COLLATED Q&A QUESTIONS – DR BERTRAND CHEW

Category: Pre-Op Management/Planning

1. **Any pre-patient management steps?**
   Yes, there are. It includes radiographs, indications, consent, discussion and Medisave claims. However, the lecture is centric to the surgical removal, hence the above are not mentioned.

2. **Would you routinely take a CBCT for any wisdom tooth that lies within 3 to 4 mm of the IDN as viewed from OPG?**
   Nope (the short answer). As mentioned in the lecture, start off with an OPG/DPT first. Unless the roots passed the IDN or have the signs described in Rood & Shehab's paper (Br J Oral Maxillofac Surg. 1990), then CBCT may be warranted.

3. **How do you locate IAN? Do you use CBCT?**
   You may use CBCT, but the OPG/DPT would suffice.

4. **What is the superior-inferior location/path of the lingual nerve as it passes anteriorly?**
   It is usually superior to the IAN when it passes anteriorly toward the tongue.

5. **Why do you have to cover the patient's eyes with a surgical drape?**
   It is not a must, but to reduce the field of operation and to keep the rest sterile. It also prevents eyelashes, hair and eyebrows from shedding. Overall, it can be replaced with a goggles.

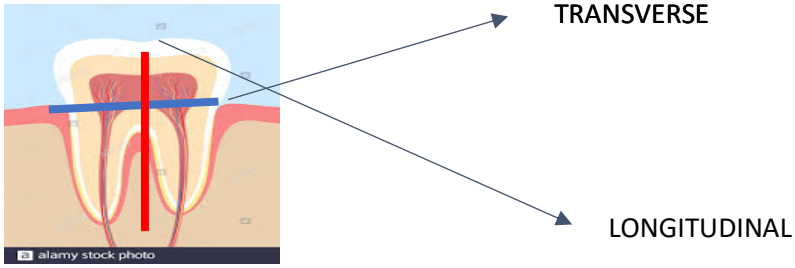
Category: Technical

1. **Why trapezoidal flap is used in presence of infection?**
   Pardon me, I do not think this was mentioned. The decision for a flap design is not dictated by infection, but the three factors which I emphasised on.

2. **Regarding sectioning 99.9%, it means we must not section the tooth completely in lingual direction to avoid injury to lingual nerve?** *Yes.* **How does the lingual runs in in relation to 3rd molar?** *Up to 20% of the cases, the lingual nerve curves upwards to the distal lingual of the third molars.*

3. **Can you explain more about how to gauge the completeness (near 99.9%) of our longitudinal sectioning using the 2nd molar as a guide?**
   Place the bur onto the second molar and gauge the buccal lingual width. Note the distance from bur or perio probe. Then using the same bur, continue with the sectioning and once you reached the intended length, you are almost 90%. If you go in a little the whole marking is covered by tooth during sectioning, it would be more than 90%.

4. **Can you use a picture or video to demonstrate what you described on transverse and longitudinal sectioning of teeth please?**
   May I try with a picture, a video would be tough. The blue line is transverse and the red line is longitudinal.



5. **Hi Dr Chew, how do you estimate drilling depth with the burs?**
   There are two ways: one is to get a bur with markings, the other is to use the second molar or first molar as a gauge.

6. **In Case 1, there is free space at distal and occlusal. So in order to tilt tooth distally, we must elevate at mesial of 8?** *Yes.* **Elevating from buccal will cause the tooth to come out from lingual?** *Yes and a little occlusal.*

7. **Possibility of slipping when elevating buccally?**
   Yes, but if you are in bone, the chances are lower, as in the fulcrum has to be bone, not soft tissue or tooth. And if thin bone, it may break and slip.

