MANAGEMENT OF PATIENTS WITH DENTIST-PHOBIA. A CASE REPORT

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Abstract

Patient’s anxiety during dental treatments still represents a major problem in our daily practice. The treatment applied and the attitude towards the patient should be therefore individualized for each person in part. When a susceptible ground exceeds a psychological profile and the patient manifests fear, the dentist must do additional efforts to find the right way to communicate with him, to motivate and encourage him to follow the treatment.

The most frequent causes of fear of dentist include: anticipated fear of pain, fear of losing control, fear of being lied, fear of unknown (due to lack of information or lack of communication with the doctor), fear of invasive procedures, fear of the noise made by different dental instruments, fear of repeating previous negative experiences, fear of bleeding, fear of unpleasant smells, fear of “unfriendly” medical personal or fear of being in a narrow space, and so on.

Keywords: dentist-phobia, dental practice, doctor-patient communication

1. INTRODUCTION

Dentist-phobia represents an emotional state of mind, essential and inevitable [1], with which many patients confront themselves in response to the stress induced by the dental procedures [2]. The phobia can be manifested as mild nervousness or anxiety, up to terror, [2,3] so that it appears as an important obstacle in a successful completion of the dental treatment [1].

The duty of the doctors is to sympathetically deal with such patients, to help them overcome their fears. Unfortunately, many times, because of their fear, patients address the dentist too late, when teeth cannot be saved, any more, because of complicated cavities or fractures or, if they start the treatment in due time, they interrupt it after a few sessions, being afraid of pain.

When not treated, the inflammatory process can determine pulp necrosis, also followed by periapical pathology [4].

2. CASE REPORT

Patient C.T., 39 year-old, male, architect, presented himself to the dental office with a severe malocclusion due to an accident he had suffered at the age of 10 years, and also with many carious lesions (Fig. 1), asking for complete rehabilitation.

The patient had delayed his dental treatment all these years due to his dentist-phobia.

After the initial consultation, it was obvious that a complex oral rehabilitation is necessary, and that more dental specialties will be involved. Considering patient’s anxiety, we decided to start with occlusal and endodontic treatments for the first sessions, to get him used to them.

Consequently, after a professional cleaning, tooth 4.7 was endodontically treated, followed by 15, and a class II cavity on 17.

For the endodontic treatment on teeth 47 and 15, we used sodium hypochlorite to disinfect the roots (especially on 47, which had gangrene), and a final root canal filling was made by injecting warm thermoplastic gutta-percha and Ah plus (Dentsply, Meileffer) as a sealer. For the class II cavity on tooth 17, Dycal (Dentsply, Meileffer), Tetric Flow A2 (Ivoclar), Gradia Lo Flo A3 (GC) and Tetric EvoCeram A3 (Ivoclar) were used.
Tooth 47 needed 5 sessions, due to its severe gangrene, as well as to the fact that the patient lost the temporary filling before fiber post restoration, as shown in Figure 3.

After the patient got acquainted with the dental office and he had no anxious feelings, surgery in the upper jaw was performed. First, the prosthodontist did the fixed prostodontic restoration ablation on teeth 21-24 (Fig.2) and then roots 16, 14, 11, 23 and 26 were extracted, followed by intra-alveolar bone grafting.

Teeth 11, 12, 15, 17, 24, 27 were prepared for a temporary fixed prosthodontic bridge.

In position 22, an extraalveolar bone graft was made, required by the bone defect present in that area. The implantologist used Bio-Oss (Geistlich), Miner Oss and Helitape membrane (Collagen) (Fig.3).

An immediate temporary bridge was made directly in the office and a long-term impression (made by the dental technician) was taken.

After healing and bone integration, the patient came in the office for the upper jaw implants (Fig. 4): 26- Alpha Bio Implant DFI 4, 2 /11, 5 followed by an internal sinus lift of approximately 1.5 mm, 25 Alpha Bio Implant DFI 4.2 /13 (in the 2.7 area, as well as a mild bone graft with Bio Oss -Geistlich), 21 Alpha Bio Implant DFI 3.3 /13mm, 23 Alpha Bio Implant DFI 3.7 /13 mm, 22 Alpha Bio Implant DFI 3.3 /11.5 mm (in the 21- 22 area, a vestibular Bio Oss- Geistlich- bone graft was made and Oro-Mem membrane –Collagen- was used), 13 Alpha Bio Implant DFI 3.3 /11.5 mm, 14 Alpha Bio Implant DFI 3.3 /11.5 mm, 16 Alpha Bio Implant DFI 3.3 /11.5 mm.

After 6 months of healing, teeth 12 and 24, previously prepared, also suffered a vital pulpectomy. The canals were prepared using the rotary Protaper system, and filled with thermoplastic gutta-percha injection. The sealer used was Ah plus (Dentsply, Meileffer). Teeth 17, 11 and 27 maintained vital.

All endodontically treated teeth were restored using different systems of fiber posts (Anatomic posts from Micromedica on tooth 47, 15 and 24 and White Post DC no 1 from FGM on 21). Build-It A3 and A2 from Pentron Clinical were used as restoration materials.

For the final restoration, metal-ceramic crowns were made (17 single crown, 16, 15, 25, 27- single crowns, 13-14 metal-ceramic bridge on implants, 13-12 metal-ceramic bridge on teeth, 21-23 metal-ceramic bridge on implants).

The lower jaw was not completely restored, due to the fact that the patient asked for a separate treatment. Considering his phobia, we agreed and he promised that he will come for treatment the following year.
The anxiety of patients [5-11] still represents an important problem in dental practice [1]. The treatment and attitude towards the patient must be personalised for each case in part.

The most frequent causes of fear of dentist include: fear of pain through anticipation, fear of losing control, fear of being lied, fear of unknown (through lack of information or lack of communication with the doctor), fear of invasive procedures, of the noise made by different instruments, fear of repeating previous negative experiences, fear of bleeding and so on. [2,12-15].

In cases of dentist-phobia, the dentist has to make special efforts to best communicate with the patient, to motivate and encourage him to finish his dental treatment and also to avoid more suffering of the dental-maxillary apparatus. The frequency of dental caries can be also influenced by the composition and volume of saliva, and by oral hygiene [16] (which, in such cases, is not satisfactory).

The advances recorded in dental medicine allow people to enjoy their dental health more than one century ago [17]. However, the level of dental health is different from one person to another, which represents a real problem, if considering that dental caries can be prevented and that they are not inevitable [18].

4. CONCLUSIONS

The cases of patients with fear of dentist represent a continuous challenge for the dentist, who should adopt an understanding, friendly attitude, to share additional information on the treatment anytime he is asked, and to acquire patient confidence, for completing the therapy with full success.

Personalization of the treatment is essential for helping the patients to overcome their fear and to understand that, in recent years, the new dental materials and techniques make the dental treatment less painful as 20 or 30 years ago.

3. DISCUSSION

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