

Dr. Paul Belzycki – Don't Rush to Judgment – A Molar Falsely Accused

Chiraz: Hello and welcome to CDA Oasis. My name is Chiraz Guessaier. It is my pleasure to welcome once again, Dr Paul Belzycki after some time off our screen. By now, most of our viewers, if not all know that Dr. Belzycki is a dental surgeon from Toronto who shares more than four decades of clinical experience with his colleagues on Oasis and he is back once again with an interesting case in which he offers more clinical tips and advice. Dr. Belzycki, as always, thank you for being with us today. It is a pleasure to see you again. Welcome to CDA Oasis.

Dr. Belzycki: It's good to be back. Thank you.

Chiraz: So, before we had to view the case, I'd like to take a few minutes to talk with you about a few interesting and important elements. First, when you get this or any other case, what is your philosophy of treatment? What is your approach to patient care?

Dr. Belzycki: That's a very interesting question. Functioning as a quasi mentor for this series kind of forced me to focus on my philosophy of practice and put it into words, try to make it concise. So, I have given it some thought and each and every one of us practices with some philosophy of practice, whether we've thought about it consciously or not, it could evolve on the day to day stresses that we face. But to break it down, there's four important components as I see it. Number one, as licensed healthcare professionals, we have a fiduciary duty to put the patient's needs above all else. So, the business of dentistry or your stresses and strains at home, financial or otherwise, must not influence your decision making. Number two is patients deserve an accurate diagnosis. In the absence of an accurate diagnosis, treatment is useless at best or dangerous at worst, if it's surgically invasive. Patients deserve treatment carried out to a high standard, if you are going to treat. And finally, patients deserve the truth and it's my task, our task as I see it, is to combine evidence-based knowledge with clinical experience that comes with age, exacting technique, using durable materials to deliver trouble-free long-lasting restorations. And because that's what we would want if we're sitting in the chair. So, all of the above is just an elaborate way of stating the golden rule of any human interaction: provide care to others as you would wish to receive. And again, that's old-school dentistry.

Chiraz: How does this case relate to this philosophy? Have you applied this approach to patient care in this case?

Dr. Belzycki: Well, I think it's universal. This case made its way to me is a result of errors in judgment made by a previous dentist relating to putting the patient's needs first, arriving at an accurate diagnosis and treatment delivery issues. In my mind, there was a rush to judgment on the long-term prognosis of a particular tooth. When I start problematic cases, under these circumstances, I know that I have to set aside a lot of time to investigate what occurrences transpired that

resulted in the current dilemma. I become a dental Sherlock Holmes, if you will. I've made the analogy that success is a link-chain of events where the ultimate strength of that chain rests on the weakest link. Every case has a weak link or an important salient link and it's my job to identify and manage that link and not to repeat the errors of others.

Chiraz:

I know we're going to go and see the case in a few minutes, but before we do that, there are two things. First of all, I'd like to request that our audience stays with us because on the other side of the presentation you will still be talking about more clinical advice and clinical tips, particularly for new and young dentists. But my question for you before we see the case is, what are some of the main messages that you'd like your audience on Oasis to keep through watching this case?

Dr. Belzycki:

It's interesting that you ask this question because I have a statement that I usually respond with; and I used that on a patient today we're trying to figure out what the source of discomfort and it's very ill defined; and I just tell everybody, the human body is an infinitely complex biological system. When you consider all the chemistry, the dance of life that has to take place for a body to remain healthy. So, we have to recognize that no matter how certain we might feel about our diagnosis and our treatment, always recognize that you may be mistaken, you can make a mistake and overlook something and providing good dentistry is not making mistakes.

Dr. Belzycki:

When I set out on treatment, I try to form an image in my mind of what is required and to try to perform that to the highest standards. I have to have a vision and you must develop a vision of what's the ideal outcome of a case; and how to get there, all the steps involved. And you may have to have plan a, b, c, and d, if the first one doesn't work out and know that you may have to switch to that and what all the steps are; and that's difficult to do when you're a dentist, but it comes with experience. And if you have that vision and you're working with other clinicians and specialists and the like, you have to make sure that somebody becomes a quarterback and we share that one vision amongst everybody involved. So, nobody works at cross purposes.

