TRAINING MEDICAL CARD OF AN OUTPATIENT SURGICAL DENTAL PATIENT

Minsk BSMU 2024

МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ
БЕЛОРУССКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ
КАФЕДРА ХИРУРГИЧЕСКОЙ СТОМАТОЛОГИИ

УЧЕБНАЯ МЕДИЦИНСКАЯ КАРТА АМБУЛАТОРНОГО ХИРУРГИЧЕСКОГО СТОМАТОЛОГИЧЕСКОГО ПАЦИЕНТА

TRAINING MEDICAL CARD OF AN OUTPATIENT SURGICAL DENTAL PATIENT

Учебно-методическое пособие

Минск БГМУ 2024

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LIST OF ABBREVIATIONS AND CONVENTIONS

AP — acupuncture points
B — basophils
HIV — human immunodeficiency virus
WHO — World Health Organization
MS — maxillary sinus
IIP — infectious-inflammatory process
IGTM — index of hygienic condition of third molars
TI — tartar index
PI — plaque index
ISI — integral severity index
CBCT — cone beam computed tomography
CPI — complex periodontal index
CFE — index of caries, fillings, extracted teeth
CT — computed tomography
LII — leukocyte intoxication index
LIIO — leukocyte index of intoxication V. K. Ostrovsky
Lph — lymphocytes
M — monocytes
MAO — monoamine oxidase
Me — myelocytes
microL — microliters
OPG — orthopantomography
R — rod-nuclear
Pl.c. — plasma cells
S — segmento nuclear
SCT — spiral computed tomography
ESR — erythrocyte sedimentation rate
SHI — simplified hygiene index
CIL — caries intensity level
CNS — central nervous system
E — eosinophils
Y — young forms
NI — nuclear intoxication index
NMR CT — nuclear magnetic resonance computed tomography
∑ — sum
AA — auricular acupuncture points
n — number of observations
O-HIS — simplified Green–Vermillion hygiene index
RC3 — acupuncture point (yin-tang)/reference point in the head and neck area during thermography

INTRODUCTION

Learning aim: learn how to independently supervise an outpatient surgical dental patient and writing a training outpatient dental card.

Documentation is extremely important in a dentist's work. Based on detailed and carefully made entries in the outpatient dental record, it is possible to draw fairly reliable conclusions: about the completeness and correctness of the examination performed on the patient; correct diagnosis; adequacy of the treatment carried out or performed; timely and complete recovery period; reliability of prognosis of the course and outcome of the disease.

Working on a training outpatient dental card is a big and serious stage in the formation and self-education of a future doctor. Through creative work on an educational outpatient dental card, each student should define it as a document that has medical, scientific and legal significance (В. А. Птицын и соавт., 2014).

It should also be remembered that the patient's outpatient dental card is a document that ensures continuity and consistency in the patient's treatment, and one of the main sources of information when carrying out scientific research. Therefore, this document must be written logically, competently and accurately.

From a methodological point of view in writing a clinical educational outpatient card for a surgical dental patient, a student should use elements of a descriptive reflection of facts with mandatory subsequent comprehension of them. In this educational manual, students are presented not only with a diagram of the patient's outpatient dental card, but also with a description form, while emphasizing the importance of certain factors.

Working on a clinical outpatient card of a surgical dental patient at the Faculty of Dentistry has its own characteristics. Particular attention should be paid to such sections as: anamnesis, special status, substantiation of diagnosis, differential diagnosis, prognosis and epicrisis, and, if necessary, clinical observation.

The educational outpatient dental surgical card should demonstrate the student's proficiency in handling this important document, and therefore the student's level of clinical thinking. Underestimation of clinical data and additional research methods leads to an incorrect clinical diagnosis, and subsequently to an incorrect choice of treatment tactics, which can harm the patient's health, including disability and death.

Writing an academic outpatient card for a dental surgical patient requires students to be scrupulous and focused in successfully mastering the principles of correct comprehension, formation, and logically correct detailed presentation of data from a subjective and objective clinical and additional examination in chronological order.

The educational and methodological manual consists of: the title page of the outpatient card of a dental surgical patient, brief and detailed outlines of the specified document and special appendices.

The brief diagram is intended to show the amount of information about the patient that should be presented in the outpatient chart of a dental surgical

patient. A detailed diagram of an outpatient chart of a dental surgical patient focuses the student's attention on those indicators that should be analyzed when examining the patient and correctly methodically present the information obtained in the mentioned document.

Drawing up a detailed outpatient card for a dental surgical patient is the only and extremely important way to master the correct skill of filling out this type of documentation, which is drawn up by a practicing dental surgeon.

Objectives of the educational manual:

– provide special methodological guidance for drawing up a plan and presenting in accordance with it the data of the academic clinical outpatient record of a dental surgical patient;

– to help students develop the correct sequence in receiving, accumulating, analyzing incoming information, in carrying out dynamic observation, in conducting a comparative assessment of the data obtained and making decisions.

To successfully write an academic outpatient record for a dental surgical patient, the **student must** have an understanding of this document and its medical, scientific, and legal components.

The student must study academic outpatient card of a dental surgical patient.

The student must be able to correctly prepare an academic outpatient card for a dental surgical patient.

Requirements for initial knowledge level. To fully write an educational medical record for an outpatient surgical dental patient, you need to know:

– normal and pathological physiology — physiological functions and pathological changes in the function of organs of the maxillofacial region and neck;

– fundamentals of microbiology: the main representatives of microflora, which are the etiological factor in the development of infectious and inflammatory diseases of the maxillofacial area and neck;

– propaedeutics of internal diseases: basic principles of medical ethics and deontology, principles of patient examination, basics of clinical diagnosis;

– laboratory diagnostic data in normal and pathological conditions;

– basic principles of radiological diagnostics of surgical pathology of the maxillofacial region and neck, diagnosis and verification of infectious and inflammatory processes and foreign bodies of the specified localization;

– general surgery: basic principles of treating the surgeon's hands, the surgical field, basic principles of caring for patients with surgical pathology of the maxillofacial area and neck;

– pharmacology: drugs, their metabolism, interactions, routes of their administration and elimination from the patient's body.

Test questions from related disciplines:

1. Indicate what the sanitary and epidemiological regime of the surgical department includes?

2. List the representatives of normal and pathological microflora of the oral cavity.

3. What types of immunological response of the macroorganism to the introduction of infectious agents do you know?

4. Outline the sequence and rules for examining and examining a patient with surgical pathology of the maxillofacial area and neck.

5. Outline modern rules for cleaning the surgeon's hands, sterilizing surgical instruments and dressings.

6. What are the features of processing the surgical field on the surface of the skin of the head, face, neck and in the oral cavity?

7. List the drugs used for injection and non-injection local anesthesia in maxillofacial surgery and dental surgery.

8. Pharmacodynamics and pharmacokinetics of drugs and auxiliary agents used for injection and non-injection local anesthesia.

9. Interaction of drugs used for injection and non-injection local anesthesia with other drugs and chemical agents.

10. Basic methods of radiological diagnostics used in patients with surgical pathology of the maxillofacial region and neck.

11. Basic laboratory diagnostic methods used in patients with surgical pathology of the maxillofacial area and neck.

12. Rehabilitation of patients after surgical treatment.

Test questions / tasks for students:

1. Independently conduct a survey and examination of a patient with surgical pathology of the maxillofacial area and neck.

2. Be present at the operation and participate as a teacher's assistant in the process of dressing the supervised patient.

3. Draw up a plan for examining the patient depending on the complaints he makes, based on the data from the survey and examination.

4. Be able to interpret the obtained clinical data from laboratory, instrumental, and radiation research methods.

5. Based on the data obtained during the examination, justify the surgical tactics and the corresponding complex treatment of the supervised patient.

6. Competently prepare the analyzed information about the patient and his disease in the educational medical card of an outpatient surgical dental patient.

METHODOLOGICAL INSTRUCTIONS FOR WRITING A STUDY MEDICAL CARD FOR AN OUTPATIENT SURGICAL DENTAL PATIENT

Plan of an educational medical card for an outpatient surgical dental patient:

FRONT SIDE OF THE STUDY MEDICAL CARD. At the top center of the page you should indicate the full legal name of the educational institution, department, head of the department (academic degree, academic title, last name, first name, patronymic).

By skipping two empty lines indicate: "EDUCATIONAL MEDICAL CARD OF AN OUTPATIENT SURGICAL DENTAL PATIENT".

By skipping two empty lines in the next one, indicate the patient's last name, first name, and patronymic. The next line shows his age and gender. The next line contains the diagnosis. The next line contains complications of the underlying disease. The next line contains concomitant diseases.

By skipping two empty lines, indicate the last name, first name, patronymic and group number of the curator — the author of the educational medical record. In the next line — the period of patient supervision (from day/month/year to day/month/year).

The next line contains the signature of the student-supervisor.

By skipping two empty lines, indicate the last name, first name, patronymic (in full) of the teacher. The next line indicates his academic degree (if any), academic title (if any), medical category (if any). The next line is the grade for the educational medical record of the dental surgical patient. The next line contains the date and signature of the teacher. The next line contains the decryption of the signature.

The next page provides an example of the design of the title page of an educational medical record for an outpatient surgical dental patient.

