

LEARNING FROM MISTAKES



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WELCOME!

This workbook is an overview of common clinical mistakes and how you can learn from them. You will find practical, implementable, step-by-step strategies to learn how to avoid the failures, achieve the successes and *be better*.

Thank you for your time and participation. I welcome and encourage you to continue the conversation with me at the contact information below.

Regards,

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Thank you.

CLINICAL “OH CRAP” MOMENTS



Letter from an attorney or dental board
Failure to diagnose
Perceived poor quality dentistry



A few years later, your restoration looks terrible



Bonded core stuck to temp material



Dropped tiny instrument down someone's throat



Something we did is now failing



It wasn't hurting until you worked on it



Your restoration looks terrible a few years later

Let's start with the assumption that you did everything right when you did the procedure.

Sadly, the patient has poor dentition for a reason. The reason they need a root canal, a filling, crowns, replacements, etc. Is because they have sub-optimal habits at home.

What are the best ways to encourage excellent oral hygiene and prolong the life of your restorations?

Home care:

Waterpik and interdental brushes rank highest in reducing gingival bleeding, as *adjuncts to brushing*.

Patients report that they find interdental brushes and water-jets more convenient and enjoyable to flossing.



Guided biofilm therapy:

- Does not damage the implant
- Does not damage the tissue, root, or surrounding bone
- Is less painful and invasive
- Does not rely so heavily on the dexterity of the clinician
- Allows for the patient to regularly comply, despite their own limitations in dexterity and discipline
- Does not leave plastic residue
- Is affordable (both for me and for the patient)
- Does not encourage antibiotic resistance
- Effectively disrupts the growth of bacteria and extracellular matrix

Perio Protect:

Custom Trays that deliver Hydrogen Peroxide on a regular basis

- Hydrogen Peroxide disrupts the protein skeleton and proteoglycan aggregate
- It breaks down to oxygen within the sulcus, which
 - Allows macrophages to work effectively
 - Lyses the cell wall of gram negative anaerobes
 - Converts the environment away from anaerobic
- Non-invasive, atraumatic, and can be used every day



HybenX:

- It is an "Oral Tissue Decontaminant"
- Uses "Desiccation Shock Debridement Technology"



Something we did is now failing

First tool: the intra-oral camera

- This was originally purchased as a tool to aid in patient education
- What it has become, for me, is a **highly affordable** “magnification scope”
- It allows me to see things that I might have missed using just my loupes



The camera I use is the EyeCam by Shofu



It wasn't hurting until you worked on it

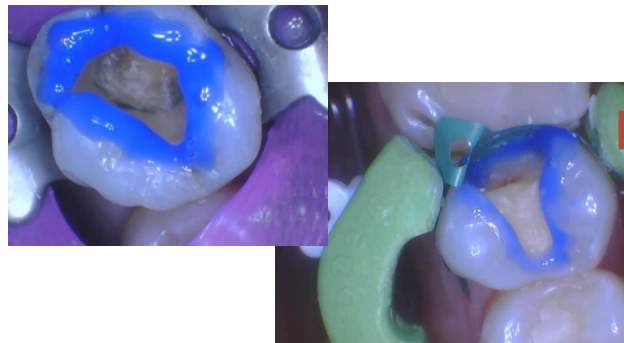
Why does this happen?

- Acid etching can create pulpal inflammation
- Deep restorations can elicit pulpal inflammation
- Occlusal interference can elicit pulpal inflammation

Instead of etching the whole prep



Selective etch



When cavities are deep, use a bioactive composite

- Mineral-releasing layer throughout the life of the composite
- Bacterio-static outer layer, almost eliminating brown lines
- Flowable and packable are similarly radiopaque
- Properties similar to a liner as you get close to the pulp
- Very easy to polish



Letter from an attorney or dental board

According to the Senior Risk Solutions Dental Lead at MedPro Group, which specializes in HealthCare Malpractice Defense, the costliest reason that dentists get sued is:

Failure to ***diagnose tissue pathology***

How to avoid this?

