



MAHE INSTITUTE OF DENTAL SCIENCES & HOSPITAL
Affiliated to Pondicherry Central University, Recognized by Dental Council of India
Chalakkara, P.O. Pallor, Mahe-673 310
U.T. of Puducherry. Ph : 0490 2337765

2.2.1 : The Institution assesses the learning levels of the students, after admission and organises special Programmes for advanced learners and slow performers The Institution:

- 1. Follows measurable criteria to identify slow performers**
- 2. Follows measurable criteria to identify advanced learners**
- 3. Organizes special programmes for slow performers**
- 4. Follows protocol to measure student achievement**

INDEX

S.NO	DESCRIPTION	PAGE NUMBER
1	Certificate of the Head of the Institution	2
2	Criteria to identify slow learners and advanced learners and assessment methodology	4

**Dr Anil
Melath**
Digitally
signed by Dr
Anil Melath
Date:
2026.08.21
10:30:05
+05'30'



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CERTIFICATE OF THE HEAD OF INSTITUTION



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Dr. ANIL MELATH, MDS.,

PRINCIPAL

TO WHOMSOEVER IT MAY CONCERN

This is to certify our Institution assesses the learning levels of the students, after admission and organizes special Programmes for advanced learners and slow performers

The Institution:

1. Follows measurable criteria to identify slow performers
2. Follows measurable criteria to identify advanced learners
3. Organizes special programmes for slow performers.
4. Follows protocol to measure students achievement details are given below



PRINCIPAL

Dr. Anil Melath, MDS
Principal
Mahe Institute of Dental Sciences & Hospital
Chalakkara, P.O. Pallor, Mahe - 673310
U.T. of Puducherry



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SPECIAL PROGRAMMES / PROCESS ADOPTED FOR SLOW LEARNERS



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Action plan to be done after the identification of Advanced learners (Process outputs)

- Participation in CDE Program
- Attending International /National Conferences
- Presentation of papers / posters / in Conferences /seminar
- Presentation in Clinico pathologic conferences

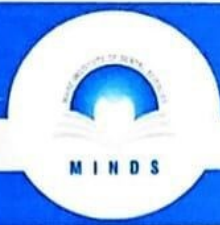
S.NO	PROGRAM NAME	ACTIVITIES / ACTION TAKEN
1	External Participation in CDE Program	1.Participation certificate
		2.In-house Seminar presentation
2	Attending International /National Conferences	1.Participation certificate
3	Presentation of papers / posters / in Conferences /seminar	1.Participation certificate
		2.Presentation in CPC
4	Presentation in Clinico pathologic conferences	1.Participation certificate



DR ANIL.M

Principal
Mahe Institute of Dental Sciences & Hospital
MAHE

PRINCIPAL



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A Unit of Mahe Educational & Charitable NRI trust | Chalakkara, Pallor, Mahe- 673310, U.T of Puducherry

Ref. No: MINDS.P.O/02012025/01

Date: 02.01.2025

CIRCULAR

This is to inform all HODs to prepare the attendance percentages (Theory & Practical) and the list of slow learners (Second Internal) for IR Batch students, and submit them to examwingminds@mahedentalcollege.org on or before 07.01.2025(Tuesday).

Dr. Anil Melath
PRINCIPAL

Principal
Mahe Institute of Dental Sciences & Hospital
MAHE

Copy to

1. Chairman
2. CEO
3. Vice Principal
4. Administrator
5. All HOD's
6. IQAC





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Ref. No: MINDS.P.O/19072024/01

Date: 19.07.2024

CIRCULAR

This is to inform all the HOD's to prepare the attendance percentage (Theory & Practical) and slow learners list (2nd internal) of regular Batch students up to 30th June 2024 and submit it to the Principal office(Hard copy) on or before 22.07.2024(Monday).

Dr. Anil Melath
PRINCIPAL

Copy to:

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3. Vice Principal
4. Administrator
5. All HOD's
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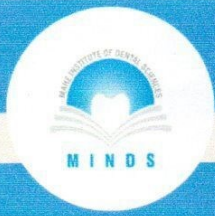
Principal
Mahe Institute of Dental Sciences & Hospital
MAHE



☎: 0490 2337406, 2336190, 2336191, 8301046544

✉ @: principal mahedentalcollege.org | administration@mahedentalcollege.org

🌐: www.mahedentalcollege.org



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Ref. No: MINDS.P.O/17032025/01

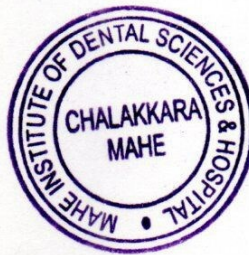
Date: 17.03.2025

CIRCULAR

All HOD's are hereby informed to submit the list of students with Attendance Shortage and Slow Learners for both the Regular Batch (First Internal) and IR Batch (Third Internal) up to 15th March 2025. The reports must be submitted to the Examination Wing at examwingminds@mahedentalcollege.org on or before **22nd March 2025**.

