CARE MODIFICATIONS FOR SPECIAL NEEDS

DENTALELLE TUTORING

WHAT DOES SPECIAL NEEDS PATIENTS MEAN?

- A patient with special needs can be defined as someone with medical, physical, psychological or social circumstances that require a change in their normal routines. In the context of dentistry and oral health, a patient with special needs requires a change in regular approaches to dental care in order to receive treatment. A patient with special needs is not, however, always severely physically and/or mentally disabled.

AGING AND ELDERLY

- These individuals may need more frequent dental visits to monitor tooth wear, pain and the effects of medications that they cannot detect themselves due to decreased pain sensations. These individuals are often sensitive to glare and have a hard time hearing dental information or instructions if background music is loud. Therefore, blinds or shades may need to be drawn and the music lowered during their appointments to enhance their comfort.

OTHER EXAMPLES

- Patients with mobility issues may need assistance in and out of the dental chair, as well as to and from the dental office.

- **Mentally disabled individuals.** Those who are mentally challenged or intellectually disabled may need to be accompanied to dental appointments by a caregiver, since they may not be able to comprehend dental hygiene requirements or homecare instructions.

IMMUNOCOMPROMISED

- **Immunocompromised people and those with complex medical problems.** People with cardiovascular disease, diabetes, bleeding disorders or other systemic conditions need to have their conditions – as well as their medications – taken into account before receiving dental treatments. Dentists will likely need to collaborate with their physicians.

- **People with a mental illness.** An individual with a mental illness may have difficulty following proper dental hygiene regimens, obtaining dental care and countering the effects of medications that affect oral health (such as antidepressants that cause dry mouth). These individuals may need shorter appointments that are scheduled when they are in a balanced state, as well as be accompanied by a caregiver or case manager.

CHILDREN

- **Children with behavioral or emotional conditions.** Children with autism, for example, are averse to changes of any kind. These patients with special needs would likely need to be seen by the same hygienist – wearing the same outfit, working in the same dental office – whenever they visit the dentist to receive care. Or, children who need medication for ADHD may need to be given their medications at such a time that they are able to sit through a dental appointment.

WHAT DENTAL CLIENTS WITH SPECIAL NEEDS ACTUALLY NEED…

- First and foremost, you or the person with special needs for whom you provide care need a qualified and experienced dentist. Any other requirements thereafter will be specific to the individual and the particular illness, condition or disability.

- An efficient and systematic approach to the examination and treatment so that appointments are short, when necessary
- Knowledge of the medical, physical, mental or behavioral condition in order to better manage the appointment and oral health needs
- More assistants during examinations and treatment procedures to better control and monitor the patient and the appointment
- Sedation dentistry to promote patient comfort if longer appointments are required
- Flexible appointment scheduling
- Caregiver or case manager involvement in treatment planning, providing instructions and information, and while performing dental procedures

SALIVARY GLAND DISORDERS

- Your salivary glands make saliva - sometimes called spit - and empty it into your mouth through openings called ducts. Saliva makes your food moist, which helps you chew and swallow. It helps you digest your food. It also cleans your mouth and contains antibodies that can kill germs.
- Problems with salivary glands can cause the glands to become irritated and swollen. This causes symptoms such as
- Bad taste in the mouth
- Difficulty opening your mouth
- Dry mouth
- Pain in the face or mouth
- Swelling of the face or neck
- Causes of salivary gland problems include infections, obstruction or cancer. Problems can also be due to other disorders, such as mumps or SS.

EATING DISORDERS – TERMS TO KNOW

- **diabetic ketoacidosis (DKA)** – a complication of diabetes that results from insulin deficiency.
- **disordered eating** – the full spectrum of eating-related issues from problematic eating behaviors to clinically defined eating disorders; multidimensional paradigm.
- **dating disorders** – psychiatric illnesses marked by disordered eating, food intake, and eating attitudes, and often accompanied with ineffective methods of weight control; criteria for diagnosis established by the American Psychiatric Association; multidimensional paradigm.
- **hyperglycemia** – abnormally increased level of glucose in the blood.
- **hypokalemia** – abnormally low potassium concentration.
- **lanugo hair** – fine, soft, lightly pigmented hair.
- **perimolysis** – a wearing down of the tooth enamel by mechanical or chemical means; example: a patient with an eating disorder that uses repeated vomiting as a means of purging.
- **restrained eating** – a pattern of dietary restriction interspersed with episodes of disinhibited overeating.
- **syrup of Ipecac** – an emetic drug sold over-the-counter for the intended use of preventing accidental poisoning by causing the victim to vomit.

