

Warning: In the following pages, I am going to make some emphatic statements. It may seem that I am lecturing to you, but after all, this is supposed to be an educational newsletter. Please read the following with an open mind and accept my opinions in the spirit in which they are intended. My primary goals are to help you to avoid some of the mistakes that I have observed over the years and to help you provide better dental care for your patients.

# D e n t a l M y t h o l o g y

The admonition in the opening paragraphs is borne from an all too common experience. Being in referral practice, I see only those cases that general practitioners choose to send my way. Often, the reason for the referral is that the G. P. has been managing a problem that is not responding well. In many instances, both patient and client would have been better served if more aggressive treatment had been instituted or the case referred much earlier in the course of the condition.

It occurs to me that one reason for the delay in instituting definitive care or referring the case is that there are still a number of myths concerning veterinary dentistry and referral services. I cannot speak for all veterinarians accepting dental referrals, but I will try to dispel some of the more common misconceptions with some illustrations taken from my own case files. If it seems I am being critical of my friends and colleagues, consider that the wise learn not only from their own mistakes but also from the mistakes of others. By sharing these observations, I am not attempting to fix blame but to share information for the common good.

## **Myth #1: “Dogs and cats do not feel dental pain the way people do. They have a higher pain threshold.”**

**Basis for Myth:** It is common for serious dental problems to be detected as incidental findings during routine examination. When questioned, the owners may say that they have observed no indication that the animal is uncomfortable. The animal still eats and may even still chew on hard toys.

**The Truth: Dogs and cats feel dental pain in the same way and to the same degree as humans.** A series of articles on pain perception and management published in the Compendium on Continuing Education in January, May and June of 1991 indicated that dogs and cats have the same pain thresholds and tolerances as humans. They react and withdraw/defend at the same level of stimulation and have the same physiologic reactions to pain as humans. This was true across all categories of pain, including dental pain.

The explanation for this apparent paradox is actually very logical. If a dog has a sore tooth, that is one problem. If the dog allows that sore tooth to keep her from eating, she now has two problems, a sore tooth and hunger. From her perspective, it is better to eat with a sore tooth than to go hungry. Also, dogs live in an outwardly co-operative but internally competitive, hierarchical society. A pack member seen as weak or distressed will lose social status and may even be cast out as a liability to the pack. Therefore, nature has taught dogs to mask their pain and pretend everything is fine. Finally, the pet animal has no way of knowing that by complaining, she can increase her chances of getting relief. Therefore, she has no reason to complain and a few reasons not to.

Cats are not socially co-operative, so that argument does not hold for them. However, being small animals, they are subject to predation. Therefore, they too have a dis-incentive to advertising their distress.

Often, under further questioning pre-operatively, the owners will agree that the animal has been showing signs that might well be related to dental disease. There may be a history of a change in preference toward softer food and toys, chewing on one side (as evidenced by excess calculus accumulation on the disused side), a general decrease in vigor, drooling, pawing or rubbing at mouth, decreased enthusiasm for food and games, ocular discharge, sneezing...

Time and again, I have had owners state pre-operatively that their pet was showing no signs of pain but once the problem has been treated, they realize that the pet was suffering. The improvement in attitude and well-being after successful dental treatment is often very dramatic.

**Recommendation:** If you see a condition that would cause pain in your mouth, assume that it is causing pain for the pet. If you see a condition that would cause you to seek dental care for yourself, recommend dental care for the pet.

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**Myth #2: “If a broken tooth does not seem to be bothering the patient, there is no need to treat it.”**

**Basis for Myth:** Often patients will present with a fractured or worn tooth in which the pulp has been exposed but the owner will state categorically that it is not bothering the animal. They point out that the dog or cat is still eating and chewing normally and shows no signs of discomfort (see Myth #1). On physical examination, there is often no evidence of oral swelling or gingival inflammation.

**The Truth: If a tooth has been broken or worn to allow pulp exposure, it is a problem that must be treated.** A tooth with an open pulp chamber becomes a direct pathway for bacteria to enter the periodontal ligament space around the root tip and the body is powerless to stop this. The result will be a chronic inflammatory response (periapical periodontitis) at the root tip. This causes a chronic, dull ache as well as acting as a source of septicemia. Occasionally, these periapical inflammations will fenestrate through the alveolar bone and allow the infection into the surrounding tissues. This is the situation with infra-orbital swelling associated with fourth upper premolar fractures. However, only about 20% of endodontically diseased teeth will provide such an obvious indication for treatment. The other 80% of periapical lesions will remain encased in bone or fistulate to a less obvious site (nasal passages or oral cavity).

