Endodontics

Tavga81@gmail.com -1-10

QUESTION: which teeth do you perform pulp eval on?
a. tooth only
b. tooth and neighboring teeth
c. tooth, neighboring teeth, contralateral tooth-ans
d. tooth, neighboring teeth, opposing tooth
QUESTION: Is an apical radiolucency present for a long time with no symptoms and no sinus tract associated with necrotic pulp or asymptomatic apical periodontitis? Asymp chronic periodontits
QUESTION: You have a tooth, no pulp, but periapical radiolucency, you do access and find no canal, what do you do? - I said don't try to be a hero, refer to an endodontist
QUESTION (DAY 2): A molar is super-erupted, but has irreversible pulpitis, what do you do? – RCT and Crown (other choices were EXT, just do crown – this was tricky because to answer the question, you have to look at the patient dental chart and findings
QUESTION: 5yrs old patient, he fell down 2 months ago, and hit his #E when he fell down, the tooth is now discolored, what do you suspect? – Necrotic pulp
QUESTION: Same patient as above, there is a red swollen lesion on the gingival of tooth #E, what is most likely be? – Sinus tract (other choices, periapical cyst, periapical granuloma, etc)
QUESTION: Same kid from above, What do you recommend for this tooth? – EXT!
QUESTION: What does radiolucency at furcation of primary M1 in 5yo usually indicate: erupting permanent PM1, necrotic pulp, normal anatomy

a. Necrotic pulp – it is in a 5yo so man PM1 shouldn't be causing resorption yet

QUESTION (DAY 2): A case of a patient with tooth that has sensitivity that lingers with thermal test, and positive to percussion, what does the patient have? – Irreversible pulpitis with acute periapical abcess (other choices were Irreversible puplitis with no acute peripical abcess, and 2 other choice with reversible pulpitis in them).

QUESTION: Prolonged, unstimulated night pain suggests which of the following conditions of the
pulp?
A. Pulp necrosis
B. Mild hyperemia
C. Reversible pulpitis
D. No specific condition
QUESTION: Chronic periradicular abscess indicates: necrotic pulp
QUESTION: X-ray of PA R/L of a primary teeth: Normal R/L because perm tooth is erupting underneath
QUESTION: Little girl had ALL, had radiolucency in furcation of primary 2nd molar. What is the treatment?
• Extraction

• Pulpotomy
• Pulpectomy

A- should be done before radiation therapy.because

the contra indications of pulpotomy are : Contraindications for Primary Tooth Pulpectomy

• 1. Teeth with nonrestorable crowns,
• 2. Periradicular involvement extending to the permanent tooth bud,
• 3. Pathologic resorption of at least one-third of the root with a fistulous sinus tract,
• 4. Excessive internal resorption,
• 5. Extensive pulp floor opening into the bifurcation,
• 6. Systemic illness such: as congenital or rheumatic heart disease, hepatitis, leukemia, and children on long-term corticosteroid therapy, or those who are immunocompromised,
• 7. Primary teeth with underlying dentigerous or follicular cysts.

QUESTION: primary tooth got necrosis, and the inflammation went down through furcation and affects permanent tooth. What is it gonna cause to permanent tooth? Can disturb ameloblastic layer of permenant successor or spread infection

QUESTION: Radiolucency in furcation of primary tooth? Necrotic, extract
QUESTION: In a primary tooth apical infection the first radigrapoh sign is where?- in the furcation.
QUESTION: Most common medication for pulpectomy/pulpotomy? FOROMCRESOL
QUESTION: calcium hydroxide is contraindicated in pulpotomy in a child because it causes irritation leading to resorption in primary teeth
QUESTION: 5.38 picture: know when to extract

If it's a primary 1st with furcation involvement: EXT
If it's a primary 2nd, furcation, but restorable: PE

If its any other primary tooth no furcation: PO

QUESTION: The best method to test newly erupted primary teeth – cold test
QUESTION: Which is incorrect? Do EPT for traumatic tooth

QUESTION: Most common medication for pulpectomy/pulpotomy? formacresoll

question:least reliable test on primary teeth?swelling
pulp testing
spontaneous pain
internal resorption

• Electric pulp test(least reliabe)
• Percussion (MOST RELIABLE)

QUESTION: If you have pain, what would be the hardest to anesthetize?

a. Irreversible pulpitis and maxillary
b. Irreversible pulpitis and mandibular
c. Necrotic pulp and maxillary
d. Necrotic pulp and mandibular

“When irreversible pulpitis is a factor, the teeth that are most difficult to anesthetize are the mandibular molars, followed by the mandibular premolars, the maxillary molars and premolars, and the mandibular anterior teeth. The fewest problems arise in the maxillary anterior teeth.”
Hargreaves, Cohen. Cohen's Pathways of the Pulp, 10th Edition. Mosby, 052010.

QUESTION: pulpal pain that only occur at night with no stimulation: pulpal necrosis
QUESTION: when the heat apply to tooth, lingering pain for several minutes: irreversible pulpitis
QUESTION: what is diagnosis: lingering pain to cold and sensitivity to percussion?Irreversible pulpitis
and acute periapical abscess

Usually periodontal abscess is sensitive to percussion…irreversible is usually percussion
Positive

QUESTION: A tooth is not responsive to cold, not to percussion, and palpation is tender: necrotic pulp
and chronic apical periodontitis. – irreversible pulpitis and normal apex) there was not an item saying
necrotic pulp and normal apex)

QUESTION: Which of the following least important factor in referring an endo case to specialist?
Dilacerations, calcifications, inability to obtain adequate anesthesia? Lease import is mesial inclination
of a molar*** correct answer0

QUESTION: 7 yr old boy has vital exposure of tooth 1st perm max molar. What do you do for treatment. Pulpotomy carious? Pulpotomy.
QUESTION: Child had carries exposure on primary 1st molar….what to do pulpotomy

QUESTION: Did pulpotomy in a 7 yr old’s pulp exposed decayed tooth #30 why? To allow completion of root formation (apexogenesis)

Apexification: Create an apical barrier in a necrotic tooth with an open apex.
? Induce a calcified apical barrier by placing dense calcium hydroxide paste after the instrumentation. Canals are obturated when barrier is formed in 3–6 months.
? Placement of an artificial apical barrier, such as MTA, prior to obturation. This method, can be completed in a day or two, appropriate when patient compliance or long-term follow-up care is questionable.

Apexogenesis: Vital pulp therapy performed to allow continued physiologic development and formation of the root.
? Place calcium hydroxide over the radicular pulp stump. Recall every 3 m pulpal status.
? RCT is indicated when the root development is completed.

apexogenesis & apexification on primary vital & non vital teeth
• apexogenesis: tx of VITAL tooth w/ an OPEN apex & pulp exposure using calcium hydroxide to
preserve vitality & encourages the continued development of the root
• apexification: tx of NONVITAL tooth w/ incomplete apex formation & pulp exposure using
calcium hydroxide to achieve apical closure

Apicoectomy: (Root-end resection): Prep of flat surface by excision of apical portion of root.
Most common medication for pulpectomy/pulpotomy?
QUESTION: Know when to do indirect pulp cap, pulpotomy, apexification (non vital teeth with MTA),
and pulpectomy (ZOE if apex is not closed in primary teeth) in pedo patients.
QUESTION: Indications for apicoectomy: RCT can't be done by conventional means, failed existing
RCT and can't re-treat

QUESTION: why you do apico surgery except : When an apical portion of canal cannot be cleaned,
persistent apical pathology after RCT, apical fracture, overextension of material interferes with healing.
QUESTION: If a tooth with previous endodontic treatment becomes reinfected, it is best to retreat it
conventionally by removing the filling material, debride the canals, and refill. However, if the tooth has
been restored with a post, core, and crown, then apical curettage, then an apicoectomy and retrofill
should be performed.

QUESTION: PEriapical lesion biopsied after apicoectomy of RCT treated tooth, tooth still sensitive
tooth, with neutrophils, plasma cells, nonkeratanized stratified epithelieum (islands of), and fibrous connective tissue→ abcess, granuloma, cyst,
QUESTION: Extraradicular biofilm theory recommends endo with: Crown down, debridgement, Ca(OH)2
therapy? (irrigate and debride)

QUESTION: Why you perform apexification: When you have necrosis on an open apice tooth.
QUESTION: why you do apico surgery : When an apical portion of canal cannot be cleaned, persistent apical pathology after RCT, apical fracture, overextension of material interferes with healing.
QUESTION: Patient (6 yo), the treatment of choice for a necrotic pulp on permanent first molar would be:
1. Apexification (Non vital) 2. Apexogenesis, (vital) 3. Root Canal Treatment
QUESTION: why you perform apexification(non-vital) :?When you have necrosis on an open apex tooth

QUESTION: Definition of apexification:The process of induced root development or apical closure of the
root by hard tissue deposition NONVITAL
QUESTION: Tx for Traumatic pulp exposure on max incisor that root has not completed formation?
Apexogenesis

QUESTION: irreversible pulpitis with open apex apexification

QUESTION: Six months ago you did a RCT on central with an open apex (the pt was young, but can't
remember the exact age). You place calcium hydroxide in canal and waited the 6 months. You open the
canal but can still pass #70 file through the apex. What would you do?
- *calcium hydroxide
- Zinc oxide eugenol
- gutta percha

QUESTION: Pulp is vital, pt's a 8 year old. Apex is open. What do you do.
A. Apexification
B. Apicoectomy
C. Pulpectomy
D. calcium hydroxide pulpotomy.**

Tooth Avulsion: complete dislodgment of a tooth out of its socket by traumatic injury. Short extraoral
dry time and proper storage medium are key factors in offering favorable treatment outcome.

? Indications for treatment: Treatment is indicated when a tooth is completely dislodged from its alveolus.

QUESTION: Reason for failure of replantation of avulsed tooth: external resorption, internal resorption
QUESTION: Most important factor about avulsed tooth – Time (other options were like what you store it
in, etc)
QUESTION: Before 15 min what is success rate of avulsed tooth? 90 percent success rate, by 30 min? success rate decreases to 50%
QUESTION: why an implanted avulsed tooth fail : a) the dentist curettage the socket b) too much
extra oral time c)the dentist clean the root surface d)failure to place the tooth in the solution (Fl)
QUESTION: Which is incorrect: should rinse with water if tooth is taken out

QUESTION: Splinting Avulsed tooth – 1-2 weeks **yes..mosbys says splint for 7-10 days
QUESTION: How long do you splint after tooth has been avulsed? 1-2 weeks
QUESTION: Best substance to place avulsed tooth.? hanks solution(na, K,calcium plus glucose) if not
milk.
QUESTION: If tooth has closed apex, immerse tooth in 2.4% sodium fluoride solution with what pH
for how many minutes? pH of 5.5 (changed the pH) for 5 min…

QUESTION: Avulsed tooth should be treated with what to reduce root resorption? 2% Sodium fluoride for 20 minutes.

QUESTION: If tooth has open apex, and it gets avulsed, how you close it? You use MTA.
QUESTION: Which material is least cytotoxic for perforation repair? MTA
QUESTION: CaOH tx for an avulsed tooth????? Yes or no?
QUESTION: Splint tooth for pt comfort
Avulsion – 7-10 days non rigid splint, antibiotics
Rigid splint for horizontal root fractures 3 months
Extrusion is a splint for 2-3 weeks

QUESTION: Intrusion tx of permanent teeth? Reposition and splint
QUESTION: Patient intrudes mature maxillary incisor. Trauma causing deep intrusion to a permanent tooth causes PULP NECROSIS and conventional RCT is necessary.
QUESTION: Tooth with closed apex gets intruded, what is most likely to occur? Necrosis
QUESTION: Intrusive trauma pulp necrosis, what percent is rate of pulp necrosis? 96 %

RCT related:

Endo tests?

Percussion- presence of inflammation in PDL or not.

Palpation- spread of inflammation to perodotium from PDL or not.

EPT- Pulp vitality (necrosis or not)

Thermal test (hot & cold)-pulp vitality. Hot (irrev), cold (rev)

.

QUESTION: Primary purpose of sodium hypochlorite? Dissolve necrotic tissue

***Sodium hypochlorite NaOCl is NOT a chelator, (it dissolves organic tissue)

QUESTION: Bleach is not a chelating agent

QUESTION: Sodium hypochlorite is used for everything except? Chelation

QUESTION: Sodium hypochlorite is not a chelating agent. **It is an 5.25% irrigation solution—germicidal. It is also vital to tissue. Other irrigation solutions include urea peroxide (glycerol based) and
3% hydrogen peroxide. Chelating agents are good for sclerotic canals. Substitute sodium ions and soften
canal walls.

QUESTION: What is the job of Ca(OH)2 during a root canal procedure: Intracanal medicament

QUESTION: which is a chelator for endo? EDTA, sodium hypochlorite, etc.

EDTA is chelator, removes SMEAR LAYER and inorganic material.

(NaOCl = sodium hypochlorite only dissolves organic material, only disinfects and is most common irrigant.)

QUESTION: EDTA: **Percentage of EDTA: 17%

QUESTION: What is the function of EDTA: remove inorganic material and smear layer

QUESTION: Which one is false about NaOH? – It's a chelating agent.

QUESTION: Chelating agent: EDTA

QUESTION: contraidication for CaOH: Pulp symptomatic for last month..

QUESTION: PAR seen on asymptomatic tooth, when opened the canal is calcified what do you do: do
nothing, refer to endodontist, place EDTA

QUESTION: Internal resorption left untreated can lead to? I think Pink tooth

QUESTION: Similar question: What causes Pink Tooth Mummery? internal
resorption

QUESTION: treatment for internal resorption (endo): RCT

QUESTION: Internal resorption shows all BUT – radiography is symmetrical with the pulp space, can

resorb all the way to the PDL, a treatment option is observe until resorption stops, resorb to create
pink tooth
QUESTION: when a tooth is ankylosed what type of resorption : replacement resorp

QUESTION When you replant teeth, what will happen
a. Ankylosis (will not say that) – replacement bone formation ANS

QUESTION: The treatment-of-choice for an external inflammatory root resorption on a non-vital tooth is
which of the following?
A. Extraction
B. Surgical curettage of the affected tissue
C. Pulpectomy and obturation with gutta-percha and sealer
D. Removal of the necrotic pulp and placement of calcium hydroxide
E.Observation since it is a self-limiting process

QUESTION: when a reimplanted tooth presents external resorption what is the Tx : a) RCT with gutta percha JUST OBTURATE AND PLACE CaOH
QUESTION: How you manage tooth with external root resorption
b. Instrument and put CaOH

QUESTION: when a reinplanted tooth presents external resorption what is the Tx : a) RCT with gutta percha b) obturation with CaOH c) extraction
(do CaOH every 3 months until PDL is healthy then complete RCT)

QUESTION: which has the best prognosis
• perforation in extneral resorption
• perforation in internal resorption??
• extruded gutta percha

QUESTION: least likely to result in endo failure? overfilling with gutta percha, inadequate either obturation or cleaning and shaping (can't remember), lateral root resorption, perforating internal resorption

QUESTION: cause of grey tooth
• blood products in the dentinal tubules (what I put, I think this is correct)
• internal resorption
• external resorption
• calcified canal

(hyperbilirubinemia: grayish-blue: Xtina)

QUESTION: Why are traumatized primary incisors discolored? Pulpal Necrosis and Pulpal Bleeding

QUESTION: elective endo
• pulp exposure
• unrestorable tooth…
• endo contraindicated in: non restorable tooth

QUESTION: Most common cell in necrotic pulp? PMN cells

QUESTION: Biggest reason for failure of RCT – cleaning of the canals, proper obturation …
QUESTION: root canal failed on upper canine - (lack of seal)
QUESTION: RCT done 1.5 yrs ago, now radiolucency and fistula - incomplete RCT

QUESTION: Pt comes in for a RCT on a non-vital tooth with 1mm apical lucency. 5mo later comes back
with 5mm lucency, why?- Improperly done endo, retx. Others another canal, osteosarcoma, carcinoma.

Most common cause of RCT failure is inadequate disinfected RC, 2nd most common cause is poorly
filled canals.
QUESTION: Incomplete removal of bacteria, pulp debris, and dentinal shavings is commonly caused
by failure to irrigate thoroughly. Another reason is failure to
A. use broaches.
B. use a chelating agent.
C. obtain a straight line access.
D. use Gates-Glidden burs.

QUESTION: least likely cause for failed RCT
a. GP beyond apex---causes of failure 1) insufficient canal debridement 2) insufficient obuturation/leakage.
b. clean & shaping no good
c. obturation no good

QUESTION: Gutta percha, all except – adapts to tooth (needs sealer)
QUESTION: Which of the following is not a property of gutta-percha . radiopacity, Biocompatibility,
Antibacterial, ?Adaptation
QUESTION: Gutta percha has the following advantages EXCEPT: 1.easy manipulation, 2. Adapts to
tooth surface, 3.Anti- microbial,4. Biocompatible

QUESTION: Patient comes back few months after RCT & Crown with pain upon biting, what

happened…cracked tooth, hypersensitivity

QUESTION: Pt has pain in tooth after crown and root canal: vertical root fracture, a lot of these type of
questions, know wehter it's vertical, or occlusion problems (sensitive to cold, hot and all that).
QUESTION: Similar questions: Crown cemented two weeks ago is sensitive to pressure and cold, why?
Occlusal trauma
QUESTION: Pain on tooth 2 weeks after crown placement? I put root fracture
***No why would it be root fracture after a crown placement?? it would make more sense that it's a root
fracture after RCT not crown placement. I think answer should be hyperocclusion, if the option was there

QUESTION: Tooth with endo treated and post with crown have pain after several days esp during biting
and cold: ? vertical root fracture
QUESTION: Patient has pain 1 month after cemented crown and post and rct, pain on biting, why?
Vertical root fracture
QUESTION: You did endo on patient, weeks later you did CPC after that? Patient has post-op pain on
tooth? Vertical fracture

QUESTION: RCT is contraindicated for a vertical root fracture
QUESTION: Vertical root fracture – non restorable after
QUESTION: Most common cause of vertical rt fracture?
• In endo tx'd teeth: excessive lateral condensation of GP
• In vital teeth: physical trauma
QUESTION: Vertical Root Fracture is most likely found? Mand posteriors

2 Doc Soniya 11-20

Page 11 -20
QUESTION: Which teeth do vertical fractures more common?
– Lower posterior teeth.
QUESTION: What causes most vertical root fractures?
Condensation of gutta percha
QUESTION: most probability of vertical root fracture
- isolated pocket depth
QUESTION: isolated pocket . What condition?
Vertical root fracture
– Cracked tooth

syndrome
QUESTION: Which one has a different transillumination?
-cracked tooth
QUESTION: which allows the enitre tooth tooth to light up under transillumination?
Again cracked tooth

QUESTION: When does transillumiator show evenly through tooth: craze line, crack, fracture from crown to root:craze line
Craze QUESTION: when does translumination shows the whole crown : a) fracture cusp b) cracked tooth
c) craze lines
TRANSILLUMINATION: shows cracks.
Whole tooth = craze line
QUESTION: Type of fracture that lets light pass completely through…
a. crazed CRAZE LINE
b. split tooth
QUESTION: Which will show up on transillumination best?
Cracked tooth
Fractured cusp
Craze line
QUESTION: Which will show up on transillumination best?
Cracked tooth
Fractured cusp
Vertical root fracture
Craze line
QUESTION: Vertical root fractures are also called cracked teeth. The prognosis of cracked teeth varies
with extent and depth of crack.
a. Both statements are true
b. Both statements are false.
c. First statement is true, second is false.
d. First statement is false, second is true.
QUESTION: If two cavities were thought to be two separate fillings but upon exam it was a crack through
the isthmus. What do we tx this symptomless crack with?
- observe
QUESTION: most common tooth associated w/ cracked tooth syndrome:
Mandibular second molars,
followed by mandibular first molars and maxillary premolars, are the most commonly affected teeth.
QUESTION: Crack tooth syndrome is most likely found?
Mandibular Molars
QUESTION: Most common to have cracked tooth
= mand 1st molar (mand 2nd first) MD
direction

QUESTION: horiz root fracture
a. reduce & immobilize
QUESTION: How do you first tx a horizontal root fracture?
Immobilize the segments for
12weeks b.SPLINT
QUESTION: Apical horoziontal root fracture: no pain, what do you do? Rct, scaling, rct if tested nonvital, monitor 1 year
QUESTION: Horizontal Root Fracture more common in anteriors, the success and healing of horizontal root fractures is the immediate reduction of the fractured segments and the immobilization of the coronal segment 12 weeks
QUESTION: Horizontal rooth fracture: take multiple vertical angulated xrays
QUESTION: Most common teeth with crown to root fracture? Mand molars
QUESTION: which tooth is least likely to fracture: mx premolar, mx molar, md premolar, md molar
QUESTION: which tooth is most commonly fractured? mx incisors, md incisors, etc.
QUESTION: Chronic endo lesion, what type of bacteria? Anerobes ANS (multiple anerobes)
QUESTION: Reason for failed endo?
Seal 2mm away from apex
Bacterial infection
RCT sealer beyond apex
Forgot other one
QUESTION: Endo f ile breaks when you at 15 file. refer to endodontist.(retrieving it was not an option)
QUESTION: If file breaks tooth asx:
• Leave and monitor
QUESTION: You being the best doctor in the world, you broke a 5mm dental instrument in a canal during
RCT procedure, what's the best thing to do? – Tell the patient what happened, and refer her to an endodontist. (Other choices were, take a picture and only tell patient if you see the instrument in there, reschedule
patient to continue with RCT, Put a watch on it)
QUESTION: Endo on a molar.
Break a file on apical level, what should you do?
-write on med history and continue?
-refer patient to specialist?- if it was in middle third you would continue treatment.
QUESTION: what file was the endodontist using?
Stainless steel
Ni Ti
QUESTION: What is not an advantage of NiTi over stainless steel
Ability to stay centered in canal
Something aided depth penetration into canal
QUESTION: all are advantages of using nickel titanium endo files over regular steel files except?
a. flexibility (yes)
b. bending memory (yes)

c. direction of the flutes (no)?
QUESTION: What is the weakness of Ni files vs regular- strength, flexibility... and some other choices (I
wrote strength)
QUESTION: What is the NOT an advantage of stainless steel files? 1. More flexible.., 2. Less chance for
breaking, 3. Allows the file to be centered in canal,
NiTi rotary files remain better centered, produce less transportation, and instrument faster than stainless
steel files due to their superior flexibility and resistance to torsional fracture. They have 10x the stress
resistances of stainless steel (stronger).
QUESTION: Which of the following is not an advantage of Ni-Ti over stainless steel file?
a. Maintains the shape of canal,
b. flexibility,
c. resistance to fracture.
QUESTION: you separate an endo file 3mm from the apex and obturate above it... which case will
show the best prognosis?
a. vital pulp w/ no periapical lesion(yes)
b. vital pulp wI periapical lesion
c. necrotic pulp wI no periapical lesion
d. necrotic pulp wI periapical lesion
QUESTION: Best prognoses for a broken instrument at apical third?
Vital pulp with no PA abscess
Necrotic pulp with no PA abscess
Vital pulp with PA abscess
Necrotic pulp with PA abscess
QUESTION: which has worst prognosis?
File fracture, transportation, through furcation
QUESTION: How many canals do you expect in primary M2:
four
QUESTION: Access design
–mandibular is trapezoid
QUESTION: What is the shape of the access of mandibular 1st molar?
A. Square
B. Trapezoid**
QUESTION: maxillary 1st molar access opening
: triangular
QUESTION: Pulpal anatomy dictates a triangular-access cavity preparation in the MAXILLARY CENTRAL INCISOR
QUESTION: why do you do triangular access on incisors (max central inccisor?)
a. to help with straight line access
b. help expose pulp horn
c. to follow the shape of the crown

QUESTION: Ept tests whether its responsive or nonresponsive that's it
=not tell level of necrosis/how vital the tooth
QUESTION: EPT – responsivness
Means not healthy tooth
QUESTION: How does a tooth covered with crown react to pulp testing---
cold is better test (thermal)
QUESTION: what can you diagnose with the EPT test :
pulpal necrosis
QUESTION: How do you differentiate between an endo/perio lesion?
EPT
QUESTION: EPT: to differentiate if perio (some response to ept) or endo(necrotic, no response to EPT)
involvement
QUESTION: Vitality test used to distinguish periodontal from endo lesion –
vitality and probing depths
QUESTION: know best way to diagnose irreversible pulpitis ?
heat. Cold/ thermal test
QUESTION: EPT is more accurate than cold test for pulp necrosis?
FALSE
QUESTION: What is untrue about EPT?
It is more reliable than cold testing for necrotic teeth (false!!!)
It gives relative health status of pulp (true)
Tells if there are vital nerve fibers (true)
QUESTION: EPT does NOT indicate health of the pulp
QUESTION: EPT- compared to cold test it is superior (False)….
QUESTION: What is not true regarding electric pulp test
: Doesn't tell you about vascular or
something like that (doesn't tell you about vascularity of pulp which is true pulpal diagnosis)
QUESTION: Did not respond thermal and ept but response to palpation and percussion?
Necrotic pulp
QUESTION: Most reliable way to test vitality of a tooth?
EPT
THERMAL TEST
a final diagnosis, because EPT can have may false readings
QUESTION: Luxated tooth, negative EPT - disruption of nerves to tooth
QUESTION: Best prognosis of perio endo lesion
• Endo with rct – perform first
• Perio scaling and root planning
QUESTION: what is initial treatment of combination perio and endo lesion:
do rct first
perio first,
QUESTION: Pulp vitality testing. Difference between perio and endo periapical lesions. Best prognosis –
perio started from endo DONT KNOW
, or endo started from perio?

QUESTION: test performed to differentiate endo vs. perio lesions
: Percussion
QUESTION: Percussion: can identify perio involvement
QUESTION: Difference b/w acute apical abscess and lateral periodontal abscess:
Vitality
QUESTION: lateral periodontal abscess is best differentiated from the acute apical abscess by?
a-pulp testing
b.radiographic appearance
c.probing patterns
QUESTION: how do you distinguish acute apical absess and periodontal absess : vitality
QUESTION: differential diagnosis of periodontal abscess and periradiculal abscess?
a.percussion
b. vitality test
c.palpation
QUESTION: on primary teeth you dont want to use ept ? thin enamel false results and after trauma you don't want to use electronic pulp tester.
QUESTION: What is test to diagnose acute periradicular periodontitis
– sensitive to percussion
QUESTION: Good way to diagnose acute periradicular periodontitis
– sensitive to percussion
QUESTION: acute apical periodontitis is best diagnosed with:
percussion
QUESTION: acute periradicular periodontitis sensitive to what?
Cold, Percussion
QUESTION: radiographically the acute apical abscess
a. is generally of larger size than other lesions
b.may not be evident
c.has more diffuse margins than other lesion
QUESTION: What is test to diagnose chronic periradicular periodontitis?
Percussion
QUESTION: How do u test a tooth to differentiate between chronic perio and supperative perio?
a. cold test
b. percussion (and lateral percution of course)
c. EPT
QUESTION: Indications of perio lesion vs endo lesion: apical radiolucency and pain upon lateral pain pressure (not apical)
QUESTION: Which of following is not endodontic in origin:
tooth with wide sulcular pocket not extending to apex

QUESTION: What is feature that makes it a perio lesion that’s not seen on an endo lesion
pain on lateral percussion of tooth and wide space of pocket against tooth
QUESTION: Which of the following conditions indicates that a periodontal, rather than an endodontic problem, exists?
A. Acute pain to percussion with no swelling
B. Pain to lateral percussion with a wide sulcular pocket

C. A deep narrow sulcular pocket to the apex with exudate
D. Pain to palpation of the buccal mucosa near the tooth ape
16
(true perio-endo lesion) Evaluate strategic value of the tooth. If tx is warranted, initiate endo therapy first. Perio treatment may be combined with periapical surgery, if needed. Prognosis is poorest.
If Endo lesion is draining through periodontal ligament space, Complete endodontic treatment and
wait several months to evaluate healing of periodontal lesion
If Perio Lesion has spread to the periapical region, Evaluate vitality of the pulp, institute periodontal treatment alone if vital (treatment may devitalize pulp).
Endo-perio: pulpal necrosis leading to a perio problem as pus drains from PDL.
Perio-endo: infection from pocket spreads to pulp causing pulpal necrosis.
QUESTION: Endo abscess but no sinus tract, can pus drain through the PDL:
True
QUESTION: endo lesion with sinus tract. Do RCT and leave the sinus tract alone, will heal
QUESTION: What treatment is required with tooth with draining sinus tract has been treated via RCT:
ANS-?no further treatment
QUESTION: when do you puncture?
An abcess.
ANSLocalized chronic fluctuant in palpation.
Localized chronic hard in palpation (if hard there is no pus)
QUESTION: A patient has a non vital tooth and a fistula is draining around gingival sulcus. What to do?
endo and perio at same time
perio and then endo
only endo
only perio
QUESTION: There usually is no lesion apparent radiographically in acute apical periodontitis. However histologically bone destruction has been noted.
a. Both statements are true
b. Both statements are false.
c. First statement is true, second is false.
d. First statement is false, second is true.
QUESTION: Based solely on the sharp transient response of pulp to hot stimuli, what is the periradicular diagnosis?
a. Acute apical periodontitis
b. Cannot diagnose
c. Acute Apical abscess DNT KNOW
d. Irreversible pulpitis
QUESTION: What is the clinical ‘hallmark’ of a chronic periradicular abscess?
a. Large periradicular lesion
b. Sinus tract drainage
c. Granulation tissue in the periapex.

d. Cyst formation.
QUESTION: Hallmark of periradicular abscess
- sinus tract
based on information
QUESTION: First thing do with periapical abscess?
Incise and drain,
Use gutta percha to find it
QUESTION: number one thing for acute apical abscess is drainage and cleaning the canal (multiple
questions reformatted that ask about this)
QUESTION: after an endo in maxillary molar what Tx would you for sinus track : no tx
QUESTION: Most critical for pulpal protection ANS. Remaining dentin thickness (2mm)
QUESTION: What will not regenerate after RCT:
dentin formation,
cementum,
PDL,
alveolar bone
QUESTION: Each of the following can occur as a result of successful rct tx except which one? -

Formation of reparative dentin
QUESTION: What will not regenerate after RCT: dentin formation, cementum, PDL, alveolar bone
QUESTION: Boy has horizontal root fracture in apical 3rd, no symptoms or mobility, what tx?
Monitor,
RCT, extract, pulpotomy, splint
QUESTION: A maxillary central incisor of an adult patient is traumatized in an accident. The tooth is slightly tender to percussion, is in good alignment, and responds normally to pulp vitality tests.
Radiographic examination shows a horizontal fracture of the apical third of the root. The best treatment is
which of the following?
A. Root canal treatment
B. Splint and re-evaluate the tooth for pulpal vitality at a later time
C. Apexification
QUESTION: Worst prognosis for RCT
– ledge formation, vertical fracture during obturation,
instrument gets stuck in apical 1/3 …
QUESTION: Fracture at apical 1/3, how long do you splint –
7-10 days, 2-3 weeks, 4-6 weeks
QUESTION: Nonvital after a fracture?
Reevaluate at a later time
QUESTION: a Pt with an endo in a molar tooth, after one year a cyst form, the tooth was extracted,after another year the cyst was bigger what happened :
ans- bad endo, the dentist did not curettage well when the extraction was done

QUESTION: during root canal you notice you left debris in the canal most likely due to lack of use of which?
Gates burs, broaches, chelating agents
QUESTION: Taurodontism has enlarged pulp chamber in which direction?
apical, occlusal or apical
QUESTION: Taurodontism pulp bigger:
Apically

Operative

QUESTION: Critical pH of developing cavity?
pH 5.5*
QUESTION: pH that enamel starts to demineralize –
5.5
QUESTION What can tell best thing about caries:
past caries history
QUESTION Which is least likely to predict future caries?
Amount of sugar intake
Frequency of sugar intake
Amount of caries and restorations
(I would have prob put amount of caries and restorations b/c this is known to be an indicatior of past caries not future caries.)
QUESTION: 3 factors that affect caries initiation? substrate, bacteria, host susceptibity
QUESTION: Which of the following is the earliest clinical sign of a carious lesion?
A. Radiolucency
B. Patient sensitivity
C. Change in enamel opacity
D. Rough surface texture
E.Cavitation of enamel
QUESTION: What is true of Strep. mutans?
• Can live in plaque,
• Can live on gingival
• Can live in a child with no teeth
• Has to live on a non-shedding surface
QUESTION: Most Cariogenic? Sucrose... S.mutans adheres to the biofilm on the tooth by converting sucrose into an extremely adhesive substance called dextran polysaccharid.
QUESTION: How do cells first attach- dextran or lextran?
Ans -DEXTRAN
QUESTION: Caries progression –
lactobacillus

QUESTION: what contributes to caries formation
– Lactobacillus
QUESTION: What helps in carious process but it is not the primary inititator for caries:
Lactobacillus
QUESTION: Lactobacillus: does not initiate caries but is part of the progression of caries
QUESTION What is the most important etiologic factor in getting caries?
Saliva ph
Refined sugar
fluoride tx
saliva flow
QUESTION: Which race has most caries in kid population?
• Hispanics
QUESTION: What race for children has highest caries incidence?
HISPANIC
QUESTION: early childhood caries-
centrals and molars
QUESTION: Which population has the most number of UNRESTORED caries
: black
QUESTION: White females have the most caries in permanent teeth
QUESTION: Know how to determine if a patient is a high caries risk?
Assessment
QUESTION: most recent increase in caries is seen in:
roots

QUESTION: New data regarding caries shows:
more smooth surface caries,
more pit-fissure caries,
same, more root caries
a. More root caries
QUESTION: Recent survey, what kind of stats on caries?
• inc in smooth surf caries - wrong
• inc in pit/fissure caries - wrong
• smooth surf caries and pit/fissure caries is same - wrong
• inc in root caries****
QUESTION: How do you diagnose root caries?
Soft
QUESTION: Best indicator of root caries is a soft spot
QUESTION: best clinical determinant of root caries ?
sensitivity to cold
sensitivity to sweets
soft spot on tooth -
QUESTION: Remineralized teeth are they stronger than regular enamel
QUESTION: For a lesion in enamel that has remineralized, what most likely is true?
1. The enamel has smaller hydroxyapatite crystals than the surrounding enamel,
2. The remineralized enamel is softer thanthe surrounding enamel,

3. The remineralized enamel is darker than the surrounding enamel,
4. The remineralized enamel is rough and cavitated
QUESTION: Sign of remineralization:
rougher than tooth structure and darker, but not sure
QUESTION: What's the characteristic of a remineralized tooth?
Darker, harder, more resistant to acid
QUESTION: Remineralized lesion is shiny and more resistant to future decay
QUESTION: Characteristic of a lesion that is remineralized:
black, dark, bright
black, dark, opaque
black, dark, cavitated
QUESTION: remineralized lesions, yellow: -more resistant to future caries
QUESTION: Remineralization?
Harder than normal. (Pit and fissure are most prevalent caries)
QUESTION: What does arrested caries look like?
Black dark
QUESTION: Leathery brownwhite lesion?
arrested, acute, chronic
QUESTION: Scleoritc dentin:
harder, better to bond to?
QUESTION: Which of these is NOT an important reason for a clinician to be able to distinguish remineralISATION?

QUESTION: What is the most common site of enamel caries?
• pit and fissure*
• at the contact point
• slightly
QUESTION: Where does caries start?
Apical to proximal contact.
QUESTION: location of interproximal caries lesion :
below the contact
QUESTION: Most interproximal decay happens where?
– Just under the contact.
QUESTION: A class II caries is
: Apical to contact
QUESTION: When do you restore a lesion? –
When there is cavitation
QUESTION: When do you tx caries: half way to the enamel, through enamel, when you can see it
on xray (NO) Answer: cavitation
QUESTION: In which of these cases do you start restoration:
can see on x-ray,
cavitation present,
lesion ½ into enamel,
cross CEJ (not DEJ)

QUESTION: when you start to do a caries :
a) more than half way into enamel
b) in the DEJ
c) in CEJ
d) when you see it in the xray
QUESTION: When do you restore a tooth?
a. Either when its CAVITATED
when its ½ in enamel (but this can remineralize..)?
b. Nothing about dentin involvement

Composites

question:two things that account for a successful posterior composite restoration?
a. type of resin and size of tooth
b. size of tooth and type of prep
c. type of resin and type of prep
answer-c. type of resin and type of prep
QUESTION: Postoperative MOD composite pain, most likely due to?
Answer-hyperocclusion
QUESTION: what type of bond is composite on tooth structure?
a. chemical bond
b. mechanical bond (micromechanical) ans
c. organic coupling
d. Adhesion

QUESTION: What determine class 1 composite prep?
answer-The depth of decay

QUESTION: What indicates the design of composite class I preparation
Only incorporates pits of lesion - this one
2mm pulpal floor depth
45 degree bevel cavosurface
Ortho
answer-B i think...
A. It shud conservatively involve only d defective portion/carious portion of d tooth which can b both d pit or fissure

B. its pulpal depth is 1-2mm

C. Cavosurface angle in composites is >90 or obtuse bevel so dat more surface area of rods for etching.

We need an uniform cavity depth in composite like we need in amalgam but there is an ideal pulpal floor depth for different restorative materials n for composites it's 1-2 mm

QUESTION: When doing a class 1 with composite what is the requirement?
Answer- contains only pit and fissure.

QUESTION: What determines composite class 2 prep?
Answer-caries

QUESTION: prep shape for composite is determined by ?
Answer- extent of caries

QUESTION: When do you replace class 2 composite?
Answer- recurrent decay and marginal break

QUESTION: You are doing a composite slot on mesial and distal of 1st molar, dds decided to connect by crossing the oblique ridge, why?
answer-when oblique ridge is less than 1.5mm you involve it
QUESTION: Restoration of class 2 for posterior with heavy occlusion ?
amalgam,
composite,
Microfilled resin
Answer-amalgam
QUESTION: Class II prep into cementum, how should you restore?
GIc,
Hybrid ,
Non-restorable
Answer-open sandwich technique(The liner is completely covered with the restorative material. In the open sandwich technique, RMGI is used to replace the dentin and also to fill the cervical part of the box, which results in a substantial part of the glass ionomer cement being exposed to the oral environment.)
QUESTION: What is the main problem with class 2 composite?
A)water
b) constructions of material

answer-Polymerization shrinkage and also poor interproximal contour
QUESTION: Small occlusal fillings need to be done on posterior, what do you use ?
amalgam,
Composite
GIc
Answer-composite
QUESTION: Large MOD composite, what's disadvantage?

Answer-occlusal wear(low wear resisistance)
QUESTION: What is not a class I cavity preparation?
gingival 1/3 of #19,
Lingual pit of #7,
Lingual pit of #18
Answer-gingival ⅓ of#19
QUESTION: C factor in class 1 composites, which one is correct?
– less walls is lower C factor
–More walls, higher C Factorans

QUESTION: Which part of composite stains the most-?
gingival proximal,
facial proximal,
lingual proximal,
occlusal
answer-gingivo/facial proximal
QUESTION: 2ndary caries is most likely at ?
Answer- gingival margin
FLUORIDE:

QUESTION: how many mg of fluoride in 1 liter of water at 1 ppm : 1 mg

QUESTION: Patient has 1ppm fluoride in water-what is that equal to in mg/L?- 1mg/L = 1ppm

QUESTION: What ion is replaced to get hydroxyfluoroapatite? ---HYDROXYL

Hydroxyapetite + Flouride ------> Flourapetite + Hydroxy The incorporation of fluoride into the enamel hydroxyapatite crystal: Fluoride ions replace the hydroxyl radicals of the hydroxyapatite crystals in the enamel, producing fluorapatite. This form of enamel is less soluble in catabolic acids produced by oral bacteria.

QUESTION: Fluoride becomes fluoroapetite which is insoluable

QUESTION: ***Fluoride works in all these ways except: --Increases strength of collagen**

Fluoride BREAKSDOWN collagen, is bacteriocidal, fluoroapetite is more resistant to acid attack, decreases solubility of enamel, excreted by kidneys, helps remineralize

QUESTION: Fluoride helps prevent caries in all ways except? I put lower pH of the oral cavity, since it does not do that! Fluorapetite has a lower critical pH of 4.5

QUESTION: Flouride accumulated most- away from DEJ (surface of tooth)

QUESTION: Where does fluoride localize? Outer enamel**

QUESTION: Fluoride spot makes enamel more resistant to future caries

QUESTION Fluoride does all the following, except? – Direct action on plaque

QUESTION What does floride do? Floroapitate that's acid resistance.

QUESTION How do you determine the severity of fluorosis? Look at the two worst teeth? Higher the fluoride level, greater degree of enamel change

QUESTION What conc of acidulated phosp fluoride is used in the dental office? 1.23%

QUESTION How many minutes do you place Neutral sodium fluoride tray on teeth? 4 minutes

QUESTION: Floride supplementation is effective in:

everybody,

only kids,

anyone but most beneficial to children-answer

QUESTION: what age should fluoride supplements be started? 6 months

QUESTION:At what age does florousis of teeth anterior permanent teeth occur?- answer 4-6mo (others 0-4mo, 1year, 2years and 6 years)

QUESTION: Fluoride – toxic dose 5-10 mg/kg

QUESTION: Usual water flouridation- 1.0 ppm

QUESTION: 1ppm for average fluoride in water (FYI in January of 2011 this statement was issued: "The Department of Health and Human Services today announced that it will revise the recommended levels for optimally fluoridating community water systems. Historically, the recommended optimal level for community water fluoridation has been 0.7 to 1.2 parts per million. The new recommended level is 0.7 ppm.")

QUESTION: What is the EPA highest conc of natural fluoride in drinking water? 4 ppm

QUESTION: Maximum allowed fluoride in the water by EPA (environmental protection agency)? 4.0mg/liter

QUESTION: Community fluoride: 0.2% / week in underprivelaged areas

QUESTION: How do they administer Fluoride in schools? 0.2% fluoride rinse 1X week.

QUESTION: What happens when a kid with primary teeth ingests fluoride?--It affects their

permanent teeth.

QUESTION: Fluoride table, 5yrs old with .75ppm intake - Floridation supplement -0ppm

QUESTION: 4 yr old lives in community with .28 ppm: systemic fluoride supplement / prescription / fluoride rinse

Ans- systemic fluoride supplement 0.50mg/day

QUESTION: 4 yo with .4ppm fluoride. Supplement? 0.25PPM or 0.25mg/L

QUESTION: 2 yr takes 20mg fluoride pill – coma, nausea, renal failure, cardiac arrest Ans- Nausea

Early symptoms of fluoride poisoning include gastrointestinal pain, nausea, vomiting, and headaches. The minimum dose that can produce these symptoms is estimated to be 0.1 to 0.3 mg/kg of fluoride (i.e., 0.1 to 0.3 milligrams of fluoride for every kilogram of bodyweight). A child weighing 10 kilograms, therefore, can suffer symptoms of acute toxicity by ingesting just 1 to 3 milligrams of fluoride in a single sitting.

QUESTION: 7 year old patient has no fluoride in drinking water. What do you give them systemically... 5 mg, 1 mg, .25 mg ans:1mg

6 months-3 year = 0.25mg 3 -6 years = 0.5mg 7–16y.o. = 1mg

doubtful QUESTION: IF PATIENT GETS 0.3-0.6mg from water then half supplement from 3-16years

QUESTION: 4.5 years old child with .75ppm fluoride in their water req. how much fluoride supplement? 0 mg.