Dr. Anil Melath
PRINCIPAL

Principal
Mahe Institute of Dental Sciences & Hospital
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4. Administrative Manager
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Ref. No: MINDS.P.O/07102024/01

Date: 07.10.2024

CIRCULAR

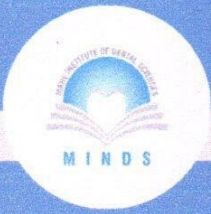
This is to inform all the HOD's to prepare the attendance percentage (Theory & Practical) and slow learners list (First internal) of IR Batch students and submit it to the Principal office(Hard copy) on or before 14.10.2024(Monday).

Dr. Anil Melath
PRINCIPAL
Principal
Mahe Institute of Dental Sciences & Hospital
MAHE

Copy to:

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MINDS.P.O/070624/02

07.06.2024

CIRCULAR

This is to inform that Slow learners of the Second Internal Theory Examination of Regular batch has to attend additional classes on the required departments as per following timetable from 03 PM to 04 PM. All the departments are advised to file a separate attendance for the slow learners.

Date	Day	Final BDS	Third BDS	Second BDS	First BDS
15.07.2024	Monday	Public Health Dentistry		General Pathology	
16.07.2024	Tuesday	Periodontics		Microbiology	
17.07.2024	Wednesday	Orthodontics		Pharmacology	
18.07.2024	Thursday	Oral Medicine and Radiology		Dental Materials	
19.07.2024	Friday	Oral Surgery			Anatomy
20.07.2024	Saturday	Conservative Dentistry	Oral Pathology		Physiology
22.07.2024	Monday	Prosthodontics	General Medicine		DAOH
23.07.2024	Tuesday	Pedodontics	General Surgery		Biochemistry

Dr. Anil Melath,
PRINCIPAL

Copy to:

- Chairman
- Vice Principal
- All Departments
- Admin Manager
- Minds Nest
- IOAC



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Abhinand, a final- year student identified as a slow learner, initially scored 11 marks in the internal theory examination(without MCQs) In the subsequent betterment examination,his score improved to 20 marks.

INTERNAL EXAM ANSWER SHEET

MAHE INSTITUTE OF DENTAL SCIENCES & HOSPITAL CHALAKKARA, MAHE U. T. Of PUDUCHERRY - PIN 673 333

INTERNAL ASSESSMENT BOOK

SUBJECT: Oral medicine & Radiology.

Tick Questions Attempted :

Q₁ ☒

Q₂ ☐

Q₃ ☒

Q₄ ☐

Q₅ ☒

Q₆ ☒

Q₇ ☒

Q₈ ☐

Q₁ 10

Q₂ 10

Q₃ 5

Q₄ 5

Q₅ 5

Q₆ 5

Q₇ 5

Q₈ 5

No. of Additional

TOTAL

Sheets used.

Total in Words

Evaluated by:

Name of the candidate: Abhinand.P

Reg. No: 21DS0202

Signature

Date:

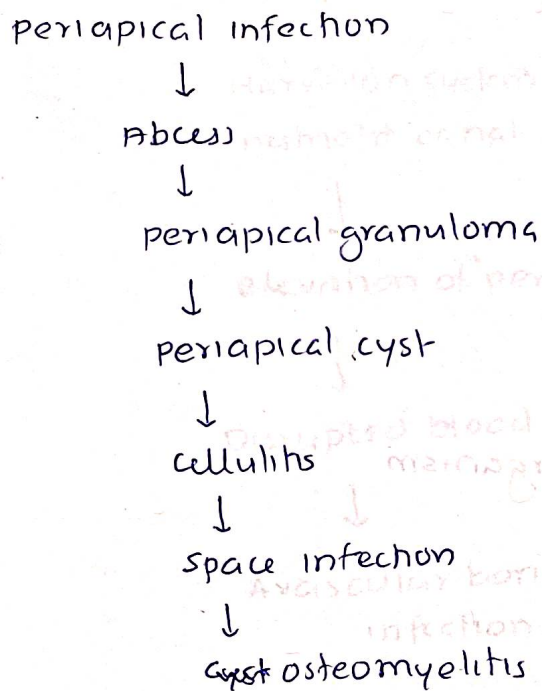
14-05-2025

Signature of Invigilator

11 45 + 9 = 20

3

osteomyelitis:



Definition:

osteomyelitis is an inflammatory condition of bone, begins - with infection to the medullary cavity & Haversian system of cortex and then extend into the periosteum.

inflammatory agent reach bone by means of

- dental caries
- periodontal disease

predisposing factors:

- Low host resistance
- Diabetes
- Cancer
- chemotherapy
- Age
- malnutrition
- Anemic
- Leukemia
- High virulence of organism
- AIDS.

