COLLATED Q&A QUESTIONS – DR NG JING JING

Q1. How frequently will you review traumatized teeth?

I will try my best to review traumatized primary tooth according to the IADT (traumatology guideline).

But the general principal is:
Soft tissue or bony fracture - aim to review 1 week (to check for healing).
Then 1-month, 3-month, 6-monthly for the more severe trauma, or 6-monthly for the milder ones.
In most trauma there is no need for review after 1 year, but I follow up all severe luxation injury (intrusion, avulsion, lateral luxation) until the adult tooth erupts. I also follow up on teeth that had been pulpected yearly.

Q2. Is antibiotic prophylaxis needed for IE pts whom you want to replant an avulsed tooth? If yes, what guideline would you follow?

Re-implanting an avulsed tooth is contra-indicated in VERY SEVERE heart cases.

For the milder cardiac cases, I will prescribe antibiotic if I replant the avulsed tooth. I am using the IADT (International Association of Dental Traumatology) guideline.

Q3. If there is a laceration wound, would it be possible to stop bleeding without suturing?

Yes, applied pressure might be enough. Most of the time when patient come into clinic, the bleeding would have stopped, but in the event that the area is still bleeding profusely, apply pressure and if it fails, suturing is needed.

Q4. Is treatment for adults with special needs same as for typically developing children?

Not exactly, that is because they usually have very different dental problems.
For young patients, we are concern about dental caries, whereas in special needs adults, we are mainly faced with periodontal and health issues.
They also have different behavior issues. Hence adult special needs patients should be taken care by special needs specialists.

Q5. How will you manage an 8-year patient with Trisomy 21 having severe caries?

Firstly, we need to assess if the caries is giving patient pain, swelling and infection. Trisomy 21 patients also tend to have cardiac issues, so we must be aware that infection is detrimental for these patients. If they need antibiotic cover, it will be better to have all the treatment done in one session under general anaesthesia. However, these cases need to be attended to in the hospital (i.e. KKH).

If there are no signs and symptoms, and patient has no cardiac issue, then we can try to arrest the caries first, and slowly treatment plan. It will be ideal to do treatment slowly, to get acceptance. That will benefit patient with trisomy 21 in the long run.

Q6. What is the best time to bring a child for their first dental checkup?

I think, especially for first time parents, the first dental visit should be when the first tooth erupts.

Q7. Is bribing an uncooperative child during the first visit a good practice?

It really depends on the parenting practice of the parents. Nowadays, there are variable parenting styles, hence the children's behavior differs greatly.

In my practice, I try not to bribe patients, but I strongly encourage rewards after treatment.

Q8. What are your methods for handling the really 'cannot make it' nightmare children and their parents?

I feel that for these patients and parents, the conventional "tell-show-do", and "positive re-enforcement" technique might not work very well. But nonetheless we should still try that first.
It is always important to remain calm and composed.
I feel we just need to be as factual as possible:

1) *List all dental issue that the child is facing;*
2) *List all possible treatment options for the individual teeth; and*
3) *List all possible treatment methods: restrain/sedation/GA*

They might need written proof of what has been discussed.
It will be ideal to let them go home and think about the options and do not try to rush into treatment.

Q9. What if the parents don't want to have sedation/GA for F1 (*not sure what is that*) patients, will you use the papoose board to treat a kid?

I do not have a papoose board, if the parents want to do treatment under restrain, they need to hold the child down.

Q10. What would you do for a tooth that has a history of pain and abscess and was previously given antibiotics for the young patient? What is your management if the tooth has a pulp polyp?

Firstly, we need an x-ray to check the status of the root. To keep the tooth the roots should be pretty much intact with minimal root resorption. If the tooth is still "restorable" we can try to perform pulpectomy.

The treatment for tooth with pulp polyp is either pulpectomy or extraction.

Q11. What are your thoughts on Cvek pulpotomy with MTA / Biodentin for trauma with pulp exposure in permanent teeth?

It is the treatment option for complicated crown fracture. We should always try to be conservative, so Cvek pulpotomy should be attempted before full coronal pulpotomy and pulpectomy, especially in the young immature permanent tooth.
Non staining MTA or non-setting calcium hydroxide will be the medicament placed over the pulp tissue.

Q12. Is Pulpotec (formaldehyde) contra-indicated due to its carcinogenic nature?

It is very difficult to purchase the medicament.
It has one of the best success rates in pulpotomy. However, MTA pulpotomy is also found to be as effective.

Q13. Is it necessary for IDN for pulpotomies? Would infiltration with articaine suffice?

IDN is generally used for pulpotomy of the lower molars in children age 6 and above. However, I have had quite good results with articaine infiltration. Note that articaine is NOT recommended for blocks and also children below age 4.

Q14. When would you suggest extracting submerged deciduous molars?

I will extract infra-occluded deciduous molars if I find that the rate of infra-occlusion is fast, and I might not be able to see the coronal portion when it "submerged" into the gum.
I will also extract unrestorable and symptomatic molars due to caries.

Q15. What is your management when you see the natal teeth and neonatal teeth?