QUESTION: The appropriate amount of fluoride in the community water/optimal range of fluoride in water lies between
0.7-1.2ppm

QUESTION: Supplementation for 10 year old with no other fluoride source? or 1 mg/day

QUESTION: 2.5 year old with 0.4 ppm fluoride in water... normally I would say rx nothing but that wasn't a choice – I put 0.25 mg supplement

QUESTION: The drinking water supply of a community has a natural F level of .6ppm. The F level is raised by .4ppm. Tooth decay is expected to decrease by what % after 7 years?--
40%

0.4/1 becoz 0.4+0.6=1 so 0.4/1 *100= 40%-explanation

QUESTION: 3 year old patient lives in area with 0.4ppm fluoride. How much do you supplement? 0.25 mg

QUESTION: 7 year old child living in area with .2 ppm fluoridated water-supplement 1.0 mg

QUESTION: what type of Fl in water: include fluorosilicic acid (hydrofluorosilicate) – most commonly used, sodium fluorosilicate, and sodium fluoride

QUESTION: Types of Fluoride used in toothpaste:--- sodium fluoride, Stannous fluoride (most effective), Sodium monofluorophosphate

Stannous fluoride has been shown to be more effective than sodium fluoride in reducing the incidences of dental caries and controlling gingivitis. sodium monoflorophosphate and stanous flouride is also used in tooth paste.. source=wikki

QUESTION: Which fluoride is not found in toothpaste? Acidulated fluoride

QUESTION: what toothpaste should not be used in a patient with multiple porcelain crowns? acidulated

QUESTION: What mouthwash is good for children with caries? NaF

QUESTION: What rinse is used at home for developmental disabled child to reduce of plaque:

1:NaF,

2:stannous fluoride,

3: chlorhexidine ans-3

QUESTION: the usual metabolic path of ingested fluoride primarly involves urinary excretion with remaining portion in skeletal tissue

QUESTION: where is the biggest store of fluoride in tissues? Skeletal tissues

QUESTION: Where does fluoride work the best?

A. interproximal**
B. Pit and fissure prr/sealant)

** Ans-A

WORKS BEST ON SMOOTH SURFACES***

QUESTION: What is least likely to cause baby bottle caries?

a. Breast milk at night

b.Formula made with fluoridated water

c. water with no fluoride

d. juiceans-c

QUESTION: ECC which location?

a. Max incisors and molars?

b.Max incisor and molars?

c. Max canine

d.Man canine and molars?

Primary max incisors (B&L), then primary molars, mandibular unaffected becoz tongue blocks

QUESTION: Question about what determines fluoride supplementation for a city - temperature

QUESTION: percentage of fluoride water in US - 85% (should be about 65-70%)**ADA site talks about percentage of people receiving fluoridated water.. couldn't find percentage of fluoridated water itself. Percentage went up from about 65% to 74%.

QUESTION: What is percentage of community water fluoridation- 67, 85, 35 ans-67

QUESTION: Fluoridation for water: effectiveness: early studies showed that it prevents

50%-70% of caries in permanent teeth, Howerver currently the effectiveness is 20%-40%

QUESTION: Fluoridation: daily use of tablet cause 30% reduction in new carious lesions

QUESTION: Fluoridation: know the primary/secondary/tertiary prevention differences.

Primary: aims to prevent the disease before it occurs. Health education, community fluoridated water, sealants.

Secondary: Elimates or reduces disease after they occur. Composite filling
Tertiary prevention: Rehabilitates an individual in later stages to restore tissues after the failure of

secondary prevention. Examples include dentures and crown and bridge.

QUESTION: Fluorosis does what – inhibits remineralization (irreversible)
, however fluoride induced enamel hypoplasia or hypocalcification which is characteristic of fluorosis is caries resistant

QUESTION: Do certain fluorides stain? Stannous fluoride may stain.

QUESTION: Dentist places sodium fluoride on patient with GI fillings rather than acidulated fluoride because – acid of fluoride will wear away at GI. TRUE

QUESTION: Applying Fluoride (APF) on GI cement what happens? A. dissolves it b. stains c. it (decks says loos glace) roughens it Ans-c

QUESTION: Pt has veneers from 6-11, which fluoride do you use to not stain? A. Stannous Flouride

B. Sodium Flouride**

C. Acid Flouride ans-b

QUESTION: What fluoride tx used in a pt with amalgams, pfm's , composite restorations, implants? NaF

àmore profound= acidulated

QUESTION:Pt has fillings and full porc. Crowns, but has decalcification on class V? 1.1 % NaF

QUESTION: Caries in elderly, which one is not useful in managing: use of 1.1% fluoride as a standard of care

QUESTION: what is her dental age based on xrays à advanced, chronological lags behind dental, Tx for #D-TE, c. what to do with lesion on distal of #S (look incipient, resorbed)àapply fluoride varnish every week, do DO comp or amalgam, observe and reassess next visit, disc the distal

surface, d. both child and guardian should receive oral health instructions, oral health care should include daily fluoride rinsesàboth statements are true.(didnt understand clearly)

QUESTION: Sealants- mechanical microretention binding to tooth

QUESTION:Contradiction of sealant: when you have rampant or gross caries

QUESTION: Patient has deep grooves but no decay on permanent molars, what do you suggest? - Sealants

QUESTION: Ortho pt: has never had a restoration? Wut wud you do?àsealants, do nothing, etc. Ans--- do nothing

QUESTION: High caries risk patient, when is he indicated for sealants? Obvious clinical cavitation on the occlusal,/deep fissures without caries

Ans: deep fissures without caries

QUESTION: pictures of molars in 16 y/o – does it need sealants, no treatment, Class I. Book says do sealant age 6-12, so no treatment most likely unless caries visualized.

Bleach:

QUESTION :In home bleaching percentage - 10% carbamide

QUESTION: H_2O_2 – 35% used in in-office bleaching

QUESTION Material used for mouth guard vital bleaching:10% carbamide peroxide

QUESTION :home bleaching what causes : sensitivity

QUESTION:Most successful teeth for bleaching? Aged yellow staining

QUESTION:What is the most effective way of bleaching teeth? In-home vital bleaching.

QUESTION:Non vital bleaching is with? hydrogen peroxide 35%, carbamide peroxide, and sodium perborate. Ans-- sodium perborate.

QUESTION:Bleach most often used in internal bleaching: sodium perborate

QUESTION:Difference b/t dentist and home bleaching.. strength of peroxide

QUESTION:Bleaching tray at home? Make sure custom fit

QUESTION:best way to decrease gingival irritation w/ home bleaching? well fitting trays

QUESTION:Bleach used to dissolve organic tissue

QUESTION:
Purpose of bleach except- getting past foramen to treat bone

Vital bleaching Agents-->

(in office)-- H_2O_2 [25-38%]

(At home)-- H_2O_2 [3-7.5%] or Carbamide peroxide [10-30%]

Side effects-- tooth sensitivity & gingival irritation

Diadv.-- More expensive than non-vital bleaching..

Non-vital bleaching-->

Walking bleach-- Sodium perborate mixed with water/H_2O_2 [3-30%] or

Carbamide peroxide [37%] is also used in non-vital bleaching...

Side effects-- External cervical root resorption (more seen in thermocatalytic bleaching with superoxol) &

Acute apical periodontitis (where endo-treated tooth is not properly obturated prior to bleaching)

3 Bhavani Bandi 21-30

QUESTION: Tx of root surface caries
gic true

QYESTION:what kind of dentin should not be restored?

Eburnated dentin(Sclerotic dentin)

QUESTION: Fluoride works best onr?
Smooth interproximal surfaces.

QUESTION: Smooth surface caries most likely due to?
Plaque

QUESTION: What caries lesion has a V shape pointing to pulp-
smooth caries true

QUESTION: Which of the following is a factor for smooth caries and sugar in-take?
– Consistency–consistency b/c if it's the sticky type it stays on the tooth longer allowing bacteria to keep ph lower longer

QUESTION: Caries in children depend most on: amount, consistency, time
all true

QUESTION: occlusal caries where is base and cone?
Triangle Base towards dej and apex towards tooth surface

QUESTION: Pit and Fissure caries is described as two cones:
A. Two bases are pointing toward the pulp
B. Two apexes are pointing toward pulp>>>> in smooth surface (proximal caries)
C. One apex toward the pulp and one base toward DEJ
D. Both bases facing DEJ(answer both bases facing dej)

QUESTION: DEJ- diff btw smooth caries(conical), occlusal (apex at occlusal), interprox (apex at DEJ) true

QUESTION: conical shaped caries w/ broad base with apex towards pulp is commonly seen in?
A. Root caries
B. Smooth caries TRUE
C. Pit/fissure caries

QUESTION: Diagnosis of pit and fissure caries,
- explorer catch,

QUESTION: enamel caries best detected by explorer catch
-, true

QUESTION: 40 y pt w/ all 32 teeth. No cavities. Has stain & catch in pit of molar. what do you do?
a. watch and observe
b. sealant

c. composite

QUESTION: if you inadvertently seal over caries what happens?
Arrested caries.

QUESTION: If you feed a person through a tube,
then you decrease risk of caries true

QUESTION: mechanism of caries indicator: enters the dentin and binds to the denatured collagen
• A colored dye in an organic base adheres to the denatured collagen which distinguishes between infected dentin and affected dentin

QUESTION: What type of caries detection is the Dyfoti used for?
Class I Class II, Class III {all occlusal and interproximal} answer- all

QUESTION: DaignoDent is Class I
– ONLY OCCLUSAL CARIES (pit and fissure) true

QUESTION: Number of people with caries or other stat your looking for in your office this year is 300 out of 1000, last year it was 200, so what is it for this year?
300/1000 im pretty sure incidence
is NEW cases. And the answer is 300-200/1000= 100/1000 =0.1 DESCRIPTIVE STUDY

QUESTION: Radiographic decay most closely resemble which zone of carious enamel?
Body zone*,
 dark zone,
translucent zone,
 surface zone

QUESTION: Know what DMFS stands for decay missing filling surface

QUESTION: DMFS is for surfaces including 3rd molars
 true

QUESTION: in DMFS " s" stand for ----------
surface DECAY MISSING FILLED SURFACE

QUESTION: DMF indexà
measures how permenant dentition is affected by caries

QUESTION: DMFT is for permanent teeth in WHO modification 3rd molars are included

QUESTION: Which race has a higher F in DMFT index:
Whites true

QUESTION: Which population has the most number of unrestored caries:
Black

QUESTION: deft= for primary (e=extraction)

QUESTION: which of the following acronyms is only used for kids?
PI,
def,
DMF,
OHI-S,

QUESTION: Whats the D__ the one that's only three letter system of tooth carries tracking, what can it not do?-
Track how teeth were lost. true

QUESTION: Differences between 245 and 330 burs-
245 bur is 3mm in length, 330 is 1.5mm. All other dimensions the same except for length.

QUESTION: burs 245 vs 330 question = 245 is longer nd sharper angle!!! (3mm) 330 is 1.5mm in length.

QUESTION: Example pear shape bur- 56 or 699? (Isn't pear shaped…more like a 330?)
Pear = 329, 330, 245 (330L)

QUESTION: Bur used that converges F and L walls? #245, 7901, 245
245 = 330L = pear and elongated bur, 169 = tapered bur, .9 diameter

QUESTION: What bur do you use to shape convergent walls for amalgam
-245

QUESTION: Which bur do you use for peds? A.245 B.18 C.51?
I think its 330

QUESTION: which is best for occlusal convergence in a prep,
245 true

QUESTION: Diameter of 245 bur ?
0.8

QUESTION: What bur use for Amalagam retenetion in class II
- 245

QUESTION: Burs and smoothing out preps? More flutes and shallow, more flutes and deeper,

less flutes and shallow, less flutes and deeper

QUESTION: More blades on bur:
SMOOTHER, DECREASED CUTTING EFFICIENCY true

QUESTION: Which burr is used to smoothe the prep?
Carbides for cutting diamonds for finishing true

QUESTION: Which high speed bur gives a smoother surface?
Plain cut fissure bur = best for smoother surface
cross cut fissure have a higher cutting efficiency

QUESTION: Bur used for polishing –
STEEL BURS FOR POLISH

QUESTION: What is the correct method of excavation of deep caries.
Long bur from periphery to the center,true
large bur from center to periphery,
small bur from periphery to center,
small bur from center to the periphery

QUESTION: How to excavate if think might be close to pulp- **I would think you would use the largest bur that fits, and go around the periphery and then towards the deepest true

QUESTION: Rotary hand instrument: high speed how many round per min? 200,000 rpm 25

QUESTION: know applications of chisel and spoon
Chisels are intended primarily to cut enamels, but spoons remove caries and carve amalgams

QUESTION: whats difference btwn an enamel hatchet and gingival marginal trimmer (both chisels)
GMT has curved blade and angled cutting edge. Enamel HA: cutting edge in plane of handle

QUESTION: main difference and advantage of using GMT instead of Enamel hatchet?
a. bi-angled cutting surface
b. angle of the blade true
c. push/pull action instead of

QUESTION: what can't you use to bevel inlay prep?
a. enamel hatchel
b. ging marg trimmer
c. flame diamond
d. carbide.

QUESTION: Instrument to plane gingival margin on a class II?

• 2 with 3 number and 2 with 4 numbers
• Answer has 4 numbers – last number is different. Answer is not clear but it might be gmt it has 4 numbered formula for bevening the gingival margin

QUESTION: How do you bevel occlusal floor (gave list of instruments)
• 13,8
• 15,80
• 15,95
15 95 gmt for beveling distal gingival margins,15 80 for bevening mesial gingivalmargins

QUESTION: What instrument would not be used to bevel the gingival margin of an MOD prep?
Enamel Hatchet

QUESTION: Proper pulpal floor depth using Bur 245? true
is 3mm, so half of it is 1.5 mm which is proper pulpal floor depth

QUESTION: Hydrodynamic theory?
Definition: Postulates that the pain results from indirect innervation caused by dentinal fluid movement in the tubule that stimulates mechanoreceptors near the predentin

QUESTION: Most commonly accepted theory of dentinal sensitivity?
A: Hydrodynamic theory z

QUESTION: You did a prep with high speed and diamond bur, tooth is sensitive, what is it about bur and handpiece that it caused sensitivity?
A) Desiccation b) traumatized dentin? Heat

QUESTION: Most common pulpal damage from cavity prep
– heat

QUESTION: Which method of sterilization does not corrode instruments
– Dry Heat

QUESTION: which Sterilization most destructive to burs:
steam heat (autoclave)

QUESTION: What is best to sterlize carbide burs?
DRY HEAT or unsaturated chemical vapor->no corrode or dull
Ethylene oxide is for heat-sensitive instruments. true

QUESTION: Acute mercury toxicity for dentists, first signs – tremors
Paresthesia are early signs in mercury poisoning true

QUESTION: Subacute mercury poisoning symptoms –

hair loss

QUESTION: Amalgam failure in primaryteeth
–moisture contamination

QUESTION: MOD amalgam with hole why?
-poor condensation

QUESTION: Most common reason for Amalgam fracture occuring in a primary tooth:
Inadequate cavity prep (especially the isthmus area)

QUESTION: Most common fracture of Class II amalgam:
isthmus true

QUESTION: Most common reason for failure of dental amalgam:
moisture contamination
answer-improper prep design- not enough depth true(first preparation faulit den followed by moisture contamination)
improper titrutration,
improper condensation

QUESTION: Patient had occlusal amalgam on tooth #30 few weeks ago, one day the dude went to China-town and was having lunch with his hommies. He bit down on something and the amalgam broke off. He came back to your office demanding how could this happen with a new filling. What should be crossing your mind? – The prep was not deep enough. true

QUESTION: Page 48. Table 2-3….Prepped the amalgam, which is incorrect?:
Cavo surfaces is greater than 90 degree

QUESTION: Axial pulp should be ?
0.2-0.5 into DEJ

QUESTION: how far extend pulpal floor in class I amlgam cavity on primary dentition
a. 0.5 -1mm into dentin

QUESTION: Greatest wear on opposing tooth: amalgam, porcelain, microfill, hybrid composite?
Porcelain

QUESTION: Picture of deep amalgam with overhang but it looks really bad why does it look like that?
Corrosion

QUESTION: What is wrong with marginal ridge of DO amalgam of #29? All of the following (except maybe)?

Occlusal wear,
wedge not placed right,
OVER CARVING

QUESTION: Which tooth will the matrix band be a problem with when placing a two surface amalgam?
to give an idea of the anatomy of the region:
mesial on maxillary first molar b/c of the cusp of carabelli also Mesial Of max 1st premolar (MOST DIFFICULT) > Distal of max molar

QUESTION: worse restorative material for class3 canine? gold, glass ionmer, composite, amalgum? worst will be Composite > GIC> Amalgam> Gold(according to dental decks composite not given for class 3 DL in canines)

QUESTION: What is the corrosive phase of amalgam?,
Gamma2 – tin/mercury

QUESTION: What causes corrosion in amalgam? Tin
- The most common corrosion products found with conventional amalgam alloys are oxides and sulfides of tin
- The chief function of zinc in an amalgam alloy is to act as a deoxidizer, which is an oxygen scavenger that minimizes the formation of oxides of other elements in the amalgam alloys during melting.

QUESTION: What type of Mercury is in the dental office?
Inorganic,
elemental

QUESTION: most toxic mercury - methyl mercury (organic mercury) 28

Question: Type of mercury most hazardous to dentist health: ethylmercury,

QUESTION: Amalgam large condenser with lateral condensation is used in:
Spherical

QUESTION: What type of amalgam needs to be condensed more?
Irregular or lathecut
Spherical requires light pressure,irregular more pressure
Large condenser produces light pressure,small condenser produces more pressure

QUESTION: Type of amalgam to use for best interprox contact of a CLASS II is
Admix Amalgam

QUESTION: Over triturating amalgam? sets too fast,
decreases setting expansion (increase compressive strength)

QUESTION: Huge MOD in posterior à
restore with amalgam

QUESTION: MOD amalgam with tooth pain?
– fractured true

QUESTION: Tooth #30 has huge MOD amalgam and is deep. Hurts pt when he eats french bread. what is the cause?
a. root fracture

QUESTION: Patient has a line of separation coronoapical (the wont say vertical fracture on the test), the tooth is asymptomatic and it only hurts when patient eats French bread. What should you do? Ext only if moveable pieces. If asymptomatic & not moveable àfair prognosis àRCT true

QUESTION: days after placed an MOD amalgam pt present pain in biting and cold :
check occlusion. true

QUESTION: Placing pin in amalgam restoration, only choices I remember are 1mm pin or 1.5mm 2mm into amalgam true

QUESTION: Threaded pin- Amt in tooth/restoration/angulation
The optimal depth of the pinhole into dentin is 2mm.
Threaded pins used in a dental amalgam restoration should be placed -2mm in depth at a position axial to the DEJ and parallel to the external surface between the pulp and tooth surface. Pins should be 2mm into dentin, 2mm within amalgam, and Imm from the DEJ (to be safe) with no bends in the pins.

QUESTION: Moisture contamination during amalgam restoration?
Decreased strength

QUESTION: If there is water while you are condensing amalgam, what happens? I put **decrease in strength**

QUESTION: If there is water while you are condensing amalgam, what happens?
Delayed explansion (severe expansion, corrosion and decreased compressive strength)

QUESTION: Marginal leakage in an amalgam after 1 year, then what happens? I put that it **decreases**. true

QUESTION: You have an amalgam that is ditched at the margin by .5mm and no signs of recurrent decay what do you do:
observe/monitor, remove and replace

QUESTION: Where is it acceptable to leave unsupported enamel?
Occlusal of class V amalgam

QUESTION: What do class I & class V Ag ideal prep have in common
a. both slightly extend into dentin
b. both have flat axial & pulpal wall

QUESTION: Indirect restoration over amalgam:
in order to get ideal contours

QUESTION: What is the reason you would do MOD onlay vs Amalgam:
Better facial contour true

QUESTION: Class 2 amalgam vs class 2 gold inlay except:
line angles round in amalgam and sharp in gold true

QUESTION: Advantage of inlay over amalgam?
less tooth reduction true

QUESTION: Is the isthmus the same for inlay and amalgamà
YES {one third of intercuspal distance}

QUESTION: Proximal retention in class II box for amalgam?
Retentive grooves, convergence of facial lingual walls, bevel on axiopulpal line angle, all of the above, none of the above-
answer- convergent walls and dovetail provides retention

QUESTION: Resistance form for amalgam prep :
bevel in the axiopulpal line angle to reduce stress and increase RESISTANCE form- "ways to resist stress".
Flat pulal floor also resistance feature

QUESTION: how to prevent proximal displacement of Cl II filling
– occlusal dovetail

QUESTION: What's the best way to prevent proximal dislodgement/fracture of class II amalgam filling?
• Retentive grooves*or (dovetail)
• converging axial walls (B&L walls)
• depth of prep

QUESTION: Proximal resistance form of amalgam restoration comes from what?
a. convergence of buccal/lingual wall
b. retention grooves in axiobuccal/axiolingual walls - for proximal resistance true

c. Dovetail - provides retention form
resistance form is by rounding of axiopulpal line angle and flat pulpal floor

QUESTION: Mesial and distal walls of class I amalgam must be divergent not to undermine marginal ridges true
RETENTION: 1st = BL walls converge, 2nd = Retention grooves/Occlusal dovetail
RESISTANCE: 1st = Flat floors, rounded angles (bevel in axiopulpal line angles) 30

QUESTION: How to account for mesial concavity on maxillary 1st premolar when restoring with amalgam:
answer custom wedge or wedge wedging

QUESTION: BWX, Tooth #18 has mesial amalgram restoration with overhang and very light contact. – ! (or poor adaptation of matrix band) true

QUESTION: premolar restored with open contact, why?
Wedge not placed right-I think ive seen this question before
Matrix band was not well adapted

QUESTION: Put wedge after matrix
true

QUESTION: From pt images, Which amalgam filling has the lowest Copper content?
One that looks corroded.

QUESTION: a pt presents with amalgams restorations in good shape, the dentist suggest to change them for composites due to systemic toxicity of the amalgam what ethic principle is there or the dentist is violating what principle:,
veracity,

QUESTION: Definition of Veracity - doctor lied to patient about amalgam should be replaced with composite, because amalgam causes toxicity
Gold:
Malleability – deform (without fracture) under compressive strength; ability to form a thin sheet; gold is malleable
Greatest malleability to least: gold, silver, lead, copper, aluminium, tin, platinum, zinc, iron, and nickel
Ductilty – deform (without fracture) under tensile strength; ability to stretch into wire
greatest ductility to least: gold, silver, platinum, iron,nickel, copper, aluminium, zinc, tin, and lead.
Gold inlay/onlay – divergent walls (2-5 degrees per wall), 30 degree bevel margins

QUESTION: onlay /retention:
2 to 5 degrees of taper per wall, as long a wall as possible, . primary retention is from wall height and taper. Secondary retention is from retention grooves, skirts, and groove extensions

QUESTION: What is the hardest type of gold?
Gold Type IV

QUESTION: When do use base metal apposed to gold…. Long span bridges ?

QUESTION: Ductility –Golds ability to be worked into different shapes true

QUESTION: only advantage of porcelain over gold :
esthetics.

QUESTION: advantage of gold on occlusal surface, porcelain in facial surface----conserve tooth structure, minimal reduction...???? Gold is compatable in wear with natural tooth, porcelain gives esthetics. Gold crown is more conservative. true

QUESTION: Reduction dimension for functional/non-functional cusps in gold and PFM-gold-1.5mmfunctional,1mm non functional;

pfm 2mm functi 1.5mm nonfunctional

4 Mai Amr mai_saadeldeen@yahoo.com 31-40

5-sachindravid 41-50

QUESTION: complementary color used to change

Answer- Orange stain is the most often used to change the HUE. Staining a porcelain restoration will reduce the VALUE (aswill using a complementary color). It is almost impossible to increase the value.

QUESTION: If you add a complementary color yellow, what happens to the hue?

answer- Decrease red content of yellow red shade.

Side note: adding yellow stain=Inc chroma of basic yellow shade Pink purple makes yellow yellow red.

QUESTION:Which represents position on the spectral wavelength?

Answer-hue denotes the specific wavelength of light .

Notes- it should be in hormony with the patient's skin color or else it produce an artificial look

on teeth.

QUESTION: what is best way to determine value?

answer- open eye as wide as you can, arrange the shade guide in increasing value .

The canines are a good reference point in selecting a shade because they have the highest chroma (intensity) of the dominate hue (color) of the teeth..

When making shade selections it is important not to view the comparison for more than 7 seconds at a time to avoid fatiguing the cones of the retina. We recommend you gaze at a neutral grey wall card. In fact, looking away at a grey card between each 7-second shade evaluation will reset the focus of your eyes and depth perception.

question:How pick shade or value?

answer- Most important, Lightness. Put shade guide from light to dark. Half close eyes to increase sensitivity to better select value. Squint test for chroma.

Notes-squint test-it is used to check and compare the color of the teeth with the color of the face . the dentist should partially close his eyes to reduce light and compare artificial teeth of different shades with the colour of the face and teet. The colour of the teeth that fades first from view is least conspicuous (contrasting) to the colour of the face.

Question:in order to prevent metamerism , which of the following a dentist should do?

- Use a consistent look in light.
- Shade under multiple light sources.

answer: Shade under multiple light sources.

notes-Metamerism is a complication in color perception as various light sources produce different perceptions of color. It will create problems in shade selection.(or) Metamerism is the phenomenon inwhich a color match under a lighting condition appears different under a different lighting condition.

question:FUNCTIONAL/NON FUNCTIONAL MOVEMENTS

Answer-non working LUBL

Working BULL

Protrusive mudl

Retrosive duml

Interference

Working=LUBL incline

Non working = BULL incline

Protruding =DUML

Work-->upper buccal

No work-->lower lingual

question-Centric Relation and Centric Occlusion?

Answer-centric relation=the most anterior and superior position of the mandibular condyles within glenoid fossa (ligamnet guided position).

Centric occlusion=maximum intercusspation of opposing arches(tooth guided)* this creates VDO.

QUESTION: Non-working movement, which one is true?

answer- Lingual cusps of upper molars hit lingual inclines of facial cusps of mandibular molars

QUESTION: Contact on lingual portion of buccal cusp of mandibular molar ,what kind of interference?

Non-working,

Working,

Protrusive

Answer =non working

Doudt Question:wear facets on lingual inclines of maxillary lingual cusp and facial inclines of mandibular facial cusp on left side?

- Left working interface
- Protrusive interface
- Right non working interface

- Left working interface

Answer-right non-working interference or left working interface

According to this left working

-Right Non-working interference.... because those aforementioned inclines are involved in the left laterotrusive (working) and right mediotrusive (balancing/non-working) interference, as shown in the image. The inclines involved in protrusive interference are always mesial and distal inclines.

QUESTION: Wear on buccal of maxillary premolars due to, due to mandibular movement?

working

nonworking

Answer- working

question: When will the BULL rule be utilized with the selective grinding

a. working side

b. balance side

c. protrusive movement

d. all of the above

Ans-working side

question:The mesiobuccal incline on the mesiobuccal cusp of mand molar has wear: this is because of movement in which direction(s) !!!

1. Working and protrusive movement
2. Non working and protrusive movement
3. None of the above

Answer- working and protrusive movements.(when u move to the working side the MB cusp if man 1st molar will get in contact with the distal incline of the buccal cusp of the maxillary 2nd premolar)

question:Tooth 30 gold crown has wear located on the MB cusp of the MB incline, cause –

A. protrusive and working side movement

B. protrusive and non-working side movement

C. only protrusive

D. Non-working side movement

answer-protrusive and working side movement

question:Max molar on mesial slope of mesial lingual cusp where do you have wear on lower teeth?

answer: Distal incline of midfacial cusp

question:The mesial angle of the ML of max 2nd molar occludes with what on the man 2nd molar

a. Mesial MB cusp

b. Distal MB cusp

c. Mesial DB cusp

d. Distal DB cusp

answer-b. Distal MB cusp

QUESTION: Pt bites down after cementing down and deviates to the right #30
answer-Lingual incline of the buccal cusp
QUESTION: Crown on number 30, pt tries to close, contact interference deviates to left,
answer-buccal incline of the lingual cusp

QUESTION: In restoring a canine protected occlusion, with anterior overbite of about 2mm. The buccal cusps of posterior teeth should be flat, BECAUSE they will guide the protrusion.
a. both are true
b. only the second statement is true
c. both are false
Answer-both false(flat teeth cant guide occlusion and anyways its canine protected.. so canines will guide eccentric movements)
notes-anything away from centric is eccentric (protrusive included).. but anteriors and condylar guidance play a bigger role in protrusion, if Canines are removed. And nothing changes then rest of the anteriors guide it.. if canine protected is impaired due to some restoration e.g. Crown then it might become a group function

QUESTION: what kind of occlusion is if in right lateral movement all posterior teeth are not in occlusion?

Answer- canine guidence

QUESTION: which of the following would result in inaccurate terminal hinge record?
acutely apprehensive patient,
severe skeletal cl III,
tooth contact,
muscle pain,
answer-1 and myospasm or joint pathosis in TMJ (4), but not just any muscle pain, so only 1.

doudtQUESTION: IF you are making a crown but before you begin, when you do equilibration, what are you trying to achieve to get rid of the non-working interference?
answer-Posterior dissocculusion

QUESTION: You have a patient who wants an all porcelain on number 8 – the incisal edge keeps breaking off and u have to come in to repair, why does it keep breaking off?
Because the anterior 43 guidance and the protrusive movements.

QUESTION: Where to the condyles go in CR?
Answer-superio-anterior -medially

QUESTION: Which anatomical components are responsible for rotation of the mandible?
Answer-articular disc and condyle(hinge movenment)

QUESTION: If you both condyle break, what you get?
Answer-posterior open bite

QUESTION: Dislocation of condy
Answer-deviates same side

QUESTION: What is Bennett angle?
a. it is the angle that is formed by the non-working condyle and the sagittal plane during lateral movement
b. it is the angle that is formed by the condyle and the horizontal nansnnplane during protrusive movements.
c. It is an difference in condylar inclination between protrusive and lateral movements
d. It is the difference between in the condylar and incisal inclinations
answer-a. it is the angle that is formed by the non-working condyle and the sagittal plane during lateral movement

QUESTION: bennett shift
Answer-working side condyle bodily shifts laterally(towards working side)

question-Transillumination is useful in the diagnosis of :
1) Class I cavity
2) Class II
3) Class III
4) Class V
Answer-class 3
QUESTION: What do u place on a 75 yo patient with like 8 class v carious lesions?
a)gic
b/)amalgam
c)composite
Answer-gic
QUESTION: Class V lesions?
Composite
GIc
answer-RMGI widely used in class-5 lesions
Doudt QUESTION: #5 cervical lesion Class V what do you need to consider?
Answer-isolation
QUESTION: Class V onto root?
Bevel enamel,
90 butt margin on cementum
Both
Ans-both

QUESTION: What is not an indication for restoring class V abrafaction?
a. sensitivity,
b. esthetics,
c. prevention of decay,
d. prevention of further structure loss,
e. restoring physiological contour
Answer -c

=========
QUESTION: Too light on class v composite, how would u treat?
Answer-repalce
QUESTION: if a class IV is too light what to do? Or Class IV composite, notice it is too light 2 weeks later. ?
Stain composite,
veneer ----------
Replacement-answer
QUESTION: If a dentist notices that a large but acceptable composite is too light a few weeks after placing it, what should he do?
Answer- nothing
if patient insists Removal of the superficial layer n restoring it with lighter shade can work too without disturbing the whole restoration

QUESTION: class 3 extends to facial. The restoration is pigmented but margins are perfectly sealed, however they have bad color. What should you do?
answer-remove 1mm prep and add more composite
QUESTION: Recently placed a class 3 comp, pt isn't happy with it and has a huge staining on margins what to do?
Replace, -answer
remove on margins and place composite,
extract/implant,
questio;After caries removal sound tissue is on cementum. How do you restore?

According to dd -restore it with GIC,
QUESTION: Prep you did went down to cementum , what do you do to fill it:?
rmgi than composite on top
question:subgingival composite where cementum is exposed. What type suld you place?
dual cure
Fluoride releasing composite
use GI and then composite-answer

question-Class 3 composite w/ radiolucency under it. This could be due to All of the condition except one. Which of the following is the exception?
A) Liner.
B) recurrent caries.
C) contraction from shrinkage of curing.
D) None of the above.
Answer- contraction from shrinkage of curing
QUESTION: MOD amalgam that passes the 1/3 distance of cusp height, do what ?
MOD amalgam,
MOD composite,
MOD onlay,
MOD inlay
Answer-mod onlay(Inlay is also limited to 1/3rd. Onlay will protect the weakened tooth)
question;Indirect composite inlay has the following advantages over the directcomposite EXCEPT:
a. Efficient polymerization.
b. Good contact proximally.
c. Gingival seal.
d. Good retention/
Answer-d
notes-The line angles are converging towards gingival floor in inlay and diverging in case of direct restoration. The resistance will be fine but retention will be low due to obtuse line angles in proximal box.That's why usual point of breakage is the isthmus between dove tail and proximal box due to outward directed forces.
In direct restorations, the gingival floor in proximal box is made reclining or the axial lines angles are acute due to which proximal box is self retentive and not relying on the dove tail for retention. While in indirect restoration, to be able to place cured ingut in the prepared cavity, the

axial line angles are obtuse, hence retention comes from.the dove tail, the weakest part of which is the isthmus.
QUESTION: Most important factor when placing a composite in post teeth?
Answer-case selection
QUESTION: You place a conservative composite on a posterior tooth and the patient returns due to sensitivity. What is the most likely reason?
A. Putting large amount of comp while filling,
B. microleakage,
C. trauma to dentin during preparation,
D. Etch causing pulpal pain,
answer-shrinkage occurs with most of composite restoration even minor degrees because of factor C ,then if bacteria enter and leakage it's then considered failure
With other options can be higher occlusion(Failure decay, microleakage 2-Sensitivity occlusion, debonding)
QUESTION: Most common reason for replacing posterior composites?
REcCURENT caries
inadequate margins
fracture of composite
(ONLINE SAYS: The two main causes of posterior composite restoration failure are secondary caries and fracture (restoration or tooth)
QUESTION: After placing a crown with composite resin, after six month around the porceline gingiva there is a discoloration (brown color) what is the cause: ?
Answer-amines
question:How long have to wait after bleaching to do a composite on an anterior tooth
A one week
B two weeks
C three weeks
D four weeks
Ans-one week
QUESTION: Why do you bevel when placing anterior composite?
answer-Beveling does everything except strong margin in composite
QUESTION: why do we bevel cavosurface of composite?
1. For more surface area
2. Esthetics
3-.both
Answer-both
question:Which one is not reason for post-op sensitivity Class I comp?
cusp deformation due to shrinkage force,
Gap for microbes,
Gap for leakage and movement of fluid from pulp outwards,
Direct contact of etchant and bonding to pulp
answer- cusp deformation due to shrinkage force(bcs of C factor, remember that in class 1 we have the most shrinkage force. Bcs of acid-etch bonding micro leakage is minimum right after treatment.)

QUESTION: Restore tooth with MOD comp. then pt. comes back 2 days later with sensitivity. Then you put composite over it and relieves the pain. What is reason?

answer-Creates better seal and helps reduce marginal microleakage

question-Post operative sensitivity following placement of composite, which is the least likely reason?

1. Shrinkage allowing fluid in dentinal tubules

2.Shrinkage allowing bacteria to get in and cause sensitivity

3. Acid in the etchant material causing pulpal sensitivity

answer-B -- coz sensitivity occurs due to open dentinal tubules...bacterial invasion-->causing caries n demineralization--> n opening of dentinal tubules is a long term effect

question:final answer

When do you see microleakage with composite restoration done without rubber dam?

Same amount of time as if done with rubber dam

2 weeks later

2 months later

Answer-2-4 weeks later

QUESTION: Highest chance of leakage under rubber dam?

Holes too wide

Holes too far apart

Too close-answer

question-What is not an advantage of rubber dam when compared to not using it:

A. Improved properties of materials,

B. shortens operative time,

C. facilitates the use of water spray

answer-c(because water spay is beneficial in any dental procedure but when using rubber dam it become difficult to use it as the water spray will block the vision and accumulate in the procedure field)

QUESTION: Placement of rubber dam affect the colour selection by?

Answer-dehydration of tooth gives inaccurate color and black background

QUESTION: W on the rubber dam clamp means it is?

Answer-wingless.

QUESTION: How to fix porcelain chip on PFM with composite?

answer- microetch or HF,>silane, >bond and composite

QUESTION: pt has composite restoration with severe pain with localized swelling?

Answer-incision and drinage

QUESTION: Pt had #8 & had a bunch of little pits in #8; how would you fix it? Composite over pits, or over entire tooth, or veneer w/ porcelain,

Answer-composite over pits

QUESTION: pt complains of a marginal stain on #8, what do you do?

answer-Marginal stain polishing

Doudt QUESTION: Similar question: Patient's chief complaint is #8 and #9 don't look right. Picture shows nothing is wrong with #9, #8 has extra enamel at the incisal-distal aspect. What do you do? – Shave the inciso-distal aspect of #8. (Other choices were stupid; like put composite on both teeth, put a crown on #9, etc)

QUESTION: Advantage of a direct composite vs.indirect composite?
answer-the effect of polymerisation shrinkage is eliminated in indirect composite onlay.
but then the direct method is less time consuming.Better marginal adaptation with direct
indirect composites are superior to direct composites because the bulk of polymerization shrinkage takes place outside the mouth and consequently there is less stress at the tooth-restoration margin and as a result there is:
- Less microleakage
- Less marginal breakdown
- Less post-operative sensitivity u Less marginal staining.
QUESTION: You place a CaOH on the tooth for a direct pulp cap what is needed?
Answer-gic liner
question-Etchant does all except?
A) Increase surface area,
B) remove debris,
C) Increase wettability of enamel,
D) dec irregularities at cavosurface margin.
Answer- decrease irregularities at cavosurface margin.
QUESTION: Beveling in acid etching composite?
answer- Increase surface area
QUESTION: Etch dissolves smear ?
answer-etching with acid, in addition to removing the Smear Layer and exposing the surface collagen, also removed the peritubular dentin from the top 5 –10 μm of the tubules, yielding a tubule with a funnel shaped orifice.
QUESTION: Acid-etching does not cause.
Reduced leakage,
better esthetics,
increased strength of composites
Answer-better esthetics
Acid etch technique: conserves tooth structure, reduces microleakage, improves esthetics and provides micromechanical retention. Etch does improve marginal seal, helps in wetting enamel, cleans surface debris, created micropores (roughness of surface)
QUESTION: if contamination after etch?
Answer- re etch
QUESTION: the difference of total etch and self etch
answer-Total etch requires separate phosphoric acids top to etch enamel n dentin a subsequent rinse and application of primer n bond..
Self etch system Hav an acidic resin which etched n primes without the needful etchings ringing ten subsequent application of bond. Most unreliable
Self etch - smear layer not removed
Total etch- smear layer removed
QUESTION: Function of filler in resin?
answer- Improved workability by increasing viscosity 2-Reduction in water sorption, softening & staining 3- Increased radiopacity & diagnostic sensitivity 4- Reduction in thermal expansion & contraction 5- Increased compressive strength, tensile strength, modulus of elasticity 6- Increase

in abrasion resistance Increased fracture toughness 7-Enhances physical & mechanical properties to the level of tooth tissue clinical performance & durability8- Increases translucency 9- Improves handling properties.
QUESTION: Filler composites?
answer-Larger fillers have more strength, but do not polish as well
QUESTION: HEMA used by dentist, what phenomenon have
– anaphylaxis,
contact dermatitis,
immune mediated reaction,
arthus phenomenon
Answer- contact dermatitis
Question;composition of glass ionomer cement?
Powder- silica, alumina,aluminium fluoride,Calcium fluoride, cryolite,aluminium phosphate,lanthanum strontium,barium.
Liquid- polyacrylic acid, itaconic acid, maleic acid, tartaric acid, tricarballylic acid, water

QUESTION: purpose of a cool glass slab when mixing cement is?
answer- to incorporate the most powder into liquid as possible.
QUESTION: Veneer after a month time has some brown stain?
not enough cement at margin,
Microleakage
Answer-microleakage and if there is some surface porosity present. This may be able to be lightly buffed. Often the more common place for stains involving veneers is around the edges where the porcelain meets the tooth.
QUESTION: Which indicated for high caries risk or multiple class Vs?
answer-GIC
question-When you receive a crown back and want to seat it what is the first thing you check for?
a. Shade (Aesthetics)
b. Proximal contacts
c. Margins
d. Seating
Answer-proximal contact
Check proximal contacts first when cast that fits on die cannot be seated on the tooth in the mouth
QUESTION: What is the most practical way to seat a casting at the time of cementation?
Answer- check internal first
If other options-Parallel path of insertion
doudtQUESTION: Make sure casting seats do the following EXCEPT?
• Increase thermal expansion of investment
• Mix cement thin

• Remove internal nodule with occlude-answer(given)

as b -And anyways if u mix cement thin it causes dec in exapansion and dec strength
QUESTION: You notice void on occlusal of cast. Crown will ?
a. Fit on die and not on tooth-answer
b. Fit on tooth and not on die
c. Fit on both
d. Not fit on either
QUESTION: With resin cement on all porcelain what is NOT the reason why you use it?
answer-for added retention …cements shouldn't be used for added retention, to fill small openings at margin
QUESTION: Why do we lute all ceramic crowns with composite:
increase strength,
color stability,
sealing of margins, answer
enhance retention
QUESTION: Why don't you use GI resin cement in cementation of all ceramic restoration?
answer-its expansion could cause cracking of porclain
doudtQUESTION: Which is not correct?
answer-resin ionomer used to cement crown

sandhya start

QUESTION: Hairy tongue – hypertrophy filly form papilla.
Ans. Hairy tongue is a beningn condition of the tongue.
Poor oral hygiene
Extended use of antibiotics
Corticosteroids
Hydrogen peroxide
Smoking
Hairy leukoplakia is a non malignant lesion seen exclusively in AIDS PATIENT

20) which of the following is seen with hyperplastic foliate papillae?
Ans. Lingual tonsil hyperplasia

QUESTION: Loss of filliform papilla- vitamin def- vit b

QUESTION: Bilateral swelling of parotid cannot be caused by: Anorexia
Metabolic conditions associated with bilateral parotid gland enlargement include diabetis mellitus,hypertension,sjogrens syndrome,alcoholism.

QUESTION: Patient has bilateral white lines @ occlusal plane, what is primary microscopic finding?
Epithelial hyperkeratosis

QUESTION: Pt has hyperkeratosis around occlusal? linea alba

QUESTION: What is white and bilateral on buccal mucosa (leukoedema not choice)**, Linea Alba**

QUESTION: Ulcer on tongue repeated every 4 months- apthous ulcer

QUESTION: why brush tongue - to reduce odor

QUESTION: Pic: had a red thing on tongue where is it from (candidiasis, Kaposi, syphilis, gonnaria) candidiasis

QUESTION: Behçet's disease Pic of something on tongue: aphthous ulcer –
Apthous ulcer – common in behcets syndrome & apthous ulcer

BEHCETS SYNDROME- It is a rare disorder that causes chronic inflammation in bloos vessels throughout the body
Oral & genital apthous ulcers
Conjunctivitis, uveitis,arthritis, headache complication blindness
QUESTION: Pathognomonic for measles? Koplik's spots……buccual mucosa ulcerated

QUESTION: Transillumination in children – Koplik? (Koplik's spots are associated with measles)

QUESTION: Syphilis: hutchinson triad (presentation for congenital syphilis, and consists of three
phenomena: interstitial keratitis, Hutchinson incisors, and eighth nerve deafness.

QUESTION: indents on incisal edge with narrowing at mesial and distal? I guessed congenital syphilis (Hutchinson's tooth?) screw driver incisors

QUESTION: A chanker due to Syphilis mostly resembles: herpes
QUESTION: stages of syphilis is most infectious: primary, secondary, tertiary,
Secondary stage is most infectious with mucopapular rash
Condylomata lata is seen in secondary stage

QUESTION: Heck disease: 13 and 32
(also known as focal epithelial hyperplasia) multiple dome shaped warts on oral mucosa human papilloma virus types 13 and 32.

