



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

2.5.1: The Institution adheres to the academic calendar for the conduct of Continuous Internal Evaluation and ensures that it is robust and transparent

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CERTIFICATE OF THE HEAD OF INSTITUTION



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Chalakkara, P.O. Pallor, Mahe-673 310
U.T. of Puducherry. Ph : 0490 2337765

Dr. ANIL MELATH, MDS.,
PRINCIPAL

TO WHOMSOEVER IT MAY CONCERN

This is to certify that, our institution adheres to the academic calendar for the conduct of Continuous Internal Evaluation and ensures that it is robust and transparent details are given:



PRINCIPAL

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

DETAILS OF INTERNAL EVALUATION



MAHE INSTITUTE OF DENTAL SCIENCES & HOSPITAL

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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/010125/03

Date: 01.01.2025

CIRCULAR

This is to inform that First Internal Theory Examination for BDS –Regular batch students will be scheduled from **04th February, 2025**.

Question Paper to be submitted through Email: examwingminds@mahedentalcollege.org, on or before **20.01.2025** without fail. Regular Classes are scheduled as from the Time Table for all the students on the days of Examination.

Last date to update mark list in HMS software **on or before 28.02.2025**.

Date	Day	Final BDS	Third BDS	Second BDS	First BDS
04.02.2025	Tuesday	Public Health Dentistry			Anatomy
05.02.2025	Wednesday	Periodontics			Physiology
06.02.2025	Thursday	Orthodontics			DAOH
07.02.2025	Friday	Oral Medicine and Radiology			Biochemistry
08.02.2025	Saturday	Oral Surgery	Oral Pathology	General Pathology	
10.02.2025	Monday	Conservative Dentistry	General Medicine	Microbiology	
11.02.2025	Tuesday	Prosthodontics	General Surgery	Pharmacology	
12.02.2025	Wednesday	Paedodontics		Dental Materials	
Examination Hall:-UG Library					
Time:-8.00 AM to 11.00AM					

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1. Chairman
2. Admin Manager
3. All Dept's
4. Nest MINDS
5. IQAC



Dr. Anil Melath,

Principal

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MAHE INSTITUTE OF DENTAL SCIENCES AND HOSPITAL, MAHE
THIRD INTERNAL REGULAR INTERNAL EXAMINATION - FEBRUARY - 04, 2025
INVIGILATION DUTY 23.01.2025

Date	Year	Subject	LECTURE HALL - I		LECTURE HALL - II		U G LIBRARY	
			8 to 9.30 AM	9.30 TO 11 AM	8 to 9.30 AM	9.30 TO 11 AM	8 to 9.30 AM	9.30 TO 11 AM
04.02.2025	4 th Year	PHD	Dr. Nirosha V	Mr. Rahmathulla			Dr. Saicharan, Dr. Hemalatha, Dr. Ahnaf Abdulla	Mrs. Parvathy, Dr. Sreelakshmi R Dr. Vyshnavi R
	1 st year	Anatomy						
05.02.2025	4 th Year	Periodontics	Dr. Aravind H	Dr. Fazila A			Dr. Chythannya, Dr. Mridhul M U, Mr. Rahmathulla	Dr. Vishnusripriya, Dr. Ramnesh, Dr. Sneha Valsaraj
	1 st year	Physiology						
06.02.2025	4 th Year	Orthodontics	Dr. Steve	Mrs. Riya			Dr. Manju Krishna Dr. Megha B, Dr. Pooja Sanjeev	Dr. Lino Paul, Dr. Rilna P, Dr. Anjana S
	1 st year	Dental Anatomy						
07.02.2025	4 th Year	Oral Medicine	Mr. Rahmathulla	Mrs. Riya			Dr. Dipin, Dr. Aparna M, Dr. Ankitha T	Dr. Mridhul M U, Dr. Akash M, Dr. Theertha
	1 st year	Biochemistry						
08.02.2025	4 th Year	Oral Surgery	Dr. Dipin P P	DR. Noufal	Dr. Manas	Mrs. Riya	Dr. Saron R Nair, Dr. Pooja Sanjeev, Dr. Sidharth S	Dr. Anjali K, Dr. Anjana S, Dr. Rugma Kannan
	3 rd year	Oral Pathology						
	2 nd year	General Pathology						
10.02.2025	4 th year	Cons & Endo	Mrs. Sona V	Dr. Cimmy A	Dr. Aravind H	Dr. Ahnaf Abdulla	Dr. Saicharan, Dr. Bhuvaneswar, Dr. Theertha	Dr. Anjaly Sudhakaran, Dr. Anusree, Dr. Sreelakshmi R
	3 rd year	General Medicine						
	2 nd year	Microbiology						
11.02.2025	4 th year	Prosthodontics	Mrs. Sona V	Dr. Ankitha T	Dr. Sidharth	Dr. Anjali K	Dr. Ramnesh R, Dr. Steve, Dr. Vyshnavi R	Dr. Roshin C N, Dr. Cimmy A, Dr. Fazila A,
	3 rd year	General Surgery						
	2 nd year	Pharmacology						
12.02.2025	4 th year	Paedodontics			Dr. Ankitha T	Mrs. Sona	Dr. Lino Paul, Dr. Thrishna, Dr. Sidharth	Dr. Hemalatha, Mrs. Parvathy, Dr. Pooja Sanjeev
	2 nd year	Dental Materials						



PRINCIPAL
(Signature)
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Ref. No: MINDS.P.O/240125/02

Date: 24.01.2025

CIRCULAR

This is to inform that the commencement of First internal Practical Examination for First year BDS Regular batch is scheduled on..

TIME: 8.00 AM TO 12.30 PM				
SUBJECT	12.02.2025	13.02.2025	14.02.2025	15.02.2025
Anatomy	1 to 25	26 to 50	51 to 75	76 to 100
Physiology	26 to 50	51 to 75	76 to 100	1 to 25
DAOH	51 to 75	76 to 100	1 to 25	26 to 50
Biochemistry	76 to 100	1 to 25	26 to 50	51 to 75

*Kindly note regular classes will be continued from 01pm onwards


DR ANIL.M

Dr. Anil Melath,
Principal

Principal
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MAHE

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Ref. No: MINDS.P.O/240125/01

Date: 24.01.2025

CIRCULAR

This is to inform that the commencement of First Internal Practical Examination for second year BDS Regular batch is scheduled on.

TIME: 8.00 AM TO 12.30 PM			
Subject	17.02.2025	18.02.2025	19.02.2025
Microbiology	I	II	III
Pharmacology	II	III	I
Dental Materials	III	I	II
Subject	26.02.2025	27.02.2025	28.02.2025
Gen Pathology	I	II	III
Pre-Clinical Prostho	II	III	I
Pre-Clinical Conserv	III	I	II

BATCH I	BATCH II	BATCH III
23DS0201 TO 23DS0233	23DS0234 TO 23DS0266	23DS0267 TO 23DS0296

*Kindly note: Regular classes will be continued from 01pm onwards

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DR ANIL.M

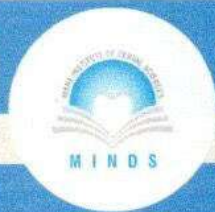
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Ref. No: MINDS.P.O/240125/03

Date: 24.01.2025

CIRCULAR

This is to inform that the commencement of First Internal Practical Examination for third year BDS Regular batch is scheduled on.

TIME: 8.00 AM TO 12.30 PM			
Subject	12.02.2025	13.02.2025	14.02.2025
Oral Pathology	I	II	III
General Medicine	II	III	I
General Surgery	III	I	II

BATCH I	BATCH II	BATCH III
21DS0203 TO 22DS0223	22DS0224 TO 22DS0243	22DS0244 TO 22DS0268

*Kindly note: Regular classes will be continued from 01pm onwards

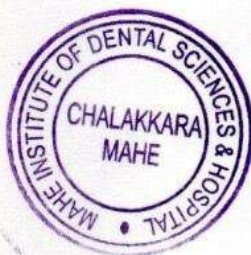
DR. ANIL M

Dr. Anil Melath,
Principal

Mahe Institute of Dental Sciences & Hospital
MAHE

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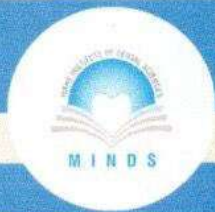
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Ref. No: MINDS.P.O/240125/04

Date: 24.01.2025

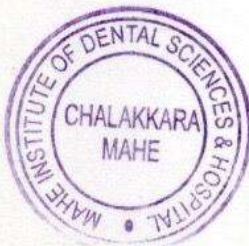
CIRCULAR

This is to inform that Practical Examination for IVth year BDS Regular batch is scheduled on the following dates, from 08.00 AM to 01.00 PM.

Department	17.02.2025	18.02.2025	19.02.2025	20.02.2025	21.02.2025	22.02.2025	24.02.2025	25.02.2025
Public Health Dentistry	I	II	III	IV	V	VI	VII	VIII
Periodontics	II	III	IV	V	VI	VII	VIII	I
Orthodontics	III	IV	V	VI	VII	VIII	I	II
OMR	IV	V	VI	VII	VIII	I	II	III
OMFS	V	VI	VII	VIII	I	II	III	IV
Conservative Dentistry	VI	VII	VIII	I	II	III	IV	V
Prosthodontics	VII	VIII	I	II	III	IV	V	VI
Paedodontics	VIII	I	II	III	IV	V	VI	VII
Batch-I	Batch-II	Batch-III	Batch-IV	Batch-V	Batch-VI	Batch-VII	Batch-VIII	
21DS0201 To 21DS0214	21DS0216 To 21DS0226	21DS0227 To 21DS0237	21DS0236 To 21DS0246	21DS0247 To 21DS0257	21DS0258 To 21DS0266	21DS0268 To 21DS0273	21DS0274 To 19DS0271	

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Ref. No: MINDS.P.O/100425/01

Date: 10.04.2025

CIRCULAR

This is to inform that Second Internal Theory Examination for BDS –Regular batch students will be scheduled from 06th MAY, 2025.

Question Paper to be submitted through Email: examwingminds@mahedentalcollege.org on or before 28.04.2025 without fail. Regular Classes are scheduled as from the Time Table for all the students on the days of Examination.

Last date to update mark list in HMS software on or before 08.06.2025.

Date	Day	Final BDS	Third BDS	Second BDS	First BDS
06.05.2025	Tuesday			General Pathology	Anatomy
07.05.2025	Wednesday			Microbiology	Physiology
08.05.2025	Thursday			Pharmacology	DAOH
12.05.2025	Monday			Dental Materials	Biochemistry
13.05.2025	Tuesday	PHD	Oral Pathology		
14.05.2025	Wednesday	OMR	General Medicine		
15.05.2025	Thursday	Orthodontics	General Surgery		
16.05.2025	Friday	Paedodontics			
26.05.2025	Monday	Periodontics			
27.05.2025	Tuesday	OMFS			
28.05.2025	Wednesday	Conserv			
29.05.2025	Thursday	Prosthodontics			
Examination Hall:-UG Library					
Time:-8.00 AM to 11.00AM					

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MAHE INSTITUTE OF DENTAL SCIENCES AND HOSPITAL, MAHE						
SECOND INTERNAL REGULAR INTERNAL EXAMINATION - MAY - 06, 2025						
INVIGILATION DUTY 28.04.2025						
Date	Year	Subject	LECTURE HALL - II		U G LIBRARY	
			8 to 9.30 AM	9.30 TO 11 AM	8 to 9.30 AM	9.30 TO 11 AM
06.05.2025	2 nd year	General Pathology	Mrs. Sona V	Mr. Rahmathulla	Dr. Hemalatha, Dr. Ahnaf Abdulla	Mrs. Parvathy, Dr. Vyshnavi R
	1 st year	Anatomy				
07.05.2025	2 nd year	Microbiology	Mrs. Riya	Dr. Fazila A	Dr. Saicharan, Dr. Thrishna	Dr. Jilu Jessy, Dr. Vishnusripriya
	1 st year	Physiology				
08.05.2025	2 nd year	Pharmacology	Dr. Bhuvaneswar R	Dr. Ankitha	Dr. Mridhul M U, Dr. Theertha	Dr. Ashwathi, Dr. Rilna P
	1 st year	Dental Anatomy				
12.05.2025	2 nd year	Dental Materials	Mr. Rahmathulla	Dr. Noufal K P	Dr. Saron R Nair, Dr. Chythannya	Dr. Roshin C N Dr. Akash M
	1 st year	Biochemistry				
Date	Year	Subject			U G LIBRARY	
					8 to 9.30 AM	9.30 TO 11 AM
13.05.2025	4 th Year	PHD			Dr. Unni Pypallil, Dr. Aparna M,	Dr. Sharath C, Dr. Anjali K
	3 rd year	Oral Pathology				
14.05.2025	4 th year	OMR			Dr. Manju Krishna Dr. Megha B	Dr. Cimmy A, Dr. Rugma Kannan
	3 rd year	General Medicine				
15.05.2025	4 th year	Orthodontics			Dr. Steve, Dr. Vyshnavi R	Dr. Dhanya K B, Dr. Pooja Sanjeev
	3 rd year	General Surgery				
16.05.2025	4 th year	Paedodontics			Dr. Dipin P P	Dr. Anjaly Sudhakaran
26.05.2025	4 th year	Periodontics			Dr. Manas	Dr. Suhana
27.05.2025	4 th year	OMFS			Dr. Nirosha V	Dr. Nanditha C
28.05.2025	4 th year	Conserv			Dr. Lino Paul	Dr. Teenu Thomas
29.05.2025	4 th year	Prosthodontics			Dr. Aravind Haridas	Dr. Ramnesh

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Ref. No: MINDS.P.O/060525/02

Date: 06.05.2025

CIRCULAR

This is to inform that the commencement of Second internal Practical Examination for First year BDS Regular batch is scheduled on.

TIME: 8.00 AM TO 03.00 PM				
SUBJECT	14.05.2025	15.05.2025	16.05.2025	17.05.2025
Anatomy	1 to 25	26 to 50	51 to 75	76 to 100
Physiology	26 to 50	51 to 75	76 to 100	1 to 25
DAOH	51 to 75	76 to 100	1 to 25	26 to 50
Biochemistry	76 to 100	1 to 25	26 to 50	51 to 75

Dr. Anil Melath,
Principal

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Ref. No: MINDS.P.O/060525/01

Date: 06.05.2025

CIRCULAR

This is to inform that the commencement of Second Internal Practical Examination for second year BDS Regular batch is scheduled on.

TIME: 8.00 AM TO 03.00 PM			
Subject	19.05.2025	20.05.2025	21.05.2025
Microbiology	I	II	III
Dental Materials	II	III	I
Pre-Clinical Conserv	III	I	II
Subject	22.05.2025		23.05.2025
Gen Pathology	I		II
Pre-Clinical Prostho	III		I

BATCH I	BATCH II	BATCH III
23DS0201 TO 23DS0233	23DS0234 TO 23DS0266	23DS0267 TO 23DS0296

FOR GEN PATHO & PRE - PROSTHO

BATCH I	BATCH II
23DS0201 TO 23DS0250	23DS0251 TO 23DS0296

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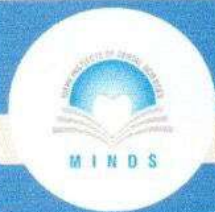
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Ref. No: MINDS.P.O/060525/02

Date: 06.05.2025

CIRCULAR

This is to inform that the commencement of Second Internal Practical Examination for Third year BDS Regular batch is scheduled on.

TIME: 8.00 AM TO 03.00 PM			
Subject	19.05.2025	20.05.2025	21.05.2025
Oral Pathology	I	II	III
General Medicine	II	III	I
General Surgery	III	I	II

BATCH I	BATCH II	BATCH III
22DS0201 TO 22DS0224	22DS0225 TO 22DS0244	22DS0245 TO 22DS0265

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Ref. No: MINDS.P.O/060525/04

Date: 06.05.2025

CIRCULAR

This is to inform that Second Internal Practical Examination for IVth year BDS Regular batch is scheduled on the following dates, from 08.00 AM to 01.00 PM.

Department	02.06.2025	03.06.2025	04.06.2025	05.06.2025	09.06.2025	10.06.2025	11.06.2025	12.06.2025
Public Health Dentistry	I	II	III	IV	V	VI	VII	VIII
Periodontics	II	III	IV	V	VI	VII	VIII	I
Orthodontics	III	IV	V	VI	VII	VIII	I	II
OMR	IV	V	VI	VII	VIII	I	II	III
OMFS	V	VI	VII	VIII	I	II	III	IV
Conservative Dentistry	VI	VII	VIII	I	II	III	IV	V
Prosthodontics	VII	VIII	I	II	III	IV	V	VI
Paedodontics	VIII	I	II	III	IV	V	VI	VII
Batch-I	Batch-II	Batch-III	Batch-IV	Batch-V	Batch-VI	Batch-VII	Batch-VIII	
21DS0201 To 21DS0214	21DS0216 To 21DS0226	21DS0227 To 21DS0237	21DS0236 To 21DS0246	21DS0247 To 21DS0257	21DS0258 To 21DS0266	21DS0268 To 21DS0273	21DS0274 To 19DS0271	

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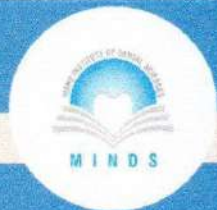
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Ref. No: MINDS.P.O/050824/02

Date: 05.08.2024

CIRCULAR

This is to inform that First Internal Theory Examination (IR Batch) for IInd, IIIrd and Final year BDS will be scheduled from **02nd September, 2024**.

Question Paper to be submitted through Email: examwingminds@mahedentalcollege.org, on or before **25.08.2024** without fail. Regular Classes are scheduled as from the Time Table for all the students on the days of Examination.

