What Dentists wish Physicians knew about Dentistry

Timothy R. Martin, DDS
Dentist
Board Certified in Dental Sleep Medicine

1. Dr. Moss’ Story
2. Dental Sleep Medicine
   a. 95% of obstructive sleep apnea is undiagnosed
   b. Signs and Symptoms include:
      i. Excessive daytime sleepiness
      ii. Blood pressure difficult to control
      iii. Snoring
      iv. Maintenance insomnia
      v. Obesity
      vi. Large neck
      vii. Memory Problems
   c. Oral Appliance therapy recommended by AASM as first line treatment for mild to moderate obstructive sleep apnea and as an alternative to CPAP in severe obstructive sleep apnea
   d. Maintains the airway by holding the mandible forward as the patient sleeps so that the tongue does not collapse into the airway
   e. Effectiveness rate in maintaining an AHI below 5 is 80%
   f. Side effects are minimal and effectively managed in most patients
      i. Most common are TMJ soreness and tooth soreness
3. Oral Anatomy that Promotes Obstructive Sleep Apnea
   a. High Narrow Palate
   b. Posterior Cross-bite
   c. Tongue higher than the occlusal surface of the mandibular teeth
   d. Scalloped Tongue
   e. Mallampati Class IV
   f. Swollen tonsils and adenoids
   g. Tongue Tied
   h. Retrognathic Mandible
   i. Bruxism
   j. Loss of enamel due to GERD
   k. Excessive overbite or overjet
4. Antibiotic Premedication Prior to Dental Procedures for a Patient with a Prosthetic Joint
   a. American Dental Association and the American College of Orthopedic Surgeons joint statement says not needed (2012 and 2014)
   b. Reasons Include:
      i. Not really effective
ii. Build up a resistance  
iii. Possible allergic reaction  
c. Dentists and Orthopedic Surgeons continue to be nervous about not using antibiotics

5. Tori  
a. Large knots of dense bone that build up as a result of the patient clenching teeth  
b. Can be so large that the patient cannot lay their tongue down in the floor of the mouth  
c. Patient may be clenching to preserve the airway, so think sleep apnea  
d. Can complicate intubation during surgery  
e. Usually not removed unless absolutely necessary

6. Referral of TMJ Patient  
a. TMJ surgery is very, very rare  
b. Treatment is usually conservative and involves splint therapy, possible trigger point injections, orthodontics, and restorative dentistry using crowns, bridges, and implants  
c. Referrals should be to a general dentist with experience in treating TMJ, not an oral surgeon.

7. Dental Implants  
a. Have been in use since the 1960’s, originally developed to support a lower denture.  
b. Now used routinely to replace single teeth as well as entire arches  
c. Often requires bone grafting  
d. Surgically guided by cone beam CT scans

8. Dentists and Medicare  
a. Medicare does not cover general dentistry  
b. TennCare in Tennessee covers dentistry only for children  
c. DME provider

9. Dental protocol for patients receiving radiation treatments to the head and neck  
a. Greg’s Story  
b. Dentist should be involved before radiation is done  
c. Dental treatment aimed at not losing teeth after radiation is done  
i. Removing questionable teeth before radiation is done  
ii. Restore savable teeth  
iii. Treat periodontal disease  
iv. Immaculate oral hygiene  
v. Sodium fluoride treatments / twice a day  
vi. Periodex twice a day  
vii. Drink plenty of water for dry mouth  
viii. More frequent professional cleanings  
ix. Biotene Products  
x. Sugar restrictions  
xi. Diabetic Diet  
xii. Miracle mouthwash for sore spots

10. Tongue Piercings  
a. Infection
b. Broken Teeth
c. Allergies to metal
d. Possible choking if the device comes loose
e. Blood borne diseases such as tetanus and hepatitis

11. Bisphosphates for Osteoporosis
   a. Risk of antiresorptive agent –induced osteonecrosis of the jaw prevalence is approximately 0.10 percent
   b. Osteoporosis is responsible for considerable morbidity and mortality
   c. Benefits provided by antiresorptive therapy outweigh the low risk of osteonecrosis in the jaw
   d. Impossible to predict a specific patient’s risk
   e. Risk Factors for developing osteonecrosis
      i. Over age 65
      ii. Periodontitis
      iii. Prolonged use of bisphosphonates (more than 2 years)
      iv. Smoking
      v. Denture wearers
      vi. Diabetes
   f. Insufficient evidence to recommend a holiday from antiresorptive drug therapy or waiting periods before performing dental treatment
   g. Risk seems to increase with extended drug use
   h. Dental Procedures
      i. Ok to do implants
      ii. Root canals OK
      iii. Surgery- do not want to extract tooth if at all possible
      iv. Orthodontics- moving teeth in bone may be affected, one in five orthodontic patients is an adult
      v. Removing unsalvageable teeth prior to drug use
      vi. Dental treatment may vary based on patients dental IQ and predicted oral hygiene
      vii. Use of chlorhexidine rinse when having a tooth extracted ( twice a day for 4-8 weeks)
   i. Prevention
      i. Excellent Oral Hygiene
      ii. Regular dental visits

12. Burning Mouth Syndrome
   a. Local Factors
      i. Denture Fit
      ii. Trauma
      iii. Mechanical or Chemical irritants; galvanic reactions
      iv. Parafunional Habits
      v. Allergic contact stomatitis
vi. Infection
vii. Hypo salivation
viii. Oral mucosal lesions

b. Systemic Factors
   i. Deficiencies
   ii. Endocrine
   iii. Hypo salivation
   iv. Medications
   v. GERD
   vi. Neuropathy or Neuralgia

c. Psychological Factors
   i. Depression
   ii. Anxiety
   iii. Obsessive-compulsive disorder
   iv. Fear of Cancer
   v. Psychosocial stressors

13. Final Thoughts
   a. Meth mouth
   b. Eating Disorders
   c. Soft Drinks- acid as well as sugar
   d. Gatorade
   e. Cough Drops
   f. Sugar Consumption
   g. Electronic Cigarettes