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Treating the Dental-Phobic Patient

Helping even the most fearful people attain ideal results.

This case involves a 55-year-old male who presented extreme dental fear with resulting dental neglect. His last visit to a dental professional had been 25 plus years prior. Due to the intense anxiety experienced by the patient involving dental procedures, he severely neglected his dentition (fig. 1). The patient was referred to me for evaluation of pain in the maxillary anterior area. Because of continued neglect due to fear

and avoidance, this treatment required extensive dental procedures.

CASE STUDY

Proper diagnostic workup consisted of a complete health history which revealed the patient to be in good health, with no medical conditions and taking no medications.

His dental neglect resulted in multiple teeth

being categorized as non-restorable. Again avoidance and fear precluded his commitment to his dental needs. (This was until acute pain occurred. See fig. 1)

01 Full mouth x-rays were taken along with a standard intraoral and extra oral exam. A cancer screening was carried out with the results being negative. Periodontal charting

TREATING A VERY NERVOUS PATIENT



Fig. 1 Patient upon initial evaluation



Fig. 2 Caries control, core build ups and extraction



Fig. 3 Provisionalization



Fig. 4 GC Initial Porcelain



Fig. 5 Amann Girschbach copings (Various base shades available.)



Fig. 6 Substructure (Notice interproximal design to maximize strength and minimize unsupported porcelain.)



Fig. 7 Pre sintering



Fig. 8 Post sintering



Fig. 9 Substructure fit to die prior to layering of porcelain



Fig. 10 Completed prosthesis



Fig. 11 Patient prior to treatment



Fig. 12 Patient post treatment with beautiful "Hollywood Smile."

was performed and fortunately for the patient, he did not present any irreversible periodontal pathology.

Protocol of S.O.A.P. was followed:

S (Subjective)—Patient experiencing acute pain and knows that he is in need of extensive dentistry but is apprehensive.

O (Objective)—Standard procedure regarding prosthetic protocol was completed and treatment priority was outlined.

A (Appraisal)—Treatment sequence involved: taking care of his acute needs and performing extractions where indicated.

P (Procedure)—After consulting with his M.D., there was no contraindication regarding the use of conventional local anesthetic or any other medications that are used in prosthetic dentistry. Diagnostic models were fabricated, face bow transfer and S.O.P. (standard operative prosthetic) procedures were followed through.

02 A diagnostic wax up was fabricated by LSK121 along with a provisional acrylic template and temporaries. Patient was pre-medicated to aid in relaxation due to his high level of trepidation concerning the lengthy procedure. Treatment was directed toward the maxillary anterior component (maxillary right second bicuspid to maxillary left cuspid). This area took priority to his other needs.

03 Procedures were followed to evaluate the teeth involved for this 8-unit prosthesis. Extraction of a non-restorable tooth ensued (fig. 2). Provisionals (utilizing acrylic temporaries. See fig. 3) were fabricated and placed. The relign material chosen was

non-exothermic, thus reducing any injury caused by heat with conventional acrylics.

04 Caries control was followed and appropriate core build ups were completed (fig. 2) After a period of healing, standard operating prosthetic protocol was adhered to concerning impression techniques using custom trays. Other prosthetic protocols were completed which consisted of centric records and face bow transfers.

05 Custom shade was selected according to LSK121 Seasons of Life shade system, offering a multitude of options in color selection, texture and enamel characteristics. While discussing the color, the patient indicated that he desired a very bright, high value "Hollywood smile". Post-operative instructions were given.

06 After the appropriate lab time and try-ins, a zirconium oxide CAD/CAM substructure (figs. 5, 6, 7, 8 & 9) with a porcelain overlay using GC Initial (fig. 4) was fabricated at LSK121 (fig. 10). After all of the parameters were established; occlusally, esthetically and marginally, bonding protocol was carried out.

07 It is important to note that once a crown or bridge has been tried in the mouth, it is contaminated with oral phosphates. To aid in the elimination of these phosphates, application of Ivoclean before the bonding procedures is recommended. It is known that zirconium oxide cannot be etched, therefore a metal primer was applied to the bridge, and bonding protocol was accomplished using my pre-

ferred bonding product. It is important to use a glycerin gel after the initial light cure for 20 seconds in order to remove any excess bonding material. The glycerin is applied around the margins of all the abutments. This will allow the set to occur in absence of oxygen.

08 All oral hygiene instructions were given to the patient and any occlusal adjustments were rendered (these being minimal). Standard procedures in polishing of the adjusted surfaces were performed and the patient was given instructions to return in one week for a post-operative visit. This article is not designed to discuss the continued work that the patient needs, but only directed toward the protocol that was established from a priority standpoint. All other restorations and preventative measures were carried out after the above procedures were completed.

CONCLUSION

In closing, the complexity of this treatment was more psychological. In our profession we need to address both the physical, biomechanical procedures, as well as discussing and understanding the psychological aspect of treatment. This last statement was placed to have the reader understand it is not so much the procedures that were accomplished, but more important, the management of a patient with extreme psychological fears. This is in no means to infer that the patient will be completely relaxed for further dentistry, but that he was made aware that his fears were mostly unfounded. By commitment, it is understood and patient realizes that he overcame the initial obstacle of his apprehension (figs. 11{before} & 12 {after}). **lab**