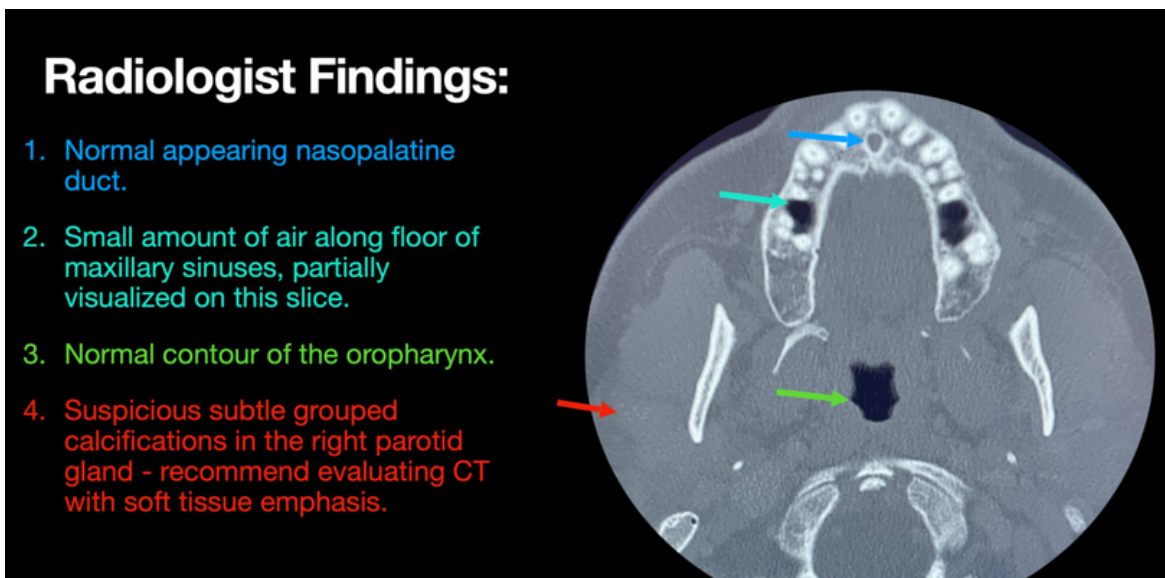
1. Explain what you are doing
2. Document that you did it
3. If you see something unusual, be persistent

CBCT Imaging

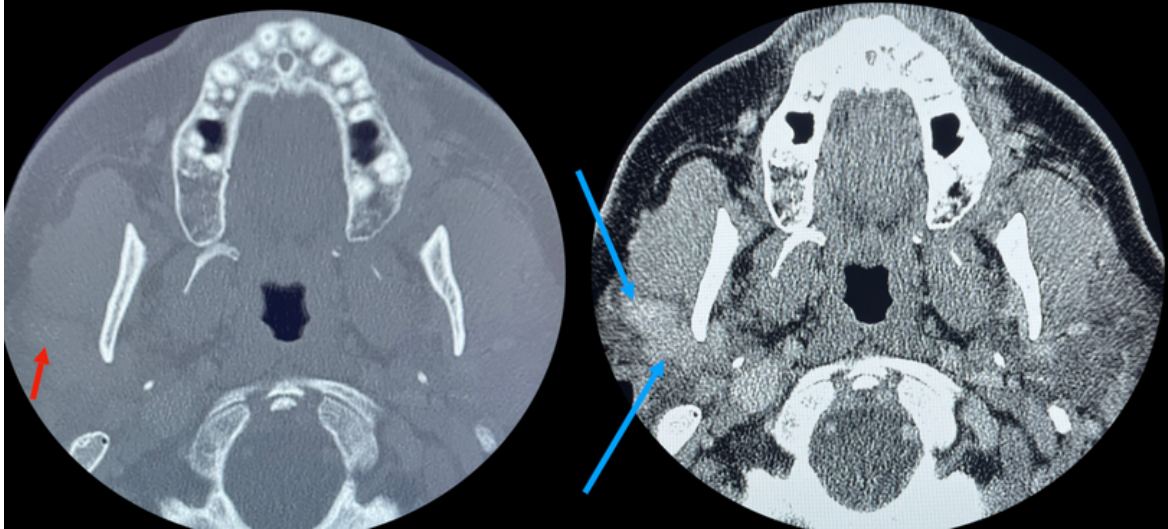
- Implant Planning
- Airway Imaging
- Coolness