→ pathology:

Acute inflammation
(edema & pus formation)



increase in intermedullary pressure



vesicular collapse
(ischemia of bone)



Avascular bone



↓
pus discharge (Liquifaction necrosis)

↓
Harvesion system /
nutrient canal involvement

↓
elevation of periosteum

↓
Disrupted blood supply

↓
Avascular bone
infection.

classification:

- 1) suppurative osteomyelitis
- 2) non suppurative osteomyelitis.

1) suppurative osteomyelitis

a) acute suppurative osteomyelitis

b) chronic suppurative osteomyelitis

2) non suppurative osteomyelitis

- focal sclerosing osteomyelitis
- diffuse sclerosing osteomyelitis
- garreys sclerosing osteomyelitis
- osteoradio necrosis.

→ Acute suppurative osteomyelitis

- It is commonly due to odontogenic infection
- most commonly seen in mandible

• clinical features:

Fever

Leukoplakia

parasthesia

trismus

deep intense bone pain

pus discharge

commonly in adults

Radiographic Features:

Initially no radiographic changes

Then decrease in density of bony trabeculae

multiple radiolucent area due to necrosis of bone

chronic suppurative osteomyelitis

- It may be occur as subsequent to the acute phase
- clinical features are similar to acute type
- sometimes pain is not present.

→ Focal sclerosing osteomyelitis

- commonly seen in childrens
- mandibular molar is most commonly involved
- pain & pus discharge

Radiographic Feature:

- widening of periodontal ligament
- intact lamina dura

→ Diffuse sclerosing osteomyelitis

- common in adult/old age
- mandible is most commonly affected
- recurrency may be occur
- R/F → onion peel appearance

Osteo radio necrosis:

radiation greater than 50 Gy cause osteoradionecrosis

normal range 30-40 Gy

induration/ulceration may present

Investigation:

- CT
- MRI

management

- Evaluation and correction of ~~defence~~ decrease defence
- Imaging to rule out bone tumour
- culture & staining
- Antibiotic guided by culture
- Antibiotic guided by stains

Treatment:

- 1) penicilline 2 M intra venous on 4 Hourly
- 2) metronidazole 500 mg 6 Hourly
- 3) clindamycin - 600-900 mg Intra venously, 6 Hourly
- 4) cephalexin/cephazolin - 500mg - 1g intra venously 8th hourly

note:

Osteomyelitis commonly affect mandible, less to maxilla because

- cortical bone thickness
- more blood supply
- gravitational force.

7

Fibrous dysplasia:

Fibrous dysplasia is a non hereditary developmental disorder of bone forming mesenchyme which induce defect on -
osteolysis of bone

The normal bone in the affected area of fibrous dysplasia - is replaced by fibrous connective tissue, and these fibrous connective tissue undergo metaplastic & produce new bone in that area.

The newly formed bone is not like the original bone. They have some similarity but histologically certain difference are there.

Types -

monostotic fibrous dysplasia - include one bone

polyostotic fibrous dysplasia. - include multiple bone

Etiology:

- The exact etiology of Fibrous dysplasia is unknown
- It is believed that mutation of GNAS1 gene is the main factor of this disease
- If mutation of GNAS1 will take place before the skeletal development or initial stage it is polystrophic fibrous dysplasia
- If mutation of GNAS1 will take place after or during skeletal development it is termed as monostrophic fibrous dysplasia.

Clinical features:

Age: most commonly First & 2nd decade of life

Sex: polystrophic fibrous dysplasia 2-3 times more often occur in females than males

monostrophic have ~~prevalence~~ equal predilection for both sexes.

Site: polystrophic - clavicle

pelvic

skull

monostrophic - Jaw bone

Femur

Tibia

In jaw bones maxilla is most commonly affected than the mandible.

Clinical presentation:

• Types:

monostotic & polyostotic

polyostotic Fibrous dysplasia have 2 subtype

Jaffey's type

Mccune - Albright syndrome

Jaffey type: Fibrous dysplasia involving multiple bone with cafe-au-lite pigmentation

Mccune-Albright-associated Fibrous dysplasia:

it involves multiple bone, and cafe-au-lite pigmentation and endocranial dysfunction.

Clinical presentation:

- monostotic fibrous dysplasia is more common (80-85%) than the polyostotic type

- maxilla is more affected
- it may be extend to maxillary sinus
- monostotic is less dangerous compared to polyostotic
- cortical bone expansion may seen
- polyostotic is the most severe type
- café au lait pigmentation - ~~By~~ light brown discoloration on the skin overlying the affected are
- pigmentation seen most commonly - trunk
back
Thigh
- 31/2 ✓ • polyostotic fibrous dysplasia in women may cause vaginal bleeding
- Trismus
- malignant transformation of fibrous dysplasia may occur in rare conditions.

