Oral rehabilitation in a patient with odontophobia – Case report

Carla do Socorro Jatahy Brazão[1], Lurdete Maria Rocha Gauch[2], Renata Antunes Esteves[3], Isabelle Rocha Gauch[4], Tasso César da Costa Pereira[5], Hercules Bezerra Dias[6], Davi Lavareda Corrêa[7], Vania Castro Corrêa[8], Suelen Castro Lavareda Corrêa[9], Sue Ann Lavareda Corrêa Uchôa[10], João Pedro Costa Pedrosa[11] and Simone Soares Pedrosa[12]

ABSTRACT
Despite technological advances in dentistry, negative feelings still prevail in the area, such as odontophobia, which the World Health Organization classifies into three stages. Patients with this condition often postpone treatments, cooperate little, and resort to palliative medications, compromising their oral health. This study reports the case of a patient who faced oral complications due to odontophobia, highlighting the rehabilitation treatment plan adopted, its phases and results obtained. The diagnosis of anxiety was made using the Dental Anxiety Scale (DAS), created by Corah in 1969. It is concluded that understanding the patient's general conditions and motivation to seek dental treatment is crucial for a proper diagnosis and to establish an effective treatment plan. The installation of the prostheses resulted in a significant improvement in the patient's self-esteem, social well-being, reduced anxiety and improvements in diet.

Keywords: Dentistry, Anxiety, Treatment, Prosthodontics.

[1] Student at the Faculty of Dentistry of the Federal University of Pará (UFPA)
E-mail: Carlajatahyb@gmail.com
[2] Associate Professor III, School of Dentistry, Federal University of Pará (UFPA)
E-mail: lrgauch@ufpa.br
[3] Associate Professor II, School of Dentistry, Federal University of Pará (UFPA)
E-mail: estevesra@gmail.com
[4] Resident in General Surgery SUS-SP
E-mail: Isabellegauch.uepa@gmail.com
[5] Dentistry student at the Federal University of Pará (UFPA).
E-mail: Tarso.cesarp@gmail.com
[6] Adjunct Professor, School of Dentistry, Federal University of Pará (UFPA)
E-mail: herculesdias@ufpa.br
[7] Adjunct Professor, School of Dentistry, Federal University of Pará (UFPA)
E-mail: davilavareda2@yahoo.com.br
[8] Associate Professor III, School of Dentistry, Federal University of Pará (UFPA)
E-mail: vania@ufpa.br
[9] Brazilian Air Force (FAB)
E-mail: suelenlavaredam@gmail.com
[10] São Leopoldo Mandic Research Center
E-mail: sueann.lavareda@yahoo.com.br
[11] Origin: Undergraduate student of Dentistry at UFMA
E-mail: joao.pedrosa@discente.ufma.br
[12] Associate Professor III, School of Dentistry, Federal University of Pará (UFPA)
E-mail: sspedrosa@ufpa.br

INTRODUCTION

Despite the numerous technological advances in dentistry over the years, negative feelings are still common in this area[1]. "Odontophobia," an irrational aversion to dentistry, is officially recognized and described in the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems[2]. The World Health Organization (WHO) classifies odontophobia as a real disease and estimates that it affects approximately 15 to 20% of the world's population[3]. This condition is divided into three stages of severity. Mild: characterized as dental anxiety:

1. Moderate: characterized as dental medium.
2. Severe: characterized by dental phobia.

In these cases, patients often postpone their dental treatments, show a lack of cooperation, and resort to the use of palliative medications, which can aggravate and seriously compromise oral health[4]. In Brazil, a study conducted in the Northeast region indicates that fear and anxiety about dentistry are significant, with an incidence ranging from 10% to 44%7.

Anxiety inside the dental office is often triggered by the use of instruments such as drills, needles, and syringes, as well as the sounds of motors and sudden movements, which can cause apprehension and make the experience unpleasant[6]. Anxious people tend to have a lower frequency of dental visits, resulting in a higher number of decayed or missing teeth and fewer fillings compared to non-anxious individuals. As a consequence, compromised oral health can negatively affect the patient's social life[7].