EATING DISORDER CLIENTS

- Individuals affected by eating disorders have low self-esteem and evaluate themselves negatively. These individuals seem to judge themselves more vigorously in terms of body shape, weight and eating and their ability to control these variables. The undue influence of shape and weight on self-evaluation is required for a diagnosis of an eating disorder.

- An individual's eating pattern is influenced by the balance between physiological factors prompting the desire for food and efforts to resist that desire. The cognitively mediated effort to combat the urge to eat is called restraint. A item restrained eating scale assesses the degree to which a person eats less than he or she actually would like to eat and a high score is considered a risk factor for eating disorders.

RATIO

- **The three most common eating disorders are *anorexia (starvation)*, *bulimia nervosa (binge purge)*, and *binge eating disorder (bingeing)*.**
- Many people have variations of disordered eating and many of these disorders go undiagnosed and untreated for a significant period of time.
- The male-female prevalence ratio has been estimated at 1:6 to 1:10.27 Approximately eleven million adolescents and young adults present with eating disorders in the U.S. and the typical age of onset is 12-18 years. Eating disorders is a chronic syndrome that is complex and multi-symptom. There is a pressing need for oral healthcare professionals to be a part of the patient's eating disorder healthcare team. This commitment means the dental professional needs to be fully informed about these conditions, recognize signs and symptoms, take the appropriate dental action, and refer the patient to their health care provider. Dental professionals have an obligation to be concerned not just about the patient's oral health, but their overall health as well.

HEALTH PROFESSIONALS

- All health professionals are encouraged to expand their views of eating disorders beyond the stereotypical person or groups of people, such as dancers, gymnasts, or cheerleaders, to include dietetic students and individuals with diabetes. One eating disorder that is new to the healthcare community, but is not yet a recognized medical condition, is called diabulimia. It is occasionally seen in teens and adults with diabetes. Due to the restrictive nature of the treatment for the disease, it follows that individuals with diabetes may have an increased risk for eating disorders. The relationship between diabetes and eating disorders exists due to feelings associated with the intensive nutrition guidelines, reactions related to a lack of control, or that diabetes is controlling their life and concerns with issues of dependence.

ANOREXIA

- Goals of treatment for individuals with anorexia includes: slowly restore weight to a healthy level; resumption of normal eating; treat physical complications; enhance motivation to cooperate with treatment; relief from guilt and depression; education in nutritional and physical exercise; correcting maladaptive thoughts; treating associated psychiatric conditions; enlisting family support and attempting to prevent relapse; and initiating realistic goals.

- Medication, especially serotonin reuptake inhibitors are frequently used for depression, anxiety, obsessions, or impulse disorders but are not the sole or primary treatment. A small percentage of patients recover without any or limited assistance. This may occur because the individual has a marked change in their life, such as falling in love. Total recovery for anorexia is only 25-35%.

BULIMIA NERVOSA

- The lifetime prevalence of bulimia is 1.1 to 4.2% and the male-to-female prevalence ratio for both anorexia and bulimia is 1:6 to 1:10.9 Individuals with bulimia will be of all sizes ranging from small to morbidly obese and can gain or lose many pounds in short periods of time.

- Bulimia nervosa (binge-purge) is characterized by recurrent episodes of bingeing and purging. The individual can binge anywhere between 1,000 to 60,000 calories at a single time over a one to two hour span. Feelings of panic, disgust, guilt, or depression will set in and the individual soon recognizes the need to purge, often minutes after the binge. Purging includes vomiting; excessive use of diuretics, enemas and laxatives; and fasting or excessive exercise. Individuals who participate in these behaviors will usually experience low self-esteem, shame. Patients with bulimia often understand their eating behavior is abnormal.