Last date to update mark list in HMS software **on or before 25.09.2024**.

Date	Day	Final BDS	Third BDS	Second BDS
02.09.2024	Monday	Public Health Dentistry		General Pathology
03.09.2024	Tuesday	Periodontics		Microbiology
04.09.2024	Wednesday	Orthodontics		Pharmacology
05.09.2024	Thursday	Oral Medicine and Radiology		Dental Materials
06.09.2024	Friday	Oral Surgery	Oral Pathology	
07.09.2024	Monday	Conservative Dentistry	General Medicine	
09.09.2024	Tuesday	Prosthodontics	General Surgery	
10.09.2024	Wednesday	Paedodontics		
Examination Hall:- UG Library				
Time:-8.00 AM to 11.00AM				

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Ref. No: MINDS.P.O/200824/01

Date: 20.08.2024

CIRCULAR

Invigilation Schedule for First Internal Examination for IR Batch Students:

Date	Year	Dept	UG LIBRARY	
			8 to 9.30	9.30 to 11
02.09.2024	Final Year	PHD	Dr. Dipin P P	Mrs. Parvathy
	Second Year	General Pathology		
03.09.2024	Final Year	Periodontics	Dr. Aparna M	Mrs. Sona V
	Second Year	Microbiology		
04.09.2024	Final Year	Orthodontics	Dr. Ankitha Thejus	Dr. Mridhul M U
	Second Year	Pharmacology		
05.09.2024	Final Year	OMR	Mrs. Riya	Dr. Rugma Kannan
	Second Year	Dental Material		
06.09.2024	Final Year	OMFS	Dr. Esha Barkavie	Dr. Sreelakshmi
	Third Year	Oral Pathology		
07.09.2024	Final Year	Conservative Dentistry	Dr. Nirosha V	Dr. Hemalatha
	Third Year	General Medicine		
09.09.2024	Final Year	Prosthodontics	Dr. Jilu Jessy	Dr. Cimmy Augustine
	Third Year	General Surgery		
10.09.2024	Final Year	Pedodontics	Dr. Ahnaf Abdulla	Dr. Fazila A

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3. Adm Manager
4. Nest MINDS
5. IQAC



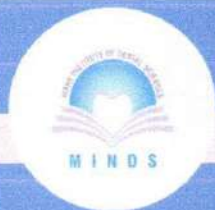
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Ref. No: MINDS.P.O/210924/03

Date: 21.09.2024

CIRCULAR

This is to inform that the commencement of First Internal Practical Examination for second year BDS IR batch is scheduled on..

TIME: 8.00 AM TO 12.30 PM			
23.09.2024	24.09.2024	25.09.2024	26.09.2024
Pre - Prostho	Pharmacology	Dental Materials	Gen Pathology
27.09.2024		28.09.2024	
Microbiology		Pre - Conserve	

*Kindly note: Regular classes will be continued from 01pm onwards

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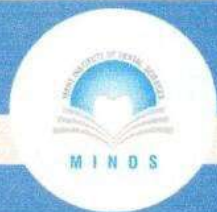
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Ref. No: MINDS.P.O/210924/04

Date: 21.09.2024

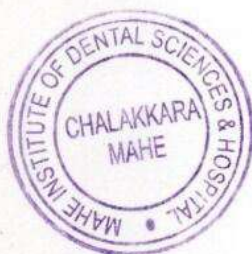
CIRCULAR

This is to inform that the commencement of First Internal Practical Examination for third year

BDS IR batch is scheduled on.

Sl No	Date	Department
1	19.09.2024	Oral Pathology
2	20.09.2024	General Medicine
3	21.09.2024	General Surgery

***Kindly note: Regular classes will be continued from 01pm onwards**



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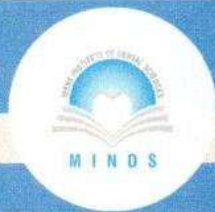
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Ref. No: MINDS.P.O/210924/03

Date: 21.09.2024

CIRCULAR

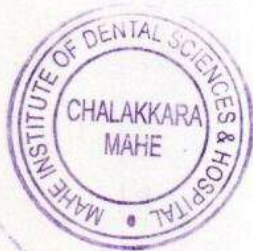
This is to inform that the commencement of First Internal Practical Examination for Final year BDS IR batch is scheduled on.

Department	23.09.2024	24.09.2024	25.09.2024	26.09.2024
Public Health Dentistry	I	II	III	IV
Periodontics	II	III	IV	I
Orthodontics	III	IV	I	II
OMR	IV	I	II	III
Department	27.09.2024	28.09.2024	30.09.2024	01.10.2024
OMFS	I	II	III	IV
Conservative Dentistry	II	III	IV	I
Prosthodontics	III	IV	I	II
Paedodontics	IV	I	II	III
BATCH I	BATCH II	BATCH III	BATCH IV	
19DS0271 TO 20DS0206	20DS0214 TO 20DS0233	20DS0237 TO 20DS0259	20DS0270 TO 19DS0280	

*Kindly note: Regular classes will be continued from 01pm onwards

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Ref. No: MINDS.P.O/061124/03

Date: 06.11.2024

CIRCULAR

This is to inform that Second Internal Theory Examination (IR Batch) for IInd, IIIrd and Final year BDS will be scheduled from 03rd December, 2024.

Question Paper to be submitted through Email: examwingminds@mahedentalcollege.org, on or before 25.11.2024 without fail. Regular Classes are scheduled as from the Time Table for all the students on the days of Examination.

Last date to update mark list in HMS software on or before 31.12.2024.

Date	Day	Final BDS	Third BDS	Second BDS
03.12.2024	Tuesday	Public Health Dentistry	Oral Pathology	
04.12.2024	Wednesday	Periodontics	General Medicine	
05.12.2024	Thursday	Orthodontics	General Surgery	
06.12.2024	Friday	Oral Medicine and Radiology		General Pathology
07.12.2024	Saturday	Oral Surgery		Microbiology
09.12.2024	Monday	Conservative Dentistry		Pharmacology
10.12.2024	Tuesday	Prosthodontics		Dental Materials
11.12.2024	Wednesday	Paedodontics		
Examination Hall:- UG Library				
Time:-8.00 AM to 11.00AM				

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Ref. No: MINDS.P.O/251124/01

Date: 25.11.2024

CIRCULAR

Invigilation Schedule for Second Internal Examination for IR Batch students:

Date	Year	Subject	U G LIBRARY	
			8 to 9.30 AM	9.30 TO 11 AM
03.12.2024	4 th Year	PHD	Dr. Vyshnavi R	Dr. Cimmy Augustine
	3 rd year	Oral Pathology		
04.12.2024	4 th Year	Periodontics	Dr. Lino Paul	Dr. Rugma Kannan
	3 rd year	General Medicine		
05.12.2024	4 th Year	Orthodontics	Mrs. Sona V	Dr. Anjana S
	3 rd year	General Surgery		
06.12.2024	4 th Year	Oral Medicine	Mr. Rahmathulla	Dr. Fazila A
	2 nd year	General Pathology		
07.12.2024	4 th Year	Oral Surgery	Dr. Sreelakshmi	Mrs. Riya
	2 nd year	Microbiology		
09.12.2024	4 th year	Cons & Endo	Dr. Pooja Sanjeev	Dr. Theertha
	2 nd year	Pharmacology		
10.12.2024	4 th year	Prosthodontics	Dr. Bhuvaneswar	Dr. Sneha Valsaraj
	2 nd year	Dental Materials		
11.12.2024	4 th year	Paedodontics	Dr. Sidharth S	Dr. Vyshnavi R

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Ref. No: MINDS.P.O/071224/01

Date: 07.12.2024

CIRCULAR

This is to inform that the commencement of Second Internal Practical Examination for second year BDS IR batch is scheduled on.

TIME: 8.00 AM TO 12.30 PM			
12.12.2024	13.12.2024	14.12.2024	16.12.2024
Pharmacology	Microbiology	Dental Materials	Gen Pathology
17.12.2024		18.12.2024	
Pre – Conserve		Pre - Prostho	

*Kindly note: Regular classes will be continued from 01pm onwards


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Ref. No: MINDS.P.O/091224/03

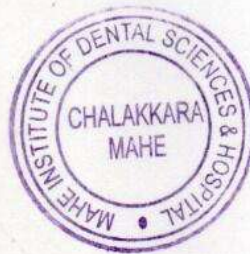
Date: 09.12.2024

CIRCULAR

This is to inform that the commencement of Second Internal Practical Examination for third year BDS IR batch is scheduled on.

Sl No	Date	Department
1	11.12.2024	GENERAL MEDICINE
2	12.12.2024	GENERAL SURGERY
3	13.12.2024	ORAL PATHOLOGY

*Kindly note: Regular classes will be continued from 01pm onwards




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Ref. No: MINDS.P.O/091224/01

Date: 09.12.2024

CIRCULAR

This is to inform that the commencement of Second Internal Practical Examination for Final year BDS IR batch is scheduled on.

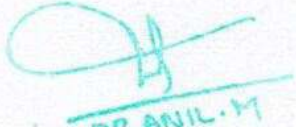
Department	16.12.2024	17.12.2024	18.12.2024	19.12.2024
Public Health Dentistry	I	II	III	IV
Periodontics	II	III	IV	I
Orthodontics	III	IV	I	II
OMR	IV	I	II	III
Department	20.12.2024	21.09.2024	23.12.2024	24.12.2024
OMFS	I	II	III	IV
Conservative Dentistry	II	III	IV	I
Prosthodontics	III	IV	I	II
Paedodontics	IV	I	II	III
BATCH I	BATCH II	BATCH III	BATCH IV	
19DS0271 TO 19DS0269	20DS0206 TO 20DS0250	20DS0256 TO 20DS0270	20DS0279 TO 20DS0230	

*Kindly note: Regular classes will be continued from 01pm onwards

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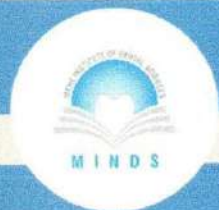



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Ref. No: MINDS.P.O/010125/04

Date: 01.01.2025

CIRCULAR

This is to inform that Third Internal Theory Examination for BDS – IR batch students will be scheduled from **04th February, 2025**.

Question Paper to be submitted through Email: examwingminds@mahedentalcollege.org, on or before **20.01.2025** without fail. Regular Classes are scheduled as from the Time Table for all the students on the days of Examination.

Last date to update mark list in HMS software on or before **28.02.2025**.

Date	Day	Final BDS	Third BDS	Second BDS
04.02.2025	Tuesday	Public Health Dentistry		
05.02.2025	Wednesday	Periodontics		
06.02.2025	Thursday	Orthodontics		
07.02.2025	Friday	Oral Medicine and Radiology		
08.02.2025	Saturday	Oral Surgery	Oral Pathology	General Pathology
10.02.2025	Monday	Conservative Dentistry	General Medicine	Microbiology
11.02.2025	Tuesday	Prosthodontics	General Surgery	Pharmacology
12.02.2025	Wednesday	Paedodontics		Dental Materials
Examination Hall:-UG Library				
Time:- 8.00 AM to 11.00 AM				

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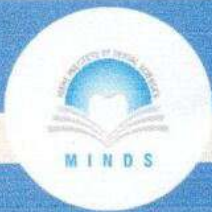
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Ref. No: MINDS.P.O/010225/03

Date: 01.02.2025

CIRCULAR

This is to inform that the commencement of Thid Internal Practical Examination for second year BDS IR batch is scheduled on.

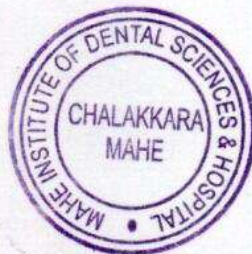
TIME: 8.00 AM TO 12.30 PM			
18.02.2025	20.02.2025	21.02.2025	24.02.2025
Pharmacology	Microbiology	Dental Materials	Gen Pathology
27.02.2024		28.02.2025	
Pre – Conserve		Pre - Prostho	

*Kindly note: Regular classes will be continued from 01pm onwards

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Ref. No: MINDS.P.O/010225/02

Date: 01.02.2025

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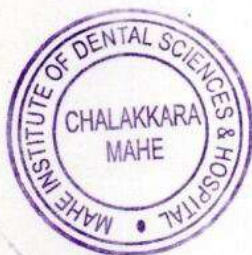
This is to inform that the commencement of Third Internal Practical Examination for third year BDS IR batch is scheduled on.

Sl No	Date	Department
1	06.02.2025	GENERAL MEDICINE
2	07.02.2025	GENERAL SURGERY
3	08.02.2025	ORAL PATHOLOGY

*Kindly note: Regular classes will be continued from 01pm onwards

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Ref. No: MINDS.P.O/010225/03

Date: 01.02.2025

CIRCULAR

This is to inform that the commencement of ^{1st} Internal Practical Examination for Final year BDS IR batch is scheduled on.

Department	21.02.2025	22.02.2025	24.02.2025	25.02.2025
Public Health Dentistry	I	II	III	IV
Periodontics	II	III	IV	I
Orthodontics	III	IV	I	II
OMR	IV	I	II	III
Department	26.02.2025	27.02.2025	28.02.2025	01.03.2025
OMFS	I	II	III	IV
Conservative Dentistry	II	III	IV	I
Prosthodontics	III	IV	I	II
Paedodontics	IV	I	II	III
BATCH I	BATCH II	BATCH III	BATCH IV	
19DS0271 TO 19DS0269	20DS0206 TO 20DS0250	20DS0256 TO 20DS0270	20DS0279 TO 20DS0230	

*Kindly note: Regular classes will be continued from 01pm onwards

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U.T. of Puducherry. Ph : 0490 2337765

DEPT OF ORAL MEDICINE & RADIOLOGY

FIRST INTERNAL EXAMINATION

FOURTH YEAR (R) MARKLIST

DATE : 07/02/25

SL NO	NAME	MCQ	THEORY	TOTAL
1.	ABDULLA NABRAZ	11	4	15
2.	ABHINAND P	13	11.5	24.5
3.	AFRA P	19	25.5	44.5
4.	AGALYA B	19	33.5	52.5
5.	AKSHAYA PRAMOD	15	11.5	26.5
6.	ALBIN JOB	19	27.5	46.5
7.	ANNU ROY	13	16.5	29.5
8.	ANSHANA	18	17.5	35.5
9.	ANUVIDHYA SUJAYAN	21	25.5	46.5
10.	ARCHANA A C	22	29.5	51.5
11.	ARPITHA	16	19.5	35.5
12.	ARSHA HIDAYATH	16	9	25
13.	ASWANA ASOK	17	14.5	31.5
14.	ASWATHY SANTHOSH	19	18	37
15.	ASWIN K RAJEEV	9	2	11
16.	ATHIRA CHANDRAN	19	7	26
17.	AYISHA FIDHA	16	18.5	34.5
18.	AYSHA BASHEER	15	10.5	25.5
19.	AZZA FATHIMA	12	7	19
20.	BALAMANIKANDAN	17	20.5	37.5
21.	BELMA JIJU	17	13.5	30.5
22.	BENNY SALLY	AB	AB	AB
23.	DEVIKA SURESH BABU	7	9	16
24.	DILNA VINOD	17	26	43
25.	DIYA AJAY	13	11.5	24.5
26.	ELJU SARA	14	12	26
27.	FARHANA SHERIN	15	17.5	32.5
28.	FATHIMA NASHVA	17	22	39
29.	FATHIMA SHAMNA	14	12	26
30.	FIDHA FATHIMA	16	24	40
31.	FITHA KHAN	19	15.5	34.5
32.	HUSANA C H	20	19	39



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33.	JAGILAN S	14	18	32
34.	JAZEERA K N	15	21	36
35.	JELINA	15	26	41
36.	KAILAS NANDAN	16	7	23
37.	KEERTHANA K	22	32	54
38.	KRISHNA S	16	29	45
39.	LINTAMOL P K	12	14	26
40.	LIYANA HASSAN	17	19.5	36.5
41.	MEGHA R P	14	32.5	46.5
42.	MERIN BINU GEORGE	19	26	45
43.	MUDRA MARIA MATHEW	17	13.5	30.5
44.	NIDHA FATHIMA	10	10.5	20.5
45.	ONESIPHOUR	14	12.5	26.5
46.	RENSA ANNA SAJI	17	22	39
47.	SALMA R SHUKOOR	14	20.5	34.5
48.	SALOMI MANOJ	19	29	48
49.	SAPTHA ANIL	10	9.5	19.5
50.	SHADIYA ABDULLA	18	16	34
51.	SHAHANA FATHIMA	17	17.5	34.5
52.	SHAHANA KATHOON	21	27	48.5
53.	SHANMATHY S	20	34.5	54.5
54.	SHIFA HAMZA	25.5	17	42.5
55.	SHIFANA R	16	28.5	44.5
56.	SHIREEN SHAHANA	19	13.5	32.5
57.	ALISHA FEROOK	4	1	5
58.	MUHAMMED SHAHAS	10	1.5	11.5
59.	ADITHYA RAMESH	15	9.5	24.5
60.	SONA RACHEL JOSE	19	27.5	46.5
61.	THUSHARA K S	16	22	38.5
62.	VADREVVU MOUNIKA	14	19.5	33.5
63.	VISWAVINODHINI R	19	18	37
64.	ZAINA K HARIS	21	20.5	41.5
65.	DAISY C	10	9	19
66.	PAVEETHRA	AB	AB	AB
67.	ASHA M	10	5.5	15.5

[Signature]
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 Dept. of Oral Medicine & Radiology
 Mahe Institute of Dental Sciences & Hospital
 Chalakkara, Mahe



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DEPT OF ORAL MEDICINE & RADIOLOGY

