CHILDREN'S EDUCATION SOCIETY (Regd.)
THE OXFORD DENTAL COLLEGE
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Bommanahalli, Hosur Road, Bangalore – 560 068.
Ph: 080-61754680 Fax : 080 – 61754693E-mail:deandirectortodc@gmail.com
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DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY

IV BDS regular batch (SL 10)

List Of Slow Learners, Remedial Classes and Improvement Methods

List of slow learner's final year regular batch

Sl no.	Registration number	Name of the student	
1	17D4853	Raina Raju	
2	17D0444	Priya GP	
3	17D4869	Rishika P	
4	17D0389	Anakha Raj	
5	17D0405	Divya Suresh	
6	17D0414	Sayeed UR Rahman	
7	17D0436	Uthara M Das	
8	17D0443	Farheen Rafeek	
9	17D0456	Halekya	
10	17D0417	NeehaLakpoti	
11	17D4806	Aseela Saniya	
12	17D4856	Meghana S	

Remedial Class and Improvement Methods

A revision class was conducted on the topic "TRIGEMINAL NEURALGIA", "MAXILLOFACIAL FRACTURES" ON 24/11/2021 and 14/12/2021 By Dr Pradeep V Pattar. The classes were held for two hours, and 10 students attended the class. The students were selected based on their performance in the previous internals. Positive feedback was received from the students regarding the class. A follow up assessment test conducted, and their performance was assessed to ascertain the improvement in their performance.

3

PRINCIPAL
The Oxford Dental College
Bommanahalli, Hosur Road,
Bangalore

Outcome

Sl no.	Registration number	Nameofthestudent	2nd IAmarks	Re-assessment marks	% improvement
1	17D4806	AseelaSaniya	10	47	53
2	17D4856	MeghanaS	07	50	61
3	17D4869	RishikaP	06	45	56
4	17D0389	AnakhaRaj	10	45	50
5	17D0405	DivyaSuresh	09	50	59
6	17D0417	NeehaLakpoti	16	58	60

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DEPARTMENT OF ORAL AND MAXILLOFACIALSURGERY
IVBDS odd batch (SL 5)

ListOfSlowLearners,RemedialClassesAndImprovementMethodsListofsl

ow learnersfinal yearoddbatch

Sl no.	Registration number	Nameofthestudent
1	17D4838	AnneShivani
2	17D4853	Likhitha
3	17D4855	Maria
4	17D4866	ChandraSaiReddy
5	17D4878	Sriharika

RemedialClassandImprovementMethods
A revision class was conducted on the topic "EXODONTIA" ON 28/01/2022 By Dr HARISH KUMAR.A. Theclass was held for two hours, and 5 students attended the class. The students were selected based on theirperformance in the previous internals. Positive feedback was received from the students regarding the class. Afollow up assessment test was conducted, and their performance was assessed to ascertain the improvement intheirperformance.

Outcome

Sl no.	Registration number	Nameofthestudent	2nd IAmarks	Re-assessment marks	% improvement
1	17D4838	AnnneShivani	08	45	53
2	17D4853	Likhitha	06	48	60
3	17D4855	Maria	01	40	56
4	17D4866	ChandraSaiReddy	11	50	56
5	17D4878	Sriharika	07	44	52

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2.5.4DOC-1

List of opportunities provided for the students for midcourse improvement of performance in the examinations

Initiatives

1. Counselling of students is done by respective mentor
2. Course content shall be discussed to identify weak areas of students
3. Previous years university question papers to be made available to the students
4. Discussions are carried out on previous years university question papers
5. Information regarding teaching notes, PPTs (Power Point Presentations), videos, etc./ access to the e course or e content to be given to the students
6. Remedial lectures shall be scheduled by respective departments
7. Teacher may decide type of assignments to be given to students
8. Practice of drawing diagrams, flowcharts and writing exam papers are given to students as per teacher's decision.
9. Models, training models, embryology models are shown and discussed.
10. Question bank for MCQ, SAQ and LAQ are given for practice
11. Subject seminars in special topics may be planned for such students.
12. Stimulation based learning /bedside learning etc may be arranged to enhance the performance.
13. Tests may be rescheduled and performance will be considered for MID course improvement.
14. The performance in this mid-course improvement is considered for final outcome.

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Opportunities

- **Mentor** is assigned to each student. Mentor meets student every month and issue if any is discussed.
- **Remedial teaching** – it is done for failure in preliminary/university exam and also for prolonged absenteeism due to health-related issues.
- **Retest**- it is conducted for students who fail in preliminary/university exam or who have missed internal assessment for exam for some reason or who want to improve the performance before marks are sent to university.
- **Discussion**- discussion is done for the performance in retest.
- **E - repository** - Students are given access to question bank (MCQ, SAQ and LAQ for practice), ppt teaching notes, PPTs (Power Point Presentation) and videos
- **Assignments** – Further assignments and necessary support is given to the students
- **Emphasis** – Emphasizing on specific difficult topics in theory and practical exam
- **Extra classes** – Conducting extra classes for clinical case presentation, for demonstrating use of various instruments
- **Diagrams / Flowcharts** – Practice of drawing diagrams flowcharts and writing exam papers are given to students as per teacher's decision.

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2.5.4DOC-2

Teachers of the Institution participate in following activities related to curriculum development and assessment oftheaffiliatingUniversity and/are representedonthefollowing academic bodiesduringthelastfiveyears (5)

1. Academiccouncil/BoSofAffiliatinguniversity
2. SettingofquestionpapersforUG/PGprograms
3. DesignandDevelopmentofCurriculum forAddon/certificate/DiplomaCourses
4. Assessment/evaluationprocessoftheaffiliatingUniversity

Year	**Nameofteacherparticipated**	**Name of the body in which thefull timeteacherparticipated**
2021-2022		Academiccouncillingcommittee
2021-2022		Questionpaper committee
2021-2022		Curriculumcommittee
2021-2022		Assessmentandevaluationcommittee

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2.5.4DOC -3

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Policy document of mid-course improvement of performance of students

Policies adopted by the Board of Management for Midcourse Improvement.

This policy applies to students who have failed in preliminary examination and/or university examination or prolong absenteeism due to health issues.

Following are the actions initiated as a part of Mid -Course improvement:

1. Mentors to guide/council their mentees at frequent intervals.
2. Discuss with respective student to identify weak areas.
3. Provide the students Information regarding teaching notes, power point presentations, videos, etc. access to the e-course or e-content.
4. Type of assignments to be given to students may be decided by Teachers.
5. Show and discus Models, training models , embryology models etc., -
6. Teachers can take decision to provide practice of drawing diagrams, flowcharts and writing exam papers to students
7. Make arrangements for Simulation based learning / Bedside learning to enhance the performance.
8. Plan for Subject seminars in special topics for such students.
9. Schedule for Compensatory exams before university examination to comply for eligibility/ betterment.
10. Make available previous year's university question papers to the students.
11. Provide Question bank for MCQ, SAQ and LAQ for practice.
12. Conduct Re-tests and consider overall performance for MID Course improvement.
13. Schedule for Compensatory exams before university examination to comply for eligibility/ betterment.

