150max/151mand

31). On xray radiographs you see bone loss, reason is overhang restoration harbors plaque

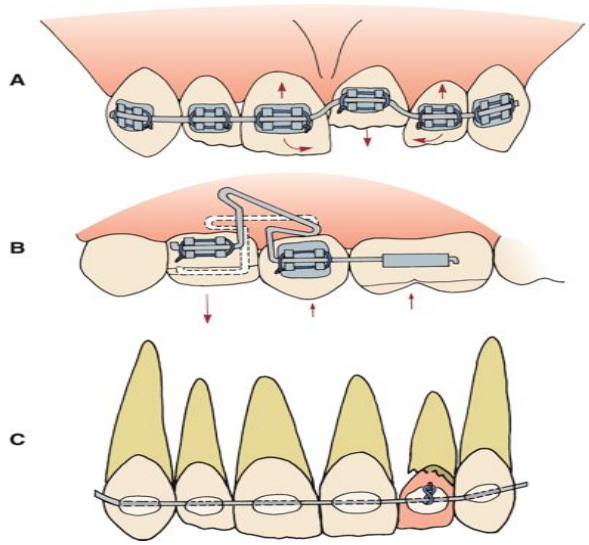
32). To choose which reason is most affecting future prognosis Alcohol or **Smoking**?

33). On xray radiographs you can see patient lost enamel. He has gout disease. What question is appropriate? Do you eat a lot of sugar? Did you drink a lot of beer? Are you working on acid producing factory?

- Drinking 7 or more ounces of spirits a week -- roughly five drinks -- doubled the gout risk in men and tripled it in women. Heavy beer drinking was associated with a doubling of risk among men and a sevenfold increase in risk among women.

Beer contains high levels of the chemical purine, which breaks down into uric acid in the body. But it is not clear why beer drinking would pose a higher gout risk for women than for men.

35). Pedo patient needs extrution of #8 Does he needs a Nance band-loop, t-loop, fixed appliance?



A, Although a **straight orthodontic wire** activated apically will produce an extrusive force on a tooth, it will also cause the teeth on either side to tip toward each other, reducing the space available for the extruding tooth. **B, A modified T-loop in a**

rectangular wire (17 × 25 steel in 18 slot brackets, 19 × 25 beta-Ti in 22 slot) will extrude a tooth while controlling mesio-distal tipping. **C,** Extrusion also can be done without conventional orthodontic attachments, by bonding a 19 × 25 steel stabilizing wire directly to the facial surface of adjacent teeth. An elastomeric module is stretched between the stabilizing wire and a pin placed directly into the crown of the tooth to be extruded. If a temporary crown is used for better esthetics while the extrusion is being done, it must be progressively cut away to make the tooth movement possible. (**C,** courtesy Dr. L. Osterle.)

(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 18.5.3.2).

36). To know Eruption of Permanent dentition table

37). Diabetes patient has a shock during procedure. Should you give him a drink of carbonate water (sugar)

38). You are given a PAN with wide black stripe (almost a third of PAN) on your Right and on you right side you can see a spine of patient. Middle of PAN is normal. How can you describe defect / error of PAN? Is it an open mouth? Was film too long in developer or fixer? Was the door open during development? Was mashine stucked during PAN rotation (upon pt's shoulder)?

39). Patient is on Warfarin. You need to do extraction. What should you do: tell pt to stop taking drug a week before extraction? **A 3 days before extraction** ? A month before extraction?

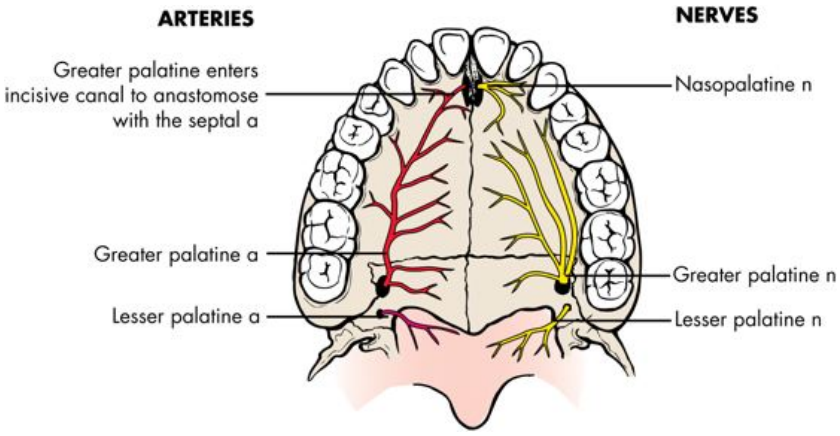
Patients requiring warfarin for anticoagulation but who also need elective oral surgery benefit from close cooperation between the patient's physician and dentist. **Warfarin has a 2- to 3-day delay in the onset of action**; therefore, alterations of warfarin anticoagulant effects appear several days after the dose is changed. **The INR is used to gauge the anticoagulant action of warfarin**. Most physicians will allow the INR to drop to about 2.0 during the perioperative period, which usually allows sufficient coagulation for safe surgery. **Patients should stop taking warfarin 2 or 3 days before the planned surgery. On the morning of surgery, the INR value should be checked; if it is between 2 and 3 INR, routine oral surgery can be performed. If the PT is still greater than 3 INR, surgery should be delayed until the PT approaches 3 INR**. Surgical wounds should be dressed with thrombogenic substances, and the patient should be given instruction in promoting clot retention. Warfarin therapy can be resumed the day of surgery.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 1.3.6.2).

40). What test needed to be checked for Warfarin/Caumadin? INR or bleeding time?

The **INR** is used to gauge the anticoagulant action of warfarin.

42). What nerve is inervating a soft palate? Lesser palatine nerve (V2)



(Malamed, Stanley. *Handbook of Local Anesthesia, 5th Edition*. Mosby, 072004. 12.1.2.2.2.2).

The **lesser palatine nerve** (**posterior palatine nerve**) descends through the pterygopalatine canal, and emerges by the lesser palatine foramen. It also has nasal branches that innervate the nasal cavity. It supplies the soft palate, tonsil, and uvula

43). Patient is in your office with infection/inflammation on nose, cheek, eye. You must t identify infection – is it Odontogenic or not?

44). Need to be able to count some coefficient from Ortho Upper 4 Incisors = 34mm, lower 4 Incisors = 28mm … count… (with numbers I'm not sure ☺)))

Moyers Analysis: measure the mand. incisors to predict the max & mand canines and premolars

	LEFT	INCISORS	RIGHT
Space available	20.1	19.8	19.5
Tooth size		23.0	
Difference		−3.2	

(1) Measure mesial-distal diameter of the mandibular incisors and sum.

(2) Measure the space available for mandibular incisors.

(3) Subtract (1) from (2); a negative number indicates crowding in the incisor region.

(4) In the example, there is 3.2 mm of crowding in the anterior region.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 5.2.9).

45). About Nitrous everything – it's not explosive, metabolized where in body? Is it in lung? It is not metabolized. Per Dr. Williams notes: Nitrous is an inorganic gas, colorless,nonirritating to respiratory mucosa, faintly sweet odor, not metabolized in body and is excreted unchanged through the lungs. Elimination of nitrous oxie is through the alveoli. Primary satuation of blood and brain is 3-5 minutes.

46). To know Cross-Sectional- study in which the health conditions in a goup of people who are or are assumed to be a sample of particular population is assessed at one time.

Case Control- study people with a condition (cases) are compared with people without but are similar in characterisitic s Mosby pg 210…

47). Uncooperative pedo patient what to do/to use: Modeling/Voice control/Refer to pediatric dentist; in case of emergency can do physical restraint if the pt is physical and cry accessively

48). Patient doesn't like a bridge 7,8,9,10 (it looks very good for me☺) What's wrong with it: **Value**/Chroma/Hue/Translucensy?

49). What can tricyclic depression drugs NOT DO: immediate relieve from depression…

50). From Asthma - epinephrine(epi can be use but it is better to use a Beta 2 blocker like albuterol because it has less cardiovascular effect) or can use theophylline

51). Is N2O is absolute contraindication for Asthma or for Angina: **No it's indicated for both Per Dr. Williams notes. Indications: anxiety, cardiovascular disease, respiratory disease (asthma) hepatic disease (not metabolized), epilepsy and seizure disorders allergy diabetes, and gagging (it helps with gag reflex to some extent.**

CONRAINDICATIONS: pregnancy. Compulsive personality, claustrophic patients, child with severe behavioral problems-bc cant get them to cooperate, severe personality disorders, upper respiratory tract infections (COPD)

Inhalation sedation (N2O2) is the most recommeneded sedative technique for both adult and pediatric asthmatic patients. Its sedative properties and additional oxygen administration is enough to prevent an asthmatic attack. (P.561 sedation book)

Angina patients have a discrepancy between myocardial oxygen demands and oxygen delivery in the coronaries artery. Therefore, nitrous oxide is especially indicated in these patients because you want to minimize stress and increase oxygenation (p.552 sedation book)

If patient has Angina have **Nitroglycerine and Oxygen ready/available**

52). Carpules calculation for LA for patient, by weight (kid 55lb/25kg) of 2% lidocaine, 3% meto…, 4%...for Lidocaine: 2mg/lb or 4.4mg/kg max is 300mg

53). Ethics…

54). Kid has a diastema. We can't predict if it'll close of if he will have crowding before Canine eruption – if it is 2mm btw 8 and 9 it will most likely close if more maybe not

55). How epinephrine work by which receptors: Alpha1/2 /Beta1/2 / Muscarinic?epinphrine is a nonselective agonist of all adrenergic receptors, including α_1, α_2 , β_1, β_2, and β_3 receptors.

56). For implant to know absolute Minimal space 4mm or between 0.5mm?between implant 3mm; implant and tooth 1mm;

Structure	Minimum Required Distance Between Implant and Indicated Structure
Buccal plate	1 mm
Lingual plate	1 mm
Maxillary sinus	1 mm
Nasal cavity	1 mm
Incisive canal	Avoid midline maxilla
Interimplant distance	3 mm between outer edge of implants
Inferior alveolar canal	2 mm from superior aspect of bony canal
Mental nerve	5 mm from anterior of bony foramen
Inferior border	1 mm
Adjacent natural tooth	1 mm

57). Candidas, what test do we need, what drug…do **cytology smear** and use nystatin,mycelex or sys:fluconazole

58). Kid is very skinny, thin, pale, long nails what is disease ?

59). Radiographs was too light/dark what should be change to fix it? Mosby pg 132 Increase/decrease kVp Note light radiographs is due to insufficient mA, kVp, time, film packet revered in mouth, or too great of distance of film-source. Dark Radiographs is excessive mA, kVp, time, and too short film to source distance.

60). You can see PAN with impacted 3rd molars. What should be done: who must to do extraction you or Oral Surgery specialist? If it's you how to do it - left side first visit, right side next or 2 Upper first then 2 lowers next? With General or Local Anesthesia?

61). Picture of tongue with blue bump on it… I put Varicosity or it was other name…hemangioma

62). Patient has Amoxicillin for some other old infection… He has some cardiac problem (don't remember) and needs extractions. What to prescribe for antibiotic prophilaxis – Amoxicillin +

Clindamicen? Or more/add to old dose of Amoxicillin? I put don't change anything, I thought he doesn't need prophilaxis for that kind cardiac problems.

If a patient is already receiving long-term antibiotic therapy with an antibiotic that is also recommended for IE prophylaxis for a dental procedure, it is prudent to select an antibiotic from a different class rather than to increase the dosage of the current antibiotic (according to American heart association new guidelines)

63). Coefficient LD50 know definitions LD50 - to 50% of the people that take the medication it is lethal. TD = LD50/ED50 higher TD is better

64). In order to do etching we need to use acids in patient's mouth. Which acid is harmless for patient: Phosphoric acid or some other names… don't remember. I choose Phosphoric acid 30-40% because we using it every day (it's just my guess)

65). Know treatment order in TxPl: Cleaning, Extractions, Operative, fixed,removable…

1. *Preliminary or emergency.* Hopeless teeth may be extracted in this phase.

2. *Nonsurgical (phase I therapy).* The objective of this phase is to alter or eliminate the microbial etiology and contributing factors to periodontal diseases, leading to reduction in inflammation. This is achieved by caries control in patients with rampant caries, removal of calculus, correction of defective restorations, treatment of carious lesions, and institution of oral hygiene practices. It also may include local or systemic antimicrobial therapy, minor orthodontic tooth movement, occlusal therapy, and provisional splinting and prostheses. The evaluation phase is designed to determine the effectiveness of treatment provided during phase I therapy. It should occur about 4 weeks after the completion of phase I therapy. This permits time for epithelial and connective tissue healing by the formation of a long junctional epithelium.

3. *Surgical (phase II therapy).* This phase includes all surgical therapy, including placement of implants and endodontic therapy.

4. *Restorative (phase III therapy).* This phase includes placement of final restorations and fixed and removable prosthetic appliances, evaluation of the response to these restorations, and periodontal examination.

5. *Maintenance (phase IV therapy).* Periodontal procedures include periodic evaluation of oral hygiene status, presence or absence of local factors, and condition of the periodontium (pocket depths, attachment levels, mobility, occlusion). This phase actually should begin after the completion of phase II therapy.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 7.5).

66). Everything is INITIAL Perio treatment Except: OHI / Calculus Scaling / Root Surface Planing / Antibiotic

> *Nonsurgical (phase I therapy). The objective of this phase is to alter or eliminate the microbial etiology and contributing factors to periodontal diseases, leading to reduction in inflammation*. This is achieved by caries **control in patients with rampant caries**, **removal of calculus**, **correction of defective restorations**, **treatment of carious lesions**, and **institution of oral hygiene practices**. It also **may include local or systemic antimicrobial therapy**, **minor orthodontic tooth movement**, **occlusal therapy**, and **provisional splinting and prostheses**. The evaluation phase is designed to determine the effectiveness of treatment provided during phase I therapy. It should occur about 4 weeks after the completion of phase I therapy. This permits time for epithelial and connective tissue healing by the formation of a long junctional epithelium.

67). The tooth must to be used as an abutment. What restoration will you choose: amalgam,3/4 crown, full-crown? I put **full-crown**…

68). Out of all selections water- irrigation is always the weakest/less efficient

69). Patient is very old, treatment cost a lot for him… we still can't make a decision for him

70). What do we call combination perio-endo case: when patient needs RCT and perio scaling (combination of both infections) do RCT first

71). LA esters/amines remember each group, their property

1). Longituginal study

> A longitudinal study involves the follow-up of the initial baseline respondents at a later date. The longer the follow-up from baseline the more likely that respondents will be lost to the study (through mobility away from the study area) and interpretation becomes more difficult. An important check is to determine who is lost to the study on follow-up, and an analysis is then conducted that shows whether the people lost to the study are different from those who are successfully followed-up. The importance of attempting longitudinal studies should not be underestimated as they do make possible firmer interpretations of causality not possible with cross-sectional designs. To illustrate with an example: if children are exposed to a traumatic first dental visit and these children are subsequently found to exhibit higher levels of disruptive behaviour in the dental surgery, then this finding would be more meaningful to understanding how experiences might cause behavioural difficulties than if the study was cross-sectional with the variable, traumatic experience and behavioural problems associated strongly at the same point in time. The cross-sectional interpretation of the results could be that the disruptive child causes the dentist to resort to management strategies that become coercive and result in a traumatic experience for the child. The cross-sectional approach therefore may produce equivocal results that encourage researchers to embark on the more ambitious longitudinal studies.

(Humphris, Gerry. *Behavioural Sciences for Dentistry*. Churchill Livingstone, 022000. 13.4).

2). Case control

Case control study: people with a condition ("cases") are compared with people without it ("controls") but who are similar in other characteristics. Hypothesized causal exposures are then sought in the past medical records of the participants. If the researchers had chosen to conduct a case control study to explore the same hypothesis, subjects would have been split into two groups— those with oral cancer and those without it, based on examinations. To search for an association with alcohol drinking, a history before the occurrence of oral cancer would be sought (e.g., through past medical records). Thus, the case control study could establish a temporal relationship between the exposure and disease of interest, in this case a history of alcohol drinking before the appearance of oral cancer.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

3). T-test

t-test: the *t*-test is used to analyze the statistical difference between two means. It provides the researcher with the statistical difference between treatment and control groups or groups receiving treatment A versus treatment B.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

4). Chi 2 test

Chi-square (χ^2) test: the chi-square test measures the association between two categorical variables. It is used for the comparison of groups when the data are expressed as counts or proportions. For example, an investigator might wish to compare the proportion of caries-free children living in a district whose water supply is fluoridated to the proportion of caries-free children living in a nonfluoridated district. In each district, the investigator would count the number of caries-free and noncaries-free children. The research question involves two categorical variables: caries status of the child (caries-free or not) and fluoridation status of the district (yes or no)

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

5). Retrostudy Cohort test

Retrospective cohort study: used to evaluate the effect that a specific exposure has had on a population (e.g., occupational hazards). The investigator chooses or defines a sample of subjects who had the outcome of interest. He measures risk factors in each subject that may have predicted the subsequent outcome.