**Recommendation:** If you see a fractured or worn tooth with pulp exposure, you must recommend either extraction or root canal treatment. To recommend neither could be considered negligence.

In the case of a facial swelling or draining fistula associated with an abscessed tooth, antibiotics will often bring temporary relief, but the problem will recur after the medication is discontinued. Giving antibiotics for a few days pre-operatively is a good idea, but antibiotics should never be offered as a substitute for surgical treatment.

If the owners wish to save the tooth through root canal treatment, this should be done as soon as possible. If the condition is left untreated for long enough, the inflammatory process can destroy the root tip making standard root canal treatment impossible.

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**Myth #3: “For minor tartar accumulations and mild gingivitis, a simple scaling without anesthetic will often be sufficient.”**

**Basis for Myth:** This myth likely grew from client concerns about the risks involved in general anesthesia. In order to offer some level of dental care at reduced risk, some veterinarians have offered the “Standing Dental”. Groomers and breeders have also been known to offer this service. When finished, the visible portions of the teeth look clean to the naked eye and the animal’s breath is often less offensive. This, coupled with a much lower fee and no anesthetic risk tends to satisfy the client.

**The Truth: Proper dental care requires a general anesthetic with a properly fitted, cuffed endotracheal tube.** For an oral hygiene procedure (prophy) to be therapeutically beneficial, it must involve a total removal of all calculus and plaque supra-gingivally and, more importantly, sub-gingivally. All periodontal pockets must be probed and charted prior to root planing (either with or without flap surgery). All exposed tooth surfaces must be polished after scaling to remove residual plaque and create a smooth tooth surface that will be easier to keep clean. Other concerns such as oral and gingival masses, fractured and worn teeth, orthodontic problems, etcetera, should be investigated, charted and either treated or referred.

In the “Standing Dental”, only the buccal surfaces of the crowns are scaled. It is not possible to probe and clean below the gum-line, in between teeth or on the tongue and palate side of the teeth. It is not possible to polish the teeth in the conscious patient, nor is it possible to conduct a thorough oral and dental examination. I challenge anyone to prove me wrong on this.

“Standing Dentals” leave plaque and calculus in places where the owners can not see it, so the owner is given a false sense of security that the mouth is healthy. “Standing Dentals” scratch the enamel surface but do not allow polishing so the tooth is left even more plaque retentive than before. “Standing Dentals” are unpleasant for the animals and so can make them head-shy which makes instituting an effective home-care program much more difficult. “Standing Dentals” often lead to damage to the gingiva as the animal wiggles about while there is a sharp instrument in the mouth. “Standing Dentals” do not allow for a thorough oral examination and so subtle problems are left undetected and untreated until they become serious and obvious problems which are usually much more difficult to treat.

I recently saw a very sweet, 14 year old sheltie owned by a very dedicated and capable owner. This owner will do anything for her dog if she feels it will improve his health and well-being. Unfortunately, the advice she received over the years was that her dog needed only coronal scaling with sedation. This had been done many times throughout the dog’s life. By the time I saw the dog, he had such severe periodontal disease that I had to extract 24 teeth (2 canines and all his remaining posterior teeth). The good news is that, within two weeks, the owner reported that the dog was chasing squirrels like he had not done in years.

If this dog had received appropriate dental treatment from an early age and had the owner been given proper instruction regarding home-care, the extractions and the years of suffering from dental infection would have been prevented.

**Recommendation:** Since “Standing Dentals” do more harm than good, refuse to offer this service. A “Standing Dental” is bad for the patient (there are risks with no benefit), bad for the owner (who pays for worthless, potentially harmful treatment) and bad for the profession (as it under cuts those offering proper dental care and undermines our recommendations).

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#### **Myth # 4: “Old animals are not suitable candidates for dental treatment.”**

**Basis for Myth:** Generally, older patients have higher anesthetic risks and so some veterinarians feel the benefits of treatment do not justify these risks. In the past, anesthetic risks were higher and the level of dental treatment available lower and so the risks might not have been justified. Things have changed!

