When I teach surgical concepts and techniques to students and practicing dentists, one of the key topics I discuss is the thought process that goes into patient evaluation and treatment planning. Part of that discussion is the concept of mentally walking through the entire procedure, and visualizing that all of the instruments, which might be needed for the case, are on the surgical tray or are quickly available. One of the most important points for students to understand is gaining the ability to envision what they will be doing. This thought process will allow them to anticipate and avoid, or manage potential complications. Oral surgery is not something that should be done without proper visualization of the surgical field.

The first component of this concept is to use an appropriate surgical incision for the procedure at hand. I do not advocate the philosophy I was taught in oral surgery residency more than 20 years ago, “Small flap, small surgeon,” which basically meant that all surgical extractions require a large flap, regardless of the situation. My techniques have evolved over many years in practice to support “minimally-invasive” surgery. I remove teeth using “flapless” surgery whenever possible. However, I will not say that I never lay a flap. A well-planned, properly designed and well-executed surgical flap results in a less-traumatic procedure and an easier post-operative recovery for the patient.

Proper illumination and magnification is the other essential component to seeing what one is doing. In residency, one becomes very proficient at working in the dark in the most distal areas of the mouth. When root tips broke, it took tactile sense, some guesswork, and some luck to retrieve them. After removal of third molars, one could never be completely sure whether all of follicle had been removed. And, after extraction of an infected tooth, removal of all the granulation tissue from the apical area could only be speculated by sensing the curette against bone.

That all suddenly changed for me at an oral surgery meeting during my third year of private practice. I had always resisted using a headlight in surgery because of the associated discomfort. While strolling through the convention hall, I stumbled upon the booth of a headlight manufacturer and noticed something different. They had a new model that was touted to be lightweight and actually comfortable to wear. I tried it on and was pleasantly surprised. I bought it on the promise that I could return it if not satisfied. As soon as I started using it, I was amazed at how much more I could see.

I also purchased that year my first pair of surgical telescopes. I thought they would come in handy for fine facial suturing and apicoectomies, but never had thought of using them for routine dentoalveolar surgery and impactions. A few months later, the senior surgeon in my practice suggested I try wearing them for third-molar surgery, as he had found them very helpful. The first day using my loupes and headlight for dentoalveolar surgery was a revelation. I could actually see what I was doing! I could visualize the furcation of the tooth I was sectioning. If the roots broke off, rather than picking at them by Braille, I could definitely see them, which made their removal significantly easier. After extraction of a tooth with a large periapical lesion, I could look directly into the socket and see the residual granulation tissue that I needed to remove. And, I genuinely could see that the socket had been thoroughly debrided.

Looking back, I don’t know how I practiced in the dark for so long. Dentists (in general) and surgeons (especially) are creatures of habit. We learn a technique to perform a particular pro-
procedure, and are content for the rest of our lives to always do it the exact same way. When I have suggested to my colleagues that they try using a headlight and surgical telescopes for every extraction and minor procedure, the typical response is “I do just fine with the naked eye and the overhead light. Besides, headlights just give me a headache.” That was my M.O. until that day about 12 years ago. I learned first-hand that smarter practitioners are the one who constantly improve their skills and evolve their techniques. That means making major changes in some areas, and seemingly minor ones in other areas.

The simple advancement of using a headlight and loupes in oral surgery, no matter how minor the procedure, will elevate your standard of care overnight. Being able to clearly see every detail of the surgical field, even in the most distal areas of the mouth, will make surgical procedures less stressful, faster and more successful. There are now a number of manufacturers marketing very lightweight, comfortable headlights. Some of them connect to a light source via a thin fiber-optic cable. Others are completely self-contained or run off a small battery pack. Today’s headlights are a vast improvement over those that were available during my residency 20 years ago. The surgical telescopes of today have also been significantly improved, with lighter weight frames and lenses, making them much more comfortable to wear.

If you choose to do surgery in your practice, I would recommend stopping by the booths of various manufacturers of loupes and headlights at your next dental convention. I personally use the products from SurgiTel and Designs for Vision, and highly recommend them both. Try them on and ask if you can take a unit to your practice to try for yourself. You will be amazed what a difference this small investment will make in improving your surgical skill and making your surgical procedures more enjoyable. Seeing truly is believing.

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Author’s Bio

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