SECOND INTERNAL EXAMINATION

FOURTH YEAR (R) MARKLIST

DATE : 31/05/25

SL NO	NAME	MCQ	THEORY	TOTAL
1.	ABDULLA NABRAZ	11	12	23
2.	ABHINAND P	9	11	20
3.	AFRA P	17	30	47
4.	AGALYA B	18	31	49
5.	AKSHAYA PRAMOD	12	17	29
6.	ALBIN JOB	20	26	46
7.	ANNU ROY	20	21	41
8.	ANSHANA	16	21	37
9.	ANUVIDHYA SUJAYAN	13	25	38
10.	ARCHANA A C	13	22	35
11.	ARPITHA	19	21	40
12.	ARSHA HIDAYATH	15	6	21
13.	ASWANA ASOK	12	20	32
14.	ASWATHY SANTHOSH	14	21	35
15.	ASWIN K RAJEEV	13	6	19
16.	ATHIRA CHANDRAN	16	23	39
17.	AYISHA FIDHA	17	23	40
18.	AYSHA BASHEER	17	23	40
19.	AZZA FATHIMA	15	14	29
20.	BALAMANIKANDAN	14	26	40
21.	BELMA JIJU	16	24	40
22.	BENNY SALLY	AB	AB	AB
23.	DEVIKA SURESH BABU	11	18	29
24.	DILNA VINOD	14	25	39
25.	DIYA AJAY	14	15	29
26.	ELJU SARA	13	22	35
27.	FARHANA SHERIN	8	20	28
28.	FATHIMA NASHVA	13	26	39
29.	FATHIMA SHAMNA	13	28	41
30.	FIDHA FATHIMA	14	27	41
31.	FITHA KHAN	13	23	36
32.	HUSANA C H	17	31	48



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33.	JAGILAN S	16	22	38
34.	JAZEERA K N	16	31	47
35.	JELINA	14	23	37
36.	KAILAS NANDAN	15	9	24
37.	KEERTHANA K	17	31	48
38.	KRISHNA S	16	24	40
39.	LINTAMOL P K	10	19	29
40.	LIYANA HASSAN	12	15	27
41.	MEGHA R P	15	22	37
42.	MERIN BINU GEORGE	14	30	44
43.	MUDRA MARIA MATHEW	9	12	21
44.	NIDHA FATHIMA	10	12	22
45.	ONESIPHOUR	19	17	36
46.	RENSA ANNA SAJI	14	23	37
47.	SALMA R SHUKOOR	16	27	43
48.	SALOMI MANOJ	18	25	43
49.	SAPTHA ANIL	14	9	23
50.	SHADIYA ABDULLA	15	23	38
51.	SHAHANA FATHIMA	12	17	29
52.	SHAHANA KATHOON	15	21	36
53.	SHANMATHY S	15	29	45
54.	SHIFA HAMZA	16	26	42
55.	SHIFANA R	14	21	35
56.	SHIREEN SHAHANA	14	16	30
57.	ALISHA FEROOK	AB	AB	AB
58.	MUHAMMED SHAHAS	12	3	15
59.	ADITHYA RAMESH	14	13	27
60.	SONA RACHEL JOSE	18	19	37
61.	THUSHARA K S	17	22	39
62.	VADREUVU MOUNIKA	14	23	37
63.	VISWAVINODHINI R	14	25	39
64.	ZAINA K HARIS	14	21	35
65.	DAISY C	9	11	20
66.	PAVEETHRA	4	11	15
67.	ASHA M	5	10	15
68.	NIMA NIHALA	8	5	13


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DEPT OF ORAL MEDICINE & RADIOLOGY

FIRST INTERNAL EXAMINATION

MARKLIST

FOURTH YEAR (IR)

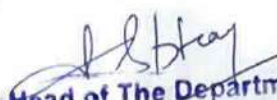
DATE : 05/09/24

SL NO	NAME	MCQ	THEORY	TOTAL
1.	AKASH S BIJU	8	8	16
2.	ARSHIN	10	13	23
3.	ELNA	12	8	19
4.	FATHIMA NASMI	10	1	11
5.	FATHIMATHUL SAFAH	11	2	13
6.	KEERTHANA S	14	22	36
7.	MHD AL SHAMEEL	8	5	13
8.	MHD THAHA	8	8	16
9.	PENNUMAKAL LIZA	11	10	21
10.	PRIYA DHARSHINI	12	6	18
11.	KAVYA PRIYA	14	4	18
12.	NIMA	11	2	13
13.	SARJADA	AB	AB	AB
14.	RINSHA	AB	AB	AB
15.	SHAHADA RASHEED	AB	AB	AB



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16.	SALWA FATHIMA	AB	AB	AB
17.	GAUTHAM GOKUL	AB	AB	AB


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DEPT OF ORAL MEDICINE & RADIOLOGY

SECOND INTERNAL EXAMINATION

MARKLIST

FOURTH YEAR (IR)

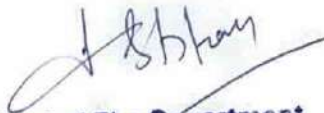
DATE : 04/12/24

SL NO	NAME	MCQ	THEORY	TOTAL
1.	AKASH S BIJU	14	5	19
2.	ARSHIN	15	9	24
3.	ELNA	12	4	16
4.	FATHIMA NASMI	10	2	12
5.	FATHIMATHUL SAFAH	9	10	19
6.	KEERTHANA S	AB	AB	AB
7.	MHD AL SHAMEEL	AB	AB	AB
8.	MHD THAHA	11	3	14
9.	PENNUMAKAL LIZA	AB	AB	AB
10.	PRIYA DHARSHINI	12	13	25
11.	KAVYA PRIYA	11	5	16
12.	NIMA	AB	AB	AB
13.	SARJADA	AB	AB	AB
14.	RINSHA	AB	AB	AB
15.	SHAHADA RASHEED	AB	AB	AB



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16.	SALWA FATHIMA	AB	AB	AB
17.	GAUTHAM GOKUL	10	4	14


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DEPT OF ORAL MEDICINE & RADIOLOGY

THIRD INTERNAL EXAMINATION

FOURTH YEAR IR MARKLIST

DATE : 07/02/25

SL NO	NAME	MCQ	THEORY	TOTAL
1.	AKASH S BIJU	10	6.5	16.5
2.	ELNA RAJESH	18	14.5	32.5
3.	FATHIMA NASMI	10	1	11
4.	FATHIMATHU SAFA	AB	AB	AB
5.	KEERTHANA S	8	9.5	18
6.	MUHAMMED AL SHAMEEL.M	8	1.5	9.5
7.	MUHAMMED THAHA	11	6	17
8.	PENUMAKA LIZAA	5	8.5	13.5
9.	C.PRIYADHARRSHINI	11	10	21
10.	S.KAVIYAPRIYA	10	13	23
11.	NIMA NIHALA	AB	AB	AB
12.	RINSHA	AB	AB	AB
13.	SALVA FATHIMA	AB	AB	AB
14.	SARJADA NASRIN	AB	AB	AB
15.	GOUTHAM GOKUL	14	9	23
16.	SHAHADA RASHEED	AB	AB	AB
17.	ARSHIN	12	17	29


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15
25

1. Cervical burn out is the

- ☒ a) Burn out effect caused by the radiation on teeth
- b) Triangular radiolucency produced by caries on the proximal surface of teeth under the contact point
- ☒ c) Cervical radiolucency normally found between the cemento-enamel junction and the crest of alveolar bone
- d) Radiolucency produced by cervical caries

2. Nikolsky's sign is seen in

- a) Chronic desquamative gingivitis
- ☒ b) Epidermolysis bullosa
- ☒ c) Pemphigus
- (d) All of the above

3. Specific test for pernicious anaemia

- (a) Schick test
- (b) Mantoux test
- (c) Shilling test
- ☒ (d) Paul Bunnell test

4. PID is

- ☒ (a) Position indicating device
- (b) Patient indicating device
- (c) Problem indicating device
- (d) Patient inducing device

5. Filtration is used to

- ☒ (a) Remove high energy X ray photon
- (b) Absorb excessive heat during X ray photon
- (c) Narrow the beam to a specified diameter
- (d) Remove the low energy X ray photon

6. Constant feature associated with a radicular cyst is

- ☒ (a) Impacted tooth
- (b) missing tooth
- (c) Non-vital tooth
- (d) anomalous tooth

7. In the bisecting angle technique, the film is placed:

- (a) Parallel to the tooth
- ☒ (b) As close to the tooth as possible
- (c) Parallel to the bisector
- (d) Perpendicular to the bisector

8. Which of the following is electromagnetic radiation

- (a) Alpha rays
- ☒ (b) X rays
- (c) Beta rays
- (d) None of the above

9. Daughter cysts are a feature of

- ☒ (a) Odontogenic keratocyst
- (b) Dentigerous cyst
- (c) Primordial cyst
- (d) Radicular cyst

10. Tungsten is chosen as the target material because of

- (a) High atomic number
- (b) High melting point
- (c) Low vapour pressure
- ☒ (d) All of the above

11. The quality of X ray beam is decided by

- (a) MA
- (b) KVP
- ☒ (c) Exposure time
- (d) Line voltage

12. Father of dental radiology
(a) Wilhelm.C.Roentgen (b) Edmund Kells
(c) William H.Rollins (d) Weston A. Price
13. 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) $I_1/I_2 = [D_2/D_1]^2$
14. When 1% toluidine blue is applied over a lesion dark staining is seen retained even after cleaning & swabbing the area with 1% acetic acid in
(a) Benign keratinized lesions (b) Early carcinomas
(c) Mechanical retention of strain (d) None of the above.
15. Slip sign is the characteristic feature of
(a) Fibroma (b) Papilloma (c) Lipoma (d) Mucocele
16. The best view for visualizing inter proximal caries
(a) Occlusal (b) Bitewing (c) Lateral oblique (d) IOPA
17. Size of the X ray beam is regulated by
(a) Collimation (b) Filtration
(c) Target inclination (d) Thermionic emission
18. The reflecting layer in an intensifying screen is made of
(a) Plastic (b) Zinc oxide (c) Lead (d) Titanium Dioxide
19. A bilateral grey white lesion of the buccal mucosa disappears when the mucosa is stretched the most likely condition is
(a) Leukoedema (b) Leukoplakia (c) Lichen planus (d) White sponge nevus
20. Which of the following structure is considered to be radiolucent?
(a) Zygomatic process (b) Lateral wall of nasal fossa
(c) Lamina dura (d) PDL space
21. The safe light in the dark room is placed at a height of
(a) 3 feet (b) 4 feet (c) 2 feet (d) 1 feet
22. Localization of object is done by
a) Paralleling technique b) Bisecting angle technique c) Tube shift technique d) Bitewing
23. Which of the following white lesion is caused due to allergy
(a) OLP (b) Leukoedema (c) Hairy leukoplakia (d) Lichenoid reaction
24. Penny test is used to test
(a) Film contrast (b) Image density (c) Image resolution (d) Light leak in dark room
25. An example for Scrapable white lesion is:
a) Leukoplakia
b) Acute atrophic candidiasis
c) Chronic atrophic candidiasis
(d) Oral thrush

MAHE INSTITUTE OF DENTAL SCIENCES & HOSPITAL
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INTERNAL ASSESSMENT BOOK

SUBJECT: ORAL MEDICINE + RADIOLOGY

Tick Questions Attempted :

Q₁ ☒ Q₂ ☒ Q₃ ☒ Q₄ ☒ Q₅ ☒ Q₆ ☒ Q₇ ☐ Q₈ ☒

Q₁ 7 10

Q₂ 7 10

Q₃ 2 5

Q₄ 1 5

Q₅ 4 5

Q₆ 4 5

Q₇ NA 5

Q₈ 1 5

No. of Additional

TOTAL

Sheets used.

Total in Words

Evaluated by:

Name of the candidate: Jelina J-A

Reg. No: 21DS0245

Signature

Date: 7/2/2025

Signature of Invigilator

26 45 + 15 = 41

Section-A

1. White lesions of the oral cavity

Classification:

1) Scrapable lesions

- * oral thrush

- * chemical burns

- * pseudomembrane formation by diphtheria

- * mucocutaneous patches by syphilis

2) Non scrapable lesions

- * leukoplakia

- * squamous cell carcinoma

- * chronic atrophic candidiasis

- * lichen planus

- * lichenoid reaction

- * oral submucous fibrosis

→

1) Immunological lesions

- * lichenoid reaction

2) Malignancy / leukoplakia

- * frictional keratosis

- * chronic cheek bite

- * leukoplakia - speckled, nodular, ulcerative type

- * squamous cell carcinoma

3) Bacterial / viral / fungal lesions

- * candidiasis

- * diphtheria

- * syphilis

Candidiasis

- * Candidiasis is a fungal disease caused by the fungi *Candida albicans*.
- * various other fungi are also responsible for this disease.
- * *Candida* is a gram positive organism which is a normal commensal of the oral cavity.
- * If any Etiological factors cause its overactivation, Candidiasis develops.
- * Candidiasis most commonly occurs in the oral cavity.

Clinical features

- * Age: Candidiasis most commonly occurs in the older individuals above 50 years of age.
- * Sex: Males are more commonly affected by the candidiasis.
- * Site: In the oral cavity the most common sites for candidal infections are dorsum of tongue, buccal mucosa, marginal gingiva, palate etc.

Etiology:

- * Candidiasis is caused due to various etiological factors, which includes

→ Microbial infections

- * AIDS by HIV
- * Syphilis by *Treponema pallidum*
- * diphtheria by *Corynebacterium diphtheriae*
- * Meningitis by *Meningococci*
- * Tuberculosis by *Mycobacterium tuberculosis*
- * Leprosy by *Mycobacterium leprae*

→ Precancerous lesions + conditions

- * leukoplakia
- * lichen planus
- * oral submucous fibrosis
- * erythroplakia
- * oral hairy leukoplakia
- * lichenoid reaction

→ Malignant + benign tumor

- * squamous cell carcinoma
- * papilloma
- * fibroma
- * lipoma
- * carcinoma in situ

→ Nutritional deficiencies

- * Vitamin A deficiency
- * Vitamin B deficiency
- * Vitamin C deficiency
- * Zinc deficiency
- * Iron deficiency

→ Hereditary

→ Hormonal

→ Trauma

→ Chronic denture wear

→ Autoimmune disorders

→ Improper oral hygiene

Classification

* Acute

- Acute pseudomembranous candidiasis
- Acute Atrophic candidiasis

* Chronic

- Chronic atrophic candidiasis
- Mucocutaneous candidiasis
- Familial mucocutaneous candidiasis
- Chronic hypertrophic candidiasis
- candidiasis associated with systemic diseases & conditions

Acute pseudomembranous candidiasis

- * It is also called as oral thrush
- * it is a scrappable form of candidial lesion
- * a pseudomembranous layer is formed on the mouth
- * it occurs mostly on the buccal mucosa
- * it is soft, smooth, homogeneous, with ill-defined borders
- * it can be easily scrappable from the oral mucosa
- * after scrapping, a erythematous layer is formed on the oral mucosa
- * This type of candidiasis is the most commonly occurring form of candidiasis
- * It can be due to improper oral hygiene or it can also be due to other microbiological factors
- * this type of candidiasis can be easily treatable
- * if acute pseudomembranous candidiasis is not treated, it leads to acute pseudomembranous candidiasis

Acute

Chronic atrophic candidiasis

* It is a non-scrapable form of candidiasis

* It is erythematous in nature

* It mostly occurs in the dorsum of the tongue

* The dorsum of the tongue looks like shiny & soft in appearance

* Depapillation is present in the dorsum of the tongue

* If the acute pseudomembranous candidiasis is not treated, it leads to acute atrophic candidiasis causing atrophy of the surrounding structures

* Burning sensation occurs while consuming spicy food and also hot food

Chronic atrophic candidiasis

* Chronic atrophic candidiasis may be of 3 types

→ denture stomatitis

→ angular cheilitis

→ Median Rhomboid glossitis

Denture stomatitis

* Denture stomatitis mostly occurs in the denture bearing areas of the mouth

* Palate is the most common region where denture stomatitis is present

* Patients who wear denture continuously may face this type of candidial lesion

* Sometimes for retention suction cups are kept in the palatal aspect of the denture which induce candidiasis

- It occurs commonly in the old age people because they are the one who wear denture commonly
- Not properly cleaning the tissue surface of the denture base can also lead to this
- Every day after using the denture, the denture should be cleaned to avoid this type of candidiasis
- Doctor must advise the denture wearing patient to properly clean and use the denture

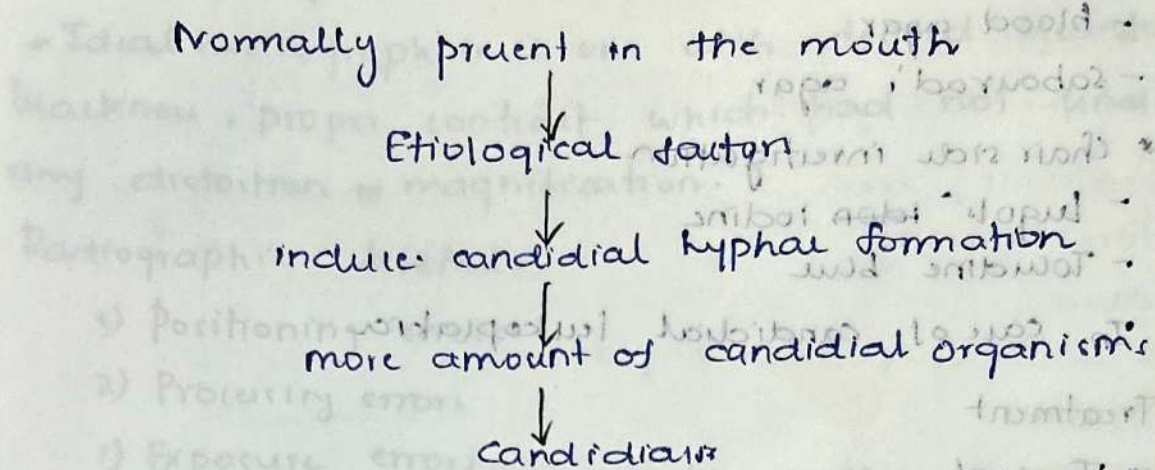
Angular cheilitis

- Sometimes candidiasis can occur in the commissure of the lip region
- This type of candidal lesion is very painful
- It can spread to the buccal mucosa also
- Patient may feel difficulty in eating, drinking and talking also

Median rhomboid glossitis

- It is one of the developmental disturbance of the tongue
- A rhomboid shaped area at the junction of the posterior one third and middle one third of the tongue is devoid of papilla where candidal organisms are present
- It is called as kissing lesion because it spreads to the palate
- Then, candida also develop in the palate which may spread to the other areas of the mouth

Pathogenesis



- * *Candida albicans* is normally present in the oral mucous membrane as a normal commensal.
- * The etiological factors such as microbial factors, systemic diseases, poor oral hygiene, trauma, precancerous lesions, malignancies, chronic denture wear cause the formation of pseudo hyphae formation.
- * *Candida albicans* multiply more in the oral cavity by pseudo hyphae formation leading to the presence of more amount of candida organisms leading to candidiasis.
- * Oral thrush develops at the early stage.
- * If it is left untreated, ^{acute chronic atrophic} candidiasis develops.