QUESTION: baby with streaks on palate

• bone nodulus
• Epstein pearls
• congenital epulus

QUESTION: neonate with a bunch of nodules on alveolar ridge. What is it?
a. Bohn's nodule
- keratin-filled cysts of salivary gland origin on palate of newborn
? Eruption cyst
? Congenital cyst of newborn

Oral Pathology:
Lupus Erythematosus:
Chronic autoimmune disease
Discoid lupus erythematosus.... chronic skin conditions of sores & inflammation scarring of face ,ears,scalp & oral mucosa
ORAL LESIONS MIMIC EROSIVE LICHEN PLANUS
Systemic lupus erythematosus...chronic connective tissue disorderthat involves oragans including kidneys,heart,joints,skin,mucous membrane,&blood vessels
BUTTERFLY SHAPED RASH

QUESTION: Xerostomia, complication of :Sjögren's syndrome, dry moth dry eye ,enlargement of parotid &submandibular bilatareally

Cavernous Sinus Thrombosis:
QUESTION: cavernous sinus problem - due to infection of upper lip / canine space infxn / max ant
Teeth

QUESTION: Most likely to cause **cavernous sinus thrombosis**: valve infected by endocarditis, **soft tissue abcess of upper lip**

Nerves invoved are OCCULOMOTOR, TROCHLER ,ABDUCENS,TRIGEMINAL , (OPTHALMAIC,&MAXILLARY

QUESTION: Site of infection most likely to enter cavernous sinus? Anterior triangle
Cyst

QUESTION: Danger triangle of the face – cavernous sinus (no valves in the veins)

QUESTION: Why are you afraid of having infection in anterior triangle (i.e. upper lip) because there
are valve-less veins that can send infection back to the brain

QUESTION: Which of the following causes Cavernous sinus thrombosis: A)Subcutaneous Abscess of
upper lip

Infections in upper front teeth are within the area of the face known as the "dangerous triangle". The
dangerous triangle is visualized by imagining a triangle with the top point about at the bridge of the
nose and the two lower points on either corner of the mouth

QUESTION: Danger zone of Cavernous Sinus: Signs and symptoms. What is the first one?
HEAD ACHE(GOOGLE)

QUESTION: first sign of cavernous sinus:
bulging eye??
loss vision
HEADACHE
QUESTION: Pathognomonic sign of CST? Ptosis, bulging eye, periorbital edema

QUESTION: Cavernous sinus thrombosis early indication? Peri-orbital swelling, blurry vision
QUESTION: Cavernus sinus has : ptosis, decreased vision, opthalplagia

Cavernous sinus thrombosis (CST) is the formation of a blood clot within the CS at the base of the brain which drains deoxygenated blood from the brain back to the heart. usually from a infection from nose, sinuses, ears, teeth or Forunculo. Staphylococcus aureus and Streptococcus are often the associated. symptoms include: decrease or loss of vision, chemosis, exophthalmos (bulging), ptosis, headaches(1st one) and paralysis of the cranial nerves which course through the cavernous sinus. This infection is life-threatening and requires immediate TX.

Ludwigs Angina:

QUESTION: What space is not associated with ludwigs angina? Associated with sublingual, submental, submandibular

QUESTION: Ludwig's angina seen in all spaces except: Retropharyngeal

QUESTION: Cellulitis most of the time involves unilateral, ludwigs angina is bilateral and complication is
edema of GLOTTI

QUESTION Bilateral submandibular infection, tongue was elevated due to infection – Ludwigs angina

QUESTION: What u need to worry most abt ludwigs? swelling of glottis

QUESTION: complication of lugwig's angina:edema of glottis
QUESTION: Ludwig's Angina symptoms? Swelling, pain and raising of the tongue, swelling of the neck
and the tissues of the submandibular and sublingual spaces, malaise, fever, dysphagia (difficulty swallowing) and, in severe cases, stridor or difficulty breathing.

QUESTION: What is the main danger in Ludwig's angina? **closing of the airway**

QUESTION: Mandibular 2nd molar infection spreads to what space? Submandibular space.

QUESTION: Infxn of mnd 2nd pm goes into submandibular space

QUESTION: Premolars and molars infection –submandibular space

QUESTION: Which muscle separates 2 potential infection spaces from a maxillary 2nd molar? **Buccinator or Masseter**

QUESTION: if you have an infection in the lateral pharyngeal space what muscle is involved? Medial
Pterygoid

The lateral aspect is more involved, and is bordered by the ramus of the mandible, the deep lobe of
the parotid gland, the medial pterygoid muscle, and below the level of the mandible, the lateral aspect is bordered by the fascia of the posterior belly of digastric muscle.

QUESTION: You are extracting a mandibular 3rd molar and the distal root disappears into which 68
space? **submandibular space**

QUESTION: IAN tract infection, '-[involves what space? Pterymandibular space

Treacher Collins Syndrome:

Downw=ard facing eyes
QUESTION: Which disorder least developmental delay-trecher collins syndrome
QUESTION: Treacher Collins-loss (hypoplasia) of zygomatic bone, what do patients with cleidocranial

dysplasia have? Loss of clavicle

QUESTION: Malformed ear, mandibular hypoplasia – **Treacher Collins**

QUESTION: Describes patient saying they have mandibular hypoplasia, Malformed ear eyelids, ear pinna-- **Treacher Collins**

Scarlet Fever:
QUESTION: Strawberry tongue seen in scarlet fever, Also in Kawasaki disease and toxic shock syndrome

Fordyce Granules:
QUESTION: Fordyce granules – **ectopic sebaceous gland**
•
Turner Toot

QUESTION: turners tooth – single tooth affected

QUESTION: Turner's tooth is caused by: I put "trauma or local infection"

QUESTION: What gives you Turners incisors
• syphilis
• trauma during delivery
• *trauma during pregnancy
TURNERS HYPOPLASIA IS WITH HISTORY OF TRAUMA/INFECTION IN THEIR PRIMARY PRECEDECESSORS

Recurrent Aphthous Stomatitis:
aphtous ulcers in non keratinized tissue – herpes in keratinized tissue

aphthous stomatitis: recurrent discrete areas of ulceration that are almost always painful. Occurs on freely movable mucosa that does not overlie bone,Aphthous can be differentiated since it usually does not occur over bone, does not form vesicles and is not accompanied by fever or gingivitis

QUESTION: Pt has occasional sores on mucolabial fold on mandibular arch that healed without scarring:
minor aphthous

QUESTION: Ulcer that appears often on buccal vestibule that goes **away without scarring** after a week or
so? **Minor Apthous ulcer.**

QUESTION: Ulcer healing with scar tissue: major apthous ulcers AIDS

QUESTION: A chancre due to Syphilis mostly resembles: herpes ulcers

QUESTION: History of lesions that go away after 1 week – recurrent aphthous ulcers

QUESTION: What don't u treat aphthous ulcers with – acyclovir

Benign Mucous Membrane Pemphigoid (cicatricial):
Pemphigoid = D = DEEPER (subepithelial separation) than pemphigus S = SURFACE (epithelial
separation)
70
Know Pemphigoid--**autoimmune disorder where antibodies attack the fibrous attachment of the skin and membrane epithelium. Blisters and vesicles
Histology: subepidermal ,no acantolysis

QUESTION: Pemphigoid – separation of basement membrane

QUESTION: Subepithelial separation on immunofluorescence indicates? benign mucous membrane pemphigoid…….subepidermal / subepithelial -pemphigoid
Pemphigus vulgaris……..suprabasilar vesicle, acantholysis

QUESTION: Another name for chronic desquamative gingivitis? Cicatricial pemphigoid

QUESTION: The oral lesions of benign mucous membrane pemphigoid most commonly present as desquamative gingivitis

Disease with Desquamative gingivitis: lichen planus, mucous membrane pemphigoid (95%) and pemphigus
A band of red atrophic or eroded mucosa affecting the attached gingiva is known as dequamative gingivitis. Unlike plaque-induced inflammation it is a dusky red colour and extends beyond the marginal gingiva, often to the full width of the attached gingiva and sometimes onto the alveolar mucosa.

QUESTION: Desquamative gingivitis is associated with which 2 conditions. Lichen planus and Pemphigoid

Pemphigus vulgaris is MUCH LESS SEVERE and blistering of skin caused by binding of antibodies to the surface of the cells of the outer skin
Clinical features: ulcerations & erosions covered by blood tinged exudates

QUESTION:Sloughing of gingiva epithelium in max and mand arches:
A) pemphigus
B) pemphigoid

C) both

QUESTION: Child formed blisters with minor lip irritation? Epidermolysis bullosa

QUESTION: Which pemphigoid like lesion most often in infants?

EPIDERMOLYSIS BULLOSA : it is characterized by fluid filled blisters on the skin especially on hands and feet due to friction.skin thickenening on the palms and soles of the feet.internal blistering

QUESTION: Young child/infant exhibits **ulcerations** of mouth: **epidermalysis bulosa**

Condyloma Acuminatum:
QUESTION: Condyloma accuminatum (genital wart) is caused by which virus? HPV 6 &11

QUESTION: Which of the following does not have cauliflower like , pebbly appearance?
Verrucous
carcinoma, fibroma , condyloma accuminata, papilloma.
Ans fibroma…..A FIBROMA IS A BENING NEOPLASM OF CONNECTIVE TISSUE ORIGIN

Candidiasis:
Candida forms – ulcer, Erythema, white hyperplastic, white/curd

QUESTION: Systemic antifungal in HIV patient?? Fluconazole

QUESTION: Hiv patient with oropharyngeal candidiasis, what would u prescribe-
fluconzole ????

QUESTION: Patient with HIV has candidiasis- bec it is HIV related, increased CD 4... (I wrote increase
CD4...?)
QUESTION: which oral medication would you give to tx vaginal candidiasis? Nystatin, griseofulvin,
monistat, Diflucan (fluconazole)
QUESTION: If pt undergoes radiotherapy for cancer, the most common oral infection that necessitates
drug tx in this stage is? 1. Candida albicans (answer)

QUESTION: Candidasis in cancer patients due to- chemotherapy, radionecrosis

QUESTION: Inhaled methacholine (steroid) produce oral candidiasis

QUESTION: Pt has multiple white patches that can be scraped off ? candidiasis

QUESTION: Oral cytology smears are MOST appropriately used for the diagnosis of which of the following? **Pseudomembraneous candidiasis**

QUESTION: What oral manifestation is seen in children with HIV? Candidiasis #1

QUESTION: Patient is 4yrs old on lots of AB what is most likely? Candidiasis

QUESTION: Candida- can wipe away: Nysatatin

QUESTION: systemic med for candida: amphotericin B
S
QUESTION: broad spectrum antibiotics : ?increase superinfection (infxn by candidiasis) and resistance.

QUESTION: Which is associated w/ burning mouth? **Candida**

QUESTION: Lesion in the middle of tongue also pt had it on palate before and pt is healthy? Karposi, candidiasis, Syphilis

QUESTION: Rhomboid tongue thought to be- a type of candidiasis

QUESTION: Median rhomboid glossitis—***smooth red area of tongue that lacks the papillae

QUESTION: Healthy 36 year old, red patch on palate, redness in middle of tongue:
-kaposi sarcoma,
-syphilis
-median rhomboid glossitis
-gonorrhea

Primary Herpes:
Gingivostomatitis Herpetica: initial presentation during the first ("primary") herpes simplex infection. of greater severity than herpes labialis (cold sores) which is often the subsequent presentations. is the most common viral infection of the mouth,affects both the free and attached mucosa. Tx Acyclovir, valacyclovir, Penciclovir Famciclovir.

QUESTION: 85% of people have herpes

a. 65-90% worldwide; 80-85% Usa(I hav no idea)

QUESTION: Age of primary infection of herpes? 2 yo, 4 yo, 6 yo, 8 yo, 10 yo (added info below

From oral path book under viral infections; "acute herpetic gingivostomatitis arise between 6 months and 5 years, with peak prevalence btwn 2-3 years of age. Development before 6 months is
rare due to protection of maternal anti-HSV antibodies.

QUESTION: Young person w/ fever & vesicles: FEVER = PRIMARY herpes stomatitis
QUESTION: Primary herpatic gingivostomatitis- fever, ulcer in mouth. No symptoms
QUESTION: Primary herpatic gingivostomatitis- child 2 yrs , fever, not ant to eat

QUESTION: After orthodontic tx, pt with no other systemic disease develop high fever?

due to canker sores by newly placed brackets.

QUESTION: ways to treat kid w/ herpetic gingivostomatitis EXCEPT
a. antibiotics
b. give numbing anesthetic before eating
c. have pt rest and drink lots of water

Recurrent Herpes Simplex:
aphtous ulcers in non keratinized tissue – herpes in keratinized tissue

QUESTION: Herpes can be diagnosed by exfoliative cytology. A characteristic multinucleated cell appears in the smear of herpes infections.

QUESTION: Recurrent intraoral herpes occurs almost exclusively on mucosa overlying bone. The hard palate is the most common site, alveolar mucosa

QUESTION: 2ndary herpes ? lip, gingival, and palate pg 106, table 4-1

QUESTION: Herpes simplex is ASSOCIATED WITH Bell's palsy& TRIGEMINAL NEURALGIA

QUESTION: Herpetic withlow? Herpes on finger

DRUG OF CHOICE:
acyclovir: herpes I, II, VZV,EBV
ganciclovir (IV): CMV or (valancyclovir – oral)
Primary HSV: PALLATIVE
recurrent herpes medication: docosanol (abreva), acyclovir (zovirax)

Know drugs that are used for Herpes: Acyclovir, valtrex (valacyclovir), docosanol (abreva), andPENCICLOVIR

QUESTION: Acyclovir given for herpetic lesions. Also, phosphorylated and activated in infected viral cells.

QUESTION: herpes, zoster – Valacyclovir treats herpes labialis

QUESTION: Patient gets recurrent herpetic lesions very often with gingivostomatitis. What should
be done?
Acyclovir.
Palliative trt

QUESTION: Hiv pt with oral herpes, what would u prescribe- vir

QUESTION: Tx for herpatic gingivostomatitis?
• palliative tx**
• acyclovir
• systemic antibiotic
• steroids

QUESTION: best med for herpes, CMV…acyclovir
.
QUESTION: Valcyclovir (Valtrex): Tx for herpes simplex/herpes zoster

QUESTION: Tx for herpes simplex and herpes zoster : Valtrax

QUESTION: Which most closely mimics dental pain: herpes zoster

CORTICOSTEROIDS ARE CONTRAINDICATED IN PATIENTS WITH HERPES SIMPLEX INFECTIONS

QUESTION: Patient comes with recurrent herpetic stomatitis on the lips and history shows no signs
of primary herpetic gingivostomatitis. Why? Most primary infections are subclinic

QUESTION: pt presents at 3 days with secondary herpes lesion? What the treatment of choice?
Antiviral?
Palative treatment****

Acyclovir was an answer choice (but acyclovir works best before you get the lesion)

QUESTION: Herpetic gingivostomatitis – within 3 days of onset: treat with Acyclovir 15mg/kg 5 times
per day for 7 days
All patients: palliative care: plaque removal, systemic NSAIDS, and topical anesthetics
Contagious when vesicles are present

QUESTION: Primary herpretic stomatitis? Reactivation of the primary can cause **recurrent herpes**
Infection

QUESTION: Which dz is caused by the virus that causes acute herpetic gingivostomatitis?
A: herpes simplex 1

QUESTION: Herpes lesion intra orally how do u treat? Palliative, acyclovir?? *Tx is supportive—topical
before eating, analgesics, maintain fluid/electrolyte balance, anti-viral agents. DO NOT GIVE CORTICOSTEROIDS.

QUESTION: acyclovir inhibits mrna. How does it have selective toxicity MOA? Only phosphorylated in infected cells and inhibits viral mRNA…does not work on dna

QUESTION: Acyclovir-inhib mRNA?-phosphorylated-. nucleoside analogues--can't make RNA
The mechanisms of antiviral action of acyclovir are well known (Figure 40-9). The nucleoside analogue is **phosphorylated to form acyclovir monophosphate** by herpesvirus-encoded **thymidine kinase** and phosphorylated further by other enzymes to acyclovir diphosphate and triphosphate. Acyclovir triphosphate acts to **inhibit viral DNA polymerase** and to terminate elongation of the viral DNA chain as spurious nucleotide is incorporated into DNA. In the noninfected host cell, phosphorylation of acyclovir occurs to a limited extent. Acyclovir triphosphate inhibits HSV DNA polymerase 10 to 30 times more effectively than it does mammalian cell DNA polymerase.

QUESTION: how is Acyclovir selective toxicity mechanism of action?
1. only phosphorylated in infected cells and inhibits viral mRNA
2. does NOT work on DNA

QUESTION: Post herpetic neuralgia cause by: (VZV)**herpes zoster**,

QUESTION: What does histoplasmosis oral lesion look like? NONHEALING ULCER TUBERCULOSIS

QUESTION: Same patient as #49, has upper denture, when he removes it, there is unilateral lesion on the
palate. What could it be? – Herpes (other choices were more serious pathological lesions).

QUESTION: Pic with half the tongue (left side) that looks like herpes lesion and other nothing on it- I

wrote zoster

QUESTION: Pic of tongue one side with messed up: herpes zoster

QUESTION: Antivirals(wrong match)- azt with herpes zoster

QUESTION: Herpetic neuralgia seen after Herpes Zoster (complication of longer shingles) (hh3, VZV)
QUESTION: Syphilis Chancre resembles herpes virus

QUESTION: Kaposi sarcoma by herpes 8

QUESTION: Kaposi sarcoma most likely on hard palate

Traumatic Neuroma:
QUESTION: A patient has a denture and a firm, swelling under the buccal flange midway between incisors and molars. What is it? **traumatic neuroma**

QUESTION: Mandibular Denture: Lump hurts: Anterior to posterior areas cause is: traumatic neuroma

Pyogenic Granuloma:
QUESTION: Picture said: "erythematous, bleeding swelling" mandibular swelling right next to premolars on R side? **pyogenic granuloma**

QUESTION: Pyogenic granuloma develops RAPIDLY

QUESTION: Pink growth on palatal between canine and 1st pre? Papilloma, pyogenic granuloma, peripheral ossifying, irritation fibroma?

QUESTION: Which lesion shows the most rapid change in size?
• fibroma
• *pyogenic granuloma

QUESTION: Which one is common in pregnancy and in normal condition--pyogenic granuloma

QUESTION: Patient is female and pregnant and is said to have this enlargement and picture has it
on the corner of her mouth (vermillion border) and she said it just developed; the picture had it shown as a boil and very red, said it bled, and was no painful – I went with pyogenic Granuloma other option that could have made sense bc I didn't know what it was a varix (dilated vein)
QUESTION: Picture... Lesion near labial comissure? Canditits Pyogenic Granuloma???
QUESTION: Lesion on gingival – if you press, it blanches and it bleeds easily – dx = **pyogenic**

Granuloma

Giant Cell Granuloma:

QUESTION: Giant cell lesion found in bone what test would you run to help with diagnosis? COMPLETE BLOOD TEST

Squamous Papilloma:
QUESTION: Lesion on the palate verrucous and pedunculated: Papilloma

QUESTION: The causes of Verrucus xanthoma? Unknown etiology,

QUESTION: Cauliflower looking lesion, no picture given – Papilloma

QUESTION: lesion in lip with cauliflower shape : PAPILLOMA - the **most common benign**

neoplasm of EPITHELIAL TISSUE ORIGIN. It appears as apedunculated (foot-shaped), or sessile
whitish **cauliflower-like mass** on the tongue (posterior border), **lips,** gingiva, or soft palate.

QUESTION: The most common between five? 1-Papilloma 2-Rhabdomyoma 3-Leiomyoma 4-Lymphangioma 5-Neurofibroma ans : papilloma

Fibroma:

QUESTION: Which one resembles Epilus Fissuratum – Fibroma (both share trauma as etiology)

PAPAILLARY HYPERPLASIA – ILL FITTING DENTURES ,HARD PALATE (NUMEROUS RED PAPILLARY PROJECTIONS) COBBLESTONE APPEARENCE

usually make new denture or modify; don't just wear same denture)

QUESTION: Fibromas are a result of what dysfunction? HYPERPLASIA

EPULIS FISSSUTATUM IS DENTURE INDUCEDFIBROUS HYPERPLASIA

Granular Cell Tumor:
pseudoepitheliomatus hyperplasia: IS OVERLYING EPITHELIUM IS FREQUENTLY SEEN IN GRANULAR CELL MYOBLASTOMA

QUESTION: Congential epulis histological similar to: , granular cell Myoblastoma

QUESTION: If you have leukoplakia for biopsy, do you incise or excise for biopsy? 1. Incision (answer)
QUESTION: Leukoplakia all over- incise multiple areas w incisional.

Erythroplakia:
QUESTION: In smoker's soft palate, theres red points, wut could it be? ? erythroplakia, initial stages of SCC, nicotinic stomatitis (hard palate), etc.

QUESTION: Lesion commonly with dysplasia and carcinoma in situ—Erythroplalakia

QUESTION: White ppl have least oral carcinoma: or asian, Indian, blacks

QUESTION: Worse rate of SCC is in? I put **Black men**

QUESTION: Etiology of Squamous Cell Carcinoma, external factors and stress.
(alcohol, tobacco, UV radiation, certain HPV types, vitamin deficiency, immunocompromised, iron
deficiency anemia – plummer Vinson syndrome…etiologies added from First Aid)

QUESTION: Xerostomia increases risk of SCC ???(I dnt kw)

QUESTION: lateral boarder of the tongue picture looked like squamous cell carcinoma

QUESTION: Which of the following has the best survival rate?
a. squamous cell carcinoma
b. adenocarcinoma
c. osteosarcoma
OSTEOSARCOMA> CHONDROSARCOMA<FIBROSARCOMA<EWINGS SARCOMA(rate of malignancy)

QUESTION: SCC on tongue, What you do? Incisional

QUESTION: #1 risk factor for oral cancer **Tobacco**

QUESTION: Most likely site for SCC? **Ventrolateral tongue** (other choices were weird…palate (least)…)
QUESTION: Beetle nut case? SCC, xerostomia ? gingival recession ?

QUESTION: Pt has been a smoker (60 pack yr history); ulcer in lower lip, non-indurated; wuts most
probable diagnosis? SCC
QUESTION: Most common malignancy in the oral cavity?

a. metastatic ca (most common malignancy found in bone)

b. basal cell ca (most common type of skin cancer)

c. epidermoid ca (aka SCC…I'm pretty sure this is the right answer…Xtina)

d. mucoepidermoid ca (most common salivary gland carcinoma)

e. adenoid cystic ca (second most cmoon salivary gland carcinoma)

QUESTION: Most malignant cancer in oral cavity? Epidermoid carcinoma ***SCC! (look it up)
IN DD MOST MALIGNANT WAS GIVEN AS BASAL CELL CARCINOMA.>SCC

QUESTION: Which of these is the most likely to become malignant? low grade
mucoepidermoid
carcinoma;
QUESTION: Radiographic Picture: image was upside down, had pink tissue-two teeth on
bottom, bump
on palate-what is the lesion? ---SCC?

Leukoedema:
QUESTION: Leukoedema – blanches, no treatment
QUESTION: Leukoedema: Stretch and it disappears

QUESTION: dr stretches buccal mucosa, white, and spreads out thinner: leukoedema

QUESTION: Similar question: Which white lesion disappears upon stretching? Leukoedema
QUESTION: White on mucosa-no information-hyperkeratosis? Gauri put leukoedema;
SNOFF POUCH IS A FORM OF HYPERKERATOSIS WITH WHITE MUCOSAL CHANGE
IN TOBACCO HELD CHANGE

Leukemia:

lymphocytic leukemia-involves lymphocytes.
• Chronic lymphocytic leukemia runs a variable course (older patients may survive years even without treatment). lymph node enlargement is the main pathologic finding. May be complicated by autoimmune hemolytic anemia.

CML – Philadelphia chromosome (chromosomal translocation)**Chronic myelogenous leukemia

QUESTION: Leukemia picture
o Says bleeding gums
o 20 yr old patient
o Been bruising easily

QUESTION: Leukemia Picture: young person that is fatigued and has a jacked-up mouth
QUESTION: Pic of kid with bleeding gums problem healing- leukemia

QUESTION: Most common type of leukemia in children? 1. ALL (answer) (lymphoblastic)

QUESTION: Pt had erythematous and gingival enlargement over past 5 weeks. And increased report
of bruising on body – cause is acute leukemia:

QUESTION: A 6 years old patient has acute lymphatic leukemia. Her deciduous molar has a large carious
lesion and furcation lucency. How will you treat this person?
a. pulpotomy
b. pulpectomy
c. extraction
d. nothing
QUESTION: An 18 year old man complains of tingling in his lower lip. an examination discloses a
painless, hard swelling of his mandibular premolar region. the patient first noticed this swelling three
weeks ago. radiograph indicate a loss of cortex and a diffuse radiating pattern of trabeculae in the mass.
which of the following is the MOST likely diagnosis?
a. leukemia
b. dentigerous cyst
c. ossifying fibroma
d. osetosarcoma
e. hyperparathyroidism

Verrucous Carcinoma:
QUESTION: Best prognosis? Verrucous carcinoma in vestibule, verrucous carcinoma floor of mouth,

SCC floor of mouth, SCC in other areas
ANS .VERRUCOUS CARCINOMA IN VESTIBULE

QUESTION: smokeless tobacco : verrucous carcinoma

QUESTION: Verricus leukoplakia, HPV 16 and 18(HIGH RISK FORM OF LEUKOPLAKIA)

QUESTION: Verrucous carcinoma presents with
• warty lesion
• white ulcerated patch (that's what it looks like on google images)
• smooth pedunculated lesion

• I put large warty mass- variant of SCC
(large broad based exophytic papillary leukoplakic lesion: Xtina, First aid)

Salivary Gland Tumors:
Most common salivary gland benign major & minor : Pleomorphic adenoma
Most common malignant minor: Adenoid cystic carcinoma(50-70%)
Most common malignant major& MINOR IS MUCOEPIDERMOID CARCINOMA
QUESTION: Most common salivary gland tumor: Pleomorphic adenoma
POLYMORPHOUS LOW GRADE ADENOCARCINOMA IS THE SECOND MOST MALIGNANCY IN THE MINOR SALIVARY GLAND TUMOUR
ACINIC CELL CARCINOMA IS THE SECOND MOST PAROTID MALIGNANCY AND THE SECOND MOST COMMON PADIATRIC SALIVARY GLAND
MOST COMMON SITE = MINOR GLANDS OF PALATE
MOST COMMON TUMOR OF PAROTID GLAND
QUESTION: Pleomorphic adenoma – most common benign tumor of salivary glands

QUESTION: which s most common salivary gland tumor pleomorphic adenoma and mucoepidermoid
**Pleomorphic adenoma-most common belign
Mucoepidermoid: Most common malignant

QUESTION: Which of the salivary tumor glands has the best prognosis: Mixed Tumor, Adenoid cystic carcinoma (perineural spread), Mucoepidormoid Carcinoma (most common)
Acinar Cell Carcinoma
ANS ;ACINIC CELL CARCINOMA (LOW GRADE MALIGNANCY)

QUESTION: Best prognosis for oral cancers: Adenomatoid od. Tumor, low-grade --, malig. Mixed tumor
Benign Mixed tumor (pleomorphic adenoma) = best prognosis
Low grad mucoepidermoid is also good
ADENOCARCINOMA IS RARE BUT MOST AGGRESSIVE

POLYMORPHOUS LOW GRADE ADENOCARCINOMA IS THE SECOND MOST COMMON MALIGANANCY

QUESTION: Adeno cystic carcinoma : neurotrophic factor and perineral invasion
81

QUESTION: Table 4. 3: swish cheese? adenoid cystic carcinoma
[?] [?] Adenoid cystic carcinoma
o High grade salivary malignancy
o Palate most common
o Most common malignant
o “swiss cheese” microscopic pattern
o spreads through perinueral spaces*****

Ameloblastoma:
Most common EPITHELIAL ODONTOGENIC TUMOR...mand molar area
QUESTION: Ameloblastoma histology : stellate reticulum in bell stage, epithelium in net flex pattern

QUESTION: What cyst is ameloblastoma most likely to stem from? **Dentigerous cyst**

QUESTION: Which describes ameloblastoma best? I put **local invasion**

QUESTION: What is the most definite way to distinguish ameloblastoma from OK?
a.smear cytology
b.reactive light microscopy

QUESTION: Ameloblastoma case Q. You get a picture, slow progessing, other false choices included
dentigirous cyst.

QUESTION: Multiluncency in bone and ramus: ameloblastoma
[?] [?] ameloblastoma
o benign, aggressive odontogenic tumor w/recurrence
o most common tumor

- [?]**Ameloblastoma – consists entirely of odontogenic epithelium.** MOST AGGRESSIVE odontogenic tumor.

MOST COMMON epithelial odontogenic tumor.

Solid (multicystic or polycystic) – most aggressive kind and requires surgical excision

Ameloblastic Fibroma: compared to ameloblastoma - younger age, slower growth, does not infiltrate

QUESTION: A painless, well-circumscribed radiolucency and radioopacity in the posterior mandible of
11yrs old boy. what is the differential diagnosis? Ameloblastic fibro –odontoma

QUESTION: Xray - Ameloblastic fibro odontoma/odontoma?
Odontoma:

QUESTION: pic of compound odontoma
82
QUESTION: x-ray of odontoma (anterior lots of little tooth in the x-ray around the canine)

QUESTION: recognize odontoma--- **compound odotoma—looks like a tooth more defined; complex
odontoma—giant mass that is also radiopaque, but does not look like a tooth—

QUESTION: Syndrome with multiple odontomas-gardners syndrome

QUESTION: Picture of multiple small **teeth within a radiolucency**: **compound odontoma**, pindborg
tumor, calcifying odontogenic
- The other tumor of mixed, (epithelial and mesenchynal) origin is the odontoma. These calcilied iesions take one or two general configurations. They may appear as multiple miniature or rudimentary teeth, in which case they are known as **compound odontomas,**

Adenomatoid Odontogenic Tumor (AOT):
QUESTION: AOT (Adenomatoid odontogenic tumor) radiograph picture
o Exact picture used

QUESTION: Max canine surrounded by lesion: AOT

QUESTION: 2/3 tumor: adenomatoid odontogenic tumor: 2/3rd in maxilla, 2/3 in female, 2/3rd in anterior jaw

QUESTION: Radiolucency at the end of a tooth that looks like there might be an AOT but the patient is
having symptoms (I wrote pericapical cyst)

QUESTION: Radiolucent lesion Between canine -lateral with radiopacity inside: adenomatoid tumor
QUESTION: mixed density young child: **AOT**

QUESTION: AOT on xray- REMEMBER lesion goes to apex
83
QUESTION: A 16 year old boy. Xray showed maxillary anterior tooth with a radiolucency with "SPECKS" in it (yes that's the word that was used). Adenomatoid Odontogenic Tumor

Amelogenesis Imperfecta:
QUESTION: amelogenesis imperfecta is autosomal dominant.

QUESTION: Amelogenesis imperfect: X-ray: open contacts

QUESTION: Pictures of teeth, premolars just erupted. Thick dentin thin enamel, pulps not obliterated, no contact – **AI**
QUESTION: Radiographic picture with large decay and radiolucency. In addition to periapical radiolucency what other thing do you see? amelogenesis imperfecta (tooth lacks enamel)
QUESTION: Know the Imperfectas Amelogenisis: Hypoplastic pitting enamel

QUESTION: All of the following are congenital except…
a. dentinal dysplasia
b. amelogenesis imperfecta
c. regional odontodysplasia
d. ectodermal dysplasia

QUESTION: Question describing regional odontodysplasia: ghost teeth. (enamel, dentin and pulp
are all affected. Non hereditary)

QUESTION: when does enamel hypoplasia occur: Altered matrix formation. (BELL STAGE)
DI vs Dentinal Dysplasia:
DI: Crowns are short & bulbous, narrow roots, obliterated pulp
DD: Short roots (sometimes rootless), obliterated pulp, sometimes PA RL, mobile teeth

Sandhya end
6 ravali ---51 -62

Question: sensitivity of pulp in regards to cement in regards to cement, which is correct?Ans: resin ionomer and glass ionomer cause highest pulp sensitivity

question: which cement is the easiest to remover after procedure. Ans: zinc phosphate

Question: zinc phosphate ph is is 3.5, what is the significance of that? -Pulp sensitivity
Gic is sensitivite to pulp but not harmful to pulp... While zinc phosphate causes sensitivity n harmful due to its low initial ph
Question: what component of cement contributes to adhesion? Polycarboxylic acid, benzoyle peroxide, others, polyacrylic side group --chelation between carboxyl groups and calcium in tooth.

---depend on type of cement if gi so polyacid if polycaroxylate so pocarboxylic acid

question: photo initiator/ resin activator of composite? Camphoroquinone

Question: diketones activate by ? Ans: visible light

Blue light to produce slow reactions. Amines are added to accelerate curing time.
- crosslink reaction

question: most radio opaque in porcelain/ composite

A. Barium and zirconium glass

B. Silica

C. Quartz ans-a

Question: heat cured indirect composite (increase strength)vs direct composite. Which is incorrect?
a. Heat composite is harder

b.Heat composite is more resistant to abrasion

c.Heat = less irritation to tooth due to less shrinkage

d.Heat indirect has better bonding to the dentin and enamel **
ans-d

doubtful Question: which composites have more color stability? I put light cure due to tegdma heat cured (light cured) resins have superior color stability

Microfill composites are more color stable than hybrid. Microfill have the smoothest finish compared to hybrids which are rougher. Rougher will pick up stain easier.

Question: what is importance of light cured vs autocured in terms of shade balance;

Ans: the less number of nitrates when you use lightcure;

Nitrogen dioxide gives a brown discoloration, hence there is less number of nitrates with the light cure, that will lead to more shade balance than in the autocured which contains more nitrates.

Question: curing light intensity: 400

The dental led curing lights use led's that produce a narrow spectrum of blue light in the 400- to

500-nm range (with a peak wavelength of about 460nm), which is the useful energy range for activating the cpq molecule most commonly used to initiate the photo-polymerization of dental monomers

question: what is false about led vs halogen curing lights:

A. Blue light is 340-370

B. Battery powered/cordless led is acceptable

c. Led lasts longer than halogen

D. Something about a photoinitiator

E. Blue light is not 340-370

----ans: a expl:blue light wavelength is 400-500 nm at peak of 476

QUESTION:Lasers and LED lights don't cure all resins b/c some resins photoinitiatiors have require light sources is out of range.-true

QUESTION:Which of the following will be not be good against enamel :
hybrid resins
enamel
amalgam
unfilled resins

ans -enamel porcelin>enamel>hybrid> amalgam

QUESTION:Glass ionomer has more a good :
1) Tensile strength
2) Compressive st
3) None

ans:2 GI is brittle = high compressive, low tensile strength

QUESTION: *** VRMGI? Advantage beside fluoride release? Ionic bond btwn enamel and dentin,

QUESTION: How do you improve the success of calcium hydroxide on a direct pulp cap? in order to protect the pulp Place 2mm GI thickness base /liner over calcium hydroxide.

QUESTION: What is the composition of Glass Ionomers? Silica glass and polyacrylic acid.

GI cement ---low pH can cause sensitivity, pulp irritation, least erosive .As a restorative

material---releases F, low solubility, thermal ins, sim therm exp to tooth, chemical adhesion, biocompatible. However, GI has less surface hardness, compressive strength, and tensile compared COMposite

QUESTION: What is a compomer? GI and Composite modified with polyacid groups, used in low-stress-bearing areas (Less wear resistant than composite, Releases fluoride) Root caries and Class 5. RMGI is better.

QUESTION: What is the material in reinforced IRM(zoe) that give it strength

A. amalgam powder
B. Zinc phosphate
C. Poly methyl methacrylate** D. Titanium powder
ans:c

QUESTION: pH of ZOE (near 7), zinc phosphate: **pH of 3.5—acidic irritates pulp.

QUESTION: Zinc eugenol good temp filling: gives a good bacterial seal, high compressive strength, high tensile strength, good biological seal

QUESTION: the main component of any root sealers- zinc oxide

QUESTION: what do you fill a root canal with on a primary tooth Gutta percha
/ Sealer alone
/ ZOE with accelerator
/ ZOE without accelerator

ans: ZOE without accelerator
Lack of catalyst gives adequate working time filling the canals

QUESTION: Zinc phosphate cement is used as luting agent : the initial acidity may elicit a traumatic response if...
a. Only a thin layer of dentin is left btwn cement and pulp
b. very thin mix of cement is used
c. tooth has already a previous traumatic injury d. No cavity varnish is used

ans: all

QUESTION : Cross-linking in polymers(Addition of long chains in PMMA) leads to what? – Better Strength.

QUESTION : Crosslinking factor of P-MMA? bis-gma

QUESTION :If too much monomer is added to polymer: Causes excessive shrinkage

QUESTION:
increased water:powder ratio will increases setting time, decreases expansion(doubtful about only expansion)

mix faster, increase water temp will decreases setting time

QUESTION: If you decrease water temp (make it colder), you have more working time for an irreversible hydrocolloid

QUESTION: Increase set time with Alginate (Irreversible Hydrocolloid)? Cold water and more water

QUESTION: IF you have decrease spatula/mixing, you decrease expansion

QUESTION: Increased trituration time will increase compressive strength/decrease setting expansion;

QUESTION: Know what increases and decreases setting time for gypsum (slurry/temperature/ spatulation) – longer spatulation time, greater expansion (shorter time) ---- ***Gypsum bonded investments. Type I, II, III gold. Gold shrinks, so mold must expand to compensate. Older invst —decrease expansion; Increased time between mixing in water bath immersion---dec exp; Increase water:powder ration—dec exp; Increase spatulation time—increase expansion (its correct but check out with any reference book)

QUESTION: What happens if you increase water in gypsum stone? Less expansion and strength (b/c particles are farther apart)

QUESTION: How to decrease setting time by all- increase spatulation time, increase water temperature, use of slurry water, decreases water:powder ratio

QUESTION: what happens when you increase w/p ratio of an investment:

a)increase thermal expansion,b. decrease thermal expansion, c.increase setting expansion ans b

QUESTION: take an impression and lip immediately swells? Angioedema

QUESTION: Which of the following systems is thought to malfunction in the hereditary form of angioneurotic edema?A. C-1 esterase -- C1 inhibitors are used in angioedema to inhibit the complement system B. C-1q inhibitor
C. CH50 consumption
D. Serine phosphatase E.Complement synthetase ans A

Dd prosth-77 table covers all these questions

QUESTION: Alginate imp 100% humidity will shrink: syneresis= extraction or expulsion of a liquid from a gelshrinkage

QUESTION: With alginate in 100% humidity, why will shrinkage still occur? Imbibemnt, syneresis, historgysm Ans-b

QUESTION: Most inaccurate? Irreversible hydrocolloid

QUESTION: Synerisis imbibition applies to which impression mat? ans:Reversible hydrocolloid. if Irreversible is not an option

QUESTION: when pouring gypsum material into an impression which material will cause the least amount of bubbles? Polysulfide, polyether, silicone, irreversible hydrocolloid
ans-silicone

QUESTION: Dimensionally stable impression/which provides best dimensional quality - additional silicone (polyvinylxsiloxane?...Xtina) /(PVS)

QUESTION: Most stability:

hydrocolloid reversible/hydrocolloid irreversible/polysulfide
*PVS and polyether were not option -answer

QUESTION: polyvinyl siloxanes gets affected by latex (handle with latex gets messed up the sulfer in latex gloves that retards the setting of PVS addistion silicone))

QUESTION: Polyether disadvantage compared to other elastomerics? Hard to take out cuz sticks to teeth and engages undercuts , so most likely to get stuck in mouth, longer working time, less accuracy ,Are much stiffer

QUESTION: Most rigid impression material-Polyether

QUESTION: what material you would not use for a single crown : a) polyether b) polysulfide c)pvs Ans-b

QUESTION: Which of the following is the best for tear strength – polysulfide / polyether Ans-polysulfide

QUESTION:Polysulfide gives out ? water

QUESTION:Catalyst of POLYSULFIDE impression material- lead dioxide

QUESTION:Condensation silicone – ethyl alcohol as by product

QUESTION:Condensation silicone releases? Alcohol

QUESTION:
Don’t use for casting impression? not recommended for final FPD impression? ----IRReversible Hydrocolloid.

QUESTION:
Acceptable impression material for a casting? --
Reversible hydrocolloid

QUESTION: All of the following are good impression materials for crowns except:- irreversible hydrocolloid,

QUESTION: Addition silicon(PVS) releases?-- H2 (as secondary reaction)

QUESTION: The most stable elastic impression in moisture environment/least distorted by water? a. polyether
b. additional silicon
c. condensation silicon d. polysulfide Ans-b

QUESTION: imbibition and syneresis affect which one the most

a. reversible hydrocolloid---- answer

b. impression compound c. polysulfide
d. Silicone

7 sandhya chitty --63-83

Oral Pathology

Radiology

8 Rashmi-84-100
QUESTION: osteogenesis imperfecta usually assoc w/ Ans-Dentinogenesis Imperfecta
a. DI
b. AI

c. Hypercementosis

d. cleidocranial dysplasia

QUESTION:Dentinogenesis Imperfecta: Obilterated pulp chambers/pulp is gone (Type I and 11 only)
QUESTION: all of the following are differential for Dentinogensis imperfecta except? ectodermal dysplasia, -answer
amelogenesis imperfecta,

enamel dysplasia,

dentinal dysplasia

QUESTION: Which is not associated with dentogenesis imperfecta? Ectodermal dysplasia because the enamel is the ectoderm, dentin is mesoderm I think
QUESTION: Which one is associated with dentinogenesis imperfecta?
* blue sclera (this is from osteogenesis imperfecta)
-Answer
* hypodontia

* Other characteristics of this condition: opalescent teeth, affects both primary and permanent, teeth are bluish-brown and translucent, enamel is lost early, type 1 is with osteogenic imperfecta, type 2 is not with OI, type 3 is the bradywine type which occurs in absence of OI and is isolated to Maryland. Type 3 also exhibits multiple periapical radiolucencies and large pulp chambers.
Dentinogenesis imperfecta has been subdivided into three types:
• Type 1: dentin abnormality occurs in patients that have osteogenesis imperfecta (characterized by blue sclera or a history of bone fractures). In this form, primary teeth are more severely affected than permanent teeth.
• Type 2: most common, only the dentin abnormality exists with no bone involvement.
• Type 3 (Brandywine Type) like Type II, only the dentin abnormality exists, however, there are clinical and radiographic variations in this type. Features of type III that are not seen in type I and II include multiple pulp exposures, periapical radiolucencies, and a variable radiographic appearance

QUESTION: Dentin dysplasia looks like dentinogenesis imperfect, WITH ONE DIFFERENCE? Dysplasia type 1 has radiolucency.
2-no PR
QUESTION: Radiograph what is it: Dentinogenesis Imperfecta pulpless tooth 1 and 2...Type 3 are shell teeth

dentinal dysplasia (coronal type II) –no/short roots, large pulp chamber
look like dental imperfercta radicular is type-1-complete pulpal obliteration, short roots, PA RL

QUESTION: Dentinal dysplasia type 1 is pulpless

QUESTION: Dentinogenesis Imperfecta poorly mineralized dentin, enamel frequently fractures from the teeth leading to rapid wear and attrition of the teeth due to unsupported dentin..