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Re-test and Answer sheets

Summary:

CPA card of all batches (regular and odd) is maintained which records each student's total attendance, submission of preclinical work, record book completion, seminar presented, assignments written.

The internal exams (theory, Practical and Viva Voce) are scheduled once in 3 months to assess the students understanding of the subject. The students were assessed accordingly based on their performance in the internals and the class tests. Students who scored less than 50 % in the 1st internals were identified and were motivated to do better. A parent-teacher meeting is scheduled to keep the parents/ Guardians well informed about their candidate's attendance and performance in the exams. To encourage the students' remedial classes were scheduled for the students who have underperformed. A performance improvement test is given to help the students regain confidence.

The improvement tests are assessed by all the teachers and the same is informed to the students. They are further motivated to do better in their internals.

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StudentMarksAssessment

MORETHAN70%

- Encouraged toattendconferencesandpresentposters

LESSTHAN50%

- Couselledandgiven timetoreadandreportback.
- Discussionstaken
- Mid courseimprovementtestaregivento helpandmovivatethem

TemplateofCPACard

Estd. 1974

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Continuous Performance Assessment Card for Department of Pedodontics & Preventive Dentistry

Name : ____________________

Roll Number : ____________________

Scheme : ____________________

Batch : ____________________

Children's Education Society (Regd.)
C.A. Site No. 40, 1st Phase, J.P. Nagar, Bengaluru, Karnataka, India – 560 078.
Tel.: +91 80 3041 0501/02 Fax : 080-2654 8658
Email: info@theoxford.edu
Website: www.theoxford.org.edu, www.oxford@vsnl.net

DEPARTMENT OF PEDODONTICS

Comprehensive Progress Assessment Card

Attendance

3rd BDS	Classes conducted	Classes attended	Percentage
Theory attendance			
Practical attendance			

4th BDS	Classes conducted	Classes attended	Percentage
Theory attendance			
Practical attendance			

Theory and Clinical Performance

	1st Internal	2nd Internal	3rd Internal	4th Internal	Clinical Grades	1st Test	2nd Test	Average	
								Theory	Clinical
Max. marks									
Marks obtained									
%									

Projects/Assignments:

Posters:

CD:

Any Other:

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Clinical Work	Quota	Work Done	Pre-clinical Work	Quota	Work Done
Detailed Case History recording			Restoration on typhodonts, Class - I		
Oral prophylaxis			Restoration on typhodonts, Class - II		
Fluoride application			Restoration on typhodonts, Class - V		
Restoration, Class - I			Habit breaking appliance		
Restoration, Class - II					
Extraction of primary teeth					

Please note the shortage in attendance and failure in internal assessment examination are marked in RED colour.

To be eligible to write the university examination a minimum attendance of 75% is required as per the university rules. The higher the internal assessment marks, the greater are the chances of getting good percentage in the university examination.

Teacher Signature

CHILD

SOCIETY

DENTIST

PARENTS

"Every child has a fundamental right to his total oral health"

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Local Anaesthesia

Atoula Ramyani
17/2/17

(1) Def- It is defined as Reversible loss of Sensation from Circumscribed area of body Caused by depression in excitation and Inhibition of Conduction to peripheral nerve.

Mechanism of Action

Removal of Ca^{++} ion from Sodium Receptor Site
↓
LA Bind to the Receptor Site
↓
Blockade of Sodium Channel
↓
Decrease in Sodium Conductance
↓
Decrease in Rate of electric depolarization
↓
Failure to achieve threshold
↓
Inhibition of Conduction

Specific Receptor Theory → This theory State that LA Bind to Specific Receptor Site and Cause the Blockage of permeability of Sodium ions.

Properties of Local Anaesthesia

2% Lidocaine hydrochloride
i) ~~It~~ Act as Vasoconstrictor.
ii) It ~~Act as Anti Oxidant~~ Adrenaline (1:80,000) act as (Antioxidant)
iii) Sodium Metabisulphite act as preservative
iv) Methyl Paraben
v) Sodium Chloride - Isotonicity
vi) Water - Act as Solvent

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Decrease failure to achieve threshold
↓
Inhibition of conduction

Properties

i) It must be Reversible
ii) It should not produce any local Reaction.
iii) It should free from allergic Reaction
iv) It should be Non-Irritating to tissue
v) It should produce low degree of systemic toxicity
vi) It should be sterilized and capable of producing sterilization
vii) It should have advantageous duration
viii) It should have Rapid onset
ix) It should without deterioration

Specific Receptor theory - This theory states that LA binds to specific Receptor and cause Blockage of permeability to sodium Pore. This is the most Acceptable theory.

(5) Def - It is defined as Reversible loss of sensation in circumscribed area of body caused by depression in excitation or inhibition of conduction in peripheral nerve.

Mechanism of Action

Removal of Calcium from Sodium Receptor site
↓
LA Bind to Receptor
↓
Blockage of Sodium Channel
↓
Decrease in Sodium Conduction
↓
Decrease in Rate of electrical depolarization

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↓

Failure to achieve threshold

↓

Inhibition of conduction

Properties of local anaesthesia.

i) It must be reversible

ii) It should not produce any local Reaction

iii) It should free from allergic Reaction

iv) It should Non-irritating to tissues

v) It should produce low degree of systemic toxicity

vi) It should sterilized and capable of producing sterilization

vii) It should have Rapid onset

viii) It should without deterioration

Specific Receptor theory - This theory states that LA Binds to specific Receptor and Blockage of permeability to sodium ions. It is most Accepted theory

Cleft Lip & Cleft Palate

Cleft Lip - A congenital deformity that presents as an abnormal lack of continuity of the lip musculature, lip skin and mucous membrane. The unusual breach can extend from the base of the nose to the free margin of the lip. The deformity may range from simple notch at the free margin to a complete disjointed lip that also results in a nasal deformity.

Cleft Palate - An abnormal discontinuity in the palatal musculature, mucous membrane with or without involvement of the hard palate, that may extend from the uvula to the alveolus.

Tessier's Classification :-

The breach in continuity that occurs at birth at any other part of the face other than the lip is termed orofacial clefts. There are also called tessier's cleft.

Tessier 0-14 -
The midline cleft is a median craniofacial dysrhaphia. The cleft involves median encephalocele, the ethmoid, maxilla and lip

Tessier 1-13 -
It is a paramedian craniofacial cleft. It separates the dome of the alar cartilage and occasionally present in the lip as in cleft lip. In the forehead region No.13 is the cranial equivalent of the facial cleft 1.