EDUCATIONAL INSTITUTION
"BELARUSIAN STATE MEDICAL UNIVERSITY"

DEPARTMENT OF SURGICAL DENTISTRY

Head of the department

_____

_____

STUDY MEDICAL CARD OF AN OUTPATIENT
SURGICAL DENTAL PATIENT

Patient's full name_____
Patient age_____ Sex _____
Diagnosis_____
Complications of the primary disease _____
Concomitant diseases _____

Curator's full name_____ group number_____
Patient supervision period from_____ to _____
Curator's signature _____

Teacher's full name_____
Academic degree_____ Academic title _____ Medical category _____
Mark for study medical card _____
Date_____ Teacher's signature _____
Decryption of the teacher's signature _____

BRIEF CASE HISTORY

I. Passport part:

1. Last name, first name, patronymic of the patient.
2. Age.
3. Sex
4. Time of circulation.
5. Profession, place of work, position held.
6. Place of permanent residence.
7. Diagnosis upon presentation.
8. Clinical diagnosis:
9. Operation.
10. Complication after surgery.
11. Disease outcome.
12. Supervision time.
13. Last name, first name, patronymic of the curator.

II. Patient complaints (at the time of supervision).

III. Life history (life history) of the patient — systems survey:

1. Previous diseases.
2. Bad habits (smoking, alcohol abuse, taking drugs).
3. Patient's heredity (oncological, skin and venereal diseases, tuberculosis, etc.)
4. Allergy history.

IV. History of the present disease (anamnesis of the disease) with which the patient applied for specialized medical care.

V. Objective examination of the patient's maxillofacial area and neck:

1. External examination.
2. Palpation.
3. Examination of the oral cavity:

а) examination of the oral vestibule;

б) examination of the oral cavity itself;

в) dental examination:

– determination of the index of caries, fillings, extracted teeth (CFE);

– determination of the caries intensity level (CIL);

– determination of a simplified hygiene index (O-HIS) according to Green–Vermillion (1964);

– determination of the index of hygienic condition of third molars (IHTM) by I. O. Pokhodenko-Chudakova, Ali Tergam Abdulamir Ali (2022);

– determination of the complex periodontal index (CPI) according to P. A. Leus (1988).

VI. Special (additional) investigation methods:

1. Laboratory (studies of biological environments of the body).
2. Instrumental.
3. Radial.
4. Allergological.

5. Morphological.
6. Anthropometric.
7. Acupuncture diagnostics (electropuncture testing).

VII. Differential diagnosis.

VIII. Clinical diagnosis and its justification.

IX. Etiology and pathogenesis of the disease.

X. Treatment of the disease (indications for choosing treatment methods).

XI. Course of the disease (diary).

XII. Epicrisis (final conclusion on the course and outcome of the disease).

XIII. Recommendations for the patient when completing treatment.

XIV. Prognosis of the disease.

XV. List of special literature used by the curator.

Curator's signature.

Date of submission of the educational medical card.

EXPANDED WRITING SCHEME EDUCATIONAL OUTPATIENT SURGICAL MEDICAL CARD DENTAL PATIENT

I. Passport part (filling in all items is required):

1. Last name, first name, patronymic of the patient.
2. Age (number of completed years).
3. Sex (male/female).
4. Time of circulation (day, month, year).
5. Profession, place of work.
6. Place of permanent residence (with mandatory telephone number).
7. Diagnosis upon presentation.
8. Clinical diagnosis:
   а) primary disease;
   б) complication of the main disease;
   в) concomitant disease.
9. Operation (name, time of intervention, anesthesia).
10. Complication after surger.
11. Outcome of the disease: recovery; improvement; without changes; deterioration of condition; death.
12. Supervision time: beginning (date, month, year); end (day, month, year).
13. Last name, first name, patronymic of the curator.

II. Patient complaints.

In this section of the educational medical record, the curator describes changes in health status noted by the patient himself. First, a brief list of complaints is given, then the main complaints that are currently troubling him, which forced him to seek help from a doctor, are identified, their changes in the course of the disease before seeking medical help are indicated (according to the patient).

The reason for treatment of outpatient dental patients may be sanitation of the oral cavity before somatic planned surgical interventions, surgical sanitation of the oral cavity before prosthetics of the oral cavity (the patient was referred by an orthopedic dentist), which should be reflected in the educational medical record: "He has no complaints, he was referred by orthopedic dentist", or "Sanitizes the oral cavity before lens replacement surgery," etc.).

If the patient complains of pain, the curator should describe its localization, irradiation — distribution (if any), nature (duration, paroxysmal, increasing or decreasing), intensity, frequency (if any), dependence on irritants, time of day, position of the patient's body. The connection of pain with work, physical activity, breathing, eating, talking, chewing, swallowing, shaving, washing must be indicated.

When a patient complains of swelling or a tumor-like formation in the maxillofacial area and on the neck, it is necessary to clarify whether the swelling or tumor-like formation is increasing quickly or slowly; is there any pain; Is the function of other organs of the maxillofacial region and neck impaired, the duration of the specified complaint in time.

The curator should be interested in the patient's subjective sensations accompanying attacks of pain.

It is necessary to check with the patient whether he has complaints of limited mouth opening, disruption of the natural act of eating, impaired chewing, difficulty swallowing, excessive salivation or dry mouth (xerostomia). By asking specific questions, the curator helps the patient remember changes that he had not previously paid attention to.

III. Life history (anamnesis of life) of the patient — systems survey.

This section of the educational medical record of an outpatient surgical dental patient is completed according to the patient's words and is therefore also subjective.

It is necessary to find out the patient's previous diseases (including infectious diseases — tuberculosis, syphilis, human immunodeficiency virus (HIV) infection, infectious hepatitis), surgical interventions, injuries, for women — pregnancy, childbirth.

It is also necessary to find out the presence of occupational hazards during the patient's work activity; heredity regarding oncological diseases; bad habits — smoking, alcoholism, taking drugs; allergological history; transfusion history, medications the patient takes on an ongoing basis.

It should be remembered that in recent years there has been a significant increase in many allergic diseases caused by the increasing use of various medications, quite often without a doctor's prescription and uncontrolled. In parallel with this, an increase in the use of xenobiotics in industry has been noted. Collecting an allergy history of a dental patient is essential. It is known that many drugs, including antibiotics, sulfonamides, amidopyrine, heavy metal salts, novocaine, iodine, phenol, etc. may have cross-allergy with local anesthetics.

The participation of the allergic component in the etiology and pathogenesis of a dental disease can significantly contribute to changing its clinical course and

manifestations, often causing aggravation of the patient's condition, sometimes introducing unwanted and sometimes unforeseen "adjustments" to the complications of the disease and its outcome. Allergens, the nature and types of allergic reactions may vary. All this predetermines the choice of components of complex both pre- and postoperative treatment of a dental surgical patient.

Pathological conditions caused by allergies can be aggravated and complicated by viral, bacterial and fungal infections, leading to toxic-allergic disease. In this situation, a circle of mutually aggravating symptoms of the disease is created, which significantly complicate the diagnosis and treatment of the underlying disease for which the patient came in.

In connection with the above, when taking an allergy history, it is important to establish the patient's body's reaction to contact with animals, plants, flowers, insect bites, preventive vaccinations, and administration of medications.

The curator must necessarily analyze possible blood transfusions and blood substitutes, blood products in the observed patient, as well as the reasons for their transfusion and reactions. In this case, it is imperative to indicate whether viral hepatitis occurred and when?

At the same time, the patient should be carefully questioned about his **concomitant somatic diseases and medications taken on an ongoing basis** for the treatment of the latter or as maintenance therapy. This information is necessary for correctly drawing up a dental surgical treatment plan:

– choice of treatment tactics — outpatient or inpatient (emergency or planned hospitalization);

– determining the method of surgical treatment;

– choice of pain relief method;

– selection of medications for the chosen method of pain relief;

– prescribing proper and effective comprehensive (local and general) postoperative treatment for the patient's general condition.

The survey is carried out to subsequent organ systems.

1. **Respiratory system.** Particular attention should be paid to patients with bronchial asthma.

2. **Cardiovascular system.** It is imperative to ask the patient (and measure, if necessary) about his blood pressure, the presence of arterial hypertension, vegetative-vascular dystonia, the presence of heart and vascular diseases, previous myocardial infarctions, strokes, heart surgery, the presence of an artificial pacemaker.

3. **Digestive system.** It is imperative to indicate whether the patient has chronic diseases of the gastrointestinal tract (GIT): acute or chronic gastritis, pancreatitis, cholecystitis, cholelithiasis, duodenitis, previous operations on the GIT. Here it should also be noted that there is a history of factors (if any) that negatively affect the hepatobiliary system of food poisoning, toxicosis during pregnancy, chronic hepatitis, alcohol abuse, frequent use of antibacterial drug therapy, chemotherapy or radiation therapy, frequent and long-term use of medications, medications (maintenance therapy) that have a negative effect on the liver.

4. **Urinary system.** You should ask about the presence of acute and chronic diseases of the kidneys and urinary tract, previous operations on the kidneys and urinary tract.

5. **Reproductive system.** In women, it is necessary to find out about the presence of menstruation at the time of surgical treatment to prevent bleeding, the presence and duration of pregnancy, the postpartum period, severe gestosis of pregnancy, surgical interventions on the uterus and ovaries, the number of premature and normal births, the number of abortions.

6. **Musculoskeletal system.** It is necessary to find out whether the patient has systemic diseases of the connective tissue ("major collagenoses"), and a history of previous operations on the musculoskeletal system.

7. **Nervous system.** It is necessary to find out whether the patient has diseases of the central and peripheral nervous system and whether he is taking monoamine oxidase inhibitors (MAOIs) or antidepressants.

8. **Past infectious diseases.** Indicate if the patient has a history of tuberculosis, syphilis, HIV infection, infectious hepatitis, actinomycosis, COVID infection.