QUESTION: Dentinogenesis imperfect type I when? part of osteogenesis imperfect BLUE SCLERA or it can be a separate inherited dominant trait without OI (DI type II)
QUESTION: Dentinal Dysplasia --Clinically the dental crowns appear normal while radiographically, the teeth are characterized by pulpal obliteration and short blunted roots. The

teeth are generally mobile, frequently abscess and can be lost prematurely.
QUESTION: KID x ray cant see shit on xray however you can tell the roots are short. Sister also has same condition. What condition is this?
DI-autosomal dominant!!
AI-autosomal recessive
Dentin dysplasia – autosomsal dominant -answer
QUESTION: A picture of dentin dysplasia – Short rooted teeth with periapical lucencies
QUESTION: Teeth with very large pulp chambers and open apex, 12 yo boy, sister also effected: Dentinal dysplasia
QUESTION: Some teeth appear to be clinically normal, but exhibit (1) globular dentin, (2) very early pulpal obliteration, (3) defective root formation, (4) periapical granulomas and cysts, and (5) premature exfoliation. The condition is known as which of the following?
A. Shell teeth B. Dentin dysplasia C. Regional odontodysplasia D. Amelogenesis imperfect E.Dentinogenesis imperfecta
QUESTION: Ectodermal dysplasia expressed as? , with or without a cleft lip and palate. Anodontia also manifests itself by a
; as a result, the vertical dimension of the lower face is reduced, the vermilion border disappears, existing teeth are malformed, the oral mucosa becomes dry, and the lips become prominent. The face of an affected child usually has the appearance of
anodontia or hypodontia
lack of alveolar ridge development
old age.
QUESTION: Ectodermal dysplasia definition
QUESTION: Ectodermal dysplasia? . Hair loss, thick nails, light skin,
QUESTION: Congenitally missing teeth often seen in? Ectodermal dysplasia
QUESTION: Ectodermal dysplasia: which of the following is correct? It is xlinked, not autosomal dominant
- Ectodermal dysplasia – hereditary, abnormal skin, hair, nails, teeth, sweat glands. Teeth develop abnormally causing anodontia or oligodontia (partial). Retained primary teeth. CONICAL shaped anterior teeth.
QUESTION: Characteristic of Ectodermal Dysplasia is? – Oligodontia (some missing teeth, not all) QUESTION: Ectodermal dysplasia: Oligodontia
QUESTION: ectoderman dysplasia : partial or complete anodontia QUESTION: hypohidrotic child --> ectodermal dysplasia QUESTION: Ectodermal dysplasia – sparse hair
QUESTION: Ectodermal dysplasia- sparse hair
QUESTION: ectodermal dysplasia...oligodontia and lack of sweat glands
QUESTION: what characterizes ectodermal dysplasia? Skin, hair, nails, SWEAT GLANDS?
QUESTION: What does hypodontia affect the most? I put growth of the alveolar bone?
Abnormality of 2 or more ectodermal structures
no sweat glands, missing teeth.
85
QUESTION: Having hypodontia/anodontia will prevent/undermine formation of what? I said alveolus (others were maxillary and mandibular arch but not together)
QUESTION: What do you see when you have hypodontia: maxillary deficiency, mandibular deficiency, atrophic ridge, midface deficiency

QUESTION: Hypodontia affects maxillary constriction QUESTION: Hypodontia- FEWER number of teeth
1. max deficiency

2. man deficiency

3. mid-face deficiency

4. cortical bone deficiency

QUESTION: Radiographs of a patient's teeth reveal that the crowns are bulbous; the pulps, obliterated; and the roots, shortened. These findings are associated with which of the following?
A. Osteogenesis imperfecta
5.
alveolar bone deficiency
QUESTION: Radiographs of a patient's teeth reveal that the crowns are bulbous; the pulps, obliterated; and the roots, shortened. These findings are associated with which of the following?
Porphyria
Pierre Robin syndrome Amelogenesis imperfecta Osteogenesis imperfecta Erythroblastosis fetalis
osteogenesis imperfect
QUESTION: Blue sclera seen in?
QUESTION: Blue sclera? Ectodermal dysplasia or OI
QUESTION: What is the most common? Dentinal dysplasia, amelogenesis imperfecta, dentinogenesis imperfecta, cleft lip (Cleft Lip/palate)
Cherubism:
QUESTION: Cherubism: Bilateral jaw expansion
QUESTION: A kid presents for bilateral enlargement, painless, etc (they are implying Cherubism, what is
the Tx? No Tx required! Fibrous Dysplasia:
QUESTION: Fibrous Dysplasia – ground glass appearance**Mccune-Albright Syndrome—polyostotic fibrous dysplasia—areas of radiolucent/radiopaque---potential for malignant transformation
QUESTION: fibrous dysplasia on xray: lucency w/ no opacity, no tooth involved
QUESTION: Panoramic with big radiopacity?
-fibrous dysplacia: it is diffuse radiopacity-vital tooth -osseous fibroma:radiolucent vital tooth
-cementous dysplacia
86
QUESTION: Fibrous dys (diffuse expansion of the mandible)
QUESTION: Picture of couple radiolucency lateral to lateral incisors, asymptomatic, 35 yo female: fibrous dysplasia- Monostotic fibrous dysplasia may be completely asymptomatic and is often an incidental finding on x-ray
QUESTION: Which of the following is frequently accompanied by melanin pigmentation (cafe-au- lait spots)?
A. Osteomalacia

B. Hyperparathyroidism
C. Osteogenesis imperfecta
D. Polyostotic fibrous dysplasia
QUESTION: McCune Albright's Syndrome – Café au lait spots (coast of Maine)—bone and skin disorder—brown spots! Coast of maine hahaha
Condensing Osteitis:
QUESTION: Cause of radio opacity of infected tooth- condensing osteitis QUESTION: Xray – condensing osteitis
Traumatic Bone Cyst:
QUESTION: Scalloped and vital : traumatic bone cyst
QUESTION: Traumatic bone cyst (simple bone cyst) – nothing inside
QUESTION: Traumatic bone cyst pic-
QUESTION: Picture said: "scalloped border, patient is asymptomatic" I put traumatic bone cyst-Psuedocyst, heals by itself
QUESTION: question about traumatic bone cyst—not a true cyst b/c not epithelial lined d. scallops around the roots of teeth
QUESTION: Young patient with traumatic bone cyst, what tx? None, spontaneous healing
Pagets Disease of Bone:
QUESTION: Paget's Disease – cotton wool appearance of skull 87
QUESTION: picture of paget disease : cotton wool in skull QUESTION: picture of paget disease : cotton wool in skull
QUESTION: Pagets disease : increase alkaline phosphatase QUESTION: Pagets disease : increase alkaline phosphatase
QUESTION: Which one most likely has potential for malignant transformation: osteomas, paget's, QUESTION: what has high incidence of becoming malignant? Cant remember options but I put Paget's disease
QUESTION: Which of the following has the potential for undergoing spontaneous malignant transformation?
A. Osteomalacia
B. Albright's syndrome
C. Paget's disease of bone
D. Osteogenesis imperfecta
E. von Recklinghausen disease of bone
QUESTION: Which has the highest potential for malignant transformation? Pagets disease-> Osteosarcoma
QUESTION: QUESTION:
- -->Paget's Disease – aka Osteitis Deformans – chronic bone disorder where bones become enlarged and deformed – dense but fragile. Seen in pts OLDER pts. Dentures stop fitting. Develops slowly. COTTON WOOL appearance, hypercementosis, and loss of lamina dura. Labs – INCREASE serum ALKALINE phosphatase but normal serum phosphate and calcium. Risk of osteosarcomas.
Langerhans, Histocytosis X:
QUESTION: Langerhans x- floating teeth in air.
QUESTION: Radiographic Picture: Floating tooth-not in bone, opacities in lesion-what is it?
Pagets can lead to osteosarcoma

Denture does not fit anymore as a result of
88
? paget disease aka osteitis deformans! –

cotton wool

* Whole jaw cyst

* Ameloblastoma

* Keratocyst

* Dentigerous cyst
QUESTION: Hand-Schuller-Christian triad o Diabetes insipidus
o Exophthalmos
o Bone lesions (Langerhans dis)
Oral signs of hand-schuler-christ. = bad breath, sore mouth, loose teeth
lesion are sharply punched out radiolucency and teeth appear as FLOATING IN AIR
Nasolabial Cyst:
QUESTION: Not a bone cyst? Nasolabial cyst, occurs outside of bone QUESTION: Which one is soft tissue involvement, not bone - Nasolabial Cyst
QUESTION: Soft tissue cyst- nasopalatanine duce, nasolabial,
QUESTION: A patient has a swelling under the upper lip that is by her lateral incisor and raises the ala of the nose from the outside. What is it? I put nasolabial cyst
QUESTION: Radiolucency radiating from root of central incisor toward midline, could be all of the below except ... lateral periodontal cyst, nasopalatine cyst, some sort of fibrous dysplasia, nasolabial cyst
- Because this cyst is extraosseous, it is not likely to be seen on a radiograph.
QUESTION: Which one not seen radiographically? Naoslabial cyst
QUESTION: Nasolabial angle: angle b/w base of nose and lip; should be perpendicular, if its acute, that means patient has big lips
QUESTION: Lining of nasolabial cyst- pseudo stratified squamous
QUESTION: What is the rarest cyst? Lateral Periodontal Cyst

• Nasolabial cyst? Lymphoepithelial Cyst:
QUESTION: Round yellow-white bump underneath tongue? Lymphoepithilial cyst? Yellowish cyst on floor of mouth? Oral lymphoepithelial cyst
QUESTION: Round yellow-white bump underneath tongue? Lymphoepithalial cyst?
QUESTION: Patient (young child) w/ nodules on right side of tongue that are fluid filled the rest of the mouth is WNL no other systemic signs
a. Neurofibromatosis
* Lymphangioma *

* Granular cell tumor

Odontogenic Keratocyst:
OKC
Xtina)
* High recurrence

* Intrabony, post mandible;

* basal cell nevus syndrome (a.k.a. Gorlin's syndrome, multiple OKC's seen:

89
QUESTION: Which is most likely to recur? I put OKC
High recurrence!
– Intrabony, posterior mandible but anywhere; BCNS association
QUESTION: Largest incidence of recurrence? OKC QUESTION: Most reccuring :okc
QUESTION: What has the highest recurrence rate?
* *Odontogenic keratocyst

* Dentigerous cyst
QUESTION: initial treatment for OKC is enucleate or resect?? (Usually therapy is enucleation and
cryosurgery...not sure...Xtina)
Nevoid Basal Cell Carcinoma:
QUESTION: Gorlin syndrome = nevoid basal cell carcinoma. Commonly seen OKCs and palmar pitting, plantar keratosis (odontogenic keratin cyst)
QUESTION: which disease has multiple OKC's? nevoid basal cell carcinoma. Is answer.
QUESTION: What else most often seen with bifid rib, nevoid basal cell? Odontogenic keratocyst
QUESTION: Nevoid basal cell
carcinoma: lots of cyts OKC or NEW NAME ---keratocystic odontogenic tumor (KCOT)
QUESTION:
QUESTION: What else most often seen w bifid rib, nevoid basal cell? Odontogenic keratocyst.
QUESTION: What does multiple OKC tell you? Gorlin syndrome! **also called basal cell nevus syndrome
QUESTION: multiple OKC=GOrlin gotz
QUESTION: Basal cell nevus bifid rib syndrome (gorlin-goltz syndrome)
QUESTION: What else most often seen with bifid rib, nevoid basal cell? Odontogenic keratocyst
QUESTION: Nevoid basal cell carcinoma causes – cyst in the jaws?
QUESTION: nevoid BCC and palmer melatonin indicative of: OKC
OKC – from remnants of dental lamina
QUESTION: Gorlin's- calcified falx cerebri
QUESTION: Which syndrome Pt has calcified falx cerebri, multiple okcs, bifid ribs? - Gorlin Goltz syndrome aka Basal cell bifid rib syndrome.

Basal cell nevus syndrome (a.k.a. Gorlin's syndrome, multiple OKC's seen
- nevoid basal cell carcinoma

Has Lots of odontogenic keratocysts (OKC): Nevoid Basal Cell Carcinoma Syndrome
multiple OKC
(Gorlin Syndrome; Basal cell nevous syndrome)
90
Gardner Syndrome:
QUESTION: Which syndrome includes osteoma? Gardners QUESTION: multiple osteomas are found in--> garderners
QUESTION: Which condition presents w/ many osteomas? Gardner's Syndrome (Multiple facial osteomas & skin nodules)
Bells Palsy:
QUESTION: unilateral eye and lip, unable to close (picture of black chick) - bells palsy photo of a person to identify the condition : bell palsy (see mosbys photo)
QUESTION: Know bell's palsy: unilateral facial paralysis
QUESTION: What causes bells palsy? I chose idiopathic.
Decks: Bell's palsy: involves unilateral facial paralysis with no known cause, except that there is a loss of excitability of the involved facial nerve. The onset oft his paralysis is abrupt, and most symptoms reach their peak in 2 days. One theory of its cause is that the facial nerve becomes inflamed within the temporal bone, possibly with a viral etiology.
QUESTION: Which cranial nerve affected bells palsy? Facial nerve (7th)
Temporomandibular Dysfunction:
QUESTION: Clicking in tmj: internal derangement with reduction
QUESTION: Which artery supplies the TMJ? Deep auricular, maxillary, superficial temporal...MADS
Middle meningeal from maxillary, ascending pharyngeal, Deep auricular, superficial temporal
QUESTION: Best imaging for TMD: MRI
QUESTION: Best way for soft tissue (disc of TMJ) : MRI
QUESTION: Mri is best way to look at condyle/tmj
QUESTION: best diagnostic eval for TMJ disc? MRI, CT, PA radiograph
QUESTION: Which radiograph will give you a direct view of the TMJ? (TMJ Tomography?)
QUESTION: Scanning disk tmj- mri best view
Gardnermultiple osteomas and intestinal polyps
In which syndrome Pt has ? Gardner's syndrome and esophageal stenosis syndrome
Colon polyps and some kind of oral lesion? Gardners syndrome
gardners syndrome with multiple osteoma and intesbtinal polyps
What do Gardners and Peutz-Jeghers syndrome have in common? GI polyps?
What has polyps...Gardners , Peutz-Jegher, and Crohn's
What do Gardners and Peutz-Jeghers syndrome have in common? GI polyps?
In Gardners Syndrome there may be cancerous transform of what?- polyps in intestine.
91
QUESTION: Part of the TMJ that purely rotates : Articular eminence of condyle QUESTION: Rotation involves what structures? condyle, glenoid fossa, disc, TMJ
Condyle and articular fossa
QUESTION: Which anatomical components are responsible for rotation of the mandible? Condyle and articulating disk
QUESTION: When TMJ is in rotational movement, rotation is in lower compartment

QUESTION: Lower compartment of TMJ is for? Rotation, upper compartment – translation
QUESTION: what causes tmj ankylosis? Trauma?? Rheumatoid arthritis
QUESTION: Patient can't speak English well, she doesn't work, she has TMJ problems, she is on meds. Which one will not affect her oral hygiene prognosis? - TMJ problems. (Rationale here is; she may not be able to afford hygiene procedure, she might not understand doctor's recommendations, and her meds can contribute to hygiene issues. TMJ problem was not serious enough, as in she can open her mouth to clean her teeth)
QUESTION: Man comes in after years of tmjd with reduction and is now only able to open 25mm and that's it with muscle pain. Whats his disorder?- Myofacial pain syndrome.
QUESTION: Pt is clicking in the jaw suddenly cannot open 25 mm: myofacial pain syndrome (can cause clicking, limited opening, pain), internal derangement without reduction has no noises or clicking but limited opening to <30mm
QUESTION: Patient always had internal derangement with clicking all of a sudden no noise and open max 30 mm what happened? Myofascial pain
QUESTION: Football player with mouthguard, crepitation of left TMJ, trigger zone tenderness L temporalis, stiffness upon wakening: Myofacial pain syndrome
QUESTION: Highschool football player wears a mouthguard, very tender to palpation of temporal area, muscle soreness..? question never said about noises: Myofacial pain disorder (possibly osteoarthritis)
QUESTION: Football player with a mouthguard tenderness to temporalis and hard to open mouth in morning
* myofacial pain

* tmj dislodgement
QUESTION: Most immediate sign after high occlusion bridge? Myofacial pain
QUESTION: symptoms of pain and tenderness upon palpation of the TMJ are usually associated with
which of the following
a. impacted mandibular third molars
b. flaccid paralysis of the painful side of the face
c. flaccid paralysis of the non painful side of the face
d. excitability of the second division of the fifth nerve
e.deviation of the jaw to the painful side upon opening the mouth.

92
QUESTION: TMJ pain are mostly related to: 1- VII, 2-V3, 3-V2, 4-V111
QUESTION: What branch off facial nerve gets damaged the most during TMJ surgey? Temporal
QUESTION:
QUESTION: TMJ ligaments purpose – limit the movement of mandible, helps open mandible, helps closes mandible
QUESTION: Which muscle mainly responsible for positioning and translating condyles? Lateral pterygoids
QUESTION: Stress causes immune weakness which leads to disease and bruxism QUESTION: How do you treat bruxism? Mouthguard
QUESTION: Occlusal guard-distribute occlusal force

QUESTION: Main function of the occusal guard:
* Distribute forces more evenly

* To relax the musculature

* Bruxism
Erythema Multiforme:
QUESTION: Target lesions? Erythema Multiforme (also has positive nikolsky sign)
QUESTION: Steven-Johnson syndrome? conjuctiva, and genital problems
Pemphigus:
QUESTION: A patient has painful lesions on her buccal mucosa. A biopsy reveals acantholysis and a suprabasilar vesicle. Which of the following represents the MOST likely diagnosis?
A. Pemphigus
B. Psoriasis
C. Erythema multiforme
D. Bullous lichen planus E.Systemic lupus erythematosus QUESTION:
QUESTION: intraepithelial-pemphigus
QUESTION: immunofluorescence of antibodies , Pemphigus intraepithelial , demosomas.
Pemhigoid and pemphigus: which one comes apart from Connective Tissue Actinolysys is present in pemphigus
If antibody is linear... pemphigoid

Nerve most damaged in tmj surgery-
FACIAL
basic question of pemphigus...asked which was a vesicular disease. BUT classmate did

get question on which layer it effects.
Lichen Planus and pemphigoid =subepithelial
93
, and

pemphigus is suprabasilar vesicle.

If antibody is fishnet... pemphigus
QUESTION: immunofluoresence used for dx of a. pemphigus
b. LP
Know Pemphigoid--**autoimmune disorder where antibodies attack epidermis. Blisters and vesicles develop—BMMP—benign mucous membrane pemphigoid. This is DIFFERENT than Pemphigus vulgaris because—less severe and HISTO: vesicales are SUBepidermal and NO acanthylosis.
Pemphigus--**autoimmune disorder where there is acanthylosis, tzanck cells. Antibodies are directed against the epithelium. Target the desmosomal Dsg3 and cause sloughing. Nikolsky’s

sign is when the epithelium can just be rubbed off of an unaffected area—HISTO: vesicles are suprabasilar and there is presence of acanthylosis
QUESTION: Pic that looked like herpangia in back of palate-
is it- I wrote herpangia... but pemphigus was also a choice (
both show Nikolsky sign
QUESTION: White film w/ pos nikolsky-pemphigus tx w incisional biopsy
QUESTION:
erythema mutiforme)
1. nikolski sign:

2. basement separation between ET: pemphigus

Scleroderma:
(maybe
this disease, patients have autoantibodies against desmogleins, which are part of
INFO: In Pemphigus
the spot desmosomes
Types: Most commonly Vulgaris
INFO: In Pemphigoid, the antibodies are directed against hemidesmosomes
Types of Pemphigoid (Bullous -Rarely affect mouth), Blisters of skin Cicatrical-- Affects mucous lining,
QUESTION: Widening of PDL and loss of ramus of mandible: Scleroderma
QUESTION: scleroderma: symmetrical widening of PDL and deposition of collogen in organs leads to failure
QUESTION: Picture of fissured tongue
QUESTION: Description of geographic tongue
QUESTION: Guy with lesions on his tongue that seem to move locations --> erythema migrans (geographic tongue)
QUESTION: burning sensation on tongue,, moves around: geographic tongue
QUESTION: cause of geographic tongue: unk
a. ulceration of mucosa
b. LP
Know Pemphigoid--**autoimmune disorder where antibodies attack epidermis. Blisters and vesicles develop—BMMP—benign mucous membrane pemphigoid. This is DIFFERENT than Pemphigus vulgaris because—less severe and HISTO: vesicales are SUBepidermal and NO acanthylosis.
Pemphigus--**autoimmune disorder where there is acanthylosis, tzanck cells. Antibodies are directed against the epithelium. Target the desmosomal Dsg3 and cause sloughing. Nikolsky's sign is when the epithelium can just be rubbed off of an unaffected area—HISTO: vesicles are suprabasilar and there is presence of acanthylosis
QUESTION: Pic that looked like herpangia in back of palate-
is it- I wrote herpangia... but pemphigus was also a choice (
both show Nikolsky sign
QUESTION: White film w/ pos nikolsky-pemphigus tx w incisional biopsy
QUESTION:

erythema mutiforme)
1. nikolski sign:

2. basement separation between ET: pemphigus

Scleroderma:
(maybe
this disease, patients have autoantibodies against desmogleins, which are part of
INFO: In Pemphigus
the spot desmosomes
Types: Most commonly Vulgaris
INFO: In Pemphigoid, the antibodies are directed against hemidesmosomes
Types of Pemphigoid (Bullous -Rarely affect mouth), Blisters of skin Cicatrical-- Affects mucous lining, MOUTH

pemphigus
QUESTION: Widening of PDL and loss of ramus of mandible: Scleroderma
QUESTION: scleroderma: symmetrical widening of PDL and deposition of collogen in organs leads to failure
QUESTION: Picture of fissured tongue
QUESTION: Description of geographic tongue
QUESTION: Guy with lesions on his tongue that seem to move locations --> erythema migrans (geographic tongue)
QUESTION: burning sensation on tongue,, moves around: geographic tongue
QUESTION: cause of geographic tongue: unk
a. ulceration of mucosa
CREST Syndrome=SCLERODERMA
QUESTION: . disease of skin, blood vessels, muscles, and internal organs. autoimmune disorder. Blue fingers, Hair loss Skin hardness Skin that
connective tissue
is abnormally dark or light

9 Sharadha 101-110
Sharadha paste u work here

10 Abhi.dahuja@gmail.com-111-120

11 Salvan008@gmail.com 121-130

12 MELIKA.ML: 131-150(meleni400@gmail.com)

Oral Surgery

QUESTION: Bleeding time has to do with platelet count

QUESTION: asprin has no affect on PT or PTT or INR... it affects platelets

QUESTION Aspirin is CONTRAINDICATED with which of the following drugs?

A. Coumarin (Coumadin®)

B. Triazolam (Halcion®)

C. Barbiturates (Phenobarbital®)

D. Pentobarbital (Nembutal®)

E.Methylprednisolone (Medrol®)

QUESTION: Patient taking aspirin for hypertension: Consultation with physician

QUESTION: prostaglandin inhibitor cause all expect: increase gastric mucous

PG:decrease gastric acid and increase gastric mucous ..... Inhibiting PG will increase gastric acid and decrease mucosa. That's why people taking too much aspirin can get stomach bleeding cause more acidic and no protection>

QUESTION: What makes prostaglandin: Arachidonic acid

QUESTION: ginseng- antiplatelet (interferes with coagulation – not given with aspirin).

pt on warfarin, aspirin

QUESTION: Before doing extraction you look at a patient's CBC report. What causes to contact patient's physician? Hematocrit was given as 25. While in males it is 45% and females 40%

QUESTION: Anticoagulants act antagonize Vitamin K to work, prolong bleeding.

***INR used for Coumadin patients.

QUESTION: INR 1.75 what do you do after extraction to control bleeding?

Keep stuffing shit in it,

bite on normal gauze,

squeeze b/l plate to collect bone fragments,

QUESTION: extractions for a pt with an INR of 2. what should you do? Nothing

Safe INR is 2 for coumadin pt

QUESTION: pt on coumadin, INR 2--- (I think it is okay to continue tx. Mosby's states that normal INR of people on anticoagulants is 2.5-3.0.)

a. extract, use sutures, hemostatic agents

b. get pt off coumadin for 2 days before extraction

Not sure

QUESTION: Patient had extraction and socket is still bleeding 5 hours later? refer for INR

QUESTION: Tooth extraction, 3 days later starts hemorrhage what is the cause? Fibrinolysis

QUESTION: PT (12-14 secs, Factors 2, 7, 9, 10) and INR are extrinsic pathway

QUESTION: PTT – intrinsic factor 8.9.11.12 test for detecting coagulation defects of the intrinsic system - hemophiliac

QUESTION: Factor VIII is hemophila A

QUESTION : The drug contra indicated in pt taking gingko biloba: HEPARIN

Glucocorticoides are contraindicated in: Diabetes

QUESTION: Glucocorticoids side effects? Infection, reduce inflammation, hyperglycemia.

QUESTION: Negative effect of chronic use glucocorticoids? Pg. 303 mosby section D adverse effect

QUESTION: Overweight patient that has to piss 2wice at night? Diabetes

QUESTION: Oral hypoglycemic drug for diabetes (type 2) --?sulfonylurea and metformin (MOA)

QUESTION: Why don't you give Sulfonylureas to Type I diabetic patients? They do not have beta cells for insulin & Sulfonylureas MoA is to stim those cells.

Sulfonyl ureas : They act by increasing insulin release from the beta cells in the pancreas.

QUESTION: MOA of sulfonylureas: Stimulate insulin release from Beta cells, stimulate binding,

decrease glucagon levels.binds to ATP-dependet K channels as receptors.

QUESTION: Metformin suppresses glucose production in liver (decreasing hepatic gluconeogenesis

decreases glucagon levels) – bind to AMP protein kinase receptors.

QUESTION: Proposed modes of action for the oral antidiabetic agents include each of the following EXCEPT one. Which one is the EXCEPTION?

A. Blockade of glucagon release from pancreas

B. blockade of catecholamine release from adrenal medulla

C. Stimulation of insulin release from pancreatic beta cells

D. Action as direct receptor agonists for the insulin receptor

E. Increase affinity of tissues for utilization of available plasma glucose

Melika: given answer is D in golden. However, people in fb group say B is true. Anyone with new information pls let me know to update it.

QUESTION: Hb1AC: Measuring glucose level over extended period.

QUESTION: Pt who took too much insulin will have all except- Hyperglycemia

QUESTION: decrease in ⬇ glycogenolysis in the liver would be expected with insulin

QUESTION: Which one of the following affects males almost exclusively?

- *hemophilia (it is carried by the female but only affects the male)
- downs
- diabetes

QUESTION: which happens more in males?

Mandibular dysostosis ,

hypothyrodisim,

Diabetes,

sickle cell anemia

sign of hypoglycemia-

a. bradycardia

b. mydriasis

c. diaphoresis (sweating)

Which is risk factor for hypoglycemia?

Age

, alcohol,

hypertension

Hypotension

Explanation from golden :Well-known risk factors for the development of hypoglycemia include exercise, alcohol, older age, renal dysfunction, infection, decreased intake of energy, and mental health issues, including dementia, depression, and psychiatric illnesses. In the ADVANCE trial, cognitive dysfunction increased the risk of hypoglycemia.(not sure about this)

QUESTION: Controlled diabetes has same perio problems as those who don't have diabetes TRUE.

QUESTION: Controlled diabetic patients do not get more perio disease than non-diabetic

QUESTION: Diabetic patients have more of the following except:

higher glucose levels in gingiva

increased anaerobic bacteria in pockets,
Incresaed IL1, collagenase

QUESTION: Diabetics are more prone to perio and are less resistant to the effects of bact.- both statements are true.

QUESTION: By recent studies, which one has a correlation with periodontitis? Diabetes - diabetics are 15 times at risk

QUESTION: pt presents with aggressive bone loss, bleeding gums, mobile teeth…. Etc

- uncontrolled diabetes
- non hodgkins lymphoma

QUESTION: ASA III: uncontrolled diabetes

QUESTION: Diabetes you get infections more likely, not bleed easier

QUESTION: diabetes most common: black men

QUESTION: Endo surgery contraindicated when… diabetes? HTN

QUESTION: When would elective endo treatment be contraindicated? diabetes, hiv, etc

QUESTION: What disease will alter healing after root canal treatment? HIV or diabetes?

QUESTION: Diabetes can you place implant if HbA1c is 8: refer to physician, and no cant place Implants.

QUESTION: Pt with hemoglobin A1C of 12%. Pt just visited the MD, what kind of TX we can do? Consult with an MD prior to tx

In most labs, the normal range is 4-5.9 %.

In poorly controlled diabetes, its 8.0% or above

In well controlled patients it's less than 7.0

QUESTION: LA with epinephrine contraindicated in? Uncontrolled Diabetes, hypothyroidism,

hyperthyroidism.

QUESTION: Type I Diabetes leads: a) Aphasia b) Ataxia c) Blindness d) Deafness

QUESTION: Treat diabetic patient 2 hours after eating and taking insulin.

QUESTION: Kidney dialysis: best to do tx when, day after dialysis, or inbtwn days of dialysis

QUESTION: Insulin shock in consciuos patent, what do u give?-

give insulin,

give oral sucrose, orange juice

glucagon shot

Do NOT give more insulin, blood sugar is already low enough. Give OJ or oral sucrose maybe.. depends on the answer choices.

QUESTION: child goes into insulin shock in the chair (hypoglycemia)

a. give OJ----?

b. ask parent to give kid insulin shot

QUESTION: Unconscious diabetic in shock is treated with: 50 % dextrose in water I V.

QUESTION: HgbA1c is 12 for a patient in your office? , refer him to physician for diabetic/ sugar management.

HbA1c stands for Glycosylated hemoglobin. Measures blood glucose in past 2-3 months. NORMAL = 4-6%. Increased is above 7%.

QUESTION: Diabetic for IV sedation. If insulin dependant, have them not eat, not take short acting insulin and take half dose of long acting insulin. If not dependant, no food and no meds.

QUESTION: Patient is non-insulin dependent diabetic and needs minor oral surgery w/ IV sedation. What should he do? I put clear-liquids and regular dose of diabetes meds.

Minor surgery: normal as long as procedure occurs within 2 hours of eating and taking meds.

QUESTION: Day of surgery- diabetic what do u tell him-

no food no insulin,

food and insulin,

clear liquid and ½ insulin,

clear liquid and normal insulin

QUESTION: You have a diabetic patient, you can manage him all the following ways except? –

Tell him to eat light breakfast on the day of the appointment

schedule the dude a morning appointment,

tell him not to take his hypoglycemia meds for his appointments,

monitor his blood sugar level on the day of the procedure

QUESTION: how are the diabetic drugs classified by?

duration of action

mechanism of action

QUESTION: Patient has ketone breath and is confused. Why? HYPerglycemia.

so Ketone breath and alter state of consciousness relates to hyperglacemia..

QUESTION: Ketone breath: Diabetes type 1

QUESTION: Patient with orthopnea(shortness of breath-dyspnea-while laying flat), dyspnea, pedal edema

a. Emphysema

b. Pulmonary edema

c. COPD

d. Congestive heart failure

QUESTION: What is common symptom of CHF?

Orthopnea* (other symptoms: dyspnea, fatigue, paroxysmal nocturnal dyspnea, edema).

QUESTION: Tx of CHF pt? early morning appts.

QUESTION: Most common reason for cardiac arrest of kids (heart failure) – respiratory distress.

QUESTION: what is the most common heart problems in children: Ventricular septal defects

QUESTION: Peripheral edema : congestive heart failure.

QUESTION: Patient has distended jugulars, pitting edema and dyspnea? congestive heart failure

QUESTION: why is pt taking ACE inhibitor (hypertension / CHF),

QUESTION: pt taking cardiac glycosides. what is it used for?

hypertension, congestive heart failure, etc..

QUESTION: what do cardiac glycosides(Digitalis) do?

blocks Na/K/ATPase = increase influx more Ca(Inhibits Na/K ATPase of cardiac cell membranes resulting in increase of Na concentration intracellularly ALSO increases intracellular Ca++) and increases the refractory period.Increase Ionotropic (contractions) effect of the heart.

QUESTION: Use of digitalis:

Post myocardial infarction, Supraventricular arrhythmia,

…common indications for use is for" atrial fibrillation".

QUESTION: Ginseng: CI with aspirin or digoxin?

QUESTION: Pt taking ginseng. Which med should be avoided?

• Penicillin

• Aspirin*

• Digitoxin

QUESTION: Pt has history of cardiovascular disease and now pt is taking aspirin. Pt needs ext. What should dentist do?

• Med consult with physician*

• Normal extraction

• Stop aspirin 3 days before and 2 days after surgery

QUESTION: Mechanism of most drugs that tx arrhythmias? Decreases repolarization rate, Prolongs refractory period.

QUESTION: Cardiac referred pain not consistent with? Pain goes away with LA.

QUESTION: MI and arrhythmia difference? Thrombosis, arthrosclerosis

Melika: given answer is thrombosis but im not sure. Plz check it out.

QUESTION: drug for artial arrythimia ; Quinidine, Verapamil, and Digitalis for atrial…and the

side mechanism of Quinidine is it increases the refractory period..

QUESTION: general question about arrhythmias.: They increase calcium inotropic effect, decrease SA node transmission, increase refractory period…(not sure)

QUESTION: Angina at rest?

a. Pseudo-angina

b. Unstable angina

c. Infarction

QUESTION: nitrites /nitrates : Vasodilation

QUESTION: side effect of nitroglycerin : orthostatic hypotention and headache.(Vasodilation of arteries decreased BP tachycardia)

QUESTION: Nitrates/Nitriles, how do they respond to Angina? through blood vessels. (dilate

blood vessels).

QUESTION: You give the nitroglycerin to the pt with angina and heart rate goes up what's the reason? natural reflex to the decrease in blood pressure.

QUESTION: Nitrates effect in blood vessel? . Nitroglycerin is a nitrovasodilator. It produces nitric oxide, which activates guanylyl cyclase which, in turn, catalyzes the production of cGMP.

QUESTION: Amilnitrate & Nitroglycerine? Vasodialate coronary arteries **for angina Pectoris.

QUESTION: For Angina drug, which drugs can't you take: some type of hydrothiazide med.

QUESTION: Diuresis(excessive urine production) after tx of angina w/ a glycoside ? b/c of increased blood flow caused increased blood flow to kidney.

QUESTION: Epi and Nitroglycerine : ....antagonist.

QUESTION: Transient Ischemic Attack what is false

o More prone to heart attack

o Should take nitroglycerin

Explanation:give nitroglycerine to patient with angia to prevent heart attack. Not give to transient ischemic attack. It cause better chance of getting stroke.

Lungs:

QUESTION: Asthma causes constriction on bronchioles and inflammation true:

Beta 2 receptors for the lungs.

note:BETA 1 FOR HEART

QUESTION: What do asthmatic patients have problem with? – Wheezing Exhalation

QUESTION: Child makes a wheezing sound before injection? Asthma (induced by stress)

QUESTION: Wheezing exhale with high pitch.

QUESTION: Wheezing sound: insp or exp? Asthma have problem breathing in,(but wheeze when exhaling),

QUESTION: COPD vs Asthma? COPD has problem exhaling.

QUESTION: Most breathing problem in dental setting? –

Asthma

hyperventilation,

COPD

QUESTION: Most common respiratory emergency in dental office: hyperventilation

QUESTION: What is the most common cause for breathing difficulty in the dental chair?

asthma(melika: given answer in golden is asthma but i think its hyperventilation)

QUESTION: Hyperventilation causes – tachycardia and tachypnea

QUESTION: Soft tissue emphysema: endo

QUESTION: face swelling after air spray in perio pocket: soft tissue emphysema (sudden painless swelling).

QUESTION: Emphysema: constriction of air sacks

QUESTION: Pt has emphysema. What are his symptoms? Dyspnea, wheezing, cough, chest tightness. Air sacks are all destroyed (narrowing of distal airways)

QUESTION: Crowing sound when breathing? Stridor??

• asthma attack

• COPD

neumothorax

laryngeal SPASMS

QUESTION: Stridor- laryngospasm- blockage of UPPER resp tract.

QUESTION: Epinephrine for laryngiospasm what does it do? brochodilater, increase HR, increase BP.

QUESTION: Theophylline – drug used for asthma sometimes. Particularly for wheezing,

shortness of breath, chronic bronchitis, emphysema.

QUESTION: Which drugs for ***asthma?

(Albuterol was not in it,)

levabuterol(xopenex), answer

ipratropium(atrovent),

Combivent,

Advair,

Smbicort,

Spiriva,

Budenoside

QUESTION: Most effective during acute asthma attack: albuterol- generic name is Salbutamol.this is a beta 2 agonist causes bronchodialation.

QUESTION: medication for severe asthma attack aminophiline.or albuterol?

QUESTION: Singulair(montelukast) action? Block action of leukotrienes, is a leukotriene receptor antagonist.used for asthma tx and seasonal allergies.

QUESTION: Pt has asthmatic attach, took albuterol, and it didn't work. What's next step?

- epinephrine
- atropine
- something else…

QUESTION:Which of the following drugs is can trigger asthma?

a) narcotic analgesic

b) NSAID

c) corticosteriod

d) sympatolytic amine.

QUESTION: Patient begins to wheeze what do you not do?

o Beta2 blocker inhaler, sit pt more comfortable, corticosteroid inhaler

o Give oxygen

asthma patient, most important thing NOT to give O2.

QUESTION: Pt goes home from elective orthognathic sx and in 24hrs, without sign of inflam or edema, but a fever of 102oF- Atelectasia (or pneumotosis – depending on answers. Atelectasia and pneumotosis = most common cause of fever within 24 hour of GA)

Syncope:

QUESTION: Pregnant women with syncope – what hip should they lay on?

Right

left

Trendelenburg

why do you do that? To avoid compression of vena cava.

QUESTION: If a 3rd trimester pt all of a sudden feels a drop in BP what do you do?- Have pt lay on left side.

QUESTION: Prego question – syncope, which side you put pt? Raise right hip.

QUESTION: 2 questions on prego

a. Baby crushing IVC

b. Lay on left hip, Right hip UP

QUESTION: during dental procedure, Pregnant in supine position, what gets too much pressure?

A. inf. vena cava

B. sup. vena cava

C. fetus

D. placenta

note:orthostatic hypotension (colloquially as head rush or dizzy spell, is a form of hypotension in which a person's blood pressure suddenly falls when standing up or stretching. Vs vasovagal syncope (the most common type of fainting. is a malaise mediated by the vagus nerve.

QUESTION: Most important thing to do when patient syncope –

maintain airway,

loosen up buttons,

place head below heart,

Supine

QUESTION: Crown disappears down patient's throat, what position do you put them in?

Supine,

Upright,

Trendelberg

QUESTION: Want to determine patient physiologic rest position, place in – supine,

upright/standing, tredenlburg.

QUESTION: what position you place the Pt when is having syncope? (TRENDELENBURG POSITION) (SUPINE WITH FEET ELEVATED SLIGHTLY), The most common early sign of syncope is PALLOR (paleness).

QUESTION: Purpouse of the trendelberg position is to- maint circulation so that the most vital organs are never hypoxic.

QUESTION: U walk to office, pt is unconscious? Supine, tendenberg, upright

QUESTION: Trendelenburg position: (for anaphylaxis)

Position in which the patient is on an elevated and inclined plane, usually about 45°, with the head down and legs and feet over the edge of the table. It is used in abdominal operations to push abdominal organs towards the chest. This position is also usually used in treating shock, but if there is an associated head injury, the head should not be kept lower than the trunk.

QUESTION: All forms of shock have?

• Hypovolemia

• Decreased perfusion to tissue

• Sepsis

QUESTION: Vasovagal syncope is a common cause of transient loss of consciousness.

QUESTION: Syncope? Inhale ammonia, irritates es trigeminal nerve sensory. 100% oxygen works.

QUESTION: High-flow 100% 02 is indicated for treating each of the following types of syncope

EXCEPT one. Which one is this EXCEPTION?

A. Vasovagal

B. Neurogenic

C. Orthostatic

D. Hyperventilation syndrome

QUESTION: most lilkely Emergency in dental chair : syncope

QUESTION: Most common dental complication in office? – Syncope

QUESTION: Most common ER after use of local: syncope

QUESTION: You gave Local Anesthetic, BP went up to 200/100 and HR went up too, what could be due to? – Due to vasoconstrictor injected into venous system.