Dr. Belzycki:

Now, we've all had instances where we started, and we provide a treatment as best as we could and we had a less than favorable outcome. If you haven't had this experience, then you just haven't been practicing long enough, practice long enough and you will be humbled. Every once in a blue moon, it does happen. So, it's in that light that I offer this following presentation and there's no intent here to ascribe blame or shame to anybody, but it's to chronicle as dispassionately as I can what happened to a patient that came to me. This is an actual case where diagnosis and treatment by previous dentists were called into question by the patient.

Dr. Belzycki:

So, late one night I get a phone call. Typically, I work from nine till five or six, but I'm usually here late just doing paperwork, charting and all the paperwork that's incumbent upon us right now. And, it's an area code out of town where I thought my daughter was calling me, picked up the phone and it was a male voice and the person said, oh, Dr. Belzycki, so good to know you're still in practice. I was a patient of yours over 15 years ago when I was a law student and working in your building. I needed a lot of work done but didn't have funds. So, you provided treatment and you said I could pay when I was finally earning a living on graduation. At that point, I stopped and I said, well, it's great that you're making the phone call now to pay me? And he got a chuckle out of that. And he says, no, no, no. I'm calling on behalf of my mother. She's a 70-year-old woman and she had a recent sudden onset of pain to biting pressure. So, I took her to a GP where I live. It was a large office, multiple associates. She was seen by somebody. And a temporary filling placed and then we were informed that tooth 26 would require endodontics and they were referred to an affiliated office. So, it's an office owned by the same dentist with multiple associates. They're going to another office presumably to see one who specializes in endodontics and those were his words, not mine. So, they attended that appointment. Endo was started and then at some point during that appointment, they were informed that endodontics was not possible because canals were blocked and endo just wasn't the way to go and the tooth should be extracted, so they were referred back to the other office to see somebody that specializes in extractions. And it was at that point that the son thought of me. All the work I had done for him was still functioning just fine. So, he gave me a call. So, I said, fine, why don't you come in and we'll see what's what.

Dr. Belzycki:

So, here's that molar on presentation and you can see that there's a provisional filling, a temporary filling that was in the tooth and I was led to believe that the endodontics had been started. So, she didn't bring in a radiograph and the first thing I did was take my own radiograph and I still shoot film in my office. I don't have digital radiography and before I go much further, I'd like to say that I have been following Dr. Bob Wood and his presentations on radiography, dental radiography, and I must say I feel vindicated in doing what I do, thanks to his kind words; and I put this presentation together before his came online, so I kind of agree. When I take a film, the first thing I do is not look at the tooth that everybody thinks is the problem, because you can be fooled and you can miss things. So, I do force myself to look at all the other teeth in the area and even when testing a tooth, when somebody first comes in, I will always go to a tooth they don't think it is and start there. So, looking at this radiograph, I can see that indeed there's a little bit of bone loss at the distal and there's a clump of calculus, probably responsible for that. I saw a small little radiolucent area and I think that's decay at the CEJ that's just started and I should say she's a 70-year old lady and there does seem to be a good root length to this.

Dr. Belzycki: So, extracting this tooth will require a little bit of effort and the canals are calcified, the pulp chambers and the molars are difficult to see. I've just shot this film in front of a view box with my camera. It looks a lot better on the view box. This is the best I could do just to digitize it, but I've outlined there where the pulp chamber isn't and if I was going to go and do an endo for this tooth, I'd probably want to center the drill straight down the middle to try to engage that. So, there are the roots of the 26 were the endo was started and there's the canals. So, this begs the question, what are they doing out here?

Dr. Belzycki: So, I called the office and I said, I'm Dr. Belzycki, I've got a patient here that you'd been seeing. And I heard endodontics was not possible. Then, I would just like to speak to who's ever done this, just to get a sense of where we're at, like what was encountered; and I had thought at this time that an endodontist had started this for the patient. So, I figured let me get their take on it. And the receptionist said, no problem, I'll send you the pre-operative films that we have and then I'll get the dentist to talk to you. And I said, fine. So, in short order on email, this came through and the receptionist came back and I said, is this the only film you have of this area? And yes, that's the film. So, I thought to myself, okay, so this is the diagnostic film that was taken to try to discern sensitivity in this area.