Tessier 2-12 .
Identical to preceding cleft, but more lateral, but not paranasal. On the soft tissue it affects the ala of the nose, the alar cartilage on the lip. On skeleton

2. Genes having biological activities linked to the OC's pathogenesis without direct involvement, e.g., the retinoic acid receptor.
3. Genes on locus identified in experimental animals as the homeotic genes MSX-1 and MSX-2
4. Genes involved in the interaction with the xenobiotics metabolism as those in P-450 cytochrome system

Environmental Factors,

1. Smoking
2. Alcohol intake
3. Drugs such as phenytoin diphenyl hydantoin
4. Pesticides such as dioxin
5. Hyperthermia during pregnancy.

Inheritibility ;

- If the first child has a cleft, the chance of the second being affected is around 30-40 times more.
- Monozygotic twins are far more likely to be concordant for CL/P.

Associated Anomalies :-

- It may be associated with other congenital defects.
- Association with cardiovascular system accounts for 24% of cases and association with malformation of upper and lower limbs or the vertebrae

Anatomy :-

Unilateral Cleft Lip.

- The abnormality minimal in incomplete clefts and maximum in wide complete clefts.

Nose.

→ The premaxilla is externally rotated, the lateral segment is retroposed and nose is rotated towards the normal side. The columella is deviated to the opposite side; the columella on the cleft side being short. The nasal floor is completely cleft and the nostril is transversely placed on the cleft side.

Lip.

→ The muscles comprising of orbicularis oris of the lips are unable to balance each other as mesenchyme from which they develop fail to penetrate between layers of the maxillary process.

→ The orbicularis oris in its development from lateral side to medial side fails to meet the fellow on the opposite side and turns upwards at the cleft to insert partially into its margin.

Bilateral Cleft Lip :-

→ Central frontonasal segment is not attached to the maxilla and so there is marked forward projection of the premaxilla. The abnormal forward projection of premaxilla is due to a marked forward position of the alveolar bone and the hypoplastic maxilla on both sides.

Problems faced by Cleft Children.

1. Feeding problems and regurgitation
2. Associated systemic anomalies.
3. Speech
4. Ear infections
5. Malocclusion
6. Maxillary growth retardation.
7. Severe class III defect
8. With or without collapse and posterior crossbite
9. Scarring

Management of Patients with Clefts

1. Primary
   a. Feeding plate/presurgical alveolar moulding
   b. Primary lip and nose repair
2. Secondary
   a. Secondary alveolar bone grafting
   b. Pharyngoplasty
   c. Orthodontic treatment
   d. Orthognathic procedures
   e. Rhinoplasty and scar revision of the lip.

Unilateral Cleft Lip Repair.

1. Tennison triangular flap repair
2. Millard rotation advancement repair.

Bilateral Cleft Lip Repair.

1. Straight-line closure
2. Adaptation of Tennison unilateral cleft lip repair
3. Black's technique
4. Skoog technique
5. Manchester method

Trigemenal Neuralgia

Sijo Freddy
20/9/18

Also called tic doulouréur, is the most commone of cranial neuralgia & chiefly affects individuals older than 50 years of age.

Anatomy

- It is the largest cranial nerve. Its sensory part supplies to the face, greater part of scalp, teeth, oral & nasal Cavities. Its motor part supplies the muscle of mastication.
- It divides into three branches: Ophthalmic, maxillary & mandibular.

Course

- The trigeminal nerve is continous with the ~~set~~ ventral surface of the pons, by a small motor root & a large sensory root.
- The fibers of the root arise from the cell of trigeminal ganglion.
- The ganglion occupies recess in the duramater, the ganglion is crescent shaped.
- The other nuclei are: sensory nucleus, motor nucleus & spinal nucleus
- The peripheral branches are grouped to form the ophthalmic & maxillary nerve & the sensory part of mandibular nerve.
- The central branches constitute the sensory root, which leaves the ganglion backwards & medially to enter the pons.

Ophthalmic Nerve:

Superior & smallest division of trigeminal nerve, wholly sensory, gives branches to the eye ball, lacriminal gland, conjunctiva, part of the mucosa, memberane of nasal cavity, skin of the nose, eyelids, forehead & scalp. Arises from the anteromedial part of TG & passes forward in the cavernous sinus close to its lateral wall & below the occulomotor & trochlear nerve.

It divides into three branches, i.e, [illegible]
frontal & nasociliary.

Maxillary Nerve

It is a true sensory nerve. It originates in the middle of TG & passes horizontally forward along the lateral wall of the cavernous sinus. It exists in the skull through the foramen rotundum into the pterygopalatine fossa, to enter the orbit through the inferior orbital fissure. Within the orbit it continues as infraorbital nerve occupying infraorbital groove & canal. It exist ~~in~~ through the infraorbital as labial, palpebral & nasal branches.

Mandibular Nerve

Largest division of trigeminal nerve. Consists of large sensory & small motor root. The nerve passes through the foramen ovale to enter the infra temporal fossa. The two root unite just below the foramen forming a single main trunk, which lies between the tensor veli palatini medially & lateral pterygoid laterally. The main trunk then divides into a small anterior & a large posterior trunk providing branches to the tongue mandible, all muscles of mastication etc.

Aetiology

i) Idiopathic
ii) Secondary.

Tumors

- Accoustic neurinoma

· Demyelination of thesenerve fibers causes uncontroll fibringof smallunmyelinated TN fibers. Lack of inhibitory input from largemyelinated nerve fibers cause prolonged exitation of the smaller trigemina fibers to the stimuli;

· Pathogensis of idiopathic TN is unclear. Compression of artery or vein over the ganglia or nerve causes ectopic impulses resulting in pain. Most commonly, superior Cerebella artery is the compression artery. Compression causes demyelination of the trigeminal roots at these sites. Reactivation of the HSV may also be suggested.

Clinical Features

· It is a chronic condition through symptoms may not be present for few months.

· It typically manifest as a sudden unilateral, intermittent paraoxysmal, sharp, shooting, lancinating, shock like pain.

· The pain is so severe that it prevent eating or drinking

· The attack is precipitated by touching the superficial triggerpoint.

· After the episode a bothersome sensation is present over the region.

· Mandibular & maxillary divisions are commonly involved.

· Pain is always unilateral & does not shift sides through bilateral cases.

Trigger points,

- V_1 - Supra orbital ridge of the affected side.
- V_2 - Skin of upperlip, ala nasi or cheek or on the upper gum.
- V_3 - Lower lip teeth or gums of lowerjaw.