Prospective Cohort Test:

A a general population is followed through time to see who develops the diseae and then the various exposure factors that affect the goupr are evaluated

7). CAL (clinical attachment lost) = probing depth + recession

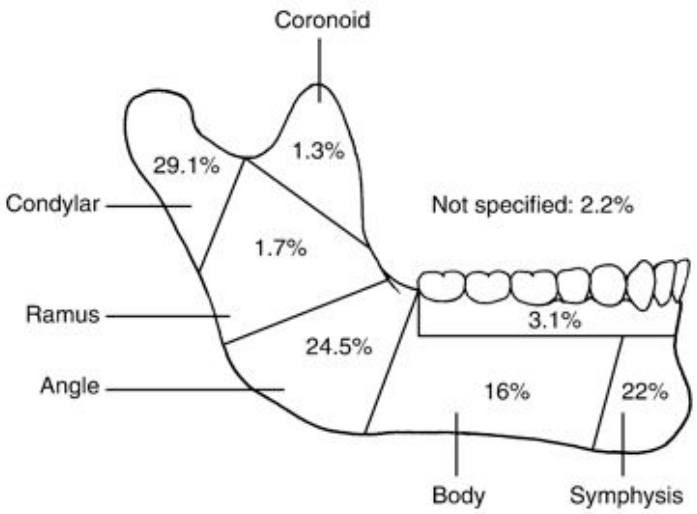
Width of keratinized gingiva = free gingival marghin to the mucogingival junction

Probind Depth= free gingiva margin to base of the pocket

8). Recession = space between CEJ and free gingival margin

9). Polyether – hardest, stiffer, more rigid

10). Fractures, most common location**… (condyle**)



condyle>angle>symphisis>body>ramus>coronoid

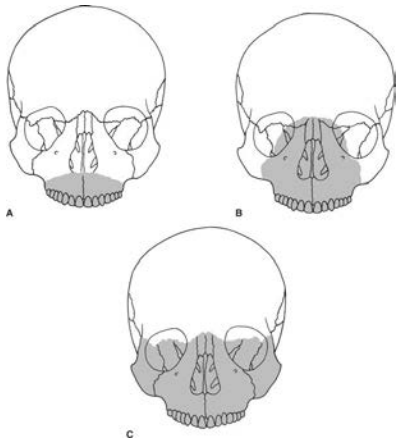
(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 3.1.3).

11). Osteotomy, La Fort 1, move head mandible

Maxillary surgery. Maxillary surgeries are referred to as **LeFort I osteotomies. The maxilla can be moved forward and down more easily than it can be moved up or back.** It can also be segmented into two or three pieces to better position the occlusion.

2. *Mandibular surgery.* Mandibular surgery is most often done using one of two osteotomies: bilateral

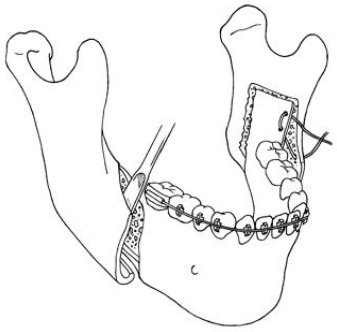
Figure 3-3.



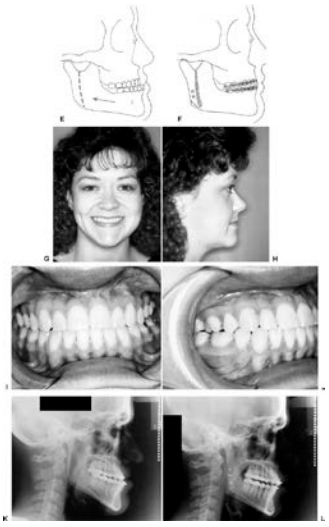
LeFort midfacial fractures. A, LeFort I fracture separating inferior portion of maxilla in horizontal fashion, extending from piriform aperture of nose to pterygoid maxillary suture area. **B,** LeFort II fracture involving separation of maxilla and nasal complex from cranial base, zygomatic orbital rim area, and pterygoid maxillary suture area. **C,** LeFort III fracture (i.e., craniofacial separation) is complete separation of midface at level of naso-orbital-ethmoid complex and zygomaticofrontal suture area. Fracture also extends through orbits bilaterally. (From Peterson LJ, Ellis E, Hupp JR, Tucker MR: *Contemporary Oral and Maxillofacial Surgery*, ed 4, Mosby, St Louis, 2003.)

sagittal split osteotomy (Fig. 3-6), or **vertical ramus osteotomy** (Fig. 3-7). **The mandible can be moved anteriorly to correct a retrognathia, or posteriorly to correct a prognathism. In addition, the chin can be moved using a genial osteotomy (genioplasty) to correct macrogenia or microgenia.**

Sagittal split osteotomy

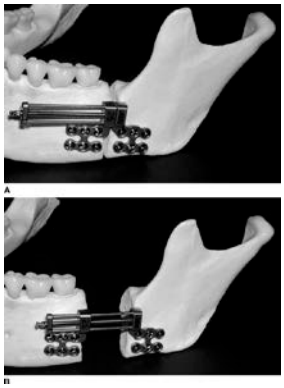


Vertical split osteotomy



3. *Distraction osteogenesis* (DO). Distraction osteogenesis has provided oral and maxillofacial surgeons much greater flexibility in treating difficult deformities of the facial skeleton. **Patients with deformities such as cleft lip and palate and hemifacial**

microsomia have previously required difficult surgeries. DO involves cutting an osteotomy to separate segments of bone and the application of an appliance that will facilitate the gradual and incremental separation of bone segments.



(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 3.1.4).

12). Anesthesia

13). LA ester(plasma-blood)/amide(liver). What is cross-allergic to ester?

Pt. couldn't take ester

Hypersensitivity to the ester-type local anesthetics is much more frequent: procaine, propoxycaine, benzocaine, tetracaine, and related compounds such as procaine penicillin G and procainamide.

Amide-type local anesthetics are essentially free of this risk. However, reports from the literature and from medical history questionnaires indicate that *alleged* allergy to amide drugs appears to be increasing, despite the fact that subsequent evaluation of these reports usually finds them describing cases of overdose, idiosyncrasy, or psychogenic reactions.[59,60] **Allergy to one amide local anesthetic does not preclude the use of other amides because cross-allergenicity does not occur**.[61] **With ester-type local anesthetic allergy, however, cross-allergenicity does occur; thus all ester-type local anesthetics are contraindicated with a documented history of ester allergy.**[61]

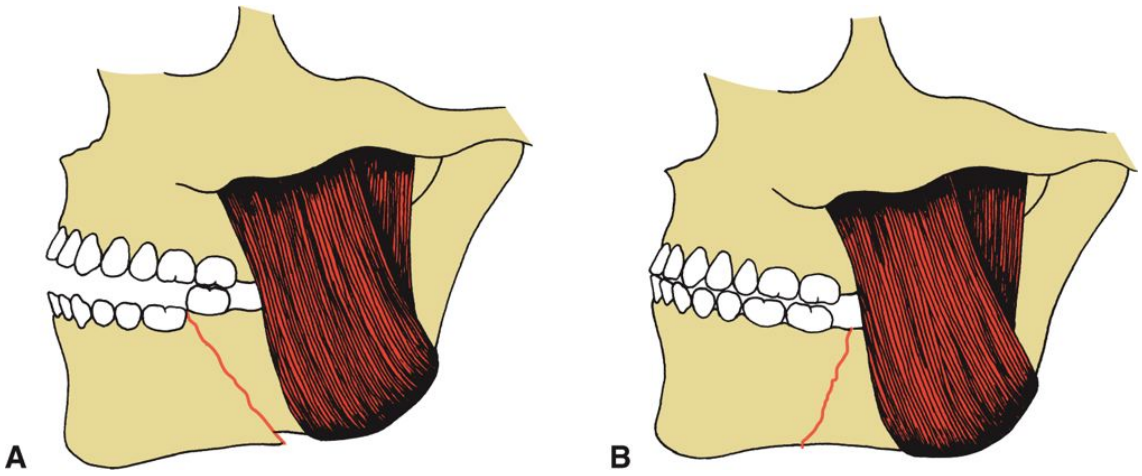
Allergic reactions have been documented for the various contents of the dental cartridge.. **Of special interest with regard to allergy is the bacteriostatic agent *methylparaben*. The parabens (methyl, ethyl, and propyl) are included, as bacteriostatic agents, in all multiuse drugs, cosmetics, and some foods.**

(Malamed, Stanley. *Handbook of Local Anesthesia, 5th Edition*. Mosby, 072004. 18.3.1).

14). Angle Fracture Favorable: **masseter**/digastrics/hyoid…

Fractures of the mandible are referred to as ***favorable*** **or** ***unfavorable*****, depending on the angulation of the fracture and the force of the muscle pull proximal and distal to the fracture. In a favorable fracture, the fracture line and the muscle pull resist displacement of the fracture** (Fig. 24-13). **In an unfavorable fracture, the muscle pull results in displacement of the fractured segments.**

FIGURE 24-13



Favorable and unfavorable fractures of mandible. **A**, **Unfavorable fractures resulting in displacement at fracture site caused by pull of masseter muscle**. **B**, **Favorable fracture in which direction of fracture and angulation of muscle pull resists displacement.**

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 24.2.2).

15). Horizontal apical fracture, no symptoms – **splint and observe (no extraction)**

16). Pulpotomy/pulpectomy

Pulpotomy procedures Mosby pg 187

Indications

- When the pulp is reversibly and minimally inflamed.
- Where the marginal ridge is already destroyed in first primary molars
- Where radiographic evidence of caries extends more than two-thirds in depth through the dentine.

- If there is any doubt as to whether or not the pulp has been exposed (mechanical or carious) .

In all other situations, where there is irreversible pulpitis or there is pulpal necrosis, a pulpectomy or extraction should be performed.

Medicaments used (formocresol- 5 minute application or cotton pellet, ferric sulfate or mineral trioxide aggregate (MTA)

Success rate

- **Formocresol 90–98%.**
- Calcium hydroxide 60%.

Pulpectomy procedures

Where there is irreversible pulpitis, or there is pulpal necrosis, a pulpectomy or extraction should be performed. Pulpectomy carries a success rate of 67–80%.

Indications

- Evidence of pulpal necrosis.
- Hyperaemic pulp. The most common presentation of a hyperaemic pulp is persistent bleeding during a pulpotomy procedure. In this case, the radicular pulp should be removed and a pulpectomy performed instead.
- Evidence of furcation or periapical involvement on radiographs.
- Spontaneous pain (unstimulated pain). It must be remembered, however, that not all the pulpal tissue may be necrotic and that such a tooth can still be painful when attempting to remove the remaining pulp.
- Buccal or extra-oral swelling and increased mobility.

(Cameron, Angus C.. *Handbook of Pediatric Dentistry*, *2nd Edition*. Mosby Ltd., 062003. 4.7).

Filling methods: 1.) pressure syringe using a paper point or file and coat the walls of the canals with creamy mix of zince oxide eugenol and build up.

Decision making tree for pulp therapy on primary molars: Mosby pg 187-188

1.) Furcation -→ NO--→ Pulpotomy

a. Yes-→ 1st Primary Molar---→EXTRACTION due to the difficulty of adequately removing diseased pulp tissue

b. Not a 1st Molar--→ is it restorable--→ can a SSC appropriately sit on tooth?

c. Not a 1st Molar----→ non-restorable--→ EXTRACTION

d. Not a 1st Molar→Restorable--→ Root Resorption-→EXTRACTION and EXCEPTION TO THIS RULE IS IF THE TOOTH IS LOCATED STRATEGICALLY like if it there to mantian space unil 1st perm molar comes in→ pulp treatment, once the perm molar comes In then extraction and do space maintainer

e. Not a 1st Molar-→ Restorable-→ NO ROOT RESORPTION-→Pulpectomy

Treatment options for primary teeth

Clinical event	Signs or symptoms	Pulpal status	Treatment choice
Caries without exposure	No spontaneous symptoms	Healthy	Restore tooth
Caries with possible or near exposure	Occasional pain on stimulation	Minimal or reversible pulpitis	Pulpotomy
Iatrogenic/non-carious exposure	Asymptomatic	Healthy	Pulpotomy
Carious exposure	Minimal history of pain No mobility No radiographic evidence of pathology	Reversible pulpitis	Pulpotomy
Carious exposure	Spontaneous pain Swelling Mobility	Irreversible pulpitis	Pulpectomy Intermediate dressing Extraction
Carious exposure	Draining sinus Swelling Mobility Radiographic pathology (inter-radicular or periapical root resorption)	Necrotic pulp	Pulpectomy Intermediate dressing Extraction
Gross caries	Caries through bifurcation Extensive root resorption Tooth unrestorable Extensive periapical pathology	Necrotic pulp	Extraction

(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 4.8.4).

17). Apexogenesis – Vital, immature, root open use MDTA

18). Apexofication – Non-Vital, same root open, create a barrier HTA/Ca(OH)2

Apexification

1. **Apexification is *not* vital pulp therapy because the tooth is pulpless**.
2. Definition

a. A method to stimulate the formation of calcified tissue at the open apex of pulpless teeth.

b. Creation of the proper environment for formation of the calcified barrier involves cleaning and removal of debris and bacteria, as well as placement of a material to induce apical closure.

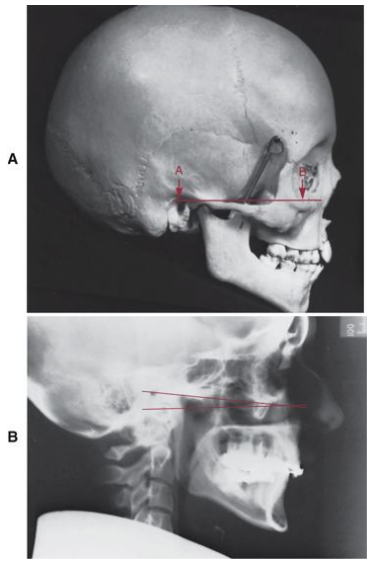
3. Indication

a. For teeth with open apices in which standard instrumentation techniques cannot create an apical stop to facilitate effective obturation of the canal.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 1.5.2).

19). Franfort horizontal – line orbitale portion to ear on PAN

A, The Frankfort plane as originally described for orientation of dried skulls. **This plane extends from the upper border of the external auditory canal *(A) (porion)* anteriorly to the upper border of the lower orbital rim *(orbitale)* .**



(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 6.5.2.2.1).

20). for ORTHO know SNA 82 +/- 2, SNB 78 +/- 2, ANB

In the Steiner analysis, the first measurement is the angle **SNA, which is designed to evaluate the anteroposterior position of the maxilla relative to the anterior cranial base** (Figure 6–50). **The "norm" for SNA is 82 ± 2 degrees**. *Thus if a patient's SNA were greater than 84 degrees, this would be interpreted as maxillary protrusion, while SNA values of less than 80 degrees would be interpreted as maxillary retrusion.* Similarly, **the angle SNB is used to evaluate the anteroposterior position of the**

mandible, for which the norm is 78 ± 2 degrees. This interpretation is valid only if the SN plane is normally inclined to the true horizontal (or if the value is corrected as described above) and the position of N is normal.

FIGURE 6–49 If the cephalometric film is taken with the patient in natural head position (NHP), a line perpendicular to the true vertical (shown by the image of the freely-suspended chain that is seen on the edge of the film) is the true (physiologic) horizontal line. NHP is preferred in modern cephalometrics to anatomic head positioning.

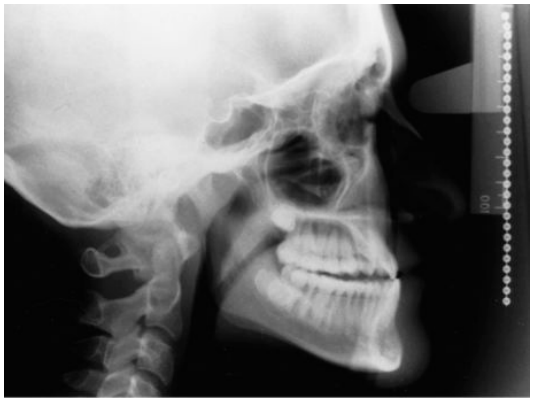
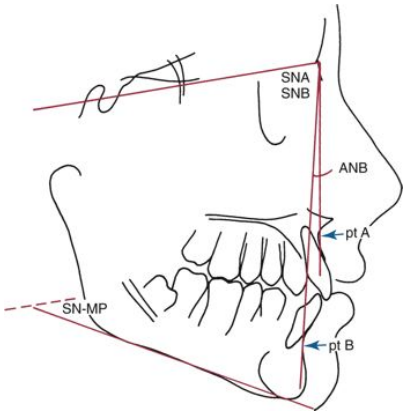


FIGURE 6–50 In the Steiner analysis, the angles *SNA* and *SNB* are used to establish the relationship of the maxilla and mandible to the cranial base, while the *SN-MP* (mandibular plane) angle is used to establish the vertical position of the mandible



The difference between SNA and SNB—**the ANB angle—indicates the magnitude of the skeletal jaw discrepancy**, and this to Steiner was the measurement of real interest. One can argue, as he did, that which jaw is at fault is of mostly theoretical interest: what really matters is the magnitude of the discrepancy between the jaws that must be overcome in treatment, and this is what the ANB angle measures.

(Proffit, William R.. *Contemporary Orthodontics, 4th Edition*. C.V. Mosby, 122006. 6.5.2.2.2).
21). If ANB = 2 Normal Class1, If ANB>2 Class2, If ANB<0 Class3 (check DESK)

ANB: A-P difference between maxilla and mandible: more positive indicates skeletal Class II; more negative indicates skeletal Class III.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 5.1.4).
22). Operative 10-52-50-60 last is angle of blade, must to know each one-WALA

23). Behavior, angry patient…

24). All LA – they are vasodilators, except **COCAINE** – vasoconstriction

25). Radiology: KVP – speed energy, quality, mA – quantity, # number of electrons

26). TMJ, a lot…

27). Radiology, know anatomy, PAN what is what… ?