Dr. Belzycki: And I am sorry, I'm, one of my failings is I'm quick to judge, I'm judgmental, and I just thought, well, if this is what you used in my mind, I thought there's so many ways of doing any task poorly, but only through a few precious ways of doing anything properly. And even something as routine as taking a radiograph. And I'll tell you, I've pretty much taken all the radiographs in my office, the hygienists take their bitewings, but usually I'll take all the films, all the PAs because there's a talent to it, there's a knack to it. And, I think I do a good job. So, going back to the words of Dr. Bob Wood you need a proper radiograph because that is key to an accurate diagnosis.

Dr. Belzycki: So, the receptionist said the dentist is on her way and I just said, look, there's no, I really don't want to talk to anybody is she an endodontist? And she said, no, we don't have an endodontist here. It was a GP that started the endo. So, I said, okay, thank you very much. Don't need to talk to that person. Goodbye. So, I sat with the woman and her son and I said, look, if this tooth is going to be extracted, let's go that route. We'll extract the tooth. But before we do that, I just want to take it apart. Once I've given you the local, I just want to take it apart slowly and see is endo possible? And if it is, we'll switch gears and they agreed to that. So, I started poking around and I had seen that this little cusp, the mesial lingual cusp had come loose and I didn't know was it broken before or after?

Dr. Belzycki: Unfortunately, in my haste to disengage from that other office, they did send me another email with the photograph that they too did see this fracture in

place; and I can also see from this photograph that they didn't have a filling in place there. So, I think what they ended up doing was try to bond that fragment back to the tooth because when I popped it off, I did see in this area, I did see cement. Whatever this material is, it has interposed between the fragment and the tooth. So, I think it was broken at that time. Now trying to bond that fragment to the tooth, subgingival with bleeding. As you can see, it proved impossible. So, taking the tooth further apart. I got into the pulp chamber straight away and I'm wondering, how did you end up there?

Dr. Belzycki:

Now, those of us that do endo, sometimes it's easy to be fooled and it's easy to get misdirected, so a little point that I would try to make is when getting into molars where you think it's going to be problematic to negotiate or enter into the pulp chamber, do that without a rubber dam in place because then you can get a better idea of the anatomy. With a rubber dam in place, sometimes you can be fooled and misdirect your drill where it should not be. So, I got into the calcified canal. It was calcified to the point that it wasn't solid. You could just pick away at it with an endo explorer. The pebbles started to come loose, just drilled a little bit with a small round bur and I defined the pulp chamber. And now, for the next hour or so, this is my world. This is my universe. All the talent, everything. 39 years of dentistry is brought to bear in this small little volume of the tooth because I have to negotiate these tight canals and there you can see the three of them. So, I worked those up and I know that if there is an MB two, it should be somewhere along that yellow line, so I troughed a little bit more tooth material away. I'm sorry I didn't take a photograph of that, but I convinced myself that was not an MB two and there's the finished case endodontically. So, I got the endo sorted out.

Dr. Belzycki:

There's the two buccal canals and there's as I said, the vision of where those canals should be. And straight away, I put a band on the tooth and just restored it provisionally with amalgam because this patient knows that they're getting a crown. This was discussed with the patient beforehand. If we're doing endo, you're going to have a crown. And I said that before I knew that the tooth was broken. So, I love Amalgam and that song, another post that I've done for oasis, it's durable, robust, predictable. It hardens underwater. Everything's there that you would need in a material to save the day; and amalgam will do this. So, the next step, and this is all at one appointment, the next step is I have to deal with the fracture, I have to define that fracture.