8. **Do you routinely suture the flap with primary closure entirely?** *Yes, I do, unless the whole tooth or a large area is exposed, then a gap is left.* **Or do u leave a gap especially if the wisdom tooth is partially erupted in the first place?** *Depends on the size of the tooth exposed but I do leave a gap if the whole tooth or a large area is exposed.*

9. **Should we suture the socket completely?** *Ideally, we should.* **Will it cause haematoma which may dislodge n become nidus of infection?** *It is possible, but rare.*

10. **Would a watertight closure cause more post-operative swelling?**
    Not always, there is no need to close it watertight. Just re-position the cut ends together.

11. **What is your tie, 2-2-1?**
    Depends on suture material. A Prolene (monofilament/ non resorbable) is 3-2-1.

12. **Why are roots of impacted lower tooth (after sectioning of crown) much easier to remove than an fully erupted tooth say the 6 or 7 with a broken down carious crown.**
    This is an excellent observation, I would guess that it has to do with occlusion. The fully erupted tooth undergoes much forces, whereas the impacted wisdom tooth doesn't.

13. **In coronectomy, what happens to the exposed pulp?**
    It is left exposure and covered with blood clot.

14. **Any role for PRF following wisdom tooth surgery?**
    There are always roles for PRF, it all depends on the indications.

15. **Do we do crown lengthening for second molar if there is subgingival caries?**
    This depends if the restorative dentist is able to restore the caries. If required, then a crown lengthening may be done.

Category: Post-Op

1. **When is the appropriate time to refer if the nerve remains persistently numb at VAS 2**
   There is no fixed appropriate time, but it depends on how deep and in contact with the IDN is. Unless the roots are not in proximity and there is nerve injury, it would be prudent to refer if the VAS is persistently 2 for 3 months.

2. **Has Bertrand ever heard of no paraesthesia in the 1st 24 hrs post op, but onset only after 24hrs for the lingual nerve?**
   Yes, there was one such case. The patient claimed that he drank a soda drink (Coca-Cola), which after that he experienced numbness. However, this was not well documented and not really proven. Hence, although he did recovered after a long 6 months, it cannot be taken into account due to a lack in proper documentation of diet.

3. **(In ref to treating IDN/lingual nerve paraesthesia/anaesthesia) How successful is micro surgery? When do you offer as there seems to be a general opinion that better results are obtained the earlier surgery is carried out and an obvious dilemma in that most cases will recover spontaneously even without treatment. So… when do you refer. Is there a time window from a clinical or medico-legal perspective?**
   Once again, it depends on the type of injury to the IDN. If it is cut or transected, then an early referral for micro surgery would be ideal.

4. **If no antibiotics is given post op, what are the chances of getting parapharyngeal abscess?**
   The chances of infection are not high post wisdom teeth surgery. Hence, the chances of a spread to the parapharyngeal spaces are even rarer. If the surgery is done in a non-sterile setting, perhaps it may be augmented with one antibiotic.

5. **Do you prescribe short term steroid?**
   Yes I do, but it is not common.

6. **Hi Dr Bertrand, thank you for the awesome lecture. Can you repeat the recommended dosage for steroids as post treatment medication to reduce swelling?**
   From my empirical evidence, a 5mg 3 days OM would suffice.

7. **And do you recommend to give steroids for all wisdom tooth removal cases?**
   It is not recommended, but it is dependent on the duration and depth of surgery as well as the amount of bone trimmed away.

8. **I have come across surgeons who give 20mg Prednisolone stat followed by 10mg on the second day for all cases.**
   Yes I have heard of this as this is the steroid tapering cycle for the management of sinusitis and post-op reduction of swelling.

9. **Cn pts brush their teeth after 6hrs of mos?**
   Yes, but lightly.

10. **How about use of IM dexamethasone 1 ml to reduce swelling and pain?**
    Some dentists noted that there are less swelling and pain with IM dexamethasone given to the operation area post-surgery. This is no difference from the oral form given except one is systemic and another is localised.

11. **Is there anything that can be done if there is no bleeding in the socket after removing the tooth?**
    If there is no bleeding, immediately after removal, it is acceptable. This question is different from a dry socket.