Radiographic feature:

ground glass appearance

orange peel appearance

Differential diagnosis

- Cementifying osseous fibroms
- Erythema ~~multi-forme~~
- Paget's disease.

Treatment:

Fibrous dysplasia usually self limiting

surgical replacement of bone can be done

Administration of calcitonin improves the condition.

5) TMJ radiography

To evaluate bony component

1) TMJ view

a) Transcranial

b) Trans pharyngeal

c) Trans orbital

2) Reverse townes projection

3) submento vertex

4) panormic radiography

5) MRI

6) Bone scintigraphy

7) computed tomography

8) Digital TMT tomography

To evaluate soft tissue component:

- MRI

- USG

- Arthrography:

Transcranial radiography:

Film position:

cassette is placed flat against the patient's ear and centered over the TMT of interest parallel to sagittal plane:

patient position:

sagittal plane is vertical

ala tragus line is parallel to the floor

Transcranial radiography taken in 2 methods

1) open mouth

2) closed mouth

Central ray:

Vertical direction:

central ray is directed downwards at an angle of $+20^{\circ}$ - $+25^{\circ}$

Horizontal direction:

20° anterior to the TMJ of interest

Point of entry of x-ray beam depends on the technique used.

1) Grewcock ~~approach~~ technique

2) Ghills approach.

Grewcock technique:

x ray beam enters through 2" above the external auditory meatus

Ghills approach:

x ray beam enters through $\frac{1}{2}$ " anterior and 2" above to the external auditory meatus.

Parts seen:

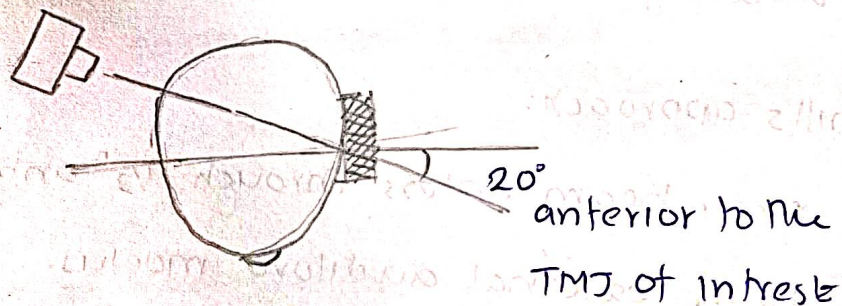
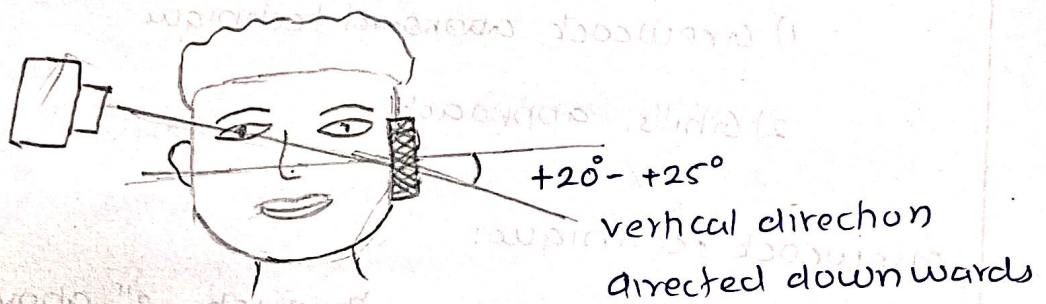
Lateral aspect of condyle
and temporal region

Indication:

To evaluate joints bony relationship

To evaluate any arthritic change in articular disc

To ^{evaluate} ~~sketch~~ the range of movement of condyle



6

Anemia:

Anemia is the condition due to low level of Haemoglobin in blood compared to the normal.

decrease in circulatory red blood cells.

Types:

- microcytic hypochromic
- microcytic hyperchromic
- macrocytic hypochromic
- macrocytic hyperchromic

major anemias:

- Iron deficiency anemia
- megaloblastic anemia
- pernicious anemia.

Iron deficiency anemia:

- most common type in developing countries like India
- Iron is the main component of haem
- It is due to:

- Blood loss by haemorrhage

- Insufficient intake of iron

- malabsorption

- Increased need

(pregnancy, puberty, menstruation)

It is microcytic hypochromic.

Symptoms:

weakness

fatigue

muscle pain

dizziness

pallor on eye, skin, etc

Treatment:

Iron tablet

Iron rich foods

megaloblastic anemia

It is due to vitamin B₁₂ deficiency

due to

inadequate intake

malabsorption from GIT

increased need

Symptoms-

weakness

fatigue

dizziness

ulcer

Treatment:

vitamine B12 Supplements.

1

Tuberculosis

It is bacterial infection to the lungs caused by ~~Bacillus~~-
Tuberculosis. mycobacterium tuberculi

Types:

primary tuberculosis

secondary tuberculosis

pulmonary tuberculosis

mode of transmission:

Through aerosols

- infection reaches lungs
- primary bronchi, 2° bronch, & 3° bronchi
- Diffuse necrosis in lungs
- Long standing cough is the main symptom.

