Quality Resource Guide

Treatment Planning

Author Acknowledgement

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Dr. Trummel has no relevant financial relationships to disclose.

Educational Objectives

Following this unit of instruction, the practitioner should be able to:

- 1. Describe the information necessary to develop a comprehensive treatment plan.
- Create a defined list of problems, given the information derived from a comprehensive oral examination.
- Describe factors which determine the sequence of treatment procedures in a comprehensive treatment plan.
- 4. Develop a comprehensive and appropriately sequenced treatment plan, given examination data and a defined problem list.

MetLife designates this activity for 1.0 continuing education credits for the review of this Quality Resource Guide and successful completion of the post test.

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Introduction

Success in complex endeavors is closely related to the quality of planning, and this is no truer than in the practice of dentistry. Patients are highly unique in type and severity of oral diseases, systemic complications, responses to previous treatment and current expectations. There is no standard patient and there can be no standard "blueprint" for treatment. Effective dental care results from the dentist's ability to develop a comprehensive and integrated plan of interventive and prophylactic strategies tailored to the unique needs of each patient. This process, commonly called treatment planning, although honed by clinical experience is based on principles derived from a current understanding of the etiology, prevention and treatment of oral diseases and conditions. The treatment plan is the ultimate expression of the generalist's knowledge and understanding of medicine and dental medicine, clinical skills and experience. The objective of this Quality Resource Guide is to review these principles and the elements and process of treatment planning.

Treatment plans may be limited or comprehensive. A limited plan typically focuses on management of a single problem or a subset of a larger number of problems, and may or may not be delivered by a specialist. A comprehensive plan is a strategy for addressing all of the patient's current problems and implementing measures to maintain oral health once it is achieved (**Figure 1**). This Guide focuses on comprehensive treatment planning, which is the province of the general practitioner. The generalist is ultimately responsible for formulation and implementation of a comprehensive treatment plan, although he or she may not deliver all of its elements.

In the context of treatment planning, it is worth noting that healthcare practitioners have both an ethical and legal obligation to obtain informed consent prior to treatment. The preparation and recording of a comprehensive treatment plan provides the essential basis by which the dentist communicates the broad goals of treatment, describes specific procedures to be performed, discusses alternatives (including no treatment) and receives the patient's consent to proceed.



Preparation for Treatment Planning

The process of creating a treatment plan that will effectively resolve oral diseases, minimize or eliminate functional or esthetic problems and achieve a stable maintainable condition is a four-step process. These are as follows:

1. Examination and documentation of findings.

The importance of examination and recording the information obtained cannot be overstated. The examination must be comprehensive, systematic and accurate and documentation must be clear and complete. Use of well-designed forms for recording is recommended, because these can remind the dentist to complete all elements of a comprehensive examination. Techniques for evaluating and documenting the various components of the orofacial complex are intensively taught to students, and are well described in textbooks and in a Quality Resource Guide, *Dental Record Keeping* by Dr. Michaell Huber and will not be repeated here.

Examination of a new patient consists of the following elements typically performed in the order listed:

 Reason for presentation, often termed chief concern or complaint. Reasons may range from desire for routine examination to cosmetic concerns and/or dysfunction to complaints of pain and infection. The dentist must also elicit the history of each expressed concern or complaint (duration and course, signs, symptoms, severity, etc.). Although all complaints should ultimately be addressed in development of a treatment plan, appropriate steps must be taken to immediately mitigate pain and acute infection prior to completing a comprehensive examination and treatment planning.

• Health history and present medical status. Accurate assessment of the patient's medical history and present health is critical. This includes measurement of blood pressure, heart rate and respiration and notation of other signs or symptoms of systemic impairment. The dentist is alerted to systemic diseases, medications or conditions (*e.g.*, allergies) that must be considered in the planning and delivery of dental therapy. The medical history may also reveal systemic factors that may contribute to oral diseases or conditions. Finally, analysis of the medical status will identify the need for consultation with or referral to a physician for further evaluation.

The Quality Resource Guide, *The Medical History in Dental Practice* by Elisa Chavez contains detailed information on this subject.

 Dental history. This important component in comprehensive evaluation is often incomplete or missing. The dentist should question the patient regarding the pattern and nature of dental care previously received; the perceived outcome of this care; any adverse physiological or psychological reactions; and oral self-care practices. This information will provide historical data as well as insight into the patient's attitudes, fears, expectations and health practices.