The section "Survey on systems" is of particular importance, since often both students of the Faculty of Dentistry and, unfortunately, practicing dentists consider this section unnecessary, ignore a thorough collection of somatic anamnesis, and, in the outpatient medical records of a dental patient are limited to formal phrases, describing all systems together, which is UNACCEPTABLE!!!

It should be remembered it is the survey on the systems that will allow the curator to resolve a number of important issues: is only one organ to which the complaints relate to affected, or are there changes in other organs; Is this organ primarily affected or should complaints be regarded as a symptom of damage to another system.

System survey makes it possible to exclude damage to other organs and systems.

When determining the indications for surgery, the curator will have an idea of the presence or absence of contraindications from other organs and systems.

When determining the indications for surgery, the curator is obliged to find out whether there are any contraindications for the proposed method of pain relief, for which a survey on the systems is also important.

The choice and prescription of complex postoperative treatment must also be associated with mandatory consideration of the general condition of the patient and the medications he is taking.

IV. History of the present disease (anamnesis morbi) with which the patient applied for specialized medical care.

This section refers to subjective information and is filled out from the patient's words.

Anamnesis morbi or the history of the development of the disease with which the patient came in, is one of the most difficult sections of the educational medical record of an outpatient surgical dental patient, and it is extremely important and useful for determining the diagnosis. Collection of anamnesis should be carried out

according to the level of intellectual development of the patient and the capabilities of his speech apparatus. The curator is obliged to help the patient correctly present information about his illness, if it necessary.

It is necessary to determine the length of time during which the patient suffers from a real illness (for example, "considers himself sick within a week").

The onset and course of the disease should be described in strictly chronological order.

It is important to trace changes in the same symptom and the sequence of addition of other symptoms. Sometimes patients can forget a number of signs of the disease in the presence of a curator and remember them later. For this reason, sometimes it is necessary to return to the medical history more than once. And if the curator, having filled out this section of the patient's medical record, finds out important data in the following days of supervision, then in such a situation, an entry should be made in the diary of the disease for the day, month, year when an important fact of the life history or medical history was identified, titling it "Addition to the anamnesis".

Consistent presentation of complaints helps to establish the nature of the disease development, which is necessary to identify the underlying disease, its complications and concomitant pathologies. For example, if at the beginning of the disease the patient was bothered by aching pain in only one specific tooth when biting, then later he may note that the pain has become spontaneous, pulsating with irradiation along the branches of the trigeminal nerve, and even later — report that the pain has become worse diffuse character in the jaw and since that time there has been numbness in the lower lip area.

The curator is able to conclude that the disease continues its development, that the process began with the "causal" tooth, and then moved to the jaw bone. Clarification of this information is also necessary for differential diagnosis with other diseases similar in etiology, pathogenesis and clinical manifestations. In the given example — with pulpitis, trigeminal neuralgia, osteomyelitis of the jaw, etc.

If there is a tumor-like formation in the maxillofacial area, it is necessary to find out how it arose, its initial size, consistency, mobility, and growth rate. It is imperative to find out whether it disappears from time to time, or is present constantly, whether it causes pain, whether it interferes with eating, tongue movement, swallowing, breathing, speech, etc.

If there is a congenital defect of the lip, cheek, gum, palate, or ears, it is necessary to find out how the mother's pregnancy proceeded (try to determine the teratogenic factor).

If a tissue defect in the maxillofacial area is acquired, the cause of its occurrence should be found out.

If there is a patient with an injury to the maxillofacial area, it is necessary to find out: where, under what circumstances and what caused the injury, whether the patient lost consciousness, whether there was vomiting, nausea, bleeding from the mouth, ear, nose, by whom and where the victim was taken, what he received

help. In this case, it is imperative to find out whether the patient was administered tetanus serum or toxoid.

When a patient presents with postoperative bleeding (after tooth extraction, after periosteotomy, performed in a clinic, etc.), the curator should find out whether similar complications have previously occurred after operations, incisions or accidental injuries (to exclude blood diseases accompanied by hypocoagulopathy, etc.).

If there are several diseases, the history of the disease that caused the patient's treatment should be presented. Other diseases should be noted in the "Concomitant diseases" column and the time (day, month, year) of their onset in this patient should be indicated. For example, if a patient presented with a fracture of the body of the lower jaw on the right, then the date, circumstances and mechanism of injury should be indicated, when and what kind of assistance was provided to the victim before the moment of supervision. In a situation where the patient suffered from chronic sialadenitis of the right submandibular salivary gland before the injury, this disease should be classified as concomitant and its presence should be indicated in the appropriate section.

After presenting the chronological sequence of the development of the disease and the appearance of its symptoms, the curator needs to find out where and how the patient was treated, in which medical institution, outpatient or inpatient, and how effective the previous treatment was. The curator should analyze the medical documentation available to the patient related to the disease for which he is applying and regarding his somatic status (certificates from medical institutions, laboratory tests, advisory reports, etc.). This will help the student evaluate previous treatment methods and make him think about other, more rational and effective types of treatment measures.

Filling out this section of the educational medical record of an outpatient surgical dental patient, the curator will have to solve the following tasks:

– establish the time of onset of the disease and thereby determine its duration;

– monitor the consistent development of complaints;

– determine previous treatment methods and their effectiveness;

– make a preliminary conclusion about what in what phase the disease is now (acute, chronic, in remission, progressing, regressing, relapsing, etc.).

The completeness of the history of the disease presentation is directly dependent on the ability of the curator to find out the patient's medical history and on the patient's ability to express his feelings.

It should be remembered that some individuals try to hide the cause of the disease if it puts the patient in an unpleasant position in society: women hide the beatings of their husbands; men tend to hide the true circumstances of the injury, especially those resulting from family fights; if manifestations in the oral cavity are symptoms of sexually transmitted infections.

Some patients exaggerate their illness and this phenomenon is called aggravation in medicine. Other patients make up illnesses — this is called "simulating". Some patients hide the symptoms or causes of the disease, which is called dissimulation.

V. Objective examination of the patient's maxillofacial area and neck.

In this and next sections of the clinical history of the disease, the curator records the data that he obtained during visual examination, auscultation, percussion, palpation, during measurement and additional examination methods and is objective.

It is necessary to give a general assessment of the patient's **condition**: good, satisfactory, moderate, severe, extremely severe.

Consciousness: clear, confused, in a twilight state, restless, unconscious.

Facial expression: calm, excited, indifferent, mask-like, sad, tired, suffering, without painful manifestations.

Patient position: active, forced (describe the position that the patient takes to alleviate his condition), passive, indifferent, the patient is immobilized.

Body type: normal, some deviations; stoop, deformation, height, weight.

Nutrition: correspondence to height and weight; subcutaneous fat layer — moderate (satisfactory), weak (reduced), excess (excessive), depleted.

Skin: color (flesh, pale, bluish, icteric, sallow, red, purple, dark brown, hyperpigmentation, depigmentation); elasticity; humidity; dryness; rash; peeling; scratching; hemorrhages; scarring). Signs of a patient's endocrine system disruption may include: changes in the skin — thickness, color, dryness, moisture, its appendages — hair growth.

Temperature during palpation: hot, cold, homogeneous in all parts of the body or not.

Edema: local (localization), general.

Hair, nails: dryness, brittleness, slow growth.

Regional lymph nodes: localization (mental, submandibular; premaxillary; occipital; cervical superficial and deep; supraclavicular; subclavian); the multiplicity or singleness of nodes is determined; their sizes; form; consistency; soreness; mobility (displacement between each other and relative to surrounding tissues; adhesion to the skin and underlying tissues).

The curator should note how nasal breathing occurs (free; difficult; nasal discharge: volume of discharge; its color; character (consistency); smell; from which half of the nose).

Larynx: voice, clear, quiet, strong; absence of voice or soundlessness — aphonia. Breathing is free or difficult.

Visual inspection. The curator must determine the presence of changes in facial configuration, the presence of fistulas, scars, abrasions, skin tears, gaping wounds, swelling, tumor-like formations, defects and deformations of the facial skeleton and soft tissues of the maxillofacial area. In this case, their topography, size, visual boundaries, depth of wounds and defects are necessarily determined (indicating: penetrate into the oral cavity, nose, maxillary sinus, orbit).

Any damage to the skin leaves a mark in the form of a scar. By the nature of the scar one can judge the nature and timing of the damage.

The educational medical record of an outpatient dental patient must reflect the following data on scars: a) location (localization); b) shape; c) dimensions; d) relation to the underlying tissues (mobility/immobility); e) color (red, pink,

white); f) density; g) ulcerations, cracks, peeling on the scar; h) scar sensitivity/pain; i) dysfunction of the organ of the maxillofacial region (ectropium, deformation, etc.) caused by scar deformation.

A special form of scar is the so-called “keloid” — tumor-like scar. They rise above the level of the skin and have a lumpy surface of a bright pink color and are dense in consistency. In the area where such scars are located, patients experience itching and pain. Keloid scars form more often after chemical burns and are prone to recurrence.

Particular attention should be paid to damage to the cranial nerves (determine the sensitivity of the skin and mucous membranes, the functional state of the facial muscles (impaired closure of the eyelids, lips with damage to the facial nerve)), examine the external auditory canals.

Palpation is a method of clinical research that allows to determine the physical properties of tissues and organs, their anatomical and topographic location, sensitivity to external influences, and also, for some of them, functional properties by touch. The examination is carried out in the following sequence: lower lip, chin, body of the lower jaw (its angle, branch, temporomandibular joint, parotid salivary gland area, cheek area, upper lip, upper jaw, zygomatic arch, zygomatic bone, lateral surface and dorsum of the nose , chin and submandibular areas, lateral surface of the neck, supraclavicular area. If present, the following are noted: thickening, induration, swelling, pain, condition of the lymph nodes, fluctuation. If a tumor process is suspected, pay attention to the consistency, size, nature of the surface, mobility. If present traumatic injury, palpation begins with a known undamaged area, gradually moving to the site of injury, establishing the consistency, boundaries, size of the swelling and areas of greatest pain.