Investigations

- * Histopathological examination
 - the scrapable part of pseudomembrane is removed from the oral cavity and is sent for histopathological examination.
 - if a gram positive, organism producing pseudo hyphae is formed, it is candidiasis.

* Culture media

- blood agar
- Sabouraud's agar

* Chair side investigation

- Lugol's iodine
- Toluidine blue

In case of candidal leukoplakia

Treatment

* Topical

1. Clotrimazole (1st drug of choice) - cream

- Amphotericin B

- Ketokonazole

- Nystatin

* Systemic

1. Fluconazole (1st drug of choice) - 100-400mg

- Ketokonazole

2. Ideal Radiograph

* Ideal radiograph is a one with desired density, overall blackness, proper contrast which had not undergone any distortion or magnification.

Radiographic Artefacts

1) Positioning errors

2) Processing errors

3) Exposure errors

Positioning errors

* foreshortening

* Elongation

* Concave cut

* Apical cut

* Coronal cut

* Maxillary teeth visible in mandibular arch

* Heming bone pattern

* distortion

* magnification

* double image

* finger mark

Processing errors

* dark image

* light image

Exposure * Black streak

* Black spot

* Black mark

* white streak

* white mark

Exposure errors

* dark radiograph

* light radiograph

Positioning error

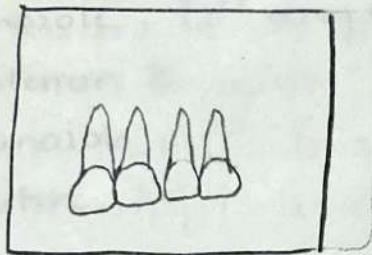
Foreshortening

cause:

* Increased vertical angulation

correction:

* proper angulation of the film



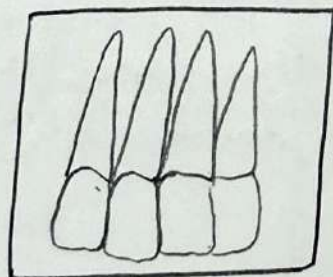
Elongation

cause:

* decreased vertical angulation

correction:

* proper angulation of the film



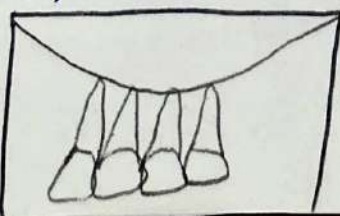
concut

cause:

* improper horizontal angulation

correction

* proper angulation of the film



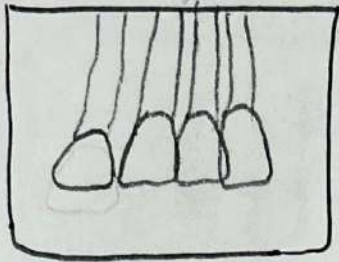
Apical cut

cause:

* film is placed more coronally

correction:

* proper placement of the film



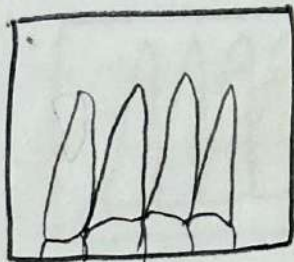
coronal cut

cause:

* film is placed more apically

correction:

* proper placement of the film



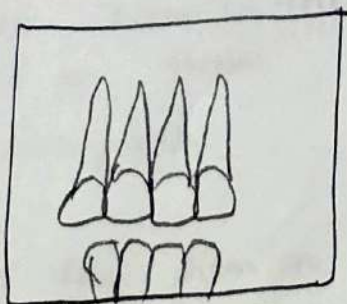
Maxillary teeth visible in mandibular arch

cause:

* improper placement of the film

correction:

* proper placement of the film



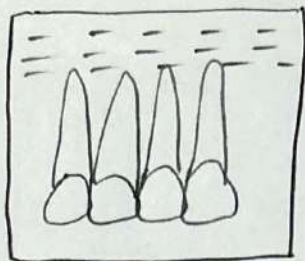
Herring bone pattern

cause:

* lead foil is placed towards the cone

correction:

* lead foil should be placed away from the cone



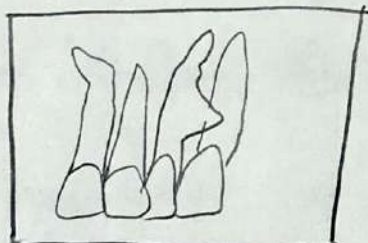
Distortion

cause:

* bending the xray film for patient's comfort

correction:

* should not bend the film while placement



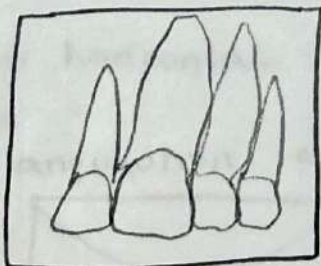
Magnification

cause:

* tube head is placed towards the patient

correction:

* correct positioning of the tube head



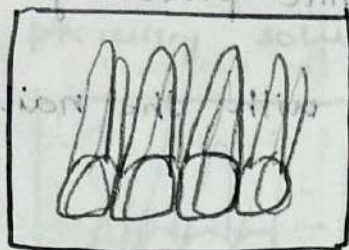
Double image

cause:

- * exposing the film two times

correction:

- * film should be exposed only once



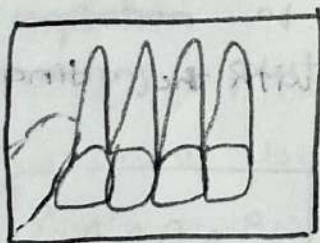
Finger mark

cause:

- * placing the finger inside the mouth while exposing

correction:

- * finger should not be placed while exposing



Processing errors

Dark image

cause:

- * placing the film in the developer for too long
- * placing the film in the fixer for little time

correction:

- * place the film in the developer + fixer for correct amount of time

Light radiograph

cause:

- * placing the film in the developer for little time
- * placing the film in the fixer for too long

correction:

- * place the film in the developer + fixer for correct amount of time

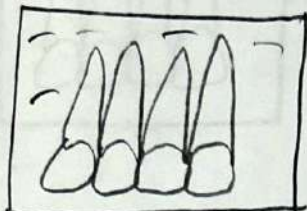
Black streak

cause:

- * Nail marks on the film while processing

correction

- * should not hold the film with the nails



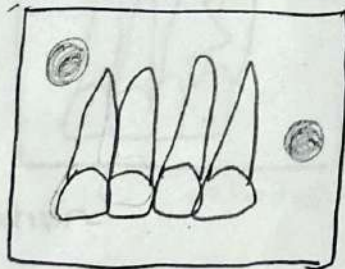
Black spot

cause

- * finger spots on the film while processing

correction

- * should be hold the film with the fingers



Black mark

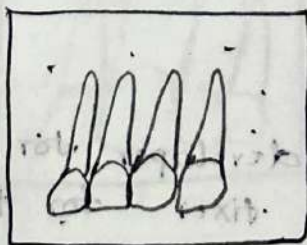
cause:

- * dust in the processing solution

correction

- * the processing solutions

should be neat and clean



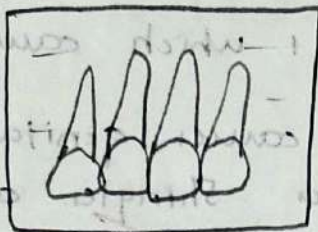
White streak

cause

- * chemicals in the processing solution
- * failure to agitate the solution

correction

- * proper agitation of the solution
- * the processing solution should be new



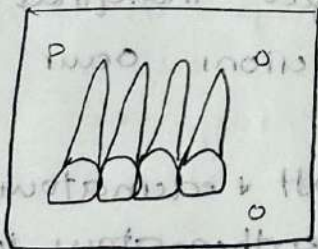
White spot

cause:

- * entrapment of air bubbles in the processing solution

correction

- * proper agitation of the solution
- * the processing solution should be new



Exposure errors

Dark radiograph

cause:

- * too much exposure of the film

correction

- * proper amount of exposure time, kV and mA

Light radiograph

cause:

- * little amount of film exposure

correction

- * proper exposure time, kV and mA

Section - B

3. Primary herpetic gingivostomatitis

Etiology

- * The causative organism for primary herpetic gingivostomatitis is Herpes simplex virus type 1
- * Herpes simplex virus is of the following types
 - Herpes simplex virus type 1 which causes herpetic gingivostomatitis
 - Herpes simplex virus type 2 causes genital + neonatal herpes
 - Varicella zoster virus causes Shingles and chicken pox
 - Cytomegalovirus causes Kaposi sarcoma

* The oral lesions of the Herpes simplex virus are mostly caused by Herpes simplex virus type 1

Clinical features

- * Primary herpetic gingivostomatitis primarily presents with the features of enlarged marginal gingiva
- * More amount of oral lesions occur in this type of condition
- * The gingiva presents as soft + edematous in consistency, round + blunt edge, red + erythematous in colour, without the presence of stippling
- * Common oral finding of herpetic gingivostomatitis is the papules in the oral cavity
- * The oral cavity is filled with minute papules which turn into ulceration after it is broken down
- * The lesion is painful
- * Increase in the keratinization also takes place

4. Properties of x-rays

- physical property
- Biological property
- chemical property

Physical properties of x-ray

- * it travels in a wave motion
- * it travels at the speed of light
- * electromagnetic radiation
- it obeys
 - * inverse square law
 - * in free space it travels in a straight line
 - * the intensity of the x-ray is more

Chemical property

- * colour changing capacity
- * conversion of ferrous to ferric

Biological property

- negative property
- positive property

* In negative property, the x-rays are capable of producing cancer in a normal cell

* In positive property, the x-rays are capable of reducing cancer cells through chemotherapy & radiotherapy

5. Pemphigus vulgaris

- * Pemphigus is a vesiculobullous lesion
- * It is characterized by the formation of vesicle and bulla
- * Vesicle is the fluid filled elevation $< 3\text{mm}$ in diameter
- * Bulla is the fluid filled elevation $> 3\text{mm}$ in diameter
- * The other vesiculobullous lesions present are pemphigoid, chicken pox, shingles
- * Pemphigus has various types, they are
 - Pemphigus vulgaris
 - Pemphigus vegetans
 - Pemphigus folliciaceus
 - Brazilian pemphigus
 - Paraneoplastic pemphigus

Clinical features

- * It is a mucocutaneous condition
- * It is present in both oral mucous membranes and skin
- * Various fluid filled elevations are present inside the oral cavity
 - * Itching sensation is present
 - * Sometime it can also be painful
 - * The commonly involved sites in the oral cavity are buccal mucosa and dorsum of tongue
- * Mostly pemphigus vulgaris is present as an cutaneous lesion mainly in the head, toes and foot region
- * These vesicles break down and a clear fluid comes out from that which can be spreading into other parts

Nickolsky's sign

• the most important and common clinical finding feature in the patient with pemphigus vulgaris is the Nickolsky's sign

• if the patient is having a vesiculobullous lesion and if Nickolsky's sign is positive, means it is mostly pemphigus vulgaris.

Pathogenesis:

• there is a suprabasilar split due to the destruction of the desmosome with attachment of the 2 cells by IgG

Autoimmune reaction

↓
IgG

↓
destruction of desmosome

↓
suprabasilar split

↓
Tzanck cells

• Due to the loss of desmosomal attachment between the 2 cells, suprabasilar split develop and the cell which loses all the attachment is called a Tzanck cell

Treatment

• steroid therapy can be given

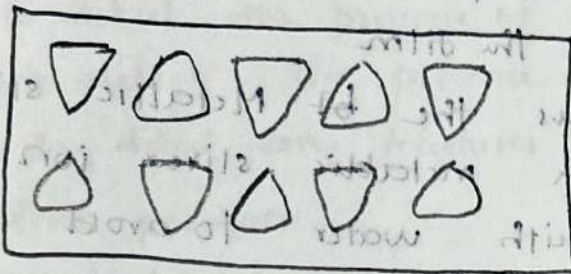
Dexamethasone

Prednisolone

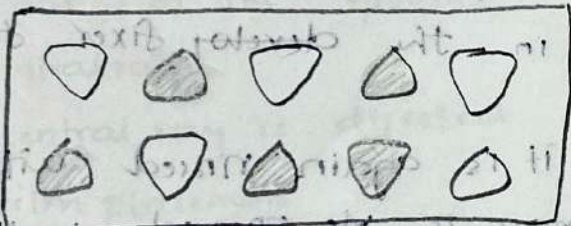
6 Latent image and formation of image

* the invisible image which is formed in the xray film after the exposure of the film is called as latent image

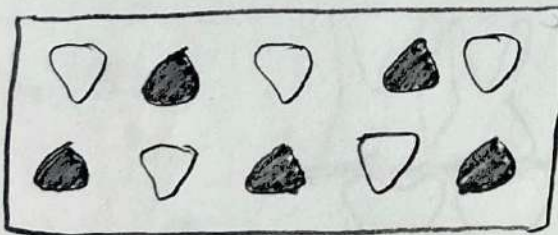
* the latent image is then processed to form a ideal radiograph



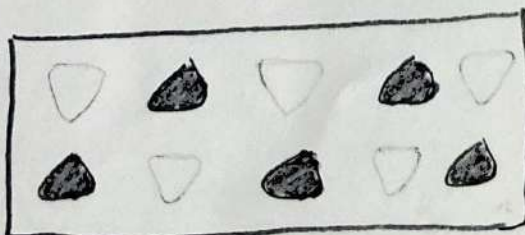
unexposed film



latent image



processed image



final radiographic image

unexposed film $\rightarrow$ latent image $\rightarrow$ processed image $\rightarrow$ final radiographic image

* First the unexposed film is kept in the patient's mouth and is exposed

* The silver halide and silver bromide crystal reacts with the present in the tube head is directed into the unexposed film, forming a metallic silver image which is not visible called a latent image

* The latent image is then put into a processing solution i.e. developer to develop the film

* In the developing process the latent metallic silver image is converted into black metallic silver ion

* Then it is rinsed with water to avoid the formation of black metallic silver ion in the other parts where latent image is not formed

* Then it is kept in the developer fixer for the fixation process

* After fixation process it is again rinsed with water

* After fixation the image is opened in the darkroom

* The final image is formed

Latent image

↓
developer

↓
water

↓
fixer

↓
water

↓
final image

8. Occlusal radiograph

Indications

- * to detect the occlusal caries
- * to detect any supernumerary tooth
- * to detect the presence of impacted tooth
- * to detect the extent of the lesion
- * to detect the presence of cyst or tumor
- * to detect the presence of sialolithiasis
- * to detect the presence of arch discrepancies
- * to detect any fractures of maxilla or mandible

Patient position

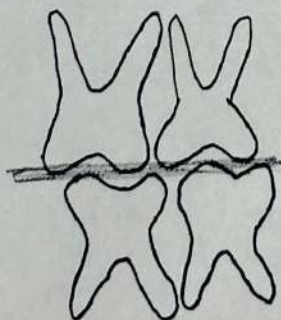
- * patient is positioned in such a way that the sagittal plane of the patient is perpendicular to the floor of the ground

central ray

- * central ray is directed parallel to the floor

film placement

- * the film is placed in the occlusal surface of the patient's mouth and the patient is asked to bite it



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

Fourth year BDS - REGULAR BATCH - July 2025 Exam Going - Batch

SECOND INTERNAL Examination

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

15/25

01. Destructively invasive locally malignant with rare metastasis

- (a) Fibroma (b) Papilloma (c) Ameloblastoma (d) None of the above

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

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

✓ 14. Following is an indication of CBCT except

- ✓ a) Assessment of tumor spread b) Implant imaging
c) Assessment of root canal morphology d) Assessment of fractures

✓ 15. Fordyce granules

- ✓ (a) Salivary glands (b) Sweat glands ✓ (c) Sebaceous glands (d) Lacrimal glands

✓ 16. The form of lichen planus has tendency for malignant transformation

- ✓ (a) Macular ✓ (b) Erosive (c) Keratotic (d) Vesiculobullous

17. Gingival bleeding, gingival enlargement, chloromas & generalized lymphadenopathy are clinical features of

- ✗ a) Thrombocytopenia b) Leukemia ✓ c) Scurvy d) Hemophilia

18. Kissing lesion is associated with

- ✗ a) Denture stomatitis b) Angular cheilitis
c) ✓ Infectious mononucleosis d) Median rhomboid glossitis

19. Production of digital image requires a process called

- ✗ (a) ADC (b) BDC
✓ (c) CDC (d) DDC

20. The purpose of filter in x-ray tube is:

- ✗ a) Shape the x-ray beam ✓ b) Remove short wave length x-rays
c) Remove long wave length x-rays d) Prevent tube head leakage

21. Screens are commonly incorporated in extra oral film cassette primarily for the purpose of

- ✗ (a). Increasing the contrast quality ✓ (b). Enhancing the image definition
(c). Reducing distortion ✓ (d). Reducing patient radiation dose

22. Using an E speed rather a D speed film to produce a radiograph requires

- ✓ (a) A longer exposure time ✓ (b) A shorter exposure time
(c) A longer processing time (d) A shorter processing time

23. Well circumscribed flat lesion that is noticeable because of its change from normal skin colour is known as

- ✓ a. Papule ✓ b. Macule c. Nodule d. Pustule

24. The reflecting layer of an intensifying screen is made up of

- ✗ A. Calcium tungstate B. Sodium sulphite
C. Titanium dioxide D. Rare earth crystals

25. Which of the following is a non-inflammatory growth of the oral mucosa

- ✗ (a) Irritation fibroma ✓ (b) Parulis (c) Adenoma (d) Fibrous epulis

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

INTERNAL ASSESSMENT BOOK

SUBJECT: *OMR*

Tick Questions Attempted :

Q₁ ☒ Q₂ ☒ Q₃ ☒ Q₄ ☒ Q₅ ☒ Q₆ ☒ Q₇ ☒ Q₈ ☐

Q₁ *5* 10

Q₂ *5 1/2* 10

Q₃ *1 1/2* 5

Q₄ *1* 5

Q₅ *4* 5

Q₆ *3* 5

Q₇ *3* 5

Q₈ *NA* 5

23 45

No. of Additional

TOTAL

Sheets used.