The fear of dental treatment represents a challenge for both the patient and the dental surgeon[8]. This problem is closely linked to one's perception of the dentist. Therefore, it is crucial that the professional, in addition to their technical skills, is equipped with the necessary knowledge to identify and manage fear and anxiety effectively[4]. The Dental Anxiety Scale (DAS), developed by Corah, is the most widely used instrument internationally to identify odontophobia and determine its level, and is recognized for its simplicity and reliability in repeated tests[9]. The initial management of anxiety should be approached in a non-invasive way, establishing a good relationship between professional and patient, explaining the procedures and using behavioral techniques, such as concealing sharp instruments. In more severe cases, intervention with pharmacological therapies may be necessary[10].

Clinical problems in the oral cavity, especially tooth loss, significantly impact the quality of life of many people, affecting various aspects such as function, appearance, interpersonal relationships and even professional opportunities[11]. The main concerns of patients involve comfort, functionality and aesthetics. When these aspects do not correspond to the patient's expectations, it is

common to observe psychosocial responses such as anxiety, insecurity, reduced self-esteem, and introversion[12].

Oral rehabilitation plays a crucial role not only in treating diseases but also in promoting the social and mental well-being of patients. Maintaining good oral health is essential for the psychological and functional well-being of the individual[13]. The absence of teeth can affect important functions such as speech, due to changes in the morphology and musculature of the oral cavity, since teeth play a vital role in the production of sounds by obstructing the passage of air. In addition, tooth loss negatively impacts chewing ability. To solve these problems, the solution is oral prosthetic rehabilitation, which may include partial dentures, total dentures, or dental implants[14].

Prosthodontics is the area of science that is dedicated to the replacement of the coronary portion of the teeth, aiming to restore lost functions, improve aesthetics, comfort and health of the patient. It also focuses on phonetics, posture, and restoring balance to the stomatognathic system[17].

The present study aims to report the clinical case of a patient who faced oral complications due to odontophobia. In addition, it aims to demonstrate the rehabilitation treatment plan adopted, describing its stages and the results achieved.

CASE REPORT

A 50-year-old female patient went to the School of Dentistry of the Federal University of Pará (UFPA) and was treated at the Integrated Clinic III. She complained of pain, compromised aesthetics, inefficient chewing, low self-esteem and teeth in precarious condition, which negatively impacted her quality of life. She reported difficulties in eating, socializing, professional opportunities, and even weight loss. With a traumatic history in dental offices, the patient felt fearful and unable to seek the appropriate treatment for her teeth, leading her to seek help at UFPA.

During the first consultation, a detailed anamnesis was performed to assess the patient's degree of anxiety and fear, as well as her dental and medical history, main complaint, and oral hygiene habits. To diagnose anxiety, the Dental Anxiety Scale (DAS), developed by Corah in 1969, was used. This scale includes four items, each with five alternatives, specifically designed to measure the patient's level of dental anxiety by assigning scores from 4 to 20. A score of 15 or higher indicates a high level of anxiety. In the first consultation, the patient achieved a score of 16 and was classified as extremely anxious.

The use of the Dental Anxiety Scale (DAS) proved to be crucial for the proper conditioning of the patient. Due to the high levels of anxiety identified, a referral for psychological counseling was requested. In addition, to ensure that the consultations at the college's dental clinic were productive, it was necessary to establish a relationship of trust between the student, acting as a dentist, and the patient. In the first sessions, explanatory dialogues were held about each stage of the treatment.

Agreements were established to ensure the patient's comfort and confidence, including the assurance that the procedure would be stopped immediately in case of pain, the importance of attending appointments, being honest about the sensations during treatment, and aligning expectations regarding results. In addition, the basic instruments that would be used were presented, such as the clinical kit, the dental chair and its operation, as well as the clinic environment and the role of teachers in supervising students. The patient was receptive and understanding with these first approaches and, motivated by the severe oral problems and their impacts on her health and social life, was willing to change her perspective and accept the proposed treatments.

Extraoral clinical examination revealed a small asymmetry to the left side and a well-demarcated nasolabial fold. Upper lips drooping and covering the smile, allowing only the lower teeth to appear (Figures 1).