Fluctuation is a symptom of fluid being in a closed cavity. One or two fingers of one hand are placed on the area to be examined. Then, with one or two fingers, a sharp push is made in the area under study. The movement they cause in the cavity is perceived by the applied fingers in the form of a sensation of a wave blow. Fluctuation must be determined in two mutually perpendicular directions.

By palpation it is necessary to examine the “exit” points of the branches of the trigeminal nerve (at supra-, infraorbital and mental points).

If the patient has infiltrates of inflammatory etiology or a tumor-like formation (neoplasm), the curator determines the possibility of gathering the skin into a fold in the affected area.

Palpation of the lymph nodes in the submandibular and submental areas is performed with a slight tilt of the head forward, without straining the neck muscles. Then the retromaxillary and cervical lymph nodes are examined. Moreover, whenever regional lymph nodes are palpated, which is not the norm, their size is expressed in centimeters. In this case, it is necessary to additionally indicate: pain/painlessness on palpation; consistency; mobility/immobility; adhesion to the skin and underlying tissues or lack of adhesion to the skin and underlying tissues.

In an acute inflammatory process caused by odontogenic, stomatogenic, hematogenous infection (regional lymph nodes are enlarged, painful, adherent to

surrounding tissues — perilymphadenitis) and form packets, inactive or mobile. In chronic inflammatory processes in the oral cavity, the lymph nodes enlarge slowly and gradually, remain mobile, and palpation does not cause significant pain.

In case of malignant neoplasms that affect organs and tissues of the oral cavity and jaw bones, the lymph nodes are quickly affected by metastases. In these situations, they are enlarged, gradually become motionless with fuzzy, uneven contours, dense, welded together, as well as with the skin and underlying tissues.

With tuberculosis, a slightly painful, dense package of lymph nodes is observed.

With primary lymphatic lesions, the mucous membrane of the oral cavity — the lymph nodes are enlarged and dense (sclerosed).

Conduct a study of the functions of the trigeminal, facial, glossopharyngeal, and vagus nerves.

When studying the functional activity of the trigeminal nerve, they evaluate:

– tactile, pain, temperature sensitivity of the skin and mucous membranes of the innervated area using tactile tests;

– taste sensitivity of the anterior $^{2}/_{3}$ of the tongue;

– motor function by determining the tone and traction force of the masticatory muscles, the correct position of the lower jaw during its movements.

When studying the functional activity of the facial nerve, the state of the facial muscles of the maxillofacial area is determined at rest and during functional tests.

When studying the functional activity of the glossopharyngeal nerve, the taste sensitivity of the posterior third of the tongue and the implementation of the act of swallowing are determined.

The study of the function of the vagus nerve consists of determining the timbre of the voice, the mobility of the soft palate and vocal folds, as well as observing the act of swallowing.

Examination of the temporomandibular joint. An external examination determines the degree of mouth opening and lateral movements of the lower jaw. Normal mouth opening in an adult corresponds to 45–50 mm between the incisors. Also, the amount of mouth opening can be measured by the width of the fingers. Opening is considered normal if the patient opens his mouth to the width of three fingers. The volume of lateral movements is to determine the distance by which the lower jaw moves from the midline passing between the central incisors.

There are three degrees of restriction of mouth opening: 1 — mild degree — mouth opening 2 fingers across; 2 — moderate severity — mouth opening 1 finger across; 3 — severe degree — the dentition is so closed that it is difficult to pass a dental mirror or spatula between them.

When palpating the area of the temporomandibular joint, the condition of the tissues in this area is determined. Additionally, the presence of swelling, hyperemia, infiltration and pain should be indicated. In the absence of inflammation, the ends of the little fingers are inserted into the external auditory canals, the patient is asked to slowly open and close his mouth several times, and the degree of mobility of the articular heads, the synchronization of their movement,

pain, crunching, and clicking in the joints are assessed. Auscultation allows you to identify “noise phenomena” in the joints, such as “crunching” and “clicking”.

Oral examination. The patient is examined in a dental chair with sufficient natural or artificial lighting.

Examination of the oral cavity includes: a) examination of the vestibule of the oral cavity; b) examination of the oral cavity itself.

This examination should be carried out in the dental chair. To do this you need to have a set of sterile instruments:

– spatula — for retracting the tongue when examining its root and pharynx, the inner surface (lingual) gum of the alveolar process, the lower jaw, the floor of the mouth;

– dental mirror for examining teeth and palate;

– dental tweezers (to determine the degree of tooth mobility);

– dental probe — angular (for examining dental tissues) or button-shaped (for determining the depth of gingival pockets and supra- and subgingival deposits);

– thin Bauman probe (from an ophthalmological set for probing the ducts of the salivary glands);

– button-shaped surgical probe — for probing external and internal odontogenic fistulous tracts, maxillary sinus fistula, palate defects.

Next, you should evaluate the patient’s breath odor. It can be sour, putrid, ammonia, alcohol, etc. The smell can be caused by diseases of the teeth, gums, esophagus (diverticula, cancer), stomach (gastritis, cancer), lungs (abscesses, gangrene).

The examination of the vestibule of the oral cavity begins with parting the lips and, with a half-open mouth, examines the vestibule of the oral cavity, the mucous membrane of the lips, cheeks, gums, gingival margin, interdental papillae, the mucous membrane of the upper and lower fornix of the vestibule (transitional folds), frenulum of the upper and lower lips. The curator should pay attention to color (hyperemia, anemia, cyanosis, pigmentation, shine); the presence of lesions (vesicles, aphthae, erosions, ulcers, cracks), defects and cicatricial deformities of the mucous membrane of the oral vestibule.

When examining the oral cavity, the following sequence should be followed.

Each section of the oral cavity is examined clockwise, starting from the left or upper left sector (from the side of the curator — researcher) or from the right or upper right sector (from the side of the examined patient) (Fig.):

1) examination of the lips;

2) examination of the vestibule of the oral cavity;

3) examination of the oral mucosa (pterygomaxillary fold on the right (from the patient’s side) — hard and soft palate — pterygomaxillary fold on the left — retromolar space on the left — lateral floor of the mouth on the left — anterior floor of the mouth — lateral floor oral cavity on the right — retromolar space on the right;

4) examination of the tongue;

5) examination of the pharynx and oropharynx (tonsils forming Pirogov’s ring).

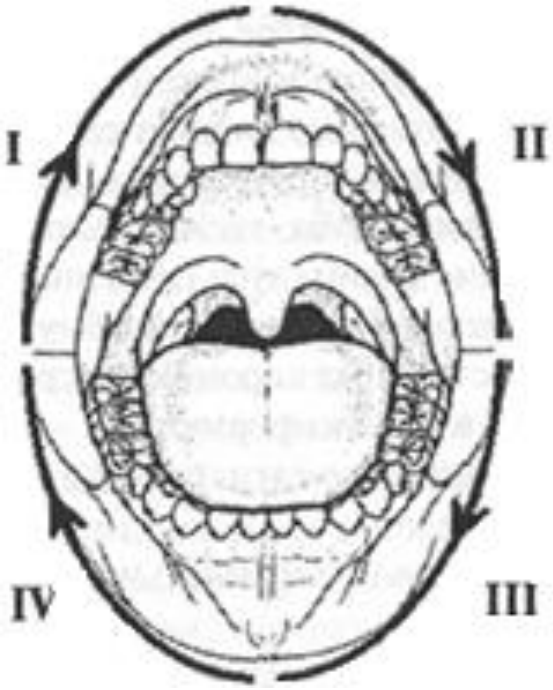


Fig. Oral examination sequence

When examining the oral cavity, pay attention to:

– color and coloration of the mucous membrane (pale, hyperemic, cyanotic, icteric);

– presence of plaque, deposits (fibrin deposits, deposits of fungal colonies);

– thickness of the mucous membrane (thinned, atrophied, hypertrophied);

– presence of wounds (cuts, lacerations, lacerations, bruises, punctures);

– the presence of primary (spot, nodule, tubercle, vesicle, abscess, bubble, cyst, blister) and secondary (erosion, aphthae, ulcer, crack, scales, scar, crust, atrophy) elements of the lesion;

– degree of moisture of the oral mucosa (wet, dry, covered with viscous foamy saliva).

To examine the posterior parts of the mouth floor and the lower surface of the tongue, grab the tip of the tongue with your fingers using a gauze pad and move the tongue up and in the opposite direction.

Then the orifices of the excretory ducts of the parotid salivary gland are examined and, if necessary, diagnostic probing is performed with a Bauman probe. Having determined the functional ability of the salivary glands and the nature of saliva, it is necessary to determine their size, consistency, soreness.

When examining the condition of the soft tissues of the retromolar zone, attention should be paid to the condition of the third molars and/or the process of their eruption. When examining the retromolar fossa — the area of the oral mucosa behind the third molars (at the base of the lower jaw branch), where pathological processes associated with the pathology of the eruption of wisdom teeth often occur (pericoronitis, retromolar periostitis, abscess, phlegmon, etc.). It is imperative to indicate the presence of an inflammatory process in the specified area associated with the eruption of the third molar (pericoronitis), if any. In this

case, the mucous membrane is brightly hyperemic, edematous, sharply painful; upon palpation, purulent exudate is released from under the edge of the mucous membrane "hood" hanging over the erupting tooth.