Total in Words

Evaluated by:

Name of the candidate:

Reg. No:

Signature

Date: *14.5.25*

Shashika Acharya

211050263

[Signature]

Signature of Invigilator

[Signature]

*23
15
38
70*

[Signature]

1. Bacterial infections

- Tuberculosis
- Syphilis
- Leprosy
- Actinomycosis
- Scarlet fever
- Diphtheria
- Cat scratch disease
- Streptococcus pneumoniae
- Gonorrhea
- Monococcal infection

Tuberculosis

chronic infection caused by acid fast bacilli "Mycobacterium tuberculosis"

mode of transmission

Airborne in the form of sneezing, coughing, droplet infection, etc.

Types

Primary tuberculosis = newly infected disease

Secondary tuberculosis: person effected TB previously & again effect in same person.

Pulmonary: pulmonary TB is involving lungs.

Extrapulmonary: TB effect other than lungs. effect lymph node & other part of body.

oral manifestation

Clinical features

weight loss

fatigue

fever

cough with sputum

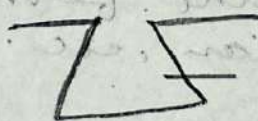
malair

upper respiratory tract infection

oral manifestation

- it is not compulsory.
- it occurs with weight loss.

if mucosa: Inflammation.
undermined edges lesion.
ulcer.



undermined edges
lesions seen in
mucosa.

ii) Palate: most commonly effect in hard palate. granulomatous & ulcerative lesions seen.

iii) Tongue: lateral border of tongue is the most common site cause trauma

iv) lymph node: ~~seen in~~ seen. the ~~the~~ Scrofula

v) Tmj = TB effect in Tmj.

vi) Granulation tissue: TB effect in granulation tissue.

2 main types

Primary: it effect directly into the oral cavity by ~~direct~~ direct inoculation of disease spread via wound.

Secondary: it effect secondarily into the oral cavity. 1st spread pulmonary and spread via blood via other site it reach into the oral cavity.

investigation

~~PCR~~ Mantoux test:

after the application of patch into the skin wait 72 hr.

inference:

15+ = Strongly positive

10-15 : positive

5-9 = effect mildly.

less than 5 = negative.

* false positive increase of atypical bacterial infect.

- microscopic examination: to detect AFB in microscopically.
- chest x-ray

Prophylaxis

Bca = Bacilli Calmette Guérin
Bca vaccine given in ^{the form of} 3 doses

Treatment - First line drugs

Streptomycin
isoniazide

Rifampicin
erythromycin
pyrazinamide

2nd line drug

ciprofloxacin
levofloxacin

2.)

Differential diagnosis of Periapical radiolucencies

in Radiographically seen many radiolucent & opaque lesions diseases;

Radiolucencies seen in Rg

- periapical granuloma.
- periapical cyst abscess.
- periapical cemental dysplasia
- median mandibular cyst
- incisive canal cyst
- Radicular cyst
- traumatic bone cyst
- surgical scar.

and also many radiopaque are seen in Radiographically.

- Radiopathic osteosclerosis
- cementifying osseous dysplasia
- Hypercementosis
- Condensing osteitis

These are radiopaque seen in radiographically.

Differential diagnosis of Radiolucencies

i) Periapical granuloma:

- well differentiated ^{teeth are without radiopacity like} radiolucency seen in apical area of the tooth

- sequelae of pulpitis
- non-vital teeth are effected.

- usually asymptomatic

- widening of pdl in this case.

- breaking the lamina dura

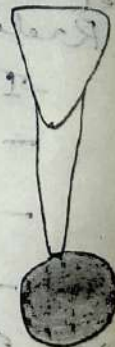


ii) Periapical abscess

- well-differentiated radiolucency seen in apical area of tooth

- it effect in non-vital teeth.

- if infected its painful



iii) Radicular cyst =

- Sequelae of periapical granuloma.
- inflammatory cyst.
- commonly seen in anterior maxillary region.
- well defined radiolucency seen in apical region.



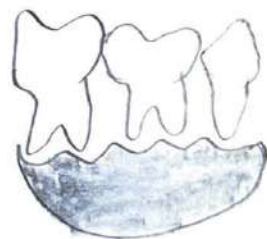
iv) Surgical scar:

well defined radiolucency seen in apical region.



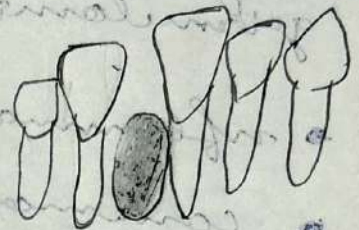
v) Traumatic bone cyst =

- it occurs most commonly in young ages.
- common site is posterior mandibular region.
- asymptomatic.
- effect on vital teeth.



vi) median mandibular cyst :

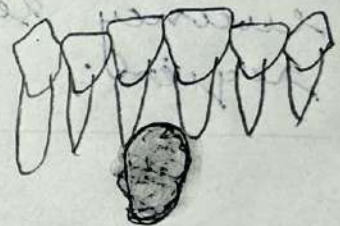
Rg radiolucency seen in mandibular anterior region.



vii) periapical cemental dysplasia :

commonly seen in the region of mandibular anterior teeth.

radiolucency seen in apical part of teeth.



5.

Transcranial Rg

it is a type of tmj imaging technique
tmj is a

- complex structure.
- connect mandibular bone to cranial base
- glenoid fossa - mandibular articulation.
- joint between condyle & mandibular fossa of temporal bone.
- many diseases cause pain.

Transcranial Rg

most popular technique.

i) Structures seen

- Joint space
- articular eminence
- condylar head

lateral aspect of glenoid fossa.

ii) Indication

- tmj pain dysfunction syndrome.
- Internal derangement.
- Range of movement in tmj joint.

iii) Film placement

- Film place parallel to Saggital plane.
- Film position is flat against patient's ear.
- Centered over the T.M.J.

iv) Patient position

- Head is adjusted, so that the Saggital plane is vertical to floor.
- Ala - tragus line parallel to floor.

v) Review

Rest
open
closed

vi) Central ray

i) Post auricular / Lindblom technique: $\frac{1}{2}$ inch behind & 2 inch above the external auditory meatus.

ii) Breue cock approach: $\frac{1}{2}$ inch above the external auditory meatus.

iii) Mill's approach: $\frac{1}{2}$ inch anterior & 2 inch above the external auditory meatus.

6. Anemia

Anemia is reduce the Haemoglobin level in blood as compared to normal range.

classification

1) pathophysiological

A) due to ^{excessive} blood loss

- ① - acute : Haemorrhage
- chronic

② impaired red cell production.

- i) ^{impaired in cytoplasmic maturation} deficiency
- Haemo deficiency: iron deficiency anemia
- globin deficiency: thalassemia

- ii) ^{deficiency in} impaired nucleus maturation
~~extrinsic~~
~~intrinsic~~

iii) chronic disease: splenic anemia

iv) congenital

v) Bone marrow infiltration.

(C) ^{increase} destruction of red cell
- extrinsic
- intrinsic

2) morphologic

macrocytic hypochromic

normocytic normochromic

hypercytic normochromic

Iron deficiency anemia

- it is a ^{microcytic} hypochromic Anemia.
- occur due to decrease absorption of iron or excess loss of iron.

Etiology

- i) decrease absorption
 - gastrectomy

- ii) increase blood loss
 - menstrual cycle
 - war

- iii) poor intake
 - economically poor status.

- iv) increase requirement
 - pregnant
 - lactating women
 - children.

Clinical feature

- malair
- pallor on skin, mucous membrane, nail
- Dizziness
- ~~Weakness~~ Murmur
- visual disturbance
- fatigue
- tiredness

Oral manifestation

- pale dysphagia mucositis

- glossopyria

- glossodypsia

- mucositis

- Burning Sensation

- Sore mouth

- angular cheilitis

- difficulty in eating

"Plummer Vinson Syndrome": it is a triad of disease

- leukositis

- glossitis

- stomatis

- Dysphagia

Investigation

- decrease total count

- decrease MCV

- $\downarrow$ MCH

- $\downarrow$ MCHC

Treatment oral administration of iron

- ferrous Sulfate 500mg.

- parenteral administration of iron

- Iron dextros.

Megaloblastic anemia & ~~aplastic anemia~~
 deficiency of vitamin B₁₂ or folic acid.
~~neutropenic aplastic is almost same.~~
etia

- inadequate absorption.
- increase requirement.
- poor absorption.

oral manifestation

- Beefy red tongue
- Bald tongue
- Burning sensation
- Sore mouth.
- mucositis

investigations

Schilling test

1) ↓ iron from absorption

Rx
 Radioactive ~~iron~~ without
 therapy IF

2) ↓ IF from blood.

~~iron~~ without
 Radioactive
 therapy

3) involvement of microbacteria

Radio active
 therapy +
 Antibiotic

4) pancrease ~~defect~~ problem

Radioactive thy
 +
 pancreatic enzyme

investigations

↓ MCV
 ↓ MCH
 ↓ MCHC

R: ~~Good~~ T conception of vit B₁₂ ↑ req.
 oral parenteral cross therapy.

other type of anemia: aplastic anemia.
it is similar to megaloblastic.

7) Fibrous dysplasia

formation of normal bone tissue & its replacement by fibrous tissue & its 2 type monostotic & polyostotic either without endocrine abnormality.

etia

CNVAS₁ gene

↓
- Gsα acyl

↓
↑ activity of cAMP

↓
Hormonal

↓
osteoblastic effect

↓
effect bone

↓
endocrine involvement

↓
proliferation of melanocyte

↓
coffee-au-lait pigment

Types

monostotic

polyostotic

Jabber type

McCune Albright Syndrome

Clinical feature

- it occurs in embryogenesis time - McC.

- Early stage: monostotic

- late stage: polyostotic

- Age: 1st & 2nd decade of life.

- Sex: monostotic effect equally.
polyostotic effect more commonly in females.

Site = monostotic (80-85%)

Short bones: ribs, tibia, femur.
commonly seen jaw.

polyostotic: long bones.
skull, pelvic, etc.

- unicellular lesion.

- pain occurs in rare case.

- rarely occurs in monostotic type.

after that polyostotic occur in later stage.

- pathological fracture.
- McCune Albright syndrome occur with endocrinal abnormality.
- effect pituitary.
- pigmentation of skin.

Rg

Radial lucency = moth-eaten appearance.

mixed radial lucency & radial opacity } orange peel appearance
around glass appearance

Radial opacity = cotton wool appearance.

~~XXXXX~~

Differential diagnosis

Paget's disease: it occur in older age group but Fibrous dysplasia is 1st decade.
- Paget's is more common in males.

centrifugal osseous fibroma: it occur 3rd decade.
lesion is round: but fibrous dysplasia is rectangular lesion.

Treatment

- Surgery.
- Bisphosphonate.
- Calcitonin.

f) Best image

- Panoramic radiograph is a - tomographic.

- Slice picture give various diagnostic
- it use in procedure.

Indication

- pathology associate with tooth.
- pathology associate with alveolar bone.
- pathology of surrounding bone.
- TMJ disorder.

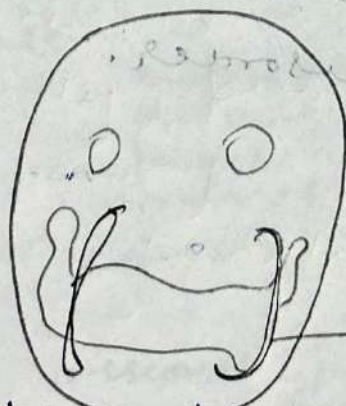
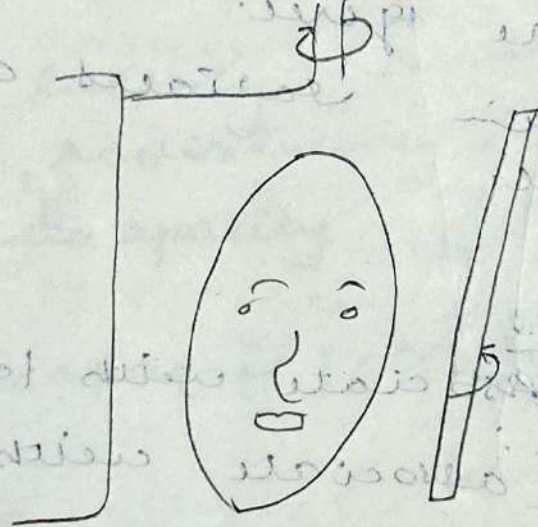
Principle under tomography.

ghost image: is a faulty image seen in panoramic radiograph.
it is one of the disadvantages of panoramic radiography.

Reason

object placed in between x-ray machine & centre point.

eg:- Ear rings appear in Rg.



ghost image of
ear ring

How to correct this problem:

- patient instructed to not wear any ornaments
- avoid wearing of ear rings, other things.

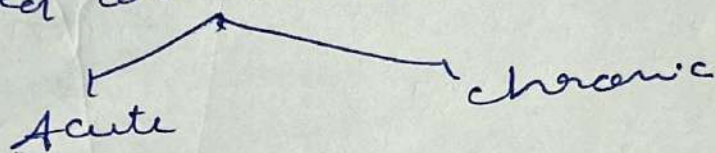
3)

osteomyelitis

Inflammation of bone begins at infected meninges of the & haemorrhagic system of cortex and it extends into periosteum of surrounding infected area.

classification

Based on duration



Acute

- Acute periosteal osteomyelitis
- Acute suppurative
- Acute periostitis

Chronic

(i) Non-specific:

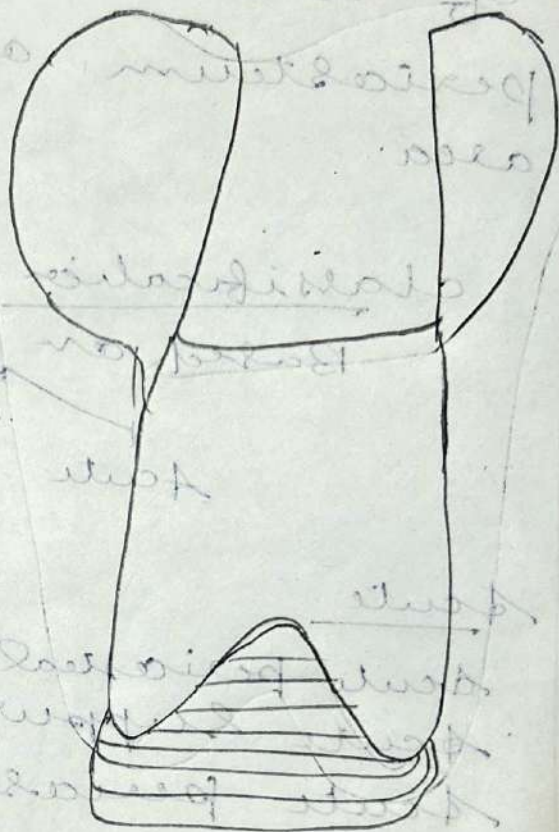
- Chronic proliferative periosteal osteomyelitis
- Chr. diffuse osteomyelitis
- Chr. focal osteomyelitis

(ii) Specific

- Tuberculous osteomyelitis
- Syphilitic osteomyelitis
- Actinomycotic osteomyelitis

Clinical feature

Chronic osteomyelitis
x chro. proliferative periosteal type



- it effect is grossly decayed teeth
- pain occur some times.
- Extra orally pus formation seen
- sinus opening seen
- pathological fracture

Other types :

- Condensing osteitis
- Osteoradionecrosis.

Rx of jaws osteomyelitis

- onion peel - appearance seen.