Figure 1. Clinical aspect. A) Frontal aspect showing the smile. B) Frontal aspect. C) Profile appearance.

Intraoral clinical examination revealed missing teeth in both upper and lower arches (Figure 2).

Figure 2. Intraoral clinical appearance. A) Upper arch. B) Lower arch.
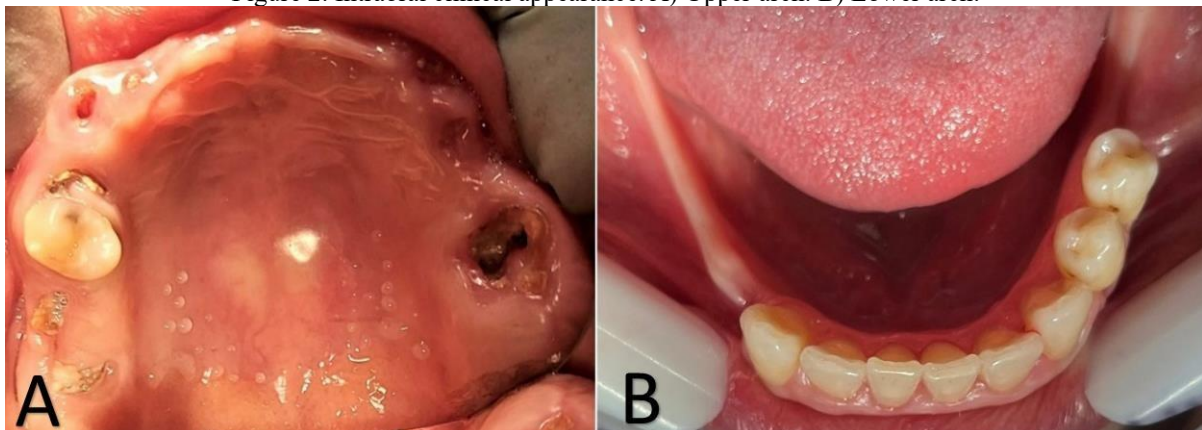
In the upper arch, there was absence of a crown of multiple teeth, with the exception of element 15, without mobility and with caries lesions. A panoramic radiographic examination was

requested (Figure 3) where residual roots of elements 11, 12, 13, 21, 22, 23, 26 and 27 were identified in the upper arch, as well as fragments of elements 14, 16, 17, 24, 25 and 27. In the mandibular arch, the presence of all anterior elements was observed, in addition to premolars 34 and 35 and the residual root of element 44. The molars were absent in the lower arch.

Figure 3. Panoramic radiography.

The oral fibromucosa of the upper arch showed signs of inflammation (Figure 4), such as redness and pain to the touch reported by the patient.

Figure 4. Intraoral clinical appearance.

The diagnosis and treatment plan were carried out by the teams of the Integrated Dental Clinic III and IV of UFPA in the specialties of periodontics, with scaling of the lower elements; surgery to

remove residual roots, fragments and element 15; dentistry, to reduce retention in the cervical areas of the teeth; and prosthesis, for definitive total prosthesis (PT) in the upper arch and removable partial prosthesis (PRP) in the lower arch.

To start the oral treatment, two sessions of periodontal scaling were performed on the lower elements with manual Gracey curettes, smoothing and polishing. At the end of each session, oral health education was carried out, explaining brushing techniques and how caries occurs. Mouthwash with 0.12% chlorhexidine for 1 minute, 2x a day was recommended to assist in hygiene, mainly due to the residual roots that the patient had and that facilitated the accumulation of food in these regions, not being possible normal cleaning with a toothbrush. Then, study models were made using stock and alginate trays, poured with stone plaster.

The extraction of residual roots, dental fragments and element 15 was planned. The extraction was planned with analysis of clinical examinations, radiographic and complementary examinations (complete blood count and coagulagram with normal results) and blood pressure (110 x 80 mmHg). In the preoperative period, the patient was instructed once again about the procedure, talking about which extractions would be performed in each session and the importance of the treatment. Due to the patient's anxiety, the extractions were performed in 4 sessions, calmly and always talking to the patient during the procedure to distract her and maintain confidence in the treatment. In the first session, the residual roots of elements 11, 21, 12 and 22 were removed. In the second session, the residual root of element 13, the crown fragment of element 14 and element 15 were removed. In the third session, the residual roots of elements 23, 26 and 27 and crown fragments of elements 24 and 25 were removed. In the fourth session, the dental fragments of elements 16 and 17 and the residual root of element 44 were removed.