• Extra- and Intraoral Examination. A careful and systematic examination of the face, neck and non-dental structures and tissues of the oral cavity is clearly the province and responsibility of the dentist. It should include visual and manual assessment of skin, lymph nodes, salivary glands, lips, oropharyngeal mucosal surfaces, tongue, floor of mouth and temporomandibular joints.

For additional information the reader is referred to the Quality Resource Guide by Dr. James Sciubba, Performance of an Oral and Head and Neck Examination.

• Dental examination. Standard examination measures are used to obtain a detailed recording of the condition of teeth, restorations and the periodontium. A complete assessment of the latter includes determination of gingival health, pockets and attachment levels. The pulpal status of teeth with caries, large restorations, symptoms or a history of trauma should be ascertained.

• Disease risk assessment. While recognition of present disease is paramount, the importance of estimating a patient's risk of future disease is often overlooked. Prediction of future disease is inexact but enumeration and quantification of relevant risk factors is clearly essential for development of appropriate strategies to reduce risk. Risk assessment should include the common diseases of the teeth (caries and periodontitis) as well as mucosal diseases (oral cancer). The results of careful risk assessment help both dentist and patient make informed decisions regarding treatment.

Detailed information on assessing a patient's risk for caries and periodontitis can be found in the Quality Resource Guides Caries Risk Assessment and Management for Adults in a General Practice by Dr. Andrea Zardona, Clinical Decision-Making for Caries Management in Children by Dr. Norman Tinanoff and Periodontal Risk Assessment in a General Practice by Dr. John Grbic.

• Radiographic evaluation. A sufficient radiographic assessment must be part of the database used for treatment planning. The definition of "sufficient" is made by the practitioner based on physical signs, symptoms of disease or abnormalities and historical reports. Unnecessary exposure to radiation is a worthy goal but should not preclude the use of radiographs to gain otherwise unattainable diagnostic information.

Dentists should be familiar with and follow current guidelines for radiographic exposure (see The Selection of Patients for Dental Radiographic Examinations, American Dental Association and Food and Drug Administration, 2004; available online).

The MetLife library contains three Quality Resource Guides relating to oral radiology ranging from bitewing technique, quality assurance and digital radiography.

2. Analysis of the database to establish diagnoses and enumerate problems.

Analysis of an examination database will reveal either health or a pattern of signs and symptoms indicative of pathology. In the latter case, this should lead to a diagnosis. The precise specification of a disease enables the clinician to use the accumulated knowledge pertaining to the etiology and pathogenesis of this disease to design strategies for control and prevention. These strategies will be reflected in the treatment plan.

In addition to appropriate diagnoses, all of the examination findings should be carefully analyzed and those that constitute problems should be identified and listed as problems. For this purpose, problems can be defined and classified as follows:

• A primary problem is a disease process and its causes, an adverse outcome of disease, a developmentally acquired structural or functional alteration, or an injury of the teeth or other oral structures which results in or has the potential to result in pain, infection, disfigurement or loss of function.

• A secondary problem is an existing condition of the patient which either contributes to a primary problem (*e.g.*, neutropenia, epilepsy treated with phenytoin) or complicates resolution of a primary problem (*e.g.*, rheumatic heart disease, anxiety).

Implicit in the definition of a primary problem is the need for intervention (*i.e.*, treatment) to arrest a disease and/or correct structural, functional or cosmetic defects. In other words, a problem refers to a situation in need of resolution or improvement, and in this context the treatment plan thus becomes a problem resolution plan. It is important to note that although some problems cannot be treated or resolved, *e.g.*, neuromuscular impairment contributing to poor plaque control, they must still be acknowledged. The above definitions provide a framework by which the clinician can "sift" examination data and designate not only diseases but their causes, complicating factors and adverse sequelae as problems.

In addition, a symptom or patient perception of disease, dysfunction or esthetic defect should be considered a problem, even though no definite basis for the symptom or perception can be determined.

Creating a problem list as described above provides several advantages in treatment planning and treatment. First, the process forces a careful analysis and evaluation of all examination data. Second, a complete list of problems allows assignment of relative priority to individual problems. Third, by enumerating the primary causes of oral diseases and the factors that secondarily contribute to the initiation or progression of disease, the problem list provides a basis for developing risk reduction strategies. And finally, a problem list serves as a baseline for monitoring the progress of treatment as it proceeds.