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Surgical Managment

· Peripheral Surgery

It is done very close to the area where the trigger area is located, cryotherapy, alcohol block, laser & nevroctomy. These give short term pain relief & cause few complications. They are now rarely used & are only suitable when other procedure are not possible.

· Ganglion Procedures :

These procedures advocate precutaneous approaches to the TG via the FO.

Alcohol uses the nevrolytic agent most commonly usi injection

i) thermocoagulation ii) glycerol injection
iii) baloon compression.

Needle Placement

The technique of needle placement in common to all. of these image intensification or hard copy radiograph are almost universally employed now for visualization of the position of the foramen & than for confirmation of the depth of prenetration & the position of any contrast medium used.

· Radiofrequency thermo coagulation

- The needle used here has an insulated shaft & a bone sufficient for the passage of a radiofrequency electrode.
- Once the radiofrequency needles is in the foramen ovale it is advanced into the TG.
- When it is correctly placed CSF should emerge on removal of the style as the ganglion contain CSF.
- The patient is then asked to indicate where on the face the stimulation is felt.

Trigeminal Neuralgia

Also called tic douloureu, is the most common of cranial neuralgia & chiefly affects individuals older than 50 years of age.

Anatomy

- It is the largest CN. It senseory part supplies to the face, greater part of scalp, teeth, oral & nasal cavities. Its motor part supplies the muscle of mastication
- It divides into the 3 branches: Ophthalmic, maxillary & mandibular.

Courses

- Trigeminal N is continous with the ventral surface of the pons, by a small motor root & a large sensory root.
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Ophthalmic Nerve:

Superior & smallest division of TN, wholly sensory gives branches to the eyeball, lacriminal gland, part of mucosa membrane of nasal cavity, skin of nose forehead & scalp. Arise from the anteromedial part of TG & passes forward in the CS close to its lateral wall & below the occulomotor & trochlear nerve. Divides in 3 branches, i.e, lacriminal, frontal & nasociliary.

2. Post natal managment
By multidisciplinary approach.

Team approach to Pt's approach

Dentistry
- Ortodontic
- Pediatric dentistry
- Prosthodontics
- ENT Audiology
- Speech & language Pathology
- Pediatrics
- Psychology.

Surgery
- Oral & Maxillo facial surgery.
- Nursing
- Genetic
- Social Support & Service
- Ophthalmology

Treatment planning & timing

Stage 1 (Birth to 18 months)

1. Passive maxillary obturator
- It is an intraoral prosthetic appliance that fills the palatal cleft, provides a fake roofing
- Prevents escape of air, provides which the child can suckle.
agent which the child can suckle.

2. Infant Orthopedics
- Done before eruption of any 1 teeth & aims to correct tongue posture, feeding habits & swallowing
- Done at 2-3 weeks.

Lanthum Appliance
Expands & aligns the maxillary segments.

3. Naso/Presurgical Alveolar moulding
A new approach to presurgical infant orthopedic developed by grason reduce the severity of initial cleft alveolar & nasal deformity, initial cleft alveolar & nasal deformity.

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INTERNAL ASSESSMENT EXAMINATION
MAIN ANSWER BOOK

18/70

Sl. No.: 5519

Reg. No.:
No. of Additional Sheets:
Name: Gross Jai Krishna
Subject: Public Health Dentistry.
Course: BDS (IVth YEAR)
Date:
Examination: Ist Internals
Invigilator's Signature:

Ans. Q1.

Long Essay:

1. Epidemiology is defined as the study of the spread and control of diseases, causes, risk factors of health-related states & events in specified population.

2. Steps of RCT:

→ Gathering the Research team.
→ Determining the research Question.
→ Defining Inclusion & Exclusion Criteria.
→ Randomization.
→ Determining & Delivering the Intervention
→ Selecting the control
→ Determining & Measuring Outcomes
→ Blinding Participants & Investigators.

II Define Primary Health Care. Principles of Primary Health Care.

Primary Heath care defined as the health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment.

2

Principles of Primary health care

→ Equitable distribution
→ Community participation.
→ Intersectoral co-ordination
→ Appropriate technology.

Equitable Distribution.

• 'Inverse care Law'.
Availability of good medical care tends to vary inversely with the need for it in the population served.

Examples:

• Tripura: Helicopter service to reach the remote set of tribal hamlets.

Community participation

→ Involvement of the individuals.
→ Determines both collective needs & prior
→ Important role in formulating
→ Universal coverage.

II Short Essay

(3) WHO is a specialised agency of the UN nations that is concerned with international public Heath.

→ Establised on 7th april 1948 and is headquar in Geneva, Switzerland.

2

Objectives of WHO

→ To develop and implement multi sectorial public policies.
→ Current Objective :- To attain a level of heal

(4) Vitamins.

2

Vitamins are organic components in food that are needed in very small amounts for growth and for maintaining good health

(7) Host factor in dental caries

1-

→ Tooth
→ Saliva
→ Sex
→ Race

(8) Mechanical plaque control aids.

Teeth Brushes

- They differs in size, length.
- So Tooth Brush consists of handle & head.

1-

(9) ASHA.

Accredited Social health Activists

is a community health worker instituted by the government.

1-

(10) Cohort Study:

It is a type of pre Analytical study which is undertaken to obtain additional evidence ...

1-

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(1 -)

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(7) Host factor in dental caries

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→ Saliva
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(8) Mechanical plaque control aids.

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-1-

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-1-

(10) Cohort Study :

It is a ~~group~~ type of ~~pe~~ Analytical study which is undertaken to obtain additional ~~evidence~~

1 -

Short Answers :

11. Types of Evaluation.

- Formative Evaluation
- Summative Evaluation
- Diagnostic Evaluation

2

12. Private fee for service.

Is a Medicare Advantage (MA), health plan, offered by a state licenced risk bearing entity.

1

Short Answers :

11. Types of Evaluation.

- Formative Evaluation
- Summative Evaluation
- Diagnostic evaluation

2 -

12. Best Private fees for service.

Is a Medicare Advantage (MA), health plan, offered by a state licenced risk bearing entity.

1

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INTERNAL ASSESSMENT EXAMINATION Sl. No.: 5887
MAIN ANSWER BOOK

33/70

Reg. No.: 17D4875 No. of Additional Sheets: 1
Name: Soham Chakraborty Subject: Periodontics
Course: IVth BDS Old Date: 28/2/22
Examination: 3rd Internal. Invigilator's Signature:

Ans.

1. Periodontal pocket is defined as pathological deepening of gingival sulcus

Classification.

~~Perio~~ Classified based on no. of surfaces involved.

- Simple pocket - Only one surface
- Compound pocket - 2 surfaces are involved
- Complex pocket - 3 or more surfaces are involved.

Classification based on position of the pocket.