Before all surgical procedures, the patient's blood pressure was checked, antisepsis was performed with 2% chlorhexidine on the face and 0.12% chlorhexidine mouthwash to reduce the microbial load. The table with the sterile instruments was always covered with sterile TNT when the patient arrived at the clinic, in order to reduce her anxiety about the procedure and visualization of the instruments.

Extractions were performed with scalpel blades around the edges of the roots, molt detacher, levers and forceps. At the end, curettage and irrigation of the socket were performed with saline solution, in order to remove any lesions and residues. The sutures were performed with non-resorbable silk thread to keep the clot stable and improve healing.

Postoperative orientations, given verbally and in writing, consisted of ice packs to reduce edema; avoid physical exertion and exposure to the sun; pasty and cold diet in the first 48 hours after surgery. The prescription was prescribed with anti-inflammatory Nimesulide 100mg, 1 tablet every 12 hours for 3 days; and analgesic Dipyrone 500mg, 1 tablet every 6 hours in cases of pain. The

medications were prescribed according to what the patient already had at home and was used to taking. After 7 days, the sutures were removed. The patient healed well, as expected, and there was no report of postoperative pain.

After the oral cavity was adjusted, with the extractions performed, alginate and a stock tray were used to make the anatomical impression of the upper and lower arches (Figure 5). With the plaster models ready, the study for the planning of the prostheses was carried out.

Figure 5. Anatomical molding. A) Upper arch. B) Lower arch.
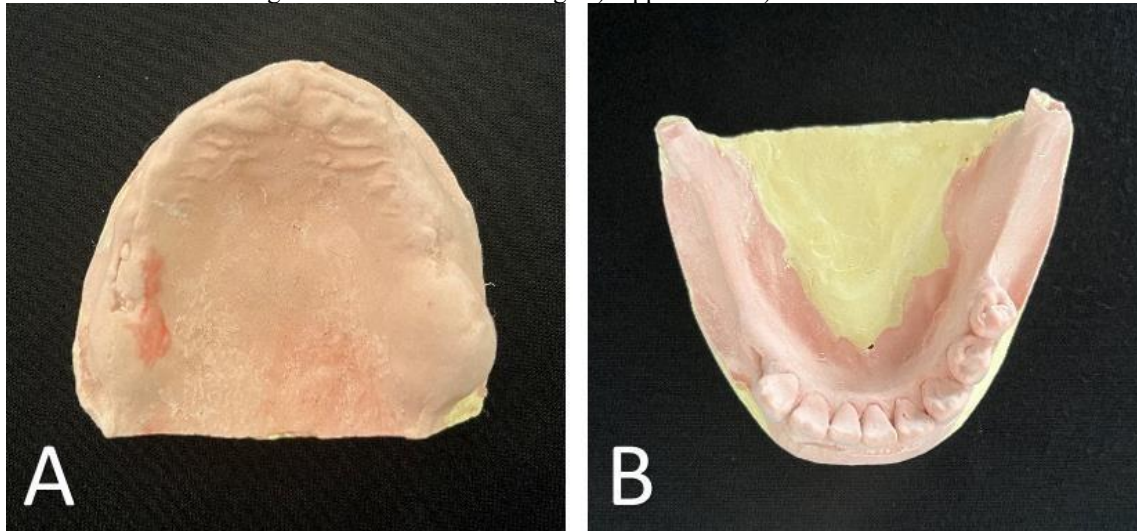
Based on the higher education model, an individual tray was made with colorless acrylic resin (Figure 6). After the adjustments of the individual tray, the mixed compression technique was performed with the godiva for the peripheral seal and the silicona involving the entire platable area, to obtain the functional model. From the model, two test bases were made; the first to perform the registration with a facial arch and assembly of the upper model in the ASA, and the second with a wax roller for the interocclusal registration and marking of the reference lines (Figure 6).