3. Realistic estimation of what can and can't be done, i.e., develop reasonable prognosess.

Prognosis in dental medicine is confounded by many factors, not the least of which are our imperfect understanding of the pathobiology of oral diseases, the relative uncertainty of preventive and treatment strategies and the unpredictability of human nature. However, in spite of the difficulty, the dentist is obliged to provide the patient a realistic projection of likely outcomes of the dentition. This projection must cover at least two scenarios: no intervention versus available treatment options. The patient is thereby better able to make informed choices regarding treatment. The Quality Resource Guide by Dr. Geistfeld, Informed Consent contains detailed information regarding this essential aspect of treatment planning.

The validity of a prognosis rests strongly on the quality of the examination, accuracy of diagnoses and problem list and the depth of clinical experience. A major problem in prognostication is predicting the level of patient commitment to achieving oral health; a patient who cannot or will not comply with treatment recommendations can seriously compromise a well-thought out and appropriate treatment plan.

4. Understanding the patient's desires, expectations and financial resources.

The interaction during the process of examination often provides clear insight into treatment goals desired by the patient. If this is not the case or if the patient's desires are equivocal, the dentist must directly pursue the issue. Just as the patient needs to know the range of available treatment modalities, the dentist must fully appreciate what the patient expects in terms of comfort, function and appearance. The goal is to develop a treatment plan that meets the patient's needs as fully as possible without creating unrealistic expectations and addresses his or her desires consistent with the concept of doing no harm.

The dentist's perception of whether the patient can afford treatment should not determine the thoroughness of examination or quality of data analysis, *i.e.*, patients should be made fully aware of their oral health status. Neither should any perception of the patient's financial status favorable or unfavorable - alter the type of treatment plan proposed. All patients are entitled to know the range of available treatment options. Once these have been presented, the dentist if necessary must then reconcile what he or she believes to be the optimal treatment plan to the reality of what the patient can or decides to afford. Cost is often a frequent confounder in the delivery of oral health care but this should not mean that patients are uninformed of optimal treatment strategies.

Table 1 - Examples of Problem Lists

Using examination findings and diagnoses, problems are identified and compiled as described in the text. The resultant list may have few or many items ranging from simple to complex. In any case, a problem list should be a highly descriptive "snapshot" of the patient's oral status and treatment needs. Below are examples of problem lists developed for two very different patients.

Patient A	 generalized light interproximal plaque supragingival calculus, mandibular incisors generalized mild gingivitis, primarily papillae buccal pit, #19; caries?
Patient B	 pain upon occlusion, #18 apical periodontitis, #18, with possible vertical root fracture mitral valve prolapse with regurgitation diabetes, type I; blood glucose control uncertain smoking, 30 pack-years generalized moderate-to-heavy plaque localized supragingival and generalized moderate subgingival calculus generalized moderate with localized severe gingival inflammation generalized periodontal pockets (4-8 mm) generalized periodontal attachment loss, 20-60% furcation exposures, all molars and #5 and 12 missing teeth, #14 and 30 tipped teeth, #15 and 31 coronal caries on proximal surfaces, #5, 13 and 20 defective restorations (poor margins/2° caries), #4, 12, 13, 18 and 21 esthetic concern (porcelain veneer, #9) severe crowding, mandibular anterior teeth

The priority for addressing the listed problems can be indicated either by the order of listing or assigning a level of priority, e.g., L(ow), M(edium) or H(igh) to each.

Formulating a Treatment Plan

Some Important Principles

 The sequence in which treatment is delivered is as important as the individual elements of treatment, *i.e.*, there are rational and irrational sequences of treatment. The order should be based on the predominant problems and diseases which have been identified, but must also take into account the need to intercept and prevent problems from becoming worse or untreatable. The emphasis must be as much on preserving what remains as on meticulously restoring what it missing. Establishing a logical order of treatment readily follows once each of the identified problems has been assigned a priority for resolution.