- Suprabony - Base of the pocket is above alveolar process

Base of pocket
Alveolar process

- Infrabony - Base of the pocket is below alveolar process.

Alveolar
Base of pocket

3

29½/70
Thradha 28/02/22

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Estd.1974

INTERNAL ASSESSMENT EXAMINATION SI. No.: 5900

MAIN ANSWER BOOK

Reg. No. : 1704851 No. of Additional Sheets :

Name : K.L.D. Yasaswini Subject : Periodontology

Course : BDS 4th year. Date : 28.2.2022

Examination : 3rd Internal. Invigilator's Signature :

Ans.

(1) Periodontal Pocket:
It is defined as Pathological deepening of gingival sulcus.

classification.

Active pocket
inactive pocket

Base on tissue involvement
fibrous pocket
Edematous pocket

Based on surface involved
Simple pocket
Compound pocket
complex pocket

Based on Position
Intrabony pocket
Suprabony pocket

Gingival pocket
Periodontal pocket

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INTERNAL ASSESSMENT EXAMINATION Sl. No. : 5888
MAIN ANSWER BOOK

Estd.1974

28/12 (29)

Reg. No. : 1704805
Name : Arundhati Roy.
Course : IV BDS
Examination : 3rd Internal
No. of Additional Sheets :
Subject : Periodontics.
Date : 28/02/2022
Invigilator's Signature : B N Shilpa

Ans.

(1) Pockets

Periodontal pockets are defined as pathologically deepened. ~~Sulcus~~ gingival sulcus.

- Classification of periodontal pockets :-

(1) Suprabony pocket

(2) Infrabony pocket

Suprabony pocket

Infrabony pocket

a) Simple pocket

b) Compound pocket

c) Spiral / complex pocket -

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INTERNAL ASSESSMENT EXAMINATION
Sl. No.: 5901
MAIN ANSWER BOOK

4½

Reg. No. : 17D4834
No. of Additional Sheets : 06
Name : Vatansh Sarhi
Subject : Periodontics 28/2/2022
Course : IV BDS
Date : 28 Feb, 2021
Examination : III Internal
Invigilator's Signature :

Ans.

PERIODONTAL POCKET

Periodontal pocket is defined as the pathological deepening of gingival sulcus, ie 3 mm or more.

(7)

Classification

1) Based on the relationship to the ~~marginal~~ migration

- Pseudopocket / gingival pocket → due to coronal migration of marginal gingiva
- True pocket - due to apical migration of junctional epithelium

2) Based on relationship to crestal bone

- Supracrestal / suprabony
- Infracrestal / infrabony

3) Based on number of surfaces involved

- Simple → 1 surface involve
- Compound - 2 surface involve
- Complex / spiral pocket → arises from

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INTERNAL ASSESSMENT EXAMINATION

MAIN ANSWER BOOK

Sl. No.: 10370

Reg. No.: 15D4852

No. of Additional Sheets:

Name: Pucha Sai Manaswini

Subject: PEDODONTICS

Course: IV YEAR BDS

Date:

Examination: II internal

Invigilator's Signature:

8/10

Ans.

CASE SCENARIO - 2

O.P Number: C095868

Name: Nithila

Age/Sex: 4 years / Female

School & Class: Vidya public school, UKG

Father/Guardian Name and Occupation: Shiva, Business

House Address: Garebhavipalya, Bangalore

Phone Number: 9645328159

Languages known: Kannada, English

Chief complaint:

Patient complains of pain and swelling in the lower right back teeth region since 1 day.

History of present illness:

Patient gives a history of pain and swelling in the lower right back teeth region since 1 day. Pain is sharp shooting in nature, intermittent in frequency, radiating type, aggravates on having food, lying down during night time and relieves on cold stimuli. Swelling present on lower right back tooth region since 1 day, sudden on onset. No pus discharge, no other associated symptoms

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INTERNAL ASSESSMENT EXAMINATION

MAIN ANSWER BOOK

Sl. No. 10370

Reg. No.: 15D4852

No. of Additional Sheets:

Name: [illegible]

Subject: PEDODONTICS

Course: IV YEAR BDS

Date:

Examination: II Internal

Invigilator's Signature: [signature]

8/10

Ans.

CASE SCENARIO - 2

O P Number: [illegible]

Name: [illegible]

Age / Sex: [illegible] / Female

School & Class: [illegible]

Father / Guardian Name and Occupation: [illegible]

House Address: [illegible], Bangalore

Phone Number: [illegible]

Languages known: Kannada, English

Chief complaint

Patient complains of pain and swelling in the lower right back teeth region since [illegible] day

History of present Illness

Patient gives a history of pain and swelling in the lower right back teeth region since [illegible] day. [illegible] to frequency, [illegible] during night time and relieved on [illegible]. Swelling present on lower right back teeth region since [illegible] day [illegible] onset. No pus discharge nor other associated symptoms

Dean and Director

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INTERNAL ASSESSMENT EXAMINATION Sl. No.: 0783

MAIN ANSWER BOOK

Reg. No. : 18DO414 No. of Additional Sheets :

Name : Mohammed Sayeed ur Rahman Subject : Oral Surgery

Course : BDS (IV Year) Date : 11/04/2022

Examination : 1st internals Invigilator's Signature :

Ans. LE:-

1. classify midface fractures. explain management of lefort I fracture
2. explain anatomy of maxillary sinus. write in detail about clinical features Oroantral fistula.

SE :-

3. fibroOsseous lesion
4. Ameloblastoma.
5. favourable & non favourable fractures
6. Anterior maxillary Osteotomy
7. CPR
8. BSSO
9. Odontogenic keratocyst C.F & Management
10. Reconstruction plates

SA

11. dry socket
12. Suture material
13. Vasoconstrictor in LA
14. principles of exodontia.
15. Enumerate surgical approach to Tmj

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Mid-face fra[illegible]

Classification

- Lefort I → low level fracture
- Lefort II → Pyramidal or subzygomatic fracture
- Lefort III → High transverse or suprazygomatic fracture

Lefort I fracture :-

- Results from a horizontal force delivered along the level of the teeth.
- The fracture courses from the lateral border of the pyriform aperture → above the canine eminence.
  - → lateral antral wall
  - → behind the maxillary tuberosity
  - → across the lower third of the pterygoid plate.
- Almost always involves the pterygoid process of the sphenoid bone.
- The fracture separates the maxilla from the pterygoid plates and nasal & zygomatic ~~[illegible]~~ structures
- This type of trauma may separate the maxilla in one piece from other structures, split the palate, or fragment the maxilla.
- May involve the maxillary sinuses
- The resultant "floating" component is the lower part of the maxilla & its teeth

Anatomy:-

→ Largest of PNS
→ communicates with the other sinuses through lateral nasal wall.
* Horizontal pyramidal shaped.
→ Base.
→ Apex.
→ 4 walls — superior, inferior, lateral, anterior

* Medial wall :-
formed by lateral nasal wall.
Below → inferior nasal conchae.
Behind → palatine bone
Above → uncinate process of ethmoid, lacrimal bone.
→ Contains double layer of mucous membrane.