MELIKA.ML. 141-150 (meleni400@gmail.com)

Pharmacology

210-

QUESTION: Best benzo for iv sedation-MIDAZOLAM.
QUESTION: What does IQUESTION: Best benzo for iv sedation-MIDAZOLAM.
QUESTION: What does IV Midazolam do? Amnesia
QUESTION: Best benzodiazepine for pt with liver cirrhosis -oxazepam
Benzodiazepines: ones not metabolized by the liver (safe to use in liver failure)
LOT:
Lorazepam
Oxazepam
Temazepam
QUESTION: Flumazenil: Benzodiazepine antagonist ; competive GABA receptor.
QUESTION: Which drug best reverses the effect of benzodiazepines?
Flumazenil Benzo flu away
QUESTION: contraindication of lorazepam: a)pregnancy
QUESTION: diazepam (Valium) is contraindicated in pregnant lady (ALL BENZOS)
QUESTION: Why do you use benzos for antianxiety? Reduced depression, does not propentiate depressents. (less respiratory depression)
QUESTION: How benzos are anxiolytic – rebound sedation or amnesia? (Qs unclear. Benzos cause Rebound anxiety)

QUESTION: How benzos are anxiolytic: moderate doses ANTIANXIOLYTIC and high doses is SEDATIVE
QUESTION: Sedative rebound (or something like that)
a. Antiphysicotic
? PART OF WITHDRAWL
QUESTION: Which of the following barbiturates MOST readily penetrates the blood-brain barrier?
Thiopental
QUESTION: Sodium Thiopental ? rapid-onset short ultra acting barbiturate(IV) for general anesthesia- for Desensation
QUESTION: A patient has appointment next morning, he is anxious, and the night before he had hard time sleeping, which of the following tx would you prescribe? Ambien! (sedative and makes patient sleep).
QUESTION: Check what is Ambien (Zolpidem) !!
(Ambien is a nonbenzodiazpine hypnotic…used for insomnia.also reversed by
flumazenil just like BDZs…potentiates GABA receptors…short half life…negative side efx: hallucinations and amnesia)
QUESTION: Chief mechanism by which the body metabolizes short-acting barbiturates is?
a. oxidation (occurs in the liver)
b. reduction.
c. hydroxylation and glucoronidation
d. sequestration in the body fats.
QUESTION: why are ultrashort acting(gave me an actual name of a barbiturate) barbituates so fast?
•Redistribution (right answer according to previous test)
QUESTION: Diazepam -No effect on respiration as oppose to other BZ
QUESTION: The reversal for Versed? (versed = midazolam)
A. Narcon
B. Flumazenil**
QUESTION: Pt is under oral sedation. You should monitor everything except?
• Respiration
• Oxygen saturation level
• *Electo cardiogram
• Skin and oral mucosa color (cyanosis?)
QUESTION: #1 cause for problems during IV sedation?—hematoma
QUESTION: A 77 years old female 110 lbs weight requires removal of mandibular teeth under local anesthesia. She is apprehensive. The appropriate dose of i/v diazepam to sedate her?
a. 5 mg
b. 10 mg
c. 15 mg
d. 20 mg
QUESTION: Drug for seizures? Dilantin (or diazepam)
QUESTION: Flumazenil combats benzos (naloxone combats opioids), disulfuriam is for alcoholics
QUESTION: Buspirone - Psychotropic and anxiolytic; low CNS depression, low psychomotor

skill impairment ***Buspar—different from benzodiazepines because it does NOT produce dependence.
QUESTION: Know drugs used for conscious sedation ? SSRIs/BDZ Diazepam and Prozac(fluoexitine)
QUESTION: 25 yo female breast feeding 12m old child and currently pregnant-which sedative would you give?
• Halcion
• Promethazine
• Nitrous
• Diazepam
• Phenobarbital
QUESTION: What anxiolytic to use for anxious 25 year old pregnant woman who is breastfeeding? Promethazine
Chloral hydrate (avoid), nitrous (avoid), benzo (avoid)
QUESTION: do not give which medication to lactating female? Codiene and tetracycline
QUESTION: Prozac (fluoxetine) - acts on serotonin SSRI "selective serotonin receptor inhibitor" this is an antidepressant
QUESTION: Fluoxetine (prozac) Mechanism of action: SSRI
QUESTION: Patient is in her 70's, she lives alone, what could she be suffering from? – Depression
QUESTION: main sign of dementia : Short term memory loss. Confusion
QUESTION: Dementia: which is not a sign of dementia: long-term memory loss
QUESTION: Substance in the brain where antidepressants works :?decrese amine mediated neurotranmision in the brain
QUESTION: TCA mechanism of action: inhibit reuptake of NE and 5-HT (serotonin)
QUESTION: TCA 2nd generation- Nortriptyline (Pamelor, Aventyl)
Desipramine (Norpramin)
Protriptyline (Vivactil)
QUESTION: know the mechanism of action of TCA.? it decreases the re uptake of Norepinephrine
QUESTION: patient is taking TCA antidepressants what do you take into consideration? Limit duration of procedures, keep in mind the epinephrine limit ….
QUESTION: Side effect of having TCA and epi : HTN, hypotension, hyperglycemia, hypoglycemia
QUESTION: Most common antidepressant does what?
• Inhibits reuptake of NE, 5-HT, & DA (TCA)
• Inhibit reuptake of 5-HT (SSRI)
• Inhibit reuptake of N & 5-HT (SNRI)
• Inhibit MAO; prevent breakdown of NE & 5-HT (MAOI)
• Block D2 receptor (phenothiazine)
QUESTION: IF someone has a history of depression, what do you give? Zyban (Bupropion), not Chantix (smoke cessation)
QUESTION: Amitrriptyline – most common tricyclic antidepressant, inhibits reuptake of NE and serotonin

QUESTION: Zoloft works on what receptor?Presynaptic monoamine transporters (inhibit reuptake of 5-ht)
Sertraline hydrochloride (trade names Zoloft and Lustral, among others) is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class.
QUESTION: Most common mood disorder?generalized anxiety
QUESTION: Depression causes- eating, lonliness, and something else
QUESTION: What do you use St. John's Wart? Depression MOA:noncompetitive reuptake inhibition of monoamines.
QUESTION: What does St. John's Wort do? Decrease the body immunity
Note: there is no option "anti depressant" in choices. in Pt with HIV it interact with anti HIV drugs such as Indinavir(increase immunity) and reduces their function so the immunity decreases
QUESTION: St johns wart- used for? • depression[?]not with benz and HIV medication
Antipsychotics
o Phenothiazines: Block DA receptors
[?] Act on the extrapyramidal pathway
o Side effects
[?] Tardive dyskinesia
QUESTION: Substance in the brain where antipsychotics works : blocking the absorption of dopamine
QUESTION: What acts on extrapyramidals? Phenothiazines (chlorpromazine)
QUESTION: Onset of action of antipsychotic is: 5-6 days
QUESTION: what is the most common psych disorder? (anxiety)
QUESTION: lithium is used for? Manic phase of bipolar disorder
Anti-inflammatory/Corticosteroids: Side effect profile: gastric ulcers,immunosuppression, acute adrenal insufissiency, osteoporosis, hyperglycemia, redistribution of body fat.
QUESTION: Strongest glucocorticoid/Long acting Corticosteroid? Dexamethasone,
QUESTION: GI with corticosteroids: Ulcers. Long term effect- osteoporosis
QUESTION: Long term side effect of corticosteroids-osteoporosis and hyperglycime
QUESTION: long term glucocorticoids use- shows all of following except? hypoglycemia
does lead to: osteoporosis, hyperglycemia, immunosupp.,
QUESTION: Where do you see moon facies: increased steroid treatment
QUESTION: Containdation use corticosteroid-diabetes (also: HIV, TUBERCULOSIS, CADIDIASIS,
PEPTIC ULCER)
QUESTION: Aspirin contraindicated with: corticosteroid use
QUESTION: How much and how long of steroid insufficiency: 200mg/two weeks in last 2 years, 20 mg 2 weeks in last 2 years
QUESTION: Critical dose of steroids for adrenal insuficience- 20 mg of cortisone or its equivalent daily, for 2 weeks within 2 years of dental treatment
QUESTION: Acute adrenal insufficiency: hypotension
QUESTION: Pt taking corticosteroid with rheumatoid arthritis, pt needs TE, why would you consult with physician: full blood panel, assess for adrenal insufficiency (want to make sure pt can produce enough
coricosteroid with addition to what they are taking so you won't have over inflammatory response from

TE)
QUESTION: Pt on 3mo tx of steroids needs what?- no tx and consult gp for dose raise
QUESTION: if a pt. has been using 10 mg of corticosteroid for 10 years, what would you do for pt.
before any tx? Have pt continue and increase the dose
QUESTION: cortisone exerts its action on…(it's a steroid hormone, so binds to intracellular receptor) - receptors on membrane, proteins in plasma…etc.
(Enter cell and bind to cytosolic receptor migrate to nucleus gene expression or With plasma membrane on target cells)
QUESTION: if pt doesn't get steroid tx in time for their temporal vasculitis what will happened
• vision loss
QUESTION: What causes asthma: NSAID (aspirin)
QUESTION: Asthma – why use corticosteroids – decrease inflammation
Inhaled corticosteroids are the most effective medications to reduce airway inflammation and mucus production.
QUESTION: Nitrous oxide – in blue cylinder (oxygen in green)
QUESTION: Nitrous oxide oxidizes the cobalt in vitamin B12, resulting in the inhibition of methionine synthase. Nitrous oxide has greater analgesic potency than other inhaled anesthetics
QUESTION: Dreaming on nitrous, what is it? Overdose, normal
QUESTION: How do u check to see if the oxygen (reserve) bag is ok: It shouldn't be that full or that collapsed
QUESTION: Contradictions of nitrous, which patient can get nitrous? Hypertention, pregnancy
QUESTION: What is an absolute contra-indication for the use of Nitrous oxide?
nasal congestion?
QUESTION: Fear anxiety, which option is better? Oral sedatives, nitrous, barbs, deep sedation
QUESTION: devise used in evaluation of N20 : Pulse oximeter
(CORRECT—used to measure amount of oxygen in blood)
QUESTION: The correct total liter flow of nitrous oxide-oxygen is determined by the amount necessary to keep the reservoir bag 1/3 to 2/3 full.
QUESTION: Nitrous oxide: Total flow rate 4-6 L per min
QUESTION: Nitrous to pedo at 50%-what we do? We stop giving it.
QUESTION: Max amount of Nitrous Oxide for a kid
a. 40 %
b. 50%
c. 70% Adult
QUESTION: Safety on nitrous tank – 70%
QUESTION: Nitrous safe switch happens? – 50% (I think it's 70 for N, 30 for O)
QUESTION: Abuse of nitrous oxide it results in peripheral neuropathy.
QUESTION: Why is nitrous oxide used on children? alleviate anxiety
QUESTION: What is an adverse effect of nitrous? Nausea,
QUESTION: If patient does not have 100% oxygen after nitrous oxide: Diffusion hypoxia
QUESTION: NO2 contraindicated in I put nasal congestion, it is ok for asthma
**contraindications for NO2 include—COPD, resp infx, pneumothorax/collapsed lung, 1st trim of pregnancy, hard to communicate with pt, contagious disease, middle ear or sinus infx, bowel obstruction, head injury

QUESTION: Nitrous oxide and preg pt, which trimester to avoid? 1, 2, 3, all trimensters (Especially 1st)
QUESTION: hydroxizyne is used with chloral hydrate because decrease nausea is a first-generation
antihistamine of the piperazine class that is an H1 receptor antagonist. It is used primarily as an antihistamine for the treatment of itches and irritations, an antiemetic for the reduction of nausea, as a weak analgesic by itself and as an opioid potentiator,
and as an anxiolytic for the treatment of anxiety
Local Anesthesia:
Lipophilic ring (aromatic) + intermediate chain (ester or amide link) + hydrophilic amino terminus
Esters are more prone to hydrolysis = shorter duration of action
Esters = no I before –caine Amide = "I" before –caine
Amide derivatives: Xylidine, Toluidine, Thiophene
Amides: metabolized in liver
Esters: Metabolized by plasma esterase
QUESTION: Know where L.A. metabolized? Amide (2 I's) met. in P450 enzyme of Liver. Esters (1 i)
met. in pseudocholinesterase of plasma.
QUESTION: How does anesthetic work? Decrease sodium influx
QUESTION: Mode of action of Lidocaine: Block sodium channels
QUESTION: adding a vasoconstrictor like epinephrine decreases its rate of absorption,
increasing the duration of action,
minimizing systemic toxicity,
and helps with hemostasis
QUESTION: Anesthetics broken down by what: biotransformation
?***thiopental= redistribution
QUESTION: Biotransformation, what is tendency of molecules, chemical similarities: more polar and more ionized and less lipid soluble
QUESTION: Which best describes biotransformation: increase in polarity and water soluble
Whatever helps its excretion – polar and more water soluble
QUESTION: Conjugating the drug does what ? something about crossing brain barrio more or other things conjugation reaction = are the Phase 2 reaction of drug biotransformation that occurs in the liver. metabolizing to a soluble form
QUESTION: In relation to their parent drug, conjugated metabolites do what –more ionized in plasma (more water soluble)
QUESTION: What happens to a drug after conjugation- more ionic, more hydrophilic, more active...
QUESTION: What do you use sodium bicarbonate for? All drugs or alcohol (phenol barbitals)
Excretion of acidic drugs is accelerated with Sodium Bicarbonate
QUESTION: After drug goes through liver? More water soluble and less lipid soluble.
QUESTION: First pass metabolism? Concentration will decrease exponentially. Drug eliminated in proportional fashion.
QUESTION: First pass metabolism:
- enzymatic degradation in the liver prior to drug reaching its site of action

QUESTION: oral meds - first pass effect on liver

1. Enterohepatic circulation
Substances that undergo enterohepatic circulation are metabolized in the liver (usually by conjugation), excreted in the bile, and passed into the intestinal lumen (where the intestinal bacteria break some of the conjugated drug, releasing the unmetabolized drug again) where they are reabsorbed across the intestinal mucosa (thus returns to systemic circulation again) and returned to the liver via the portal circulation. Drugs may remain in the enterohepatic circulation for a prolonged period of time as a result of this recycling process. thus increase in their halflives.
First pass effect:
After a drug is swallowed, it is absorbed by the digestive system and enters the portal circulation. The absorbed drug is carried through the portal vein into the liver. The liver is responsible for metabolizing many drugs. Some drugs are so extensively metabolized by the liver that only a small amount of unchanged drug may enter the systemic circulation, so the bioavailability of the drug is reduced. Alternative routes of administration (e.g., intravenous, intramuscular, sublingual) avoid the first-pass effect.
V Midazolam do? Amnesia
QUESTION: Best benzodiazepine for pt with liver cirrhosis -oxazepam
Benzodiazepines: ones not metabolized by the liver (safe to use in liver failure)
LOT:
Lorazepam
Oxazepam
Temazepam
QUESTION: Flumazenil: Benzodiazepine antagonist ; competive GABA receptor.
QUESTION: Which drug best reverses the effect of benzodiazepines?
Flumazenil Benzo flu away
QUESTION: contraindication of lorazepam: a)pregnancy
QUESTION: diazepam (Valium) is contraindicated in pregnant lady (ALL BENZOS)
QUESTION: Why do you use benzos for antianxiety? Reduced depression, does not propentiate depressents. (less respiratory depression)
QUESTION: How benzos are anxiolytic – rebound sedation or amnesia? (Qs unclear. Benzos cause Rebound anxiety)
QUESTION: How benzos are anxiolytic: moderate doses ANTIANXIOLYTIC and high doses is SEDATIVE
QUESTION: Sedative rebound (or something like that)
a. Antiphysicotic
[?] PART OF WITHDRAWL
QUESTION: Which of the following barbiturates MOST readily penetrates the blood-brain barrier?
Thiopental
QUESTION: Sodium Thiopental [?] rapid-onset short ultra acting barbiturate(IV) for general anesthesia- for Desensation
QUESTION: A patient has appointment next morning, he is anxious, and the night before he had hard time sleeping, which of the following tx would you prescribe? Ambien! (sedative and

makes patient sleep).
QUESTION: Check what is Ambien (Zolpidem) !!
(Ambien is a nonbenzodiazpine hypnotic…used for insomnia.also reversed by
flumazenil just like BDZs…potentiates GABA receptors…short half life…negative side efx: hallucinations and amnesia)

QUESTION: Chief mechanism by which the body metabolizes short-acting barbiturates is?
a. oxidation (occurs in the liver)
b. reduction.
c. hydroxylation and glucoronidation
d. sequestration in the body fats.
QUESTION: why are ultrashort acting(gave me an actual name of a barbiturate) barbituates so fast?
•Redistribution (right answer according to previous test)
QUESTION: Diazepam -No effect on respiration as oppose to other BZ
QUESTION: The reversal for Versed? (versed = midazolam)
A. Narcon
B. Flumazenil**
QUESTION: Pt is under oral sedation. You should monitor everything except?
• Respiration
• Oxygen saturation level
• *Electo cardiogram
• Skin and oral mucosa color (cyanosis?)
QUESTION: #1 cause for problems during IV sedation?—hematoma
QUESTION: A 77 years old female 110 lbs weight requires removal of mandibular teeth under local anesthesia. She is apprehensive. The appropriate dose of i/v diazepam to sedate her?
a. 5 mg
b. 10 mg
c. 15 mg
d. 20 mg
QUESTION: Drug for seizures? Dilantin (or diazepam)
QUESTION: Flumazenil combats benzos (naloxone combats opioids), disulfuriam is for alcoholics
QUESTION: Buspirone - Psychotropic and anxiolytic; low CNS depression, low psychomotor skill impairment ***Buspar—different from benzodiazepines because it does NOT produce dependence.
QUESTION: Know drugs used for conscious sedation ? SSRIs/BDZ Diazepam and
Prozac(fluoexitine)
QUESTION: 25 yo female breast feeding 12m old child and currently pregnant-which sedative would you
give?
• Halcion
• Promethazine
• Nitrous
• Diazepam

• Phenobarbital
QUESTION: What anxiolytic to use for anxious 25 year old pregnant woman who is breastfeeding? Promethazine
Chloral hydrate (avoid), nitrous (avoid), benzo (avoid)
QUESTION: do not give which medication to lactating female? Codiene and tetracycline
QUESTION: Prozac (fluoxetine) - acts on serotonin SSRI "selective serotonin receptor inhibitor" this is an antidepressant
QUESTION: Fluoxetine (prozac) Mechanism of action: SSRI
QUESTION: Patient is in her 70's, she lives alone, what could she be suffering from? – Depression
QUESTION: main sign of dementia : Short term memory loss. Confusion
QUESTION: Dementia: which is not a sign of dementia: long-term memory loss
QUESTION: Substance in the brain where antidepressants works :?decrese amine mediated neurotranmision in the brain
QUESTION: TCA mechanism of action: inhibit reuptake of NE and 5-HT (serotonin)
QUESTION: TCA 2nd generation- Nortriptyline (Pamelor, Aventyl)
Desipramine (Norpramin)
Protriptyline (Vivactil)
QUESTION: know the mechanism of action of TCA.? it decreases the re uptake of Norepinephrine
QUESTION: patient is taking TCA antidepressants what do you take into consideration? Limit duration of procedures, keep in mind the epinephrine limit ….
QUESTION: Side effect of having TCA and epi : HTN, hypotension, hyperglycemia, hypoglycemia
QUESTION: Most common antidepressant does what?
• Inhibits reuptake of NE, 5-HT, & DA (TCA)
• Inhibit reuptake of 5-HT (SSRI)
• Inhibit reuptake of N & 5-HT (SNRI)
• Inhibit MAO; prevent breakdown of NE & 5-HT (MAOI)
• Block D2 receptor (phenothiazine)
QUESTION: IF someone has a history of depression, what do you give? Zyban (Bupropion), not Chantix (smoke cessation)
QUESTION: Amitrriptyline – most common tricyclic antidepressant, inhibits reuptake of NE and serotonin
QUESTION: Zoloft works on what receptor?Presynaptic monoamine transporters (inhibit reuptake of 5-ht)
Sertraline hydrochloride (trade names Zoloft and Lustral, among others) is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class.
QUESTION: Most common mood disorder?generalized anxiety
QUESTION: Depression causes- eating, lonliness, and something else
QUESTION: What do you use St. John's Wart? Depression MOA:noncompetitive reuptake inhibition of monoamines.
QUESTION: What does St. John's Wort do? Decrease the body immunity
Note: there is no option "anti depressant" in choices. in Pt with HIV it interact with anti HIV drugs such as Indinavir(increase immunity) and reduces their function so the immunity decreases

QUESTION: St johns wart- used for? · depression?not with benz and HIV medication

Antipsychotics
o Phenothiazines: Block DA receptors
? Act on the extrapyramidal pathway
o Side effects
? Tardive dyskinesia
QUESTION: Substance in the brain where antipsychotics works : blocking the absorption of dopamine
QUESTION: What acts on extrapyramidals? Phenothiazines (chlorpromazine)
QUESTION: Onset of action of antipsychotic is: 5-6 days
QUESTION: what is the most common psych disorder? (anxiety)
QUESTION: lithium is used for? Manic phase of bipolar disorder

Anti-inflammatory/Corticosteroids: Side effect profile: gastric ulcers,immunosuppression, acute adrenal insufissiency, osteoporosis, hyperglycemia, redistribution of body fat.
QUESTION: Strongest glucocorticoid/Long acting Corticosteroid? Dexamethasone,
QUESTION: GI with corticosteroids: Ulcers. Long term effect- osteoporosis
QUESTION: Long term side effect of corticosteroids-osteoporosis and hyperglycime
QUESTION: long term glucocorticoids use- shows all of following except? hypoglycemia
does lead to: osteoporosis, hyperglycemia, immunosupp.,
QUESTION: Where do you see moon facies: increased steroid treatment
QUESTION: Contraindation use corticosteroid-diabetes (also: HIV, TUBERCULOSIS, CADIDIASIS,
PEPTIC ULCER)
QUESTION: Aspirin contraindicated with: corticosteroid use
QUESTION: How much and how long of steroid insufficiency: 200mg/two weeks in last 2 years, 20 mg 2 weeks in last 2 years
QUESTION: Critical dose of steroids for adrenal insuficience- 20 mg of cortisone or its equivalent daily, for 2 weeks within 2 years of dental treatment
QUESTION: Acute adrenal insufficiency: hypotension
QUESTION: Pt taking corticosteroid with rheumatoid arthritis, pt needs TE, why would you consult with physician: full blood panel, assess for adrenal insufficiency (want to make sure pt can produce enough
coricosteroid with addition to what they are taking so you won't have over inflammatory response from
TE)
QUESTION: Pt on 3mo tx of steroids needs what?- no tx and consult gp for dose raise
QUESTION: if a pt. has been using 10 mg of corticosteroid for 10 years, what would you do for pt.
before any tx? Have pt continue and increase the dose
QUESTION: cortisone exerts its action on…(it's a steroid hormone, so binds to intracellular receptor) - receptors on membrane, proteins in plasma…etc.
(Enter cell and bind to cytosolic receptor migrate to nucleus gene expression or With plasma membrane on target cells)

QUESTION: if pt doesn't get steroid tx in time for their temporal vasculitis what will happened
• vision loss
QUESTION: What causes asthma: NSAID (aspirin)
QUESTION: Asthma – why use corticosteroids – decrease inflammation
Inhaled corticosteroids are the most effective medications to reduce airway inflammation and mucus production.
QUESTION: what Addison disease causes :?pigmentation of the mucosa
chronic endocrine disorder in which the adrenal glands do not produce sufficient steroid hormones (glucocorticoids and often mineralocorticoids)
*Addison= lower steroid hormones…pigmentation of mucosa
QUESTION: Addisons shows what in oral cavity: pigmentation on buccal mucosa
QUESTION: Addison's Disease
adrenal insufficiency
Tx: give cortisol
QUESTION: Nitrous oxide – in blue cylinder (oxygen in green)
QUESTION: Nitrous oxide oxidizes the cobalt in vitamin B12, resulting in the inhibition of methionine synthase. Nitrous oxide has greater analgesic potency than other inhaled anesthetics
QUESTION: Dreaming on nitrous, what is it? Overdose, normal
QUESTION: How do u check to see if the oxygen (reserve) bag is ok: It shouldn't be that full or that collapsed
QUESTION: Contradictions of nitrous, which patient can get nitrous? Hypertention, pregnancy
QUESTION: What is an absolute contra-indication for the use of Nitrous oxide?
nasal congestion?
QUESTION: Fear anxiety, which option is better? Oral sedatives, nitrous, barbs, deep sedation
QUESTION: devise used in evaluation of N20 : Pulse oximeter
(CORRECT—used to measure amount of oxygen in blood)
QUESTION: The correct total liter flow of nitrous oxide-oxygen is determined by the amount necessary to keep the reservoir bag 1/3 to 2/3 full.
QUESTION: Nitrous oxide: Total flow rate 4-6 L per min
QUESTION: Nitrous to pedo at 50%-what we do? We stop giving it.
QUESTION: Max amount of Nitrous Oxide for a kid
a. 40 %
b. 50%
c. 70% Adult
QUESTION: Safety on nitrous tank – 70%
QUESTION: Nitrous safe switch happens? – 50% (I think it's 70 for N, 30 for O)
QUESTION: Abuse of nitrous oxide it results in peripheral neuropathy.
QUESTION: Why is nitrous oxide used on children? alleviate anxiety
QUESTION: What is an adverse effect of nitrous? Nausea,
QUESTION: If patient does not have 100% oxygen after nitrous oxide: Diffusion hypoxia
QUESTION: NO2 contraindicated in I put nasal congestion, it is ok for asthma
**contraindications for NO2 include—COPD, resp infx, pneumothorax/collapsed lung, 1st trim of pregnancy, hard to communicate with pt, contagious disease, middle ear or sinus infx, bowel obstruction, head injury
QUESTION: Nitrous oxide and preg pt, which trimester to avoid? 1, 2, 3, all trimensters

(Especially 1st)
QUESTION: hydroxizyne is used with chloral hydrate because decrease nausea is a first-generation
antihistamine of the piperazine class that is an H1 receptor antagonist. It is used primarily as an antihistamine for the treatment of itches and irritations, an antiemetic for the reduction of nausea, as a weak analgesic by itself and as an opioid potentiator,
and as an anxiolytic for the treatment of anxiety

Local Anesthesia:
Lipophilic ring (aromatic) + intermediate chain (ester or amide link) + hydrophilic amino terminus
Esters are more prone to hydrolysis = shorter duration of action
Esters = no I before –caine Amide = "I" before –caine
Amide derivatives: Xylidine, Toluidine, Thiophene
Amides: metabolized in liver
Esters: Metabolized by plasma esterase
QUESTION: Know where L.A. metabolized? Amide (2 I's) met. in P450 enzyme of Liver. Esters (1 i)
met. in pseudocholinesterase of plasma.
QUESTION: How does anesthetic work? Decrease sodium influx
QUESTION: Mode of action of Lidocaine: Block sodium channels
QUESTION: adding a vasoconstrictor like epinephrine decreases its rate of absorption,
increasing the duration of action,
minimizing systemic toxicity,
and helps with hemostasis

QUESTION: Anesthetics broken down by what: biotransformation
[?]***thiopental= redistribution
QUESTION: Biotransformation, what is tendency of molecules, chemical similarities: more polar and more ionized and less lipid soluble
QUESTION: Which best describes biotransformation: increase in polarity and water soluble
Whatever helps its excretion – polar and more water soluble
QUESTION: Conjugating the drug does what ? something about crossing brain barrio more or other things conjugation reaction = are the Phase 2 reaction of drug biotransformation that occurs in the liver. metabolizing to a soluble form
QUESTION: In relation to their parent drug, conjugated metabolites do what –more ionized in plasma (more water soluble)
QUESTION: What happens to a drug after conjugation- more ionic, more hydrophilic, more active...
QUESTION: What do you use sodium bicarbonate for? All drugs or alcohol (phenol barbitals)
Excretion of acidic drugs is accelerated with Sodium Bicarbonate
QUESTION: After drug goes through liver? More water soluble and less lipid soluble.
QUESTION: First pass metabolism? Concentration will decrease exponentially. Drug eliminated in proportional fashion.
QUESTION: First pass metabolism:

- enzymatic degradation in the liver prior to drug reaching its site of action
QUESTION: oral meds - first pass effect on liver

1. Enterohepatic circulation
Substances that undergo enterohepatic circulation are metabolized in the liver (usually by conjugation), excreted in the bile, and passed into the intestinal lumen (where the intestinal bacteria break some of the conjugated drug, releasing the unmetabolized drug again) where they are reabsorbed across the intestinal mucosa (thus returns to systemic circulation again) and returned to the liver via the portal circulation. Drugs may remain in the enterohepatic circulation for a prolonged period of time as a result of this recycling process. thus increase in their halflives.
First pass effect:
After a drug is swallowed, it is absorbed by the digestive system and enters the portal circulation. The absorbed drug is carried through the portal vein into the liver. The liver is responsible for metabolizing many drugs. Some drugs are so extensively metabolized by the liver that only a small amount of unchanged drug may enter the systemic circulation, so the bioavailability of the drug is reduced. Alternative routes of administration (e.g., intravenous, intramuscular, sublingual) avoid the first-pass effect.

221-230 pswinontario@gmail.com

QUESTION: Oral drugs – undergo first pass metabolism in liver

QUESTION: what is used to determine whether a drug will cross glomerulus: whether its

attached to a protein or not

QUESTION: Which drug absorbs better in stomach acid? Weak acid

QUESTION: In order for a drug to do its effect in what state should it be?

Weak acid,

Weak base

Liposoluble-NON ionized drugs are soluble in lipid.

Hydrophobic

Hydrophilic

QUESTION: When a drug does not exert its maximum effect because it is bound to ?

Albumin

QUESTION: Which of the following best explains why drugs that are highly ionized tend to be more

rapidly excreted than those that are less ionized? The highly ionized are

A. less lipid soluble.

B. less water soluble.n (e.g., intravenous,

intramuscular, sublingual) avoid the first-pass effect.

C. more rapidly metabolized.

D. more extensively bound to tissue.

QUESTION: Patient got LA, their breathing fast, hands and finger are moving, heart rate is up – You

injected into a blood vessel

QUESTION: Patient get LA injection, he started to breathe a lot, HR goes up, due to what? cardiovascular response to vasoconstrictor

QUESTION: Patient receives local anesthesia, bp goes up to 200/100, reason? Injection of

epinephrine into circulation

QUESTION: You gave Local Anesthetic, BP went down to 100/50 and HR went down too, what could it
be due to? – Syncope
QUESTION: signs of syncope: blood pressure falls
QUESTION: LA does not work when there is inflammation as the pH is acidic
QUESTION: Infection around a tooth but can't numb patient, why? - Infection reduces the free base
amount of anesthetic
QUESTION: Where do you inject if infiltration in the area will not be able to avoid the infection?- Block
QUESTION: If you have pain, what would be the hardest to anesthetize?
a. Irreversible pulpitis and maxillary
b. Irreversible pulpitis and mandibular
c. Necrotic pulp and maxillary
d. Necrotic pulp and mandibular
QUESTION: the pKA of an anesthetic will affect what. Metabolism, potency, peak effect? **ONSET**

QUESTION: When do you know that is it a non-odontogenic pain: When pain is not relieved with LA
QUESTION: Lidocaine calculation: a cartridge that contains 1.8 ml of solution at a 2% (20mg/ml)
concentration, how much drug? 36 mg/ml of drug (20 mg/ml X 1.8 ml/cart. = 36 mg/ml)
QUESTION: Know max dosage of lidocaine for a kid in mg/kg 4.4 mg/kg
QUESTION: Numb the kid, how many hours is the soft tissue numb? 3- 8 hrs
QUESTION: When you numb IA nerve, which roots of primary teeth are numb, (2.3, section C), Could not find!!
QUESTION: Kids have higher pulse, basal metabolic activity and higher respiratory rate , but lower
BP
QUESTION: Typical pulse for a 4 year old is 110 (12 yr old is 75, adult is 70)
QUESTION: 20 kg child how many mg of lidocaine: 88mg
MAXIMUM allowable dose of 2% lidocaine with 1: 100,000 EPI 7mg/kg) for adult's 4.4mg/Kg for
141-150

QUESTION::You gave Local Anesthetic, BP went down to 100/50 and HR went down too, what could it be due to? – Syncope

QUESTION: After receiving one cartridge of a local anesthetic, a conscious healthy adult patient became unconcious in the dental chair. The occurrence of a brief convulsion is

A. pathognomonic of grand mal epilepsy.

B. consistent with a diagnosis of syncope.

C. usually caused by the epinephrine in the local anesthetic.

D. pathognomonic of intravascular injection of a local anesthetic.

Answer: B signs of syncope: blood pressure falls

QUESTION: signs of epi overdose: blood pressure and heart rate rises

QUESTION: Carpopedal spasm seen in? asthmatic attack, hyperventilation,

Seizures

Answer: hyperventilation and seizures

Explanation from Wikipedia: Hyperventilation. ... When hyperventilation leads to respiratory alkalosis, it may cause a number of physical symptoms: dizziness, tingling in the lips, hands or feet, headache, weakness, fainting and seizures. In extreme cases it can cause carpopedal spasms (flapping and contraction of the hands and feet).

QUESTION: Which of these is indicated for grand mal seizure? DILANTIN phenytoin

Most common seizure in children – grand mal Febrile seizures, which occur in young children and are provoked by fever, are the most common type of provoked seizures in childhood. Then generalized tonic-clonic (grand mal)

QUESTION: Drug of choice of status epilepticus (seizure that last for long period)? `diazapams– how much too, 5ml?---***5-10 mg IV / per minute

QUESTION: drug of choice for Grand mal seizure : Valium (diazepam)

Status epilecticus : phenytoin

Note: DIAZEPAM CONTRAINDICATIONS: Pregnant, myasthenia gravis, acute narrow glaucoma

Diazepam is contraindicated in the following pt? Asthma . T/F(will be edited)

Which of the following drug can be used for patient with petit mal seizures in dental office?

A) ethosuximide (Zarontin)

B) valproic acid (Depakene)

C) Phenytoin.

D) ALL

Answer: A & C in golden. (not sure)

QUESTION: What is best to give for petit mal seizure?

1) No treatment

2) Phenytoin

3) Diazepam

4) Ethosuximide

5) None

Answer: 4

QUESTION: What may induce seizures? Hyponatremia, hypernatremia, hyperkalemia

Answer: Hyponatremia (lack of sodium)

QUESTION :Epileptic pt least likely to take

a. ethosuximide – petit mal seizures

b. diazepam

c. Lasix (furosemide)

answer: C

QUESTION: Which of the following drugs, when administered IV, is LEAST likely to produce respiratory depression?

A. Fentanyl

B. Diazepam

C. Thiopental

D. Meperidine

E.Pentobarbital

Answer: B

QUESTION: Which of the following is the current drug-of-choice for status epilepticus?

A. Diazepam (Valium®)

B. Phenytoin (Dilantin®)

C. Chlorpromazine (Thorazine®)

D. Carbamazepine (Tegretol®)

E.Chlordiazepoxide (Librium®)

Answer:A

QUESTION: Each of the following is an advantage of midazolam over diazepam EXCEPT one. Which one is this EXCEPTION?

A. Less incidence of thrombophlebitis

B. Shorter elimination half-life

C. No significant active metabolites

D. Less potential for respiratory depression

E. More rapid and predictable onset of action when given intramuscularly

Answer: C

QUESTION: The clinical activity of a single intravenous dose (10 mg) of diazepam is most dependent on which of the following?

A. Alpha half-life

B. Beta Half life

C. Renal excretion

D. Enzymatic degradation

E. Hepatic biotransformation

Answer: D

QUESTION: Each of the following are narcotics used in outpatient anesthesia EXCEPT one. Which one is this EXCEPTION?

A. Fentanyl

B. Sufentanil

C. Meperidine

D. Diazepam

E. Morphine

Answer: D (not sure, will be edited)

QUESTION: Which of the following describes the titration of diazepam to Verrill's sign for IV

conscious sedation?

A. It is recommended as an end-point.

B. It is recommended only when supplemental 02 is used.

C. It is usually not attainable with diazepam alone.

D. It is not recommended since it can indicate a too-deeply sedated patient.

E. It is not recommended since few patients are adequately sedated at that level.

Answer: A

Which of the following is the treatment of choice for lidocaine-induced seizures?

Epinephrine (EpiPen¨)

Naloxone (Narcan¨)

Diazepam (Valium¨)

Flumazenil (Romazicon¨)

Succinylcholine (Anectine¨)

Answer: C

Which of these opioid analgesics is associated with a serious life threatening drug interaction when administered with an MAO inhibitor?

Meperidine

morphine

fentanyl

propoxyphene

codeine

answer: A , Can cause life-threatening hyperpyrexic reactions

QUESTION: Opiate contraindicated in – severe head injury cases

QUESTION: An opiate type MAA with both agonist and antagonist properties is- pantazocin

Which of the following effects are common to pentobarbital, diazepam, and meperidine?

A. Anticonvulsant and hypnotic

B. Analgesia and relief of anxiety

C. Sedation and ability to produce dependence

D. Amnesia and skeletal muscle relaxation

Answer: C

QUESTION: Use for sedation of children- Secobarbitol or pentobarbital (good for pre-op/ anxious kids)

Ketamine is used in emergency situations (good anxiolytic and analgesic at low doses) Meperidine should not be used in kids.

QUESTION: Which is not done by opiates

o Diuresis (opiates cause urinary retention)

o Constipation

o Bronchiolar constrction

o Vomiting

answer: A

QUESTION: Opoid overdose side effect (from cocaine) – constipation, respiratory depression, euphoria, miosis, coma.

QUESTION: opioid OD symptoms – answer was hypotension. Other options were irritability (restlessness), hypertension, insomnia = withdrawl symptoms.

Symptom seen in oral opioid overdose:

hypothermia,

headache,

insomnia,

irritability

Answer: hypothermai(rest are withdrawal sympotms)

QUESTION: Symptoms if too much codeine? Cold and clammy skin

QUESTION: Opioid usage all except:

xerostomia,

chronic cough,

diarrhea,

miosis

answer: diarrhea (for sure get constipation) due to slow intestinal movement.

QUESTION: What is the most significant side effect of opioids as morphine: respiratory depression

QUESTION: Miosis seen in opioid abuse - except with meperidine (an exception)

QUESTION: Which of the following symptoms is the most distinct characteristic of morphine poisoning?

A. Comatose sleep

B. Pin-point pupils

C. Depressed respiration

D. Deep, rapid respiration

E. Widely dilated, non-responsive pupils

Answer: B. Pin-point pupils

QUESTION: opioids receptors are in GI tract, CNS (brain, spinal cord) and adrenal medulla.

QUESTION: Symptoms if too much codeine? Cold and clammy skin

QUESTION: Opioid usage all except:

xerostomia,

chronic cough,

diarrhea,

miosis

answer: diarrhea (for sure get constipation)

QUESTION: What is the most significant side effect of opioids as morphine: respiratory depression

QUESTION: Miosis seen in opioid abuse - except with meperidine (an exception)

QUESTION: Which of the following symptoms is the most distinct characteristic of morphine poisoning?

A. Comatose sleep

B. Pin-point pupils

C. Depressed respiration

D. Deep, rapid respiration

E. Widely dilated, non-responsive pupils

Answer: B. Pin-point pupils

QUESTION: opioids receptors are in GI tract, CNS (brain, spinal cord) and adrenal medulla.

QUESTION: opioid stomach upset - act in the brain, not in stomach receptors. (not sure)

QUESTION: Opioid agonists act by…

a. stimulating GABAergic neuron

b. increase pain threshold

c. acting as Mu receptor agonists

answer: c

QUESTION: Naloxone: use for Opioid overdose. Used Meperidine (Demerol) to decrease withdrawl symptoms.

QUESTION: Opioid (Fentanyl, Morphine, Meperidine, Methadone, Sulfentanil, Codeine, Heroin, Dextromethorphan) reversal drug? Naloxone.

QUESTION: antidote for Percodone overdose (Oxycodone+aspirin)? all opiate antidote is Nalaxone.

QUESTION: How does an antagonist work? No intrinsic activity, High affinity

QUESTION: Fentanyl is the opioid analgesic given transdermally. (TRANSDERMAL patch).

QUESTION: If you give too much of an opioid (but its not an overdose!), what's the first sign

you would see?

a. Irritation

b. Head

QUESTION: Opioid agonists act by…
a. stimulating GABAergic neuron
b. increase pain threshold
c. acting as Mu receptor agonists
answer: c
QUESTION: Naloxone: use for Opioid overdose. Used Meperidine (Demerol) to decrease withdrawl symptoms.
QUESTION: Opioid (Fentanyl, Morphine, Meperidine, Methadone, Sulfentanil, Codeine, Heroin, Dextromethorphan) reversal drug? Naloxone.
QUESTION: antidote for Percodone overdose (Oxycodone+aspirin)? all opiate antidote is Nalaxone.
QUESTION: How does an antagonist work? No intrinsic activity, High affinity
QUESTION: Fentanyl is the opioid analgesic given transdermally. (TRANSDERMAL patch).
QUESTION: If you give too much of an opioid (but its not an overdose!), what's the first sign you would see?
a. Irritation
b. Headache
c:constricted pupils and absent/slow breathing
answer: C
QUESTION: Methadone? Helps alleviate withdrawl from heroine (opiates). ***Buprenorphine and
Methadone is for opioid addiction.
Note: . Naloxene is an opioid antagonist for OVERDOSE***
QUESTION: why use methadone: long half life- extra info give to heroine addicts? to decrease withdrawl symptoms.(Methadone for detoxification of opioid addicts.Methadone is a synthetic opiod, analgesic, antitussive, antiaddictive, acts on MU receptors so produces similar effects of opioids…without addictive qualities…receptor antagonist to glutamate)
QUESTION: Why is nalbuphine contraindicated in previous heroin addict: A mixed agonist-antagonist which may potentiate withdrawal symptoms.
QUESTION: pt is addicted to oxycodone which contra indications? codeine, pentozocaine
QUESTION: Sedative drug such as hydroxyzine, meperidine and diazepam are carried in the blood in…
a. serum
b. white blood cells
c. red blood cells
d. hemoglobin
answer: a
QUESTION: where do opioids act? Medulla (bind to opiod receptors in CNS) Morphine, codeine, as well
as oxycodone, and hydrocodone all belong to the phenanthrenes class.

QUESTION: where are mu receptors?

Medulla

Periphery

Answer: medulla

QUESTION: Opioid agonists act by…

a. stimulating GABAergic neuron

b. increase pain threshold

c. acting as Mu receptor agonists

answer: c

QUESTION: Naloxone: use for Opioid overdose. Used Meperidine (Demerol) to decrease withdrawl symptoms.

QUESTION: Opioid (Fentanyl, Morphine, Meperidine, Methadone, Sulfentanil, Codeine, Heroin, Dextromethorphan) reversal drug? Naloxone.

QUESTION: antidote for Percodone overdose (Oxycodone+aspirin)? all opiate antidote is Nalaxone.

QUESTION: How does an antagonist work? No intrinsic activity, High affinity

QUESTION: Fentanyl is the opioid analgesic given transdermally. (TRANSDERMAL patch).

QUESTION: If you give too much of an opioid (but its not an overdose!), what's the first sign you would see?

a. Irritation

b. Headache

c:constricted pupils and absent/slow breathing

answer: C

QUESTION: Methadone? Helps alleviate withdrawl from heroine (opiates). ***Buprenorphine and

Methadone is for opioid addiction.

Note: . Naloxene is an opioid antagonist for OVERDOSE***

QUESTION: why use methadone: long half life- extra info give to heroine addicts? to decrease withdrawl symptoms.(Methadone for detoxification of opioid addicts.Methadone is a synthetic opiod, analgesic, antitussive, antiaddictive, acts on MU receptors so produces similar effects of opioids…without addictive qualities…receptor antagonist to glutamate)

QUESTION: Why is nalbuphine contraindicated in previous heroin addict: A mixed agonist-antagonist which may potentiate withdrawal symptoms.

QUESTION: pt is addicted to oxycodone which contra indications? codeine, pentozocaine

QUESTION: Sedative drug such as hydroxyzine, meperidine and diazepam are carried in the blood in…

a. serum

b. white blood cells

c. red blood cells

d. hemoglobin

answer: a

QUESTION: where do opioids act? Medulla (bind to opiod receptors in CNS) Morphine, codeine, as

well as oxycodone, and hydrocodone all belong to the phenanthrenes class.

QUESTION: where are mu receptors?

Medulla

Periphery

Answer: medulla

ache

c:constricted pupils and absent/slow breathing

answer: C

QUESTION: Methadone? Helps alleviate withdrawl from heroine (opiates). ***Buprenorphine and

Methadone is for opioid addiction.

Note: . Naloxene is an opioid antagonist for OVERDOSE***

QUESTION: why use methadone: long half life- extra info give to heroine addicts? to decrease withdrawl symptoms.(Methadone for detoxification of opioid addicts.Methadone is a synthetic opiod, analgesic, antitussive, antiaddictive, acts on MU receptors so produces similar effects of opioids…without addictive qualities…receptor antagonist to glutamate)

QUESTION: Why is nalbuphine contraindicated in previous heroin addict: A mixed agonist-antagonist which may potentiate withdrawal symptoms.

QUESTION: pt is addicted to oxycodone which contra indications? codeine,

pentozocainQUESTION: Sedative drug such as hydroxyzine, meperidine and diazepam are carried in the blood i

a. serum

b. white blood cells

c. red blood cells

d. hemoglobin

answer: a

QUESTION: where do opioids act? Medulla (bind to opiod receptors in CNS) Morphine, codeine, as well

as oxycodone, and hydrocodone all belong to the phenanthrenes class.

QUESTION: where are mu receptors?

Medulla

Periphery

Answer: medulla

QUESTION: The codeine produces nausea because?

1:Activates vasodialator blah blah blah

2:Works on the medulla (stimulates medullary chemoreceptor trigger zone)

Answer is 2

QUESTION: How codeine causes nausea: CHEMOTACTIC RECEPTOR ZONE (CRZ)

QUESTION: How does morphine cause emesis in the body: know the pathway – via central

action.(not sure)

QUESTION: codeine what effects? analgesic, antitussive, antidiarrheal, antihypertensive, anxiolytic,

antidepressant, sedative and hypnotic properties. IS ADDICTIVE.

QUESTION: Allergy to codeine: what do you take for pain –

1:random opioids,

2:tylenol #3,

3: hydrocodone

4: acetominophin with aspirin

Answer is 4.

I think ALLERGY TO CODEINE: can prescribe another opioid from different class: Meperidine or fentanyl for moderate to severe pain or acetaminophen or NSAID for mild pain.

QUESTION: Patient allergic to codeine what do you give?

Naproxen,

Propoxyphene,

both

answer is both

QUESTION: Codeine allergy, pain killer option? use synthetic opioids: Demerol(meperidine),

Pentazocine, tramadol.

QUESTION: Pt has hx of codeine allergy. What drug to give?

• Tylenol #3 has codeine

• Vicodine

• Naproxen *

• Hydrocodone

Answer is c

Group 1 (aka opiates) - Naturally occurring agents derived from the opium plant

o Morphine, codeine, thebaine

Group 2 - Semi-synthetics

o Hydrocodone, oxycodone, hydromorphone, oxymorphone, buprenorphine (heroin is also in this group)

Group 3 - Synthetics

o Fentanyl (alfentanil, sufentanil, etc.), methadone, tramadol, propoxyphene, meperidine

All of the group 1 and 2 agents are structurally very similar to each other and should not be given if a true allergy exists to any other natural or semi-synthetic derivative. Group 3 agents have structures different enough that they can be given to a patient intolerant to the natural or semi-synthetics without fear of cross reactivity. They are also very different from others in this same group.

QUESTION: Know the effects of histamine and that it is derived from histidine histamine is bronchospastic and vasodilator

QUESTION: what is not true about histamine?…it is released by histamine

(melika: HAHA. it was exactly written in the golden, just wrote to let you know such a question existJ)

QUESTION: Benadryl (diphenhydramine) both are H1 blockers

QUESTION: What is used for motion sickness? Diphenadryin (Benadryl)----I think this is scopolamine

QUESTION: What does diphenhydramine (Benadryl) cause? Xerostomia (anticholinergic, antihistamine, sedative)

QUESTION: What property of topical diphenhydramine would alleviate pruritus (itching)? antihistamine

The antihistamine relieves itchy/watery eyes and itchy throat by blocking a substance (histamine) released by allergies. The anticholinergic dries up a runny nose and the fluid that runs down your throat causing itching/irritation.

QUESTION: what antihistaminic cause less drowsiness :

H1 blocker 2nd generation zyrtec,

allegra,

Claritin (loratidine),

Clarinex (Desloratidine)

Certizine (Zyrtec)

all

answer: all. because they don't cross BBB, poor CNS penetration

QUESTION: Which one of these has the least sedative effect? (2nd generation H1 blocker)

Diphenylhydramine/ Benadryl (Most)

chlorpheniramine- (LEAST)

Tripelennamine

QUESTION: Least sedating anti-histamine? (2nd generation H1 blocker)

QUESTION: Which antihistamine is least likely to cause drowsiness – Loratidine

QUESTION: Claritin/loratidine – second generation H1 blocker/antihistamine

QUESTION: WHAT DO YOU GIVE SOMEONE WHO IS ALLERGIC TO ESTERS AND AMIDES?