DEPT OF ORAL MEDICINE & RADIOLOGY, M.I.N.D.S. MAHE

**Fourth year BDS – REGULAR BATCH – July 2025 Exam Going – Batch
SECOND INTERNAL Examination**

Abhinand.P
Roll No-2
21DS0202

Multiple Choice Questions: Section – C (1 * 25 = 25 MARKS); Duration: 30 min

01. Destructively invasive locally malignant with rare metastasis
(a) Fibroma (b) Papilloma (c) Ameloblastoma (d) None of the above 9
02. Vesicle or bullae are not evident clinically in which of the following?
(a) Primary herpes (b) Cicatricial pemphigoid (c) Major aphthae (d) Epidermolysis bullosa 25
03. Cooley's anemia is also known as
(a) Erythroblastosis Fetalis (b) Thalassemia (c) Pernicious anemia (d) Megaloblastic anemia
04. Strawberry tongue is seen in
(a) Scarlet fever (b) Sarcoidosis (c) Megaloblastic anemia (d) Pernicious anemia
05. Condylar fractures are best detected in
(a) Lateral oblique view (b) Waters view (c) Submentovertex view (d) Reverse townes view
06. Of the following conditions, which is not considered to be premalignant?
(a) Syphilitic glossitis (b) Leukoedema (c) Leukoplakia (d) Erosive lichen planus
07. The characteristic lesion of erythema multiforme is:
(a) Split papule (b) Target lesion (c) Koplik's spot (d) Chancre
08. Ideal radiograph for studying paranasal sinuses
(a) Waters view (b) Reverse Townes view (c) Townes view (d) Transorbital view
09. An example for Scrapable white lesion is:
(a) Oral thrush (b) Leukoplakia (c) Chronic atrophic candidiasis (d) Acute atrophic candidiasis
10. Ramsay hunt syndrome is associated with
(a) Herpetic stomatitis (b) Herpangina
(c) Chicken pox (d) Shingles
11. According to inverse square law
(a) $I_1/I_2 = D_1/D_2$ (b) $I_1/I_2 = D_2/D_1$
(c) $I_1/I_2 = [D_1/D_2]^2$ (d) $I_1/I_2 = [D_2/D_1]^2$
12. Nikolsky's sign is seen in
(a) Erythema multiforme (b) Pemphigoid (c) Pemphigus (d) All of the above
13. Which of the following is an indication of functional imaging
(a) MRI (b) CBCT
(c) PET (d) CT

BETTERMENT EXAM ANSWER SHEET

MAHE INSTITUTE OF DENTAL SCIENCES & HOSPITAL
CHALAKKARA, MAHE
U. T. OF PUDUCHERRY - PIN 673 333

INTERNAL ASSESSMENT BOOK
SUBJECT: Oral medicine & radiology.

1

Tick Questions Attempted :

Q₁ ☐

Q₂ ☐

Q₃ ☐

Q₄ ☐

Q₅ ☐

Q₆ ☐

Q₇ ☐

Q₈ ☐

Q₁ ☐ 8 10

Q₂ ☐ 6 10

Q₃ ☐ 10 5

Q₄ ☐ 0 5

Q₅ ☐ 3 5

Q₆ ☐ 2 5

Q₇ ☐ 2 5

Q₈ ☐ 1/2 5

No. of Additional

TOTAL

Sheets used.

Total in Words

22

Evaluated by:

Name of the candidate: Abhinand.P

Reg.No: 21DS0202

Signature Abhinand.P

Date: 04-07-2025

Signature of Invigilator Apas m

1 Fibro osseous lesion :

classification:

1) Fibrous dysplasia

monostotic fibrous dysplasia

polyostotic fibrous dysplasia

craniofacial fibrous dysplasia

2) osseous dysplasia

fibrous osseous dysplasia

3) ossifying fibroma

juvenile parosteal ossifying fibroma

familial ossifying fibroma

Fibrous dysplasia:

It is a non hereditary immune disorder of skeletal system where natural bone is replaced by fibrous tissue.