Figure 6. Individual tray and test bases. A) Individual tray. (bc) Proof bases.

With the lower study model, the study and planning of the PRP began. With posterior bilateral tooth loss, the case is characterized as Class I in the Kennedy classification, with elements 43 and 35 as direct retainers. Element 34 is characterized as an indirect retainer.

The planning of the structure of the PPR was carried out with the delineator. It started with the analyzer tip to define the insertion trajectory of the prosthesis using the Roach method. Next, the calibrating tips were used to verify the retentive areas of the ridge and teeth on the buccal, lingual and distal surfaces of the direct and indirect retainers. After defining the plan and fixing the table, a transfer plate was made with colorless acrylic resin and screw. To finalize the design, the prosthetic equator was traced with the graphite tips, bypassing the direct and indirect retainers. The design of the structure of the PRP was then planned, with the choice of tip action clamps, niche location and lingual plate (Figure 7).

Figure 7. Delineation process. A) Transfer paca. B) Left lateral view design. C) Outline by top view. D) Delineation by right side view.
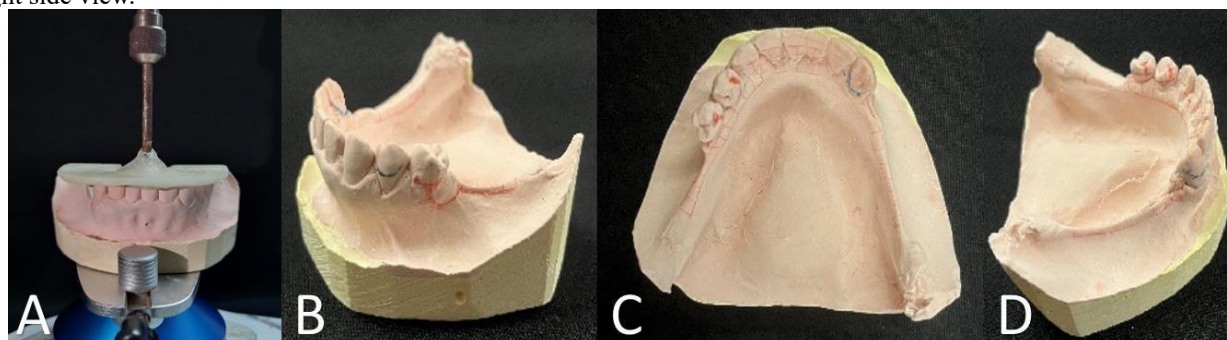

To improve the adaptation of the clamps, stability of the prosthesis and eliminate retentions, restorations were performed with composite resin in elements 35, vestibulo-distal face and 43 in distal face. The faces were submitted to the application of 37% phosphoric acid for 15 seconds. After washing and drying with absorbent paper, the adhesive system used was the 3M Single Bond Universal, with the aid of the disposable microbrush applicator. The resin used was Opallis from FGM, color A3.5. A new study model was obtained with the new alterations with resin and went through all the previous steps in the eyeliner in a judicious way. With the modifications, wear was performed on the buccal and distal surfaces of element 35 with an eyeliner pen holder and a PM82 straight drill. The preparation of a transfer casquet was necessary to perform the mouth preparation.

In the preparation of the mouth, niches were made in the occlusal-mesial of teeth 34 and 35, in the cingulate of tooth 43 and in the buccal surfaces of teeth 35 and 43 for adaptation of the staples. Then, functional molding was performed with condensation silicone in two steps (first with heavy silicone followed by light silicon) to obtain the working model. The work model was outlined and designed to be sent to the prosthesis laboratory for the manufacture of the metal structure, which was later adapted in the mouth, showing good adaptation.