DIPHENHYDRAMINE (BENADRYL)

Which of the following (from a list of H1 blockers) would have slowest onset after IV administration :

Diphenyhydramine

loratadine

Levocetirizine

Hydroxyzine

Answer is B.(melika: guys we need more information about this)

QUESTION: How does antihistamines work? Competitive inhibition of histamine receptors

QUESTION: actions of H1 antagonist:

Vasoconstriction, bronchodilation, and decrease capillary permeability

QUESTION: What property of diphenhydramine causes xerostomia?

a. Anticholinergic

b. Antihistaminic

c. Antimuscarinic

answer: A

Side effects of Benadryl – anticholinergic effects:

dry mouth and throat, increased heart rate, pupil dilation (mydriasis), urinary retention, constipation –.

QUESTION: H2 antihistamine Cimetidine – decrease ulcers H2 antihisamine ratidine.

Note: for gastric reflux and gastric ulcer use Cimetidine. all the drugs with "dine" are histamine 2 blockers. H2 Blocker (reduce the acid secretion) for GERD (gastro esophageal reflux disease).

QUESTION: effects of H1 blocker EXCEPT: (causes CNS depression)

a. CNS increase

b. CNS decrease

c. increase acid secretion

d. resp depression

e. local anesthesia

answer: a

QUESTION: Pt is allergic to aspirin? Wat can u give? Tylenol #3 is acetomenophen and codeine. Just Tylenol

QUESTION: Wat does acetametaphine do with codeine? Increase its activity, increase how long its around due to clearance,...

QUESTION: Why opioid analgesic containing both acetaminophen and hydrocodone so effective? • acetaminophen and hydrocodone works differently, and combining these effects makes it stronger* I put this, but not sure.

• acetaminophen blocks the binding of protein with hydrocodone, so hydrocodone level in blood is high, so it is strong

Narcotics work in brain (CNS) while NSAIDS/acetomenophen work in peripheral tissues (PNS) – 2 diff mechanisms compliment each other for effective pain reduction

QUESTION: How do you treat acetaminophen overdose? n-acetylcysteine (Reversal of acethaminophen: NAC , N-acethylcysteine-liposome)

QUESTION: Tylenol - can cause hepatotoxicity

QUESTION: Pt has hepatic dysfunction which pain medication can prescribe?

a-Oxycodone

b. naproxen

C-acetaminophen

Answer: b

QUESTION: what is common bet Tylenol and aspirin – anti pyretic and analagesic

QUESTION: Difference bet Tylenol and aspirin : aspirin is antimflammatory

QUESTION: Tylenol vs. NSAID: Apirin- reyes fever and adults GI, If liver problems give aspirin

QUESTION: NSAIDs--> stimulate asthma attack-->COX inhibitor. inhibit cyclooxygenase

QUESTION: NSAIDS are reversible except is aspirin which is irreversible.

Explanation from wiki by Melika: Aspirin's ability to suppress the production of prostaglandins and thromboxanes is due to its irreversible inactivation of the cyclooxygenase (COX) enzyme. ... This makes aspirin different from other NSAIDs (such as diclofenac and ibuprofen), which are reversible inhibitors.

Important: NSAIDS are REVERSIBLE…

QUESTION: Asprin stops pain by:

a. stopping the unpward transduction of pain signal in the spinal cord

b.intefere wiht signal intrepretation in the CNS

c. stopping the local signal produtction and transduction

d.stopping the signal transduction in the cortex

answer: c

QUESTION: Nsaid least likely to effect stomach –(Rofecoxib…aka Vioxx...however taken off the market) Cox 2 inhibitor CELEBREX.

QUESTION: Dyspepsia =upset stomach what drug can cause it – Less likely to be acetaminophen, ibuprofen (less GI upset than other nsaids). (not sure)

QUESTION: Aspirin inhibits platelet aggregation

QUESTION: Plavix and aspirin: alter platelet function

QUESTION: What effect does Plavix has? Inhibits platelet aggregation.(Given to patients

allergic to aspirin) no ulcer side affect, give to patients with past ulcer history

QUESTION: Clopidogrel (Plavix) inhibits platelet aggregation irreversibly.

Note from wiki by Melika: Clopidogrel, sold under the brand name Plavix among others, is a medication that is used to reduce the risk of heart disease and stroke in those at high risk. . It is also used together with aspirin in heart attacks and following the placement of a coronary artery stent (dual antiplatelet therapy).

QUESTION: Patient is taking baby aspirin.

a)how long before should you stop before surgery?

b)is it necessary to stop?

c) for long will the platelets be inhibited?

(don't have any answer. Will be edited soon)

QUESTION: For how long a single dose of aspirin will have effect on the platelets? 2h, 12h, 1 day, 10 days, 1 month – 10 days

Answer: 10 days

QUESTION: Ibuprofen doesn't cause as much GI upset as aspirin

QUESTION: After one effective dose of aspirin how long must you wait before there is not effect on bleeding : 1 week

QUESTION: baby asprin given once a day with dose 80

325 for child every 4 or 6

650 for 12-16 years every 4 or 6 houres

QUESTION: Aspirin works on which pathway for pain?- Cyclo-ox pathway

QUESTION: Aspirin works how to inhibit bleeding?- Thrombox A2

QUESTION: Bleeding time: Inhibits thromboxane A2, preventings platelet synthesis

QUESTION:, which one it is affected by aspirin(BT)? Bleeding time, PPT?

Answer: BT

QUESTION: Patient is on 3-5 grams acetylsylic acid per day for 3 months what is the most likely to see in this patient?

Increased PT and Bleeding time

Increased PT and PTT

Acidosis and increased bleeding time (I am not sure if the second part of this choice was bleeding time but I rememberly I instantly picked this as soon as I saw acidosis, since acetylsyllic acid is aspirin and its an acid and 3g daily is a lot!!!!

Melika: given answer is c. I searched in the group but couldn't found any information about this. Will be discussed soon and I will edit the answer.

QUESTION: Pt. on saw palmetto what do u want to avoid? Aspirin

Note: Saw palmetto enhances anticoagulants.

QUESTION: HERBAL supplement that potentiates anti-coagulation (CHAMOMILE DIRECT EFFECT)

a. St. John's Wort

b. Saw Palmetto

QUESTION: **Which herb complicates in someone on anticoagulants: st johns wort-dec immunity in hiv pt on heart mehs and antidepressant?

Chamomile

, ginko,

ginseng-anti-platelet (at least 2 questions)

a. Chamomile not to be bad with anti-coagulats

QUESTION: Allergic to Aspirin?. DO NOT take ibuprofen. One very important point is that most NSAID's (or Non-steroidal anti-inflammartory drugs) cross-react with aspirin - meaning that they can cause the same types of reactions in aspirin sensitive people. Instead you can take acetaminophen.

QUESTION: If someone can't take ibuprofen what can u give them?

a. aspirin

b. demerol narcotic w/out aspirin

c. pentazocaine - narcotic w/aspirin

14 anilkumar28@gmail.com 151 to 156

QUESTION: Which statement is correct for Ibuprofen?
• ceiling analgesia at 400mg (Answer)
• safe use for pt w/ peptic ulcer
QUESTION: Methotrexate toxicity increases with use of nsaids or penicillin true
QUESTION: No NSAIDs for asthmatic patient
QUESTION: in asthmatic patient===nsaid contraindications - NSAIDS cause bronchospasm.
QUESTION: What causes asthma: NSAID (aspirin)

QUESTION: longterm asthma give corticosteroid
QUESTION: Long acting Corticosteroid is Dexamethasone
QUESTION: What doesn't affect platelets of list of NSAIDS: Celebrex because it's Cox 2
QUESTION: Celebrex (cox 2) doesn't stop bleeding? It causes bleeding as side effect
QUESTION: Something about arachidonic acid breakdown….Prostaglandin? Bradykinin?
QUESTION: Oral Ketorolac: NSAID,usually used after IV dose of Ketorolac after surgery
Ketorolac (toradol) can be given orally or IM. Ketorolac is used to relieve moderately
severe pain, usually pain that occurs after an operation or other painful procedure.
The speed of absorption is faster for intramuscular injection compared to
subcutaneous injection. This is because the muscle tissue has a greater blood
supply than the area just under the skin. Muscle tissue may also hold a larger
volume of medication than subcutaneous tissue.
QUESTION: Ketoralac is an NSAID that inhibits prostoglandin synthesis (competitive non-selective
cox inhib)
QUESTION: What med to give for moderate post-op extraction pain? Ibuprofen, Acetaminophen, NSAID,
opioid is Answer) ibuprofen as per group
QUESTION: pt has mild pain from ortho. What med NOT to give?
• Aspirin
• Ibuprofen
• Hydrocodone given answer
• Naproxen

152
QUESTION: What would you prefer for a patient with renal vascular disease & why?
a.acetaminophen (the other drugs are nsaids and they affect the kidney in a more negative way. This
drug affects the liver and causes liver toxicity so Answer
b.aspirin
c.ketorolac
d.ibuprofen
QUESTION: Tylenol – non-narcotic analgesic of choice for pt taking anti-coagulants – no anti-inflamm. Properties
QUESTION: For pregnant- only give Tylenol- NOTHING WITH CODEINE
QUESTION: Pregnant patient (third trimester) needs pain medication – options: Tylenol 325mg, (Answer)
Tylenol 3m aspirin, or ibuprofen
QUESTION: Breastfeeding mother don't give her What? I was expecting tetracycline but it wasn't there
so I put Propoxyphene because it has aspirin. Maybe could Cause Reyes syndrome
QUESTION: do not give which medication to lactating female? codiene (yes)
FDA pregnancy category C. This medication may be harmful to an unborn baby, and could cause

breathing problems or addiction/withdrawal symptoms in a newborn.
QUESTION: Asthmatic only use Tylenol (not aspirin bc of hypervent)
QUESTION: 5 year old patient with fever and pain
• Codeine
• Tylenol (answer)
• Asprin
• NSAID
QUESTION: DEA schedules there drugs by their not toxicity but depending on ABUSE POTENTIAL or dependency
potential
opioids/narcotics, like codeine, oxycodeine, etc
QUESTION: dentist cant write prescription for schedule class 2 for back pain.
QUESTION: What is not true of drugs? Schedule II drugs cannot get refill without script . the following are true:
o Schedule 3, 4, 5 drugs CAN be filled over the phone.
o Scripts must have patients name and address
o DEA number must be on each script
QUESTION: Oxycodone, Hydrocodone: are schedule 2 drugs

153
QUESTION: What can be combined with tylenol to make it a level 2…oxycodone, codeine etc.
Tylenol 1 = 8mg codeine ; Tylenol 2 = 15mg codeine ; Tylenol 3 = 30 mg Codeine ; Tylenol 4 = 60mg Codeine
QUESTION: Tylenol - can cause hepatotoxicity
QUESTION Which one is a class 2 narcotic? Vicodin, percoset is Answer hydrocodone
QUESTION Vicodin schedule?: 2 acetaminophen + Hydrocodone
QUESTION Percocet schedule: 2 acetaminophen + Oxycodone
QUESTION LESS than 15 mg of hydrocodone per dosage unit is schedule 2
QUESTION schedule 2: combination products containing less than 15 milligrams of hydrocodone
per dosage unit (Vicodin®)
QUESTION Schedule 3: products containing less than 90 milligrams of codeine per dosage unit (Tylenol – acetaminophen- with codeine®).
QUESTION schedule 4 narcotic is propoxyphene (Darvon® and Darvocet-N 100®). alprazolam (Xanax®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).
QUESTION: Drug schedules II or III – they are all acetaminophen with opioid except for one that
was hydrocodene with nsaid (vicoprofen)
QUESTION: Schedule II drug- Percocet (it didn’t say oxycodone so know that Percocet is oxycodone
and Tylenol)

QUESTION: Schedule II narcotic and antipsychotic is neuroleptic analgesia
QUESTION :If a patient had some teeth extracted and asked what drug he can take that'll provide at
least 8 hours of relief
a. Tylenol
b. Ibuprofen
c. NAPROXEN- this is what I PUT nonselective Cox 2 inhibitors
QUESTION: What are you worried about when a patient is on Naproxin? (DDI w/ aspirin antiplatelet
activity)
QUESTION: Which of the following has least effect on platlets/bleeding?
• Aspirin
• Ibuprofen
• Naproxin
• Difluzole (vaginal candidiasis medication) Answer

BIOPSY

QUESTION: Pt has worn denture for 19 years, now he has a sore on Buccal with swelling what do
you do: (re-evaluate in 2 weeks)
QUESTION: White patch on buccal mucusa? Whats best way to get biopsy?? Smear**

QUESTION: You have a lesion in mouth, you tried to treat it, still looks the same after 2 weeks –
Take biopsy
QUESTION: Patient comes in with preliminary diagnosis of candidiasis on ventral tongue and floor of
mouth, white lesion rough and firmly attached. What do you do? Incisional biopsy, Do cultural testing
and confirm that it is/is not candidiasis
I chose confirm/deny with cultural test because leukoplakia is when you have no other
differential but idk cuz you have to biopsy leukoplakia and the lesion looked like it.
QUESTION: Oral candidiasis biopsy of choice is – incisional biopsy, excisional biopsy, brush biopsy
(collects the cells for cytologic smear)
QUESTION: White lesion 2x3x2 cm incisional biopsy do
QUESTION: What should you not do initially with a patient with desquamative gingivitis--> BIOPSY

QUESTION: When you do biopsy, how do you store the specimen before it gets to oral pathologist? 1.
Formalin (answer)

QUESTION: To test for malignancy what test? Incisional biopsy
QUESTION: Difference between incisional and excisional biopsy
Notes:
Incisional biopsy is a technique used when a lesion is large >1 cm, polymorphic suscpicious for malignancy, or in an anatomic area with high morbidity,
Excisional biopsy is used on smaller lesions <1cm that appear benign and on small vascular and pigmented lesions. It entails the removal of the entire lesion and a perimeter of surrounding UNINVOLVED TISSUE MARGIN

IMPLANTS

QUESTION: Diff btween 1 stage and 2 stage, immediate loading vs traditional way
QUESTION: Similarity between bone and implant? Vascular bundle below the bone
QUESTION: What kind of bacteria is under implants? At the apex of root canal
Gram (-), rods and filaments anaerobic
Strict anaerobes are predominate in endo
QUESTION: What bacteria is responsible for implant falure?- gram – anaerobics
QUESTION: best bone to implant in --- apparently ant md and WORST: pos
QUESTION: best reasoning for implant in max lateral
Because . no rest on central & canine is needed
QUESTION: what is the least important factor when evaluating for implant: (concavity of mandible, answer
Imp factors are bone density , distance to mandibalr cancal, bone width)
QUESTION: Bone should not reach temperatures above? (temperature in Celsius) 47 for 1 min to 5 min
QUESTION: Space between 2 adjacent implants 3mm. 1.5mm teeth
QUESTION: How much space between implant and tooth? Answers were 1.5, 2, 3.5 3,
QUESTION: space from implant to nerve needed…2 mm
QUESTION: Minimum width (bucco-lingually) bone should be for 4mm diameter implant
on each side 1mm req so (facial and lingual) 6mm width
minimum Vertical height of bone to place implant - 10mm (according to decks)
minimum Width of bone is 6mm
minimum distance of apex of implant From nerve - 2mm

platform of implant from adjacent CEJ - 2-3 mm
between implant and tooth (height of coutour) is 1mm
Mini implant is 2.4mm
QUESTION: When there is FPD from natural tooth to implant, the max stress is concentrated on

the
SUPERIOR PORTION OF THE IMPLANT.
QUESTION: If implant and bridge are done with natural tooth, what is the complication?, there is a
lot of force on crown of implant and cause fracture.leading to mobility
QUESTION: How does gingival fibers orient next to implant – parallel to implant with no insertion,
Tissue around implant? PARALLELL WITH CUFF LIKE
QUESTION Periodontium surrounding the implant: no periodontium, bone and implant.(false)
You have long JE and ct (parallel and circular only)
Periodontium = gingival, pdl, cementum, and bone
QUESTION: CASE: Case shows a picture of a bridge, when you look at it closely it resembles a Maryland bridge because lateral is intact. What to do if Maryland is removed?
-regular bridge
-implant- she answered this because lateral was intact.
QUESTION: know implants CI:
uncontrolled diabetes
immunocompromised patients
volume and height of bone(anatomic considerations)
bisphosphonate therary
bruxism
tobacco(relative)
cleft palate
young kids
QUESTION: Contraindications to implant placement? Adolescents should not get
QUESTION: Implants not CONTRAINDICATED – older patient
QUESTION: All affect implant placement EXCEPT – smoking 1 pack a day, cardiovascular disease (, Answer)
uncontrolled diabetes, radiation of 60 Gy
QUESTION: Does not affect implant success? Age

Periodontology

NBDELA (171 ~ 190)

Yellow Highlights = NOT sure

QUESTION: Which is contraindicated in 2nd molar region to reduce deep pocket with limited attached gingiva? Gingivectomy

QUESTION: Gingivectomy is contraindicated in: when the sulcus is apical to gingival groove, sulcus is apical to convexity of tooth, sulcus is apical to the crest of alveolar bone.

QUESTION: Contraindication of gingivectomy-not enough keratinized tissue

QUESTION: Patient has crown #18 w/ minimal attached gingival. Which do you NOT do to expose the finish line? don't do Gingivectomy

QUESTION: Contradiction to do gingevectomy is when? Infra bony pocket

QUESTION: Intrabony bone defect? Vertical bone loss.

QUESTION: What should be considered for gingivectomy? level of attached gingiva, degree of attachment loss

QUESTION: The base of the incision in the gingivectomy technique is located

A. in the alveolar mucosa.

B. at the mucogingival junction.

C. above the mucogingival junction.

D. coronal to the periodontal pocket.

E. at the level of the cementoenamel junction

QUESTION: gingivectomy - is it incisional (reverse) or Excisional of gingiva

QUESTION: Epithelium over connective tissue, how fast per day in mm? 0.5-1mm

QUESTION: How does external bevel gingivectomy heal? Primary intention, Secondary

intension, tertiary, granular

(Notes)

Primary healing = flap

Secondary healing = sc/rp and regular gingivectomy

Tertiarty healing = Tissue grafts

QUESTION: After a gingivectomy how does the site heal?

a. from the epithelium of the pockets

b. epithelium of the adjacent alveolar mucosa

c. endothelium of the blood vessels

d. primary intention

QUESTION: How does site heal after gingivectomy? Long junctional epithelium

QUESTION: After lay a flap: how does wound healing work: Long Junctional Epithelium

QUESTION: Following flap surgery, new junctional epithelium can form on either cementum or dentin. Junctional epithelium is reestablished as early as one week. BOTH ARE TRUE

QUESTION: after you perform a flap where you see regeneration: Epithelial attachment via long junctional epithelium and connective tissue adhesion.

QUESTION: What do u want from perio flap: Regeneration of PDL cementum and bone

QUESTION: The soft tissue-tooth interface that forms most frequently after flap surgery in an area previously denuded by inflammatory disease is a

E. collagen adhesion.

F. reattachment by scar.

G. long junctional epithelium.

H. connective tissue attachment.

QUESTION: Gingivoplasty? reshaping of the gingiva to create physiologic gingival contours, with the sole purpose of recontouring the gingiva in the absence of pockets.

QUESTION: Gingivectomy means? Excision of the gingiva. By removing the pocket wall, gingivectomy provides visibility and accessibility for complete calculus removal and thorough

smoothing of the roots, creating a favorable environment for gingival healing and restoration of a physiologic gingival contour.

QUESTION: External bevel, ginviectomy: apical to epithelial tissue, vascular bundle(where to you make incision) Junctional epithelium (apical to base of pocket)

QUESTION: What direction reverse bevel (internal bevel): axial toward bone

QUESTION: Periodontal regeneration involves - Sharpeys Fibers, Cementum and Alveolar Bone

< Notes>

Regeneration is defined as the type of healing which completely replicates the original architecture and function of a part. It involves the formation of a new cementum, periodontal ligament, and alveolar bone.

Repair, on the other hand, is merely a replacement of loss apparatus with scar tissue which does not completely restore the architecture or the function of the part replaced. The end product of repair is the establishment of long junctional epithelium attachment at the tooth-tissue interface.

• REGENERATION: new PDL/cementum made (bone and gingiva too)

• REPAIR: long jxnal epi formed

QUESTION: After flap surgery, where does repair occur? PDL moves occlusally, apically, laterally

QUESTION: Doing flap surgery on mandible, what structure do you watch for? mental

nerve (If 3rd molar TE= Lingual)

QUESTION: Long jxn epith was coronal to CEJ and margin was around cej, apical position flap, widman flap, replace flap

QUESTION: Extrusion of canine what flap technique is used except:

1)Envelope flap 2) Semilunar flap 3) Apically repositioning flap

QUESTION: What type of flap do you use in crown lengthening? Apical Repositioning Flap

QUESTION: Crown that came falling off? Inadequate ferrule or inadequate post

QUESTION: The most common incision given by oral surgeons is?

a. envelope flap

b. y incision

c. Z incision

d. Semilunar incision

QUESTION: To expose a mandibular lingual torus of a patient who has a full complement of teeth, the incision should be…

a. Semilunar

b. Paragingival

c. In the gingival sulcus and embrasure area

d. Directly over the most prominent part of the torus

e. Inferior to the lesion, reflecting the tissue superior

QUESTION: If removal of torus must be performed to a patient with full-mouth dentition, where Should the incision be made?

a. Right on the top of the torus

b. At the base of the torus

c. Midline of the torus

d. From the gingival sulcus of the adjacent teeth

QUESTION: What has the biggest effect on the flap?

a. initial incision

b. extensiveness of reflection

c. post op oral hygiene

d. final position of flap

QUESTION: Correction of an inadequate zone of attached gingiva on several adjacent teeth is best accomplished with a/an?

a. apically repositioned flap.

b. laterally positioned sliding flap.

c. double-papilla pedicle graft.

d. coronally positioned flap.

e. free gingival graft.

QUESTION: Whats contraindicated for pt post mand radio tx.?- flap apico on pt.

QUESTION: During maintenance therapy pt has recurrent 6mm pocket on M of #4 and D of #20 what is 1st tx option: flap surgery, scaling root planning with local microbial administration

QUESTION: Pockets are still the same and oral health care is excellent? Flap and clean out

QUESTION: To prevent exposure of a dehiscence or fenestration what kind of flap? partial or split thickness flap

QUESTION: Split thickness flap involves what tissues? Mucosa (only), submucosa, epithelium and ct (submucosa)

QUESTION: In a partial thickness flap, what do you cut through? epithelium, connective tissue, but NOT periosteum

QUESTION: Perio flap- expose bone?? - Full thickness

QUESTION: Full thickness flap will result in bone atrophy (or loss) in: thin periradicular bone (do partial-thickness flap for this), thick periradicular bone, thick interproximal bone, thin interproximal bone

QUESTION: Know about difference between regenerative surgery and flap surgery?

<Notes>

regenerative surgery - for regeneration with bone graft

flap surgery - to get access for better srp

Grafts:

QUESTION: epithelium of free gingival graft----degenerate

QUESTION: Free gingival graft gets blood from base first,

QUESTION: Most likely damage when you take tissue from gingival graft: damage to greater palatine neurovascular bundle

QUESTION: mucosal graft what nerve would u damage? greater palatine

QUESTION: What nerve is most likely injured when transferring donor tissue to area of free gingival

graft? Greater palatine

QUESTION: mucosal graft epithelization by---connect tissue from underlying tissue (recipient site)

QUESTION: Where does the epithelial for a graft come from?

a. Donor epithelium

b. Donor connective tissue

c. Recipient epithelium

d. Recipient connective tissue

QUESTION: What is the disadvantage of a connective tissue graft? Two surgical sites

QUESTION: Only 4mm of bone below ridge and sinus where do you place graft? Floor of sinus (NOT Top of ridge)

QUESTION: What graft is best for sinus lift? Autogenous and alloplastic

QUESTION: Your patient was referred to an oral and maxillofacial surgeon for an implant, and you were advised that she was going to need a sinus lift procedure with placement of an autogenous bone graft. What is the definition of that graft?

A. The graft will use an artificial, bone-like material.

B. The graft uses bone from another human being.

C. The graft uses the patient's own bone, taken from another site.

D. The graft uses bovine bone, or bone from another animal species.

QUESTION: Which is the best graft: autograft

QUESTION: how you call a graft from a different species : Xenograft

QUESTION: bone graft : iliac crest

QUESTION: What is the most osteogenic? (Choices: alloplast, autograft, etc) ONLY autograft

QUESTION: Freezed dried cadaver bone is a type of? Allograft

QUESTION: Decalcified freeze dried bone allograft: bone morphogenetic proteins

QUESTION: Freeze dried bone has the advantage of having which protein: bmp/pdgf

QUESTION: Which type of grafts causes bone growth?: •Osteoinductive •Osteoconductive

QUESTION: Maxillary canine is contraindicated in a grafting procedure True

QUESTION: least likely to need bone graft – one wall, two wall, three wall wide, three wall narrow

QUESTION: Best prognosis for bone graft: narrow 3 wall defect

QUESTION: Purpose of lateral graft (Pedicle graft): For gingival recession

QUESTION: how to fix gingival recession in anterior region: pedicle graft (never lost blood supply)

QUESTION: Recession of a single tooth, what do you do?

• Double papilla graft

• Free gingival graft

• Apical repositioning

QUESTION: 8 year old with anterior crossbite – recession

a. chlorhexadine

b. lateral sliding graft

c. pedicle graft

QUESTION: Facial recession on mandibular canine of 14 year old / graft not indicated? Reposition with ortho?

QUESTION: You take a graft from a patient to another patient, what is this called? – Allograft (alloplast was a choice, but that's synthetic)

QUESTION: Which is least likely to be successful facial soft tissue graft? – Lower 1st premolars (no canine in the choices

QUESTION: Guided grafts- better for max

QUESTION: GTR in Class II furcations is most effective

QUESTION: Class III furcations are least successful in GTR procedures.

<Notes>

Guided tissue regeneration (GTR) is a surgical procedure used by dentists to promote the new

growth of tissue in areas

QUESTION: The purpose of GTR is to prevent: Long J.E, migration of PDL cells Migration of CT cells.

<Notes>

Decks: Guided tissue regeneration is a procedure that blocks the re-population of the root surface by long junctional epithelium and gingival connective tissue to allow cells from the periodontal ligament and bone to re-populate the periodontal defect.

QUESTION: The purpose of a barrier: Apical movement of PDl cells, coronal movement of cells

< Notes >

GTR excludes gingival epithelial cells allows progenitor cells to close the wound. Gingival epithelium and connective tissue are excluded by the membrane. Progenitor cells form cementocytes and fibroblasts which form new cementum and PDL fibers. This gives you regeneration of the attachment apparatus and not long junctional epithelium. LJE is not as strong as the original attachment apparatus (which is lost by debridement).

QUESTION: which tx is best for type III furcation HEMISECTION

QUESTION: In a through and through furcation lesion, which is the least appropriate treatment? GTR

QUESTION: Tx plan for furcal involvement ? GTR, Hemisection, Root amputation

< Notes>

hemisection = mand molar. Mandibular molars to treat Class II or III furcation invasions

For max molar - we do root amputation

QUESTION: Hemisection, one wall remaining (interproximal wall) what's it called: hemiseptum

QUESTION: Elevator in oral surgery acts as what type of machine? Lever, wedge

QUESTION: Bony area between two premolars has no mesial, facial and lingual wall, what is it called? Hemiseptum

QUESTION: Class 3 furcation tooth already had RCT, best tx, ext not option? split and tx as two premolars

Healing (bone & wound):

QUESTION: Indication for periodontal/surgical dressing: Healing the tissue, Protect the wound

QUESTION: What is surgical dresses? Just protect wound, DOES NOT accelerate

QUESTION: After periodontal surgery, what type of healing is it most of the time? Repair

QUESTION: What do you want to see healing after perio surgery? PDL, bone, etc.

Restore/regen: PDL Bone Cement

Repair: Long junctional epi and CT.

QUESTION: What environment factor alters healing? Smoking

QUESTION: most common complication after extraction : dry socket.

QUESTION: What is pt more at risk of getting after ext (pt hx said she was a smoker)? dry socket

QUESTION: how do dry sockets develop? Blood clots not forming

QUESTION: Dry socket: Loss of healing blood clot

QUESTION: Dry socket: fibrinolysis of clot

QUESTION: Main symptom of alveolar osteitis – pain

QUESTION: Don't forget with dry socket = NO ANTIBIOTICS NEEDED! Just medical dressing.

QUESTION: Ways to tx dry socket except

a. curette walls to make socket bleed

b. no non-narcotic analgesic as needed

c. sedative dressingg

d. flush out debris w/ sterile solution

QUESTION: Most common negative outcome of routine TE: alveolar osteotitis, hemorrhage, infection

Fractures

QUESTION: most common trauma: avulsion, intrusion, lateral luxation, fracture

QUESTION : Mand fracture sign? Occlusal discrepency

QUESTION: Patient has a condylar fracture, what happens when mandible grows – asymmetric growth with damaged side lagging

QUESTION: Patient fractures one condyle, what is the expected growth? The fractured side will lag. The unaffected will continue growth.

QUESTION: What child has mandibular trauma, what do they have later? Midline asymmetry

QUESTION: most common trauma on children what happens to mandible? Asymmetry of face

QUESTION: what is primary consequence of trauma to jaw in kids (normal def of jaw, vs retarded

growth vs hypertrophic growth on one side, etc)

QUESTION: Fracture 1 condyle the other lags behind: Malocclusion

QUESTION: if kid had a problem with fractures in mand.. later they will have TMJ disfunction

QUESTION: most common area of fracture in children---symphysis, condyle, coronoid

QUESTION: Ankylosis of condyle most likely due to? Trauma? Fracture

The standard length of maxillomandibular fixation (MMF) is 4-6 weeks.

QUESTION: Paresthesis occurs most commonly in what type of mandibular fracture? Angle

QUESTION: Lower lip numbness is seen in what kind of mandibular fracture: Body or angle fracture

QUESTION: Le fort 1 fracture: maxillary sinus

QUESTION: Guerin sign is a feature of Le Fort 1/2/3? Guerin's sign: ecchymosis in the region of greater palatine vessels.

QUESTION: The LeFort I tx? brings the lower midface forward, from the level of the upper teeth, to just above the nostrils.

QUESTION: The LeFort III brings the entire midface forward, from the upper teeth to just above the cheekbones.

QUESTION: LeFort II: separation and mobility of the midface, Gagging on posterior teeth, Anterior open bite, Pathongnomonic sign is? Periorbital ecchymosis/hematoma, diplopia and /or subconjunctival hemorrhage , Infra-orbital nerve damage

<Notes>

Le Fort II - separation of the maxilla, attached nasal complex from the orbital and zygomatic fractures

Le Fort III - Nasoethmoidal complex, the zygomas, and the maxilla from the cranial base which results in craniofacial separation

QUESTION: Lefort II most common injured nerve: infraorbital

QUESTION: subconjuctival hemorrhage seen in what fracture? Lefort 1, nasal, frontal sinus, zygomaticomaxillary complex

QUESTION: A patient experiences numbness of the left upper lip, cheek, and the left side of the nose following a fracture of his midface. This symptom follows a fracture through the

A. nasal bone.

B. zygomatic arch.

C. maxillary sinus.

D. infraorbital rim.

QUESTION: What was the most common fracture in the face? Zygomcomplex fracture. Nasal bone fractures = 1st, zygomatic = 2nd (but first common midfacial fracture)

QUESTION: What age does the mandibular symphisis close: birth, 3, 6-9 months

QUESTION: Fracture of which part of the face would compromise pt respiration?

• *Fracture through the body of mand (bilateral)

• Fracture to condyle

• Fracture to angle of mand

QUESTION: if there is a fracture in the left body of the mandible where will the other fracture most likely be? Right Condyle

< Notes>

• Most COMMON = condyle (29%) 2nd most (angle of mandible 24.5%)

• LEAST COMMON: coronoid (1.3%) 2nd least (ramus of mandible 1.7%)

QUESTION: if hit on the right side of the jaw, what will get broken

• left condyle

• right condyle

• both

• right mandible

QUESTION: What xrays do you take to confirm horizontal fracture? 3 xrays moving horizontally, 3 xrays moving vertically,, ...

QUESTION: Horizontal fracture easily seen with – multiple vertical angulated xrays

QUESTION: Max sinus: waters

QUESTION: Which of the following images shows better the mid-facial fracture? Waters

QUESTION: Pano >>>> for mandible fracture

QUESTION: Reverse towne‟s>>>> for condyle fracture

QUESTION: Submentovertex>>>>for zygomatic fracture

QUESTION: What causes Trauma in the US? By auto-accidents!

QUESTION: Pan showing radiolucency going inferior over the body of mandible close to the angle. Informed the patient was involved in an accident. Identify the radiolucency a.pharyngeal airspace b.fracture c.artifact-retake radiograph

Frenectomy

QUESTION: Kid has a diastema b/w 8 and 9 at age 10, how do you treat?: wait till permanent canines have erupted, then do frenectomy

QUESTION: sequence to close diastema in a child with low labial frenum:

1)wait for the canines to erupt,

2)close the diastema with ortho and at the end

3)perform the frenum surgery

QUESTION: Which of the following explains why the Z-plasty technique used in modifying a labial frenum is considered to be superior to the diamond technique?

a. it is less traumatic

b. it is technically easier

c. it requires fewer sutures

d. it decreases the effects of scar contracture

e. it allows for closure by secondary intention

Orthognathic surgery

QUESTION: Most commonly used surgery for mand augmentation? - bilateral sagital osteotomy

QUESTION: How would you repair a Class II malocclusion?- BSSO (bilateral sagital split osteotomy)

QUESTION: Worst complication of BSSO: Damage to IAN BSSO = Bilateral sagittal split osteotomy

QUESTION: Biggest disadvantage of BSSO? paresthesia

QUESTION: BSSO indications: • Mandibular advancement or retraction

QUESTION: Correction of severe class II

• Maxillary Impaction and autorotation of the mandible

• BSSO

QUESTION: Patient wants to fix Class 3, what you going to do – lefort 1 with BSSO, lefort 1, BSSO, max palatal expansion with BSSO

QUESTION: Main disadvantage of BSSO – damage to the IA nerve

QUESTION: how long do you splint mandibular BSSO: You don't do MMF, as there is internal plate. Use an occlusal splint to help with occlusion but not wired shut. Keep splint on 4-6 week.

QUESTION: Most common surgery for maxilla: LeFort I

QUESTION: Which of the following is the MOST common postoperative problem associated with mandibular sagittal-split osteotomies?

a. infection

b. TMJ pain

c. Periodontal defects

d. Devitalization of teeth

e. Neurosensory disturbances

QUESTION: A patient has a skeletal deformity with a Class III malocclusion. This deformity is the result of a maxillary deficiency. The treatment-of -choice is

A. orthodontics.

B. surgical repositioning of the maxilla.

C. anterior maxillary osteotomy.

D. posterior maxillary osteotomy.

E.surgical repositioning of the mandible.

QUESTION: Distraction osteogensis: when to use over conventional: More stable movements

QUESTION: Advantage of distraction osteogenesis is that you can do bigger movements because muscles can react over time

QUESTION: complication following distraction osteogenesis: Long term follow up

< Notes>

DO = benefit of simultaneously increasing bone length and the volume of surrounding soft tissues. easier in children, shows less relapse. 2 surgical procedures, hospitalization time is less, more discomfort. Compliance of patient and parent is a difficulty in DO

Distractive osteogenesis is a surgical process used to reconstruct skeletal deformities and lengthen the long bones of the body.

BSSO = stable for normal/decreased facial height, high relapse in patient with high mandibular plane angle

An osteotomy is a surgical operation whereby a bone is cut to shorten, lengthen, or change its alignment

Orthodontics

QUESTION: Dolycocephalic – long narrow face

QUESTION: Which is correct: Growth of Mandible is both intramembranous and endocondral

QUESTION: Scammon Growth curve: Neural tissue grows until what age? 5

QUESTION: Which tissue show most growth in first 6 years and then plateaus? lymph, neural, genital

QUESTION: which is most fully developed at birth

e. muscle system

f. neural system **

g. gonadal system

QUESTION: Which grows faster, maxilla or mandible? Maxilla grows earlier and faster bc it is closer to brain

QUESTION: What is the best revealing issue for prediction about ossification? wrist hand radiograph

QUESTION: Majority of the tissues in FACE are derived from? A) ectoderm, b) mesoderm, c) ectoderm and mesoderm

QUESTION: Eruption sequence of peds? ABDCE

Order: Central-Central, Lateral-Lateral, 1M-1M, Canine-Canine, 2M-2M

QUESTION: Curve of spee and curve of Wilson? Sagital is curve of spee, frontal curve of Wilson

< Notes>

Sagital: curve of SPEEÆ Anterior-posterior

Frontal: corve of WilsonÆ Left and right

QUESTION: Overjet in permanent teeth should be ? 2-3mm

QUESTION: What do you do to camouflage class 2? you extract upper premolar

QUESTION: Based on Frank behavioral rating scale, what is the rate that indicates positive rapport with dentist? rating 4

QUESTION: Tell-show-do? most appropriate

Occlusion:

QUESTION: facial profile of class 2 malocclusion---convex, Class III is concave

QUESTION: MB max cusp in mandibular first molar: class 1

QUESTION: MB cusp in buccal groove: class I (in pic)

QUESTION: Little girls, ortho casts were taken, what class is she? – Class 1 (her 1st permanent molars were out, mesiobuccal cusp of upper 1st molars on buccal-lingual groove on lower 1st molars.

QUESTION: What occlusion when MB cusp of max 1st molar is distal to buccal groove of mand 1st molar- CLASS III

QUESTION: Diatalized occlusion w/ uprght cental anterior and deep bite: class II div II

QUESTION: Pt is in Mixed dentition and they are end on, what type of occlusion will this result in permanent dentition? Class I**, Class II, Class III

QUESTION: What's the difference btw primary class II and permanent class II? Shallow grooves, broad contacts

QUESTION: What ethnicity with most class 3? Asian

QUESTION: Class 3 is due to what? Max retrusin, mand protrusion

QUESTION: Most common type of occlusion in primary teeth: flush terminal plane

QUESTION: Most common malocclusion- ***CLASS 1***--

QUESTION: highest percentage of malocclusion in the US: class I, class II, class III?

QUESTION: What Percentage of population have class I normal occlusion? 30 %

QUESTION: What Class Occlusion gets most ant tooth fx?- Class II Div. 1

QUESTION: most common patients to have anterior tooth fractures : class II div I

QUESTION: Which class is susceptible to trauma? –as(class II division 1)

QUESTION: Most likely to cause fracture in children: class II division 1

QUESTION: in a cl III patient, which of the following is not helpful in establishing whether pt has retrognathic maxilla or prognathic mandible? photographs, study models, ceph analysis, clinical exam

QUESTION: A child who has a distal step in the primary dentition generally develops which of the following molar relationships in the permanent dentition?

A. Class I

B. Class II

C. Class III

QUESTION: What happens to the permanent molar occlusion in the presence of a flush (straight)

terminal plane and mandibular primate spaces?

A. Erupts end-to-end; early mesial shift into Class I occlusion

B. Erupts end-to-end; late mesial shift into Class I occlusion

C. Erupts with Class II tendency

D. Erupts with Class III tendency

QUESTION: primate spaces **MAX: between LATERAL and CANINE; MAND: between CANINE and 1st MOLAR

QUESTION: What is the purpose of primary teeth – space holder of permanent teeth

QUESTION: Premature loss of which tooth will cause mesial drift of permanent tooth – primary 2^{nd} molar

<Notes>

Leeway space = Sum of primary tooth widths is greater than sum of permenant successors. When primary teeth fall out, there is extra space to help relieve crowding. If nothing done, then first molars drift forward.

QUESTION: The space difference between primary canine, first & second molar and the succedaneous teeth: Leeway space

QUESTION: What will account for the anterior space for the perm. Mandibular incisors?

a. Either the flaring of the max incisors

b. Primate space!!

QUESTION: allow more space for eruption of secondary lower incisors? Allow them to protrude buccally,

QUESTION: Premature loss of which would lead to arch length deficiency? Primary canine

QUESTION: Class II is formed with distal step

QUESTION: Class I can be formed with edge to edge or mesial step

QUESTION: Primary teeth edge to edge molars...class 1 in perm. teeth w/ mesial shift of perm molar

QUESTION: What head gear would you use to correct a class III? Reverse pull headgear

QUESTION: Which headgear is used for pt who needs to bring maxilla towards protrusive? Reverse pull/facemask (protection headgear)

17….191-200 farhanarah@gmail.com

18 201-210Abhishingala143@gmail.com

211-220:

Pedo
QUESTION: Kid is 16kg* 4.4 mg/kg max amount of lidocaine? 70mg
QUESTION: 88 lbs (40kg) patient is given 2 cartridges 1.8 ml each of 2% lidocaine with 1:100,000
epinephrine. Approximate what % of maximum dosage allowed for this patient was administered ?
a. 10%
b. 20%
c. 40%
d. 60%
88lbs*2.2 kg/lb = 40 kg. 40kg*4.4mg/kg (max dose for lido) = 176mg = max dose for this patient
72mg injected/176mg = 40%
QUESTION: 50 lb patient given 5 carps of 2% lido with 1:100k epi, during procedure he convulses, why –
overdose of lidocaine, overdose of the epi, allergic
àLido: convulsions
à EPI: HTN
QUESTION: know the dosage of both anesthetics (4.4kg/ml) and epi(???) for child. This xxkg boy got
5 x 2% Lido with 100,000 epi, and 20 min later, started twitching his arms and legs and went unconscious. What's wrong? I did calculation for anesthetics, but he wasn't overdosed by anesthetics but might be by epi, so know the pediatric dosage of epi. If it's not overdosed, you can
pick other choice.
Choices were 1) this kid is overdosed with anesthetics. 2) by epi 3) some other answers I don't remember

QUESTION: Maximum recommended dosage of lidocaine HCl injected subcutaneously (not i/v) when
combined with 1:1,00,000 epinephrine is?
a. 100 mg
b. 300 mg
c. 500 mg
d. 1 gram[/QUOTE]
QUESTION: How do you treat lidocaine overdose? Diazepam
QUESTION: What slows metab of lidocaine?- **propanalol** (stays in system longer because propranolol
slows down heart à blood delivery to liver is slowed àmetabolism of lidocaine is sloweràstays in system longer)
QUESTION: How much epi for a cardio pt? 0.04mg
QUESTION: Max dose of epi for cardio pt----- 0.04mg, Two carps 1:100.000 (epi 1:50.000 max=1carp.; 1:200.000 max=4carps)
Max dose of epi for healthy pt---- 0.2 mg, Eight carps
QUESTION: Lidocaine-not metabolized in plasma
QUESTION: Lidocaine toxicity is due to - overdose - increased vasoconstrictor, due to preservative
(EPI)
QUESTION: which of the following anesthetic can be used as topical? benzocaine
QUESTION: Which pair of anesthetics is most likely to cause cross allergy? 1. Lidocaine and mepivocaine (answer)
QUESTION: What do you give IV for ventricular arrhythmia?
a. Quinidine
b. Lidocaine
QUESTION: Pt w/ muscular dystrophy condition: lower face with open bite
QUESTION: Low occlusal plane leads to what? decreased biting force, other options were tongue biting, excessive bite force
QUESTION: Cocaine overdose symptoms? pinpoint pupils, mydriasis
QUESTION: Which LA causes vasoconstriction? Cocaine
QUESTION: Cocaine -Intrinsic vasocontrictive activity
QUESTION: Pt is on rehab of cocaine. what you prescribe for pain? advil
QUESTION: Prilocaine given. Symptoms of methemoglobinemia (cyanosis, headache, confusion,
weakness, chest pain)- methemoglobinemia
QUESTION: Prilocaine causes methemoglobinemia (when given over 500mg)
QUESTION: Administer 600 mg of prilocaine. What possible result? **Methemoglobinemia**
QUESTION: 3.6ml of prilocaine contain how much anesthesia
a. 72mg
b. 80,
c.**144**
d. 36
QUESTION: Levonordefrin is added to certain cartridges containing mepivacaine: To increase vasoconstriction.
QUESTION: pt has heart problem? Mepivocaineà NO EPI

QUESTION: How many carps of 4% [X] anesthetic should be given if maximum amount that you want to
give is 600mg of drug? - approximately 8 carps (go over calculation)
QUESTION: The maximum allowable adult dose of mepivacaine is 300 mg. How many milliliters of 2%
mepivacaine should be injected to attain the maximal dosage in an adult patient?
a. 5
b. 10
c. 15
d. 20
e. 25
2% mepivicaine = 20mg/ml. 300mg/20 mg/ml = 15
QUESTION: calculation of 2% mepivacaine max amnt (*I think it's 5 cartridges for adults…and 3mg/lb in*
children
QUESTION: Maximum dose of mepivicaine? 400mg
Note: 400mg for prilocaine,300mg for lidocaine without epi,300mg for lidocaine with epi,90mg for
bupivacaine
QUESTION: Articaine(septocaine): metabolized in blood .**unique bc it is an Amide, but has an ester group, and is metabolized in the bloodstream
QUESTION: A recently-introduced local anesthetic agent is claimed by the manufacturer to be several
times as potent as procaine. The product is available in 0.05% buffered aqueous solution in 1.8 ml.
cartridge. The maximum amount recommended for dental anesthesia over a 4-hour period is 30 mg. This
amount is contained in approximately how many cartridges?
a. 1-9
b. 10-18
c. 19-27
d. 28-36 (approx 33 cartridges)1ml contain 0.05*10=0.5mg in one catridge 0.5*1.8mg
30/0.5*1.8=33
e. Greater than 36
QUESTION: anesthesia of facial nerve will cause all
• instant muscular dysfunction in half the face
• excessive salivation
• inability to smile
• inability to close eye
• corner of mouth will droop
QUESTION: Which drug is LEAST likely to result in an allergy reaction?
a. epinephrine
b. procaine
c. bisulfite
d. **lidocaine**

QUESTION: Pt taking MAO inhibitors what you CAN NOT give him: epinephrine, opioids
Local anesthetics containing EPI are contraindicated in patients taking MAO inhibitors.
QUESTION: what determines max. dose for anesthetic for a child? 1. Weight (answer)
QUESTION: What is the best indicator for success of intra-pulpal anesthesia? **backward pressure**,
QUESTION: Intrapulpal anesthesia does what – back pressure anesthesia stops hemorrhage, anesthesia
after 30 sec, patient doesn't feel it
QUESTION: What is a good indication success of intrapulpal anesthesia – feel the back pressure during
injection
QUESTION: Local anesthesia: PSA does not numb MB of M1
QUESTION: Which order will sensation disappear? 1. pain, 2.temp, 3.touch, 4.pressure
QUESTION: muscles elevating the jaw : masseter,temporal,medial pterigoid
QUESTION: Trismus includes what muscle: medial pterygoid
QUESTION: The dentist is performing a block of the maxillary division of the trigeminal nerve into which
Anatomical area must the local anesthetic solution be deposited or diffused?
a. pterygomandibular space
b. pterygopalatine space
c. retropharyngeal space
d. retrobulbar space
e. canine space

QUESTION: MS more or less anesthetic? Use Mepivicaine (no epi)
QUESTION: For a patient with multiple sclerosis
A. epinephrine is contraindicated in local anesthetic.
B. the amount of anesthetic needed for a given procedure is less than for a normal patient.
C. the amount of anesthetic needed for a given procedure is more than for a normal patient.
D. a single cartridge of anesthetic will most likely not last as long as it would for a normal patient.
Pre-Medication:
Premedicate these conditions à artificial heart valve, previous IE, congenital heart(valvular) defect, total joint replacement
Preventive antibiotics prior to a dental procedure are advised for patients with:
1. Artificial/prosthetic heart valves
2. a history of infective endocarditis
3. certain specific, serious congenital (present from birth) heart conditions, including
   - unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
   - a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure
   - any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device
4. a **cardiac transplant** that develops a problem in a heart valve.