28). Pedo, Fluoride dose table

	Concentration of Fluoride in Water		
Age	<0.3 ppm F	0.3-0.6 ppm F	>0.6 ppm F
Birth–6 mo	0	0	0
6 mo–3 yr	0.25 mg	0	0
3 yr–6 yr	0.50 mg	0.25 mg	0
6 yr up to at least 16 yr	1.00 mg	0.50 mg	0

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition.* Mosby, 042005. 14.4.3.2).
29). Pedo, tables of permanent, primary teeth eruption and calcification

30). Ortho know 1).Nance holding arch- used in maxillary arch has an acrylic button that can cause irritation. Used to prevent mesial tipping of molars 2).distal shoe- used when have early exfoliation of 2nd primary molar before eruption of permanent 1st molar once the permanent first molar has erupted the distal shoe can be replaced by band and loop 3).band and loops –used when have early exfoliation of 1st primary molar 4).lingual holding arch- used in mandibular when more than one mandibular tooth is mixing

The **band and loop** appliance is used to maintain the space after the premature loss of a single tooth. **The band and loop appliance is indicated when there is unilateral loss of a primary first molar before or after the eruption of the permanent first molar**. The loop is constructed of 36-mil round wire and is soldered to the band.

The **lingual arch** is often suggested when teeth are lost in both quadrants of the same arch. **Because the permanent incisor tooth buds develop and erupt somewhat lingual to their primary precursors in the lower arch, a conventional mandibular lingual arch is not recommended in the primary dentition; the wire resting adjacent to the primary incisors might interfere with the eruption of the permanent dentition. *Instead, two band-and-loop appliances are recommended* when there is bilateral tooth loss in the mandibular arch.**

The **distal shoe** appliance is **used to maintain the space of a primary second molar that has been lost prematurely before the eruption of the permanent first molar.** A stainless steel extension is soldered to the distal end of the band and 36-mil loop; this extension is positioned 1 mm below the mesial marginal ridge of the unerupted permanent first molar. The extension serves to guide the eruption of the permanent first molar.

(Pinkham, Jimmy R.. *Pediatric Dentistry: Infancy Through Adolescence, 4th Edition.* Mosby, 042005. 25.2.3).

31). Know benzodiazepines and barbiturates Mosby pg 283-284

32). Perio know all kind flaps, gingivitis, periodontitis, NUG / how to treat, drugs

33). Pt has 5mm pockets after S&RP: > or = 5mm, need Perio Surgery
< 5mm, no surgery, just maintenance

After 4 weeks the gingival tissues are evaluated to determine oral hygiene adequacy, soft tissue response, and pocket depth . This permits sufficient time for healing, reduction in inflammation and pocket depths, and gain in clinical attachment levels. **In deeper pockets (>5 mm)**, however, plaque and calculus removal is often incomplete,[42,46] with risk of future breakdown[7] . **As a result, periodontal surgery to access the root surfaces for instrumentation and to reduce periodontal pocket depths must be considered before restorative care may proceed.**

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition.* Saunders Book Company, 072006. 71.3.6).

34). Implants, where fail most often – screw between abutment and implant

35). Implants, osseointegration, min space between…

Osseointegration in mandibular anterior 3 months mandibular posterior 4 months and maxillary anterior and posterior is 6 months.

36). Know bone graft: Allograft, from cadaver/Autograft-same person,from you/Xenograft-from animal; alloplast-man made; isograft-from same species(twins, cousin etc/… definition

37). Tissue graft, purpose: 1). Lateral, small defect, prevent reception, increase keratinized tissue 2). Apical, gummy smile 3). Free Gingival

38). On Mylohyoid ridge removal - be careful of Lingual Nerve; BSSO-be careful of IAN

39). Know that BOP (bleeding on probing) measures inflammation

Scores and Criteria for Gingival Index (GI)

0 = Normal gingiva.

1 = Mild inflammation: slight change in color and slight edema; ***no bleeding on probing.***

2 = Moderate inflammation: redness, edema, and glazing; ***bleeding on probing***.

3 = Severe inflammation: marked redness and edema; ulceration; ***tendency to spontaneous bleeding.***

(Newman, Michael G.. *Carranza's Clinical Periodontology*, *10th Edition*. Saunders Book Company, 072006. 8.4.1.1.1).

40). Endo know eruption of primary and permanent teeth, calcification

Calcification of primary – Second semester, calcification of First Molar at birth

41). Know Apexification, Necrotic tooth + open apex

Apexogenesis, Vital tooth + open apex

42). When to do Pulpotomy-kids or Pulpectomy-can be done as in emergency to relieve pain

43). When mostly tooth fracture occur during endo? Condensation of gutta percha

Susceptibility of any root to fracture is markedly increased by excessive dentin removal during canal instrumentation or post preparation.[47,48] An additional factor occurring during condensation is the placement of excessive numbers of accessory cones requiring multiple spreader insertions.[38,49] Also, the insertion of tapered, inflexible condensing instruments into curved canals creates root distortion and the potential for fracture.[50]

(Walton, Richard E.. *Principles and Practice of Endodontics*, *3rd Edition*. Saunders Book Company, 012002. 28.8.4).

44). In Primary teeth Radiolucency, Necrotic shows in Furcation, tx-**Extraction**,unless very young

In Permanent teeth Radiolucency shows at Apex, tx – RCT; Most common response of teeth to trauma is necrosis

45).Mandible in molar area resorbs distally (the anterior boarder resorbs and apposition on the posterior boarder of the ramus) as we grow up and Exposing space for 2nd molars, 3rd molars

46). Antibiotic Prophilaxis – endocarditis in Pedo and Adult, yes/no allergy…

Pharmo

47). Benzodiazepine is safer, work on GABA neurotransmitters, cause thrombophelibitis in vein due due to propylene glycol

Barbituates are NOT for PAIN, for Sedation only. They can cause Respiratory depression, due to lower sensitivity to CO2. Shouldn't use if patient has porphoria?

opiate toxidrome include the classic triad of coma, pinpoint pupils, and respiratory depression

48). know LA = esters(blood)-plsama/amides (liver)… prilocaine metabolism-toulelene, methhemogobinemia(tx by metheline blue); articaine-metabolize by liver and plasma and it is the only with the ester ring…

49). Vasoconstrictor's purpose in LA:

Vasoconstrictors are important additions to a local anesthetic solution for the following reasons:

1. By constricting blood vessels, **vasoconstrictors decrease blood flow (perfusion) to the site of administration.**

2. **Absorption of the local anesthetic into the cardiovascular system is slowed**, resulting in lower anesthetic blood levels.

3. Local anesthetic blood levels are lowered, thereby minimizing the risk of local anesthetic toxicity.

4. Increased amounts of the local anesthetic remain in and around the nerve for longer periods, thereby increasing (in some cases significantly,[3] in others minimally)[4] the duration of action of most local anesthetics.

5. Vasoconstrictors decrease bleeding at the site of administration; therefore they are useful when increased bleeding is anticipated (e.g., during a surgical procedure).[5,6]

(Malamed, Stanley. *Handbook of Local Anesthesia, 5th Edition*. Mosby, 072004. 3).

50). Nitrious Oxide, tingling fingers-max you can give to adult patient 70%. Recommended max 50%; children mx 50%

51). If you see Ptosis (druping of the eyes) during General Anesthesia – it is adequate amount, just good enough, don't give any more…

52). Midazolam (versed)– creates Amnesia (memory lost) Side effects of midazolam include tolerance, withdrawal symptoms, confusion, amnesia including anterograde amnesia, ataxia, drowsiness, cognitive impairment, sedation and an increased risk of falls in the elderly.[13] People experiencing amnesia as a side effect of midazolam are generally unaware that their memory is impaired. Flumanezil is antagonist.

> Continuous or repeated seizures without periods of recovery between them are known as *status epilepticus*. This problem warrants notification of outside emergency assistance because it is the most common type of seizure disorder to cause mortality. Therapy includes instituting measures already described for self-limiting seizures; in addition, administration of a benzodiazepine is indicated**. Injectable water-insoluble benzodiazepines such as diazepam must be given IV to allow predictability of results, which may be difficult in the patient having seizures if venous access is not already available. Injectable water-soluble benzodiazepines such as midazolam provide a better alternative, because IM injection will give a more rapid response**. However, the doctor administering benzodiazepines for a seizure must be prepared to provide BLS because patients may experience a period of apnea after receiving a large, rapid dose of benzodiazepines.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery*, *5th Edition*. Mosby, 032008. 2.3.4.3).

53). Know Histamine2, Hydrogen2 – Antihistamine is for Gastric Acid secretion (good for heart burn) histamine 1 is for reaction allergic reaction

54). Pharmo 1). Ab-prophylaxis

2). Benzodiazepam/barbitures

3). LA

4). NO2

5). midazolam

6). H2 antihistamine

7). Alpha, beta blockers

Methadone- Methadone is useful in the treatment of opioid dependence. It has cross-tolerance with other opioids including heroin and morphine and a long duration of effect: oral doses of methadone can stabilise patients by mitigating opioid withdrawal syndrome. Higher doses of methadone can block the euphoric effects of heroin, morphine, and similar drugs. As a result, properly dosed methadone patients can reduce or stop altogether their use of these substances.

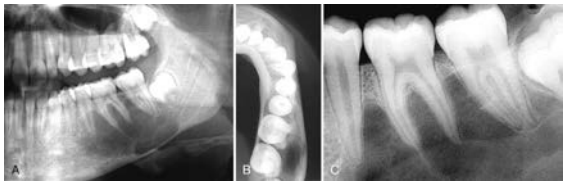
55). Behavior science, from back test… Now management of Insurance (2 questions)

If dentist done 2 surface composite & insurance pays 1 surface – is it Upcoding or Downcoding?

Oral Patho

56) Traumatic Bone Cyst – scalloped radiolucency, vital teeth, young pt, posterior mandible, empty cavity present upon entrance into area

A panoramic film demonstrating an SBC **(A),** an occlusal film **(B),** and a periapical film **(C).** The occlusal film shows that no expansion has occurred in the buccal or lingual cortical plates. Except for the superior border, **the borders are ill defined and the lesion has scalloped around the teeth** and thinned the inferior border of the mandible, but the lamina dura is still present.



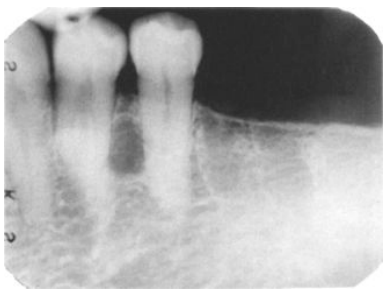
(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 21.5.4.2).

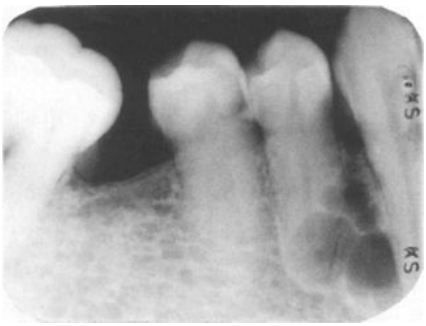
57). Lateral Periodontal Cyst Mosby pg 117 – **vital, asymptomatic, mand k9/pre-molar area, vital teeth epithelial source is dental lamina of seres**

Lateral periodontal cyst

1. Unilocular or multilocular lucency in the lateral periodontal membrane of adults.
2. Most are found in the **mandibular premolar region.**
3. Associated tooth is **vital**.
4. Gingival cyst of the adult is soft-tissue counterpart of this lesion.

Lateral periodontal cyst: **Botryoid lateral periodontal cyst:** often multilocular.

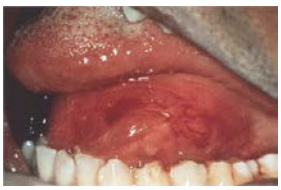




(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 4.1.13).

58). Ranula:

Ranula: rare large lesion; impairs eating.



The most common lesion of the sublingual gland is the ranula, which may be considered a mucocele of the sublingual salivary gland. Ranulas result from mucous retention in the sublingual gland ductal system or mucous extravasation as a result of ductal disruption. The two types of ranulas are the simple ranula and the plunging ranula. The simple ranula is confined to the area occupied by the sublingual gland in the sublingual space, superior to the mylohyoid muscle. The progression to a plunging ranula occurs when the lesion extends beyond the level of the mylohyoid muscle into the submandibular space . **The usual treatment of the ranula is marsupialization, in which a portion of the oral mucosa of the floor of the mouth is excised, along with the superior wall of the ranula.**

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 20.4.2).

59). Which is the most common skin cancer? Mosby pg 112 – **basal cell carcinoma**

Basal cell carcinoma, the most common skin cancer (and the most common of all cancers), is a locally invasive, slowly spreading, primary epithelial malignancy that arises from the basal cell layer of the skin and its appendages. About 80% are found on the skin of the head and neck. More than 800,000 new cases of basal cell carcinoma are diagnosed annually in the United States, representing 80% of all skin cancers.

According to the dental decks basal cell carcinoma metastasis is rare !

(Neville,Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 10.34).

60). Where do you see SCC frequently? 1) Lateral Border of Tongue 2) Floor of mouth

Increased risk of oral cancer in Patients with Plummer Vinson Syndrome(mucosal atrophy, dysphagia, and iron deficiency syndrome) Mosby pg 111

The most common site for intraoral carcinoma is the tongue, usually the posterior lateral and ventral surfaces. The oral floor is affected almost as frequently in men but is involved much less commonly in women.

Carcinoma of the tongue accounts for more than 50% of intraoral cancers in population studies in the United States. *Two thirds of lingual carcinomas appear as painless, indurated masses or ulcers of the posterior lateral border; 20% occur on anterior lateral or ventral surfaces, and only 4% occur on the dorsum. The tongue especially is the site of involvement in young patients and, in fact, is the site of the only congenital oral squamous cell carcinoma reported.*

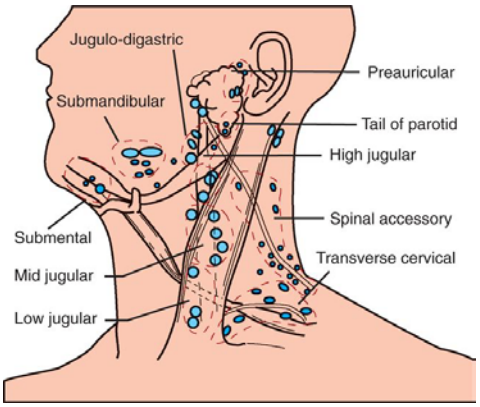
Carcinoma of the oral floor represents 35% of all intraoral cancers in epidemiologic surveys and appears to be increasing in frequency among females. It occurs a decade earlier in women than in men but is still usually a disease of older adults. **Of all intraoral carcinomas, floor of mouth lesions are the most likely to arise from a preexisting leukoplakia or erythroplakia**. **It is also the oral cancer site most often associated with the development of a second primary malignancy of another aerodigestive tract location or of a distant organ. The most common site of involvement is the midline near the frenum.**

The metastatic spread of oral squamous cell carcinoma is largely through the lymphatics to the ipsilateral cervical lymph nodes. A cervical lymph node that contains a metastatic deposit of carcinoma is usually firm to stony hard, nontender, and enlarged. **If the malignant cells have perforated the capsule of the node and invaded into surrounding tissues, then the node will feel "fixed," or not easily movable**. Extracapsular spread (extension of metastatic deposits outside of the lymph node capsule) is a microscopic feature associated with poor prognosis, including increased risk of locoregional recurrence, distant metastasis, and lower survival rates.

Occasionally, contralateral or bilateral metastatic deposits are seen, and at least 2% of patients have distant ("below the clavicles") metastasis at diagnosis; in some studies this figure is as high as 22%. The most common sites of distant metastasis are the lungs, liver, and bones, but any part of the body may be affected.

Carcinoma of the lower lip and oral floor tends to travel to the submental nodes; tumors from the posterior portions of the mouth travel to the superior jugular and digastric nodes. Lymphatic drainage from the oropharynx leads to the jugulodigastric chain of lymph nodes or to the retropharyngeal nodes, and metastatic deposits from oropharyngeal carcinoma are usually found there.

Squamous cell carcinoma, metastatic spread. Diagram demonstrating potential sites for metastatic spread of oral carcinoma to regional lymph nodes.



(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 10.26.3).

(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 10.26.2.2).

61). Herpes, on attached or keratinized gingival,

Aphthous ulcers, on NOT-keratinized mucosa soft tissue

62). Angular Chelulitis (candidas), loss of VDO

63). Clefts – basic, palate

A cleft is a congenital abnormal space or gap in the upper lip, alveolus, or palate. The colloquial term for this condition is *harelip.* The use of this term should be discouraged because it carries demeaning connotations of inferiority. The more appropriate terms are *cleft lip, cleft palate,* or *cleft lip and palate.*

Clefts of the lip and palate are the most common serious congenital anomalies to affect the orofacial region. The initial appearance of clefts may be grotesque. Because clefts are deformities that can be seen, felt, and heard, they constitute a serious affliction to those who have them. Because of their location, clefts are deformities that involve the dental specialties throughout their protracted course of treatment. *The general dentist will become involved in managing these patients' special dental needs because these patients may have partial anodontia and supernumerary teeth*. Malocclusion is usually present, and orthodontic therapy with or without corrective jaw surgery is frequently indicated.

The occurrence of a cleft deformity is a source of considerable shock to the parents of an afflicted baby, and the most appropriate approach to the parents is one of informed explanation and reassurance. Parents should be told that the defects are correctable and need not adversely affect the child's future. However, parents should be prepared for a protracted course of therapy to correct the cleft deformities and to allow the individual to function with them.