A lower test base with a wax roller in the edentulous regions was made on top of the metal structure for the interocclusal record together with the upper test base, and then for the assembly of the lower functional model in ASA. The position of the mandible in relation to the maxilla, in the centric relationship and definition of the Vertical Dimension of Occlusion (OLD) were analyzed, based on phonetic, aesthetic, metric and facial proportions tests. With the oral test bases, reference lines were marked, and artificial teeth were selected. In the same session, the selection of the color of the gums was also performed. The selected teeth were on the Trilux scale and the color was A2. The articulator with the models, test bases and markings was sent to the prosthetic laboratory for the assembly of the lower and upper teeth (Figure 8). In the following session, with the assembly of the artificial teeth done, the prostheses in the mouth were tested for the necessary functional and aesthetic adjustments. Then, the prostheses were returned to the laboratory for acrylization.

Figure 8. Articulator with the models and test bases.
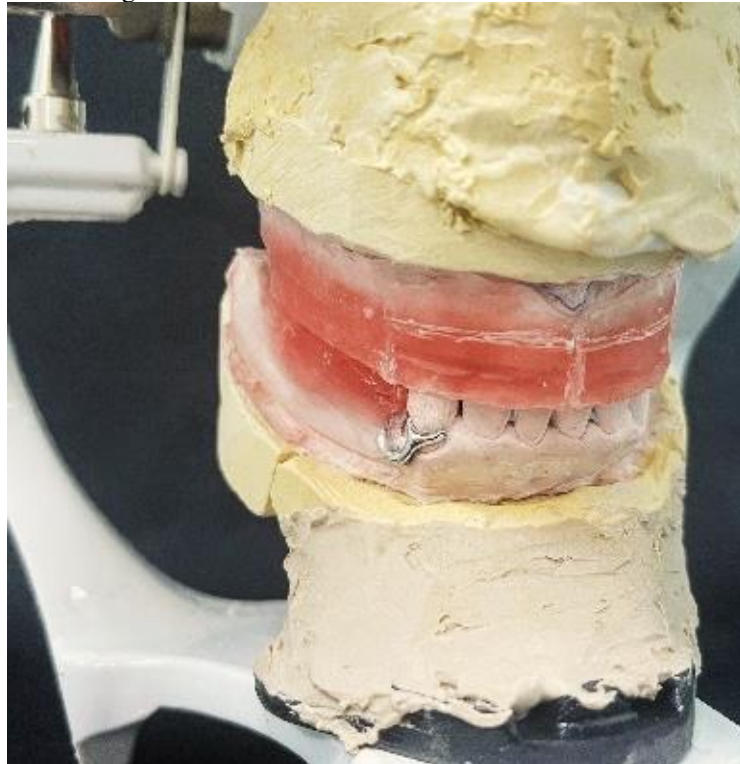
The prostheses were installed in the following session. Zincoenolic base paste was brushed on the prostheses to make the adjustments and not cause injury to the patient's gums, identifying points of friction. For this, the prostheses were placed in the mouth and the patient was asked to bite and make different movements with the mandible. The places where the base paste was removed had to be relieved, because there was pressure with the mucosa in a disproportionate way to the rest of the prosthesis, which could cause injuries to the oral tissues (Figure 9).

At the end of the case, the patient was instructed again regarding oral hygiene and care with the prostheses. The importance of visits to the dentist was reinforced, and the Corah Scale was

performed again to verify the patient's evolution regarding Odontophobia during the dental treatment of the present study. The result of the Scale was a score of 9, characterizing the patient as mildly anxious.

Figure 9. Final clinical aspect. A) Frontal clinical appearance with smile. B) Frontal clinical appearance without smiling. D) Intraoral aspect of the superior arch. E) Intraoral aspect of the inferior arch. F) Dental prostheses.

DISCUSSION

Fear of dental treatment usually originates from painful and traumatic experiences experienced in childhood or adolescence, in addition to a lack of knowledge about dental procedures5,16. These factors were determinant for the development of odontophobia in adulthood of the patient described in the clinical case. Due to the fear of the dental office and the lack of proper guidance on oral hygiene at home, the patient faced several negative consequences for her oral health. Commonly, she postponed treatments whenever she experienced dental pain, resorting to the use of medications such as painkillers and anti-inflammatories, which only exacerbated the initial problem. This resulted in significant tooth loss and both aesthetic and functional impairment.