Radiographic Interpretation must be:

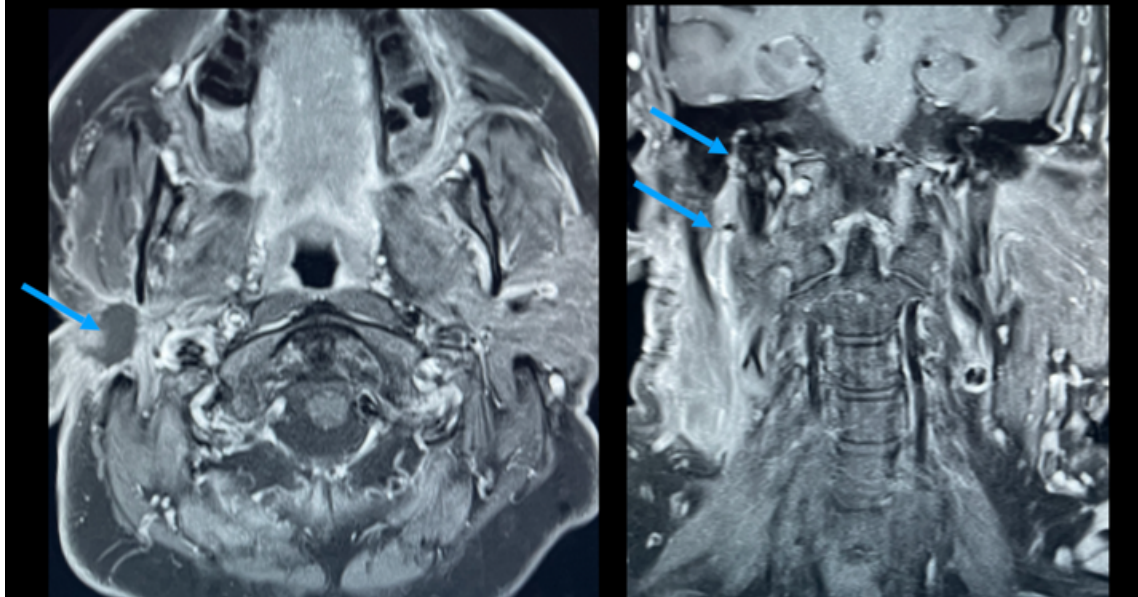
- Automatic
- Seamless
- Affordable
- Easy to read
- Aligned with Medical Insurance



Use soft tissue window



Follow up MRI showing Adenoid Cystic Carcinoma with perineural spread along right facial nerve