Next, using a dental probe, the gum pockets are examined (normally, the gum edge is thin, tightly covers the necks of the teeth, pink in color; normally, the mucous membrane of the transitional folds of the vestibule of the oral cavity is the same color). In pathological conditions, the gums may be: pale; loosened; bleeding; ulcerated, etc.

Palpation of the alveolar process and transitional folds of the vestibule of the oral cavity allows the curator to determine areas of compaction, infiltration, the presence of defects and neoplasms of both soft tissues and jaw bones, pain in the area, and its boundaries. Palpation is performed with the index finger of the right hand, pressing either the mucous membrane of the gums or the tops of the roots of the "causal" teeth. Palpation is carried out on symmetrical areas of the jaws on both the affected and healthy sides simultaneously (bimanually).

Also, when examining the mucous membrane of the lower jaw, covering the lingual surface of the alveolar process, the gingival margin with interdental papillae and the entire mucous membrane of the oral cavity, you should pay attention to the condition of the excretory ducts of the submandibular and sublingual salivary glands, located on both sides of the frenulum of the tongue — the mouth of Wartonov and Bartolinov ducts. The size, consistency, soreness, functioning of the submandibular and sublingual glands and the nature of the saliva released from them are also determined. If there is a suspicion of the presence of an inflammatory process in the submandibular salivary glands and in the area of the floor of the oral cavity, the bimanual palpation method is used: the fingers of one hand press on the tissues in the submandibular area in the direction from bottom to top, and the index finger of the other hand is placed in the posterior part of the floor of the mouth (in zone of the maxillo-lingual groove), while inflammatory exudate appears from the mouth of the duct. If necessary, diagnostic probing is performed using a sterile Bauman probe at the mouth of the Wharton ducts.

It should be remembered that hypersalivation can be observed in diseases of the esophagus, stomach ulcers, pancreatic pathologies, and enterocolitis. Then the sublingual ridges are examined, which are normally located in the form of oval elevations on either side of the midline of the lower surface of the tongue. Beneath the mucous layer are the sublingual salivary glands.

Next, the hyoid grooves (the depression between the ridge and the tongue) are examined. Using a dental mirror in the curator's right hand, with which he pulls back the corner of the mouth on the right, and a spatula in his left hand, with which he pushes the lateral surface of the tongue in the root area to the midline, the maxillo-lingual groove is examined on the right (from the patient's side). The maxillo-lingual groove on the right is limited on the medial side by the lateral surface of the tongue root, and on the lateral side by the lingual surface of the alveolar process of the mandible. Normally, the maxillolingual groove on both sides is well defined and always free. When examining the maxillo-lingual groove

on the left, the position of the hands and instruments in them changes accordingly. The examination of the maxillo-lingual grooves ends with palpation of the latter.

In the presence of inflammatory processes localized in the area of the lingual (inner) surface of the lower jaw, and in the area of the root of the tongue and the floor of the mouth, the maxillary lingual groove is smoothed, that is, poorly expressed.

Then the curator examines the pharynx, determines color, hyperemia, asymmetry, hypertrophy or atrophy of the tonsils, the presence of plaque, necrosis. Continuing the study, the curator examines the soft and hard palate, gingival margin and interdental papillae of the alveolar process of the upper jaw from the palatal surface.

The tongue, its back, lateral surfaces and the surface facing the bottom of the mouth should be examined separately. In this case, it is necessary to determine the condition of the papillary layer of the mucous membrane of the tongue in the anterior section, in the area of the back and root of the tongue, its lateral surfaces (filamentous, mushroom-shaped, leaf-shaped papillae). Particular attention must be paid to the glandular apparatus of the tongue, its grooved papillae, and it is imperative to indicate their condition in the completed medical record (without deviation, with deviation (in the latter situation, it is necessary to indicate with what deviation, in what area and with what it may be connected)). The curator pays attention to the color of the tongue, moisture, plaque, pattern ("geographical tongue"), inflammatory changes, cracks, ulcers, tooth marks.

The tongue is called the mirror of the digestive tract. It is known that changes in the tongue occur in most infectious and inflammatory processes accompanied by a febrile state (influenza, scarlet fever, typhus, sepsis, peritonitis, etc.).

In the educational medical record of an outpatient surgical dental patient, the curator should reflect: dry tongue (which may indicate dehydration of the body)/wet; thickened or not. On a thickened tongue, tooth marks are usually visible along the edges of the lateral surfaces as a result of a violation of the water-electrolyte balance. As a rule, in this case there is a violation of salivation towards hyposalivation.

Normally, the tongue can be clear. If intestinal evacuation is impaired — covered. A white-yellow coating is more often noted, which is observed in most gastrointestinal diseases, as well as in smokers and alcohol abusers. Dry tongue and brown coating are observed in septic diseases. A yellow-brown coating with a clear triangle on the tip of the tongue is characteristic of typhus. Brown tongue occurs in Addison's disease. A tongue coated at the root, with ulceration at the edges (desquamation of the epithelium) and severely hypertrophied papillae, is characteristic of gastric and duodenal ulcers. A clear pale red or red smooth tongue with atrophied papillae is characteristic of anacid gastritis and stomach cancer.

The attention of the curator may be drawn to white plaques in the oral cavity, which rise above the mucous membrane of the tongue, and are also located on the mucous membrane of the oral cavity or the red border of the lips. These lesions indicate leukoplakia, which should be considered a precancerous lesion.

When examining a patient with a congenital and acquired palate defect, it is necessary to describe the location, size of the defect, as well as the nature of its edges, determine the degree of mobility of the soft palate, shortening of the palate, combination of the palate defect with an alveolar cleft, lips.

If you suspect a fistula of the maxillary sinus (MSF), which has arisen after tooth extraction, you should find out its connection with the sinus or cyst of the upper jaw (to do this, ask the patient to puff out his cheeks, which is impossible to do in the presence of a sinus fistula).

If the curator suspects a cyst in the maxillofacial area, if possible, a diagnostic puncture should be performed.

In case of injuries to the maxillofacial area, during the examination both from the vestibule and from the oral cavity itself, the curator checks the condition of the mucous membrane, the location and degree of hemorrhage, dental arches, pathological mobility of individual teeth, parts of the alveolar process, areas of the jaw, or identifies possible mucosal ruptures, their localization, hematomas and bone defects. With freely movable fragments of the upper jaw, the latter are easily displaced even during examination. The study of the mobility of bone fragments in fractures of the upper jaw is carried out as follows: the first fingers of both hands with the palmar surface rest on the chewing surface of the molars of the upper jaw, and the index fingers on the anterior wall of the upper jaw in the area of the canine fossa, after which a very careful attempt is made to displace the bone fragments.

In case of fractures of the lower jaw, the mobility of bone fragments is examined as follows: the index fingers are placed on the chewing surface of the molars of both sides, and the first fingers (thumbs) are placed on the lower edge of the body of the lower jaw and a careful attempt is made to displace the bone fragments.

If there are wounds or ulcers, it is necessary to describe them in detail in the patient's medical record, indicating the condition of the mucous membrane around the edges, the bottom of the wound or ulcer, the nature of granulations and wound discharge, color, consistency, volume, smell (in its absence, indicate "odorless". Be sure to note if the process of epithelization of the wound has already begun.

Speech. This section should describe the function of speech. Note if there are changes in it, indicate in connection with the presence of which pathology in the maxillofacial area the speech function is changed/impaired. For example, rhinolalia is noted as a consequence of congenital through bilateral cleft palate.

1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8
4.8	4.7	4.6	4.5	4.4	4.3	4.2	4.1	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8

The examination of teeth begins with that part of the dentition where, in accordance with the patient's complaints and his anamnestic data, the localization of the pathological process is assumed. The examination data obtained must be reflected in the educational medical record of an outpatient surgical dental patient in the form of a clinical dental formula:

Detected dental defects are indicated using appropriate symbols above- (for the upper jaw) or below- (for the lower jaw) according to the dental formula:

0 — healthy (intact) tooth;

1 — caries, complicated caries (pulpitis, periodontitis);

3 — seal;

4 — deleted;

7 — artificial crown;

8 — unerupted tooth;

— ortopedical briges.

CRE index = ☐

Determination of the caries intensity level (CIL) is carried out according to the formula presented in Table 1 based on the obtained data of the CIL index and the patient's age.

CIL = ☐

Table 1

Formulas for calculating the UIC based on age and CFE data and its interpretation

Level of caries intensity			low	medium	high	very high
	1–8 years	CFE / N years	< 0.4	0.5–0.8	0.9–1.2	> 1.3
	6–19 years	CFE / N – 5 years	< 0.3	0.4–0.6	0.7–0.9	> 1.0
	> 20 years	CFE / N years	< 0.15	0.15–0.3	0.31–0.6	> 0.6

Determination of the simplified hygiene index (O-HIS) according to Green–Vermillion (1964).

This index allows you to obtain a quantitative assessment of plaque and tartar. The vestibular surfaces of teeth 1.1, 1.6, 2.6, 3.1 and the oral surfaces of teeth 3.6, 4.6 are examined. Plaque is determined using a dental probe or using dyes (3–5 % tincture of iodine, Lugol's solution, eosin, erythrosin tablets).

Plaque index values:

0 — no plaque;

1 — plaque covers no more than $^1/_3$ of the tooth surface;

2 — plaque covers up to $^2/_3$ of the tooth surface;

3 — plaque covers $^2/_3$ of the tooth surface.

$$\text{Plaque index (PI)} = \frac{\text{Summ every tooth index}}{6} \qquad (1)$$

To evaluate tartar, the dye does not need to be used.