The problems encountered in rehabilitation of patients with cleft deformities are unique. Treatment must address patient appearance, speech, hearing, mastication, and deglutition. A team manages most children currently affected with orofacial clefts.

Cleft teams are found in most cities of at least moderate size. *These teams commonly comprise a general or pediatric dentist, an orthodontist, a prosthodontist, an oral and maxillofacial surgeon and a plastic surgeon, an audiologist, an otorhinolaryngologist, a pediatrician, a speech pathologist, a psychologist or psychiatrist, and a social worker*. The number of specialists required reflects the number and complexity of the problems faced by individuals with orofacial clefts.

The occurrence of oral clefts in the United States has been estimated as 1 in 700 births.[1] Clefts exhibit interesting racial predilections, *occurring less frequently in blacks but more so in Asians.* **Boys are affected by orofacial clefts more often than girls, by a ratio of 3:2. Cleft lip and palate (together) occurs about twice as often in boys as in girls, whereas isolated clefts of the palate (without cleft lip) occur slightly more often in girls.**

Oral clefts commonly affect the lip, alveolar ridge, and hard and soft palates. Three fourths of clefts are unilateral deformities; one fourth are bilateral. **The left side is involved more frequently than the right when the defect is unilateral**. The cleft may be incomplete; that is, it may not extend the entire distance from lip to soft palate. Cleft lip may occur without clefting of the palate, and isolated cleft palate may occur without clefting of the lip. A useful classification divides the anatomy into primary and secondary palates. The primary palate involves those structures anterior to the incisive foramen: the lip and alveolus; the secondary palate consists of those structures posterior to the incisive foramen: the hard and soft palates.[2] Thus an individual may have clefting of the primary palate, the secondary palate, or both.

Clefts of the lip may range from a minute notch on the edge of the vermilion border to a wide cleft that extends into the nasal cavity and thus divides the nasal floor. Clefts of the soft palate may also show wide variations from a bifid uvula (Fig. 27-2, *D*) to a wide inoperable cleft. The **bifid uvula is the most minor form of cleft palate**, in which only the uvula is cleft. Submucosal clefts of the soft palate are occasionally seen. These clefts are also called *occult* clefts because they are not readily seen on cursory examination. The defect in such a cleft is a lack of continuity in the musculature of the soft palate. However, the nasal and oral mucosa is continuous and covers the muscular defect. **To diagnose such a defect, the dentist inspects the soft palate while the patient says "ah." This action lifts the soft palate, and in individuals with submucosal palatal clefts, a furrow in the midline is seen where the muscular discontinuity is present. The dentist can also palpate the posterior aspect of the hard palate to detect the absence of the posterior nasal spine, which is characteristically absent in submucosal clefts. If a patient shows hypernasal speech without an obvious soft palatal cleft, the dentist should suspect a submucosal cleft of the soft palate**.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 27).

64). Cyst and Granuloma - both: 1 Contain Epithelium 2 Can tell only by Microscope (cyst is an epithelium lined cavity

65). Dentigerous cyst, can be changed to Ameloblastoma

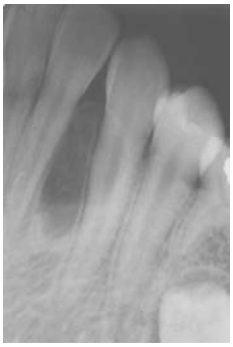
> The distinction between an area of proliferating odontogenic epithelium in the wall of a dentigerous cyst and early ameloblastoma may be difficult to make, and studies of lectins and other cell markers on the proliferating epithelial cells have so far failed to identify those lesions that are most likely to develop into an ameloblastoma.[154] **There is no clear origin for the ameloblastoma; the dentigerous cyst is only one possibility**, but remnants of the dental lamina and the basal layer of the oral mucosal epithelium also are strong contenders.

(Greenberg, Martin S.. *Burket's Oral Medicine: Diagnosis and Treatment, 10th Edition*. B.C. Decker, 012003. 7.4.2.2).

66). AOT young, female, maxilla by canine

> The **adenomatoid odontogenic tumor** represents 3% to 7% of all odontogenic tumors, and more than 750 examples have been reported in the literature. Although this lesion was formerly considered to be a variant of the ameloblastoma and was designated as "adenoameloblastoma," its clinical features and biologic behavior indicate that it is a separate entity. Although there is evidence that the tumor cells are derived from enamel organ epithelium, investigators have also suggested that the lesion arises from remnants of dental lamina.
>
> **Adenomatoid odontogenic tumors are largely limited to younger patients, and two thirds of all cases are diagnosed when patients are 10 to 19 years of age. This tumor is definitely uncommon in a patient older than age 30. It has a striking tendency to occur in the anterior portions of the jaws and is found twice as often in the maxilla as in the mandible. Females are affected about twice as often as males.**
>
> Most adenomatoid odontogenic tumors are relatively small. They seldom exceed 3 cm in greatest diameter, although a few large lesions have been reported. Peripheral (extraosseous) forms of the tumor are also encountered but are rare. These usually appear as small, sessile masses on the facial gingiva of the maxilla. Clinically, these lesions cannot be differentiated from the common gingival fibrous lesions.
>
> **Adenomatoid odontogenic tumors are frequently asymptomatic and are discovered during the course of a routine radiographic examination or when films are made to determine why a tooth has not erupted.** Larger lesions cause a painless expansion of the bone.
>
> **In about 75% of cases, the tumor appears as a circumscribed, unilocular radiolucency that involves the crown of an unerupted tooth, most often a canine**.

Adenomatoid odontogenic tumor. A small radiolucency is present between the roots of the lateral incisor and canine. *(Courtesy of Dr. Ramesh Narang.)*



(Neville, Brad. *Oral and Maxillofacial Pathology*, *3rd Edition*. Saunders Book Company, 062008. 15.3.4).

67). Osteoradionecrosis , in mandible more common, before/after extraction,

tx hyperbaric oxygenation (need prophylaxis - ?)

One of the most severe and complicating sequelae of radiotherapy for patients with head and neck cancer is **osteoradionecrosis**. **Basically, osteoradionecrosis is devitalization of the bone by cancericidal doses of radiation. The bone within the radiation beam becomes virtually nonvital from an endarteritis that results in elimination of the fine vasculature within the bone.** The turnover rate of any remaining viable bone is slowed to the point of being ineffective in self-repair. The continual process of remodeling normally found in bone does not occur, and sharp areas on the alveolar ridge will not smooth themselves, even with considerable time. The bone of the mandible is denser and has a poorer blood supply than that of the maxilla. Thus the mandible is the jaw most commonly affected with nonhealing ulcerations and osteoradionecrosis.

After radiation treatment the dentist should see the patient every 3 to 4 months. A prophylaxis is performed during these postirradiation visits, and topical fluoride applications are made. The patient should be fitted with custom trays to deliver topical fluoride applications. The patient should be instructed in the use of the trays and in *daily* self-administration of topical fluoride applications. The use of a 1% fluoride rinse for 5 minutes each day has been found to decrease the incidence of radiation caries.

Pre-extraction (more chance of favorable outcome)

Traditionally, 7 to 14 days between tooth extraction and radiotherapy have been suggested.[17,22,23] Most authors base their recommendations on the clinical impression that reepithelialization has occurred in this period. **However, radiotherapy should be delayed for 3 weeks after extraction, if possible. This helps to ensure that sufficient soft tissue healing has occurred.** The radiotherapy should be delayed further, if possible, if a local wound dehiscence has occurred. In this instance, daily local wound care with irrigations

and postoperatively administered antibiotics are mandatory until the soft tissues have healed.

Post extraction(more risky)

Postirradiation extractions are also the most undesirable extractions the dentist will ever perform because the outcome is always uncertain.

The answer to the question of whether extractions *can* be done after radiotherapy is certainly yes. The more important question is, How? **If the tooth is to be extracted, the dentist can perform a routine extraction without primary soft tissue closure or a surgical extraction with alveoloplasty and primary closure**. Either of these techniques yields similar results, with a certain concomitant incidence of osteoradionecrosis. **The use of systemic antibiotics is recommended.**

Another technique that has been shown to be effective and that is gaining in popularity is the use of hyperbaric oxygen (HBO) *before and after* tooth extraction. HBO therapy is the administration of oxygen under pressure to the patient. HBO has been shown to increase the local tissue oxygenation and vascular ingrowth into the hypoxic tissues.[24,25] **The usual protocol for such treatments is to have between 20 and 30 HBO dives before extraction and 10 more dives immediately after extractions**. HBO chambers are not available in all communities and, when present, are usually in select hospitals. A physician that is experienced in hyperbaric medicine manages patients referred to these facilities. **The patient usually undergoes one HBO session each day. Therefore, it takes 4 to 6 weeks to get the 20 to 30 treatments before surgery, and 2 weeks of treatment after surgery.**

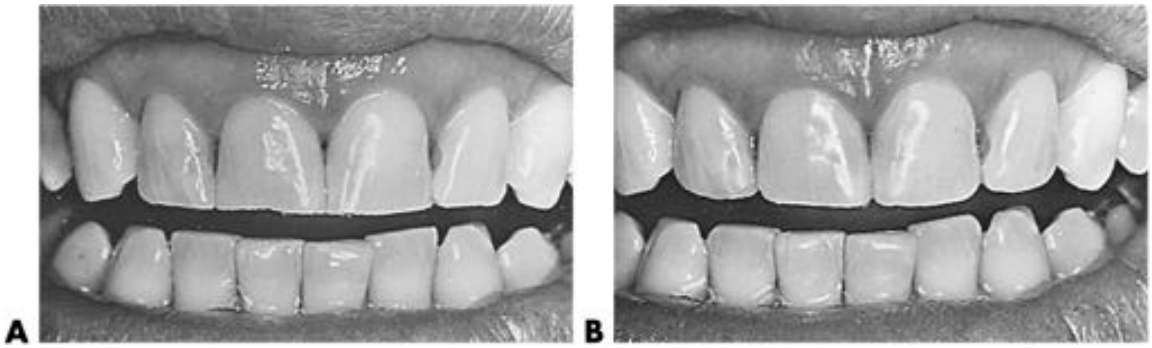
(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 18.1.12).

68). Extraction: #150 = maxillary universal forcep, 151 = mandible universal forcep

69). To make front teeth to look younger – **round off edges**

cosmetic contouring to achieve ***youthful, feminine characteristics*** **often includes rounding incisal angles, reducing facial line angles, and opening incisal embrasures. The opposite characteristics typically are considered more *masculine features*.** Cosmetic reshaping to smooth rough incisal edges and improve symmetry is equally beneficial to women and men.

Loss of incisal embrasures from attrition.



Before **(A)** and after **(B)** recontouring teeth to produce a more youthful appearance and improve resistance to fracture.

(Roberson, Theodore. *Sturdevant's Art and Science of Operative Dentistry, 5th Edition*. C.V. Mosby, 042006. 15.2.1.2).

70). To look SMALLER – bring line angels closer (M-D smaller); polished shiny crown looks larger than it really is

71). Add orange to crown to **change HUE**

72). Ortho: ANB – to check class norm2, SNA- measure maxillary norm82, +/- 2 SNB- measure mandible norm 78 +/- 2

73). Missing Primary molar – unilateral Loop band,
Missing both, bylateral molars 1). Mandible – Lingual bar

2). Maxillar – Nancy retainer

If extracted Second primary molar, still no First Permanent molar – crown on First Primary molar and **Distal shoe**

74). If severe crowding, class 1 malocclusion – serial extraction

Many children with arch-length inadequacy have spectacular growth when least expected and may be treated successfully without sacrificing permanent teeth. **The primary canine is removed first, the first primary molar second, and the first premolar last in the serial extraction procedure. The interval between extractions varies from 6 to 15 month**s. After removal of the primary canines, there is a degree of self-correction in the position and alignment of the permanent incisors. Dewel advocates an alternative extraction sequence in the borderline malocclusion when extraction of the first premolar can be avoided; in this case, growth may yet be sufficient to accommodate all the teeth. The first primary molar is extracted 6 to 12 months before the extraction of the primary canine to encourage first premolar eruption and to retard canine eruption. If growth exceeds expectations, as it occasionally does, there will be no need to extract the first premolar.

(McDonald, Ralph. *Dentistry for the Child and Adolescent, 8th Edition*. Mosby, 022004. 27.3.5).

75). Most commonly missing Permanent teeth: 1). Third molars 2). Mand. Second premolars 3). Max Later Incisors

76). Composite shrinks toward center of mass

77). Purpose of Post is to retain Core

5. Post preparation

a. **The primary purpose of the post is to retain a core** in a tooth when there is an extensive loss of coronal structure.

b. The need for a post is dictated by the amount of remaining coronal tooth structure.

c. Posts do not reinforce the tooth, but further weaken it by additional removal of dentin and by creating stress that predisposes to root fracture.

d. At least 4 to 5 mm of remaining gutta-percha is recommended.

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 1.6.1).

78). Latex gloves – **delay PVS setting**

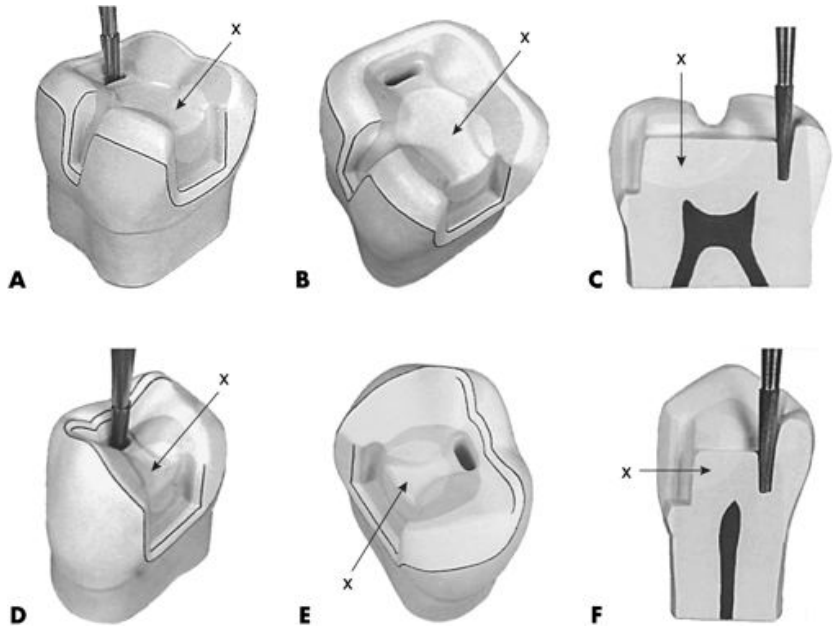
> Some brands **of latex gloves and some hemostatic agents contain chemicals that can inhibit the setting of polyvinyl siloxane impression materials**. Judicious cleaning of the teeth and the retraction cord to remove any chemicals that could prevent the setting of the impression material may be necessary.

(Roberson, Theodore. *Sturdevant's Art and Science of Operative Dentistry, 5th Edition*. C.V. Mosby, 042006. 20.8.3.1).

79). Patient back after finished restoration, with sensitivity on bite- check occlusion

80). Class 2 most conservative prep – slot prep

> If approximal caries extends well into the dentin, undermining the marginal ridge areas to the extent that a tunnel preparation with glass-ion-omer cement and composite resin becomes non-viable, then **the slot preparation** may be an alternative. This preparation incorporates the marginal ridge and proximal surface but not the complete occlusal surface; thus it is an esthetic, conservative alternative to full-coverage or compound cast-metal restorations.



Occasionally, the use of a slot in the dentin is helpful to provide the necessary retention form. An example is the mandibular second molar that has no molar posterior to it and requires a mesio-occlusal onlay restoration capping all of the. The distal, facial, and lingual surfaces are free of caries or other injury, and these surfaces also are judged not to be prone to caries. After cusp reduction, the vertical walls of the occlusal step portion of the preparation have been reduced so as to provide very little retention form. The necessary retention can be achieved by cutting a distal slot**. Such a slot is preferred over preparing a box in the distal surface because (1) the former is more conserving of tooth structure and of strength of the tooth crown, and (2) the linear extent of marginal outline is less.**

(Roberson, Theodore. *Sturdevant's Art and Science of Operative Dentistry, 5th Edition*. C.V. Mosby, 042006. 20.7.2.3.6).

(Garber, David A.. *Porcelain & Composite Inlays & Onlays: Esthetic Posterior Restorations.* Quintessence Publishing (IL), 011994. 4.3.4).

81). For Class 4 what is the best material – mod resin GI cement ???? I think nanofil composite..

(Microfill composite)

82). Radiology = density, potencial, intensity, Cathode to Anode, what cause error to film, to PAN…

To change density-change focal and film

Dark,put in developer/white, put in fixer film, short roots, Negative Angulation

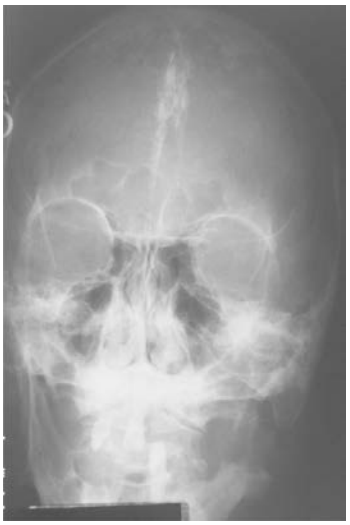
83). Radiopacity MB cusp of 14 – cusp of carribelli

(not sure but this carabelli business more likely the 2nd canal MB2…could be calcified !!!)