Ostium:- Opening of the maxillary sinus is called Ostium
→ It opens in middle meatus at the lower part of the hiatus semilunaris
→ Lies above the level of nasal floor

Superior wall :- forms roof of sinus & floor of orbit
→ Imp structures :- Infraorbital canal
Infraorbital foramen
Infraorbital nerve & vessels

* Posterolateral wall
* made of zygomatic & greater wing of Sphenoid bone
* Thick laterally. thin medially
* Important structures → PSA nerve
→ maxillary artery.

* Anterior wall :-
Extends from pyriform aperture anteriorly to zygomatic suture & inferior orbital rim superiorly to alveolar process inferiorly
* convexity towards sinus
* Thinnest in canine fossa
* Important Structures:
→ infraorbital foramen.

floor of sinus :-
formed by junction of anterior sinus wall & lateral nasal wall.
→ 1-1.2 cm below nasal floor.
close relationship between sinus & teeth facilitate spread of pathology

Oroantral fistula -
Def :- Abnormal connection b/w the Oral & antral cavities

Causes :-
* Extraction of maxillary posterior teeth
* Tumor
* Cyst
* Trauma.

Signs & Symptoms :-
→ Unpleasant tasting discharge & odor
→ leakage of air
→ Difficulty in tobacco smoking

Clinical Examination -
* Gentle suctioning of the socket produce a hollow sound
* Leakage of air while blowing against closed nostrils

Management -
* The primary purpose is closure of the defect and prevention of sinusitis
* Suturing or periodontal pack
* Rinses with physiologic solution
* Rinses with antibiotic solvent
* Antibiotic prophylactic.

→ Buccal flap :-
Inj of LA in mucobuccal fold
It reduces local capillary bleeding by vasoconstriction at time of operation
• Excision of fistulous tracts
* Incision is made, 3-4 mm marginal to orifice
* ~~Buccal soft tissue~~
Incision making :-
→ Two divergent incisions are taken with blade no 15, from each side of orifice into buccal sulcus for a distance of 2-5c...

→ Incisions are made down till the bone.
→ extend the incisions till cheek.
→ Care must be taken to avoid injury to papilla & duct of parotid gland.
→ Mucoperiosteal flap is elevated.
→ Resection of bony margins is done, with alveolar ridge
→ Reduction & smoothening of same is carried out.

Palatal Island flap :-
→ Procedure dissects out an island of palatal mucosa.
→ Retains its connection to Greater palatine artery

Fibro Osseous le...

Defn:- Fibro osseous lesions are a diverse processes that are characterized by replacement of normal bone by fibrous tissue containing newly formed mineralized product.

Classifn:-

a) Fibrous dysplasia.
b) Reactive lesions arising in the tooth bearing

Non-Hereditary:-

- periapical cemento-osseous dysplasia.
- focal cemento-osseous dysplasia.
- Florid cemento-osseous dysplasia.

Hereditary:-

- familial gigantiform cementoma.

c) Fibro-osseous neoplasms.

- Cementifying fibroma.
- Ossifying fibroma.
- Cemento-ossifying fibroma

d) Cherubism

* Management :-

i) Surgical enucleation.

Complications :-

* OKCs have satellite cysts which during enucleation if not removed can reccur.

CPR :-

→ Cardio-pulmonary resuscitation.
→ It is the life saving technique useful in many situations
→ It is the basic life support technique
→ Purposes :-

* To maintain an open and clear airway
* To maintain breathing by external ventilation
* To maintain blood circulation by external cardiac massages
* To save life of the patient

Indications :-

* Cardiac Arrest
* Ventricular fibrillation
* Ventricular tachycardia.

* Respiratory
* stroke
* coma
* suffocation
* etc

Procedure :-

* Approach safely
* check for response.
* shout for help
* Open airway
* check breathing
* Call 108
* 30 chest compressions.
* 2 rescue breaths.

(11) Dry socket :-

→ Also called alveolar osteitis
→ Post operative condition
→ extreme pain
→ Happens when → too much pressure applied to the socket while extraction
→ Improper irrigation
→ left out bony spicules.

(12) Suture Material :-

(a) Based on method of degradation :-

→ Non absorbable
→ Absorbable.

(b) Based on filament :-

→ Monofilament
→ Multifilament
→ Pseudofilament

...sed on marking ...
Teflon coated
Chromium.

Vasoconstrictor in LA :-

- In addition in nerve blocks, Vasoconstriction is a prominent feature of LA
- It decreases bleeding & helps to maintain a cleaner view
- Ephedrine in LA acts as vasoconstrictor

principles of exodontia :-

- Good acess & clean visual field
- expansion of bony socket
- Use of controlled force.
- Unimpeded path of removal

Principles used :- 1) lever principle
2) wedge principle.

... the bone due to a defect in osteoblastic differentiation and maturation.

- Any bone can be affected. Primary defect is the replacement of bone by fibrous tissue in which secondary metaplastic bone formation occurs.

→ Etiology :

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) Based on materials coated
* ~~ɑɛɛ~~ Teflon coated
* Chromium.

) Vasoconstrictor in LA :-

→ In addition in nerve blocks, Vasoconstriction is a prominent feature of LA
(1½) → It decreases bleeding & helps to maintain a cleaner view
→ Ephedrine in LA acts as vasoconstrictor

(iv) principles of exodontia
→ Good acess & clean visual field
(2) → expansion of bony socket
→ Use of controlled force.
→ unimpeded path of removal

Principles used:- 1) lever principle
2) wedge principle.

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in GNAS-1 [guanine nucleotide binding protein, stimulating activity polypeptide]. gene located on chromosome 20q 13.2.

- This codes for G- Protein involved in production of cAMP for endocrine function, melanocyte fn, osteoblast maturation.
- Mutation leads to overproduction of cAMP which causes tissue dysfunction.
- G Protein affects the β - Catenin signalling mechanism involved in bone formation modulation
- If early postzygotic phase → all 3 tissues are involved
- If late postzygotic phase → only skeletal system is involved

→ Clinical Features:

- 2 forms:

a) Polyostotic fibrous dysplasia.
b) Monostotic fibrous dysplasia.

→ Polyostotic FD:

- 20-30% prevalance, involves more than 1 bone.
- Usually unilateral. Rarely bilateral.
- Shephard crook deformity is characteristic/pathognomic. Involves curvature of femoral neck and proximal shaft ...
- 'Cafe-au-lait' Spots - pigmented macule, seen on same side as bony lesions.
- Precocious Puberty due to endocrine dysfunction.
- McCune-Albright Syndrome → Bone defects + Cafe-au-lait spots + Endocrine dysfunction
- Jaffe's Type → Only Cafe-au-lait Spots
- Mazabraud Syndrome → FD.. multiple intramuscular myxomas.