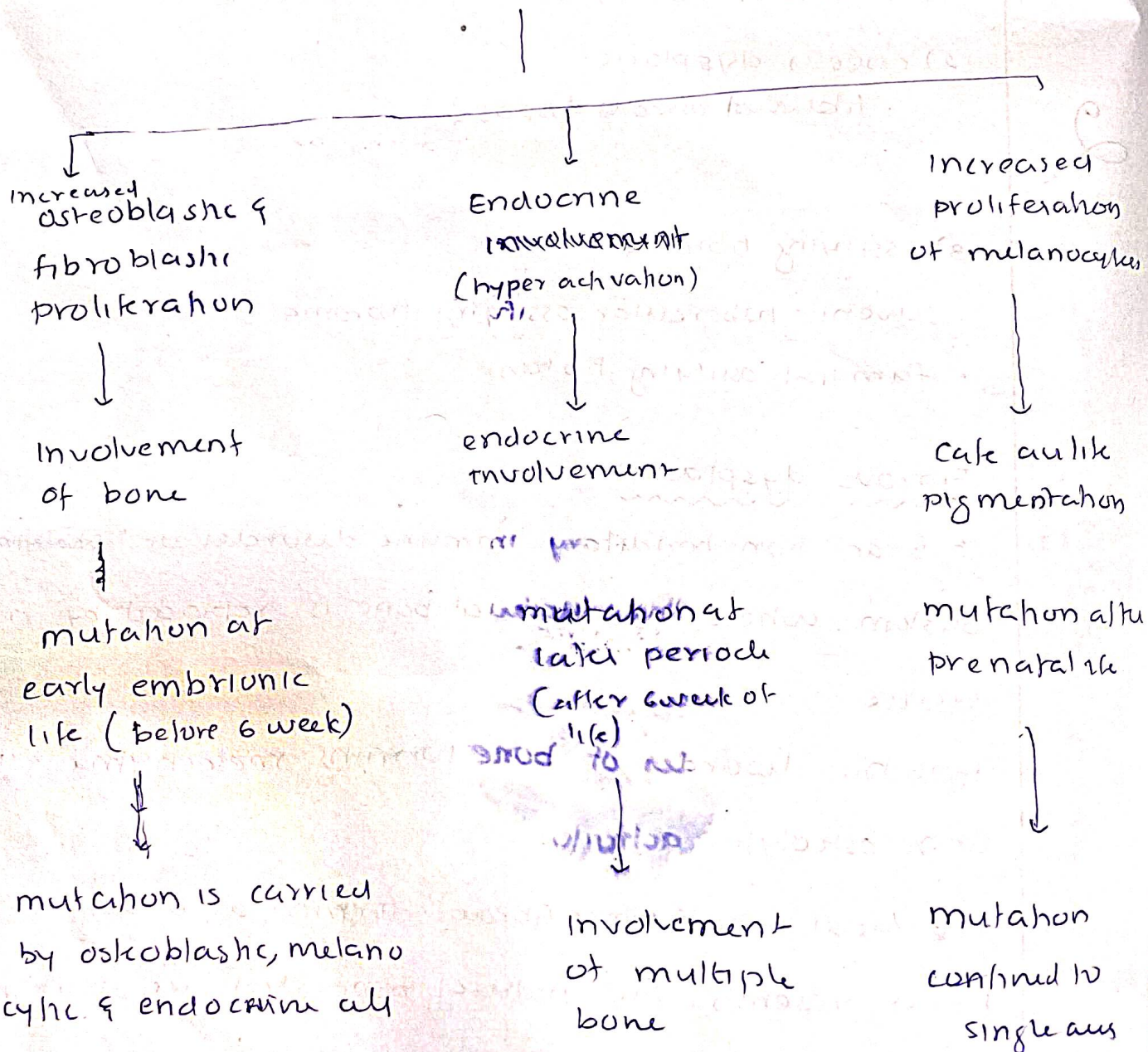
It is the disorder of bone forming mesenchyme & it begins with osteolytic activity.

The new bone (osseous fibrous) formed as a part of disease never resembles the natural bone structure, but histologically there are some similarities present.

Etiology:

mutation of GNAS1 gene

Activation of adenylyl cyclase



McCune
Albright
Syndrome

polysplenic
fibrous
dysplasia

monostotic
fibrous dysplasia

Types

(i) monostrophic type:

in this type of fibrous dysplasia single bone is affected.

most commonly jaw bones
maxilla is more affected than mandible.

(ii) polycystic fibrous dysplasia:

two or more bone is involved

They have two subtypes

(i) Jaffey's type

(ii) polystotic fibrous dysplasia with McCune Albright syndrome.

Jaffey's type:

polystichic fibrous dysplasia with café au lait pigmentation

2 or more bone is affected

FD with ~~poly~~ McCune Albright syndrome

- involvement of 2 or more bone
- 'café au lait' pigmentation is present
- Endocrine abnormality also present

clinical features

- monostotic ~~hyperostosis~~ dysplasia is more commonly occurring (80-85%)

- both male & females are equally affected

- Jaw bone,

femur

tibia

These are the common sites of occurrence.

- Age - most commonly in early ages

1st to 2nd decade of life.

- good prognosis compared to polyostotic type

- most commonly painless

- Bilateral swelling is present (some patient may complain)

- Polyostotic fibrous dysplasia is the severe type

- skull, facial bones

Sternum, ribs

These are the common bone involved in polyostotic type.