Dr. Belzycki:

So, whenever I get into the soft tissue, I always remember rule one, you can't fool mother nature; and here we're dealing with the biologic width. We've got one to two millimeters of a very complicated biological structure that is the seal between the outside world and the inside world. And you must not violate the biologic width. And I've shown this on another slide on another presentation. So, again, there's the tooth, the CEJ, here's enamel and we've got our sulcus, which is a potential space and the epithelial attachment, the connective tissue

and the bone. And, whenever I'm going to go subgingival optimally, all you would like to do is just engage the sulcus just to tuck a margin into the sulcus. But it's an imperfect world. And sometimes chasing decay, we get a little bit deeper and you have to be able to capture that impression that is more subgingival. And you need a lab that can give you a margin that's tight and clean. You don't want to do that. So, your impression has to be good and you have to have a lab technician that understands that the deeper you go into the attachment, the harder it is to get a good, accurate impression. So, you result in this scenario where you have open margins that will ultimately fail with decay and yeah crowns are no good and does no good; and you don't want to slam restorative material into the attached gingiva and to the connective tissue because you'll know you'll pay a price either acutely or chronically over time. So, this image is burned into my memory. Every time I approach the tissue, this is what I envision and see and want to avoid.

Dr. Belzycki:

So, my band is on. I know that I probably forced some amalgam subgingivally, but I'm raising a flap and there you can see quite easily I do this with a scalpel blade. I don't have a laser, I don't want the laser, I don't need a laser. Just take some cold steel, raise a flap. And now, I can define and look for the fracture line and as I said this image is front and foremost in my consciousness when I'm getting subgingival; and of course once I've got a flap, I can also address the little bit of calculus that was subgingival that wrapped around the tooth, so doing a flap kind of serves multi-purposes in this case; and there's the little fracture and I knew it wasn't too deep because the fragment that was a little bit that was subcrestal, so it was just a small matter of smoothing some of the bone in this area, ramping it a little bit to define and smooth out the fracture line so it wouldn't pose a problem.

Dr. Belzycki:

Sorry, I didn't take a radiograph of having done that, but trust me, I did do it and then just close it with Rio silk. And, there showing that conventional radiography still is valuable and good. There you can see, there's that little bit of decay at the CEJ. And, just packed it with some perio pack. Now whether to use perio pack, not to use perio pack. I liked perio pack, it keeps the area quiet for patients. It prevents food from getting dislodged inadvertently. It may be old school, but it works well. And I love old school because I know more often than not, it will result in good dentistry. And, the proof is in seeing it.

Dr. Belzycki:

So, seven days later, by providing well established protocols to an accepted standard of excellence, you can get good dentistry done quite nicely, quite easily without expensive toys. One month post-op, the tissue has matured. It's rebounded a bit. If this was an anterior tooth, I believe a little bit longer, so the tissues could model with time, but in a molar tooth, there's no need to let it go longer than this. And the pursuit of perfection. Now, when I claim here is a perfect restoration or impression, I'm not trying to toot my own horn. I fully realize that perfection is elusive and abstract. I struggle to a approach

perfection, recognizing I won't ever hang onto it or grasp it firmly, but I still try to get things as perfect as I can, because that's what a patient wants, That's what a patient deserves and that's what I would want, if I'm sitting in a chair and I'm sure you would too.

Dr. Belzycki: So, I still impress with VPS impression material and a custom tray that I make up at the office and I get a perfect impression. Not every time, but the one that gets sent to the lab is perfect and if I have to take it a second or third time, it's not a problem because I want perfection back from the lab; and if I don't supply it, they can't do their end either. So, here you can see the crown is back from the lab. The workhorse in my practice is porcelain-fused to metal because I have some of these in people's mouths for over 30 years; and they just keep taking the abuse and function quite nicely. Yes, a little bit of porcelain can break and wear over time, but you have a metal substructure that is protecting that tooth for a lifetime.

Dr. Belzycki: So, guiding the lab is very important. You have my lab script that I make up. No need to go over it except to just look at the last paragraph which in I tell the lab: you have to ensure the following is done. Impression, approved for accuracy by the lab before pouring because I can have an error; it can be a busy day; I can miss a defect. And, don't pour it, if it's not perfect. Phone me tell me and I'll take another one. I want all margins have to be perfect. No gaps under a microscope. Articulated models do not rock with the crowns in place and the occlusion is not short. If in doubt, leave the occlusion high because it's easier for me to take away than it is to add. I don't like putting in crowns or bridges that are short on occlusion; and all contacts are to be broad and secure under a microscope. I want to avoid those contacts that will ultimately lead to food entrapment and I want a list of all the dyes are models that were inadvertently dropped or broken and repaired with glue. I hate finding this out on my own when it's too late. So, they know they have to provide excellence to me; and I still use a stone model. I don't do digital. My lab technician is fond of saying he loves stone as well because you don't need software upgrades every few months just to do what you can do with stone.