DEPRESSION

- Eating disorders can be associated with mental disorders like depression. Eating disorders may be one of many symptoms of depression or it is possible that an eating disorder develops because of isolation, stigma, and physiological changes wrought by the eating disorder itself. People with eating disorders suffer higher rates of other mental disorders besides depression like anxiety, other compulsions, and substance abuse. In addition, stealing food and/or money to buy food can be a factor for several individuals

INTRAORAL

- The intraoral effects of eating disorders include signs of malnutrition, dental erosion, traumatized oral mucosal membranes and pharynx, xerostomia, dental caries, dentinal sensitivity, enlargement of the parotid glands, gingival and periodontal diseases, and soft tissue lesions. Dental erosion can affect labial and lingual surfaces of the teeth. Labial tooth erosion corresponds to acidic food/beverage consumption. Time of exposure, friction from cheeks and lips, and parafunctional habits exacerbate the loss of dental enamel. Once damage is into the dentin, lesions advance more rapidly. The palatal surfaces of the maxillary anterior teeth are oftentimes eroded with a smooth, glossy appearance.

IMAGE

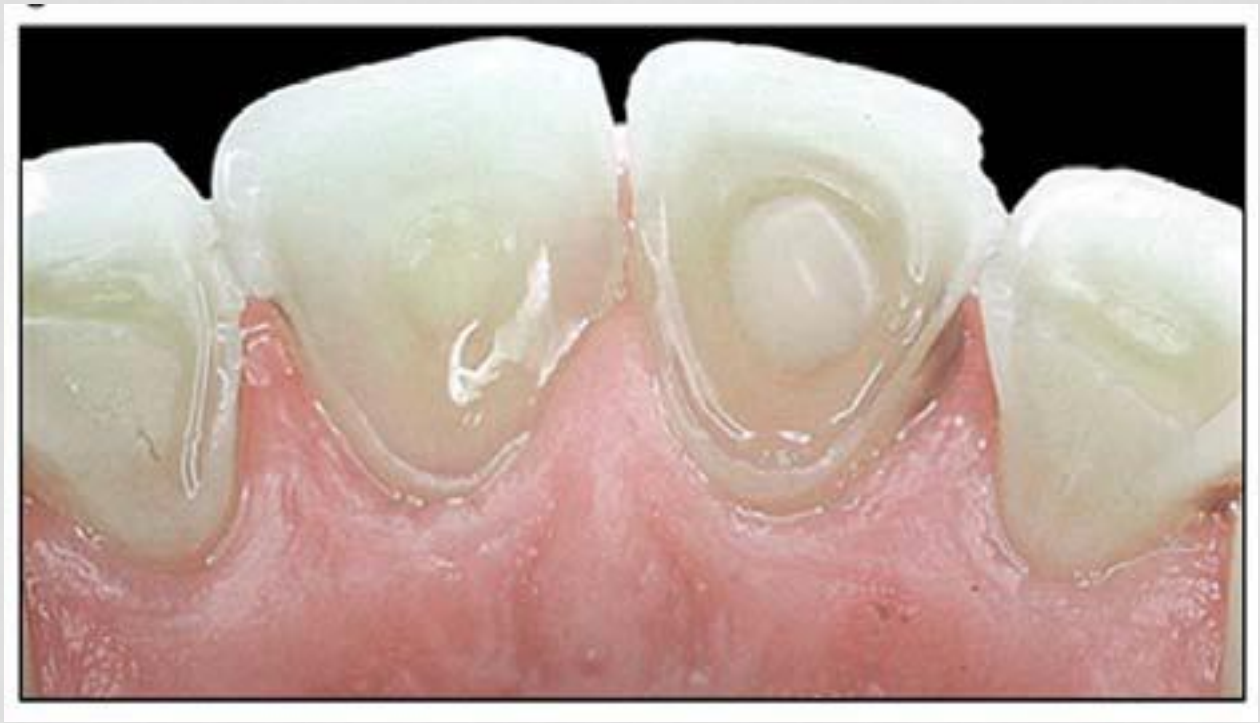
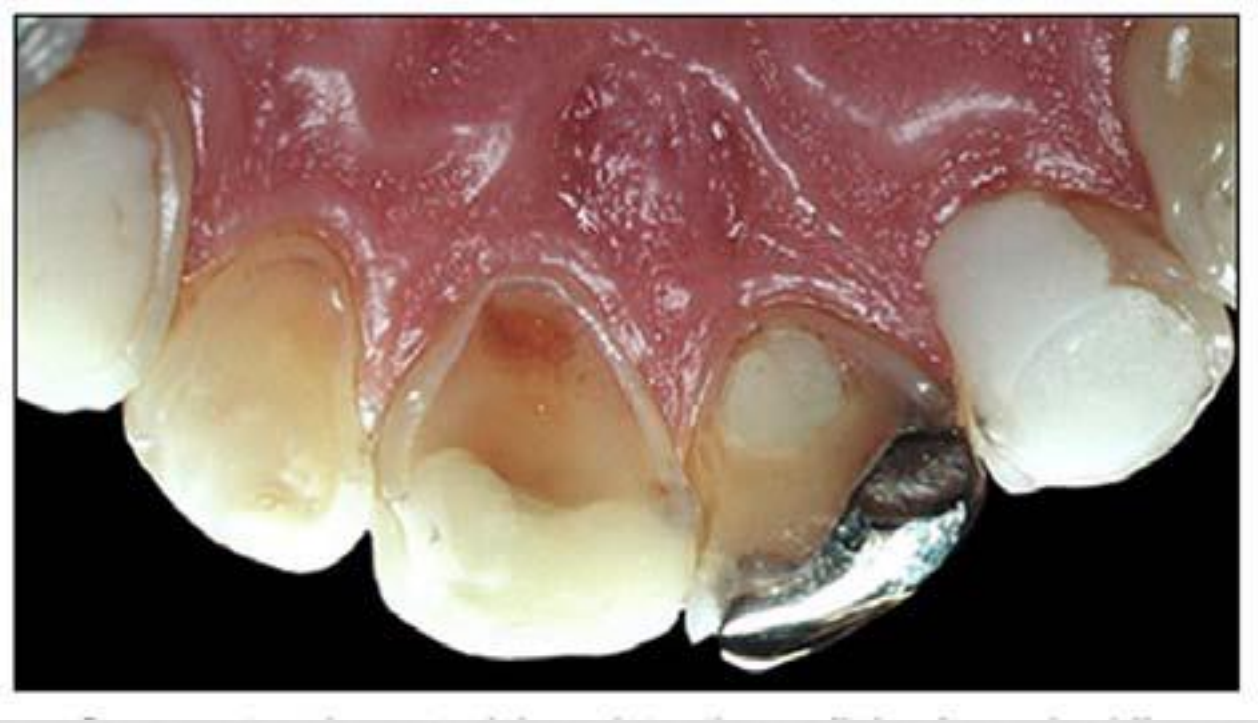
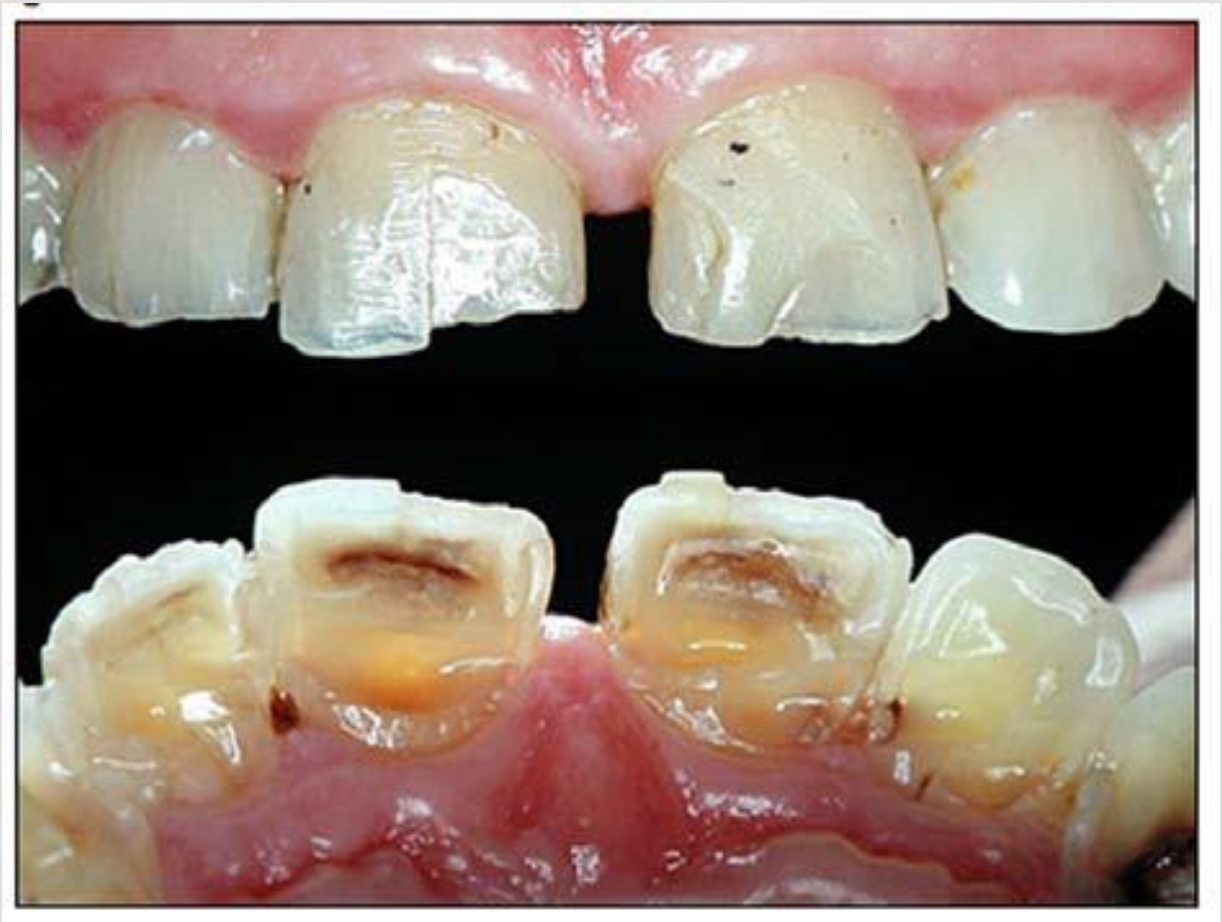


