BUT AREN’T THEY JUST BABY TEETH?

GREGORY PSALTIS, DDS
THURSDAY, FEBRUARY 20
# Chicago Dental Society MWM & REGIONAL MEETING COURSE EVALUATION

**Speaker:** ___________________________  **Date:** ___________________________

**Subject:** ___________________________  **Number of attendees:** ___________________________

## PLEASE RATE YOUR SPEAKER AS TO:

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Should this speaker be invited for future meetings?  
Yes ☐  No ☐

What topics of interest would you like to see covered in the future?  ____________________________________________

Comments (use reverse if you need additional space):  ____________________________________________

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**Name (requested but not required—please print):** ___________________________

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**RETURN EVALUATION CARD TO:**  
Chicago Dental Society  
Aloysius F. Kleszynski, DDS  
401 N. Michigan Ave., Suite 200, Chicago, IL 60611-5585
I. Introduction to Pediatric Restorative Dentistry
   A. Why do the primary teeth?
      1. Will be present until age 10-12
      2. They will be chewing food during greatest period of growth
      3. Interproximal caries can lead to space loss
   B. Why do the primary anteriors?
      1. They help to develop proper speech patterns
      2. Young children's self-esteem is often overlooked
   C. It's a great time to introduce dentistry to children before they freak out!
   D. Practice Builder
      1. Treat children well and their parents will stay with your practice
      2. Parents do for their children what they won't do for themselves
   E. Financially worthwhile
      1. With efficient operative, productivity can be high
      2. Get children caries-free and recalls are non-stressful production
      3. No lab bills

II. Philosophy of Modern Pediatric Restorative Dentistry
   A. Prevention
      1. Regular checkups
      2. Annual bitewings
      3. Fluoride treatments
         a. Systemic supplements
         b. Topical applications
      4. Sealants
   B. Conservative cutting of teeth
      1. Preservation to slow long-term progressive decline
      2. Air abrasion techniques
      3. Preventive resin restorations
   C. Attitude adjustment
      1. Positivism
      2. Sense of accomplishment
      3. High expectations
   D. Developmental Chart
III. Diagnosis
   A. Dental Development
      1. Age of patient and likelihood of retention
      2. Clinical mobility
      3. Condition of roots
   B. Radiographic
      1. 70% of lesions in primary teeth are interproximal
      2. Look at occlusals on permanent molars—sometimes show in films
   C. Clinical appearance
      1. Is a "stick" a "treat" or a "no treat?"
      2. Which grooves are involved?
      3. What is patient's history (hygiene and caries activity)
   D. When do Class II's become stainless steel crowns?
      1. Main criterion is likelihood of Class II restoration failure
      2. If half of the clinical crown (or more) is broken down, it's a crown
      3. If more than 2 surfaces are carious, it's likely a crown
   E. Pulp therapy for primary teeth
      1. Pulpotomy
         a. Consider age of the child and size of lesion
         b. If clinical crown is "dished out," plan a pulpotomy
         c. If caries are radiographically more than halfway to pulp, do pulpotomy
      2. Pulpectomy
         a. Consider age of child and clinical condition of tooth
         b. Maxillary anteriors and second primary molars are candidates
         c. First primary molars are not good candidates
         d. If the furcation area is involved, this is a poor candidate
      3. Anterior trauma
         a. Usually requires no treatment
         b. Darkening is actually normal, but not an indication
**Pediatric Restorative Dentistry**