**Truth:** It is true that some patients are too systemically ill to be candidates for a general anesthetic, however, I feel that **no animal should be denied the benefits of proper dental care merely because they were born a long time ago.**

As veterinarians, we are sworn to prevent and relieve animal suffering (see the Veterinarian’s Oath). Many dental conditions are not only sources of chronic pain, but also serious sources of chronic septicemia. These situations have significant negative impact on both the quality and quantity of life for the patient. With our present resources for pre-operative diagnostics, intra-operative risk management and post-operative care, the risk of loosing a patient to a general anesthetic has been greatly reduced (there is always a risk with any procedure in any patient). Also, the level of dental care available, particularly through referrals to veterinary dentists, has increased incredibly over the past five years. It is now safe to say that the risk to the quality and quantity of life associated with dental treatment is less than the risk associated with dental neglect.

**Recommendation:** If you hear yourself thinking that an animal is **too old** for a needed dental procedure, offer a referral.

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#### **Myth # 5: “Periodontal disease is an inevitable consequence of aging.”**

**Basis for Myth:** Many old dogs and cats have severe periodontal disease.

**Truth: Periodontal disease is entirely preventable.** Through the judicious use of abrasive foods and toys (nothing too hard), appropriate home-care programs and timely professional oral hygiene procedures, it is very possible for a dog or cat to live a long life and lose no teeth to periodontal disease. Any time a dog or cat does lose a tooth to periodontal disease, it can be seen as a failure on our part to effect an appropriate preventative program. (This comment is exclusive of Feline External Odontoclastic

Resorptive Lesions and animals with immune mediated and systemic conditions such as Lymphocytic/Plasmocytic Gingivostomatitis).

**Recommendation:** Adopt a preventative approach to oral health by starting dental care **before** disease is established.

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**Myth #6: “Referral dentists are too expensive. My clients will not be interested in a referral.”**

**Basis for Myth:** Yes, many of my invoices are large (often between \$1500 and \$2500) but most clients would tell you they felt the service provided was worth every penny and many tell me that my bills are lower than they expected. As I stated at the outset, many of the cases I see have been under management for a long time before I see them. I am often the last resort for both veterinarian and client. As a result, I rarely have simple conditions presented that would respond to simple treatments. It is not uncommon for procedures to run two to three hours.

**The Truth: My fees are within the parameters of the OVMA Suggested Fees** (many individual items below suggested). If I were presented with a simple ‘prophy’ that took 45 minutes, my fee would be very close to the OVMA sample invoice. However, if during that ‘routine prophylaxis’, I detected an unexpected problem (such as a deep periodontal pocket, pulp necrosis, tooth resorption...) I could detect, diagnose and treat it at the same time, thus maximizing the therapeutic benefit to the patient and eliminating the need for a later referral with a second anesthetic. This is value for money which your clients will appreciate. ([http://www.toothvet.ca/PDFfiles/phone\\_estimates.pdf](http://www.toothvet.ca/PDFfiles/phone_estimates.pdf)).

**Recommendation:** Consider offering dental referrals routinely, even for cases which appear on the surface to be simple. Experience has taught me that a significant percentage of animals have dental problems with subtle presentation that could easily be overlooked by most. Veterinary dentists have the training and equipment to detect and manage these problems before they become obvious and serious.

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**Myth #7: “My clients will think less of me if I suggest a referral. Referring a case is an admission of inadequacy and has a negative monetary impact on my practice.”**

**Basis for Myth:** Most veterinarians are serious Type A, over-achieving personalities. We are used to performing minor or major miracles on a daily basis. Our clients have come to expect this from us and we are hesitant to disappoint them by admitting there are problems that are beyond our personal capabilities.

**The Truth: There is just too darn much to know for anyone to be good at all areas of veterinary medicine.** Increasingly, the pet-owning public is aware of this. Referrals are common in other areas of daily life (lawyers, human dentists, physicians, contractors, financial service providers...).

Human dentists spend four years of full-time study to qualify. Veterinary Dentists (Fellows of the Academy, Diplomats of the College) have devoted many hundreds of hours over at least five years to the study of veterinary dentistry compared with the three hours of lecture provided to undergraduates at OVC.

Occasionally, I have had clients contact me directly. Clients who seek their own referral invariably harbour some resentment toward their regular veterinarian for not suggesting the referral themselves.

By offering a referral, you are telling your client that your primary concern is for the well-being of their pet. This can increase the bond your client feels toward you. Regarding future recommendations, the client now knows what your motivation is and knows that if you offer a treatment, you must be confident in your abilities to provide it effectively. They are more likely to listen to your recommendations if they trust and feel warmly towards you.

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