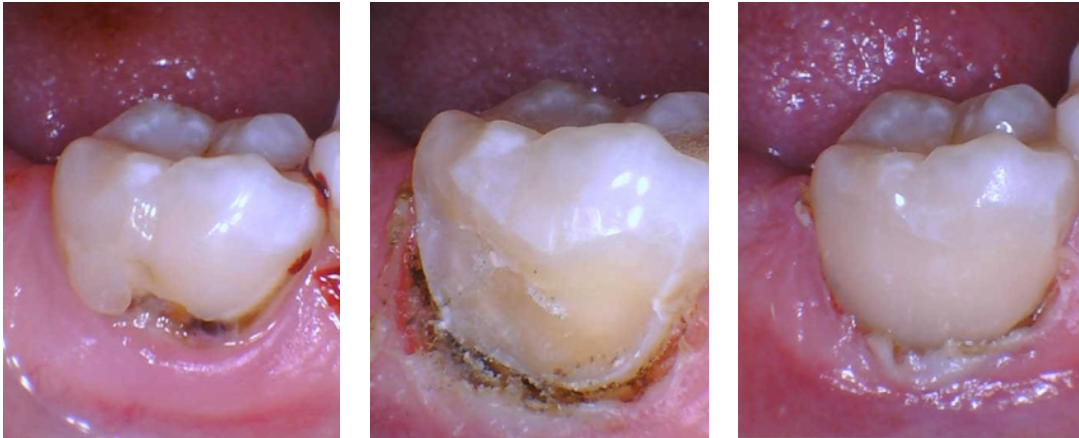
NOTES



Bonded core stuck to temp material

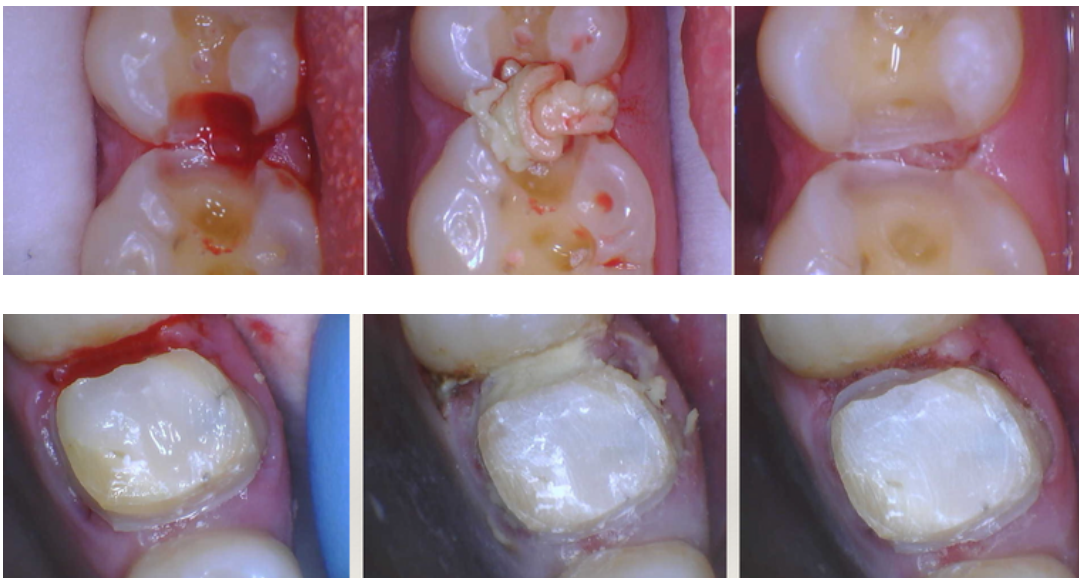
Diode Laser

- Gingivectomy without bleeding
- Elimination of already present bleeding
- Bacterial eradication within the working area

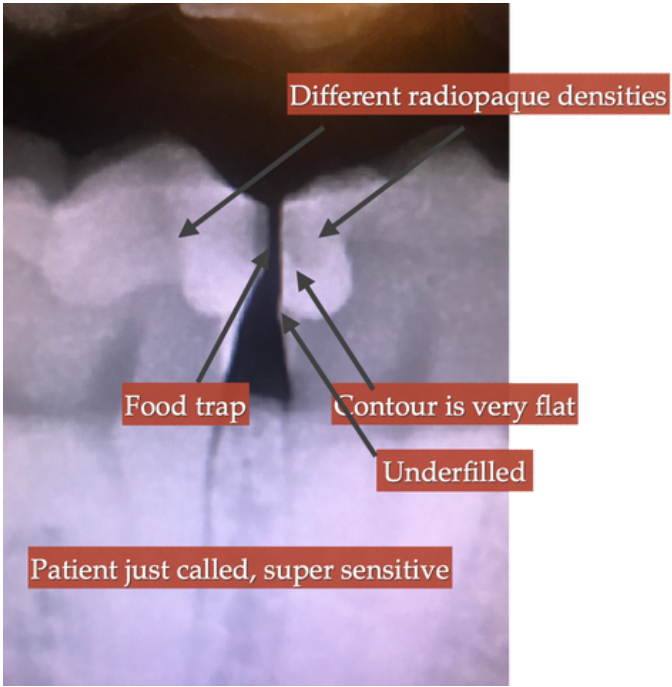
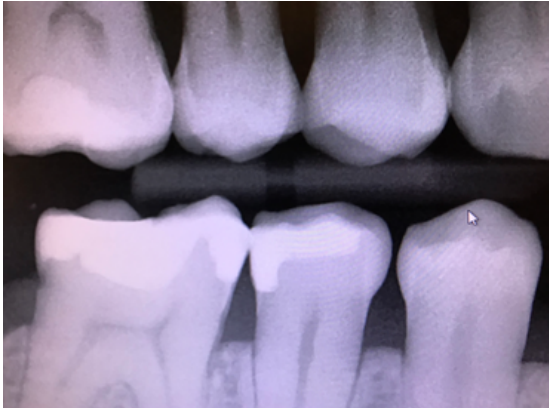


What if you don't have a laser?