84). Skull radiopacity in middle (vertical white line in forehead) – BCC, basal cell carcinoma, nasal BCC syndrome

Nevoid basal cell carcinoma syndrome. Anteroposterior skull film showing calcification of the falx cerebri. *(Courtesy of Dr. Ramesh Narang.)*

The odontogenic keratocyst occurs as an isolated cyst and as a component of nevoid



basal cell carcinoma syndrome. **Nevoid basal cell carcinoma syndrome** is inherited as an autosomal dominant trait that exhibits high penetrance and variable expressivity. In addition to odontogenic keratocysts (usually multiple), components of the syndrome include (among many others**) basal cell carcinomas developing at an early age in non–sun exposed skin, mild hypertelorism, enlarged calvarium, calcification of the falx cerebri, and rib abnormalities.**[136,137] **Pitting of the soles and palms** (local areas of undermaturation of the epithelial basal cells) is an additional finding in about half of the individuals affected by the syndrome. Despite the syndrome's name, multiple basal cell carcinomas occur in only 50% of cases. Appropriate treatment is simple curettage or marsupialization of the cysts.[138]

(Greenberg, Martin S.. *Burket's Oral Medicine, 11th Edition*. B.C. Decker, 112007. 6.3.6.1.3).

85). Tube Collimation-use lead, know definition, to reduce radiation, longer-better, increase distance of tube and rectangular reduces radiation more than circular

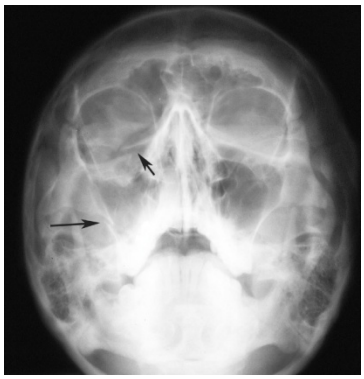
86). Water View radiograph for Maxillary sinus and infraorbital and zygomatic fracture

Removable

The occipitomental (Waters) view provides a good image of the zygomatic bone and midface that will show the displaced fracture fragment (Fig. 29-19). An underexposed submentovertex projection (the so-called jug-handle view) provides a good view of the zygomatic arch and can often show the V-shaped deformity of the zygomatic process of the temporal bone. CT is, however, the imaging modality of choice for these fractures (Fig. 29-20).

The Waters projection is optimal for visualization of the maxillary sinuses, especially to compare internal radiopacities, and the frontal sinuses and ethmoid air cells. If the Waters view is made with the mouth open, parts of the sphenoid sinuses may also be visualized.

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 27.2.3).



87). Mandible Complete denture, Disto-Buccal sore spot – masseter muscle dislodge

88). Posterior Palatal seal, purpose to compensate for shrinkage of acrylic, to create posterior palatal seal

89). Plastic teeth are better than porcelain: 1). Adhere better to the acrylic2). Don't wear opposing natural teeth

90). Anterior teeth, first goal is ESTHETIC

Chroma is easier to change, by increased by external colorants, most frequently in the gingival or interproximal areas. impossible to increase value; hue-slight change is possible (ie orange to orange brown)ds188

91). Posterior Cheek Bite created by lack of posterior Overjet

92). Sore spot on mandible ridge – check occlusion bite

93). Franfort Horisontal, know definition (orbatale-porion)

94). Clasp, passive sit

> Passivity is the quality of a clasp assembly that prevents the transmission of adverse forces to the associated abutment when the prosthesis is completely seated. **When fully seated, a clasp assembly should be passive**. The retentive arm should be activated only when dislodging forces are applied to the removable partial denture. One of the major causes of discomfort in removable partial denture therapy is incomplete seating of a clasp assembly on the associated abutment. If the clasp assembly is not fully seated, the retentive terminus will not be positioned in its intended location.

(Phoenix, Rodney D.. *Stewart's Clinical Removable Partial Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 012003. 3.1.2.2).

95). I Bar & WW = infrabulge. Akers = suprabulge…

100). What is the best way to do Centric relation with rpd – with framework and wax rim

101). If supereruption of tooth and you need to do bridge or partial on opposite side, you cut supererupted tooth and put a crown on it (for sensitivity)

102). Anterior PFM, facial reduction is 1.5mm; 2mm?

> For a metal ceramic crown, 1.5 to 1.8 mm of reduction should be provided at the junction of the incisal third and the middle third of the clinical crown according to the desired shade.
>
> ## Thickness Requirements According to Shade
>
> **Dark Shade:**
>
> - Facial reduction, 1.4 mm
> - Tooth thickness, 2.9 mm
>
> **Light Shade:**
>
> - Facial reduction, 1.7 mm
> - Tooth thickness, 3.2 mm

(Chiche, Gerard J.. *Esthetics of Anterior Fixed Prosthodontics:*. Quintessence Publishing (IL), 011994. 4.1.2).

103). Gold crown or onlay – Supporting cusp reduction 1.5mm, Non-supporting cusp 1mm

> **Cast Crown**: To achieve a desired occlusal reduction of 1.0 to 1.5 mm,21 the depth-orientation grooves should be **1.5 mm deep on the functional cusps** (maxillary lingual and mandibular facial cusps) and **1.0 mm deep on the nonfunctional cusps** (maxillary facial and mandibular lingual cusps).

(Shillingburg, Herbert T.. *Fundamentals of Tooth Preparation: For Cast Metal and Porcelain Restorations*. Quintessence Publishing (IL), 011987. 4.1).

> **Metal-ceramic crowns will require 1.5 to 2.0 mm on functional cusps that will be veneered with porcelain and 1.0 to 1.5 mm on nonfunctional cusps to receive ceramic coverage.** There should be 2.0 mm of clearance on preparations for all-ceramic crowns

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 9.3.1).

104). Jaw movement: working, non-working, Know Inner/outer inclination, interference.

Protusive: DUML Retrusive: MUDL

Nonworking: NIFL:non-working interference, inner aspect of facial cusp of lower

Working: WILU: working interference, inner aspect of lingual cusp of upper

Statistics or behavior… ?

105). Nominal, Interval – temperature, Ratio – b.p., pulse, ordinal…

Scale	Description	Example
Nominal	A variable is expressed as categories with no order in terms of one category being greater or less than another category.	Gender is categorised as either female or male. Other nominal scales include various ethnic groupings, or types of dental practices such as urban, suburban or rural.
Ordinal	A scale that comprises at least two categories in which an order is reflected by degree. An ordinal scale is often regarded as a rating that can be ranked. There is an undisputed 'order' to the scale.	An attitude scale is commonly expressed as an ordinal scale. The degree of agreement can be expressed as a three-category scale ranging from disagree, neutral, agree.
Interval	This refers to a scale that has numbers associated upon which mathematical operations can be performed and the magnitude of the values are respected and remain clear. That is, values may be multiplied, subtracted etc., and meaningful data are retained. However there is no zero point.	Examples include the various psychological scales based upon multiple questions summed together. A classic example is the assessment of IQ. There is debate about the acceptance of attitude scales as Interval Scales, notable examples include measures of stress or dental anxiety.
Ratio	Similar to interval scale but a zero point exists.	Celsius scale which has an absolute zero. Income level is another example.

106). Fucation class 1,2,3 What to do?

Class I: Early Defects

Incipient or early furcation defects (class I) are amenable to conservative periodontal therapy. Because the pocket is suprabony and has not entered the furcation, oral hygiene, scaling, and root planing are effective.[15] Any thick overhanging margins of restorations, facial grooves, or CEPs should be eliminated by odontoplasty, recontouring, or replacement. The resolution of inflammation and subsequent repair of the periodontal ligament and bone are usually sufficient to restore periodontal health.

Class II

Once a horizontal component to the furcation has developed (class II), therapy becomes more complicated. **Shallow horizontal involvement without significant vertical bone loss usually responds favorably to localized flap procedures with odontoplasty and osteoplasty. Isolated deep class II furcations may respond to flap procedures with osteoplasty and odontoplasty** (Figure 68-6). This reduces the dome of the furcation and alters gingival contours to facilitate the patient's plaque removal.

Classes II to IV: Advanced Defects

The development of a significant horizontal component to one or more furcations of a multirooted tooth (late class II, class III or IV[13]) or the development of a deep vertical component to the furca poses additional problems. **Nonsurgical treatment is usually ineffective because the ability to instrument the tooth surfaces adequately is compromised.[30,36] Periodontal surgery, endodontic therapy, and restoration of the tooth may be required to retain the tooth.**

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 68.5.1).

107). Fluoride chart/table

AGE	< 0.3	0.3–0.6	> 0.6
Birth–6 months	None	None	None
6 months–3 years	0.25 mg	None	None
3–6 years	0.50 mg	0.25 mg	None
6–16 years	1.0 mg	0.50 mg	None

108) prevalenc/incidence

Prevalence: indicates what proportion of a given population is affected by a condition at a given point in time. It is expressed as percentage and ranges from 0% to 100%, (e.g., the prevalence of periodontal disease among 100,000 adolescents was 5%).

Prevalence = Number of people with the disease/Total number of people at risk

b. *Incidence:* indicates the number of new cases that will occur within a population over a period of time (e.g., the incidence of people dying of oral cancer is 10% per year in men aged 55 to 59 in our community).

Incidence = Number of new cases of the disease/Total number of people at risk

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

109). Penumbra –

The *penumbra* is the unsharpness or blurring that surrounds the edge of a radiographic image, whereas the *umbra* is the sharp area. It is desirable to keep the penumbra as small as possible. This is done by using a small focal spot, angulation of the target, an increased FFD, and a small OFD

(Frommer, Herbert H.. *Radiology for the Dental Professional, 8th Edition*. C.V. Mosby, 062005. 3.3).

110). Biological width = **2mm**

A crown margin should not be placed any closer than 2.0 mm away from the alveolar crest, or bone resorption will occur. The combined width of the epithelial and connective tissue attachments is normally about 2.0 mm. If the margin intrudes into this "biological width," inflammation will result, and the bone will recede until it is once again at least 2.0 mm from the crown margin. This can result in an interproximal cul de sac or an infrabony pocket that would be impossible to maintain in a healthy state. **The distance from the epithelial attachment to the crest of the alveolar bone has been described as the "biologic width." It is normally about 2.0 mm wide, including the epithelial attachment and the connective tissue attachment.**

(Shillingburg, Herbert T.. *Fundamentals of Tooth Preparation: For Cast Metal and Porcelain Restorations*. Quintessence Publishing (IL), 011987. 2.4).

111). Xerostomia-opiods does not cause dry mouth; sjogren syndrome does cause arthiris

112). Gingival hyperplasia (cause it dilatin…)

113). Stain of dentin– **tetracycline**

Tetracycline is deposited in the dentin and to a lesser extent in the enamel of teeth that are calcifying during the time the drug is administered. The location of the pigment in the

tooth can be correlated with the stage of development of the tooth and the time and duration of drug administration.

(McDonald, Ralph. *Dentistry for the Child and Adolescent, 8th Edition*. Mosby, 022004. 7.13.4).

114). Flaps modified, Widman flap, not apically repositioned flap…

115). Ectodermal dysplasia, andodontia either partial or complete, thin sparse hair, sweat, dry skin, any abnormalities of things developing from ectoderm layer

116). Dr.Whitaker class - db cusp occlude where in opposite side?

117). Know all nerves – how to num pt? To extract #11 what anesthesia should I do? ASA-incisors and canine, MSA premolars and mesial buccal of 1st molar, PSA molars

118). LaFort 1,2,3 fractures nerves

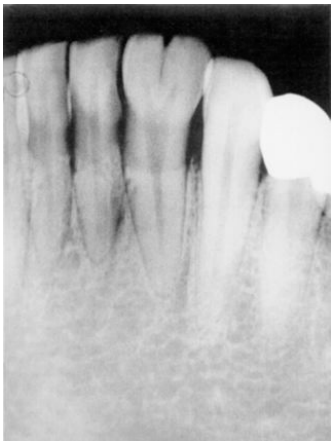
119). Fusion/Gemination

Fusion represents the union of two independently developing primary or permanent teeth. The condition is almost always limited to the anterior teeth and, like gemination may show a familial tendency. So it's a single enlarged tooth with separate roots therefore the tooth count reveals missing tooth

Fusion of a permanent central and lateral incisor.

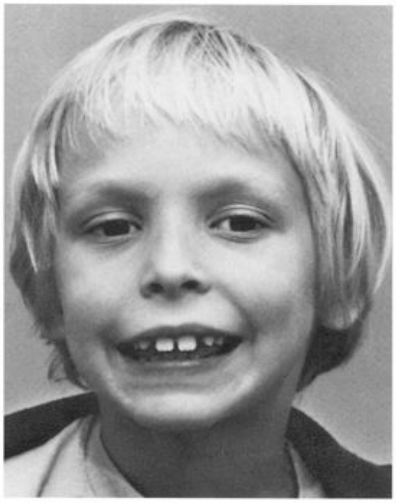
GEMINATION (single enlarged tooth with single root canal and normal tooth count)

A geminated tooth represents an attempted division of a single tooth germ by invagination occurring during the proliferation stage of the growth cycle of the tooth. The geminated tooth appears clinically as a bifid crown on a single root .



<

120). Ugly-duckling



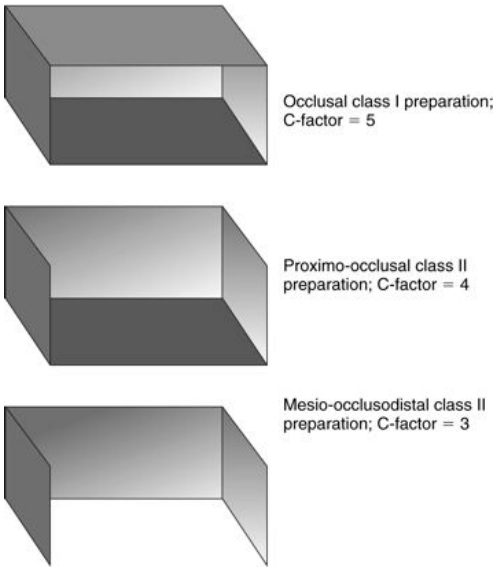
> In some children, the maxillary incisors flare laterally and are widely spaced when they first erupt, a condition often called the "**ugly duckling" stage**. The spaced incisors tend to improve when the permanent canines erupt, but this condition increases the possibility that the canines will become impacted.

(Proffit, William R.. *Contemporary Orthodontics, 3rd Edition*. C.V. Mosby, 012000. 3.3.3).

1). is it best to have 4 or 1 C-Factor? **C-factor of 1**

C-factor

The **configuration factor or ratio between the bonded surface area of a resin-based composite restoration to the unbonded or free surface area. The higher the C-factor, more will the detrimental effects of polymerization shrinkage**.



(Anusavice, Kenneth J.. *Phillips' Science of Dental Materials, 11th Edition*. Saunders Book Company, 072003. 18.1).

2). What is national % of cleft in USA? 1:700

The occurrence of oral clefts in the United States has been estimated as **1 in 700 births.**[1] Clefts exhibit interesting racial predilections, occurring less frequently in blacks but more so in Asians. Boys are affected by orofacial clefts more often than girls, by a ratio of 3:2. Cleft lip and palate (together) occurs about twice as often in boys as in girls, whereas isolated clefts of the palate (without cleft lip) occur slightly more often in girls.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 27).

3). What's Maximal temp for Implants placement to avoid bone necrosis? 40 degrees C 47 degrees C is necrosis

The heat generated during an implant osteotomy is related to the presence and temperature of irrigation,[35-37] amount of bone being prepared,[38,39] drill sharpness and design,[40-43] time of preparation,[44] depth of the osteotomy,[37,30,41,45] pressure on the drill,[40] drill speed,[39,46,47] and variation in cortical thickness.[35,48]

Bone cell survival is very susceptible to heat. Eriksson has demonstrated that in rabbit, bone temperature as low as 3° C above normal (40° C) can cause bone cell

necrosis.[49] Therefore a conscious effort is made to control temperature elevation every time a rotary instrument is placed in contact with bone. At least 50 mL/min of cooled irrigation, such as sterile physiologic saline, is used as a profuse irrigant and is a critical element to reduce heat.[35-37,50] Distilled water should not be used, as rapid cell death may occur in this medium.[51] Intravenous dextrose solution (D_5W) also may be used, with the clinical advantage of decreasing hand piece breakdown occurring from the effects of the salt in a saline solution, although the surgical gloves often feel sticky near the conclusion of the surgery.

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 29.2.1.3).

Gutta percha-

The primary ingredient of a gutta-percha cone is **zinc oxide (±75 percent)**. **Gutta-percha accounts for approximately 20 percent** and gives the cone its unique properties such as plasticity. The remaining ingredients are binders, opaquers, and coloring agents.

(Walton, Richard E.. *Principles and Practice of Endodontics, 3rd Edition*. Saunders Book Company, 012002. 14.5.1.2).

4). Space between 2 implants – 3mm, between implant and tooth 1mm

Most successful implant is mand ant, most failure is mx post.

As a general rule, the top of the implant should be placed 2- **3 mm below the planned position of the cementoenamel junction** of the final restoration.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 14.10.2).

For the evaluation of implant success, immobility and radiographic evidence of bone adjacent to the implant body are the two most accurate diagnostic aids in evaluating success. Follow-up or recall radiographs should be taken after 1 year of functional loading and yearly for the first 3 years.[105] Multiple studies have shown that, in the first year, marginal bone loss and a higher rate of failure are seen.

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 3.15.6).