- 2. A fundamental premise is that definitive treatment to correct the sequelae of disease should not be undertaken until all active diseases are arrested and preventive measures that offer promise of reduced risk are in place. However, there are common sense exceptions to this caveat, *e.g.*, full implementation of a regimen to reduce future caries would not take precedence over excavation and at least temporary restoration of teeth with deep carious lesions.
- 3. A comprehensive treatment plan provides a biologically rational "blueprint" that guides the sequence of steps to achieve stabilization, disease resolution, reconstruction of structure and function, and maintenance of health. This plan should be based on current concepts that are evidence-based. Once in place, this blueprint creates the opportunity to maximize the efficiency of treatment, i.e., the dentist can use the plan to "think forward" and plan for future appointments. For example, an impression for an upcoming temporary crown may be made during a scaling and root planning visit. For patients requiring antibiotic prophylaxis, it may be possible to perform multiple procedures in a single visit, thereby reducing the need for repeated drug dosing.
- 4. During the execution of a treatment plan, it is critical to continuously monitor treatment outcome. Assessment of the responses to therapeutic measures, as well as compliance with prescribed preventive and self-care measures will determine the efficacy of treatment which has been delivered and allow for appropriate adjustments in the remaining course of treatment. In short, planning, delivery of treatment and assessment of results become a seamless and dynamic process.

Organization of Treatment Plans

The organization and nomenclature of dental treatment plans varies widely. The system used here is based on the principles listed above and divides comprehensive care into three broad stages or phases: disease control; correction of structural defects; and maintenance of health.

These phases and their objectives are as follows:

Phase I Therapy

Phase I therapy is often termed disease-control therapy or cause-related therapy. Although not widely used in practice, these terms accurately express the primary goals of Phase I therapy, which are disease control, stabilization of the dentition and, if needed, treatment of emergent and urgent conditions. Emergent needs typically comprise pain, acute infection and trauma. Urgent needs are those conditions that are likely unstable, rapidly deteriorating or threatening the patient's dentition, other oral structures or systemic well-being. Depending upon the nature and severity of problems and diseases presented by the patient, Phase I therapy may encompass any or all of the strategies listed in **Table 2** and summarized below:

- · Eliminate pain and/or acute infection
- · Investigate mucosal or other orofacial lesions
- Refer for medical evaluation if indicated by history, symptoms or physical assessment
- · Initiate therapies to arrest active diseases
- Implement preventive or risk-reduction strategies

Table 2

Treatment and Evaluation Modalities Typically Utilized in Phase I Therapy

(Sequence will vary from patient to patient)

- · Necessary and appropriate measures to relieve pain and resolve acute inflammation
- · Education of patient in nature, prevention and control of oral and dental diseases
- · Implementation of effective plaque control measures
- Dietary counseling for caries reduction
- · Implementation of a regimen for topical self-application of fluoride
- · Routine prophylaxis (scaling, polishing, topical fluoride treatment, etc.)
- Excavation of large carious lesions and/or repair of severely damaged teeth through the placement of temporary restorations
- Restoration of carious lesions and/or the repair of severely damaged teeth utilizing definitive direct or indirect techniques
- · Extraction of hopelessly diseased or other undesirable teeth
- Scaling/root planing
- · Endodontic therapy
- Core build-ups and/or cast posts and cores
- · Placement of temporary crowns
- · Provisional splinting
- · Occlusal adjustment
- Recontouring of overhanging/overcontoured restoration margins
- Additional diagnostic procedures, e.g., S. mutans assay, biopsy or examination procedures to determine treatment outcome
- · Placement of provisional prostheses
- · Provisional alteration or repair of existing prostheses

- · Eliminate hopelessly diseased teeth
- Stabilize and protect structurally weakened teeth
- Provisionally replace missing teeth if functionally or cosmetically necessary

The order in which these are accomplished may vary according to the patient's needs. Obviously, emergent management of pain and acute infection is paramount and takes precedence over other issues. This is usually biologically rational and always ethically imperative. The second step is to address whatever urgent needs may be present. An example is investigation of suspicious lesions of the oral mucosa or structures such as salivary glands. Biopsy or other appropriate diagnostic measures should ordinarily be done without delay. Another example of an urgent problem would be an uncertain medical status with the potential to impact on or be impacted by dental treatment.

The timing of medical evaluation depends upon the nature of the problem. If the issue in guestion represents an immediate risk to the patient's wellbeing, e.g., markedly elevated blood pressure, or proposed dental treatment that carries a potential risk of infection, e.g., suspected cardiac valve dysfunction, then referral should be made as soon as possible. Evaluation of other medical questions may be less urgent. In any case, good treatment planning requires that the dentist has sufficient understanding of the patient's medical status. Only then can one determine necessary and appropriate management strategies and incorporate them into the treatment plan. For example, patients with joint prostheses may require infection prophylaxis prior to defined dental procedures. If prophylaxis is needed in such cases, the drug, dose and procedures should be determined and specified in the treatment plan.