Treatment

- pus drainage
- Antibiotics

DEPT OF PERIODONTICS, MINDS
FINAL YEAR - IRREGULAR BATCH
FIRST INTERNAL EXAM (03rd September 2024)
MCQS (1 MARK EACH) - DURATION 30 MINS

Priyadharsini
15

1. Trauma from occlusion refers to

- ☒ a) Occlusion which causes trauma
- ☐ b) Abnormality of periodontium
- ☐ c) Changes in periodontium due to occlusal force
- ☐ d) Inflammation of periodontium

2. Principle fibres of periodontal ligament are comprised of-

- ☒ a) type I collagen
- ☐ b) type II
- ☐ c) type III
- ☐ d) type IV

3. Main function of horizontal fibres of periodontal ligament

- ☐ a) Prevent extrusion
- ☐ b) Prevent rotation
- ☐ c) Maintain the mesiodistal width
- ☒ d) All of the above

4. Brushing technique advocated after periodontal surgery

- ☐ a) Bass technique
- ☐ b) Stillmans technique
- ☒ c) Charters technique
- ☐ d) Fones technique

5. End to end joint in CEJ is seen in

- ☐ a) 5-10%
- ☒ b) 30%
- ☐ c) 60-65%
- ☐ d) 40%

6. The pattern of destruction of underlying bone in suprabony pocket is

- ☐ a) Vertical
- ☒ b) Horizontal
- ☐ c) Oblique
- ☐ d) Angular

7. Periodontal fibres reconstructed even after destruction of alveolar bone are

- ☐ a) alveolar crest
- ☐ b) horizontal
- ☒ c) transseptal
- ☐ d) oblique

8. Immunoglobulin present in saliva is

- ☒ a) IgG
- ☐ b) IgM
- ☐ c) IgA
- ☐ d) IgE

9. Major route of entry of leucocytes in oral cavity is through

- ☐ a) saliva
- ☐ b) sulcus
- ☐ c) tongue
- ☒ d) plaque

10. Infrabony pocket most commonly occur on

- ☐ a) Interproximal surface
- ☐ b) Facial surface
- ☐ c) Lingual surface
- ☒ d) All of the above

11. Major salivary enzyme is

- ☐ a) lysosyme
- ☒ b) lactoperoxidase
- ☐ c) Amylase
- ☐ d) Lipase

12. Acute TFO is caused due to

- ☐ a) Abnormal occlusal force
- ☒ b) Abrupt occlusal impact
- ☐ c) Normal occlusal force to tooth with inadequate support
- ☒ d) Excessive occlusal force to tooth with adequate support

13. Earliest sign of gingival inflammation is

- a) increase in GCF b) Gingival bleeding c) both a and b d) none

14. Disease not affecting gingival pigmentation is

- a) Addison's disease b) Peutz-Jeghers syndrome c) Albright syndrome d) Sjogren syndrome

15. Other name of Spiral pocket is

- a) compound b) complex c) simple d) none

16. Relative volume of PMN to lose tissue cohesiveness in JE is

- a) 40% and more b) 50 c) 60 d) 25

17. Number of Zones seen in the tooth wall in periodontal pocket are

- a) 3 b) 4 c) 5 d) 6

18. Average width of PDL is

- a) 0.1mm b) 0.2mm c) 0.3mm d) 0.4mm

19. Clinical indicators of occlusal trauma include all, except

- a) Periodontal pocket
b) Tooth migration
c) Tenderness on percussion
d) Increased width of PDL

20. Cells of gingival epithelium that plays a role in immune reaction

- a) Langerhans cells b) Merkel cells c) Melanocytes d) Corneocytes

21. Principal cell type of gingival epithelium is

- a) Melanocyte b) Keratinocyte c) Fibroblast d) Langerhans cells

22. Lamina dura is formed of which bone

- a) Bundle bone b) Cancellous bone c) Woven bone d) Lamellar bone

23. Gingival epithelium is attached to lamina propria by

- a) Sharpeys fibres b) basement membrane c) Hemidesmosomes d) Reticular layer

24. A universal curette is called so

- a. Has only 1 cutting edge
b. Is used world-wide
c. Can be used on all surfaces on teeth
d. Is most accepted by periodontists

25. Inorganic content of cementum is

- a) 45-55% b) 55-65% c) 65-75% d) 75-85%

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INTERNAL ASSESSMENT BOOK

SUBJECT: *Periodontics*

Tick Questions Attempted :

Q₁ ☒

Q₂ ☒

Q₃ ☒

Q₄ ☒

Q₅ ☐

Q₆ ☒

Q₇ ☒

Q₈ ☒

Q₁ 5 10

Q₅ — 5

Q₂ 7 10

Q₆ 3 5

Q₃ 3 5

Q₇ 14 5

Q₄ 1/2 5

Q₈ 24 5

No. of Additional

TOTAL

23 45

Priya Dharshini

Sheets used.

Total in Words *Twenty three*
Evaluated by: *Dr. Nandini*

Name of the candidate: *C. Priya Dharshini*
Reg. No: 19DS0261

Signature *Priya Dharshini*
Date: 3/9/2024

Sane
31/9/24
Signature of Invigilator

Section-A

1. Periodontal Pocket:

Periodontal Pocket is the pathological deepening of gingival sulcus.

Classification:

Based on bone location.

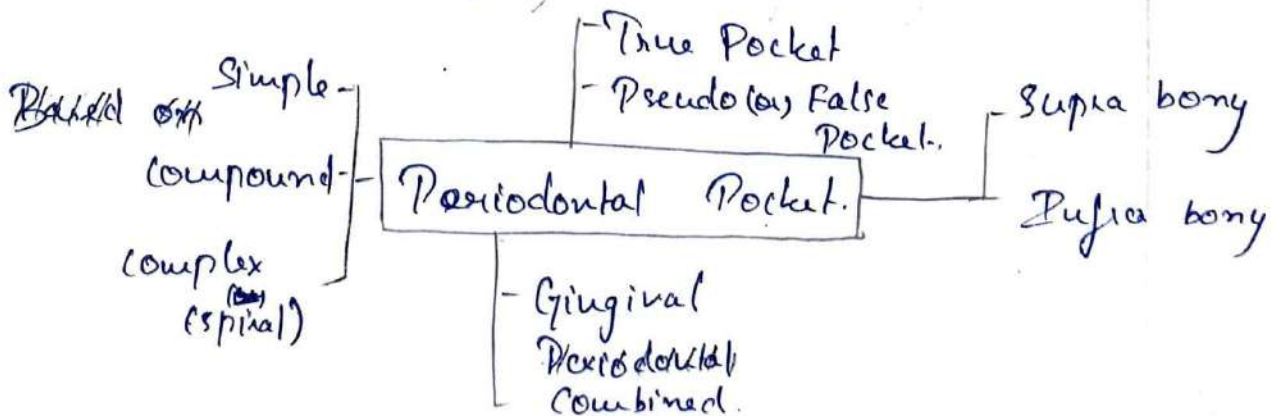
Supra bony

Suba bony

Normal

Supra bony

Suba bony.



Pathogenesis of Pocket Formation.

Content of Pocket:

GCF

Saliva mucin

Food debris

enzymes, leucocytes

Bacterial invasion.

Sometimes Purulent Exudates are also seen.

Steps:

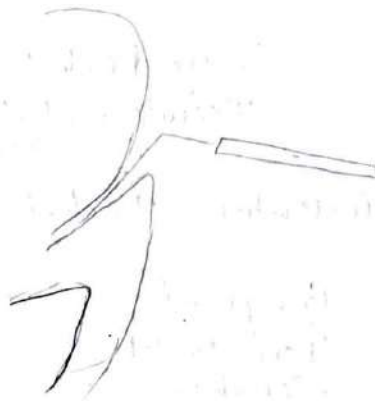
Formation of Plaque.

Invasion of Bacteria.

Migration of Neutrophils.

Tissue Destruction.

Pocket Formation.



Probing depth.

Plaque Formation on the Junctional epithelium

Inflammation is seen.

Proliferation of Spirochaetes or gram negative bacterial

collagenous Fibres.

Destruction of collagen fibre by metalloproteinase.

Destruction by ligament.

Loss of collagen

Proliferation of Macrophages. phagocytes.

Loss of Attachment in the Junctional epithelium.

Increase in Neutrophils.

Destruction of Tissue of the tooth

Increase in gram negative bacteria

Increase in Number of Neutrophils.

Destruction of Epithelium / Emigration of Neutrophils.

Functional epithelium

Replaced by the

Pocket

Formation

Emigration of Neutrophils.

Tissue Destruction

Tooth Resorption.

Pocket Formation.

Treatment :

Supra bony.

Anterior

Posterior.

Scaling and Root Planning

Scaling & Root Planning

Revaluation

Revaluation

Curettage

Flap surgery

Flap surgery

Supra bony

Scaling

Revaluation

Flap surgery.

Pseudo Pocket

Scaling

Revaluation

True Pocket

Scaling

Revaluation

Flap Surgery

2. Periodontal Ligament :

Periodontal ligament is a avascular mesenchymal tissue that connect the root of the tooth ^{to} of the alveolar bone.

Function of Periodontal ligament :

Physical Function.

Protective Function

Supportive Function

Sensory Function

Attrition Function

Hemostatic Function.

Physical Function:

It helps to withstand the occlusal force of the tooth.

Protective Function:

It protect the tooth during masticatory force by ~~transferring~~ transferring the

PDL Fibres:

Trans-septal group

Alveolar Crest fibres

Horizontal Fibres

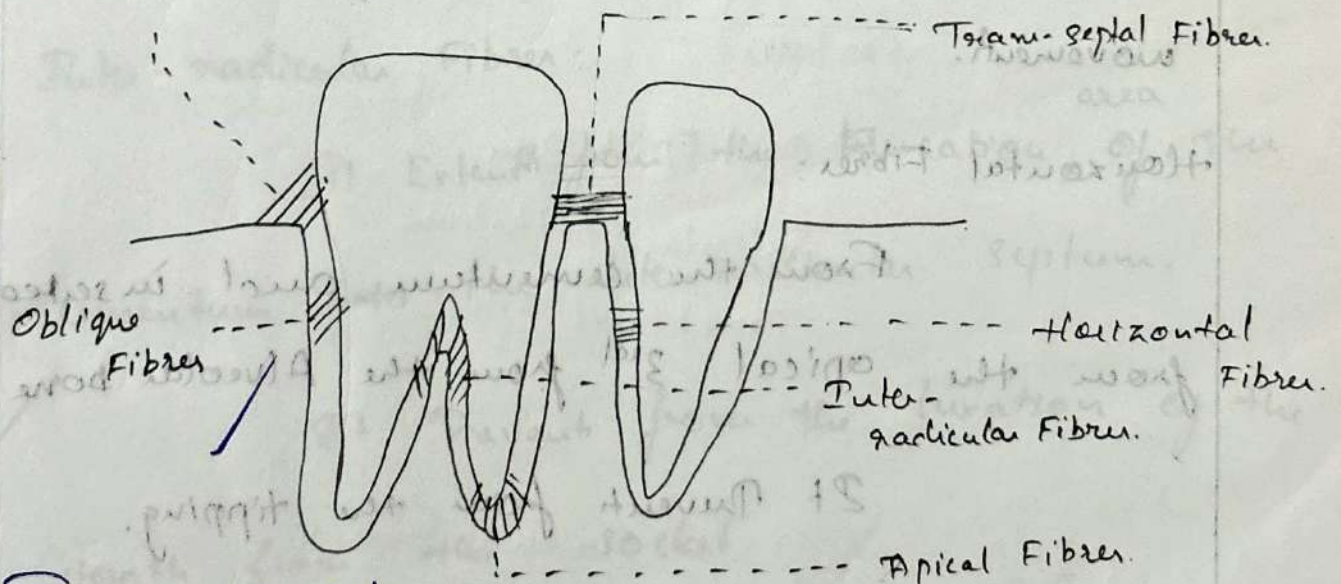
Oblique Fibres

Apical Fibres

Inter-radicular Fibres

Trans-septal Fibres:

It Extends from the Cervical to the Alveolar-crest group



Trans-septal Fibres:

It Extends from the Cervical margin of the one tooth and inserted to the cementum of the adjacent tooth.

It Prevents from the destruction of the
Periodontal surgery. It Prevents from destruction
after Periodontal surgery.

It bring back the tooth to the
normal state after the orthodontic treatment.

Alveolar crest of fibres:

It Extent from the cementum to the
Alveolar bone.

It Prevent the tooth from the lateral
movement.

Horizontal Fibres:

From the cementum and inserted in
from the apical 3^{rd} from the Alveolar bone.

It Prevent from the tipping.

Oblique Fibres:

It Extent from the cementum and
inserted to the $1/3^{rd}$ of apical portion of the

Alveolar bone.

It Prevent the tooth from mesio-distal movement.

Apical Fibres:

Apical Portion of the

It Extends from the Cementum to the fender of the bone.

It holds tight the tooth.

It Prevents from luxation.

Inter-radicular Fibres:

It Extends from the Plication area of the Cementum to the inter-radicular septum.

It Prevents from the luxation of the tooth from the socket.

Section - B.

3. Junctional Epithelium:

Gingiva is the part of the oral mucosa that surrounds the jaw of the alveolar bone and neck of the tooth.

Macroscopic features:

Marginal gingiva.

Attached gingiva.

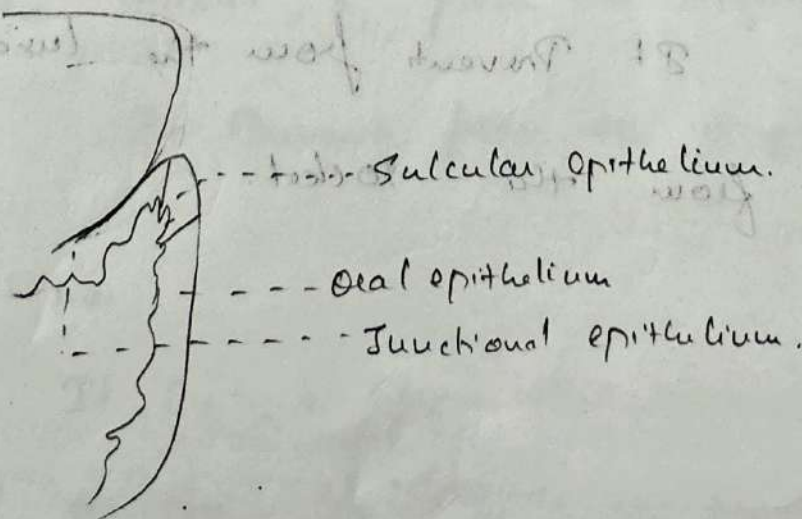
Peridontal gingiva.

Microscopic features:

Oral Epithelium

Sulcular Epithelium

Junctional Epithelium



Functional epithelium:

It is thin, non-keratinized. Squamous epithelium without rete pegs.

It continues along the surface of the enamel.

It is in contact with both hard tissue and soft tissue.

Functional Epithelium of 2 types.

Primary JE

Secondary JE

Primary JE :

It is formed by the ameloblastoma.

Secondary JE :

It is formed after surgery from the

basal cells

Formation of JE :

Enamel is at the occlusal surface.

Ameloblastoma is attached.

Ameloblastoma changes into cuticle.

These cuticle attached to the marginal surface of the enamel.

Reduced Enamel Epithelium Formed.

Eruption of tooth.

Cuticle + REE

Junctional epithelium is formed.

concept of JE:

Gottlieb concept:

When the Junctional epithelium is attached to the tooth surface.

Wachung concept:

When JE slightly detach but not has gap between the tooth and the Junctional epithelium.

Schroeder's concept:

When the basal layer along is connected the tooth.

JE into 3 types:



overlapping

Edge to Edge

gap.

when TE overlap

the enamel

60-65%

overlapping

when TE

and enamel

meet.

30-35%

Edge to Edge

when there is gap between TE & enamel.

5-10%

gap.

4. Modified Ban technique:

The brush is placed at 45° angle and placed in the marginal sulcus and interproximal area and move along the surface of the tooth and also vibratory movement in ban technique is also given (back and forth movement is given as in ban technique)

In occlusal stroke and vibratory movement is given.

It is for all Patient.

Patient with high Plaque formation.

Advantages:

It is to remove the Plaque from the interproximal area.

It is the efficient technique.

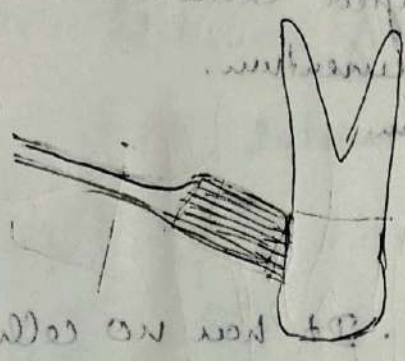
It remove the Plaque completely.

Disadvantage:

It consumes time.

Each tooth to be cleaned

1/2



(45° angle)

6. Cementum - Classification

calcified

Cementum is a vascular and highly cellular tissue that surrounds the tooth to the alveolar bone.

Classification:

> Based on location.

- Coronal

- Radicular

> Based on cellularity

- Cellular

- Acellular

- Intermediate

> Based on Presence or absence of fibres.

- Acellular A-fibrillar Cementum

- Acellular I-fibrillar Cementum

- Acellular E-fibrillar Cementum

- Cellular mixed stratified Cementum.
- cellular intrinsic ^{Fibre} Cementum.
- Intermediate Cementum.

⇒ Acellular Cementum:

It is a Primary. It has no cells. because it is acellular.

⇒ Cellular Cementum:

It is secondary fibres. It is formed first.

⇒ Intermediate Cementum:

It is seen in Pre-cervical to the apical $\frac{1}{3}^{th}$ area. It arises from the remnant of Hertwig's.

⇒ Acellular Afibrillar cementum.

Only mineralized fibres seen. There is no collagen fibres or Cementocytes.

It is the product of cementoblast cells.

⇒ Acellular Intrinsic fibres:

Cementoblast cells are seen. There is no cementocytes. cells. This is first formed fibres.

⇒ Acellular Extrinsic fibres:

Sharp fibres are seen.