We will try to preserve these teeth (they are part of the deciduous set of teeth) unless they are so mobile that there is a risk of aspiration, or they cause painful ulcers on the tongue of babies and affect feeding.

Q16. Will you still administer LA slowly on uncooperative patients who are already crying and struggling?

It really depends on how old and why is the child uncooperative.
Honestly in very young patients, especially due to trauma, I administer the LA fairly quickly. That is to allow the procedure to be completed quickly.
In fearful patients, I still apply topical anaestheic gel and do inter-papillary LA to show them that LA is not painful.

Q17. How do you charge patients when you fail to proceed with treatment due to failure to cooperate?

If it is the first visit, I will charge my regular consultation charges. For follow up treatment, I do not charge if there is no work done.

Q18. What cement do you use to cement space maintainers with?

I use type I GIC luting cement.

Q19. Given a patient's OH is good and is cooperative, how will you decide whether to place a space maintainer or not? You mentioned the patient's age as a factor, could you kindly elaborate on how the age influences the decision.

Space maintainer for the molars is only necessary if the patient lose the tooth at a fairly young age. I will not space maintain a first primary molar extraction in a child at 8-9 years old, or a second primary molar if the child is 11-12 years old. Unless the child has a very delayed dental age. Hence radiographs to check the developmental stage of the permanent successor can be a better determining factor for the need for space maintainer.

Q20. What is the interval for fluoride application for a child with rampant caries?

Three to four-monthly for fluoride varnish and fluoride gel application. Six-monthly for silver diamine fluoride application, but only top up if required.

Q21. How old do you start them on full strength fluoride toothpaste? What about those below 2 years old?

In Singapore, we have not developed a guideline.

Personally, it depends on the caries risk status of the child.

In low caries risk children, I advise full strength (>1000ppm) when they can spit (generally after two)

For high risk patient I recommend a smear of full-strength toothpaste as soon as they see me, regardless of age.

Q22. What is your opinion about the use of GC Tooth Mousse Plus?

I use GC tooth mousse plus mainly in Molar Incisor Hypominearlisation patients.

Q23. In view of the current pandemic, do you recommend doing ART at the moment?

If the cavity is suitable for ART technique it might be an appropriate management now.

I generally use ART technique in young patient who cannot manage the handpiece well. I think if the patient is very cooperative and the MOH Covid clinical management guidelines allow us to do restorations, it might be difficult to justify not doing the restoration (mainly to the paying parents)

Q24. Do you perform re-application of SDF? If yes, when do you do so and have you tried using potassium iodide to whiten/lighten the discoloration?

I generally review my SDF patients after one week to check that the lesions have turned black. I will reapply at the one-week review visit if necessary. Follow up appointment for patients with high caries risk is three months. I will reassess at every review visit.

I have not tried potassium iodide to whiten the discoloration.

Q25. What would be the ideal management for chromogenic stains?

Firstly, patient has to have very good oral hygiene, and prevent spreading of the bacteria amongst family members and friends. So, education is first.

Then they require regular prophylaxis visits.

Q26. If the child is in permanent dentition but the jaw is still growing, do you have to change the mouthguard every few years to prevent restriction of jaw growth?

I generally try to issue mouthguards for grinding only in patients after puberty, when the growth is somewhat stable.

My first mouthguard is usually the soft guard, hence even if the patient is still growing, they will not restrict the jaw development.

Q27. Any thoughts on links between breastfeeding causing caries?

Breastfeeding as a source of milk intake does not cause caries per se.

On demand breastfeeding over an extended period of time causes caries. Especially if the child is exposed to other source of carbohydrates and sugars.

Hence if the mum solely breastfeeds her baby every three hourly, without other source of sugar, it is unlikely for the baby to develop caries.

As the child gets older, they will be exposed to more food type, and hence breastfeeding should be restricted to feeding time.

Q28. Would you advise for a frenectomy for a child who displays low frenum attachment and genetically both parents have low frenum attachment with diastema?

I would only advise frenectomy if it is requested by the patient for aesthetic reasons, or for orthodontic reasons.

Q29. One of the slides showed roots of anterior teeth sticking out of buccal gingiva, is that dehiscence? Have seen multiple cases of dehiscence of primary lower molars, what could be the treatment?

The roots sticking out from the gingiva is fenestration. The treatment is extraction.

Q30. What is your management of moderately severe MIH and when should we refer to a specialist? How will you decide to retain (via RCT and crown) a permanent first molar with breakdown leading to pulp exposure versus extraction?

For moderately severe MIH with only occlusal and buccal involvement, we can get away with GIC restorations in young patients, and composite resin restoration in older children under rubber dam. If the lesion involves the proximal surfaces, a stainless steel crown might be required.

Referral to specialist is only required if you feel that you need help in managing the case. If you are comfortable performing restorations in children, there is no need for referral. However, in moderately severe MIH, I would always prefer an orthodontic consult to discuss the long-term management of the molars.

I try to extract permanent molars with poor long term prognosis. However, in oligodontia cases or patient with missing third molars, sometimes, we have no choice but to preserve the broken molars.