5). Template for Implants can control all but? **a). Number # of implants** b). implant size c). implant inclination, avoid hitting adjacent structures, saves time

The surgical guide template is a critical factor for implants placed in an esthetic area because even slight variations of angulation can have large effects on the appearance of the final restoration. **The construction of the surgical guide template is nearly indispensable for those patients for whom it is necessary to optimize implant**

placement to ensure correct emergence profiles in the anterior esthetic zone. The four objectives of using a surgical template for the partially edentulous patient are as follows: (1) delineate embrasure, (2) locate implant within tooth contour, (3) align implants with long axis of completed restoration, and (4) identify level of cementoenamel junction or tooth emergence from the soft tissue. The template most useful in the anterior esthetic zone is a clear resin template, which allows a surgeon ease of access to the bone and uninterrupted visual confirmation of frontal and sagittal angulations .

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 14.4.4).

The diagnostic template enables the dentist to incorporate the three-dimensional treatment plan of the final prosthetic result into the imaging examination; evaluate the patient's anatomy relative to the proposed implant sites, esthetics, and occlusion; and record and transfer these findings to the patient at the time of surgery.

(Misch, Carl E.. *Contemporary Implant Dentistry, 3rd Edition*. Mosby, 122007. 3.10).

6). In TMJ which part responsible for rotation, which for translation? (TURL)

The TMJ is often referred to as a *ginglymoarthrodial joint*, meaning hinge and glide. The TMJ is also somewhat capable of free movement or diarthrosis. As the mandible articulates with both left and right TMJs, mandibular movement results in actions of both joints simultaneously. **Hinge (rotation) occurs in the lower joint space**. **Glide (translation) occurs in the upper joint space.** Each TMJ is able to rotate in three separate planes or axes.

(Mosby. *Mosby's Review for the NBDE, Part I*. C.V. Mosby, 072006. 4.9).

7). What test needed for WARFARIN? a). **INR**, b).bleeding time, c). prothrombine time

8). What test is NORMAL for Hemophilia? Clotting Factors ie. PT, PTT

For hemophilia the PT, platelet, and bleeding time is normal*, only the PTT is increase thus why it is the best test.*

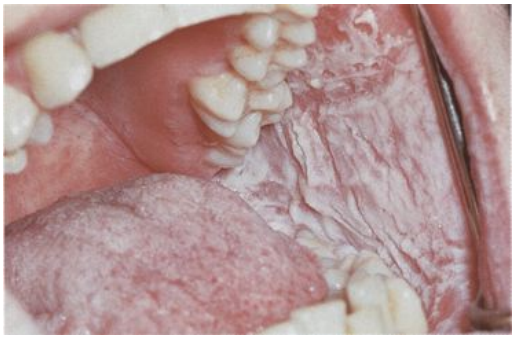
9). If pain in upper/maxillary what would be a prof that pain in NOT odontogenic? Pain is not removed by anesthesia

Nonodontogenic toothache can often be differentiated from odontogenic toothache by **local provocation. Pulpal and periodontal pains are increased by local provocation of the teeth such as percussion, hot, cold, or biting forces**. **When toothache pain is not increased by provocation, one should be suspicious of nondental toothache**. **Local anesthetic can be very helpful in differentiating true dental pain from pain referred to the teeth.[104-106] Local anesthetic applied in the region of a true dental toothache will**

reduce or eliminate the pain. Local anesthetic at the site of the nonodontogenic toothache often will not reduce the pain since the site of pain is not the true source of pain. When the clinician finds it difficult to identify a source of toothache, diagnostic local anesthetic blocking should be utilized.

(American Academy Of Orofacial Pain, Jeffrey P. Okeson. *Orofacial Pain: Guidelines for Assessment, Diagnosis & Management, 3rd Edition*. Quintessence Publishing (IL), 011996. 7.1.4).

10). Picture of Sponge/nevus (in buccal fold)



White sponge nevus: of buccal mucosa.*

(Langlais, Robert P.. *Color Atlas of Common Oral Diseases, 3rd Edition*. Lippincott Williams & Wilkins, 012003.).

11). Radiograph of SINUS – know xray all names!!!!

12). Post-herpes Neuralgia could be after which HERPES? Zoster or Regular (type1)

Post-Herpetic Neuralgia.

Up to 10% of patients who have suffered recurrent varicella zoster infection of the trigeminal nerve (shingles, herpes zoster) subsequently develop a persistent neuralgia. Damage to neural tissue or persistence of virus within the trigeminal nerve has been implicated in this condition.

The character of the pain can range from episodic severe shooting pain to a constant burning sensation. The affected area may show signs of postinflammatory pigmentation or scarring from the preceding herpes zoster infection. Diagnosis is made on the nature of the symptoms and previous history of shingles.

Post-herpetic neuralgia is difficult to manage. Medications such as TCAs and gabapentin may be effective in controlling pain. Some reports have suggested treatment with topically applied capsaicin cream or lidocaine patch, opioids, and intrathecal methylprednisolone, but these therapies need to be validated. Surgical approaches produce no benefit. Transcutaneous electric nerve stimulation (TENS) has been found helpful in certain patients.

(Regezi, Joseph A.. *Oral Pathology: Clinical Pathologic Correlations, 5th Edition*. Saunders Book Company, 102007. 5.1.4.5.3).

13). On pan both Sinuses have some opacity like fog, dxn? Sinusitis

14). On xray radiograph big amalgam restoration on #30 just slightly touching on distal #31. What cause that too light contact? Don't use WEDGE

(don't use wedge ??)

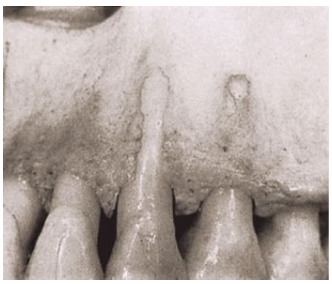
15). Which has highest % of Hyperactive kids ADDH – BOY or GIRLS? **BOYS**

> **Attention deficit hyperactivity disorder (ADHD) is a common developmental disorder affecting about 3–5% of the population, boys much more commonly than girls**. It is characterized by developmentally inappropriate degrees of impulsivity, inattention and often hyperactivity. The symptoms are noted from early childhood, usually well before school entry, and are present in all settings.
>
> The term ADHD is currently used to describe a range of children with varying functional difficulties, but who share the feature of poorly sustained attention. Some are extremely impulsive, some aggressive, others quiet and restless. Many have low self-esteem. Comorbidities include developmental language disorders, anxiety, oppositional-defiant behaviours, fine motor and coordination difficulties and specific learning disabilities. Virtually all children with ADHD have deficits in short-term auditory memory.

(Cameron, Angus C.. *Handbook of Pediatric Dentistry, 2nd Edition*. Mosby Ltd., 062003. 8.15.1).

16). Know definition FENESTRATION and DEHISENCE

> **Isolated areas in which the root is denuded of bone and the root surface is covered only by periosteum and overlying gingiva are termed *fenestrations*. In these areas the marginal bone is intact. When the denuded areas extend through the marginal bone, the defect is called a *dehiscence*.** Such defects occur on approximately 20% of the teeth; they occur more often on the facial bone than on the lingual bone, are more common on anterior teeth than on posterior teeth, and are frequently bilateral. Microscopic evidence of lacunar resorption may be present at the margins. The cause of these defects is not clear. Prominent root contours, malposition, and labial protrusion of the root combined with a thin bony plate are predisposing factors.[44] *Fenestration and dehiscence are important because they may complicate the outcome of periodontal surgery*.



Dehiscence on the canine and fenestration of the first premolar.

(Newman, Michael G.. *Carranza's Clinical Periodontology, 10th Edition*. Saunders Book Company, 072006. 5.3.7).

17). Question for metabolism drug detoxication in liver. When drug became completely useless, after? a). Redation b). Oxidation c). **Conjugation**

Phase 1 (reduction, oxidation, hydrolysis) yields slightly polar, water soluble metabolite (often still active) : cytochrome p-450. Geriatric loose phase 1 first

Phase 2(acetylation, glucorinadation, sulfation) yields very polar inactive metabolite) renally excreted. Phase 2 **conjugation.**

18). Flumazenil **a). is competitive antagonist of diazapam** b). antihistamine…

19). What is most important in determining for each PERIO surgery? Amount of keratinized tissue

20). Which one is PRIMARY support for complete mandibular denture? a). **buccal shelf** b). residual alveolar ridge

the horizontal portion of the hard palate lateral to the midline provides the primary support area for the denture. In the area of the rugae, the palate is set at an angle to the residual ridge and is rather thinly covered by soft tissue. This area contributes to the stress-bearing role, though in a secondary capacity. The submucosa covering the incisive papilla and the nasopalatine canal contains the nasopalatine vessels and nerves.

The crest of the edentulous ridge is an important area of support. However, the bone is subject to resorption, which limits its potential for support, unlike the palate, which is resistant to resorption. Because of this, **the ridge crest should be looked on as a secondary supporting area, rather than a primary supporting area**. The inclined facial surface of the maxillary ridge provides little support, although the peripheral tissues should be contacted to provide a border seal.

the bone of the **buccal shelf is covered by a layer of cortical bone**. This, plus the fact that the shelf lies at right angles to the vertical occlusal forces, makes it the most suitable **primary stressbearing area for a lower denture**

(Zarb, George. *Prosthodontic Treatment for Edentulous Patients: Complete Dentures and Implant-Supported Prostheses, 12th Edition*. Mosby, 092003. 14.2.2).

21). You need to do anesthesia on inflamed tooth. Which one you can anesthetized more predictable? a). **mandible** b). maxillary – because you can avoid inflamed spot by Inferior-alveolar block

When I&D procedures are performed extraorally, a more complex set of criteria must be met when selecting a site for the incision. Once the area of incision has been selected, a

method of pain control must be used. Regional nerve block anesthesia is preferred when it can be achieved by injecting in an area away from the site of the incision. Alternatively, infiltration of local anesthetic solution into and around the area to be drained can be performed. Once the local anesthetic needle has been used in an infected site, however, it should not be reused in an uninfected area.

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 15.3.4).

22). Which salivary cancer has NEUROLOGICAL origin (around nerve)? Mucocarcinoma… or other names.

Don't know, check in book

Adenoid cystic carcinoma and polymorphous low grade adenocarcinoma both have perineral invasion

The **adenoid cystic carcinoma** is one of the more common and best-recognized salivary malignancies. Because of its distinctive histopathologic features, it was originally called a **cylindroma,** and this term still is used sometimes as a synonym for this neoplasm. However, use of the term *cylindroma* should be avoided because it does not convey the malignant nature of the tumor, and also because this same term is used for a skin adnexal tumor that has a markedly different clinical presentation and prognosis.

CLINICAL AND RADIOGRAPHIC FEATURES

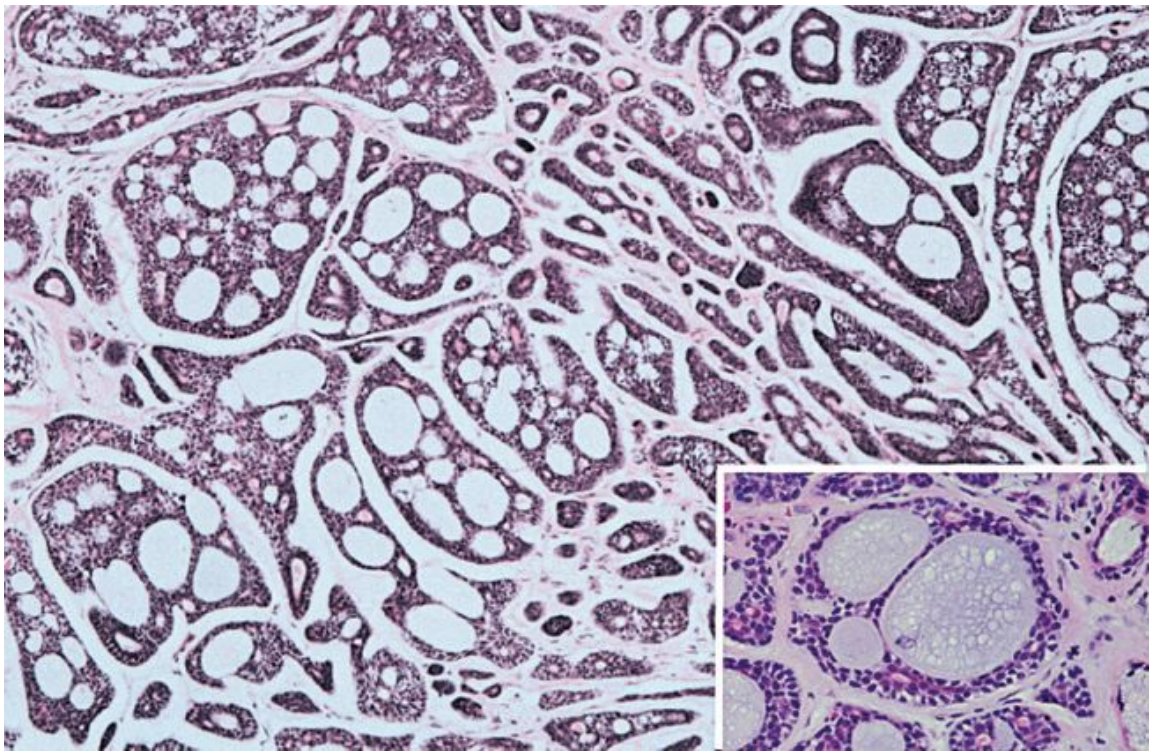
The adenoid cystic carcinoma can occur in any salivary gland site, but approximately 50% to 60% develop within the minor salivary glands. The **palate is the most common site for minor gland tumors. The remaining tumors are found mostly in the parotid and submandibular glands, with a fairly even distribution between these two sites**. On an individual basis, however, a striking difference can be seen among the various glands. In the parotid gland, the adenoid cystic carcinoma is relatively rare, constituting only 2% to 3% of all tumors. In the submandibular gland, this tumor accounts for 12% to 17% of all tumors and is the most common malignancy. It is also relatively common among palatal salivary neoplasms; it represents 8% to 15% of all such tumors. **The lesion is most common in middle-aged adults and is rare in people younger than age 20.** There is a fairly equal sex distribution, although some studies have shown a slight female predilection.

The adenoid cystic carcinoma usually appears as a slowly growing mass. Pain is a common and important finding, occasionally occurring early in the course of the disease before there is a noticeable swelling. Patients often complain of a constant, low-grade, dull ache, which gradually increases in intensity. Facial nerve paralysis may develop with parotid tumors. Palatal tumors can be smooth surfaced or ulcerated. Tumors arising in the palate or maxillary sinus often show radiographic evidence of bone destruction.

HISTOPATHOLOGIC FEATURES

The adenoid cystic carcinoma is composed of a mixture of myoepithelial cells and ductal cells that can have a varied arrangement (Fig. 11-73). Three major patterns

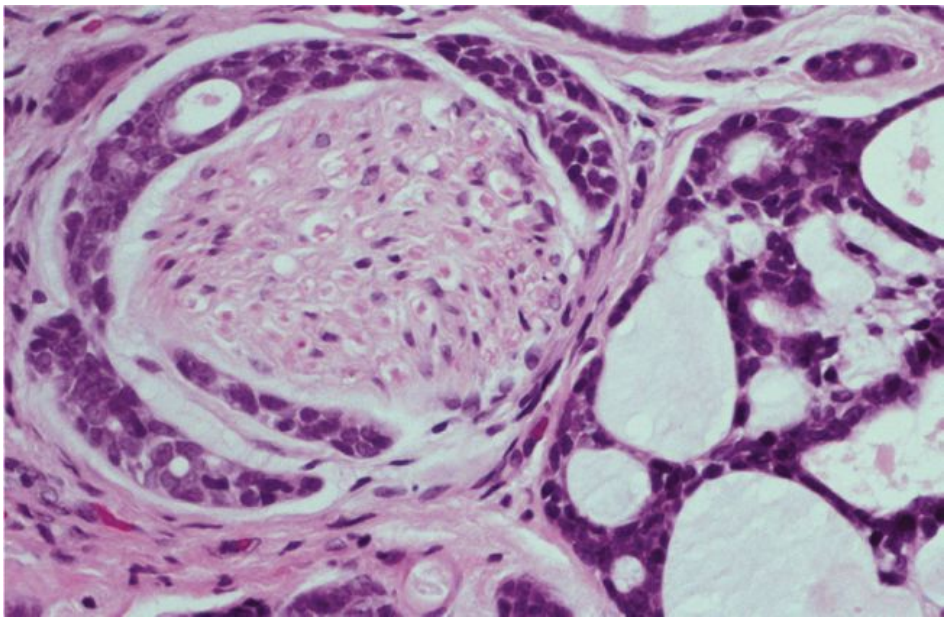
Fig. 11-73 **Adenoid cystic carcinoma.** Islands of hyperchromatic cells forming cribriform and tubular structures. *Inset* shows a high-power view of a small cribriform island.



.

The **cribriform pattern** is the most classic and best-recognized appearance, characterized by islands of basaloid epithelial cells that contain multiple cylindrical, cystlike spaces resembling **Swiss cheese**. These spaces often contain a mildly basophilic mucoid material, a hyalinized eosinophilic product, or a combined mucoid-hyalinized appearance.

Fig. 11-75 **Adenoid cystic carcinoma.** Perineural invasion.



adenocarcinoma, also may exhibit areas with a cribriform pattern.

In the **tubular pattern,** the tumor cells are similar but occur as multiple small ducts or tubules within a hyalinized stroma. The tubular lumina can be lined by one to several layers of cells, and sometimes both a layer of ductal cells and myoepithelial cells can be discerned.

The **solid variant** consists of larger islands or sheets of tumor cells that demonstrate little tendency toward duct or cyst formation. Unlike the cribriform and tubular patterns, cellular pleomorphism and mitotic activity, as well as focal necrosis in the center of the tumor islands, may be observed.