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- Monostotic Fibrous dysplasia:
- More common (70-80%), less severe, equal gender predilection
- Mostly affects ribs, femurs, craniofacial bones.
- Leonine appearance → maxilla & related structures are affected

→ Oral manifestations:

- When jaw bone is affected, there is pain, swelling, deformity.
- First clinical sign is painless swelling of the jaw.
- May lead to malalignment, tipping, displacement of teeth and tenderness.
- Endocrine disturbance may lead to delayed / altered eruption sequence and malposition of teeth.
- Fibrous dysplasia of maxilla is a serious disease, mostly affecting children. Lesions are not circumscribed, involves the sinus, zygomatic process and result in marked facial deform
Requires radical mutilating surgery to cure.

→ Radiographic Features:
- Rind Sign - Normal trabecular pattern is lost and the endosteal portion may show scalloping. The thick sclerotic border of the lucent lesion is the rind sign.

(6/3)

- Ground glass appearance - Radio-opaque spicules seen in radio lucent areas. AKA orange peel appearance. Seen in mature lesion of monostotic fibrous dysplasia.

→ Histology:
- Numerous irregular, C shaped disconnected trabeculae of woven bone
- Early lesions show more fibrous tissue, advanced lesions show bony trabeculae in characteristic chinese letter pattern.
- Typical osteoblastic rimming of bony trabeculae is absent.

2. Enumerate vesiculo bullous lesions. Write about OLP.

Ans. Vesiculo bullous may be classified based on their histopathological ~~classification~~ as:

i) Intraepithelial bullous lesion:
- HSV infection
- Varicella
- Herpangina
- Hand, foot and mouth disease
- Pemphigus
- Epidermolysis Bullosa.
- Mucosal erythema multiforme.

ii) Sub epithelial lesions.
- Bullous pemphigoid
- Cicatricial pemphigoid
- Dermatitis herpetiformis
- Dermal erythema multiforme.

→ ORAL LICHEN PLANUS

- It is a chronic dermatologic disease of the oral mucosa
- Immunologically mediated mucocutaneous disorder.
- Can affect either skin and mucosa or both
- Autoimmune disorder.

→ ETIOLOGY:

- Caused by CD8+ T cells which attack native cells of the body, primarily the basal keratinocytes
- Risk factors are:
  - drugs
  - Mechanical trauma
  - Contact allergens
  - Viral infection.

ETIOPATHOGENESIS :

Antigen Captured by dendritic Langerhans Cells

↓

Inflammatory cytokines (IL-1, TNF) cause loss of DC adhesion

↓

Migration and rounding of dendritic cells.

↓

Directed to the lymph node by chemokines (RANTES)

↓

mature DC activates naive T cells.

↓

CD8+ Tcells Cause Keratinocyte apoptosis after recognizing the MHC class I protein on it

↓

They release cytokines which attract additional lymphocytes.

6½

→ CLINICAL FEATURES

- F > M = 1.4 : 1
- Adults over 40 years
- Skin lesions appear as small, angular, flat topped lesions
- Surface is covered by a thin, fine greyish white lesion called Wickham Striae.
- Primary symptom is pruritus which maybe severe.

→ ORAL MANIFESTATIONS :

- Reticular
- Erythematous
- Erosive.
- Wickham Striae - intersecting net like lines
- Bilaterally occuring lesion.
- Predominantly seen in buccal mucosa, tongue, lips,

gingiva, floor of the mouth.

→ Histology :

- Exhibits hyperkeratosis (Para / ortho)
- Thickening of granular layer (acanthosis)
- Liquefaction degeneration of basal cells
- Saw tooth appearance.
- Max - Joseph space - histologic cleft.

→ Treatment :

- Only Symptomatic, no cure.
- ~~Pagets d~~

3. Pagets disease :

- Bone disorder characterized by abnormal bone remodelling resulting in deformed, functionally inefficient bone.
- Condition presents with excess osteoclastic activity followed by a compensatory ↑ in osteoblastic activity leading to formation of disorganized bone, which is less compact, mechanically weaker, highly vascular, more susceptible to fracture.

→ Etiology :

Increased sensitivity to factors such as
1,25 dihydroxy Vitamin D, IL-6,
RANKL
↓
Stimulation of Osteoclasts.
↓
Abnormal bone formation
↓
Increased Vascularity of bone
↓
Bone is enlarged & weakened. → deformed bone is formed

Clinical features:

Age → 40-50 years

M : F :: 2 : 1

Common in: England, Germany, France.

→ Histology:

i) Osteolytic phase

ii) Mixed osteolytic and osteoblastic

iii) Osteoblastic with sclerotic final phase.

→ Osteolytic Phase:

- Increased bone resorption
- Increased no of osteoclasts, seen as multinucleated giant cells, which may have upto 100 nuclei.

→ Mixed Phase:

- New bone matrix is formed
- Woven bone is formed.
- Jigsaw puzzle pattern → Small irregular fragments of newly formed woven bone.

→ Blastic Phase:

- Bony islands → compact
- Marrow space → Lightly vascularized fibrous tissue.

→ Treatment:

- No specific cure / treatment.

→ Ectodermal dysplasia

- Rare hereditary disorder.
- Characteristic physiognomy
- Genetic disorder affecting development of teeth, hair, nails
- Can affect skin, retina as well

→ Etiology:

- Hypohydrotic ectodermal dysplasia is aSTD or X-linked recessive trait.
- Genes responsible are situated on different chromosomes that are mutated or deleted.

→ Clinical types:

i) Clouston's Syndrome.
ii) Christ - Siemens - Touraine Syndrome.

→ Clinical features:

- Various body structures show abnormalities
- Commonly seen in whites
- However other races are rarely affected as well.

→ Manifestation:

- Oral cavity may show oligodontia of primary and permanent teeth. Primary teeth maybe congenitally absent.
- Abnormal crown formation is seen.
- Anterior teeth of maxilla and mandible have conical teeth
- Palatal arch is high and cleft palate maybe present.

5. OSTEOGENESIS IMPERFECTA:

3½ Genetic disorder of connective tissue caused by abnormality in synthesis of type I collagen.

- Also called brittle bone disease.

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INTERNAL ASSESSMENT EXAMINATION

Sl. No. : 1296

ADDITIONAL ANSWER BOOK

Reg. No. : ____________ Invigilator's Signature : ____________

Ans.
- Characterised by increased susceptibility to bone fracture & decreased bone density

→ Pathogenesis :

Genes Coding Type I collagen
↓
CoL 1A1 located in Chromosome in 17q21 & 17q22-1
↓
Mutation of the gene
↓
Osteogenesis Imperfecta.

