by Jay B. Reznick, DMD, MD

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Don’t Start What You Can’t Finish

An oral surgery case presentation for general dentists who bite off more than they can chew

I’ve been teaching oral surgery and dental implants to general dentists for the past 20 years, and I’m a little concerned about what I see happening in our profession. When I began this journey, I saw the need to educate dentists in basic surgical skills so they could safely treat patients in situations where referrals to specialists were not practical, such as dentists in rural America where the nearest specialist was more than 100 miles away or so busy that they couldn’t see a new patient for a month or more.

With a patient in pain or with an urgent problem like significant infection, these general dentists would be forced to muddle through difficult extractions or attempt management of large abscesses, with only the rudimentary surgical skills they were given—by design—in dental school. This was less than ideal for the patient and the doctor and led, as expected, to many bad experiences, unnecessary complications and sleepless nights.
After producing my first “Oral Surgery for the General Dentist” series on Dentaltown.com, I received emails from doctors thanking me. Soon thereafter, I launched OnlineOralSurgery.com to offer more advanced education and over-the-shoulder learning for basic surgical procedures. My method has been to teach dentists to “think like a surgeon” when doing surgery. Merely showing how makes you a technician; understanding why, why not and what if makes you a clinician.

In the past decade, the dental landscape has changed. Most of these changes have proven positive and helped improve the quality, efficiency and outcomes of what we do in our offices and clinics every day. The positives are due to innovations in technology, such as 3D imaging and printing, CAD/CAM and better-performing new materials that are easier to use.

But improved technology is a double-edged sword. These technological advances have created a worrisome situation: More and more dentists who lack formal surgical training are performing surgery. Admittedly, some do it quite well. However, others are blowing it.

**What makes you so special?**

After dental school, the average specialist devotes anywhere from three to seven years acquiring advanced knowledge and skills. For oral and maxillofacial surgeons, this means 60–80 hours per week of grueling training. We are taught that we are never to attempt a procedure on a patient until we understand the anatomy and physiology of what we’re planning to do. We mentally walk through the procedure start-to-finish, understand the potential complications that can occur, know how to avoid or manage them, and be able to complete the surgery without assistance. If we cannot do all of those things, then we do not even attempt the procedure. In the first year of training, we do relatively simple surgeries. The ensuing years, we operate through increasingly advanced and complicated cases—the same philosophy I’ve used to teach dentists in my online and live courses.

What I’m seeing, with increasing frequency, are dentists who take a few courses, start off with a few simple cases, then quickly get in over their heads. Or, worse, doctors who have no surgical training beyond dental school and attempt a procedure they’re totally unprepared for.

Economic pressures, economic desires or ego are most likely fueling this dangerous trend. It is folly to think that just because you have the same license as a specialist, you can do everything they can. The proper education, training, mindset and boundaries are critical to success. A couple of cases will elucidate my points.

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Case 1

A 53-year-old woman presented to her dentist with pain in her upper right third molar. The tooth was fully erupted and had a restoration with recurrent decay (Fig. 1). A decision was made to remove the tooth. The dentist gave local anesthesia and applied dental elevator and forceps. Because of the decay, the crown fractured off, and the dentist spent the next 30 minutes trying to remove the remaining roots. He obtained a new periapical radiograph to determine how much root remained (Fig. 2).

He continued working away until the situation changed drastically. He was sure that he had pushed the root into the maxillary sinus, because he saw “something yellow” coming out of the socket, which he assumed was sinus fluid. An urgent phone call was made to my office and the patient was sent to see me, accompanied by one of his dental assistants.

To get a better assessment of the location of the root and its position in the right maxillary sinus, a CBCT scan was taken when the patient arrived at my office. Figs. 3 and 4 make it apparent that the root was still in the socket and not in the sinus.

Then what was this report of a yellow fluid coming out of the extraction socket? My clinical exam immediately solved the mystery. There was a bright yellow, lobular soft solid mass coming from the buccal vestibule, just distal to the socket (Fig. 5). It took mere seconds to make the diagnosis: This dentist had just been introduced to the buccal fat pad. Reflection of the flap had perforated the buccinator muscle and exposed this normal anatomical structure.

Under local anesthesia, the exposed buccal fat pad was resected, the remainder packed superior to the buccinator muscle, and the mucosa was sutured closed. The root of tooth #1 was then easily removed.

So, what do we learn, and what concerns does this case raise? I have no issue with the dentist trying to remove the erupted tooth. That is something easily done by most general dentists. The first issue is continuing for 30 minutes and muddling through repeated attempts to elevate a stubborn tooth without a plan. This only fatigues the patient and the dentist, and the case rarely ends well. In absence of more advanced training, this doctor should have referred the patient much earlier.