Calculus index values:

0 — no calculus;

1 — calculus upper gingiva covering $^1/_3$ tooth surface;

2 — calculus upper gingiva covering $^2/_3$ tooth surface;

3 — calculus upper gingiva covering $^2/_3$ tooth surface.

$$\text{Calculus index (CI)} = \frac{\text{Summ every tooth index}}{6} \quad (2)$$

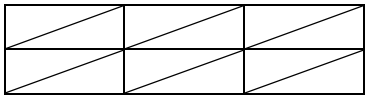
Simplified hygiene index (SHI) = PI + CI (3)

Evaluation criteria: 0–0.6 — good; 0.7–1.6 — average (satisfactory); 1.7–2.5 — bad; 2.6 or more — very poor level of hygiene.

All specified results are entered into the appropriate table, above which the date of the survey must be indicated, and below it — the evaluation criterion determined on the basis of the survey results obtained.

OHI-S

Data _____



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Determination of the index of hygienic condition of third molars (IGTM) according to I. O. Pokhodenko-Chudakova, Ali Tergam Abdulamir Ali (2022).

When determining the index, all surfaces of the third molars that have erupted and are located in the oral cavity are examined.

The sequence of examination of tooth surfaces is as follows: medial; vestibular; distal; palatal — for the upper jaw or lingual — for the lower jaw.

The sequence of examination of the third molars corresponds to that when examining quadrants of the dentition in accordance with the recommendations of the World Health Organization (WHO) from the first to the fourth: 1.8, 2.8, 3.8, 4.8.

Determination of soft (plaque) and hard (tartar) deposits is carried out using a probe, which is gradually moved along the studied tooth surfaces in the direction from the cusps of the crown (occlusal surface) to the neck of the molar. At the same time, note the level of the crown at which soft dental deposits begin to accumulate on the probe and the level when the probe detects tartar.

The points obtained during the study, as well as intermediate results of calculations, are entered into a specially designed data recording table (Table 2).

Table 2

Survey data and intermediate calculations when determining the hygiene index of third molars

Subjects teeth	Evaluated clinical signs	Examined surfaces of the third molar				IGTM
		Medial surface	Vestibular surface	Distal surface	Palatal/lingual surface	
1.8	Dental plaque					
	Tartar					
2.8	Dental plaque					
	Tartar					
3.8	Dental plaque					
	Tartar					
4.8	Dental plaque					
	Tartar					

Scale for assessing soft dental deposits (plaque):

– no plaque — 0 points;

– soft plaque covers $^1/_4$ of one of the tooth surfaces and/or there is the same amount of pigmented dense plaque — 0.25 points;

– soft plaque covers $^1/_2$ of one of the tooth surfaces and/or there is the same amount of pigmented dense plaque — 0.5 points;

– soft plaque covers $^3/_4$ of one of the tooth surfaces and/or there is the same amount of pigmented dense plaque — 0.75 points;

– soft plaque covers the entire examined surface of the tooth and/or there is the same amount of pigmented dense plaque — 1.0 point.

Scale for assessing hard dental deposits (tartar):

– no tartar — 0 points;

– tartar covers $^1/_4$ of one of the tooth surfaces and/or there is subgingival tartar in the form of conglomerates — 0.25 points;

– tartar covers $^1/_2$ of one of the tooth surfaces and/or there is subgingival tartar in the form of conglomerates — 0.5 points;

– tartar covers up to $^3/_4$ of one of the tooth surfaces and/or there is subgingival tartar in the form of conglomerates — 0.75 points;

– tartar covers more than $^3/_4$ of one of the surfaces of the tooth and/or there is subgingival tartar surrounding the cervical part of the tooth — 1.0 point.

Index calculation includes the following steps.

Calculation of the index for each third molar present in the oral cavity in the sequence indicated above using the formula:

$$\text{IGTM (number of third molar)} = \frac{\sum_{\text{plaque}} + \sum_{\text{tartar}}}{n}, \quad (4)$$

where $\sum_{\text{plaque}}$ — sum of plaque points; $\sum_{\text{tartar}}$ — sum of tartar points; n — number of examined tooth surfaces.

Calculation of the index for all third molars present in the oral cavity using the formula:

$$\text{IGTM} = \frac{\sum_{\text{ITM}}}{n}, \quad (5)$$

where $\sum_{\text{IGTM}}$ — sum of the IGTM indices of the third molars present in the patient's oral cavity, n — number of examined third molars present in the oral cavity.

The interpretation of the obtained results is carried out as follows. With index values ≤ 0.33, the good hygienic condition of the third molars is determined (consultation with a hygienist is not required, professional hygiene is necessary). With values of 0.34–0.67 — satisfactory hygienic condition of the third molars (required: correction of the teeth brushing technique with an emphasis on the third molars; professional hygiene). With values ≥ 0.68, the poor hygienic condition of the third molars is stated (required: training in oral hygiene with an emphasis on third molars, selection of oral hygiene products and items; monitoring the level of hygiene; professional hygiene).

The results obtained during the examination are entered into the dental patient's medical record as follows. First, the obtained IGTM result is indicated, and then its interpretation and related recommendations.

Determination of the complex periodontal index (CPI) according to P. A. Leus (1988). The complex periodontal index (CPI) represents the average value of signs of periodontal damage: from risk factors (plaque), early stages of the disease (bleeding, tartar) to developed stages (periodontal pocket, mobile teeth). The method has the highest reliability and reproducibility (from 80 % to 90 %). The CPI is used for individual and group determination of periodontal status in children, adolescents and adults. The average CPI is determined based on the results of a visual and instrumental study of the periodontal condition of six teeth, one in each of 6 sextants: 3 sextants on the upper jaw and 3 on the lower jaw, respectively, by groups of teeth (frontal and lateral). It is recommended to examine the periodontium of the following "key" (index) teeth: 1.7 or 1.6, 1.1, 2.6 or 2.7, 3.6 or 3.7, 3.1, 4.6 or 4.7. If there is no index tooth to be examined, the closest one should be examined, but only within the group of teeth of the same name. If all the teeth of a given group are missing, then the maximum severity of the periodontal condition is recorded (code 5). Tools necessary to determine the CPI: dental mirror, dental probe, tweezers. To determine plaque, bleeding, tartar, and pathological pockets, a dental probe is used, and dental tweezers are used to identify pathological mobility of teeth. Registration of research data is carried out in a dental patient's card, which has a dental formula and cells (six) for recording KPI index codes. The scoring criteria and codes are presented in Table 3, the scale for determining the severity of the disease is presented in Table 4. If several signs are present, a more severe lesion is recorded. When in doubt, preference should be given to underdiagnosis.

Table 3

Evaluation signs, criteria and codes for determining the complex periodontal index

Signs	Criteria	Codes for recording
Absence of plaque and signs of periodontal pathology (gums, grooves) during visual and instrumental examination	healthy	0
Any amount of dental plaque determined by a probe on the surface of the crown, in the interdental spaces or in the gingival area	plaque	1
Bleeding visible to the naked eye upon slight probing of the periodontal groove	bleeding	2
The presence of hard deposits (tartar) in the subgingival area	tartar	3
Pathological periodontal pocket identified by a probe	pathological pocket	4
Pathological tooth mobility of II–III degree	tooth mobility	5

The CPI of a specific patient is calculated using the formula:

$$CPI = \frac{\sum_{codes}}{6}, \quad (6)$$

where $\sum_{codes}$ — sum of codes, 6 — number of examined teeth.

Table 4

Rating scale for determining the intensity of periodontal diseases based on the results of the comprehensive periodontal index

CPI value	Severity (intensity) of the lesion
0.1–1.0	disease risk
1.1–2.0	***mild intensity of damage***
2.1–3.5	***average intensity of damage***
3.6–5.0	***severe intensity of damage***

In accordance with the data of the author, P. A. Leus (2009), the presented rating scale should not be used to determine the severity of periodontal disease in a particular individual. For this purpose it is necessary use more accurate diagnostic methods, such as measuring the depth of the pathological pocket, radiation examination methods, etc. Also, patients with partial or complete edentia cannot be considered “severely ill” in accordance with the high CPI index.

The results obtained during the examination are entered into the appropriate table, above which the date of the examination must be indicated, and below it — the interpretation of the result (CPI value and severity (intensity) of the lesion).

CPI

Data _____

_____

The curator always needs to remember that this part of the medical history is described in careful detail, paying attention to each item listed.

When closing the dentition, the curator determines the type of occlusion — bite: orthognathic; progenic; biprogenic; direct and the presence of deviations from the norm — microgeny; cross; open; incorrect arrangement of individual teeth, etc.

SPECIAL (ADDITIONAL) INVESTIGATION METHODS

These methods are used: to verify and clarify the clinical diagnosis; differential diagnosis; determination and correct choice of rational treatment for each individual patient; monitoring the effectiveness of treatment. Special additional research methods include the following.

1. Laboratory tests of blood, oral fluid, urine, sputum, bacteriological and cytological studies of exudates, punctates, discharge from wounds, cultures for the sensitivity of microflora to antibiotics, gastric juice, bile, feces.

Laboratory research methods should include determining blood type, Rh status, performing a “small” or “large” (detailed) coagulogram, biochemical and serological studies of body fluids (according to indications), sternal puncture.

The severity of the patient’s condition is largely determined by the syndrome of endogenous intoxication. This symptomatic complex is associated with damage to connective tissue, impaired microcirculation, accumulation of intermediate metabolic products, metabolites, and the toxic effects of endogenous and bacterial toxins. One of the criteria for the severity of a patient’s condition is the degree of intoxication. Its assessment is based on the patient’s complaints and nonspecific symptoms (general condition of the patient, skin color, tachycardia, etc.).