Dr. Belzycki: And there is the day of insertion and you can see there was a little bit of injury that had taken place, when I had done the tooth preparation here, but it had healed and rebounded quite nicely. An amalgam was placed and there's a good solid stop right on that marginal ridge. If this was composite resin, it would be gone and worn away by now. But amalgam will take the abuse decade after decade. And that tissue rebounded quite nicely because of a well-fitting provisional crown. And these are important in maintaining the health throughout the entire process. So, provisionals are important and there the final crown is cemented in.

- Dr. Belzycki: So, achieving excellence is controlling all the details. That's what a dentist is responsible for. So, our task, as I see it, is to use evidence-based knowledge with clinical experience, exacting technique and durable materials that will result in long-lasting restorations because people want it fixed right and they want it fixed once. They don't want to come back time and time again. So, I like full coverage on molars, PFM preferred on lower teeth, molars, if it's a good strong male, we'll go with full-gold crowns.
- Dr. Belzycki: So, getting back to philosophy of care, how one provides treatment to a patient. So, I ask the questions again: were the patient's needs placed above all else? Well, you know, in this day and age with the high cost of getting into school, the high cost of getting out of school sometimes that might get lost. And then these practices where there are multiple associates in several offices owned by one person, this patient got shuffled from person to person and perhaps an endodontist should've been called in earlier.
- Dr. Belzycki: Did the patient receive an accurate diagnosis? Well, to determine why the tooth was sensitive to pressure in the first place, it very well may have been that fractured mesial lingual cusp, perhaps the tooth didn't even need endo. Certainly, if this patient had presented to me right away, endo would not have been the first choice, I would have tried to just go straight to the crown. Was treatment carried out to an accepted standard? Well, this problem here almost thankfully there was no perforation that was at the crest of bone out the root. So, it was possible to restore this tooth. But I think these photographs speak for themselves. And, did the patient receive the truth? Now I'm not saying anybody lied to this lady. I just think that they gave her the truth as best as they thought it to be.
- Dr. Belzycki: And, some of these questions I think I'll leave it up to the reader and the viewer to answer on their own. But it's interesting that the literature from this office states, professional care, personal attention and superior results. And, I think it's a bit ironic that they had to go elsewhere to receive that.
- Dr. Belzycki: So, philosophy of practice again, how one provides care. You must contain the knowledge and the vision of what is correct within the self. You have to know what's right; and that comes with your training and that comes with clinical experience. And, being able to come to that decision of what is right, that ability improves with experience. If multiple practitioners are involved, GPs and specialists, everybody has to share that vision to ensure success so that nobody's working at cross purposes. And, just to show you that I do practice what I preach, I don't place implants, just beyond my comfort zone, even though I do periodontal surgery all day long, but I have this patient where we want to convert from an RPD to an implant-supported prosthesis.

Dr. Belzycki:

So, I just don't send the patient off and say make implants, send implants. This is how I envision the case before I start and I want my vision and nobody else's. So, planning it, I do use organic study models, stone models, if you will. Organic is the new fancy word, but it's just a stone model. I do the wax up and I try to see what's possible. One implant, two implants and I make the surgical guides on my own in the office; and here you can see I'm preparing where the implants should go. Now, I do this in conjunction with the oral surgeon. I send him the study models. I send them all these radiographs and we decide together and try to make a decision. I show up on the day of surgery, so I was the one that has taken these films and there are little pencil marks that were put in; the implants were placed in a coordinated fashion and agreed-upon location between myself and the surgeon so that it does result in what my vision is.

Dr. Belzycki:

So, you have to share a vision and you have to make it a reality and you have to ensure that you guide the lab as well. So, provide care to others as you would hope to receive. Know Thy self, know what you're good at, know what you're not good at, and you can try to get better at things, but early on when in doubt, refer to somebody that you can trust; and appreciate that the delivery of long-lasting restorations is the ultimate goal of good dentistry. That ain't old school, baby. It's the only school. And with that I'd like to thank you for your attention.