

It's not always as clear-cut as it seems

HERE'S a question for you. How do you do a posterior composite?

- Well obviously you cut the cavity under rubber dam, use a total etch technique with wet bonding, followed by flowable composite and incremental build-up.
 - No, no, no, you build up the bulk in glass ionomer (which removes the 'uncertainty' of dentine bonding) followed by a resin modified glass ionomer, followed by composite. This also negates the effects of relative humidity on the dentine, and thus means that you don't have to use rubber dam.
 - What rubbish. Yes, you can use GIC, but only a small amount as a liner in the base of the cavity. Then you use an all-in-one bonding technique followed by heavily filled, "packable" composite.
 - Ha ha, what a numpty. Surely everyone knows indirect composites are the only way to go. Do you really want to risk polymerisation shrinkage? You should be struck off you charlatan.
 - Posterior composite, are you mad? I wouldn't have that in my mouth. What you need is a nice pinned amalgam.
- Seemed like such a simple

question. It occurred to me that we don't really know how to do a posterior composite. Yes, we know that etched enamel is good to bond to, but it gets a bit fuzzy when it comes to the rest of it. How many bonding systems are there on the market anyway?

Ok, here is an easier question. How do you do an amalgam?

- Well that's easy. Get a big bur, cut out all the decayed tissues and create a Blacks cavity. Bit of Dycal, bit of cavity varnish and Bobs your uncle. Don't forget to trim off all those errant enamel prisms with that chisel though.
- Crazy talk! Don't you know Dycal turns to mush under amalgam? And cavity varnish? A Neanderthal device used in the times before high copper amalgams. Amalgams don't corrode anymore. Besides, you should be bonding that amalgam in with Panavia. Blacks cavity indeed. Why don't you just prescribe a course of leeches on the side?
- Amalgam bonding doesn't work. And besides, why are you trying to kill your patients by putting toxic mercury in their gobs. Composite, man, composite.
- Oh yeah, like composites are

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safe. Free acrylic monomer, oestrogen and carcinogens galore. Didn't you know there are amalgams now available which guarantee no free mercury. And they are much better when bonded in.

- Er, excuse me, but shouldn't you really be using gold?
- Bugger, that didn't work. I've got it, how do you do an examination?
- Easy. Get them in the chair, quick look round to see if anything's amiss and off you go.
- Are you insane? You haven't even tried to build rapport. This is a person with a soul. Get to know them, find out their wants and dreams and deliver them. Then have a look at their teeth.
- All well and good, but cover the basics. I want a full medical history, past dental history, and full TMJ examination noting of joint sounds and crepitus (make sure you use a stethoscope here). I want soft tissues examination, and full muscle palpation. I want a full occlusal exam, including slides, anterior guidance, with indications of working and non working side interferences. I want

to know where the first point of contact in RCP is, and the degree of slide into ICP. I want full periodontal examination and mobility scores, followed by the noting of wear facets and fremitus. Then do a BPE, and where indicated a full periodontal charting with plaque scores, bleeding index etc. Then I want full mouth rads, including vertical bitewings and an OPT.

- That's a bit over the top. All you need is a quick chart, few X-rays, BPE and a quick chat to see if they are having any problems.

Ok, I give up. Could this be why 20 dentists can examine the same patient, only to give 20 treatment plans. And this is why you have to be careful. What to you may be malpractice, may to another dentist be exceptional dentistry. Just because you do things differently, doesn't mean that you are right, or another dentist is wrong. I am not trying to defend awful treatment, and it's not always as clear-cut as it seems.

After all, we have all seen teeth root filled with silver points (stand-ard procedure back in the day)

that have been symptom free for decades. We have seen the worst crowns imaginable, with margins that you could drive a bus through, last 20 years. Are these failures? Who decides what a failure is? You? me? How about a pub full of 20 dentists?

What are we doing today that will be looked upon with horror twenty years from now? What will be the silver points and the dentine pins of our day? We practice evidence-based dentistry, but the evidence constantly changes. As we get more evidence, we get more choices; this makes things much more confusing. How many ways are there to prepare a root canal now, how many types of rotary NiTi on the market?

It reminds me of a quote by Albert Einstein when he was a university professor. A fellow lecturer noticed that he had set his students the same exam paper two years running. When asked why, Einstein said "Simple, THE ANSWERS HAVE CHANGED". Think about that next time the dental rep comes round. ■