When diagnosing the severity of intoxication, along with clinical criteria (heart rate, respiratory rate, state of the central nervous system (CNS)), various laboratory indicators are used: erythrocyte sedimentation rate (ESR), number of peripheral blood leukocytes, plasma levels of creatinine, urea, molecules average weight, paramecium test, etc. However, some of them are not informative enough or their determination is difficult, time-consuming and requires special equipment. Therefore, since the middle of the last century, practitioners have increasingly turned to indicators of peripheral “white” blood, the determination of which is simple and available in almost any healthcare institution.

To predict, assess the dynamics of the infectious-inflammatory process and select a treatment method, the following indicators are most often used: integral severity index (ISI), leukocyte intoxication index (LII), V. K. Ostrovsky leukocyte intoxication index (LIIO), nuclear intoxication index (NII).

The integral indicator of severity — ISI according to M. M. Solovyov, T. M. Alekhova (1997) is determined taking into account body temperature, pulse and hemogram.

$$ISI = 0.36 \times X_1 + 0.006 \times X_2 + 0.01 \times X_3 - 12.42, \quad (7)$$

where ISI is an integral indicator of the severity of odontogenic infection in points; X_1 — body temperature; X_2 — leukocyte content, thousand 1 μl: 100; X_3 — ESR mm/hour; 12.42 — free term of multiple regression.

The interpretation is as follows: with an IPT value of up to 1.5 points, the course of the infectious-inflammatory process (IIP) is regarded as mild, and the prognosis is satisfactory; if the IPT value is from 1.5 to 2.5 points, the course of IVP is assessed as moderate, and the prognosis of the disease is doubtful; if the IPT value is over 2.5 points, the course of IVP should be interpreted as severe, and the prognosis of the disease is unfavorable.

Leukocyte intoxication index — LII according to Ya. Ya. Kalf-Kalif (1938) is determined on the basis of a hemogram and is calculated using the formula:

$$LII = \frac{(4Mi + 3Yu + 2P + S) \times (Pl.\ class + 1)}{(Lf + M) \times (E + 1)}, \quad (8)$$

where Mi — myelocytes, Yu — young forms, P — stab, S — segmented, Pl. class — plasma cells, Lf — lymphocytes, M — monocytes, E — eosinophils.

The advantage of LII is the ability to convert hemograms into numerical indicators that reflect intoxication. The evaluation criteria in this test, as reported by different authors, are quite variable. So, according to Ya. Ya. Kalf-Kalif, LII is normally 0.47 conventional units. According to the results of research by individual authors and our data — from 0.3 to 1.5 conventional units.

During a viral infection, LII becomes lower than normal against the background of lymphocytosis, and increases during inflammatory processes. An increase in LII to 4–9 indicates a significant bacterial component of endogenous intoxication. Leukopenia with high LII is an alarming prognostic sign. An increase in LII is associated with the disappearance of eosinophils, an increase in the number of segmented forms, band and young neutrophil granulocytes, the appearance of plasma cells (the response of the hematopoietic germ to inflammation) or a decrease in the content of lymphocytes and monocytes (cellular factors of humoral immunity and the mononuclear-macrophage system).

Leukocyte index of intoxication by V. K. Ostrovsky — LIIO, calculated by the formula:

$$\text{LIIO} = \frac{(\text{S} + \text{P} + \text{Yu} + \text{Mi} + \text{Pl. class})}{(\text{Lf} + \text{M} + \text{E} + \text{B})}, \quad (9)$$

where S — segmented, P — band, Yu — young forms, Mi — myelocytes, Pl. class — plasma cells, Lf — lymphocytes, M — monocytes, E — eosinophils, B — basophils

Normally, Ostrovsky's leukocyte intoxication index is 1.5 ± 0.5.

Nuclear intoxication index — NI, is calculated by the method of G. A. Dashtoyants using the formula:

$$\text{NII} = \frac{\text{Mi} + \text{Yu} + \text{P}}{\text{S}}, \quad (10)$$

where Mi — myelocytes, Yu — young forms, P — band forms, S — segmented forms.

Normally, the nuclear intoxication index ranges from 0.04 to 0.08. When the PI is equal to 0.3–1.0, the patient's condition is of moderate severity; when it exceeds 1.0, the patient's condition is severe. In this case, the following types of shift are distinguished: to the left — hyporegenerative (against the background of neutrophilic leukocytosis of band neutrophils 6 %, young neutrophils 1 %), indicating weak stimulation of detoxification systems; regenerative (against the background of a slight increase in band neutrophils, young up to 3 %, leukocytosis up to 18,000 per μl), indicating the tension of compensatory processes; hyperregenerative (young 4 % or more, myelocytes 2 % or more, leukocytosis up to 20,000 in μl or more), indicating an overstrain of compensatory processes; degenerative (shift to the left against the background of leukopenia), indicating the depletion of the body's compensatory abilities, and therefore a decrease in its overall resistance.

2. Instrumental research methods: biopsy — urgent, planned, puncture, excisional, application, trepanobiopsy of the bones of the facial skeleton; optical

stomatoscopy, electroodontodiagnosis, myography, thermal imaging, rheoplatysmography, polarography, electromyography.

3. Radiation research methods: dental imaging, radiovisiography, orthopantomography (OPTG), cone beam computed tomography (CBCT), computed tomography (CT), spiral computed tomography (SCT), nuclear magnetic resonance computed tomography (NMR CT), ultrasound (ultrasound), fluoroscopy, sialography; radiography of the upper jaw with contrast, angiography, zonography, fluorography.

4. Electrocardiography, phonocardiography, oscillography, etc.

5. Allergological diagnostic tests (according to indications).

6. Morphological studies: biopsies (incisional, excisional, trepanation, puncture); cytological examination (smear scraping, imprint smear, reprint smear).

7. Anthropometric studies of the maxillofacial area, making facial casts, photographic materials, taking measurements in the maxillofacial area and their mathematical analysis.

8. Acununcture diagnostics (electropuncture testing). Early diagnosis is always one of the priority issues of modern medicine. One of the options for solving this problem is to use reflex diagnostic methods. In recent decades, electropuncture diagnostic methods based on the measurement of bioelectric parameters at representative acupuncture points (AP) have become increasingly widespread in recent decades.).

9. The presence of bilateral connections between the skin of the body and internal organs is an established fact. This makes it possible to judge the functional state of almost all organs and systems of the human body by changes in certain zones and AT (electrical conductivity, pain sensitivity).

Due to the easy accessibility of auricular acupuncture points (AP), comparative simplicity, non-invasiveness, high information content and relatively short duration of examination, an increasing number of specialists prefer auriculodiagnosis, considering it the most objective and promising method.

The method of electropuncture diagnostics (testing) using AP allows you to take into account individual electrical conductivity by selecting the testing voltage, and therefore has high reliability. This methodological approach is based on individual selection of the test voltage value based on a representative “reference” AT, called “Bioreper”.

The transition to an individually determined testing voltage makes it possible to increase the diagnostic significance of measurements due to a more selective assessment of the level of electrical conductivity of the exteroceptive reflexogenic zone chosen as a reference point. Comparison of the obtained voltage distributions at point PC3 and the arithmetic average values of currents in AP with the calculated measurement parameters revealed a strong correlation between the selected testing voltage and the average value of currents at the indicated biologically active points, which indicates the suitability of the “Bioreper” method for an adequate assessment of the state of homeostasis of the body.

DIFFERENTIAL DIAGNOSIS

Differential diagnosis pursues the goal of most likely establishing the similarities and differences in the clinical picture of differentiated nosological units.

The method of differential diagnosis is based on the logical method of comparison (establishing similar and different signs of the disease).

The logical result of differential diagnosis is to obtain a hypothetical conclusion about the nosological form of the disease, and the diagnosis established as a result of differential diagnosis is a more or less probable hypothesis.

The differentiation method is no less and no more reliable than justification.

In this case, the basis for a reliable conclusion is:

1) establishment of a specific etiological factor;

2) the presence of specific symptoms / symptomatic complexes;

3) specificity of the pathogenesis of the disease.

The final part of the differential diagnosis is the formulation of the diagnosis.

The curator should begin the process of differential diagnosis with the correct selection of diseases that have a similar clinical picture with the pathological process developing in the examined patient.

Differential diagnosis should be carried out not so much by denying certain signs, but by comparing and analyzing them. In this case, the results of special (additional) research methods should be widely used. In the process of differential diagnosis, the curator is required not only to establish a diagnosis of the disease, but also to resolve the issue of the individual characteristics of the patient, taking into account his age, state of reactivity of the body and general development.

CLINICAL DIAGNOSIS AND ITS RATIONALE

A clinical diagnosis is constructed as a motivated, coherently stated following conclusion from:

– conclusion drawn from the patient's complaints;

– data obtained from the patient's life history and systems survey;

– conclusions from information about the history of the development of the present disease;

– the results of an objective examination of the patient's body, including the maxillofacial area and neck;

– data obtained as a result of the use of special survey methods;

– results of differential diagnostics.

The diagnosis substantiates: the nosological form of the disease, the degree of dysfunction and the activity of the pathological process. Do the gender and age of the patient have anything to do with this disease?

The diagnosis of concomitant diseases is substantiated more briefly.

ETIOLOGY AND PATHOGENESIS OF THE DISEASE

It is presented from a modern perspective about the etiology of this disease in general, then facts from the life history and from observations during supervision that caused the present disease or contributed to its development and course are indicated. After this, the pathogenesis of the pathological process and its relationship with the main symptoms occurring in this particular patient are described.