Pre med with odontogenic infection:
• Amox for SBE prophylaxis
• Penicillin for odontogenic infections
• Tetracycline for periodontal infections
QUESTION: Condition that DOES NOT require antibiotic prophylaxis
- Prosthetic heart valve
- Rheumatic heart valve
- Congenital heart formations
- Cardiac pacemaker

QUESTION: Indication for antibiotic prophylaxis: Prosthetic valve
QUESTION: Need premedication for… prosthetic heart valve,
QUESTION: Prophylactic treatment for Prosthetic heart valves – premedication required
QUESTION: In what situation would a pt need to premedicate? prosthetic heart valve
QUESTION: What precaution you need to take for patient who has cardiac pacemaker?
a. antibiotic prophylaxis
b. avoid electrocautery
Ans B
QUESTION: premedication for child 44 lbs : 1 gram amoxicillin 1 hour prior Tx.
Amoxicillin: Clindamycin:
• Adults: 2g orally 1hr prior to appointment • Adults: 600mg orally 1hr prior to appointment
• Children: 5Omg/kg (not to exceed adult • Children: 20mg/kg orally 1hr prior to appointment
dose) orally 1hr prior to appointment
44 lbs = 20KgX 50mg/Kg= 1000mg = 1g Amoxicillin
QUESTION: Pt w/ MVP w/ regurgitation – don't premedicate
QUESTION: Antibiotic prophylaxis for mitrall valve prolapsed with regurgitation- NO
QUESTION: (Patient's medical tab say he is allergic to Amoxicillin), He needs to be premedicated, what
do you prescribe? – Clindomycin, 600mg 1hr before the dude shows up for the appointment.
QUESTION: If patient is allergic to ampicillin, then what antibiotic should be given? Clindamycin
QUESTION: one of them pt was taking penicillin everyday so I prescribed Clindamycin to avoid side
intxn
QUESTION: Man has accident and pin placed in arm. What antibiotic prophylaxis does he need?
A: None
QUESTION: Pt w/ total knee replacement but was taking Amoxicillin for a while; how do you premedicate? (give Clindamycin b/c bacteria are probably already resistant to amox by now)
QUESTION: Regular premedication case: Give amoxicillin 2g 1hr b4
QUESTION: prophylaxis antibiotic: Pt with heart transplant with valvulopathy.
QUESTION: definition of endocarditis : is an inflammation of the inner layer of the heart, the endocardium. It usually involves the heart valves (native or prosthetic valves)
QUESTION: Which of these procedures pose a risk for Infective Endocarditis?
• Primary teeth shedding
• RCT
• **Some sort of surgery ***
• IA injection

QUESTION: Guideline of antibiotic prophylaxis, especially for kids. ie 2g of amoxicillin, 600mg of
clindomycin. ***for kids Amox is 50mg/kg and Clinda is 20 mg/kg
QUESTION: Most bacteriostatic meds works by: Inhibiting protein synthesis
QUESTION: broad spectrum antibiotics : increase superinfection and resistance.
TETRACYCLINE ARE BROAD SPECTRUM
QUESTION: antibiotics least useful: LAP, NUG, **chronic periodontitis**
QUESTION: Why don't we use broad spectrum antibiotics? Produce resistant bugs

231-240 rulersam@06gmail.com

231- 240

1. Bacteriostatic antibiotics : inhibit protein synthesis
2. More usage of broad spectrum antibiotics leads to -
    a. decreased body resistance to the microbes and increases superinfections.

b. Leads to more bacterial mutations

c. Produce resistant species ex: MRSA

d.

3. Antibiotic metabolism ?

4. Doxycycline :

a. Act on 30s ribosomes,

b. 20mg = no antibacterial effects

c. 100 mg= antibacterial effect

d. it inhibits collagenase

5. You give antibiotics through IV, patient experience sudden allergic reaction, what's the FIRST thing you do? - Remove the IV line

6. Penicillin- Why is this so good to give as an antibiotic? Low toxicity , cheap.

a. Binds penicillin binding proteins;

b. blocks transpeptidase cross linking of bacterial cell wall;

c. activates autolysins in bacterias.

d. Not resistant to beta lactamase

e. Inhibits cell wall synthesis of the bacteria.(similar to cephalosporins)

f. Transpeptidase is inhibited by penicillins (similar to cephalosporins)

7. Ticarcillin (Thar) : Its main clinical use is as an injectable antibiotic for the treatment of Gram-negative bacteria, particularly Pseudomonas aeruginosa

(CIPROFLOXACIN is also effective against this pathogen). It is also one of the few antibiotics capable of treating Stenotrophomonas maltophilia infections.

8. Why do Penicillins have decreased effectiveness in abscess -hyaluronidase, pen unable to reach organism.

9. Cyst-why doesn't penicillin work well?–b/c can't penetrate cyst barrier

10. Penicillin V is phenoxymethylpenicillin. Pen VK is just its potassium salt. Penicllin V is less active than penicillin G (benzylpenicillin) against gram-negative bacteria, but penicillin V is more acid-stable than penicillin G, so it can be given orally. Penicillin G is typically given parenterally.

11. Allergic to penicillin : azithromycin 500mg, clarithromycin 500mg,

12. Antimalarial drugs : chloroquine, mefloquine, quinine

13. All are true except- Cephalosporin has a broader spec then Penecillins (cephalosporin is a beta lactam antibiotic, bactericidal, first generation more concentrated on gram positive organisms...more resistant to penicillinase...Xtina)

14. If a patient is allergic to Ampicillin, what else can you premedicate with? Clindamycin 600mg 1-hr before, Cephalexinn2000, Azithromycin 500, or Clarithromycin 500 (look at specific doses!) all 1-hr before.

15. Whats an adverse effect of a drug that you cant mix with amoxicillin? Methotrexate because it wont clear out of the system specifically with amoxicillin.

a. Penicillin antibiotics may decrease the ability of thekidneys to remove methotrexate from the body.

b. The levels of methotrexate in your body may increase and cause serious. possibly life-threatening, side effects.

16. Chlortetracycline- Broadest antibiotic effect

17. Tetracyclines :

b. Tetracycline- SUPERINFECTION

c. Tetracycline is bacteriostatic

d. tetracyclines are more concentrated in GCF more than in blood)

e. which one of the following drug is
chelated with calcium = tetracycline

18. What drug has cross allerginicity with Penicillin? Cephalosporin- both have Beta lactamase ring. If pt has allergic to penicllin then pt has allergy to cephalosporin , ampicillin.

19. Child comes in with an oral infection and is NOT allergic to Pen. What do you

a. Penicillin

b. Amoxicillin

c. Tetracyclin

20. Penicillin is ineffective when you give tetracycline why?

a. b/c it causes penicillin to be excreted in kidney (or renal reabsorption)

b. less penicillin absorbed in intestines

c. metabolized more rapidly

21. What happens when you have penicillin and decide to prescribe tetracycline with it?

a. Don't do it. The two mechanisms of action (CIDAL+STATIC) cancel each other out because when you need bacterial growth to actually use penicillin, but you don't have that growth when you prescribe Tetracycline. ANTAGONISTS

22. Penicillin and erythromycin taken together cause (cidal vs static)

•summation

•potentiation

•antagonists

23. If you have maxillary sinusitis...what antibiotic would you give: Amoxicillin with clav. Acid (the clav. Acid prevents the b-lactamase from breaking down)

24. What antibiotic used for endo? PEN VK (yes it actually say VK together)

25. Penicillinase resistant penicillins - D.COMN–Dicloxacillin, Cloxacillin, Meticillin, Nafcillin!!!!!

26. Antibiotics for ANUG - ?

27. antibiotic against only anaerobes ab parasites (protozoa):

METRONIDAZOLE

28. Metronidazole is contraindicated in patients on alcohol causing disulfiram type of reaction and has red urine

29. Clostridium dificile is treated with metronidazole. Unless pt is pregnant or breastfeeding, then use vancomycin

30. Antibiotic therapy for aggressive periodontitis

    a. Tetracycline

    b. Doxycycline

    c. Metronidazole

    d. Clindamycin

    e. Ciprofloxacin

    f. Amoxicillin-clavulanate

    g. Metro-amox

    h. Metro-cipro

31. Erythromycin:

    a. Erythromycin - bacteriostatic - inhibits protein synthesis

    b. side-effect of erythromycin is?- stomach upset.

32. Myasthenia gravis :

Antibiotics and Myasthenia Gravis

Antibiotics are one of several classes of medication that can impair

neuromuscular transmission and may increase weakness in patients with underlying junctional disorders [1]. Numerous case reports link antibiotic administration to causing neuromuscular weakness, though this occurs even in normal patients.

Low risk antibiotics in myasthenia gravis : ampicillin, clindamycin, sulphonamides, vancomycin, nitrofurantoin

High risk : -floxacins,(floroquinolones) -mycins (aminoglycosides)

33. Which antibiotic cannot inhibit cell wall synthesis?

- amoxicillin
- vancomycin
- azithromycin** (this inhibits protein synthesis)

34. Gentamycin- May cause auditory nerve deafness

35. Aminoglycosides : renal and ototoxicity

36. MRSA- What do you give for this? ○Vancomycin

37. Pseudomonas colitis: c.difficile and clindamycin

39. Minocycline :

Arestin® (minocycline hydrochloride) Microspheres is a subgingival sustained-release product containing the antibiotic minocycline hydrochloride incorporated into a bioresorbable polymer. Each unit-dose cartridge delivers minocycline hydrochloride equivalent to 1 mg of minocycline free base.

mechanism of action of Minocycline in the Arestin :
activity Minocycline, another tetracycline antibiotic, has also been shown to inhibit MMP activity.

40. Methotrexate MTX is an? . antimetabolite and drug.

tx of cancer, autoimmune diseases, ectopic pregnancy, and for the induction of abortions. inhibiting the metabolism of folic acid.

41. Methotrexate toxicity = leucovorin is indicated to diminish the toxicity and counteract the effect of inadvertently administered over-dosages of methotrexate.

42. Drug antagonist for folic acid metabolism : Sulfa, Trimethoprin, Methotrexate

43. Anti cancer drug (MECHLOETHAMINE) :that was an alkylating agent what was its affect: neurotoxic

44. Alkalizing anti-cancer drug called procarbazine causes :	Hepatotoxicity
When combined with ethanol, procarbazine may cause a disulfiram-like reaction in some patients. It also inhibits the liver's CYP450 microsomal system, which leads to an increased effect of barbiturates, phenothiazenes, and narcotics normally metabolized by the CYP450 enzymes. Has monamine oxidase inhibition properties (MAOI), and should not be taken with most antidepressants and certain migraine medications.	
Inhibits MAO in the gastrointestinal system thus can cause hypertensive crises if associated with the ingestion of tyramine-rich foods such as aged cheeses.	

45. Nonalkylating anti cancer med side effect - myelosuppression (?) BONE

MARROW SUPPRESSION

46. Race which most likely to get oropharyngeal cancer - BLACK

47. What disease is more predominate in males (hemophilia)

48. Incidence of oral cancer = 3% in males, 1.6%in females

49. How many people in the US get oral cancer: 30,000 SSC new cases annually

50. 1 risk factor for oral cancer Tobacco

51. QUESTION: What population has the worst survival rate for SCC? (whites, blacks, native Americans...)

52. QUESTION: Lowest 5 year oral cancer survival rate- black people

53. QUESTION: Radiation for cancer, which cell is more effected? Nerve, muscle, bone marrow

54. QUESTION: Mobile mass initially but is now sessile: indicative of malignancy

55. QUESTION: Discrete, non-tender, soft tissue swelling, what is it - malignancy, benign tumor, bone cancer

56. QUESTION: Which of the following is not a risk of oral cancer - alcohol, tobacco, HPV and HIV

57. QUESTION: What will cause xerostomia: chemo or radiation?

ANTIVIRALS:

1. know antivirals:

amantadine-influenza A

ribavirin-hep C and resp syncytial virus

oseltamivir and zanamivir-influenza A and b

acyclovir: herpes I, II, VZV,EBV

gancyclovir: CMV

AZT, Didanosine, Zalcitabine, Abacavir-HIV Ritonavir,saquinavir,nelfinavir,amprenair-HIV

2. QUESTION: Picture of lesion at corner of mouth, patient says it comes and goes now and then, what type of infection would you suspect? - Viral (other choices were Bacterial, etc)

3. Which one is an antiviral agent? ** AMANTIDINE

4. What antiviral is used for HSV, VZV,CMV : Valacyclovir

5. What virus causes postherpatic neuralgia: VZV

6. Acyclovir selective toxicity mechanism of action

7. how is Acyclovir selective toxicity mechanism of action?

    a. ○only phosphorylated in infected cells and inhibits viral mRNA

    b. does NOT work on DNA .

8. HIV patient with sinusitis due to what?murcomycosis

9. Most reliable measure of HIV progression? CD4 count, viral load

10. CD4 COUNT

    a. Normal - 500-1500

b. HIV- <200

11. Platelet count - 150,00 - 450,00

12. : Routine ok w/ 50,000 (emergency can be done w/ as little as 30,000 if work w/ hematologist and use excellent tissue management technique)

13. Least likely to get oral cancer?

a. Tobacco b. Alcohol c. HPV
d. HIV

14. Which of the following agents is used for HIV infection?

a. amantadine (Parkinson's)

b. acyclovir (Herpes)

c. zidovudine (also called AZT)

d. ribavirin (Hep C)

e. isoniazid (TB)

15. Give drugs and paired it with the disease. Choose the wrong pair o Retrovir with varicella zoster WRONG!!

Retrovir is for HIV- right

16. What oral manifestation is seen in children with HIV? A* Candidiasis #1

17. QUESTION: HIV pt with fungi infection systemic med- Fluconazole- diflucan

18. QUESTION: Fungal agent for HIV: Fluconazole or ketoconazole

19. QUESTION: Candisiiasis, and HIV what do you give: systemic or

topical?????? Nystatin AIDS PT likely to have candida

20. What test for every year? HepB TB

21. QUESTION: worker didn't get hep b vaccine because more concern about HIV? A. tell he its easier to get hep B must sign that they legally don't want

22. workers that are at least risk for HEP B : a) food servers b) down syndrome c) drugs addicts

23. QUESTION: Patient has HEB B antigens in surface. What state is patient? HBsAg -chronic?

-acute hepatitis contagious

-acute hepatitis not contagious

24. PATIENT tests POSITIVE HEP B ANTIBODY? All of his organs will be affect except.. (i dont know the answer)

1.Pancreas

2.Kidney

3.GI

4.thyroid

25. Hepatitis D through B

Top of Form

Bottom of Form

26. What are the hep b vaccine rules by OSHA?- all must always be offered and able to get the vaccine.

FUNGAL

1. Know which ones are systemic and which ones are topical

   •Mycelex, nystatin, ketoconazol,Nastatin rinse and Clotrinzol-troch are topical,

   •Systemic Ketoconazole, Amphoteracin B.

2. QUESTION: Easy question on Nyastatin: “swish & swallow”

3. QUESTION: Systemic antifungal: Fluconazole

4. Which systemic antifungal would u use? Nysastin, methazole *TOPICAL: Nystatin, Clotrimazole (dissolve and swallow) Amp B, Ketocanozole, Nystatin (Creams); SYSTEMIC: “FAK” Flucanazole, Amphotericin-B, Ketocanzole

5. Medication for angular chelitis: nystatin

6. Griseofulvin: used for athletes foot.

7. Anti fungal for oral candidiasis- no mycelex option Clotrimazole(Mycelex) and Nystatin are oral anti-fungals

8. action of clotrimazole: Alter the enzyme for synthesis of ergosterol, alters cell memb. Permeability

9. Azoles : inhibit lanosterol conversion to ergosterol.

10. Polyenes : bind to ergosterol on cell membrane and create a pore.

241-250Muskaankalra84@gmail.com

QUESTION: Difference between primary and secondary occlusal trauma? periodontal support/ healthy peridontium

Primary occlusal trauma occurs when greater than normal occlusal forces are placed on teeth

Secondary occlusal trauma occurs when normal occlusal forces are placed on teeth with compromised periodontal attachment

QUESTION: Healthy patient, probing shows bleeding, what could this be due to? – Gingivitis

QUESTION: Which is least likely to occur with occlusal trauma? gingivitis

QUESTION: Plaque index is used for what – patient motivation

I think the q is asking periodontal index, not plaque index: in that case, it should be disease acitivty

QUESTION: Gingival index/perio index. Know their flaws: Perio index flaws are that the gingival recession was not taken into account

QUESTION: Gingival index 1= mild, 2 = moderate, ordinal

QUESTION: What is Gingival Plaque Index? ordinal

a. Nominal like mild, moderate, severe

b. Ordinal include numbers: like furcation involvement 1,2,3

c. Interval like Celcius degree

d. Ratio e.g Kelvin degree, or BP measurement(can not be zero), length(can not be negative),weight

QUESTION: What is the CTI?- perio incidence index. ?????

QUESTION: CPITN: Community Periodontal Index of Treatment Needs

QUESTION: What is predominant in plaque 2 days after prophy: cocci and rods

QUESTION: bacterias present in gingivitis : gram + cocci and rods

gram + cocci and rods normally present, gingivitis transition includes Gram – rods and fillaments followed by spirochetal and motile organisms.

QUESTION: With the development of gingivitis, the sulcus becomes predominantly populated by

a. gram-positive organisms.

b. gram-negative organisms.

c. diplococcal organisms.

d. spirochetes.

QUESTION: Supra gingival calculus: main crystals are hydroxyl appetite 58%

QUESTION: Chronic periodontitis: has G – anaerobes

QUESTION: 2.04mm is bio width

Biologic width definition: junctional epithelium and connective tissue attachment to the tooth above the alveolar crest (at least 2mm)

measure bio width from what 2 point: base of sulcus to alv crest

How to determine attachemtn level? CEJ to depth of pocket

Attachment loss: loss of conective attachment. Apical migration of the JE away from the CEJ

Which of the following factor is most critical in determining the prognosis of periodontal disease? Mobility and attachment loss

which has the worst prognosis? deep probing with suppuration, class II furcation or class II

mobility. ***Deep probing with suppuration= Vertical fracture

Which teeth commonly relapse after perio tx? I put “maxillary molars due to furcation anatomy”

QUESTION: How to treat endo treated mand molar that has furcation: only answer that seemed logical was hemisection and place 2 crowns to act as 2 premolars. Root amputation is for maxillary teeth

QUESTION: If you have a through-and-through furcation involvement on a tooth, what do you do? –

Extract the tooth. (preferred treatment)

QUESTION: treatment of a class 2 that is nearly a class III

-convert class ii to a class i(GTR)

Furcation TX:

class 1: SRP , furcation plasty

class 2: furcation plasty , GTR , tunnel prep , RSR

class 3: tunnel prep , RSR , extraction

QUESTION: Furcation: Usually wide but cannot insert hand instrument

QUESTION: Root amputation of MB root – cut at furcation and smooth for patient to keep clean

QUESTION: Probing furcation from facial is best. Better access to facio mesial furcation from facial.

QUESTION: Best way to detect furcation – curve perio probe(naber probe),

The normal recall appointment between periodontal treatment → 3 months

Which ethnic group has the most periodontitis? Black male

use to remove interproximal plaque from a wide embrasure after perio surgery? interproximal brush

Best brushing technique: Sulcular (bass)

not useful for removing plaque?-water pick (removes debris, not plaque)

how much can reach in perio pocket: Brush (1mm) and floss (2-3mm)

SRP removes diseased cementum

Best way to prevent sensitivity of newly exposed root surface? Keep it free of plaque

After you do ScRP and flap surgery, how does new attachment form? long junctional epithelium - SECONDARY INTENTION

QUESTION: how do you treat gingivitis in puberty : debridement and OHI

QUESTION: What is not the initial treatment for gingivitis?- srp, OHI, corticosteroids

QUESTION: Common in school kids - Marginal gingivitis

QUESTION: Class 2 furcation, what is worst at keeping area clean? tooth brush, floss, waterpik, rubber stimulating tip

QUESTION: Ultrasonic: The type of the stroke, know the magnetostrictive and piezoelectric ultrasonics

Ultrasonic Instruments: active portion is the tip, 20-45k cycles/seconds

MagnetOstrictive: elliptical vibration pattern, all sides of tip are active (4 sides total)

PieZoelectric: linear vibration pattern, 2 sides are more active (sides are only active)

CONTRAINDICATED in patients with Pacemaker, communicable diseases, titanium implants (use plastic tip)

QUESTION: Which is true? Water and air from sonic kill bacteria

QUESTION: Which therapy in adding an Ab + debridement have minimal effect for: anug, Localized aggressive, chronic perio

QUESTION: Direction of root planning?—from base of pocket to CEJ

most benefits from SRP: more edematosous is the gingival will be more benefitial

SRP and they came back for maintenance but still 5-6 mm pocket. What to do? Open debridement (Perio surgery)

why check occlusion in perio abscess = edema can cause teeth to supra erupt **

QUESTION: What's the FIRST thing you do in maintenance appointment (recall)? – Update medical history (other choice were address patient's pain, prophy, etc)

QUESTION: What happens after the periodontal re-eval? the recall interval is set but may be changed if the patient's situation changes, should be less to motivate pt, more to motivate pt

QUESTION: Pt is on a periodontal recall system. What best denotes good long term prognosis:- BOP, Plaque, Deep pockets (BOP probable answer)

not do at the perio maintenance apt.?- S&P (scale and plane) pockets of 1-3mm

BOP most indicative → Inflammation

mature plaque: 24-48hrs

How many hours until plaque accumulation (after brushing or eating?): 1 hour

Localized perio: <30%

Generalized perio-- *>30%

*LAP: high ab response to infecting agents; disease on 1st M or I, with attachment loss on at least 2 teeth (one of which is a 1st M). Remmeber that chronic includes attachment loss on at least 3 teeth (other than M or I) and there is low ab response to infecting agents.

Where are the most teeth lost in local aggressive periodontitis? Max molars

QUESTION: What kind of bone loss in aggressive perio? Vertical.

QUESTION: Reason pts get aggressive perio- host cant fight off

QUESTION: classical sign of aggressive perio ---> (tooth mobility and deep pockets with lack of inflammation are initial signs of LAP)

QUESTION: Which of the following is not associated w/ Localized Aggressive Periodontitis?

local factors (i.e. inflammation, plaque, calculus) not consistent w/ bone loss*

QUESTION: What is not associated with LAP(Localized aggressive periodontitis): calculus

QUESTION: Initial tx for Localized aggressive periodontitis

f. Sc/RP

g. AB's

h. Sc/RP and AB's **

i. AB's for 1 week and then Sc/RP

Aggressive periodontitis localized: AA (Aggregatibacter actinomycetemcomitans and capnocytophaga), First molar & incisors

dominant serotype antibody is IgG2 (poor serum antibody response)

How do you treat localized aggressive periodontitis? – Sc/Rp and ABX - Tx: surgery, metronidazole with amoxicillin, tetracycline

Fusobacterium nucleatum—important bridging microorganism btw early and late colonizers of dental plaque (ele 'e conFUSO)

ANUG: Interproximal necrosis and cratered gingiva, no pockets!

tx(srp/rinse/if systemic ab metronidazole, if not systemic no ab needed)

Electron microscopic examination of the bacterial flora of necrotizing ulcerative

gingivitis indicates the presence of microorganisms within non-necrotic tissues in advance of other bacteria. The organisms involved are: fusiform, spirochetes (treponema denticola, *predom) and prevotella intermedia

Usually 15-35 years old, aka Vincent's infection and trench mouth, punched out papilla, fetid odor,

NUG/NUP: Normally, you don't give antibiotic. You only do debridement, rinse, and oral hygiene. But if the patient has a fever or systemic indications like HIV, give Metroniadozle.

Tx for NUG pt with no systemic involvement? Debridement, chlorhexidine and OH

QUESTION: Which of the following pdl disease causes rapid destruction of alveolar bone? 1. Periodontal abcess (answer), 2. ANUG, 3. Chronic periodontitis.

.

QUESTION: Acute ulcertaive gingivitis what could be indicated: host overreacting to infection. Bacteria is releasing deadly toxins (no toxin in acute periodontitis or is not main reason) and the answer was normal bacterial flora is what youd find in acute ulcerative gingivitis.

QUESTION: Least associated w/ perio disease? Hypophosphatism (related), acrodynia (related)

QUESTION: all associated w/ perio problems accept

a. stevens-johnson syndrome (target lesions, eye, mouth, skin)

b. pap-lefev syndrome (palmoplantar keratoderma with periodontitis)

c. down syndrome (related)

d. hypophosphatasia (bone disease similar to rickets, premature loss of primary teeth)

QUESTION: Least cause of bone loss around primary teeth? Hypophosphatsia, leukemia, plaque, one other one I didn't know, I put plaque

QUESTION: The depth of sulcus is 5mm, the distance between CEJ and the base of sulcus is 2mm.what is the attachment loss: 2mm

QUESTION: If recession is 2mm and probing is 1mm how much attachment loss? 3mm

pocket depth: marginal gingiva to depth of sulcus

CAL - CEJ to depth of sulcus

Recession → pocket depth + CAL

Hyperplasia → pocket depth - CAL

QUESTION: Best angle to place curette on root is 45-90 (repeat)

QUESTION: What edge of curette do u want to be in contact at line angle? (Apical) Lower ⅓ with tip

QUESTION: Subantimicrobial dose doxycycline (SDD, periostat) Periostat- twice daily 20 mg has doxycycline which works by inhibiting collegenase, inhibits MMP, no antibacterial effect reported at this dose

…Periochip is 2.5mg of chlorohexidine gluconate

Orange complex (FPC) = fusobacterium, prevotella, campylobacter j.)

Precedes red complex k. Plaque formation and maturation

red complex = P. gingivalis, Tannerella forsythia, treponema denticola i. BOP & deep pockets

QUESTION: •How does Listerine act?) Antiseptic mouthrinse is a broad-spectrum antimicrobial . The mechanism of action of Listerine involves bacterial cell wall destruction, bacterial enzymatic inhibition, and extraction of bacterial lipopolysaccharide

it disrupts adhesion of bacteria to plaque

is a phenolic compound

QUESTION: What type of agent is Listerine – charged or noncharged?? (according to

google…uncharged…Xtina)

QUESTION: What daily oral rinse would you give to a medically compromised child for plaque control?

(choices were CHX, Listerine, Nystatin, stannous fluoride, sodium fluoride)

QUESTION: What does sodium pyrophosphate do?

inorganic pyrophasphates in anti-tartar toothpaste: sodium pyrophosphate acts as a tartar control agent, serving to remove calcium and magnesium from saliva and thus preventing them from being deposited on teeth

QUESTION: The role of chlorohexidine is cause: Substantivity (anti-plaque): binds to cell wall cell membrane disruption/rupture fluid leaks out, cell lysis (CHX bursts membrames)

(broad spectrum against gram positive and negative bacteria and fungi – Positively charged)

QUESTION: Each of the following is a mode of action of an ultrasonic instrument EXCEPT one.

Which one is this EXCEPTION?

A. Lavage

B. Vibration

C. Cavitation

251-260 indhirmelo@gmail.com

QUESTION: Ultrasonic Instruments: active portion is the tip, it works 20-45k cycles/seconds
Ultrasonic instrument types:

- Magnetostrictive: elliptical vibration pattern, all sides of tip are active (4 sides total)
- Piezoelectric: linear vibration pattern, 2 sides are more active (sides are only active)

CONTRAINDICATED in patients with Pacemaker, communicable diseases, titanium implants (use plastic tip)

QUESTION: Which is true? Water and air from sonic kill bacteria

QUESTION: Why don't u use Acidulated Fluoridated Toothpaste?
Ruins Polish of Crown
http://worldental.org/oral-hygiene/5-mistakes-cosmetic-dentistry-maintenance/

QUESTION: Which type of fluoride not in toothpaste?
Acidic fluoride
(Sodium fluoride (NaF) is the most common source of fluoride, but stannous fluoride (SnF_2), olaflur (an organic salt of fluoride), and sodium monofluorophosphate (Na_2PO_3F) are also used)

QUESTION: Why you do perio before ortho:

b/c perio you have gingival and osseous changes

QUESTION: Old and young person w/ same perio. Which has better prog?

- Older (b/c younger pt had shorter time frame to get to the same condition so more aggressive in nature)

QUESTION: 2 Patients, one young, one old, both have better prognosis if they both had bone loss, periodontitis, etc? –old people have better prognosis

QUESTION: which tooth most likely to lose from periodontal disease? Max molars

QUESTION: Lots of questions on cerebral palsy (something about whether or not it is a developmental disorder) (2^{nd} after autism)

is neither genetic nor a disease, and it is also understood that the vast majority of cases are congenital, coming at or about the time of birth, and/or are diagnosed at a very young age rather than during adolescence or adulthood. It can be defined as a central motor dysfunction affecting

muscle tone, posture and movement resulting from a permanent, non-progressive defect or lesion of the immature brain.

QUESTION: CP patient - which is not true?

a. 95% have cognitive impairment

b. all bruxim

c. increase in periodontitis

https://www.nidcr.nih.gov/oralhealth/Topics/DevelopmentalDisabilities/PracticalOralCarePeopleCerebralPalsy.htm#12

QUESTION: Cerebral palsy – patient will have spastic oral mucosa during treatment

QUESTION: Pt has involuntary uncoordinated movements with larynx problem?
Cerebral palsy
QUESTION: Common finding in a patient with cerebral athetoid palsy.
Anterior Teeth fracture.
QUESTION: Best results from srp will be from a patient who has: edematous gingiva vs fibrotic gingiva vs loss of attachment[LV1]

QUESTION: Which of the following is NOT a sign of periodontal inflammation?
color, consistency, bop, and attachment
QUESTION: Which of the following causes bone loss?

a. C3a, C5a

b. Endotoxin

c. Interleukin

d. B glucorinidase

QUESTION: What cytokine responsible for osteoclasts?
IL-1, IL-8,IL-5, IL-3
QUESTION: Root surface tx with what agents?
Use citric acid, fibronectin and tetracyclin.
QUESTION: Which part of dental anatomy on a central collects the most plaque?

Facial surface, lingual surface, cingulum, mamelon, gingivopalatal groove

QUESTION: Reverse architecture- interproximal is lower than on facial and lingual

QUESTION: After periodontal surgery, the dentist leaves interproximal bone apical to radicular bone. What is this called: negative architecture.
QUESTION: What can make teeth green? Bacteria, gingival hemorrhage, medications or hyperbilirubinemia

QUESTION: What can make teeth orange? Bacteria
QUESTION: Green and orange stains on maxillary incisors can usually be attributed to

A. drugs.

B. diet.

C. poor oral hygiene.

D. fluoride consumption

QUESTION: What are proper ways to reinforce OHI: verbal and in the dental office

QUESTION: OHI should be? written and oral, Oral in office, written, video tape,

QUESTION: What is most difficult to maintain oral hygiene with home preventive care?

- pit and fissure
- proximal smooth surface
- facial smooth surface
- lingual smooth surface

QUESTION: Rapid tooth mobility is due to advanced periodontal or periapical pathology??
Advance periodontal (cause number 1 of tooth mobility)
QUESTION: Which of these is reversible with tooth movement?

- Tooth mobility *
- Bone resorption
- Crestal bone
- Gingival recession

QUESTION: Pregnancy gingivitis caused by?

hormones (progestrone) and P intermedia

QUESTION: Person who is pregnant,you should not give meds:

Tetracyclin, metronidazole, gentamicin and vancomycin

QUESTION: Puberty bacteria?

P-Intermedia

QUESTION: What's the #1 cause of med induced gingival hyperplasia?

dylantin-30% of all drug induced

QUESTION: What does NOT cause gingival hyperplasia?

a. phenytoin
b. cyclosporin
c. nifedipine
d. digoxin** (first three causes gingival hyperplasia)

QUESTION: wich drugs cause gingival hyperplasia?

Cyclosporine A, phenytoin, dilti, nifedipine all cause gingival hyperplasia

QUESTION: Know drugs that cause gingival hyperplasia: Cyclosporines, phenytoin, calcium channel blockers

QUESTION: Patient is on calcium blockers, picture show gingival hyperplasia, what do you do? – Tell them to see their doctor to switch meds

QUESTION: When pt is on imunosupessents for transplanted liver, what happends in the mouth?- CT overgrowth and hyperplasia. (Due to cyclosporine)

QUESTION: Picture of gingival hyperplasia on 14-year old girl –hormonal induced

QUESTION: Stress long term cause problem in periodontium bc it increases cortisone and cortisone and brings immune system down

Dentures:

1. Retentive clasp: engages undercut below height of contour
2. Reciprocal clasp: passively touches above the height of contour
3. if you don't have good indirect retention, it lifts off the soft tissue
4. SUPPORT (rigidity): Denture base, major connector, and rests
5. STABILITY: minor connector (lingual plates, guide planes, etc)
6. RETENTION: indirect and direct retainers

QUESTION: Purpose of Major Connector – Stability and Rigidity, Stability and Retention, Retention and Rigidity, Rigidity and Esthetics

QUESTION: Requirement of a major connector? Rigidity

QUESTION: Reciprocating arm of clasp? Stabilization

QUESTION: Reciprocating arm Counteracts the effects of direct retainer

QUESTION: What does the reciprocal clasp do? Indirect retainer

QUESTION: what does the reciprocal brace do? Counteract retentive clasp, stabalize the tooth, indirect retainer

QUESTION: Function of clasp arm? both stability (reciprocal arm) and retention

QUESTION: Reciprocal clasp is placed on or above the height of contour

(Reciprocation as applied to partial dentures refers to the function of the lingual clasp arm (which is the reciprocal clasp arm or stabilizing clasp orm) to counteract forces exerted by the buccal clasp arm (which is the retentive clasp arm).

QUESTION: Where does the retentive clasp engage on abutment:
passively on the suprabulge,

**Retentive clasp-- gingival third of the crown w/I the undercut (suprabulge)
**Reciprocal Clasp-- middle third of the crown

QUESTION: Retentive clasp is not base metal alloy

QUESTION: Where does the retenetive clasp engage on abutment: passively on the suprabulge?

It exerts a positive direction movement; sits on the height of contour and another was not touch the tooth at all (engage in undercut to resist removal of prosthesis and to help prevent dislodgement)

QUESTION: What is function of Rest? Support

QUESTION: What is the primary function of rest seats? To resist vertical tissue force (to provide vertical support for RPD)

QUESTION: Whats the purpouse of an indirect retainer?

prevent distal extention from lifting up

QUESTION: What is the purpose of an indirect retainer? It is located on the opposite side of the fulcrum line . assists direct retainer to prevent displacement of denture base in an offlucsal direction. Consists of one or more rests, their minor connectors, and proximal plates adjacent to edentulous areas. Should always be placed as far as possible from the distal extension base.

QUESTION: Function of minor connector? Stability

QUESTION: Main purpose of buccal flange of Mx denture?
A: Stability[LV2]
QUESTION: What does not have an effect on clasp flexibility? Undercut
- Metal, width, and length all have an effect on clasp flexibility

QUESTION: The peripheral seal is the most important part of the denture for proper retention

QUESTION: Primary stress bearing area in mandible: buccal shelf --
and incase the residual ridge is in good shape it also contributes to primary support.

QUESTION: Primary support for denture – max: ridge, 2nd-rugae

QUESTION: mand: buccal shelf, 2nd-anterior lingual border

QUESTION: Best indicator for success of denture is – Ridge

QUESTION: Definition of a combination clasp: cast reciprocal arm and a wrought wire retentive clasp

QUESTION: What connects major connector with rest seats- Minor connector

QUESTION: For bilateral distal extension - indirect retention because it is supported by tissue
QUESTION: How far do we extend a CD: Hamular notch

QUESTION: Post extension of post palatal seal is 2mm beyond vibrating line (fovea palatini)

QUESTION: What does dentist look at before placing palatal seal – vibrating line, throat configuration, tension of tissue throat form, tissue type and fovea location.

QUESTION: Purpose of placing posterior palatal seal: compensates for shrinkage
QUESTION: Excessive depth of the posterior palatal seal usually results in
A. unseating of the denture.
B. a tingling sensation.
C. greater retention.
D. increased gagging.

QUESTION: if the palatal vault is too deep : àvibrating line is more pronounced and forward

QUESTION: if the palatal vault is to deep : vibrating line is more pronounced and forward à The higher the vault, the more abrupt and forward is the vibrating line.

*From Dr. Nasr's lecture: In the class III variation (of palate forms), there is a high vault in the hard palate. Soft palate has an acute drop and a wide range of movement. The vibrating line is much more anterior and closer to the hard palate. This gives a narrow posterior palatal seal area.

QUESTION: Indication for removeing max tori: interferes w/ posterior palatal seal

QUESTION: major connector design for large inoperable palatal torus

a. horseshoe

QUESTION: Palatal tori removal....after surgery u splint because helps stop HEMATOMA

QUESTION: Mandibular tori in first premolar and canine
If you were to remove the tori would you have the patient sign an informed consent of lingual nerve injury
QUESTION: What does the facebow do? translates the relationship of the maxilla to the terminal hinge axis using a 3rd point of reference

QUESTION: Primary purpose of plaster index of occlusal surface of max denture before

removing the denture from the articulator and cast: Preserve face-bow transfer

QUESTION: lab and patient remount? Why are they done- establish and maintain VDO

QUESTION: Why is the WW clasp placed far away from its minor connector?

To have room to solder it on

QUESTION: Altered cast technique. The reason for doing this procedure..

"The altered cast method of impression making is most commonly used for the mandibular distal extension partially edentulous arch (Kennedy Class I and Class II arch forms). A common clinical finding in these situations is greater variation in tissue mobility and tissue distortion or displaceability, which requires some selective tissue placement to obtain the desired support from these tissues. This variability in tissue mobility is probably related to the pattern of mandibular residual ridge resorption. Altered cast impression methods are seldom used in the maxillary arch because of the nature of the masticatory mucosa and the amount of firm palatal tissue present to provide soft tissue support. These tissues seldom require placement to provide the required support. If excessive tissue mobility is present, it is often best managed by surgical resection, as this is a primary supporting area." Carr, Brown. McCracken's Removable Partial Prosthodontics, 12th Edition. Mosby, 062010.

QUESTION: SIBILANT allow maxillary incisors to nearly touch the mandibular incisors,

QUESTION: fricative sounds are made by allowing the maxillary incisors to nearly touch the slightly inverted lower lip.

QUESTION: What can't the patient not say if upper anterior are too superior and forward for denture teeth? F and V

QUESTION: Asked about what sound will determine VDO **S sound. This will bring teeth slightly together with 1-1.5 mm separation. This is the "closest speaking space"

QUESTION: putting tongue between mx and mnd incisors: th

QUESTION: Making F sound – teeth touches lip

QUESTION: Have large incisors, difficulty with F sounds

QUESTION: What can't the patient not say if upper anterior are too superior and forward for denture teeth? **Decks say that placing anterior teeth too far superior and anteriorly make it hard to say F and V!!!

QUESTION: Burning sensation lower denture? impingement of mental nerve

QUESTION: Which denture base is not light cured?? A really weird question. Never seen it before. And none of the answers were a 100%

a. Pressure formed

b. Injectable molding

c. Some other type of molding

d. Pour or fluid resin technique

(I don't know the ans)

QUESTION: Which of the following explains why mandibular molars should NOT be placed over the ascending area of the mandible?
A. The denture base ends where the ramus ascends.
B. The molars would interfere with the retromolar pad.
C. The teeth in this area would encroach on the tongue space.
D. The teeth in this area would interfere with the action of the masseter muscle.
E. The occlusal forces over the inclined ramus would dislodge the mandibular denture.

QUESTION: You give patient maxillary denture and they come back with generalized soreness under the denture. no sore spots or anything visible clinically, what's causing this? allergy, significant malocclusion(gross occlusal misalignment)

QUESTION: Soreness all along the ridges? Hyperocclusion

QUESTION: Pt has worn denture for 19 years, now he has a sore on Buccal with swelling what do you do: refer out, biopsy, cytology, Relieve denture in area and re-evaluate in 2 weeks

QUESTION: you tell patient who has dentures to take off at night - to hydrate denture in water (it should be to rest gum/bone?)

QUESTION: Patient is edentulous and has red upper palate - allergic to denture (it should be don't take it off when they go to bed)

QUESTION: When tx planning an RPD for a pt what is the first attachment placed on the serveyor?

Analyzing rpd

QUESTION: best way to evaluate available space for rests?

mounted casts

261-270niyatiaraval@gmail.com.

271-275 nbdetwo24@gmail.com

Page 276-280
Q: Graves Disease (Hyperthyroidism) A - exophthalmos

Q: Thyroid hormone decrease, which drug do you give? A: Levothyroxin (For hypothyroidism)

Q:Patient has high cholesterol, hypertension and diabetes, metabolic problem, what does he have?
A:Metabolic Problem

Q Basal Metabolic Index of 36 is what Syndrome? Overweight always going to pee-; high lipids high cholesterol; what syndrome?
A:Metabolic Syndrome

Q: What is the normal %fat intake per day? A: 30%

Q: What is the recommended daily dose of fat?
A:30% of total calorie and saturated fat is 10% of daily calorie intake

Patient Management & Ethics + Code of Conduct

Beneficence- “Do good”.
Patient Autonomy- “Self governance”.
Nonmaleficence- “Do no harm”. Dentists are to keep skills and knowledge up-to-date and practice within their limits in order to protect the pt from harm.
Justice- “Fairness”. Veracity- “Truthfulness”.