• unlike monostotic type evidence of polyostotic type seen in early life

• Female is more commonly affected than males

• painful condition

• very poor prognosis

• maxillary lesion will extent into maxillary sinus

• expansion of cortical bone

• pathologic fracture of bone sometimes occur.

• McCune Albright syndrome have the potency for - malignant transformation

• 'café au lait' pigmentation, (a brown coloured superficial pigmentation) on the skin overlying the affected area - of bone.

• vaginal bleeding in females

Investigation

1) Biochemical investigation

- Increased alkaline phosphatase
- increased urine hydroxy proline

2) Radiographic:

- Bone scintigraphy
- IUPA
- Panoramic radiograph
- CT scan

3) Histopathologic

- Chinese letter pattern.

Differential diagnosis

- Paget disease
- ossifying fibroma
- Adenomatoid odontogenic tumour
- calcifying epithelial odontogenic tumour

Fibrous dysplasia differentiated from Paget disease by

- Fibrous dysplasia occur in early childhood
- Paget disease occurs in 3-4th decade of life
- Fibrous dysplasia have café au lait pigmentation, Paget disease does not

Radiographic features

6 Early radiolucient: ill defined radiolucency that spread into adjacent bone
moth eaten appearance

mixed radiolucient and radio opaque stage.

orange peel appearance
ground glass appearance
candle flame appearance

late radio opaque stage: - orange peel appearance
cotton wool appearance.

Treatment

surgical:

conservative shaving/contouring
radical excision & reconstruction

Other:

• Bisphosphonates:

• To inhibit osteoclastic activity

• Calcitonin

5

periapical radiolucies:

• it is the radiolucencies around the periapical region.

• periapical granuloma

• radicular cyst

• periapical abscess

• Traumatic bone cyst

• periapical cemental dysplasia

• Invasive canal cyst

Radiographic features

1. Periapical granuloma

well defined radiolucency
with or without thin radio-
opaque line

• widening of PDL space

• Size less than 1.6 cm

• loss of lamina dura

2. Radicular cyst

well defined radiolucency
with corticated border size
greater than 1.6 cm.

loss of corticated border if
secondary infection is occur.

Resorption of root of adjacent
tooth

3. Periapical abscess

ill defined radiolucency
in apical area,

Break in continuity of lamina
dura

widening of PDL space

4. Traumatic bone

cyst:

well defined radiolucency
smooth & curved borders b/w roots
no effect on adjacent tooth root
intact lamina dura

Periapical cemental
dysplasia:

osteolytic well defined radiolucency
cementoblastic mixed radiolucency
& radio opacity.
osteoblastic - radio opacity surrounded
d by radiolucent line

incisive canal cyst.

round / oval / heart shaped -
radiolucency along or b/w the
root of maxillary central ^{incisor} ~~incisor~~

7 Bisecting angle principle:

This is a radiographic technique where film is placed near to the tooth and x-ray beam is directed bisecting the tooth & film.

Principle

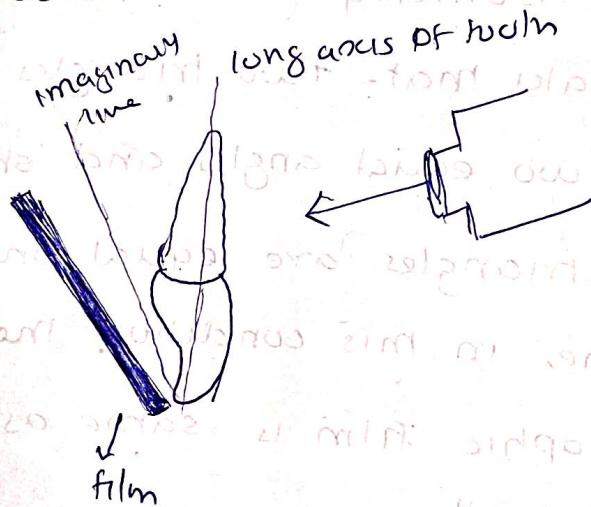
- This technique works on principle of ~~P~~ Cieszky's rule or Rule of isometry.
- This states that - two triangles are equal when it has two equal angles and share a common side.
- If two triangles are equal one side of the tooth & film is same, in this condition the tooth size in radiographic film is same as the tooth size of that natural tooth.

