Case 2023.4: Last Minute History and Physical Exam prior to Treatment

**SITUATION:** Four months after initial consultation, a 72 y/o female presents for routine dental extraction of non-restorable tooth #19. A simple verbal query “is everything the same since your last appointment” did not reveal any changed. After measurement of blood pressure, a mandibular block was administered and the treating doctor left the room, leaving an assistant present for “monitoring and conversation” as the local anesthetic took effect. It was during that time, that the patient commented that she had recently received her first injection of denosumab (Prolia™). This information was conveyed to the doctor, which triggered cancellation of the procedure and an apology for having missed this important information.

**WHAT WE LEARNED:** The Dental Patient Safety Foundation has become aware of several similar instances of close calls and near misses, where vital information about current patient status has changed, or been missed/overlooked just prior to commencement of sedation and/or treatment. The importance of a current and complete review of both the history and physical exam “just before take-off” cannot be over-emphasized.

1. Many offices use electronic health records (EHR) to maintain patient information and treatment records. Data ENTRY is often straightforward, but data RETRIEVAL and review may require acting and time-consuming “exploratory mouse clicking” of every “nook and cranny” which can lead to missed or mis-information. Some EMR offices choose to print out selected portions of patient data, where relevant information can be readily gleaned by looking, rather click and search.

2. Patient status can be subject to rapid and unpredictable change which can be overlooked. Examples include recent pregnancy, infection compromising the upper airway, COPD “flare-ups”, decompenating congestive heart failure, or just patients “not feeling well.”

3. Written health histories often are populated with YES-NO responses to ensure that “nothing is missed”. Patients might rush through lengthy questionnaires, or just simply forget when filling out these forms. Verbal review will often times reveal missed information.

4. Patients can be anxious, confused or even ashamed to report “sensitive” information out of fear of being judged about certain issues relating to their physical condition or habits. It is of utmost importance to adopt a non-judgmental approach while establishing genuine rapport with your words, actions and even facial expressions with each and every patient.

5. Many diseases “fly under the radar” can either be “yet to be diagnosed” or even mis-diagnosed by medical professionals. The dental clinician should be wary of co-morbidities: “Suspicion clinches Diagnosis”

6. Drug therapy can recently change or patients might be non-compliant with prescribed medication because of cost, side effects or drug availability, leading to underdose, overdose or withdrawal effects.

7. Drug interactions continue to be a challenge because of possible lack of coordination and reconciliation among medical specialists. The use of over-the-counter medication is gaining popularity – these drugs can have dangerous side effects or interactions and can often escape FDA approval. The legal use of cannabis and/or alcohol should be noted as well.

8. The use of “illicit” medication – sometimes referred to as “co-ingestion” exposes those who consume to unknown and possibly severe risk of injury. There is zero regulation of these agents, which are often laced with unknown substances or contaminants.

The DPSF **encourages frequent reporting** of unsafe conditions, near misses and adverse events as the only means to close the gap between knowing how to prevent these occurrences and taking the necessary action to do so. Please visit our website.

Reference:

www.dentalpatientsafety.org
16011 S. 108th Ave. Orland Park, IL 60467