Two Quality Resource Guides by Dr. Frank Nichols, one dealing with the management of patients with common medical conditions and the second focusing on patients with cardiovascular conditions contain information essential to the management of patients frequently encountered in dental practice. Just as for management of medical problems, so too must strategies be developed as needed for the control of pain and management of the anxious patient. If the need for anxiety control is apparent from the initial examination, the dentist should estimate the level of control that may be necessary and plan appropriate measures. These should be recorded in the treatment plan. Similarly, the treatment plan should specify measures to be used to manage post-operative pain.

For a given patient, Phase I therapy is designed to address specific problems. As noted above, the response should be continuously evaluated as therapy is delivered. In addition, a focused examination of outcomes should be done at the completion of Phase I therapy. This examination will determine the success of Phase I therapy in controlling disease and assess the effectiveness of preventive strategies. The information gained may also lead to modification of preventive measures, revision of diagnoses, identification of new problems, modification of prognoses and whether the problems addressed by the course of therapy have been resolved. The clinician should determine whether the problems addressed by the initial course of treatment have been resolved and the reasons for failure if problems persist.

Phase II Therapy

The broad objectives of Phase II are to replace lost structures and/or restore function and appearance. While attaining this objective in the short term does not depend on a successful conclusion of Phase I, long-term success without control of caries and inflammatory periodontal disease is unlikely. This unpleasant reality is well known to dentists but not always appreciated by patients.

Phase II therapy is specifically directed to correction of developmental defects or sequelae of diseases, such as major loss of coronal tooth structure, pockets and other periodontal defects, and missing, impacted or malposed teeth. As such, it includes a wide array of procedures, including definitive restoration of individual teeth, surgical correction of periodontal defects, orthodontic treatment and replacement of missing teeth with fixed or removable prostheses or implants. Although the focus of Phase II is restoration of structure and function, disease control and preventive strategies implemented in Phase I, whether performed by patient or dentist, must be sustained. This effort together with the outcome of procedures should be evaluated during and at the completion the Phase II plan.

If a treatment plan is based on a comprehensive problem list, the list can be used to judge the success of therapy. Such a plan, if well designed and executed, should result in a patient free of all original problems when examined at the end of Phase II. Alternately, some problems may persist or new problems may arise. This would obviously trigger an analysis of the reasons for this outcome and development of a new treatment plan.

Phase III Therapy

Phase III consists of those strategies necessary to maintain the health and stability achieved in Phase II. In a very real sense, Phase III is no longer "treatment" but rather "health maintenance." It entails continuation of patient-performed preventive regimens; periodic assessment of oral, dental and periodontal status to ensure early detection of new or recurrent diseases; and the delivery of appropriate supportive therapy. Should disease or other problems arise during the maintenance period, appropriate active treatment would be prescribed and delivered, and maintenance would continue.

Although treatment plans may be complicated, the development of a good treatment plan need not be a difficult task if the practitioner heeds the following:

- Examine extra- and intraoral structures thoroughly and comprehensively.
- Document examination findings in a manner that would meet rigorous peer-review.
- Understand your patient: make accurate diagnoses; develop a defined problem list; make reasonable prognoses with and without treatment; be aware of the patient's expectations and fears; and appreciate systemic conditions that may impact on or be impacted by proposed dental treatment.

- 4. Construct an individualized treatment plan that addresses all of the patient's defined problems as well as possible.
- 5. Base treatment strategies on current evidence.
- 6. Sequence the treatment plan based on need and priority: relieve pain and infection and address other emergent or urgent problems; arrest active diseases with strategies aimed at causes and contributing factors; implement preventive measures; correct structural defects or other sequelae of disease or injury; and maintain health once achieved by preventive and supportive therapy to minimize disease risk.
- Record the treatment plan. Written documents remember what patients and practitioners forget.
- Present and discuss the treatment plan. This is necessary to ensure that the patient fully understands both procedures and goals. This discussion is also the basis for obtaining informed consent to treat.