To obtain the isometry:

- patient should be positioned properly
- film is kept as near as to the tooth
- x-ray beam correctly aimed as bisecting the tooth and film.
- correct vertical angulation.

steps :

- proper positioning of patient
- evaluation of exposure area
- film placement
- check patients head orientation
- Aim the tube head correctly
- correct the vertical angulation, point of entry
- make exposure



For maxillary first molar

- proper positioning of patient
- evaluation of exposure area (maxillary first molar)
- Film placement
- correct the patients head orientation

vertical angulation for maxillary molar
 $\approx 20^\circ$

incisor - $+40$

canine - $+45$

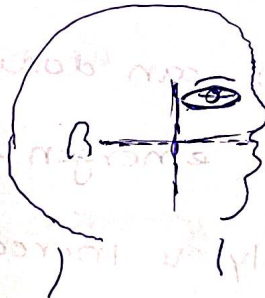
premolars - $+30$

molars - $+20$

point of entry of x-ray:

The area intersecting alar tragus line and a vertical

line from outer canthus



- Aim the tube head correctly to the center of x-ray film
- and make exposure.
- processing & fixing

6

Dental consideration in diabetics:

- In diabetic patient wound healing is delayed, and profuse bleeding will present
- So before any dental procedure the dentist must be referred the patient into general physician without general physician's consent or ~~the~~ the diabetic within the limit the dentist should not done any further treatment
- Surgical procedures can done only ~~to~~ at the hospital with major OT or emergency facilities
- Caries susceptibility is increased in diabetic patient.

8

sialolithiasis:

It is the disease causing dryness of mouth because of sialolith formation in the gland.

clinical features:

- dryness of mouth
- paleness of mucosal membrane
- difficulty in swallowing
- difficulty in eating
- difficulty in speech
- candidiasis
- salivary gland swelling
- pain.

investigation:

Biopsy

sialography

CT scan

Treatment:

- surgical treatment
- artificial saliva
- gels
- Rinses

3

Bitewing radiography:

It is the technique of taking radiograph of both crown-portion of both maxillary and mandibular teeth

Indication:

- for the detection of proximal caries
- detection of crown fracture
- To detect the alveolar bone height
- To evaluate periodontal status
- To reduce patient exposure more no. of tooth will included in bitewing radiograph

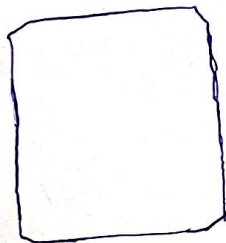
- To detect any regressive alteration of roots
- To detect any overhanging restoration

Technique:

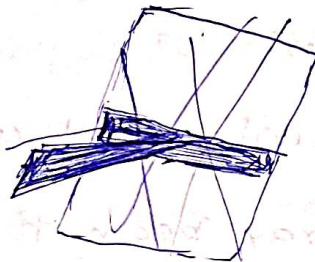
- ~~the film is held with a holding device~~
- proper positioning of patient

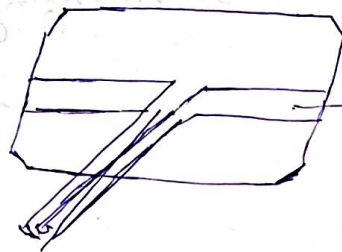
Evaluation of exposure are

- Film is held with biting tab



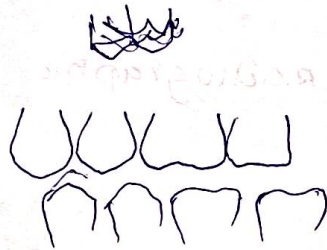
→ Radiographic film





bite wing holder

- These holder are easily disposable, most commonly papers are used
- Ask patient to close mouth with a gap, don't close completely



- place the film
- orient patient's head correctly
- Aim the x-ray beam to the center of the film so all the ~~read~~ area of film is irradiated.
- make the exposure

2

vesiculobullous lesions

vesicle - Fluid filled blisters diameter less than 1cm

Bullae - Fluid filled blisters of diameter more than 1cm

classification

a) Immunologic

b) viral

c) Hereditary

Immunologic -

• pemphigus:

pemphigus vegetans

pemphigus vulgaris

pemphigus foliaceus

Erythematous pemphigus

Paraneoplastic pemphigus

Drug induced pemphigus

• pemphigoid

- erythema multiforme

2) viral:

HSV (herpetic gingivostomatitis)

epstein barr virus

cytomegalo virus

chicken pox

3) Hereditary

• Herley & Herley disease

• Fibrous bullosa.

1° herpetic

^ gingivostomatitis:

caused by ~~herpes~~ HSV virus

It is an RNA virus

severe inflammation to gingiva.

The disease begins with reddening of oral cavity

deep

^ ulcer formation is a characteristic feature

• painful in progressive stages

• difficulty in swallowing

• difficulty in eating

- commonly in childrens

- initial ~~lesions~~ symptoms are

fever

head ache

vomiting

nausea

• spread through ~~direct~~ kissing

• lower lip of male

• upper lip of female

• non keratinized mucosa

• ~~clust~~ small ulcers are joined to form clusters

• These clusters are joined to form large lesion

• associated ~~symptoms~~ diseases are start to develop

• ~~for~~

Investigation

• PCR

• immunofluorescent test

Treatment:

Acyclovir

val acyclovir - 1g

In severe cases 700mg acyclovir throng intravenously

Dr Anil
Melath

Digitally signed
by Dr Anil Melath
Date: 2026.08.21
10:30:27 +05'30'