IMAGE OF EROSION



MORE EROSION



EROSION

- The tongue is very effective at cleaning the palate and the lingual surfaces of the maxillary anterior teeth. The erosion is also known as perimolysis and is sometimes characterized by loss of enamel with rounded margins, a notched appearance of the incisal surfaces of anterior teeth, amalgams that have the appearance of raised islands, and loss of contours on unrestored teeth. Fortunately, with the onset of improved dental materials, most restorative materials, with the exception of zinc phosphate as luting cement, resist rather well the acidic oral environment of patients with eating disorders

RESTORATIONS

- Ideally, only essential dental restorations should be performed when the patient is in active involvement in purging, while extensive restorative dental work should be reserved for when the patient is in treatment and beginning recovery. Continued purging activity will undermine the longevity of the restorations as a result of continued loss of tooth structure.

- Once the palatal surface of anterior teeth is depleted, unsupported enamel tends to crack easily and is exacerbated if the patient has parafunctional habits. Erosion can also cause hypersensitivity to touch and cold temperatures. In addition, once cracked teeth cause inverted smiles, individuals with eating disorders may seek dental care for aesthetic reasons

VOMITING

- Xerostomia can increase the potential for caries. For the patient with bulimia, a high carbohydrate diet often consumed during a binge compounded with the low pH of saliva from recurrent vomiting and/or xerostomia will also contribute to a high caries rate.

- Self-induced vomiting can also cause trauma to the soft palate and pharynx. Nutritional deficiencies can also contribute to soft tissue lesions like angular chelitis, candidiasis, glossitis and oral mucosal ulceration.

DENTAL HYGIENISTS

- Dentists and dental hygienists have the potential to become key healthcare providers in the secondary prevention of eating disorders. Oral and physical manifestations are recognizable and seem to follow fairly consistent patterns. Assessment of eating disorders among patients is dependent on knowledge of oral and physical manifestations but, unfortunately, many dental and dental hygiene students are inadequately prepared to identify, treat, and refer patients with disordered.

- There is a pressing need for the development of enhanced dental and dental hygiene curriculum and continuing education in this area so that dental practitioners will be more consistently engaged in early detection and intervention activities. Once signs and symptoms are recognized, referral to the patient's health care provider is essential.

ORAL RECOMMENDATIONS

- A common question from dental professionals is, "Should I provide recommendations to prevent further damage while a patient is actively involved in an eating disorder? Won't this knowledge just allow a patient with eating disorders to continue with their unhealthy habits?" The answers are "Yes" dental professionals are to suggest steps to prevent further damage to the hard and soft tissues regardless of the patient's control of their eating disorder and "No" suggestions will not delay the patient's desire to seek treatment. The dental professional is to emphasize that damage to the hard tissue is permanent and suggestions offer only interim solutions to minimize enamel loss. The only way to stop further damage is to discontinue continuous regurgitation.