IV. Treatment Planning  
A. Must consider age of patient for length of visit  
   1. Young children need shorter, earlier appointments  
   2. Older children (6+) can handle longer, later appointments  
B. Number of visits  
   1. Always try for 1 or 2 visits, with a maximum of 4  
   2. Consolidate treatments during each visit  
      a. If space maintainers are needed, restore abutment at banding visit  
      b. If SSC and Class II restorations abut  
         i. For resins or ionomers, complete restoration, then crown  
         ii. For amalgams, complete crown first, then restoration  
C. Prioritizing  
   1. Posteriors should always be treated first  
      a. Longevity of teeth  
      b. Chew food during child's growth  
      c. Less traumatic for treatment  
      d. Often *NOT* the parents' preference  
   2. Anteriors should be saved for last  
      a. Function for speech and smiling are secondary to mastication  
      b. More difficult to treat comfortably  
      c. Incentive for parents to continue with treatment of posteriors  
   3. Referral of abscessed teeth  
      a. Let oral surgeon complete care with general anesthetic  
      b. Have exodontia done *out of your practice*  
D. Sequencing of treatment  
   1. Generally start with mandibular arch first, if possible  
   2. Try to relieve pain at first visit  
   3. Save short, simple quadrant for last, as that memory will be held
**Pediatric Restorative Dentistry**

V. Stainless Steel Crowns  
A. Prep occlusal surface first with diamond wheel  
   1. Reduce only about 1-1.5 mm—remove occlusal anatomy  
   2. Reduces hemorrhage by avoiding gingiva  
   3. Gives better idea of crown size  
B. Prep axial walls with 1170 thin tapered fissure bur  
   1. Minimal reduction, but break proximal contacts  
   2. Use wedges to reduce hemorrhaging  
   3. Can reshape prep to the shape of the crown  
C. Select crown size  
   1. Should fit snugly, but must go all the way down  
   2. Check for crown length- if tissue blanches, trim crown  
   3. General rule is tissue should not blanch more than 1mm  
D. Shape crown  
   1. Contouring pliers to basic curvature  
   2. Crimping pliers to engage undercuts of prep  
   3. With pre-crimped crowns, these steps are not necessary  
E. Cement crown  
   1. RelyX Luting Plus cement  
   2. ZnPO4 is OK  

VII. Anterior Strip Crowns  
A. Isolate with rubber dam with individually punched holes (small)  
B. Alasticks  
   1. Retract tissue and rubber dam  
   2. Hemorrhage control  
   3. Leave facial floss to facilitate removal of alastick  
C. Caries removal  
   1. Slow speed round bur  
   2. Vitrabond Plus in deep areas (+increases retention)  
D. Prep incisal and axial walls  
   1. Minimal reduction  
   2. 169 bur  
E. Fit strip crown forms  
   1. Must trim away entire "cuff"  
   2. Crown should fit snugly  
   3. Vent holes in MI and DI angles  
   4. Fill 1/2-2/3 full with Filtek Supreme Ultra A1D and condense  
   5. Place over tooth  
   6. Remove excess material and light  
F. Removing strip crown form  
   1. Course disk to remove incisal edge  
   2. Hollenbeck to "unzip" lingual  
   3. Hemostat to remove strip crown  
   4. Finish edges with Soflex disks  
G. Remove alasticks
Pediatric Restorative Dentistry

VIII. Local anesthesia
A. Injections
1. Inferior alveolar block (IA)
2. Posterior Superior Alveolar Block (PSA)
3. Middle Superior Alveolar Block (MSA)
4. Anterior Superior Alveolar Block (ASA)
5. Greater Palatine (GP)
6. Nasopalatine (NP)
7. Mental Nerve Block
8. Long Buccal
B. Infiltrations vs. Blocks
C. Needles
1. 27 ga. short
2. 30 ga. short
3. 30 ga. extra short
D. Septocaine 4%
1. Especially effective for infiltrations
2. NOT recommended for children under 3 years of age
3. NOT recommended for mandibular blocks
4. Effective for hard-to-get-numb patients
E. Lidocaine 2%
1. For children under 3 years of age
2. For mandibular blocks
3. Can be used for infiltrations, too
F. Topical Anesthetic
1. Caine sticks
2. Can give to kids for soft-tissue extractions at home
G. Safety techniques
1. Assistant hands of child’s forehead and child’s hands
2. Mouth prop
H. Technique
I. Management
J. Vocabulary