⇒ Cellular mixed stratified Fibres:

Both intrinsic and Extrinsic are seen.

Cellular Pulpinec fibres:

Only Pulpinec are seen. No Extrinsic fibres are seen.

7. Stages of TFO

When the Abnormal force or adaptive force act on tooth, tissue injury results. This result in tissue injury is known as Trauma from occlusion.

Primary TFO [Acute
Secondary TFO [Chronic

Stages of TFO:

Stage I → Injury

Stage II → Repair

Stage III

→ Remodelling

Adaptation

Stage I - Injury:

When the normal masticatory or occlusal force is given, the force is transferred to the all tooth. When it cannot withstand the occlusal force, tissue injury takes place.

Repair :

Repair is the reparative of the tooth.
When the force is applied, the force are applied to all tooth to withstand the ~~set~~ force.
The new bony trabeculae is formed in this stage.

Remodelling:

During this stage, it prevents from injury of the tooth.

Widening of PDL is seen as funnel-shaped in radiograph.

In this stage, stress bone are less effective.

8. Gingival Fibre:

⇒ Principle Fibres:

⇒ Secondary Fibres:

Principle Fibres:

- Dento-gingival Fibres.

- Alveolo-gingival Fibres.

- Dento-Parosteal Fibres.

- Circular Fibres.

- Trans-septal or Septal Fibres.

Secondary Fibres:

- Semi circular Fibres
- Inter-circular Fibres
- Inter-Papillary Fibres
- Trans-Periapical Fibres
- Periapical Fibres

Fibres	Extent	Function.
Dento-gingival Fibres.	Cervical portion of tooth	Marginal gingiva.
Alveolo-gingival Fibres	Alveolar bone	Marginal gingiva.
Dento-Periapical fibre	Cervical portion of tooth.	Periapical.
Circular fibres	around the tooth	Cementum.

DEPT OF PERIODONTICS MINDS
FINAL YEAR IRREGULAR BATCH
SECOND INTERNAL EXAM (December 2024)
MCQS (1 MARK EACH) - DURATION 30 MINS

1. Major compound responsible for intraoral halitosis is:

- a. Methyl mercaptan b. Hydrogen sulphide
 c. Dimethyl sulphide d. Trimethylamine

2. Which of the following fiber groups can be observed even in case of extreme periodontal bone loss?

- a) Circular gingival fibers b. Gingivo-dental fibers
 c) Transseptal fibers d. Alveolar crest fibers

3. Chronic Periodontitis is considered generalized Periodontitis, when the number of sites in the mouth with attachment loss and bone loss are:

- a) > 30% b. > 40%
 c) > 50% d. > 60%

4. Which component of a true Perio-Endo combined lesion is most difficult to treat?

- a) Periodontal lesion b. Endodontic lesion
 c) Both Perio. & Endo. Lesions d. None of the above

5. Gold standard for diagnosis of halitosis is:

- a. Gas chromatography b. Chemical sensor
 c. BANA test d. Organoleptic rating

6. Bony exostoses of the alveolar bone are more commonly seen on which surface?

- a) Buccal b. Lingual
 c) Palatal d. Proximal

7. A periodontal flap using only horizontal incisions is called:

- a) Horizontal flap b. Unrepositioned flap
 c) Envelope flap d. Postal flap

8. The average diameter of bristles used in an interdental brush is:

- a) 0.075 mm b. 0.15 mm
 c) 0.25 mm d. 0.50 mm

9. The recommended dose of Doxycycline in the form of low dose Tetracyclines for host modulation in periodontal disease is:

- a) 10 mg, once a day b. 10 mg, thrice a day
 c) 20 mg, twice a day d. 20 mg, thrice a day

10. Chronic Periodontitis is considered severe, when the attachment loss is:

- a) 3mm or more b. 4mm or more
 c) 5mm or more d. 6mm or more

11. The method suited for children are:

- a) bass method b) charter method
 c) fones method d) stillman method

12. The initial incision in case of modified Widman flap is:

- a) A straight non-scalloped incision
 b) To the crest of alveolar bone
 c) To a point apical to the alveolar crest
 d) Crevicular incision

Priyadharsini

13. The major complication to treatment of Perio- Endo combined lesions is :

- a) Pulpal pathology
- b) Lateral canals
- c) Contaminated root surface due to periodontitis.
- d) Periapical granuloma

14. Several systemic diseases produce volatile substances detectable on the breath. Which of the following disorders is most likely to produce a fruity odor of acetone on the breath?

- a) Liver failure
- b) Diabetic ketoacidosis
- c) Renal failure
- d) Heart failure

15. Which prostaglandin is considered to be the most potent one to stimulate bone resorption?

- a) PGE1
- b) PGE2
- c) PGF1
- d) PGF2

16. The major purpose of modified Widman flap procedure is:

- a) To facilitate periodontal instrumentation
- b) To reduce pocket depth
- c) To remove pocket wall
- d) All of the above

17. Microorganisms associated with attachment loss and bone loss in chronic Periodontitis belong to which of the following complex?

- a) Green complex
- b) Yellow complex
- c) Orange complex
- d) Red complex

18. The major purpose of internal bevel incision in conventional flap techniques is:

- a) Removal of pocket lining
- b) Removal of pocket wall
- c) To gain access to the underlying bony defects
- d) To act as releasing incision

19. Morning bad breath is a type of:

- a) Physiological halitosis
- b) Pathological halitosis
- c) Pseudo halitosis
- d) Intraoral halitosis

20. In periodontology the most sensitive diagnostic test for the detection of periodontitis is:

- a) Measurement of pocket depth.
- b) Measurement of attachment loss
- c) Measurement of distance between alveolar crest and CEJ on bitewing radiograph
- d) Computer Assisted Densitometric Image Analysis. (CADIA)

21. In a true Perio-Endo combined lesion, which component should preferably be treated first?

- a) Periodontal lesion
- b) Endodontic lesion
- c) Both Perio. & Endo. lesions simultaneously
- d) Any of the above

22. The term Radius of action was coined by

- a) Glickman
- b) Tarnow
- c) Prichard
- d) Page and Schroder

23. The Term 'Hemiseptum' in relation with periodontal bone defects is used to represent

- a) Half wall vertical defect
- b) One wall vertical defect
- c) Two wall vertical defect
- d) Three wall vertical defect

24. Which of the following is a preparation of Chlorhexidine used as local drug delivery system in periodontal pockets?

- a) Periochip
- b) Periostat
- c) Periocline
- d) Peridex

25. The most preferred dental floss for plaque removal from fixed partial dentures or orthodontic appliances is:

- a) Waxed floss
- b) Unwaxed floss
- c) Knitting yarn
- d) Super floss

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CHALAKKARA, MAHE
U. T. OF PUDUCHERRY - PIN 673 333

INTERNAL ASSESSMENT BOOK

SUBJECT: Periodontics

Tick Questions Attempted:

Q₁ ☒

Q₂ ☒

Q₃ ☒

Q₄ ☒

Q₅ ☐

Q₆ ☒

Q₇ ☒

Q₈ ☒

Q₁ 3 1/2 10

Q₅ 5

Q₂ 3 10

Q₆ 3 5

Q₃ 1 5

Q₇ 1/2 5

Q₄ 2 5

Q₈ 2 1/2 5

No. of Additional

TOTAL

Sheets used.

15 1/2 45

Riyaalharashini

Total in Words

Evaluated by:

Do A. Subramanian

Name of the candidate: C. Riyaalharashini

Reg. No: 17DS0261

Signature Riyaalharashini

Date: 4/12/24

Signature of Invigilator



Section A.

1. Tooth brush:

Tooth brush removes plaque, food debris, etc.

length 12cm long

width 2-3 cm

tufts 5-12

bristles 40-50

⇒ Mechanical Plaque control
Tooth brush.

interdental aid. (Dental Floss)

⇒ chemical Plaque control.

Part.

~~Body~~ handle.

head.

Handle:

To hold the brush tightly, or grasp the brush.

Head:

It contains tufts which has bristles. The head

Part clean our teeth

Soft - 0.2 mm

Medium - 0.3 mm

Hard - 0.4 mm

Brushing technique:

Vibratory - Charter's Method, Ban technique,
Modified ban technique.

Rotatory - Charter's Method

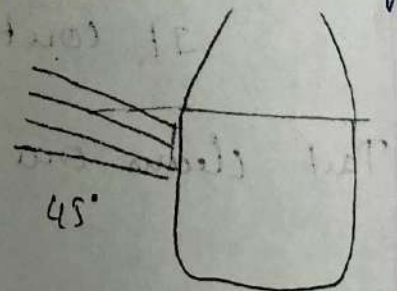
Circular - Fones Method.

Horizontal - Modified Stillman Method

Vertical - Scrub method

Charter's Method:

The toothbrush is placed at 45° angulation in the interproximal area. and gives rotatory and vibratory force, which further goes to occlusal surface as rotatory force.



Advantage:

Fang method.

Mostly Plaque removed

Disadvantage:

Interdental Plaque not removed.

Ban Method:

The toothbrush is kept at 45° angulation and gives back and forth motion. The brush is placed at the interproximal area.

Advantage:

It is widely used.

It is used after Periodontal surgery.

Disadvantage:

It is difficult to learn.

Time consuming technique.

Modified Ban Technique:

The toothbrush is placed at 45° angulation. It is as same as Ban technique along with the backward motion.

Advantage:

It is recommended technique.

It is used after immediate Periodontal surgery.

Fixed Orthodontic treatment.

Disadvantage:

Time-consuming technique

Modified Stillman technique:

The toothbrush is placed at 45° angulation and moved mesially and distally.

Advantage:

It is used in fixed orthodontic treatment.

Disadvantages:

Plaque accumulation is still present

Scrub Method:

The toothbrush is kept at 90° angulation.

Fones Method:

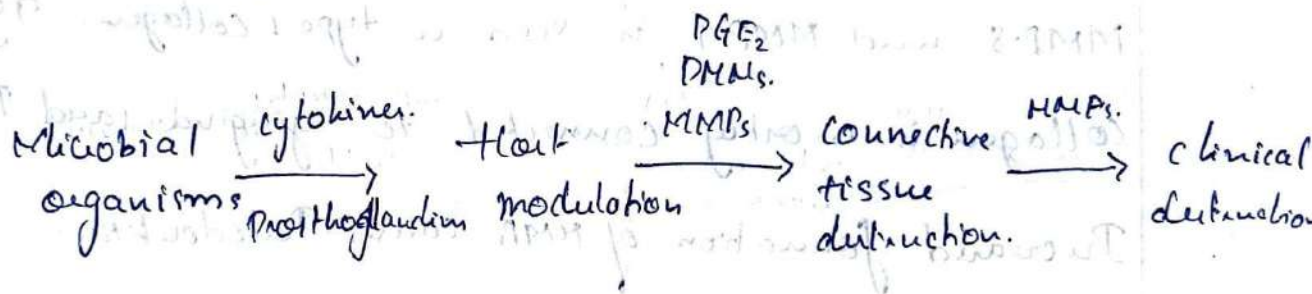
The toothbrush is kept at 90° angulation and circular movement is given.

Advantages:

It is widely used in children.

2. Host Modulation:

Host modulation is a concept of destruction of tissue and stability or even regenerate of Periodontium by degeneration or down-regulating the host response by the up-regulating the tissue response.



Classification:

Locally

- > NSAIDs [Non-steroidal Anti-inflammatory drugs]
- > Growth hormone
- > Enamel Matrix protein

Systemic.

- > NSAIDs.
- > Bisphosphonates.
- > SDD [Sub-Antimicrobial dose doxycycline].

Sub-Antimicrobial dose doxycycline:

It is administered both systemic and locally
But widely systemic Administration.

20gamm of SDD is given for the Periodontal Problem along with SRP, SDD adjunct is given for better reduction in bone destruction.

MMPs which causes increased destruction of alveolar bone. SDD inhibit the MMPs. and inhibits MMP-8 and MMP-9 is seen in type I collagen. Type I collagen is mostly connected to gingiva and Periodontium. Increased formation of MMP causes Periodontitis.

The use of tetracycline in SDD gives reduction of bone destruction. The recommended dose of Doxycycline in form of low tetracycline for host modulation in Periodontal disease is 20mg, twice a day.

Doxycycline also inhibits osteoclast formation.

Use of tetracycline after SRP is a gold standard. The data intake of SDD in rheumatoid arthritis, Diabetic Mellitus and skin disease Patient, seems to have less low Periodontal Problem. Doxycycline in Diabetic Mellitus Patient maintain glycemic level.

3 The effect of SDD after SRP shows a regenerative by the formation of collagen, osteoblast and bone formation. There is CAL of 0.5mm after SRP but with SDD CAL is gained by 0.3mm. Section - B.

4. VSCs.

Volatile sulphide compound.

Volatile sulphide compound is formed by the

2 Prokolytic degeneration of microorganism in saliva, interdental Plaque, blood.

VSCs contain: Methyl Mercaptan, Hydrogen sulphide, Dimethyl sulphide.

Diagnosis:

Portable volatile sulphide (Halimeter):

It shows any volatile causes organism is present like methyl mercaptan, hydrogen sulphide.

Gas chromatograph:

Portable volatile sulphide does not differentiate the organism but Gas chromatograph differentiate the organism.

Treatment:

Mechanical Method: toothbrush, Dental floss.

Chemical Method: Mouthwash. with chlorhexidine.

Oxidizing by Hydrogen Peroxide.

Masking: Chewing gums.

6. Modified Widman flap:

Flap is defined as section of gingiva or mucosa surgically separated from the underlying supporting tissue which provides visibility and access to the bone and root surface.

Modified widman flap:

It is a scalloped, mucoperiosteal

Procedure with internal bevel resection.

Indication:

and in exposure of bone and root surface.

Periodontal Pocket depth are seen.

Diffuse bony Pockets.

deep Periodontal Pockets.

Contraindication:

Very deep Pockets.

Medically compromised Patient.

Patient with systemic disease.

Classification of flap.

Based on Exposure:

Full thickness Flap.

Partial thickness Flap.

Based on papilla exposure displacement.

Undisplaced.

Appically displaced Flap.

Modified Widman Flap.

Undisplaced flap.

Papillary Preservation Flap.

Based on displacement:

Non-displaced Flap.

Displaced Flap.

Modified Widman Flap. Procedure:

Internal bevel incision.

Reflection of flap.

Crevicular incision.

Interdental incision

Removal of tissue tags and granulation tissue

Adaptation of flap.

Suture with simple interrupted suturing technique.

Internal Bevel incision:

2-3 mm from the margin, internal bevel

incision is given.

Reflection of flap:

Flap is reflected by the Periosteal Elevator.

Crevicular incision:

3 mm below the Pocket, Crevicular incision

given.

Interdental incision:

If needed, interdental incision at proximal

side is given.

Removal of tags:

Tissue tags and granulation tissue to be removed by tissue scaler instruments.

Adaptation of flap:

Flap to be reattached in a healthy bone.

Suture:

Simple interrupted suturing technique.

2
To prevent soft tissue damage, complete soft tissue is involved.

To stop the bleeding, Full thickness of muco-periosteal is raised.

The base of the flap to be wide.

Incision to be made by sharp scalpel.

7. Chronic Periodontitis:

Chronic Periodontitis is a infection of the inflammation of the supporting teeth, underlying loss of attachment and bone loss.

Based on distribution.

- Localized
- Generalized.

Based on loss of attachment.

- Mild
- Moderate
- Severe.

It is seen at the age of 30 to 35. both male and female are commonly affected.

Mostly generalized with deep in localized area

Risk Factor:

Microbial Factor:

- *P. gingivalis*.

- *C. Rectus*.

- *Intermedia*.

Local Factor.

- Plaque accumulation.

- Plaque retentive force.

Systemic Factor:

- Diabetic Mellitus.

- Immunological Factor.

- Hormonal Factor.

Behaviour Factor:

- Smoking

- Emotional Stress.

Genetic Factor:

- Genetic Predisposition.

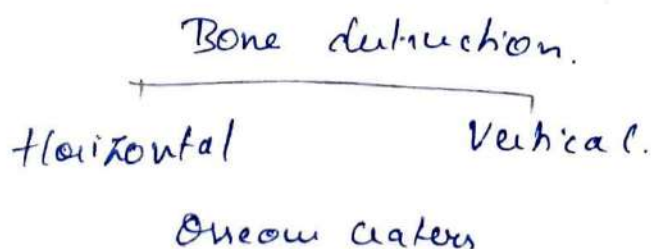
~~Septicemia~~ Parag.

- ⇒ Bull pain. Pain radiating to jaw.
- ⇒ Painless. Sometimes.
- ⇒ Gingival inflammation
 - moderate swollen inflammation is seen.
 - scalloped round margin.
 - Redden of gingiva.
 - Bleeding on probing.
- ⇒ Periodontal Pocket:
 - Pocket is seen.
 - loss of attachment.
- ⇒ Mobility:
 - In advanced stage mobility of teeth.

Treatment:

- Initial therapy
- Periodontal therapy
- Final restorative therapy
- Maintenance therapy.

8. Osseous craters:



Horizontal bone loss:

It is most commonly seen bone loss.

It shows varying resorption of surface of the same teeth.

The height of the bone is reduced.

Following inflammation, destruction of bone loss.

Vertical bone loss:

Angular defect.

Defect bony defect.

Interdental bone loss.

Periodontal Pocket is seen.

Oblique destruction of the bone.

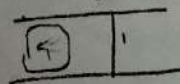
through-out of root resorption.

→ One wall defect

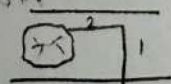
→ Two wall defect

→ Three wall defect

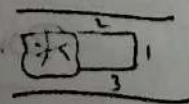
→ Combination defect.