- Cord soaked in hemodent (time consuming and painful)
- Viscostat (super gross and leaves a black stain)
- Gingival retraction paste



Class II Composites



NOTES

THE PITFALLS

- Flat Matrix = *Flat IP contour*
- Inadequate wedge or Inadequate burnish = *Open contact*
- Inability to create seal at the gingival aspect = *Overhang*
- Inadequate packing = *Void*
- Inadequate bevel/etch = *brown line*



How to avoid all the pitfalls

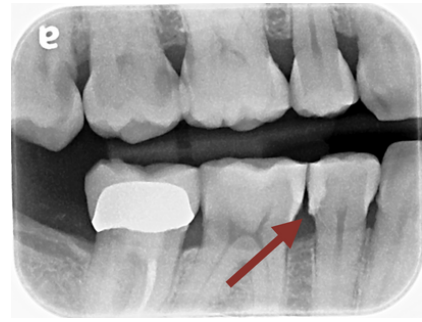
- First, bevel all of your margins (avoid the brown line)
- Second, use a sectional matrix (contoured inter proximal)
- Burnish (more contour, and better contact)
- Use a selective etch technique, using an etch material that is flowy enough to control (avoid the brown line, and reduce the chance for sensitivity)
- After etching and bonding, use a small amount of **bioactive flowable composite** *without curing*, followed by **packable composite**
- Packing the composite will result in the flowable “flowing” to the surface to be removed
- *This is the best way to avoid voids*



And, if you can't create an adequate seal with your matrix and wedge...



Profin by Dentatus



Class II

- Look good on an x-ray
- Satisfying “click” during flossing
- Minimal chances of sensitivity
- Avoid the “brown line” after several years
- Reduce the chance of a void
- Erase an overhang



Crowns

- When the build-up is huge, I'm afraid that it will come off w/ the temporary
- When the walls are very short, I lose most mechanical retention
- Sometimes I do endo *after* prepping for a crown, what should I do?

Cementation

- When walls are adequate, *every* cement will work
- When walls are inadequate, you *must* use a dual-cure bonded resin cement
- Confirm that you lab air abraded the zirconia. If not, you do it After trying in and adjusting, clean out all salivary contaminants Use a primer which will allow the cement to bond to the Zirconia Use a bond which will allow the cement to bond to the tooth
 - If the tooth has been endo treated, etch it
- Then cement with a dual cure resin adhesive cement



Dropped a tiny instrument or dental material down someone's throat



Isolation

- Isolite
- Dry Shield
- Zirc shield



NOTES

UTILIZING ARTIFICIAL INTELLIGENCE

To help point out radiographic features



o Pearl

To help interpret radiography highlights

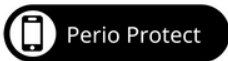
- Open margins
- Calculus
- Bone loss

PRODUCTS TO CONSIDER



For any patient w/ poor oral hygiene or tendency to have bloody gums:

PerioProtect



Dentatus

Interproximal finishing:

Dentatus Profin



Guided biofilm therapy

by EMS



HybenX

by Epien



Gingival retraction paste:

- Traxodent by Premier
- Voco Dental



EyeCam

by Shofu



Bioactive composites:

- Beautifil by Shofu
- Regen by Vista Apex



CBCT interpretation:

DentalRay



Sectional matrix bands:

- Garrison
- Ultradent
- Premier

Diode Laser

Any company



The etch that is flowy enough to selective etch:

Ultradent



**Anytime we finish
expensive treatment:**
Waterpik



**Bonding agent of choice
for most instances:**
Allbond Universal by Bisco



**The absolute strongest
bond when needed:**

- PeakU by Ultradent
- Optibond XTR



Hemostatic agent:
Astringedent by Ultradent



Dual cure bulk fill:
BulkEZ by Zest



AI X-Ray Interpretation:
Pearl



**Easiest, cleanest, most effective
dual-cure resin adhesive cement:**

- Visalys by Kettenbach
- Duo-Link Universal by Bisco