TREATMENT OF THE DISEASE (INDICATIONS FOR SELECTION OF TREATMENT METHODS)

First, all existing methods of treating the disease are given.

Then the choice of treatment method for the supervised patient is justified, taking into account: a) the nature of the disease, b) his individual characteristics.

Next, you should indicate the indications for surgical treatment. Outline a preoperative preparation plan with a mandatory indication of the method of pain relief.

Present the preoperative epicrisis.

Plan for presenting the preoperative epicrisis.

1. Brief rationale for the diagnosis: (basic clinical data and results of special research methods).

2. Indications for surgery (absolute, relative), contraindications.

3. Plan of the operation indicating the access, anesthesia technique, and surgical procedure.

4. The patient’s consent to the operation.

Obtain the patient’s consent (in a situation where the patient is not legally competent, then his relative representing his interests) for the operation.

Then you should provide a complete protocol for the surgical intervention, if one was performed.

The correct sequence of drawing up the operation protocol.

1. Last name, first name, patronymic of the patient.

2. Gender of the patient.

3. Patient's age.

4. Preoperative clinical diagnosis.

5. Name of the operation.

6. Surgeon (last name, first name, patronymic), assistant (last name, first name, patronymic).

7. Date of operation (day, month, year).

8. Duration of the operation (indicate hours, minutes).

9. Description of the operation. The method of pain relief is described in detail. Treatment of the surgical field (which antiseptics and their approximate volume). Description of the operation itself. Macroscopic description of the changes detected during surgery and the removed (excised) tissue, formation or

part thereof. Type of sutures placed on the surgical wound, their number, suture material. Type of bandage, material, fixation method.

10. Operational diagnosis.

11. Prescription of postoperative treatment.

12. The protocol describes in detail the complications that occur during the operation and their elimination.

13. Signature of the surgeon (deciphering — last name, first name, patronymic of the surgeon).

14. Assistant's signature (deciphering — last name, first name, patronymic of the assistant).

COURSE OF THE DISEASE (DIARY)

In the diary, after indicating the date (day, month, year), the curator should assess the patient's well-being, outline his complaints at the current moment and note their dynamics over the past day. The diary should be filled out for each day of supervision.

The curator must indicate brief objective data with a mandatory reflection of their dynamics: pulse rate, respiration rate, blood pressure. In the postoperative period, attention is paid to the general condition of the patient, changes in the postoperative wound, surrounding tissues, which are assessed during dressings. It is separately indicated in the description of the dressings when the sutures were removed, and, if they were interrupted sutures, their number.

The diary should also reflect the conduct of special studies with an analysis of their results and specialist consultations prescribed on their basis, with the presentation of the full text of the advisory opinions, as well as the prescription with a precise indication of the dose, time and method of administration (route of administration) of the medicines recommended or prescribed diets.

When prescribing a patient for surgery, the diary indicates indications and contraindications for surgery — the rationale for the planned operation.

The curator copies the operation protocol into a diary from the operation journal.

If the operation was performed before supervision, then the student must indicate its name, date, time and description in the section "History of the development of the present disease (history of the disease), with which the patient sought specialized medical care".

We consider it quite appropriate to provide a recommended layout for the diary (Table 5).

Table 5

Recommended scheme for recording a diary in the educational medical record of an outpatient surgical dental patient

Data	Patient's condition and course of the disease	Appointments

If the medical prescriptions made for several days do not change, then on these days in the “Prescriptions” column “Same appointments” or “Continue to carry out previously made appointments” is added”.

EPICRISIS (FINAL CONCLUSION ON THE COURSE AND OUTCOME OF THE DISEASE)

Directly translated from Greek, “epicrisis” means “after decision,” “judgment.” An epicrisis, as a rule, is the final conclusion regarding the course and outcome of the disease of the supervised patient.

The presentation of the epicrisis begins with the patient’s last name, first name, patronymic, his age, date of treatment and the diagnosis with which the patient applied for specialized medical care at an outpatient appointment with a dental surgeon.

Then the curator briefly lists what was found during the survey, an objective examination and briefly outlines the results of special research methods that were performed on the patient and are related to the substantiation of the diagnosis and its verification.

Next, information about the treatment methods performed (surgery, physiotherapy, reflexology, therapeutic exercises, prescription of medications, diets) is presented, after which the result of the treatment (its effectiveness) must be noted.

Next, the curator must indicate the outcome of the treatment (recovery, improvement, no change). If complications exist or develop, this must be noted.

RECOMMENDATIONS FOR THE PATIENT AT COMPLETION OF TREATMENT

Upon completion of treatment and if there is a sheet of temporary disability, the patient must indicate on which calendar day he should start working.

Recommendations (if necessary) for dental therapeutic/orthopedic treatment are then outlined; recommendations (if necessary) for additional examination and referrals for consultations with doctors of other medical specialties; diet tips; date of inspection.

PROGNOSIS OF THE DISEASE

When forecasting, the curator must foresee all possible scenarios for the development of events and determine how the patient’s condition may change: if he further does not carry out any therapeutic measures, if he uses restorative medical rehabilitation using traditional methods, if he replaces the use of traditional methods with non-traditional ones (reflexology), etc.

In any situation, the educational medical record of an outpatient surgical dental patient should end with a prognosis:

– for life;

– for recovery;

– for ability to work.

Favorable prognosis — the patient will fully recover, his ability to work will not be reduced; The disease is not life threatening. Poor prognosis — work ability is reduced, the disease is life-threatening (for example, sarcoma).

It is very difficult to list the entire list of questions relating to each specific patient that arise in everyday clinical practice, and it is even more difficult to take into account all the factors and patterns that determine the course of the pathological process in each specific situation. From a variety of solutions, the curator needs to choose the most suitable option for each specific situation, think through all possible deviations from it and provide ways to prevent them.

The importance of prognosis in clinical practice is determined by the main objectives of modern medicine — disease prevention and patient treatment. This, in turn, indicates that forecasting used in clinical practice meets the basic principle of modern medicine — preventive.

LIST OF SPECIAL LITERATURE USED BY THE CURATOR

When working methodically correct, intelligently with a supervised patient and writing an educational medical record for an outpatient surgical dental patient, the curator should turn to special literature: educational, monographic, periodical. In the proposed section of the educational medical record of an outpatient surgical dental patient, the list of used specialized literature is best reflected as follows.

For teaching aids, textbooks and monographs, if the publication has more than three authors:

Clinical manual: diagnosis, prognosis and treatment of severe complications of infectious and inflammatory processes in the maxillofacial region and neck: monograph / I. O. Pokhodenko-Chudakova [etc.]; ed. by I. O. Pokhodenko-Chudakova. Minsk: Publishing house. Center of BSU, 2016. 398 p.

For periodicals (articles), if there are from one to three authors: Diagnostic capabilities of saliva / E. V. Kouchurova, S. V. Kozlov // Clinical and laboratory diagnostics. 2014. N 1. P. 13–15.

For periodicals (articles), if there are more than three authors: Methods of influencing the processes of endogenous intoxication in the complex treatment of periodontal diseases / I. A. Goskov [et al.] // Russian Dentistry. 2015. T. 8, N 1. P. 43–45.

The educational medical record of an outpatient surgical dental patient must be completed with a legible signature of the student-supervisor and the date of submission of the educational medical record for review to the teacher.

NOTES

1. All abbreviations in the text of the educational medical record of an outpatient surgical dental patient are allowed only in accordance with generally accepted provisions (transcription for primary use, for example, World Health Organization (WHO)).

2. Dimensions are given exclusively in centimeters (cm), weight — in kilograms (kg), volume — in milliliters (ml).

THE MOST COMMON MISTAKES MADE BY STUDENT CURATORS

1. The value of an outpatient dental patient's medical record is not always correct, as evidenced by the completion of not all of its sections.

2. Often, supervisors limit themselves to listing the patient's complaints without clarifying them, and do not ask patients additional questions. Medical records, as a rule, do not reflect patient complaints about functional disorders of the maxillofacial area.

3. Underestimation of the patient's medical documents issued by other medical institutions when studying and analyzing the history of the development of the present disease.

4. When describing the patient's life history, a superficial questioning is allowed to determine concomitant somatic and allergic diseases.

5. The survey on systems is mixed with data from a general objective examination of the patient.

6. Pain, a subjective symptom identified from complaints, and soreness, an objective symptom identified by palpation, are considered equivalent.

7. Excessive imitation of the original outpatient card of a dental patient, insufficient understanding of the data obtained from an objective examination of the maxillofacial area and neck obtained when transferring from it (only the results of special examination methods and the conclusions of consultants should be copied from the original).

8. When describing the etiology and pathogenesis of the present disease, the curator is limited to known data from the specialized literature, without reflecting his judgment and clinical thinking based on anamnesis and observation during supervision, based on his own acquired knowledge.

9. They do not indicate complications and concomitant diseases, which is a gross violation of medical documentation.

10. Abbreviations of words that are not accepted in print are allowed without first introducing abbreviations with their decoding at the first use.

11. Dates for special studies are not indicated.

12. Excessive and unreasonable fascination with the terms "normal", "no changes", "usual".

13. They make spelling and stylistic errors, ignore punctuation marks, do not highlight red lines, and do not leave a margin in the notebook.

14. Delays in submitting a study medical record for an outpatient surgical dental patient.

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TRAINING MEDICAL CARD OF AN OUTPATIENT SURGICAL DENTAL PATIENT

Учебно-методическое пособие

На английском языке

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