Global Ceram•X Case Contest 2008/2009

**Introduction to the case**

A 59-year-old female patient presented with large fractures of her maxillary right (UR1) and left central incisors. These were a result of a traumatic fall and necessitated restorations for aesthetic and functional reasons.

The ULI responded normally to sensitivity testing and therefore considered to be vital; the UR1 had been treated endodontically, satisfactorily. This case was restored using Ceram•X™ duo; advanced nano- ceramic technology.

**Material and method**

Ceram•X™ duo (Shade E3 and D2). Nupro® prophylaxis paste (Dentsply DeTrey). 36% phosphoric acid (DeTrey® Conditioner 56. Dentsply DeTrey). Prime & Bond®NT (Dentsply DeTrey), Enhance and PoGo™ (Dentsply DeTrey), unfilled resin.

Direct adhesive bonding followed by natural layering technique. Ceram•X™ duo shade E3 used to give enamel-like translucency and shade D2 used to replace the lost dentine giving the correct opacity and chroma. Final polishing for superior surface gloss and smoothness.

**Discussion and conclusion**

A very aesthetically-pleasing, ‘life-like’ result was achieved.

This material also has excellent handling and placement properties and is understood to have good longevity. This is thus an attractive option especially for anterior restorations. Ceram•X™ duo certainly brings a smile to both the patient and dentist.

**Under-treatment & Supervised Neglect**

A 40-year-old woman presented to the practice with a complaint of sensitivity to hot and cold food. The patient did not have any obvious symptoms of pulpitis or periapical pathology.

**Diagnosis**

A radiograph was taken which revealed a periapical lesion with root resorption.

**Management**

1. Endodontic treatment was performed.
2. The tooth was restored with a composite resin restoration.

**Follow-up**

The patient was reviewed every 6 months and the tooth remained asymptomatic.

**Conclusion**

This case highlights the importance of comprehensive case assessment and management in ensuring optimal patient outcomes.
A dentist who is under stress for many reasons can sometimes lose sight of the patient’s attendance pattern, record the fact that a patient can- not be encouraged to amplify clinical notes to reflect what has been done, and stand back from time to time, or more proactively, stand back from time to time, and to legibly insert a new name. Where manual (paper) records are being used, however, it would be much more unusual for a receptionist to retrieve the patient’s notes, specifically in order to record the fact that the next appointment, a week or two later, had been can- celled by the patient. In the absence of this record, the appointment book itself can sometimes become a valuable additional record — although many receptionists prefer to erase the records simply mention that a second dentist was seen, or that some old and dis- colouration. A clinician, who has observed these same restorations over several years with little or no deterioration, is well placed to appreciate that the situation is stable.

At some stage in their career, most practitioners will have had patients who seem to stagger from one crisis to another, and whose treatment never really feels to be under the practitioner’s control. These patients often present with so many unexpected emergency problems in between their sched-uled review appointments, that one course of treatment seems to merge seamlessly into the next. There is a danger that the patient’s treatment never really feels to be complete, in order to indicate availability — although this was done, then it becomes impossible either to make, or not make, a specific treatment recommenda- tion, to discuss the options with the patient and to record the outcome of these conversations clearly in the clinical notes. This becomes particularly important when treating pa- tients with whom you have a less-than-ideal professional relationship — perhaps professional colleagues, staff, friends or family members. This is true more pro- nounced, and why, is a valuable pro- duction with patients about their oral condition, and about what treatment is (and isn’t) being pro- posed, and why, is a valuable pro- tective measure against an allegation of un- der-treatment. Full and meticulous records based upon appropriate in- vestigations are equally invalu- able. These two strategies, coupled with an up-to-date awareness of current thinking in diagnosis and treatment planning, will avoid the majority of problems in this area.

A significant number of the “multiple” cases of “supervised neglect”, tend to involve practition- ers who are nearing retirement, which is a particular concern, since a large number of the practitioner’s patients will shortly be seen by a second dentist. This is often the case, which is “supervised neg- lect” or “patch and mend”, rather than a more protracted “what’s happening here, and why?” fashion.

Assessing the Situation
In such cases it is important to stand back from time to time and to make the effort to take a more detailed overview of the patient’s oral health, approaching this in the same logical fashion as one might approach a patient who you were treating for the first time. If the records can demonstrate that this was done, then it becomes much easier to defend subsequent allegations of under-treatment or “supervised neglect”.

The records sometimes tell the story of a patient who was at one stage being treated very diligently and attentively by a practitioner, but gradually this picture changes to one in which medical histories are not being updated, periodontal health is not being monitored, x-rays are not being taken, and so on. A periodontal problem or a n i s s u e over a root apex is “treated” with a prescription for antibiotics, but with no other details recorded in the notes, and no arrangements made for follow-up. Worse still, the records simply mention that a prescription was given, with no explanation of why this was being done.

Many factors can contribute to a greater or lesser extent in the “supervised neglect” of a patient:

• Other dentists are unwell physically or mentally, and may not always realise this at the time; in one instance the explanation was no more complex than that the practitioner in question had not realised the extent to which his eyesight had deteriorated.

• Sometimes dentists are simply too busy, perhaps having been unable to replace a retired colleague, and “supervised neg- lect” becomes a response to hav- ing to see too many patients in too little time.

To avoid this situation it is sen- sible either to make, or not make, a specific treatment recommenda- tion, to discuss the options with the patient and to record the outcome of these conversations clearly in the clinical notes. This becomes particu- larly important when treating pa- tients with whom you have a less-than-ideal professional relationship — perhaps professional colleagues, staff, friends or family members. This is true more pro- nounced, and why, is a valuable pro- tective measure against an allegation of under-treatment. Full and meticulous records based upon appropriate in- vestigations are equally invalu- able. These two strategies, coupled with an up-to-date awareness of current thinking in diagnosis and treatment planning, will avoid the majority of problems in this area.

Summary
All dentists have a duty of care to exercise a reasonable standard of skill and competence when treating each patient under their care. Fail- ing to provide necessary treatment is one way in which this duty of care can be breached; recommending or providing unnecessary treatment falls at the other extreme, but is still a breach of a clinician’s duty of care.

Regular and effective commu- nication with patients about their oral condition, and about what treatment is (and isn’t) being pro- posed, and why, is a valuable pro- tective measure against an allegation of under-treatment. Full and meticulous records based upon appropriate in- vestigations are equally invalu- able. These two strategies, coupled with an up-to-date awareness of current thinking in diagnosis and treatment planning, will avoid the majority of problems in this area.

Editorial Note: This text should ideally be read in conjunc- tion with the article on history tak- ing to be published in the next edi- tion of Dental Tribune.

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