1 wall defect



2 wall defect



3 wall defect

sinus buttress:

The resorption of bone is followed by the formation of new bone causes buttress.

The bone become density.

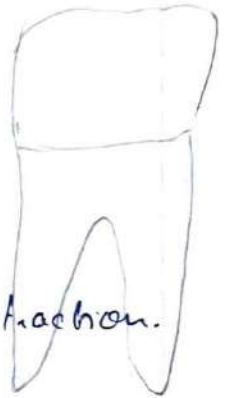
29

Thin cortical interdental bone followed by new bone formation.

The root Appears large.

Difficulty in Extraction.

It causes necrosis of bone after extraction.



3. Primary Endo Secondary Perio Lesion.

Classification:

Primary Pseudo-Lesion.

Primary endo Secondary Perio Lesion.

Primary endodontic treatment is given. Root canal treatment after the completion of the procedure. Periodontal therapy is then proceeded.

13
25

DEPT OF PERIODONTICS MINDS
FINAL YEAR IRREGULAR BATCH
THIRD INTERNAL EXAM (February 2025)
MCQS (1 MARK EACH) - DURATION 30 MINS

- ✓ 1. Buttressing bone formation is a
 - a) Congenital Abnormality
 - b) Occurs Endosteally
 - c) Occurs Periosteally
 - ✓ d) Due to Trauma Form Occlusion
- ✓ 2. Gingival abscess involves
 - a) Marginal
 - b) Inter Dental
 - c) Attached
 - ✓ d) Marginal & Interdental
- ✗ 3. Inflammatory changes in the soft tissue surrounding an implant is diagnosed as
 - a) Peri-implant gingivitis
 - ✓ b) Peri-implantitis
 - c) Pen-implant mucositis
 - d) Peri-implantosis
- ✓ 4. First implant system developed?
 - ✓ a) Noble biocare – Branemark
 - b) Noble biocare - Steri Os
 - c) ITI – Strauman
 - d) Astra
- ✗ 5. Internal bevel gingivectomy is:
 - a) Apically displaced flap
 - b) Distal molar surgery
 - ✓ c) Widman flap
 - d) Undisplaced flap
- ✗ 6. Decalcified freeze-dried bone graft is an example of
 - a) Xenograft
 - b) Autograft
 - ✓ c) Alloplast
 - d) Allograft
- ✗ 7. Based on Bokenkamp's grading of enlargements, an enlargement covering 3/4th of the crown is considered as
 - a) Grade I
 - ✓ b) Grade II
 - c) Grade III
 - d) Grade IV
- ✗ 8. Diffuse gingivitis includes
 - a) Marginal gingiva
 - b) Marginal and papillary gingiva
 - c) Marginal, papillary and attached gingiva
 - ✓ d) Marginal, papillary, attached and alveolar mucosa
- ✗ 9. Which of the following bacteria is considered a primary pathogen in chronic periodontitis?
 - a) Streptococcus mutans
 - ✓ b) Porphyromonas gingivalis
 - c) Treponema pallidum
 - d) Lactobacillus casei
- ✓ 10. Which of the following medications can cause gingival overgrowth?
 - a) Metformin
 - ✓ b) Phenytoin
 - c) Atenolol
 - d) Ibuprofen
- ✓ 11. What HbA1C level indicates poorly controlled diabetes, which may negatively affect periodontal treatment outcomes?
 - a) Below 5%
 - b) 5%–6%
 - c) 6%–7%
 - ✓ d) Above 8%
- ✓ 12. What is trauma from occlusion primarily caused by?
 - ✓ a) Poor oral hygiene
 - ✓ b) Excessive occlusal forces on teeth
 - c) Genetic predisposition
 - d) Inadequate fluoride exposure

- ✓ 13. Which of the following is NOT a common symptom of trauma from occlusion?
- a) Tooth mobility
 - ~~c) Pus discharge~~
 - b) Sensitivity to biting or pressure
 - d) Tooth migration
14. Intrabony defects are
- ~~a) one-walled defect~~
 - c) three walled defects
 - b) two-walled defects
 - d) combination of above
- ~~15. Local irritating factors in gingiva will most likely give rise to:~~
- ~~a) Pyogenic granuloma~~
 - c) Mucosal cobble stoning
 - b) Generalized fibrous hyperplasia of gingiva
 - ~~d) Periapical abscess~~
- ✓ 16. For better osseo integration modifications on implant surfaces include -
- a) Sandbasting with Aluminum oxide
 - c) Plasma sprayed Titamum
 - b) Etching with Phosphoric acid
 - ~~d) All of the above~~
- ~~17. Which of the following is a mucogingival surgery~~
- ~~a) Free gingival graft~~
 - c) Gingivectomy
 - ~~b) Widman flap~~
 - d) Gingivoplasty
- ✓ 18. Anorganic bone is an example of
- a) Autografts
 - c) Alloplasts
 - ~~b) Xenografts~~
 - d) Allografts
- ✓ 19. Transplantation between genetically different members of the same species is termed as
- a) Autograft
 - ~~c) Allograft~~
 - b) Isograft
 - d) Xenograft
- ~~20. Dilantin hyperplasia is treated with~~
- ~~a) Gingivectomy~~
 - ~~c) Apically repositioned flap~~
 - b) Gingivoplasty
 - d) Curettage
- ✓ 21. Which systemic condition is most strongly linked to periodontal disease?
- a) Hypertension
 - c) Osteoarthritis
 - ~~b) Diabetes Mellitus~~
 - d) Parkinson's Disease
22. Periodontal disease during pregnancy has been associated with:
- ~~a) Macrosomia~~
 - ~~c) Neural tube defects~~
 - b) Preterm birth and low birth weight
 - d) Eclampsia
23. A tooth with a deep periodontal pocket and a non-vital pulp is most likely to have:
- a) Primary periodontal disease
 - b) Primary endodontic disease with secondary periodontal involvement
 - c) Primary periodontal disease with secondary endodontic involvement
 - ~~d) true combined lesion~~
24. Which inflammatory marker is most elevated in both diabetes and periodontitis?
- a) Interleukin-4 (IL-4)
 - c) Interferon-gamma (IFN- γ)
 - ~~b) Tumor necrosis factor-alpha (TNF- α)~~
 - d) Platelet-derived growth factor (PDGF)
25. Which radiographic feature is commonly associated with trauma from occlusion?
- a) Horizontal bone loss
 - ~~b) Widening of the periodontal ligament (PDL) space~~
 - c) Pulpal calcification
 - d) Presence of caries

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

INTERNAL ASSESSMENT BOOK

SUBJECT: *Periodontics.*

Tick Questions Attempted :

Q₁ ☒

Q₂ ☒

Q₃ ☒

Q₄ ☒

Q₅ ☒

Q₆ ☐

Q₇ ☒

Q₈ ☒

Q₁ 4 10

Q₅ 1 5

Q₂ 3 1/2 10

Q₆ 5

Q₃ 2 5

Q₇ 1 5

Q₄ 2 1/2 5

Q₈ 1 1/2 5

No. of Additional

TOTAL

15 45

Sheets used.

Total in Words *Fifteen*

Evaluated by: *P. Sanka*

Name of the candidate: *C. Prayadharshini*
Reg. No: *19DS0261*

Signature *Prayadharshini*
Date: *5/2/25*

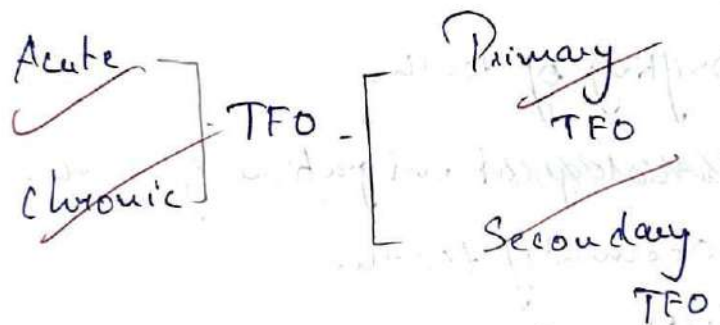
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Signature of Invigilator

Section - A.

1. Trauma From Occlusion: *occlusal Jones*

When the trauma from occlusion exceeds the ~~adaptive~~ capacity of the tissue, tissue injury results. This tissue injury result is known as Trauma from occlusion.

classification.



Acute TFO:

When the TFO results on biting on the hard object.

Etiology:

Overhanging restoration.

Prosthesis.

Orthodontic bands.

Cause:

TOOTH mobility

~~on~~ cusp fracture.

Fractured restoration.

Chronic TFO:

When TFO results from drifting movement of teeth, extrusion, etc.

Etiology:

Drifting of teeth.

Pathological migration of teeth.

movement of tooth.

Tilting of teeth.

Primary TFO:

When trauma from occlusion results from the alteration of occlusion, the tooth cannot withstand the force.

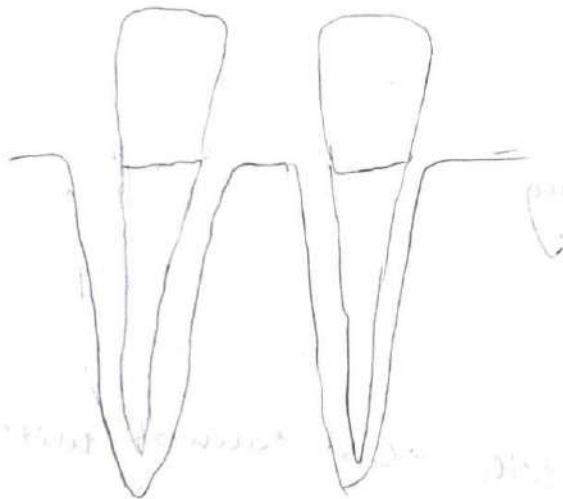
In this the PDL is healthy & the bone level is normal.

Cause:

Tooth mobility

Sensitivity to cold & heat

Weakening of PDL. Excessive force



Secondary TFO:

When TFO results from the excess force of the occlusion that cannot resist the occlusal force

In this PDL is weakened & loss of bone is

seen.

Cause:

Tooth mobility,

Sensitivity of cold & heat.

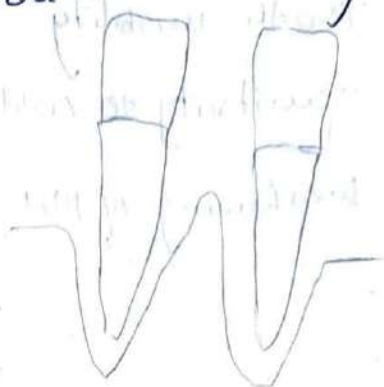
Bone loss.

Loss of Attachment

The tooth that cannot withstand the normal force of occlusion is secondary TFO.

Stages:

- > Injury ✓
- > Repair ✓
- > Remodelling ✓



Injury:

The tooth that cannot withstand the force, the tissue injury begins.

There is bone loss, weakening of PDL.

Injury to soft tissues.

Mobility is seen.

Repair:

Then, by themselves, Repair takes place.

Resorption of bone, replaced by formation of bone.

Buttressing of bone is seen in this stage.

Remodelling.

when the formation of bone fails to take place. Repair does it take place.

Remodelling of PDL takes place.

The tooth themselves comes to the

original form.

Management:

- Occlusal plane.
- Permanent or temporary splinting.

2. Endopara lesion:

Simon's classification:

Primary Endo-lesion.

Primary Endo and secondary Prio-lesion.

Primary ~~Endo~~ Prio-lesion.

Primary Prio lesion and secondary Endo-lesion.

True Combined lesion.

Primary Endo-lesion:

the endodontic lesion is seen,

eg: Non-vital tooth, Deep caries involving

Pulp.

Treatment: RCT.

Primary Endo & secondary Prio-lesion.

But 1st Endodontic lesion occurs through

that Prio-lesion takes place.

eg: Due to the caries, the Necrosis of the Pulp spread to the PDL & causing Periodontal Pocket.

Treatment: RCT followed by scaling & Root

Planing or flap surgery.

Primary Periodic lesion:

The Periodontal lesion is seen.

Eg: Periodontal Pocket.

Treatment: flap surgery.

Etiology:

⇒ Primary Periodic & secondary endo lesion.

Due to Periodic lesion, endodontic lesion

Occur.

eg: Deep Pocket spread to the Root canal.

Treatment: RCT followed by flap surgery

True Combined lesion:

This lesion cannot be differentiated, which occurred Primary.

Deep Periodontal Pocket with non-vital tooth.

Treatment: RCT followed by flap surgery.

⇒ Management of Primary, Prio secondary endo lesion:

Prio - lesion Occured Primarily followed by

Endodontic lesion.

Deep Pocket with Root apex caries.

PCT is treated & followed by scaling and

Root Planing or flap surgery.

If the Deep Pocket causing mobility is seen,

splinting of tooth.

Section-B.

3. Steps in Resective Osseous Surgery:

Step 1: Vertical Grooving

Step 2: Radicular incision.

Step 3: Flattening of interproximal bone.

Step 4: Readaptation of the bone.

Step 1:

Vertical Grooving:

Resective Osseous Surgery:

It is defined as the change in the alveolar bone to get rid of deformities caused by Periodontal destruction or other factors causing it.

Step 1: Vertical Grooving:

The vertical incision is made, on

the interproximal area.

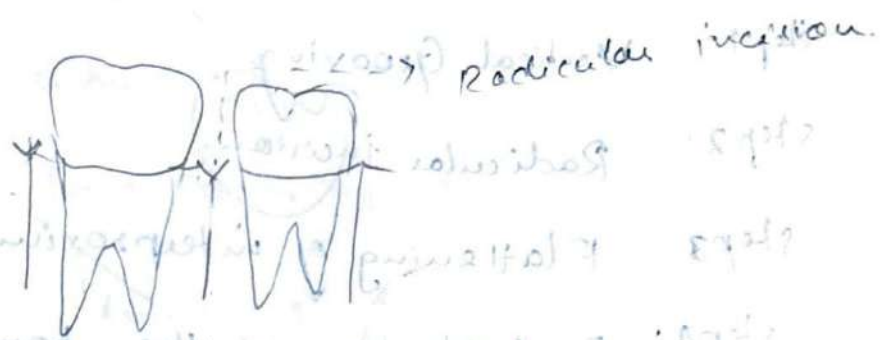
Step 2:

Radicular incision.



Vertical
grooving

A triangular shape incision adjoining the interproximal area is made,

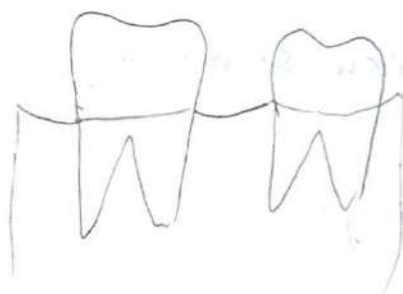


step 3:

Flattening of interproximal bone:

To equalize the levels of bone to same level

Flattening of the interproximal bone.



step 4:

Readaptation of the bone.

The ~~bone~~ interproximal area is adapted to the tooth by suturing.

4. Classification of gingival Recession:

- Miller's Classification:

Class I:
Marginal gingiva ^{is not below or to} below the level of mucogingival junction. ~~There is~~ no bone loss.

Class II:
Marginal gingiva ^{extending or to} below the level of mucogingival junction. There is no bone loss.

24 Class III:
Marginal gingiva below the mucogingival junction. There is interdental bone loss.

Class IV:
Marginal gingiva below the mucogingival junction. There is severe bone loss. ^{h soft tissue loss.}

- Stullman's & Atkin's

- shallow, narrow ✓

- shallow, wide. ✓

- Deep, narrow ✓

- Deep, wide. ✓

5. Drug Induced gingival enlargement:

Anticonvulsants ✓

Phenobarbiton.

Phenytoin.

Other Anticonvulsants.

Carbamazepine.

Ca channel blockers. ✓

Nifedipine. ✓

Immunosuppressants. ✓

Cyclosporine. ✓

Management:

Immediate stoppage of the drug.

with physician concern.

Gingival enlargement is seen in interdental space.

7. Osteointegration:

The growth of bone in the space of the

Implant:

- Fibrous
- Osseous

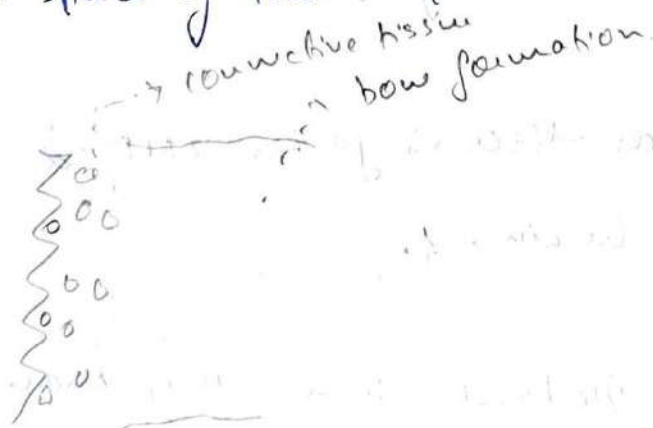
Fibrous:

The connective tissue is formed in between and the bone formation is seen.

It is Pseudo osteointegration.

Osseous:

The bone formation is seen in between the space of the implant placed.



Fibrous growth



Osseous growth

For the Osseous growth, (Titanium) ^{selection} implants
to be used. is necessary; eg: Titanium

Plasma sprayed titanium.

8. 2 way relationship between diabetes & Periodontitis.

For diabetes is systemic disease, Periodontitis
is commonly observed.

Treating of Periodontitis, control the diabetic
level.

Treating the ~~diabetic~~ ^{diabetic} patient, there increase in uptake of glycemic level in blood.

Factors:

- Tumor Necrosis factor TNF- α .
- Interleukin - 4.

Diabetic Patient seen. Dry mouth, more
caries Activity, more prone to Periodontitis.