Q:Dentist tells patient amalgam is hazardous A – veracity

Q: Telling the patient that his/her amalgam need to be removed because they toxic or harm his/her health is violating?
A: Veracity

Q:What principle has to do with patient self-governance and privacy? A: Autonomy

Q:What Principle has to do with informed consent? A: Autonomy

Q: Informed consent?
A: Figure out if the patients is able to understand and sign?

Q:What you do first before choosing informed consent? A: Make sure patient can sign or has guardian

Q: 8 2 year old patient comes with younger person who hands dentist paper saying the pt has a legal guardian. Now what?
A:must have consent of this guardian before treating the 82 year old patient

Q:90 year old patient comes in with son who has a document mentioning the guardian of the patient-
A:Must have consent from them to treat the patient

Q: 16 year old could make the decisions for the elder pts if
A-If the elders are deaf and dumb
B- if the boy makes the payment
c-if the elders are over 60yrs
D- if the kid has the power of an attorney Ans:D

Q: True or false:
Consent- do not need to discuss the witness signature A: True

Q: When should patient signed informed consent forms for surgery? A:After there has been a discussion with the dentist about the surgery

Q:Inform consent must contain all except ? A: Cost of the treatment

Q:Treatment without informed consent is ? A:Battery

Q:Dentist keeping up with new data? A: – Non-maleficence

Q:Why we need to CE and know our limitation? A:Non-maleficence

Q:Why dentist needs to keep up to date with new technology and learn and practice new procedures?
A:Non-maleficence

Q:Dentist keeps on current dental medicine to provide current standard of care. What part of the ethical code does this relate to?
A: Non-maleficence

Q:Rapport best with ? A:Empathy

Q:What best characterizes ?
A: Understanding patients feeling and talking with patient

Q:Definition of rapport?
A: mutual openness / harmonious relationship

Q:A successful practice is built on?
A- Friendship COMMUNICATION? Good clinician-patient relationship

Q:Like if a child came with a history of aggressive behavior and is crying then should the dentist show empathy or sympathy or control
A: Control
Q: Definition of Empathy?

A: Patient wanted to give you paperwork and you acknowledge their concerns

Q:what is the best to communicate with patient A:- Empathy

Q: Empathy is not?
A:Shared personal experiences

Q:When should the dentist NOT use paraphrasing? A:When giving factual values

Note: Paraphrasing=repeating, in one's own words, what someone has said. This serves to confirm one's understanding, validate a patient's feelings, convey interest in the patient's experience (thereby building rapport), and highlight important points.

Q: Patient complains of pain in relation to a particular tooth.So the best answer/reply of the dentist would be:
1-If you came here earlier things would not be bad

2-If you took more care this would not have happened I will take care of everything A: 2

Q: While the dentist is preparing a large carious lesion in Tooth #30 for a restoration, a pulp exposure occurs. The patient angrily shouts at the dentist, "You incompetent 'creep'- -you're responsible for this problem!"- Of the following possible responses the dentist could make, which one is the most emphatic?

A. Calm down, I can still restore your tooth adequately.
B. Not when I'm preparing a tooth with caries like you had.
C. I can see that you're very upset. You thought the tooth could be restored and
now this problem has occurred.
D. If you took care of your mouth the way you should, I wouldn't have been close to the pulp.
E.I'm sorry this happened, but we must get on with the procedure.

A: C

Q:If the patient tell you why you fees are so high, what would be your response A:Fee is fine according to the geographic area,

Q: Patient says, “I’ve been brushing like you showed me but I still have cavities.” What do you do?
A:Ask him/her to show you how are they brushing

Q:The closest a dentist should get to their patient is? A: Tap their shoulder

Q: Reason to not have parent in room with dentist and kid ? A: Communication barrier between dentist and child

Q:Pt. says, “I do not have time to quit smoking.” What stage is s/he in?

A: Precontemplation

Notes:

Operant Conditioning:
o Positive reinforcement : u brush u get sticker
o Negative reinforcement: stop pain from toothache pt realizes he should brush) o Positive punishment =Aversive Conditioning: everytime u don’t brush u have to clean ur room
o Negative punishment= don’t brush no allowance
o Operant extinction= child cries don’t give attention

Definitions :

Positive reinforcement- Positive consequence that increases behavior
a. Negative reinforcement- Removal of negative consequence that increases behavior

c. Negative punishment- (aversive)- Removal of positive stimulus in order to decrease an undesirable behavior

d. Basically, know that reinforcement is more effective than punishment because in punishment, you have resentment, you avoid the punisher, and you are not taught positive behavior.

Systematic desensitization

- ● Relaxing strategy like diaphragmatic breathing
- ● Most important component of systematic desensitization is exposure to
- ● fearful stimulus
- Q: Most of the questions where of behavior modification techniques in children and " what would you say " questions
- Answers:
- 1-Autistic kid: Talk slow, no direct light, give concrete commands, extra focus on reducing anxiety
- 2-Down syndrome :Permissive
- 3- kid that kicks and screams: Voice control 4-Shy kid: involvement and small talk
- Q:During the child's first visit, the dentist requested that the parents wait in the reception room. The child cried moderately, but tearfully, throughout the dental examination and prophylaxis. The dentist "gave her permission" to cry while he/she worked and then took no notice of her crying. Her crying diminished in intensity over time and then stopped. With respect ONLY to the crying behavior, the dentist has)
- A. used positive reinforcement. B. used negative reinforcement. C. extinguished the behavior. D. ignored the problem.
- Ans: C
- Q: Pt with manic depression disorder not willing to get treated for that is now getting dental treatment from you. What do you see in this patient:
- A) bipolar
- b)depression c)excitement
- Ans: A
- Q:Def of Operant extinction?
- A: Removal of reinforcers to decrease a behavior

-
- Q:How to reduce Stress-dental anxiety?
-

A:Tell-show-do

Note:
Emancipated minor:
If she graduated from high school, has been married, has been pregnant, or responsible for his or her own welfare and is living independently of parental control and support.

Q:Which describes a stage in Piaget's model of cognitive development? A: preoperational.

Q: A behavior modification device(i.E thumb sucking deterrent) is an example of ? A: negative reinforcement

Q:Patient is given oral habit reducing appliance to prevent an oral habit, what is this considered? – Negative reinforcement (other choices were positive reinforcement, and some other behavioral modification stuff. My thinking was, the lil dude was probably not going to listen to anyone about his oral habits, so the appliance is used to modify his little addiction, so if the appliance is in the way he has no choice but give it up, thus the desired behavior will be increased in the future, fo sho!).

A:POSITIVE PUNISHMENT

281-290luckystar1030@gmail.com

Patient Management
ADA Code of Conduct & Ethics

Page 281-290

There are two or three questions which I was not able to find any answer for them. If you know the correct answer, feel free to make any necessary changes. Good luck

Rose A😊

QUESTION: If patient is afraid, because of

- Parents: no this cannot be the cause. False
- In order for this question to be true, the age must be specify
- Answer: question is not completed, or clear. I think the question might have asked why 3 years old child afraid of? Child up to 3 afraid to be separated from their parents.However, for 3 or over, the cause is unknown.
- QUESTION: If child is afraid?
- Answer: Allow the child to express her/his fears.
- QUESTION: child with fear is best treated with:
- Answer: Nitrous oxide.
- QUESTION: Desensitization works if the base of the behavior problem is:
- Answer: fear
- QUESTION: How do you treat a fearful child-
- Answer: use sedation
- QUESTION: Patient is scared because he has no control over the procedure what to do?
- Answer: let them feel comfortable and tell them to raise his hand during procedure if there is something bothering him. This will reduce their fear and anxiety.
- QUESTION: Dental anxiety can be caused by Pt"s helplessness. What would reduce it?
- Answer: Give them freedom and make them feel comfortable while they are in your office such as telling them to raise their hand if the feel pain or if they are uncomfortable or explain them how the procedure is going to be. You must always look at the answer choices. Patient feels that he lost the control so he is afraid by giving them this option they feel they are in control..
- QUESTION: A kid is on recall appointment and is not cooperative. You should do voice control followed by?

- Answer: voice control and alternating appraisal.
- QUESTION: Patient is very young and fearful first time you meet them :
- Answer: try to go down at their height. Make yourself understandable for them so they can trust you and feel comfortable. Explain for them about the procedure in their own language.
- QUESTION: Patient is very young and fearful first time you meet them
- Answer: try to talk to them going down at their height
- QUESTION: Patient is given an oral habit reducing appliance to prevent an oral habit, what is this considered?
- Answer: POSITIVE PUNISHMENT
- QUESTION: 6-year-old mentally retarded child. Treatment is recall. Would you give him? sedation, ant- anxiolytic, voice control?
- Answer: positive reinforcement.
- Side note:
- The following must be done when you are dealing with a disable person.
- 1)short and brief
- 2) explain things
- 3)tell-show-do
- 4) reward
- QUESTION: What is the best way to treat a developmentally disabled patient?
- **Answer: consistency will be edited.**
- QUESTION: Autistic kids have what characteristic?
- Answer: Repetitive behavior
- QUESTION: Autistic behavior?
- Answer: repetitive behavior and sensitive to loud noise.
- QUESTION: Disable patient comes in and not cooperative, how should you act?
- Answer: Permissiveness.
- QUESTION: patients with autism will usually show?
- Answer: heightened sense of lights and sounds
- QUESTION: Providing reward for desired behavior is :
- Answer: positive reinforcement.
- QUESTION: Eye contact, smiling, and telling patient doing good job:
- Answer: social reinforcement
- QUESTION: Praising, smiling and congratulating is what type?
- Answer: Social reinforcement

- QUESTION: Child patient – you smile, tell him good job, and pat him on the shoulder. These are examples of:
- Answer:social reinforcement.
- QUESTION: If kid complained and whined in the beginning but at the end were very good what would you do?
- Answer: compliment how well they were at the end of the procedure
- QUESTION: Voice control method used with children in which condition?
- Answer: Aversive conditioning
- Side note: this can be done to deter unwanted behavior. ex Hand over mouth
- QUESTION: What is the purpose of the voice control technique?
- Answer: It Sets boundaries during Aversive conditioning
-
-
- QUESTION: 8 years old patient is afraid, because of which of the following?
- Parents
- Peers
- Tv
- ANSWER: I think is UNKNOWN since the child is 8 years. This has nothing to do with parents.
- QUESTION: If a child is afraid:
- Answer: Allow the child to express fears.
- QUESTION: child with fear is best treated with:
- Answer: Nitrous oxide
- QUESTION: Desensitization works if the base of the behavior problem is
- Answer: Fear repeated again
- QUESTION: How do you treat a fearful child?
- Answer: let him watch another patient.
- Side note: this kind of questions have many answers. Always look at the options see what is good to choose.
- QUESTION: Dental anxiety can be caused by Pt"s helplessness. What would reduce it?
- Answer: Telling Pt to raise her/his hand when feels pain
- QUESTION: A kid is on recall appointment and is not cooperative. You should do voice control followed by?
- Answer: Alternating appraisal.

- QUESTION: Patient is very young and fearful first time you meet them –
- Answer: try to talk to them going down at their height.
- QUESTION: Patient is very young and fearful first time you meet them –
- Answer: try to talk to them going down at their height.
- QUESTION: Patient 2 years old and scared?
- Answer: Ask parent to position patient for you.
- QUESTION: The restraining of uncooperative 2 years' child should be done by:
- Answer: Parent
- QUESTION: The best technique for 2-year kid is?
- Answer: Knee to knee with head on dentist lap
-
- QUESTION: Patient comes in with 1 year old child, what technique would you use?
- Answer: parent and dentist are knee to knee, baby's head is in dentist's lap
-
- QUESTION: 8-year-old boy, when will he behave better?
- Answer: Nobody inside.
- QUESTION: pediatric fears correlated with age?
-
- Answer: True
- QUESTION: what is a 3-year-old most afraid of?
- Answer :1-3 years old: separation from parents.
- Side note: 4-6 years old: UNKNOWN
- QUESTION: Uncooperative 2 years old mostly afraid of?
- Answer: separation from parents.
- QUESTION: 4-5-year child scared of?
- Answer: unknown
- QUESTION: Boy 4 years old:
- Answer: Afraid of unknown.
- QUESTION: You help a child help to recognize what they are afraid of and make outward positive connection this is called:
- Answer: cognitive restructuring.
- Side note: cognitive restructuring is a psychotherapeutic process of learning to identify and dispute irrational or maladaptive thoughts,
- QUESTION: Modeling behavior is used when:
- Answer: when the kid is afraid and use a sibling or someone older to show how they should behave
- QUESTION: Patient had a flu shot done and she is afraid of dental needle even though, she never had one. What does this term called?
- Answer: generalization.
- QUESTION: A patient is going to a dentist and has never had local anesthetic. He recently got a vaccine and is now afraid of needles. The fear is due to what?

- Answer: Generalization
-
- QUESTION: When patient say I have anxiety to pain from needle… when flu needle fear is extended to dental needle fear means?
- Answer: general anxiety.
- QUESTION: How would you manage a 4-year-old in your office?
- Answer: Empathy and respect
- QUESTION: Management of moderately apprehensive child?
- Answer: Empathy and respect.
- QUESTION: Replacing words like LA with sleepy juice is called as?
- Answer: Euphemism (relabeling) I am Not sure.
- QUESTION: What is an example of classic condition?
- Answer: pain (as you see dentist, you assume pain is coming)
-
- What is an example of stimuli in classical conditioning:
- Answer: Dentist.
- QUESTION: What is an example of stimuli in classical conditioning:
- Answer: dental chair.
- QUESTION: What is conditioned stimulus in a patient with had a bad previous experiences:
- Answer: dental chair
- QUESTION: What is conditioned stimulus in a patient who had a bad previous experience:
- Answer: dentist.
- QUESTION: Conditioned stimulus?
- Answer: Dental chair
-
- QUESTION: Def of Operant extinction?
- Answer: removal of reinforces to decrease a behavior
- Side Note:
- Fear: results from anticipation of a threat arising from an external origin.
- Anxiety: results from anticipation of a threat arising from an unknown or unrecognized origin.
- Anxious patients: most difficult patients as they often cause the dentist to become anxious as well.

- QUESTION: Difference between fear and anxiety?
- Answer: fear is painful, anxiety is a disease.
- QUESTION: What do Freud and the other guy say about anxiety?
- **Answer: I put something about how it's a part of personality that must be controlled to be socially acceptable. Probably wrong I don't know, but will be edited.**
- QUESTION: Define anxiety according to Freud and K?
- Answer: aversive inner state that people seek to avoid or escape. I don't know
- QUESTION: What do Freud and Erikson say about anxiety? I put something about how it's a part of personality that must be controlled to be socially acceptable. Probably wrong.
- Answer: Their inability to overcome a conflict in a particular stage that will lead to anxiety. Inadequate resolution ->Anxiety
-
- Side Note:
- An inadequate resolution in this case would Indicate a child's insecurity and anxiety.
- An Adequate Resolution would mean that a child was able to overcome the conflict in each stage and develop properly.
- QUESTION: What is Freud anxiety concept in kids?
- Answer: Kid overcomes it. Will be edited
-
- QUESTION: Patient has dental fear, what is most likely due to?
- Answer: previous traumatic dental procedure.
- QUESTION: what would most cause a man to have anxiety:
- Answer: traumatic past experience.
- QUESTION: Patient has dental fear, what is most likely due to?
- Answer: previous traumatic dental procedure.
- QUESTION: constantly exposing patients to get from the fear factor is:
- Answer: desensitation.
- QUESTION: Impending doom is:
- Answer: panic attack
- QUESTION: Panic attacks usually produce a sense of unreality and:
- Answer: a fear of impending doom.
- QUESTION: What is maturity:
- Answer: Environmentally dependent.
- QUESTION: Pedo t 1st visit. Multiple carious teeth on anterior. During anesthesia is well cooperative and doesn't cry or move. Once begin tx, begins to cry. What do you do?
- Answer: Voice control

• ADA code of ethics and professional conduct:

- QUESTION: what is not included in the ADA code of ethics?

- Answer: Licensure by credential and Fees
- QUESTION: Each of these is covered in the ADA code of ethics except:, advertisement, patient values…
- QUESTION: Which one is not covered by ADA code of ethics?
- Answer: fees
- QUESTION: All of these are included under the code of conduct except:
- Answer: list of credentials needed to be a dentist and also fees
- QUESTION: What cannot be advertised by a general dentist?
- Answer: Specialty
- QUESTION: A dentist has an ethical obligation to report a colleague in all the situations ... except?
- Answer: advertising by other dentist on electronic media
- QUESTION: What do you not report to the ADA?
- Answer: Reporting an advertisement for a colleague.
- QUESTION: If there is an adverse reaction to a medication in the office, who do you notify?
-
- Answer: FDA
- QUESTION: Allergy to meds or dental instrument?
- Answer: report to FDA
- QUESTION: toxic reaction to a medication should be reported to:
- Answer: FDA
- QUESTION: Asked which statement was correct for HIPPA?
- Answer: Must give privacy form to pt but you don't need confirmation of receipt, fax and email standard, etc.
-
- QUESTION: Something about HIPAA.
- Answer: Something about a fax machine and who can pick up the phone and if a patient receipt counts as something….I don't know.
- This question is not understandable for me and if you have any idea, feel free to revise it
- QUESTION: Which example is not discussed in the HIPAA ethical privacy manual??: Something about providing privacy information to patient and document, sending information over email and fax, idk
- I did not understand this question if you have any idea feel free to revise it
- QUESTION: If you need a medical record from your patient's physician, your patient

needs to give you a permission to do that. Based on which principal/policy?

- Answer: HIPAA
- I picked Medicaid/medicare bc the choices were CDC, OSHA, bloodborne, some random nonsense. There wasn't HIPAA
- QUESTION: Where does the government spend all its dental money?
- **Answer: Medicaid**.
- QUESTION: which insurance have dental coverage?
- Answer: Medicaid (poor people!!).
- QUESTION: What sector of government provides funding for dental care?
- Answer: Medicaid
- QUESTION: Who pays Medicaid:
- Answer: States and the federal government.
- QUESTION: Who pays for Medicare:
- Answer: federal program
- Side note: Federal program that pays for covered health services for most people 65 years old and older and for most permanently disabled individuals under the age of 65.
- QUESTION: Government spends most of the money in:
- Answer: Medicare.
- QUESTION: Medicare cover dental routine care?
- Answer: NO
- QUESTION: Medicare is:
- A federal thing that provide health care for elderly
- It does not cover dental routine.

Answer: Both statements are true
QUESTION: Most aid for health in poor people:

Answer: Medicaid

Pt pays for service fee/insurance pays the rest:

- Insurance pays a flat fee/patient pays the rest – co payment
- Provider is payed per patient not per procedure – capitation
- HMO – limited to selection
- PPO – allows patient selection

Answer: All of the above are correct and they explain different types of health insurance. So, memorize them to the best of your ability.
QUESTION: Most of the dental payments are?

Answer: cash for service-67%. Or out of pocket.

QUESTION: Most dental procedures for the elderly dental procedures are paid by:
Answer: Out of pocket cash
QUESTION: which of the following is the leading payer for dental treatment, Insurance or self-pay?

Answer: self-pay or out of pocket. Either one in correct. Just look at the options.

QUESTION: Who pay for most of dental care?

Answer: cash (should be this one)

QUESTION: Majority of health service in USA:
Answer: private insurance.
QUESTION: Who pays most of dental treatment?
67% patient 33 % third party's private insurance.
Side note: Some sources says 57% by the patient and the rest is paid by insurance.
QUESTION: Patient makes $23,000/year, 73yo woman, how should she receive dental care?

Answer: Private insurance.

QUESTION: A 65 years old lady living on 40k pension per year, wants to get a treatment. She does not have any other physical abnormality besides tooth pain in her molars. From where does the money covered for her treatment come from?

Answer: Private Insurance - private dental IF she has it

QUESTION: What is the name of the federal funded medical care for the elderly and its coverage? Answer: Medicare w/o dental coverage

QUESTION: insurance question about adverse selection (adverse selection deals with the idea that those at higher risk are more likely to buy an insurance policy. If the price for the policy is the same for nonsmokers and smokers, it is more likely that smokers will buy the insurance, because it is more "worth it" to them—because they are at higher risk for disease. This is adverse to the insurer. So the prices need to be different.

A. only take patients with high risk this might be the answer. Check with others.

B. only take patients with low risk

C. take both

D. something about taking pt of all ages

I DON'T KNOW WHAT THIS IS. IF YOU KNOW THE ANSWER, GO AHEAD AND REVISE IT.

QUESTION: Health care plan adverse beneficiary risk?
Answer: high risk-individuals that present a high risk for insurance
-low risk
-equal
QUESTION: Know about capitation:

Answer: Dentist is paid a fixed fee to see patients enrolled in program

QUESTION: Capitation is follow by what health insurance?

Answer: HMO

QUESTION: HMO is:

Answer: capitation dental plan

QUESTION: HMO's definition:

Answer: dentists are paid a fixed rate for each individual per month. Dentist is paid regardless patient was seen or not. If value of services exceeds payments, dentists' loss. If payment exceeds value of services, dentists gain.

QUESTION: You work at a HMO office and the patient has used up all his yearly benefits, what can you do?

Answer: still accept the same fee under the HMO.so, Charge the same fee.

QUESTION: Your office is fee schedule and patient needs new crown but patient used up all of her allowance (or something like that) now, what do you do?

Caharge same fee

QUESTION: Which one is related to employee insurance, where you get a discount from the insurance and also you can go to a dentist of your preference?

Answer: PPO. You can choose where to go.

QUESTION: Insurance allows patients to only see certain set of providers what is it?
Answer: Closed panel
QUESTION: Which one is related to a dental insurance, that only allows you to go to a group of dentists at a specific location?

Answer: Closed Panel.

QUESTION: Company offers dental insurance to its employees that can go to selected dentist, what is this example of?

Answer: Closed plane.

QUESTION: On a prepayment basis, dental patients receive care at specified facilities from a limited number of dentists. This practice plan is classified as which of the following?
Answer: Closed Panel.
QUESTION: DR is a self-funded group dental plan in which the employee is reimbursed based on a percentage of dollars spent for dental care provided, and which allows employees to seek treatment from the dentist of their choice.
Answer: If Direct Reimbursement is there Pick It.

QUESTION: If you are an employer and you provide your employee with reimbursements for dental care they received from a dentist of their choice it is called:
Answer: direct reimbursement.

QUESTION: patient goes to the dentist and needs to pay something before seen:

Answer: copayment

QUESTION: If patient agrees to pay certain percentage of treatment plan:

Answer: copayment.

Learn ALL these terms

Unbundling of procedures as "the separating of a dental procedure into component parts with each part having a charge so that the cumulative charge of the components is greater than the total charge to patients who are not beneficiaries of a dental benefit plan for the same procedure."

Bundling is the exact opposite of unbundling and can occur on the insurance carrier end. Bundling is defined by the ADA as "the systematic combining of distinct dental procedures by third-party payers that results in a reduced benefit for the patient/beneficiary."

Up coding or over coding is defined by the ADA as "reporting a more complex and/or higher cost procedure than was actually performed."

Down coding is defined by the ADA as "a practice of third-party payers in which the benefit code has been changed to a less complex and/or lower cost procedure than was reported except where delineated in contract agreements.

QUESTION: dentist didn't ask for copayment and he didn't report to insurance?
Answer: overbilling

QUESTION: If a dentist waives the copayment and doesn't tell the third party, what is this called? Answer: Overbilling.

QUESTION: You let patient not pay copay but you tell insurance that you charged the patient: Answer: overbilling

QUESTION: Dentist charge for crown $500. insurance only covers $400.Dentist waves copayment($100) but still let insurance he charges $500 for crown. what this action called?

Answer: Overbilling

QUESTION: The dentist charges separately for core build up and the crown but the insurance company says that the core build up is part of crown. what is this called?

Answer: bundling

Bundling definition:

Answer: Many procedure to a crown they only pay u for one

QUESTION: Dentist do the treatment for 2 crowns but the insurance company pay the money for one crown what is it:
Answer: down coding
QUESTION: You performed a two-surface restoration and coded it that way. Insurance came back with coding it as only one surface restoration. What is this called?
Answer: down coding
QUESTION: When you charge for multiple codes when you actually did one thing
Answer: unbundle

QUESTION: Doctor billed insurance couple of procedures, when actually there is a global procedure that combines them all, what did he commit?

Answer: unbundling to make more money. You don't want to be that kind of Dr. 😊

QUESTION: One big procedure, but if you divide it to many sub procedures is called?

Answer: unbundling

QUESTION: bundling of procedures is:
Answer: The systematic combining of distinct dental procedure codes by third-party payers that results in reduced benefit for the patient/beneficiary.
QUESTION: What is it called when a patient charges several procedures instead of on
Answer: unbundling

QUESTION: Pt asks u to change date of service on insurance claim, what is this called?

Answer: Fraud

291-301 djagaryan.inessa@gmail.com

QUESTION: Most injury/percutaneous cuts happen when

ans-recapping needles

QUESTION: What test for every year? HepB TB……
according to osha HB-we don't do annually
Tb-specific requirement??
In link the list of screening standarts

https://www.osha.gov/Publications/osha3162.pdf
QUESTION: if a pt presents with a problem reflected in the mouth , how the dentist recognize the problem : anorexia, bulimia etc…
Ans-bullemia

QUESTION: Patient is in your office for a treatment plan, all of the following should be done when you explain the proposed treatment to the patient,Except?
the risk of not getting a procedure done,
the fee of the procedure
ans- Use professional terminology
QUESTION: New patient comes into office, not of record, what do you do 1st visit?
Full exam, record probing, med history, impressions.
QUESTION: First step before/in treatment planning:
ans-make sure patient doesn't need translator, consult
with physician about pre-existing medical conditions
QUESTION: Patient is ready to hear your treatment plan, all of the following are true except? –
ans-Guaranteethe success of treatment!
QUESTION: First step in tx planning is?-
ans-treat the initial pain and discomfort of the pt.
see how you can make a preventitive plan,
treat all restorations.
QUESTION: Proper order for treatment planning –
ans-emergency care, disease control,
reevaluation, definitive treatment, maintenance care
QUESTION: Which are the two most imp. steps for diagnosis:
ans-History and clinical examination
QUESTION: Best way to determine outcome of disease?
Med history of the patient (If the lab test was choose may be that)
ESR lab results
ans-BOTH
QUESTION: pt comes in saying she's been to 5 different dentists the last 6 months. A few mins later she's telling you how great of a dentist you are and that she'll refer all of her friends to you. This example is
.schizo,
narcissistic,
ans-paranoid.
QUESTION: a patient have been visiting several dentist in the past, the first time she see you she tells you that she likes you and she will refer family and friends to your office, what type of attitude is she showing ? borderline
QUESTION: Patient with bipolar disease comes in for dental care, choses not to take his medication and states he is in the "manic phase," what do you expect from treating this patient?: he will have
ans-unpredictable reactions during the treatment,
QUESTION: Trying to change person what is most importation :
ans-trying to determine whether they are willing to change

QUESTION: Patient who has medical history but is not debilitating but will require medical management and dental modifications – ASA 3
QUESTION: ASA2- mild systemic disease, ASA3-severe systemic disease
QUESTION: You have a test that is not accurate but gives consistent result:
ans-reliable
QUESTION: Which of the following are necessary for a test to be accurate:
Specificity,
reliability,
ans-validity
QUESTION: Something about nonverbal vs verbal communication –
nonverbal is not as reliable
Ans-non-verbal is more reliable
QUESTION: What happened in 1997: SCHIP (state insureane health program)
QUESTION: SCHIP: The State Children's Health Insurance Program provides matching funds to states for health insurance to families with children. cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.
QUESTION: Who is protected under Americans with disabilities act?

Ans-AIDS pt. and accommodate the handicapped.

QUESTION: Dentists have to have proper accommodations for disable people. Dentists have to treatHIV people the same as others.

Ans-Both statements are true

QUESTION: American disabilities act does not include HIV:Ans-False

QUESTION: Disinfecting spray

Ans-let it sit for 10 minutes and then wipe

Notes: Following the manufacturers' instructions is important to ensure that the product works correctly.6 T he greater the number of pathogens, the more time is needed for complete destruction.4 Cleaning surfaces before disinfection will help in this process.4 However, some products are available for the dental office that work much faster—within minutes. OSAP advises that the "areas should be cleaned and then saturated with enough disinfectant to remain for the required contact time without evaporation .

QUESTION: One patient left, and before getting another patient, how would you clean your operatory?

=disinfect every 10 min

Ans-Gross cleaning, spray disinfectant for 10min, then wipe off

QUESTION: Disinfectants- kills mycobacterium (benchmark organism)

QUESTION: Disinfection? Destroy majority of microorganisms but not bacterial spores. They use on Innanimate objects

QUESTION: benchmark organism for sterilization- Bacterial spores

QUESTION: Definition of disinfectants – Innanimate objects non living

QUESTION: Asepsis – antiseptic...can be safely applied to tissues, but will kill most living organisms

QUESTION: Denaturation of the proteins - alcohol and autoclave; Coagulation of proteins – dry

QUESTION: Dry heat, chemical sterilization , know about them. Autoclave,

what are the exact numbers

Ans- Steam Autoclave-120 ce, 20 min, 15 Psi

132C,8min,30 psi

Dry heat- 160C 120 min

170C-60min

Chemical vapor-132C,30psi 20 min

Cold -glutaraldehide2% for 10 hours

QUESTION: Which method of sterilization needs higher temperature:

steam

ans-dry heat-320F

oxide pressure

QUESTION: OSHA

• Hep B vaccinated

• if employee does not want it need proof that they didn't get it

QUESTION: What are the hep b vaccine rules by OSHA?- all must always be offered and able to

get the

shit

QUESTION: OSHA is for inside the office to see how you handle stuff in the office. EPA is for the

outside.s OSHA IS NOT FOR BOTH INSIDE AND OUTSIDE

EPA is for transferring IN/OUT of the office

QUESTION: Whats not found on the OSHA poster?-

Ans- How many days each employee is allowed to workwith that chemicals.

QUESTION: Which one applies to OSHA guideline? Ans-Update it once a year!

QUESTION: What does OSHA mandate in regards to hep b?

• employers must take the vaccine

• employees have to take vaccine that are in contact with pt -ans

• Front office employees must take the vaccine

QUESTION: OSHA does all except: material safety data sheet MSDS (by manufacture)

QUESTION: Hazard Communication Standard:

Created by OSHA to make sure employees know about hazardous/toxic materials

QUESTION: HAZARD COMMUNICATION LAW:

a)OSHA

b) what does it control,all except:

sharps

blood

ans-amalgam

QUESTION: Hazardous communication regulation

a. train worker right after you hire (T/F)-T

b. train worker when new hazardous product in office (T/F)-T

QUESTION: MSDS-who is responsible to make it-manufacture

QUESTION: Which is NOT a reason for dentist becoming addicted:

Ans-feeling vulnerable

.easy access to and knowledge of drugs,

. feel the pressure to be perfect

.high stress

•What is t test? –

T test-used to compare whether the means of two groups are statistically different—assume

that standard deviation is unknown. Small sample size

•Z test—to see if the means of two groups are statistically different if the variances like standard deviation are known. Large sample size.

Questions about STUDIES!!!!

Case-control Study that compares people that have the disease to people that do not have the disease. And also looks back to see how the risk for the disease is compared to actually getting that disease.

•Cohort study—study where there is more than one sample/cohort, and evaluations are done to see how certain risk factors the groups have are related to developing a certain disease.

Cohort (prospective) studies - look forward from exposure to disease development

•Cross sectional study—study the entire population. Not like case control, that only studies a certain

group with a specific characteristic. Studies a population with certain characteristics.

- Cross-sectional (epidemiological) studies - all variables measures simultaneously at one point in time

Example – It was observed that there was less caries in certain geographic areas. Higher fluoride

in water supplies was suspected as the probable cause

•Longitudinal study—studies a certain set of people (same people) over a long period of time.

Longitudinal Studies - Hypothesis Testing Observational Studies

Example – Hypothesis testing observational studies supported the explanation of increased

fluoride levels causing a reduced rate of caries

Clinical Trial - Use randomization and blinding to compare effects of treatment with non-treatment. This is the Gold Standard for establishing cause and effect Hypothesis Generating Observational Studies

- Descriptive studies - time, place, person
- Ecologic studies - use groups rather than individuals

• Correlation studies - measure linear relationship between two factors within defined groups, no cause and effect established

- Clinical trials: Trials to evaluate the effectiveness and safety of medications or medical devices by monitoring their effects on large groups of people.

Clinical research trials may be conducted by government health agencies such as NIH, researchers affiliated with a hospital or university medical program, independent researchers, or private industry.

Typically, government agencies approve or disapprove new treatments based on clinical trial results.

While important and highly effective in preventing obviously harmful treatments from coming to market,clinical research trials are not always perfect in discovering all side effects, particularly effects associated with long-term use and interactions between experimental drugs and other medications.

There are four possible outcomes from a clinical trial:

- Positive trial -- The clinical trial shows that the new treatment has a large beneficial effect and is superior to standard treatment.
- Negative clinical trial: A clinical trial that shows that a new treatment is inferior to standard treatment.
- Inconclusive clinical trial: A clinical trial that shows that a new treatment is neither clearly superior nor clearly inferior to standard
- Non-inferiority clinical trial: A clinical trial that shows that a new treatment is equivalent to standard treatment. Also called a non-inferior trial.

Question:what is progressive relaxation

a. intermittent relax & tense -ans

b. something about visualized images or something.

QUESTION: Where would you look in a scientific journal to find the dependent and independent variables

Intro

Materials

Methods -ans

Conclusion

Summary

QUESTION: where in article you find a summary -ans ABSTRACT

QUESTION: What section states the purpose of the research?(ABSTRACT)

QUESTION: What are the qualities of a double blind study except? ans- EXCEPT 2 control groups.

QUESTION: Researcher wants to find incidence of oral cancer in nursing home what study

a. Cross-sectional

QUESTION: I had one about a teacher and doing a survey on kids = cross sectional

QUESTION: Research done to determine caries rate at a nursing home. What kind of study is this?

A: Cross-sectional

QUESTION: which type of study determines relative risk ratio: Cohort

QUESTION: What parameter study lets you have a risk quotient?- Cohort

QUESTION: Case control study = odds ratio

QUESTION: Efficacy, what study would u go?

Cohort,

longitudinal,

multiple short ones,

CASE CONTROL????given answer

Should it be Clinical trial???

QUESTION: Cohort: studying for the next 10 years

QUESTION: Study among smokers and nonsmokers in a period of 6 years (2000-2006) to develop disease?

Ans- Cohort,

NOTES: By: disease/non-disease: case control

Risk factor-cohort

QUESTION: study how do you find causation- ans-analytical (cross-sectional, case-control, cohort)

QUESTION: Myastenia Gravis patients are involved in a study. The doctor is conducting a study and is trying to find out how many of these patients has periodontitis. What study is he conducting?

-Cohort

-Study case

-Cross sectional?-ans

QUESTION: The problem with this study is that you don't know if the disease came from drinking or

not. What study is it?

By: drinking/nondrinking

Followed a group for 6 years -cohort

Gave patients survey about their treatment - cross sectional

QUESTION: Dentist is doing research on 5 unrelated patient with different background. He record data

...etc. Dentist is doing what kind of research?

a. clinical trial-ans

b. cohort

c. sectional

QUESTION: Study group A and B give some agents for plaque control then compare which agent is more effective. Which study is that? Clinical trial

QUESTION:A study is done to determine the affectiveness of a new antihistamine .To do this ,25 allergic pt"s are assigned to one of the two groups ,the new drug (13 pt"s) , placebo (12 pt"s) . The

pt"s are followed for 6 months . This study is called:

clinical trial (assigned or give is the clue)

QUESTION: A study is designed to determine the relationship between emotional stress and ulcers.

To do this, the researchers used hospital records of pt's diagnosed with peptic ulcer disease and pt.

diagnosed with other disorders over the period of time from july 1988 to july 1998 . The amount of

emotional stress each pt. is exposed to was determined from these records. This study is:

- Cohort B)Cross-sectional C)Case-study D)Historical Cohort E)Clinical Trial
- Ans-C

QUESTION: There are 4 people with a disease and guy wants to report/describe them: I said ti was

Ans-case report ??

QUESTION: Analyze statistical difference between two means? T-test

QUESTION: Means of caries risk assessment for 3 groups: white, black, Hispanic what test do u use to

compare? A) chi square b) variance c)ANOVA d) T-test

I think its-c

QUESTION: How do you compare between 2 constant variables?ans- Regression analysis-???

QUESTION: 2 groups of 100 ppl, gave them different foods & asked how they felt afterwards;

which

test to compare the 2 groups answers - chi squared test

QUESTION: Want to compare 2 groups of people, male and female for something, what test do you

look at? Multiple regression, Chi square Test, -

ans-Chi square

QUESTION: Chi test used for-two common variables

QUESTION: What test measures 2 nonparametric data: Chi-square

QUESTION: calculating for a non-paramater....what test would you use? Chi-square, normal distrubition, spearman, wilcoxin, kruskal wallis

QUESTION: Two common VARIABLE..what statistical test would you use?

Ans-Chi-test,

T-test,

correlation analysis,

standard deviance

QUESTION: Given a case – what is the dependent variable? independent variable influences a dependent variable, or variables. Ie: effect of Temperature on plant growth, temp = independent and growth; height, weight, # of fruits = dependent

QUESTION: confounding variants? A confounding variable, also known as a third variable or a mediator variable, can adversely affect the relation between the independent variable and dependent variable. This may cause the researcher to analyze the results incorrectly. The results may show a false correlation between the dependent and independent variables, leading to an incorrect rejection of the null hypothesis.

QUESTION: If you have a study of confounding variable –

minimize confounding variables by randomizing-ans

minimize confounding variables by randomizing groups,

utilizing strict controls, and

sound operationalization practice all contribute to eliminating potential third variables.

QUESTION: Crossover study advantages? influence of confounding covariates is reduced

because each crossover patient serves as his or her own control and are statistically efficient and so require fewer subjects than do non-crossover designs (even other repeated measures designs).

The null hypothesis (H0) is a hypothesis which the researcher tries to disprove, reject or nullify. The 'null' often refers to the common view of something, while the alternative hypothesis is what the researcher really thinks is the cause of a phenomenon.

QUESTION: Experiment was done and error 0.05 was the goal but when completed it was 0.01. The

question asks what type of error was it?

-type I

-TYPE 2

ans-no error: Error of less or equal of 0.5 no statistical significance..

Notes:*If the observed probability is less than or equal to .05 (5%) the null hypothesis is rejected and

outcome is judged as “no effect”.in this case the alternative hypothesis is adopted

*If the observed probability is greated than 5% the decision is to accept the null hypothesis and the

results are called “not statistically significant.

QUESTION: P-significant value is equal to 0.01, your theory should be right, so you you will reject

null hypothesis

QUESTION: Type I – false rejection of null hypothesis (false negative/incorrect regection) = less

dangerous in terms of research and

Type II – false acceptance of null hypothesis (false positive/failure to regect) – less problematic bc no conclusion is made from a rejected null. But type 2 is more dangerous medically bc a patient is diagnosised as HEALTHY when they actually have theHIV.

Type I Error- rejecting the null hypothesis when it is true. This is an alpha error. Another way to say this is, to reject a null that should be accepted.

Type II Error- accepting a false null hypothesis. This is a beta error. Another way to say this is, to accept a null that should be rejected.

QUESTION: fail to reject, what null? Ans-TYPE II error

QUESTION: The power of a statistical analysis is ultimately to:

a. I put reject the null

QUESTION: Incidence is when number of people like to get disease in given time

QUESTION: dentist in his clinic notice new diseases this is ? incidence

QUESTION: What is the statistical measure for the total number of cases per population,

regardless of time of onset? Ans-prevalence

QUESTION: For a population, the research divides the number of disease cases by the number of people.

By so doing, this investigator will have calculated which of the following rates?

a. incidence

b. odds ratio

c. prevalence-ans

d. specificity

QUESTION: Specificity? Proportion of truly nondiseased persons who are so identified by a screening test(measures “how good a test is at correctly identifying nondiseased persons). Sensitivity tests identifying diseased persons.

QUESTION: If a dentist was able to correctly ID disease free patients w/ the diagnostic study, it

has?ans-specificity.

QUESTION: You were looking for a disease in a study, disease was not present, what's this called? –

Specificity!

QUESTION: Study says 95 out of 100 people had the disease what is lab value: ans 95% sensitivity

QUESTION: A study failed to report 5 cases of caries. What is this called?

1. True Positive,

2. True Negative,

3. False Positive,

4. False Negative-ans

QUESTION: Biggest difference across cultures regarding pain...

Variability in pain threshold rather than pain tolerance,

variability in pain tolerance rather than pain threshold-ans

difference in stimulus awareness rather than pain tolerance,

difference in stimulus awareness rather than pain threshold

QUESTION: Which does not describe the spread of data?

median. -ans

Range.

Variance,

stand deviation,

standard error

QUESTION: What do you use for average Q? Mean, median, mode

Ans-mean

QUESTION: Which of the following represents the variability about the mean-value of a group of

observations?

A. Sensitivity

B. Standard deviation-ans

C. t-Statistic

D. Specificity

QUESTION: What most common form of standard deviation? 1. 2 stand deviations (answer)

QUESTION: Histogram is used to show (standard deviation):

mean,

correlation of 2 variables,

variance-ans

QUESTION: Outliers control has the biggest effect on which of the following?

a. mean

b. median

c. mode

d. standard deviation-ans

QUESTION: Scale of 1, 2, 3, - is it ordinal, nominal, interval, rational. Answer is ordinal.

QUESTION: GI mild, moderate severe – Ordinal

QUESTION: BP and pulse Kelvin – ratio

QUESTION: temperature – kelvins is ratio and Celsius is Interval (32 is freezing) is interval

Categorical (nominal) is like black hair, blonde hair

ORDINAL is like Low, medium, high...or highschool, college, graduate school

Interval is like ordinal but the values are EQUALLY SPACED – 10,000, 15,000, 20,000

Cardinal tells how many: 8 puppies, 14 friends

Ordinal shows ranking – 3

QUESTION: Which is least complicating for OH? Fixed bridge, rheumatoid arthritis, open

contact?

Ans-open contact

QUESTION: Mask metal, reduce porosity, make coefficients of expansion more similar???I didn't understand this one

QUESTION: Growth in buccal vestibule by flange of mandibular RPD? Most likely traumatic neuroma,

neurilemma, or neurofibroma? -_-

ans-traumatic neuroma

QUESTION: Older woman tooth extract 3 years ago, still hurts and exudate, shows cotton-wool

radiograph what is it?

Residual cyst, osteomyelitis, 2 other lesions that are radiolucent

Ans-ostemyelitis

QUESTION: Macroglossia seen in all EXCEPT?

QUESTION: All of the following are an indication for putting a temporary on a deep caries and restoring

at a later time except?

Lack of time due to it being an emergency apt-ans?????

weakened dentin

under cusps,

to assess pulp condition

QUESTION: Edema (by eye) due to?

Chemotaxis,

hemorrhage,

chymosis-ans

QUESTION: Pt has pain lower right 3rd molar and can't take intraoral xray, what kind of xray indicated?

Lateral oblique mandibular-ans

reverse town's,

lateral ceph,

anterioposterior

QUESTION: You have pano, what can't you do without intraoral photos?

Ans-space analysis...

QUESTION: Force put on crown, where is center of translation or rotation? Halfway down root, CEJ, past

apex

o Center of resistance – half the distance from alveolar crest to root apex (translation)

o Center of rotation: Apical to center of resistance (apical to halfway down root) –during translation movements and tipping movements

o During rotation movements: center of rotation=center of resistance

o 1st: rotation, 2nd: tipping, 3rd: torque

302-308 basic99.town@gmail.com

151_156 anilmadduri28 @ gmail.com