A highly characteristic feature of adenoid cystic carcinoma is its tendency to show perineural invasion, which probably corresponds to the common clinical finding of pain in these patients. Sometimes the cells appear to have a swirling arrangement around nerve bundles. However, perineural invasion is not pathognomonic for adenoid cystic carcinoma; it also may be seen in other salivary malignancies, especially polymorphous low-grade adenocarcinomas.

(Neville, Brad. *Oral and Maxillofacial Pathology, 3rd Edition*. Saunders Book Company, 062008. 11.13.14).

23). In Class2 which side of restoration more often has recurrent caries? **Gingivo-cervical in proximal box**

24). In removable partial denture what is a name of part that connect “occlusal rest” with “major connector”? **Minor connector**

25). You are doing LA Local Anesthesia to man, suddenly his b.p = 200/100. What is a reason? a). stress b). **epinephrine** c). Lidocaine

26). In one city a scientist want to check all cases of oral cancer that ever happened before. What kind of study does he perform? **Longitudinal study**

> A longitudinal study involves the follow-up of the initial baseline respondents at a later date. The longer the follow-up from baseline the more likely that respondents will be lost to the study (through mobility away from the study area) and interpretation becomes more difficult. An important check is to determine who is lost to the study on follow-up, and an analysis is then conducted that shows whether the people lost to the study are different from those who are successfully followed-up. The importance of attempting longitudinal studies should not be underestimated as they do make possible firmer interpretations of causality not possible with cross-sectional designs.

(Humphris, Gerry. *Behavioural Sciences for Dentistry*. Churchill Livingstone, 022000. 13.4).

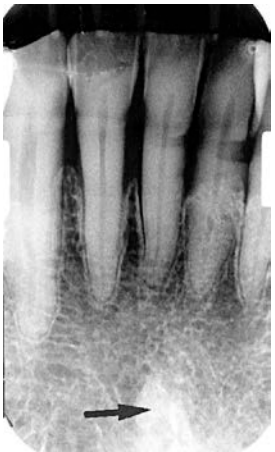
27). In that city 200 patients were sick out of 2000 in 2008 and 300 pt. are sick out of 2000 in 2009. What would be INDIDENCE? **a). 100/2000** b). 200/2000 c). 300/2000

> *Incidence:* indicates the number of new cases that will occur within a population over a period of time (e.g., the incidence of people dying of oral cancer is 10% per year in men aged 55 to 59 in our community).
>
> Incidence = Number of new cases of the disease/Total number of people at risk

(Mosby. *Mosby's Review for the NBDE, Part II*. Mosby, 042007. 6.3).

29). I have a patient that told you that she had a lot of BAD experience with all dentists in the city before you – nobody satisfied her needs. And you are the best dentist in the world, she will refer to you all of her friend and relatives… What is possible diagnosis for that patient? a). pshycis…b) pshysiod d). **borderline** - borderline personality disorder is a condition in which a person makes impulsive actions, and has an unstable mood and chaotic relationships. They tend to see things in terms of extremes, either all good or all bad. They also typically view themselves as victims of circumstance and take little responsibility for themselves or their problems.

30). Know on PROTUBELANCE anteriors



radiograph. MENTAL (genial tubricales) under lower

The genial tubercles (arrow) appear as a radiopaque mass, in this case without evidence of the lingual foramen.

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008.).

31). How morphine work to do nausea? a). affect receptors in GI tract b). affect ememics centers c). **affect medulla centers**

> Morphine and related opioids also depress the cough reflex, at least in part by a **direct effect on a cough center in the medulla.**

(Hardman, Joel G.. *Goodman & Gilman's the Pharmacological Basis of Therapeutics, 10th Edition*. McGraw-Hill Professional Publishing, 082001. 24.4.3.6).

32). What BEVEL do for restoration? How does it work? a) . decrease **Composite leakage** b). strength – Don't remember exactly question, I now that amalgam doesn't have bevel, composite – DOES NEED bevel!

> Beveling enamel margins in composite preparations is indicated primarily for larger restorations that have **increased retention** needs. The use of a beveled marginal form with a composite tooth preparation may be advocated because the potential for retention is increased by increasing the surface area of enamel available for etch and having a more effective area of etch obtained by etching the cut ends of the enamel rods. Other advantages of beveling composites are as follows: **(1) Adjacent, minor defects can be included with a bevel, (2) esthetic quality may be enhanced by a bevel creating an area of gradual increase in composite thickness from the margin to the bulk of the restoration, and (3) the marginal seal may be enhanced.**

(Roberson, Theodore. *Sturdevant's Art and Science of Operative Dentistry, 5th Edition*. C.V. Mosby, 042006. 6.7.2.4.3).

33). In what situation you shouldn't place INLAY on 26 yrs old pt. ? a**). when active caries/** frequent b). when opposing teeth are enamel c). when opposing is bridge

34). Before denture construction you find that mandibular ridge contact maxillary tuberosity. You need to do denture for that pt. What next treatment should be done? **Surgical removal of maxillary tuberosity to give space for dentures.**

35). What muscle can be cut under mandibular complete denture because of it's close location? **Buccinator**

If mylohyoid is an answer choice I would go for it. The mylohyoid can be displaced during a vestibloplasty to allow for a better seating of the lower denture. !!

36). What muscle affect lingual flange of impressions? **Mylohyoid**

37). Where is NOT recommended to do gingival graft – which site? a). pre-molar b). molar c). **CANINE area**

Pain aggravated by cold and relieved by heat – **reversible pulpit**is, just information

> Reversible pulpitis is usually asymptomatic. However, when present, symptoms usually follow a particular pattern. Application of stimuli, such as cold or hot liquids, as well as air, may produce sharp, transient pain. Removal of these stimuli, which do not normally produce pain or discomfort, results in immediate relief. Cold and hot stimuli produce different pain responses in normal pulp.[44] When heat is applied to teeth with uninflamed pulp, the initial response is delayed; the intensity of pain increases as the temperature rises. In contrast, pain in response to cold in normal pulp is immediate; the intensity tends to decrease if the cold stimulus is maintained. Based on these observations, pulpal responses in both health and disease apparently result largely from changes in intrapulpal pressures.

(Torabinejad, Mahmoud. *Endodontics: Principles and Practice, 4th Edition*. Saunders Book Company, 032008. 4.5.2.1).

38). Pain aggrevated by heat and releaved by cold (**irreversible pulpitis**). What would be the treatment for patient? a**). RCT** b). sedative filling c). temporal IRM d). composite

39). What is mechanism of Fluoride work? **a). making fluoroappetite** b). affect morphology of eamel c). make surface softer

40). Which cells are more often could be seen in gingival fluids? Plasma, **neutrophil** macrophage, mast cell… I don't know

41). Know cells for Inflamation Acute-see lots of nuetruphil and Chronic-see lots of plasma cells and names of bacteries for caries occlusial and smooth surface-strep mutan, or on ROOT surface caries by actinomyces viscosus

42). How radiation affect human body, mostly by? a) **Lysis of H2O** b) direct affect on DNA c). on mitosis…

> Because water is the predominant molecule in biologic systems (about 70% by weight), it frequently participates in the interactions between x-ray photons and biologic molecules. A complex series of chemical changes occurs in water after exposure to ionizing radiation. Collectively these reactions result in the **radiolysis of water**.

(White, Stuart C.. *Oral Radiology: Principles and Interpretation, 6th Edition*. Mosby, 092008. 2.1.2).

43). Testing new fluoride rinses. Strange results Gingival Index is high in survey (good), but we see no effect on regular patient's health. How to characterize those data? a) bias b) **bad selectional/organizational experiment** c) case controlled study

44). Which drug is least used in dentistry because of its longitudinal action? a) diazepam **b). lorazepam** c). Nitrious Oxide

45). Most often cause of failure of amalgam restoration? a**) condensation not strong enough** b) moisture contamination c) too long trituration

Normally, early failure of amalgams is uncommon, but when it does occur, it is related to bulk fracture, improper preparation design factors, or postoperative sensitivity. C

(Roberson, Theodore. *Sturdevant's Art and Science of Operative Dentistry, 5th Edition*. C.V. Mosby, 042006. 4.3.1.6).

46). Cleidocranial dysplasia could be seen radiographically? **Supernumerary teeth**

47). Treatment for Alveolar Osteities (remember "dry socket")? a). currett socket b**). dressing for calming medication** c). dressing and antibiotic

48). What kind of resorption is Ankilosis? a). **Replacement** b). External c). internal

49). When you finishing RCT on #12 and part of file separated in canal. What to do next? a). extract b). send to ER **c). refer patient to Endodontist or if in apical third, leave file, obturate, and follow up – this might be the other answer choice**

50). If dentist tell patient that he has to replace all of his Silver filling (amalgams) to white composite, because it can poison him – what ethical principal would be broken? a) Autonomy b**) Veracity** c) Non-maleficiency

51). Old patients has recession on teeth, leading to ROOT cervical caries. Best treatment would be Resin modified Glass Ionomer (RMGI) because of ability of GI to make bonds with Enamel and Dentin, Fluoride release and not big strength needed

Information: Composite make bond with Enamel only, but using adhesive help it bond even to dentin (bond adhesive/dentine and adhesive/composite) Amalgam DON'T make any bonds. Holds by strong compression and by retention form of prep.

Reversible Pulpitis:

- exaggerated response to a stimulus (cold or hot)
- does not linger after the stimulus is removed.
- PDL space - WNL; EPT – positive; percussion – not unusual sensitivity.

Irreversible Pulpitis: (symptomatic or asymptomatic)

- symptomatic irreversible pulpitis
    - o spontaneous pain and/or an exaggerated lingering response to hot or cold.

- difficult time localizing the origin of pain
- PDL space - may/may not be widened; EPT – positive; percussion – may/may not be painful.

- irreversible pulpitis
  - cold may alleviates the pain
  - may be asymptomatic
  - examples: internal resportion and hyperplastic pulpitis (pulp polyp)

Pulpal Necrosis

- partial necrosis may exhibit some of the signs and symptoms of irreversible pulpitis.
- total pulpal necrosis are asymptomatic

Acute Periradicular Periodontitis

- extremely tender to occlusion or percussion
- periradicular area may be tender to palpation.

Acute Periradicular Abscess

- swelling and mild to severe pain.
- may exhibit fever, lymphadenopathy
- NO PARL may/may not see widened PDL space.
- Percussion positive & the palpation positive.

Chronic Periradicular Periodontitis

- Asymptomatic
- PARL
- Non vital tooth, percussion and palpation negative

Chronic Suppurative Periodontitis

- Asymptomatic
- PARL
- Sinus tract

- Non vital tooth, percussion and palpation negative

Phoenix Abscess

- acute exacerbation of a chronic periradicular periodontitis
- same signs and symptoms of an acute abscess except there is a PARL

Day2

Case 1

Long face, female, does not want to have those spaces between teeth – needs to close them (she does not have Lateral Incisors) Good oral hygiene.

1). What treatment for flare out of Central Incisors? **a). With removable dentures** b). Braces c). Face-gares

Case 2

AA man 46 yrs afraid of dentist, #3 and #6 crown decayed completely – lost.

1). Low blood pressure, low pulse - **Syncope when have anesthesia**

2). Fix #8,#9 esthetic edge/yellow stain. What treatment to #8, #9? (little bit cheeped off enamel of #8) **a). polished to smooth** b). composite c). bleach

3). What treatment for #3, #6 space? **a). bridge #2-6**

4). Caries small/occlusal (brown spots on pits) on #31 can be seen on **a). picture clinically** b). xray c). from chart

5). #12 has big caries lesion on mesial up to the bone level. What treatment needed? **a). crown lengthening** b). post&core – next step because crown only can be on "sound tooth structure" (ferrule rule = 1mm circular in prep increase strength in …10? Times - check this)

Case 3

63 yrs old man… Picture teeth radiograph

1). #14 bone lost mesialy, overhang amalgam. Why? **a). forget to put wedge**

2). From #20 big amalgam restoration – you can see on xray pin goes out of tooth distally. Patient complained that floss shred all the time between #20 and #19. What should you do? **a). explain patient current situation** b). tell pt. that previous dentist performance as bellow standard of dentistry c). extract tooth #20 d). try to cut pin with hand piece

3). Can see well defined circular radiolucency under root tips of # 30, #31, #32. Diagnosis? **a). PA cyst** b). OKC c). ameloblastoma

Case 4

53 yrs old Porcelain-fused-to-metal PFM bridge #8-10. On PAN can see 3rd molars are impacted.

1). Why discoloration of bridge white color/translucency. Every explanation is possible EXECPT? **a). metal to thick** b). not enough reduction in cervical third of #10 c). opack layer is too much thick

2). On clinical picture you can see wear off mandibular incisors. What is a reason for that? **a). occlusional habite (bruxism)** b). thin dentin/enamel 3). Opposing bridge (reason for that in the next question, if it's just opposite bridge why all canines are flat?)

3). Why is that shape of canine – no cusp, flat occlusialy? **a). bruxism**

4). Should we do 3rd molar extraction for the reason that #1 is close to sinus or #32 is close to mandibular canal? **NO** (53yrs, 3rd molars are not bothering him)

5). 3rd molars are #1 disto-bucal and #32 is horizontal angulation of impaction. Plus partial bone coverage. (check in book impaction angulations) **TRUE**

6). What would be the reason to extract #1**? a). to place implant, if #2 in future would be lost and pt. need a bridge.**

7). If you do pulpal thermal test on his posterior teeth you may have Negative/False result. Why? a). Age **b). pulpal obliteration/ calcification** see xray

Case 5

On clinical picture you can see adult complete dentition (no missing teeth) in position central incisors touching edge-to-edge. On back, posterior teeth disarticulated.

1). Why discolored pre-molar? **Amalgam stain**

2). What movement of condyle in TMJ must be for that position? a). rotation **b). translation** c). both - for protrusive you do both

3). What clinical picture is demonstrating? a). free way space [the space between the max and mand occl surfaces when at physiological rest] b). maximum intercuspation c). central occlusion d).incisor guidance (I don't know the answer – I put "a" but may be "b" or "d" also, check it)

4). On xray radiograph you may see circular radiolucency on middle root (close to apex) on #9. Asymptomatic, no pain. Diagnosis? **a). lateral periodonal cyst** b). radicular cyst c). medial palatine cyst

5). What is the main test needed to be done for diagnosis? **a). Thermal** vitality test b). EPT c). percussion

Case 6

68 yrs female came for your appointment with old dentures (both max/mand), that didn't fit her anymore. She had history of using Fosamax medication (biphosphonate drug to protect bones). She is after cancer surgery, radiation, chemo therapy… On xray all teeth are missing except#6,7,8,9,10 and 25,26,27

1). What is possible diagnosis for her psychotic condition? **Depression**

2). If she is after breast cancer chem./radiation + biphosfonate drug Fosamax, what treatment for her you CAN do if needed? a). extraction **b). root canal** c). alveolar plasty/surgery d). implants (you can't touch bone – risk of osteonecrosis)

3). After Fosamax was stoped for 1 week can you do extraction? **NO, Fasle**

4). What treatment is good for her? **Root planning + cleaning, prophy**

Case 7

Kid 5 yrs. 9 month fall 3 month ago. Tooth #F fall down. You can see on clinical picture new erupting tooth is appeared. She has a FISTULAR, bump above #E.

1). Tooth #E has luxation. What treatment? **Extraction**

2). Does age of patient is identical for dental age? **Yes, pt.'s age = dental age**

3). What would be a treatment? **Sealant on all permanent 1st molars**

Prophylaxis, fluoride

4). What would be a treatment for posterior crossbite? **Bilateral expansion**

5). On biteweens you can see small insipient proximal caries on mesial of #19 (between #K and #19) What is a treatment? **a). composite** b). don't do anything c). disk between teeth

Case 8

Mexican female. Has deafness because of accident. Parents help her in transportation and financially. She complain in TMJ pain

1). What would be the easiest to improve? **a). OHI oral hygiene** b). financial limitation c). deafness because of accident d). pain from TMJ

2). On Xray radiograph you can see #21 is good, normal angulation, no carries, #19 distaly tipped, a big carries lesion, # 14 is supererrupting. What treatment would you recommend? **a). build up #19 carries** b). build up #21

3). What is next treatment after that? **Build up with post and core in only ONE root canal** True or False (I don't know, check)

3). What is LEAST possible when you are upringting #19? **a). roots of #19 move facialy** b). encorrage of anterior teeth or #21

4). When you are upringting #19 what if possible to happend? **Occlusial interfearance**

5). What is LEAST possible treatment for supererrupting #14? **a). Intrusion** b). crown c). RCT d). caries txn

6). If you do EXTRUSION of tooth #13? **crown-to-root ratio increase and prognosis decrease**

Case 9

A little girl with CLEFT on clinical picture of Maxillary you can see all teeth lined up normally in ONE line, except #6 & #7, also #10 & #11 are parallel to each other (one behind other).

1). What is reason for strange position of laterals #7 and #10? **CLEFT**

2). On Cephalometric picture what is LEAST possible diagnosis? **a) maxillary prognatism** b). class1 c).class2 div 2 d). class3

3). What arrow point on xray? **HYOID**

Case 10

Man 46 yrs also with CLEFT palate, fixed when he was a kid, by surgery. On clinical picture he has Angular Chelulitis on corner of his mouth. He's complaining that his dentures are moving and discomfort him and lesion in corner bother him.

