Instructions for Research and Clinical Excellence Day

Student Clinical Case Presentations

1. Students will form their own presentation groups of up to 2-3, and work with a clinical faculty mentor.

2. Students must submit an abstract of their Clinical Case Presentation using the link: https://ogra.wufoo.com/forms/rced-clinical-case-presentation/
   An abstract generally includes the following sections: Background, Case Description, Results, and Practical Implications.

3. During Research and Clinical Excellence Day, each group of up to 2-3 students will have 15 minutes for their case presentation, including questions and answers. We encourage the groups to practice the timing of their presentation and assign a time-keeper. The clinical faculty mentor will stand with the group at the podium and contribute as needed to the question and answer segment.
   a. Alternatively, each group of up to 2-3 students will create and present a poster of their case presentation during the noon-time poster session.

4. There are two possible formats for the case presentation:
   a. One is to follow a standard case presentation format, which describes the diagnosis, treatment, and outcome of a patient. Below is a checklist of essential elements to be included (item #5). The group should choose a patient or patients for whom they've completed some or all of the treatment, so that they can discuss the prognosis and continuing care. An example can be found at: http://www.cda-adc.ca/virtual_study_club/casestudy/1/
   b. The other format is to present a topic pertaining to patient care. For example: preparation design for indirect restorations, or rationale for an implant. This type of presentation should outline the general principles of care, give some clinical examples and must contain literature references.

5. Essential elements of a clinical case presentation:
   a. **Pre-Treatment**
      i. Patient description: an overview of your patient—age, gender, occupation, etc. Cultural issues: describe any pertinent information, including, for example, patient's mannerisms, or expectations.
      ii. Chief complaint: use patient's own words, if possible.

iii. Medical history: significant details of medical history, including allergies and medications presently used (prescribed and OTC). Is a medical consult needed, if so, why? Please mention smoking, drug abuse, etc.
iv. Dental history: date of patient's last visit, recommended treatment, etc.
v. Charting:
    - Soft tissue status, oral cancer screening (present and describe findings).
    - Hard Tissue status, tooth vitality (present and describe findings). Details such as osseous ridge shape and density are important.
    - Occlusion, TMJ, etc. (present and describe these findings). Additional information, such as vestibular height for denture patients is important.
    - Radiographic exam (present radiographs and describe findings).
    - Pre-treatment periodontal information (present and describe periodontal charting). Please include additional information, like frenum attachments, mucogingival problems, mobility, etc.
    - Pre-treatment existing restorations, defective restorations, caries (present and describe restorative charting).
    - Caries risk assessment - give details about patient's diet, hygiene, and assigned level of risk.
vi. Diagnosis and Treatment Plan: provisional and/or final diagnosis. There can be multiple, for example: generalized mild periodontitis, extensive caries, etc.
        - Treatment plan outline: present in phases.
        - Treatment alternatives: please discuss alternative treatment plans, if appropriate.
        - Indications and contraindications: for example, although the extraction of several teeth is immediately necessary, treatment cannot be performed until a medical consult allows the patient to stop taking Coumadin. Another example: patient has a nickel allergy, so restorative material must be precious metal.
        - Informed consent: please state whether this was received, and who gave it.

b. **Treatment**

i. Final procedure plan, phases of treatment: re-state the phases if you've presented them above. If applicable, include why, for example, you would start with one procedure or in one area.
ii. Instrumentation and materials used: *briefly describe*—for example, ultrasonic scaler followed by hand instruments.
iii. Post-operative instructions: be specific for each type of treatment.
iv. Initial prognosis**:** this is your beginning assessment.

c. **Follow-up**

i. Assessment of treatment outcome: POE interval, post-op periodontal charting, possible post-op radiographs if applicable (present and describe findings).
ii. Complications: be specific and describe. You may include scheduling problems and/or laboratory problems.
iii. Long-term results and prognosis: summarize your wonderful treatment and give a long-term outcome assessment.

d. **Documentation and Photos**

i. All contents of your clinical chart, including diagnosis charting, treatment record, radiographs.
ii. Include these photographs: 1.Full Front of Face, 2.Natural Smile Only, 3.Maxillary Occlusal, 4.Mandibular Occlusal, 5.Left Lateral View- teeth together, 6.Right Lateral View- teeth together, and 7. Front View with Lips Retracted (dog growl)
iii. You may also include in-treatment photographs, immediate post-treatment photos, and long-term photos of individual arch and/or extended smile.
iv. *All photographs must be obtained with the patient's written consent, and identifying features masked (e.g. black bar over eyes).*