References

1. Stefanic SJ and Nesbit SP. Treatment planning in dentistry, St Louis, 2016, Mosby.

POST-TEST

Internet Users: This page is intended to assist you in fast and accurate testing when completing the "Online Exam." We suggest reviewing the questions and then circling your answers on this page prior to completing the online exam.

(1.0 CE Credit Contact Hour) Please circle the correct answer. 70% equals passing grade.

1. A treatment plan is best described as a:

- a. listing of all operative procedures that may conceivably be needed in the management of a patient.
- b. sequence of steps by which therapeutic and preventive measures will be delivered to creates a healthy, functional and stable dentition.
- c. description of alternatives approaches to meeting the restorative and prosthetic needs of a given patient.
- d. sequential listing by CDT codes of treatment procedures that will be delivered to a patient.

2. A detailed oral and dental examination is necessary:

- a. prior to management of emergent conditions, e.g., pain.
- b. prior to implementing any preventive strategies.
- c. prior to development of a comprehensive treatment plan.
- d. in all of the above.
- 3. Which of the following statements pertaining to disease risk assessment in the planning and delivery of comprehensive treatment is/are true?
 - a. The examination on which a treatment plan is based should include an assessment of disease risk factors and the resulting treatment plan should include specific strategies to reduce these factors.
 - b. Disease risk reduction strategies should include those which may realistically be expected to be performed by the patient.
 - c. The efficacy of prescribed disease reduction strategies should be evaluated continuously during the delivery of treatment.
 - d. All of the above.

4. Phase I (sometimes referred to as initial) therapy is typically limited to all of the following except:

- a. elimination of hopelessly diseased teeth.
- b. measures aimed at controlling active disease(s), *e.g.*, inflammatory periodontal diseases, caries, pulpal infection, etc.
- c. orthodontic treatment.
- d. provisional replacement of missing teeth, if cosmetically or functionally indicated.
- 5. Which of the following statements regarding problem lists as used in treatment planning is <u>not</u> true?
 - a. A patient concern regarding esthetics is defined as a problem.
 - b. A disease, e.g., gingivitis, constitutes a problem.
 - c. A secondary problem is defined as a condition of lesser importance.
 - d. Factors that secondarily contribute to a disease, *e.g.*, a plaqueretentive overhanging subgingival margin, should be considered a problem.

6. Which of the following statements regarding treatment sequence is <u>not</u> true?

- a. The sequence of treatment is as important as the elements of treatment.
- b. Treatment of active disease, e.g., caries, should precede disease risk reduction (preventive) strategies.
- c. Active disease should be addressed and controlled prior to definitive reconstruction of affected teeth.
- d. If functionally or cosmetically necessary, provisional replacement of teeth can precede disease control measures.

7. A new patient presents seeking comprehensive care. She complains of a localized and moderately tender "bump" that appeared several weeks earlier on the facial aspect of a mandibular molar. A focused clinical and radiographic examination reveals this "bump" to be a draining fistula associated with nearly complete carious destruction of the crown of the involved tooth. There are no other symptoms. The tooth is deemed non-restorable. The patient also notes that a recent physical examination revealed mitral valve prolapse, but cannot recall whether there may be concomitant regurgitation.

What would be the most appropriate course of management for this situation?

- a. The tooth in question should be extracted immediately.
- b. Amoxicillin (1 gram) should be given and the tooth in question extracted one hour later.
- c. Full examination should be completed and development of a comprehensive treatment plan initiated.
- d. Extraction of the tooth in question and further comprehensive examination should be deferred until medical consultation regarding the cardiac status can be obtained.

8. Which of the following treatment modalities would ordinarily <u>not</u> be included in so-called Phase I (diseasecontrol) therapy?

- a. Plaque control training and monitoring
- b. Scaling and root planing
- c. Fixed prostheses
- d. Endodontic therapy
- 9. An examination specifically focused on the patient's status at the completion of Phase I treatment serves to accomplish which of the following?
 - a. Assessment of the effectiveness of the original plan of treatment.
 - b. Detection of new diseases or problems that may have arisen during the course of treatment.
 - c. Assessment of the effectiveness of risk control strategies performed by the patient.
 - d. All of the above.

10. Assessment of treatment outcomes should be done:

- a. continuously throughout the delivery of treatment.
- b. only at the completion of Phase I (disease-control) therapy.
- c. following completion of Phase II therapy.
- d. at the first visit in Phase III (maintenance) therapy.

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