The literature indicates that professionals who identify patients with fear or anxiety should investigate which specific procedure triggered this condition and offer an appropriate reception to minimize the problem. Welcoming is recognized as an effective method in the treatment of odontophobia and is a fundamental aspect of humanized care[8,18]. In the case in question, the effective reception of the patient, the willingness to dialogue and respect were crucial for the acceptance and completion of the treatment. The use of the Dental Anxiety Scale (DAS), developed by Corah, is especially valued for the diagnosis of dental anxiety. An article published in 2004 highlighted that, among three scales evaluated in a study, the DAS was considered the most reliable and capable of establishing an appropriate treatment[19]. Based on this evaluation, the DAS was the tool chosen to assist in the diagnosis and conditioning of the patient in this clinical case.

Along with the identification of odontophobia, it is recommended that the dentist refer patients to a psychologist or psychotherapist. The goal is for them to receive specialized support to overcome the fear and the various obstacles that affect their life in general[4]. In the case under discussion, the patient was referred to a psychologist, who played a crucial role in helping her to face dental care in a more effective and less distressing way.

The patient's main complaint was compromised aesthetics and inadequate masticatory function, which affected her social life and ability to eat properly, also impacting her self-esteem. According to the literature, women often have higher levels of anxiety and negative feelings related to tooth loss, resulting in lower confidence[8,17]. The treatment plan was chosen based on these aspects, aiming to restore the patient's confidence in herself and improve her social relationships.

Dentures represent a viable alternative for patients with a history of odontophobia, as they usually do not require prolonged surgeries or preparations, making treatment more easily acceptable. Curiously, the literature does not present studies that specifically relate oral rehabilitation with prostheses to the treatment of damage caused by odontophobia. This aspect highlights a potential area of research that could further explore how prosthetics can alleviate the psychological impacts associated with fear of dental treatments.

In the present case, after the installation of the prostheses, there was a considerable improvement in the patient's self-esteem and social life, in addition to a decrease in anxiety and an improvement in diet. Masticatory and aesthetic functions were restored, providing the patient with a significantly improved quality of life.

CONCLUSION

Understanding the patient's general conditions, in addition to the disease itself that motivated her to seek dental help, was crucial for adequate conditioning, diagnosis, and elaboration of the treatment plan. Based on the clinical case presented and subsequent discussions, it is clear that the

practitioner needs to go beyond technical skills, deeply understanding the patient's expectations and needs. Patients with odontophobia need a reception and rehabilitation that is aligned with their expectations. Oral rehabilitation using removable prostheses represents a less traumatic and effective option, restoring oral health, as well as the patient's function and aesthetics.

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Ao assinar este documento, você autoriza que as informações, fornecidas por você, relacionadas ao seu tratamento odontológico sejam utilizadas para fins de pesquisa científica, de ensino, de apresentação de trabalhos acadêmicos (trabalhos que os alunos apresentam durante o curso como requisito para formação) e de divulgação de resultados de pesquisas em revistas científicas nacionais e internacionais, com respeito aos princípios éticos e com a preservação de seu direito ao sigilo profissional nas demais questões.

Isso quer dizer que você concorda que suas fotografias (de dentro e de fora da boca), seus resultados de exames clínicos e de imagem (radiografias, tomografias, entre outros), seus dados pessoais (idade, sexo, raça, histórico médico e odontológico) e quaisquer outras informações relacionadas ao seu diagnóstico e/ou ao seu tratamento odontológico sejam utilizados para fins de ensino, de apresentação de trabalhos e de publicação de resultados de pesquisas em revistas científicas nacionais e internacionais. Em nenhum momento a sua identidade será divulgada.

Sua participação é voluntária. Ou seja, decorre de sua livre decisão de autorizar essas questões depois de ler este documento e de tirar suas dúvidas com os profissionais. Além disso, você poderá retirar seu consentimento (autorização) a qualquer momento.

Declaração do paciente (se maior de idade/incapaz)

Eu, LILIA MONTEIRO DE SOUZA, RG nº 2177843, declaro, para todos os fins legais, que esclareci minhas dúvidas, li e concordo com os quesitos estabelecidos por este termo.

Belém-PA, 09/07/21.

Lilia de Souza
Assinatura do paciente