1). What is treatment for Angular Chelulitis? **Clotrimasol cream 2%**

2). On PAN two opacity left/right under his mandible? **HYOID**

3). He is missing #7 and #10 and bone here (because of cleft) look like resorbed up to10 mm. What would you recommend treatment? a). extract #8, #9 and do bridge #6-11 b). saving #8, #9 (not extraction) to preserve a bone/alveolar ridge (not sure – I choose **"b"**)

4). Implants for #7 and

What makes titanium crown biocompatible? sintering b4 milling, sintering b4 casting. ***titanium makes some kind of oxide layer.***..these are 3 of the choices from that

> For dental implants, biocompatibility depends on mechanical and corrosion/degradation properties of the material, tissue, and host factors. Ti is very resistant to tarnish and corrosion. **The corrosion protection is derived from a thin (10 nm) passivating oxide film that forms spontaneously**. However, because the oxidation rate of titanium increases markedly above 900° C, it is desirable to use ultralow-fusing porcelains (sintering temperature less than 850° C) for titanium-ceramic prostheses. A porcelain sintering temperature below 800° C is desirable to minimize oxidation and to avoid the conversion of alpha phase to the higher-temperature beta phase discussed in the following.
>
> Titanium has the highest melting temperature of all metals used for metal-ceramic prostheses and is highly resistant to sag deformation of metal frameworks at porcelain sintering temperatures. This high melting point is accompanied by a relatively low thermal expansion coefficient, and special low-expansion dental porcelains are necessary for bonding to titanium.

(Anusavice, Kenneth J.. *Phillips' Science of Dental Materials, 11th Edition*. Saunders Book Company, 072003. 22.5.8).

Teeth clicking when talking caused by what two phenomena: **too much VDO and teeth set unfavorably over ridge**

Most bacteriostatic antibiotics MOA is: **protein inhibition**

which is the indirect acting sympathomimmetic? **Tyramine, ephedrine**, **amphetamine** (mixed)

By using a compatible color when tinting porcelain you accomplish what? **Decrease value**

What comprises a combination clasp? The combination clasp uses a wrought wire retentive arm. A wrought wire is preferred for retention when the undercut occurs in the mesial third of the buccal surface of an abutment tooth. The terminal third of the clasp arm lies gingival to the height of contour while the proximal two-third lies on the height of contour.

Which crown is the weakest? (pg 190 #49 of dental secrets) **Empress** is aluminius porcelain and strongest, Euphlite, and Zirconia

Dowel question…why would u use in an endodontically treated tooth?

> A dowel is placed to provide the retention for a crown that ordinarily would have been gained from coronal tooth structure. [61,62] The use of a dowel requires that the canal be obturated with guttapercha.

(Shillingburg, H.. *Fundamentals of Fixed Prosthodontics, 3rd Edition*. Quintessence Publishing (IL), 011997. 13.5.1).

Tooth whitening…just whitened tooth, how long should u wait before u do a bonded restoration? 24hr?3day?1 week? (should wait three or more weeks according to Dental secrets however this wasn't a choice)

Perio pocket and abssess around the tooth? Endo first then perio

What is the advantage of metal framework over plastic? Except type question

Bleeding time is measure of? Platelet function

> Platelet inadequacy usually causes easy bruising and is evaluated by a bleeding time and platelet count

(Hupp, James R.. *Contemporary Oral and Maxillofacial Surgery, 5th Edition*. Mosby, 032008. 1.3.6.1).

Clopidogrel bisulfate (Plavix)?Sum with aspirin and helping with blood clotting and prevent thrombosis

> an inhibitor of platelet aggregation used as an antithrombotic for the prevention of myocardial infarction, stroke, and vascular death in patients with atherosclerosis; administered orally.

(Dorland, Newman W.. *Dorland's Illustrated Medical Dictionary, 31st Edition*. Saunders Book Company, 052007.).

Two questions about dual cure composite?

Patient has low occlusal plane what problem will they have? Pain over ridge…

Patient has untreated chemical burn at corner of mouth that has healed, What are ramifications? Linugal dentition, labial displacement….

Fixed partial bridge has failed numerous times? Poor design of metal backing

Pan of radiolucency at inf border of man below inf canal that didn't break cortical plate? Stafne bone wasn't there…maybe a submandibular gland space

Pt taking drug for depression, anxiety, OCD, and something? All choices were benzos (maybe Alprazolam (xanax), Lorazepam (ativan)) the key to answering this is to find the drug that treats OCD(its somewhere in the notes I took)

Of these medications, ***clonazepam (Rivotril)*** may specifically affect serotonin balance and is a good choice for people with OCD. Other alternatives that are commonly prescribed include lorazepam (Ativan), alprazolam (Xanax), diazepam (Valium), oxazepam (Serax) and temazepam (Restoril).

Pt taking alkalyting agent for cancer(starts with M)? what are side effects of this type of drug? Think myelosuppresion (mucositis (inflammation of the lining of the digestive tract) and alopecia (hair loss))? methotextrate

What to drugs are used to treat angina? **Nitroglycerine, beta blockers**

Glass ionomer? **aluminosilicate glass with polyacrylic acid**. Releases fluoride

Direct pulp cap and place CaOH(look up double base)…cover with ZOE

Schedule 2 drugs? Things with oxycodone

What presents with congenitally missing teeth? Ectodermal dysplasia but garders there too

Diabtetic patient for routine dental visit getting IV sedation? Don't

Why does 3rd degree hurt less than second? Nerves are destroyed in 3rd degree burns therefore no pain sensation

Pt has bad hygiene need ortho do u treat with a fixed or **removable appliance?**

Chi square and when to do? Mosby pg 214

What patient isn't on bisphonphanates? **Patient with prostate cancer**

Purpose of the maintenace phase?

Sequnce of perio? Revaluation after phase one

Pt who had condesing osteitis…perfect description? PM radiopacity next to a tooth that has little or no wear

Fentanyl delivered by transdermal patch

B/t two dental implants how much space? 3mm

Pt presents with odontogenic infection? When do u refer? Have temp of 100 OR couldn't open more 10mm

Increae Kvp does what? Long scale contrast differences between structures is small and contrast goes down.

When using a high speed which bur gives the smoothest finish? Straight fissue, diamond, crosscut bur…

Pts presents with a nodule on the lip and explains that they bit their lip? Traumatic fibroma,

Vertical defect with facial, lingual, mesial wall gone? 3 wall defect so infrabony

Ulcer on the lip, what should you do? Biopsy, cytology smear, antibiotics

What neoplasm has early presentation of widened pdl space? **Ewings…??? Osetosarcoma Mosby pg 122**

Pt with RL(radioluecency) around impacted K9, most likely? AOT

Compund odontoma picture

Periapical cemento osseous dysplasis? Individual RL around the apices of vital lower incisors

What turns porcelain green? Silver

Majority of dentisty is paid how? Outta pocket

14 y.o girl presents with bleeding on probing? Gingivitis

Pt exhibiting stridor, what is causing this? Caused by laryngospasm inspiratory wheezing, tx succynlcholine

Referred pain to ear? Mandibular molars

Occurance of cleft palate? 1/700 births

Facial profile of a pt with Down Syndrome? Class 3

Causes down syndrome? Multifactorial

Perio disease not helped by adjunctive antibiotics? Chronic Periodontitis

Niti vs stainless steel(this is an except ?) know characteristics

14 y/o with a class 2 on 2nd molar how do u treat? SSC, crown and amalgam buildup

When placing an implant you shouldn't heat the bone above what temp? 40 degrees was not a choice 36 degrees was the closest

When performing an osteotomy on the ramus of the mandible parathesia of the lip results? What kind of osteotomy was performed: **saggital split osteotomy**

Distance b/t implant and nutrient vessels? 2mm

Which space is most important to maintain? 1st molar, **2nd molar**, K9, and

Im sorry you had a bad experience, your dentures really created? 1st Sympathetic and 2nd empathic

Best test to use on a pt taking warfarin, when trying to determine bleeding tendency? INR

Most congenitally missing tooth? Man 2nd PM

Most impacted? Max K9

At what point can u tell the shape of tooth? Morphodiffertiation maybe

Osteogenis imperfecta is seen with? Dentogenisis imperfecta type I

Dens in dente picture

Patient having a myocardial infarction what do you do? Start BLS

Palatal gingival groove create perio? Max lateral Incisior

Pt with symptomatic cracked tooth and no pulpal involvement, how should ou treat? Bonded restoration, extracoronal, take cusp out of occlusion… Mosby pg 9

Sinusitis of non odontogenic origin what antibiotic should you prescribe? **Amox w clav**, erythromycin, tetracyclin, metronitazole

Operculum on tooth #18, how should you treat? Tissue out of occlusion, ext, adjust #15, scale under operculum

MC

A tooth with a class 3 furcation involvement within 5mm of the apex, how do u treat? Hemisection, bicuspidization, ext

6 y/o with unilateral macroglossia with pinkish gray fluctant nodule? Lympangioma, nuerofibromatis, sterge weber

Pt wth advanced periodontitis and suspected Papillon-Lef'evre, will also present with? Palmar plantar keratanosis

Pemphigoid question? Seperation from basement membrane

When do you use a base metal over a noble metal? Long span fpd is base, crown, is noble

A non carious tooth with short clinical crown is to be used as an abutment, what typae of coverage is best? ¾ crown, **full coverage crown**, inlay/onlay…

This lesion more often than not is a severe dysplasia or carcinoma in situ? **Erythoplakia**, white sponge nevus, lichen planus, leukoplakia

Lesion on lateral border of tongue white with red? Maybe geographic tongue

Altered eruption with gingival margin coronal to CEJ and normal bone, how do you improve esthetics? Apically repositied, **mod wid**, replaced, think apically positioned

Increasing the lingual attached gingiva around man premolars and molars is inhibited by? Myohyloid ridge, sum, anatomical

Pt with bifid ribs and basal cell carcinomas will also present with? multiple OKCs

Swelling of midline of ant palate and radilucency? Nasopalaline(incisive canal)

Most common cause of cardiac failure in infants? Respiratory

What determines placement posterior palatal seal? Vibrating line

Why don't you set teeth on retromolar pad? Cause denture to dislodge

Primary reason for occlusal adjustment? Center forces down long axis of tooth, to achieve bilateral balanced occlusion

Polymethly methacrylate, what is the initiator? **Benzoyl peroxide**

Making "F" sound teeth should contact? Lower lip

Teeth on set directly over maxillary ridge with marked ridge resorption? Teeth too far lingually resorp up and backwards

Pt smile and denture fall out? Overextended flanges

No calculation

No L.A.

Just placed class 4 composite 3 days ago and good besides color is off? Compostie tint, remove outer layer of composite and veneer…

45 y/o pt with a sound crown but its lighter than surrounding teeth WWYD? bleach, 2 stain choices

Fluoride that's not in toothpaste? APF and SnF are not found in toothpaste

School based fl program, how is fluoride given to them? (Know grams, concentration, and frequent) .05% daily swallowed ,**02% weekly expectorate**…

LED curing light vs another aren't able to cure all resins because they can only cure within spectrum? 1st second true false joint

What is IgG? Recruit IgE(mast cells)

Pregnant patient, lay with right side up

Pregnant suppressing IVC

Don't take gingko with aspirin because they hav same effect

St. Johns wart…all herbal supps cause excess bleeding dnt give with aspirin

Slurred speech in dental chair? stroke

Autonomy, respecting patients autonomy is respecting their decision to make informed decision

Inverse square law? Moved from 12 to 4 feet is 9X

What type of caries is represented by broad area and comes to point at DEJ? Smooth surface

Most common salivary gland tumor? Pleomorphic adenoma

Couple slob rule question, move xray beem to lingual what, moves where?

Inferior Alveolar Canal is buccal to the root of the mandibular molar, move xray cone inferiorly. What moves with you? The canal…same buccal opposite lingual The object closest to the film will move the least with the object closes to the radiation source will move the furtherst

Seated the crown and two to three days comes back with inflammation where it was cemented? Allergic to cement, **left cement around margin**

Whats the most logical way to make a crown fit? Die spacer

Facial of tooth is divided vertically into? 5ths

Aids pt with candiasis what do you give? Nystantin

Aids pt w oralpharngeal candidiasis what do you give? Fluconozale

19yrs denture but presents with white lesion at denture border? Take margin down and call in 2weeks

Even under 100% humidity Irreversible hydrocollid undergoes? Synersis

Pt bisphosphanates and need extraction due to irrestorble teeth and EXT what do u do? Take them off bisphos for 3 months…

Cortocsteriods used for what length of time cause immunosuppresion**? 200mg/2weeks,** 2 years, 20mg 2 weeks, 2 years…

Lack of C1esterase…what does it indicate?angioedema

Insurance bill insurance for post core and crown? Bundled

What is waiting period as pertains to dental insurance? Time btw when pt signs up and when benefits kick in

Pt has distocclusion with upright max centrals with Low mandibular angle? Class 2 div 2 maybe upright central

Making immediate denture, pt has anterior and tuborosity undercuts, what would do? reduce tuberoity undercuts only

Main reason for rct failure? Coronal leakage

Opiods act on what receptors? Mu receptors

What does chemo cause? Thrombocytopenia

Inverted Y on the xray

HMO is a capitation plan

Govt based dental funds are distributed based on what? **Need**, cost, demand,

Arch perimeter is measured from what to what?

> The **arch length**, also known as **arch perimeter**, is determined by measuring from **the mesial surface of one molar to the mesial surface of the contralateral molar** along the arch form presented by the teeth

(Riolo, Michael. *Essentials for Orthodontic Practice, 2nd Edition*. Essential Press 6.4.1).
You perforate a maxillary molar while looking for canal and what is best way to treat? Repair immediately, CaOH

Gingival collar around natural tooth and soft tissue of implant have in common what?

The stimulation of Ondotoblastic neurons are moved by mechnical irritation

How do sulfaureas work? Increase insulin release from pancreas

Xerostomia can cause? Infection of salivary gland

Pt with sjogrens is likely to develop? lymphoma

Pt with 3mm pockets, you would do all except? NO SRP

Attrition on tooth is most likely caused by? Opposing tooth

When doing a gingivectomy the internal bevel should be placed?3mm coronal to MGJ 1-2 mm from gingival margins

An implant is placed but when you attempt to loaded it, it's loose what does this mean? FAIL

ANUG questions…signs and symptoms

Picture 14 y/o right man expansion and RCT on #30, key is what causes bone expansion and tooth extruded? **Osteosarcoma**, fibrous dysplasia

Pt on tertracycline…what is not the outcome? Related to having decreased bacteria in sulcus

Pt has perio abscess and chronic perio? SRP

How does mouth breather present? steep mandibular angle

Pt w midface insufficiency? Down syndrome

Which is least acceptable for final impressions for crown? Irreversible hydrocolloid

Pyrophosphate in toothpaste is used for? **Anti calculus or plaque**

Peiodontitis of pregnancy and puberty is caused by? Plaque(prevotella gingival use hormones)

Freeze dried bone from bovine

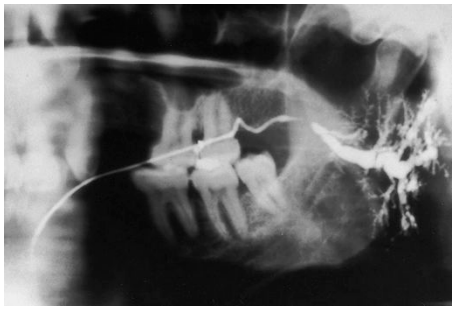
What angulation do you hold currette for SRP? 45-90

Scenario where had to do full thickness vs partial thickness flap?

Implant fails, most likely due to what? Smoking

Pt smokes see all of the following except? Bleeding on probing

Sialadentitis of wharthins duct presents with constrictions that resemble a sausage, what disease is this…uhhh



(Peterson, Larry J.. *Contemporary Oral and Maxillofacial Surgery, 4th Edition*. Mosby Elsevier Health Science, 122002. 25.2.2.2).

> Sialodochitis is a dilation of the salivary duct secondary to epithelial atrophy as a result of repeated inflammatory or infectious processes, with irregular narrowing caused by reparative fibrosis (i.e., "sausage link" pattern). Sialadenitis represents inflammation mainly involving the acinoparenchyma of the gland. Patients with sialadenitis experience sacculardilation of the acini of the gland secondary to acinar atrophy and infection, which results in "pruning" of the normal arborization of the small ductal system of the gland. Centrally located lesions or tumors that occupy a part of the gland or impinge on its surface displace the normal ductal anatomy.

(Peterson, Larry J.. *Contemporary Oral and Maxillofacial Surgery, 4th Edition*. Mosby Elsevier Health Science, 122002. 25.2.2.2).
What does OSHA require testing for every year? TB

What is least important when selecting teeth to be used for overdenture? Pg 199 DS…imp is amount supportive bone,number exist roots,type and amount occlusal force,type attachment,spint or nonspint roots

What is seen in sympysis synchondrosis of the mandible?

Which is the least appropriate way to store avulsed tooth? **Water**, hanks, milk, saliva

What is the storage media for avulsed tooth? Hanks but not called hanks (Viaspan)

A pt taking digitalis for CHF the question has something to do with fluid elimination? Digi increase pumping, diuretics get flow out

Acromegaly class of occlusion? Class 3

Head lighting is opaque layer showing through crown caused by? Improper tooth prep

headlight" show-through of the underlying tooth color or opaque-bonding resin.

(Rufenacht, Claude R.. *Fundamentals of Esthetics*. Quintessence Publishing (IL), 011990. 12.7.4).

The auriculotemporal nerve is located near the ear and the top of the jaw on both sides. Common headaches with problems to this nerve are temple headaches. This nerve is commonly damaged in TMJ surgery. it is usually pounding because it is near the temporal artery.