Secondly, exposing the buccal fat pad is also not an issue. Oral surgeons do it all the time when removing deeply impacted high third molars. The difference is that we know the anatomy of the area we are working in, know that buccal fat pad exposure is a risk and do our best to avoid it, and then know immediately what to do if it happens. Thirdly, the inability to distinguish the difference between yellow sinus drainage versus globs of fat is a concern. No clinician should ever begin any procedure unless they are intimately familiar with the biological and anatomical terrain.

Fig. 1: Preoperative periapical radiograph of maxillary right third molar tooth.

Fig. 2: Radiograph taken immediately after crown fractured off roots during extraction procedure.

Fig. 3: Panoramic CBCT projection shows residual root still present in alveolar socket.

Fig. 4: CBCT axial slice through tooth #1 socket clearly demonstrates root within the alveolar socket and lack of perforation into the maxillary sinus.

Fig. 5: Clinical intraoral photograph shows extrusion of the buccal fat pad from the maxillary right third molar surgical site.
Case 2

This case brings up another concern about what I’m seeing in practice lately. A healthy 16-year-old girl was seen for routine examination by her dentist after a hygiene visit. The dentist noted four impacted third molars and recommended that the patient be scheduled with the itinerant oral surgeon who comes to his office once per month. The patient subsequently had the two lower wisdom teeth removed in the office under local anesthesia. The procedure took about 45 minutes, according to the patient. She experienced increased pain and swelling in the days after the surgery and called the dental office on the fifth postoperative day. She was told that the doctor who removed the teeth was not available, and the doctor who owned the practice couldn’t help her, and so she was referred to my office.

On exam, there was moderate swelling in the face over the left angle of the mandible. Intraorally, the incision in the #17 area was inflamed and swollen, with pus visible in the socket. A CBCT image was obtained, which showed the defects in the mandible from the surgery (Fig. 6).

Both lower third molars appeared to have been partial-bony mesioangular impactions. Examination of the #17 extraction socket showed three bony sequestra, as well as air and fluid densities (Figs. 7 and 8). The patient was started on amoxicillin and scheduled for debridement of the socket the following day. A significant amount of infected granulation tissue was debrided from the socket, along with two necrotic bony sequestra and a residual root fragment. The patient was significantly improved by the next day and continued to improve.

Again, a number of issues are raised by this case. First is the increasing use of itinerant exodontists and other specialists in private practices. Practice gurus are advising dentists to avoid the urge to refer patients to the local specialist, because more money can be
made by keeping the patient in-house and retaining most of the revenue. Ideally, the practice owner furthers his or her education to be able to provide additional procedures and services in the office. Some feel it makes more sense to hire someone else to get their hands dirty.

When an itinerant specialist is brought into the practice, one of the biggest concerns is a deficiency in continuity of care and availability of the traveling doctor to manage postoperative complications. If the practice owner and staff do not do surgery on a regular basis, they may not have the training and experience to deal with anything but normal postsurgical care.

The American Association of Oral and Maxillofacial Surgeons long ago addressed the issue of itinerant surgeons in its comprehensive Code of Professional Ethics. Addressing the issue that occurred here, the code mandates a duty to the patient in the postoperative period:

“*It is unethical for a surgeon to delegate postoperative care to a person who is not similarly qualified to recognize, treat and manage all surgical complications. ...Therefore, if an oral and maxillofacial surgeon performs itinerant surgery, they shall be responsible for the outcome of the postsurgical care and shall maintain communication to ensure the patient receives proper continuity of care.*”

This standard of care for postoperative management is the same whether the treating doctor is a specialist or general practitioner. In surgical residency, we are taught to perform only procedures for which we can handle the complications. This seems to be ignored in the age of the “super dentist.”

Not only are there ethical issues with this activity, but there is the potential loss of patient confidence in the practice owner as well as the delegated treating doctor. Patients are not dumb; if they feel that their care in the office was subpar, they’re very unlikely to return to that practice. None of us can afford to lose patients because of therapeutic misadventures.

**Final note**

We all need to reassess our priorities and ensure that patient care comes above all else. I fully support general practitioners performing surgical procedures, if they enjoy doing surgery and want to learn new skills or improve their current ones. It just has to be done in the right way and for the right reasons.

Seek training from the most qualified and experienced doctors you can. Learn the limitations of your training, experience and comfort zone. Proper training is essential. Proper judgment is paramount. Heed this advice and you are likely to sleep well at night.

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