IX. Treatment of Posteriors
A. Primary- Class I and II Restorations
1. Materials
   a. Dyract
   b. Amalgam
2. Preparations
   a. Conservative
   b. Use 330 burs/rounded line angles
3. Use wedges
   a. Reduces hemorrhaging
   b. See prep at contact point more clearly
B. Permanent- Preventive Restorations
1. Materials
a. Heliomolar  
b. Amalgam  

2. Preps  
a. Preventive resins  
b. Traditional alloy preps  

X. Primary anteriors  
A. Cl. III and Cl. V  
1. Preps (330 bur)  
2. Dyract  

XI. Pulpotomy on Primary Teeth  
A. Open with any bur into chamber  
B. Debride coronal pulp with sharp #8 round bur  
C. For ferric sulfate, countersink into radicular chambers with next smaller bur  
D. Hemostasis with dry cotton pellets  
E. Fix pulp stumps with Ferric Sulfate or Formocresol  
F. Place ZOE packing  

XII. Pulpectomy  
A. Open with any bur into chamber  
B. Debride chamber  
1. Similar to permanent tooth—use files  
2. Use sweeping motion for posteriors  
3. Not nearly so meticulous as permanent preparations  
C. Rinse with hydrogen peroxide  
D. Fill chambers  
1. Vitapex (CaOH and iodoform paste)  
2. Add powder to ZOE and hydraulically condense  
E. Post-op film to confirm fill  

XIII. Paraphernalia  
A. Mouth prop  
1. Extends treatment time by reducing fatigue  
2. Enables better access for restorative care and injections  
3. Avoids biting of provider and handpieces  
B. Rubber dam  
1. Use slit, not individual holes  
2. Essential for bonding and sealants  
C. Clamps  
1. Maxillary teeth  
   a. Permanent molars= 3, 14, 14A, W5  
   b. Primary second molars= 3, 8A, W5, W8  
   c. Primary first molars and bicuspids= 2  
2. Mandibular teeth  
   a. Permanent molars= 3, 14, 14A  
   b. Primary second molars= 8A  
   c. Primary first molars and bicuspids= 2
**Pediatric Restorative Dentistry**

"Must-have List"

Mouth props/HuFriedy

Ferric Sulfate/Ultradent/Direct only
Astringident 15.5% Fe(SO4)

Rubber dam/Hygienic

**Suggested List**

Ultra-Seal XT/Ultradent/Direct only
with 35% Ultra-etch and Primadry

Filtrek Supreme Ultra A1D (3M)

Heliomolar/Vivadent

Anterior strip crowns/3M

APF Topical Fluoride Foaming Solution/Oral-B

KCP1000/American Dental Technologies

Flavored N2O nosepieces/Accutron

Caine tips

Clamps/Ivory

W5 and W8 for Dyclone

8A, 3 & 14A for anesthetic

Gray Alastics/Unitek/3M

RelyX luting cement/3M cementing crowns

Wedges/Premier

Dyract/Caulk

Unitek SSC's/Unitek/3M

Vitapex filling material

Matrix bands/Denovo/direct

30G X-short/Astra
Pediatric Restorative Dentistry

IX. Air abrasion in pediatric dentistry
A. High-tech
   1. Ideal for Sealants
   2. Very useful for preventive composites
   3. Often eliminates need for local anesthetic
B. Diagnostic Enhancer
   1. Instantly separates out stains from caries
   2. Eliminates "watch" areas on permanent teeth
C. Marketing Tool
   1. Parents are amazed and attracted to the technology
   2. Facilitates four quadrant dentistry
D. Consistent with pediatric philosophies
   1. Minimal tooth reduction
   2. Enhanced comfort for patient
E. Practice Enhancer
   1. Fast-- increases productivity
   2. Allows sealant repairs at recall visits
   3. Exposes some "sealants" as carious lesions

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