→ Clinical Features
- Fragility of bone and increased proneness to fracture
- New bone formed is defective due to defective collagen formed
- Sclera is thin, pigmented - bluish color.

→ Radiographic Features :
- Osteopenia
- Bowing, angulation, deformities of long bone.
- Multiple fractures
- Wormian bones in skull
- Multiple radiolucencies

→ Histological features :
- ↓ or ~~abnormal~~ secretion of abnormal collagen I, results in insufficient osteoid production.

- Osteoblastic activity is altered
- Both enchondral and intramembraneous ossification are affected
- Osteoblasts and osteoclasts are seen in abundance.
- Increased bone turnover

→ Treatment : No specific treatment

6. Benign mucous membrane pemphigoid :

- Cicatricial pemphigoid is an autoimmune blistering disease associated with auto antibodies
  ↓ directed
  against BM zone target antigens
- IgG is associated with cicatricial pemphigoid
- IgA has also been detected

→ Clinical features :

- Age : 40-50 yrs.
- Gender predilection - Female.
- Site - OMM, conjunctiva, skin etc.

→ Oral manifestations :

- Mainly on gingiva
- Mucosal lesions are also vesiculobullous, but appear relatively thick walled.
- Eventually they rupture, leaving a raw, eroded, bleeding surface.
- In advanced cases, if oropharynx is involved, with progressive Oesophageal stenosis, hoarseness of voice, dysphagia are seen.

→ H/F :

- Vessicle & bullae are subepidermal rather than suprabasillar.
- No evidence of acantholysis.

basement membrane appear to detach epithelium from underlying CT.

Acrodynia / Pink disease / Swift disease:

- Uncommon disease of unknown etiology with striking cutaneous manifestations.
- Cause maybe mercury toxicity or idiosyncrasy to metal / poisoning.

→ C/F:

- Age - Mostly young infants <2yrs, rarely 5-6 years as well.
- Site - hands, feet, nose, cheeks - turn red and clammy.
- Raw beef appearance.
- Pruritic maculopapular rash.
- Severe sweating.

→ Oral manifestation:

- Profuse salivation with dribbling
- Bruxism
- Sensitive, painful gingiva
- Difficulty in mastication.

→ Treatment:

- Administration of DMSA, dimercaprol

8. Effect of radiation on oral tissue:

- Mucosa in path of radiation first appears hyperemic and edematous. With continued radiation, mucosa becomes ulcerated & covered with fibrous exudate.
- Great discomfort, intensified by contact with highly seasoned food is common.
- Mucositis persists throughout radiotherapy + several weeks after.
- Unless 2° infection occurs, spontaneous remission follows termination of radiation therapy

- In severe pain & dysphagia, nasogastric tube feeding may
- Effect is transient & normally will be restored in 60.
after completion of RT therapy.

9. CREST syndrome

- Mild variant of Systemic sclerosis
  - C - Calcinosis Cutis
  - R - Raynauds Phenomenon
  - E - Oesophageal dysfunction
  - S - Sclerodactyly.
  - T - Telangiectasia

18. Lichenoid Reaction: ~~Target lesion~~

- Represents a group of lesions, similar to L P histologically + cli
- May involve Skin / oral mucosa.
- Unlike LP, cause is identifiable & its withdrawal leads to remission of the lesion.

17. Auspitz Sign:

- Psoriasis of Skin is characterized by occurrence of small, sharp delineated dry papules, each covered by delicate silvery scal which has been described as resembling a thin layer of MICA.
- Characteristic Feature: If deep scales are remove, 1(+) blee points are seen.

16. Cell within Cell phenomenon:

- Described as a process of non apoptotic cell death where one cancer cell surrounds another cancer cell followed by degradatio of internalized cell by lysosomal enzymes.

15. Eye to Heaven appearance: In cherubism: a rim of sclera maybe visible beneath the iris because of expansion involving orbital rim, giving classic EYH appearance.

the called battle bone an-

CHILDREN'S EDUCATION SOCIETY (Regd.)

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Karnataka & Recognised by Dental Council of India, New Delhi)
Bommanahalli, Hosur Road, Bangalore – 560 068.
Ph: 080-61754680 Fax : 080 – 61754693E-mail:deandirectortodc@gmail.c
Website: www.theoxford.edu

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INTERNAL ASSESSMENT EXAMINATION Sl. No. 1391

MAIN ANSWER BOOK

Reg. No. :

Name : Milga Maria C.R.

Course : I BDS

Examination :

No. of Additional Sheets :

Subject :

Date :

Invigilator's Signature :

Ans.

(1) Write in detail morphology of mandibular first premolar. Discuss the arch traits for premolars

The mandibular first premolar is the fourth tooth from the median line and the smallest tooth in the mandible.

The tooth is situated between the canine and second premolar.

Chronology

First evidence of calcification → $1\frac{3}{4}$ – 2 yrs

Enamel completion → 5-6 yrs

Eruption → 10-12 yrs

Root completed → 12-13 yrs

* Buccal aspect

→ well developed middle buccal lobe – resulting in pointed buccal cusp

→ mesial cusp ridge is shorter than distal cusp ridge

→ contact areas are almost at the same level mesially and distally.

→ crown is roughly trapezoid.

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⇒ Cervical line exhibits little curvature buccally.

⇒ Tip of buccal cusp is pointed and is most located little mesial to centre of crown buccally.

⇒ Distal slope of buccal cusp is narrower mesiodistally than at contact area.

⇒ Buccal surface of crown is smooth and no developmental groove and few developmental line.

* Lingual Aspect

⇒ Well developed middle buccal lobe, resulting in pointed buccal cusp.

⇒ mesial cusp ridge is shorter than distal cusp ridge.

⇒ Contact area are almost at same level mesially and distally.

⇒ Crown is roughly trapezoid.

⇒ Cervical line exhibits little curvature bucally.

⇒ Mesial outline of crown is straight above cervical line.

⇒ Tip of buccal cusp is pointed and is mostly located little mesial to center of crown buccally.

⇒ Distal outline is slightly concavity.

⇒ Cervix of crown is narrower mesiodistally than at contact area.

⇒ Root is much narrower lingual side tapers evenly from cervix to apex.

* Mesial Aspect

⇒ Crown outline is roughly rhomboidal.

⇒ Tip of buccal cusp is nearly centered over the root.

⇒ convexity of outline of lingual lobe is lingual to the root.

⇒ Tip of lingual cusp is on line apex with lingual border of root.

⇒ Buccal outline is curved from cervix to tip of

cusp is 2/3rd of that buccally.

⇒ Lingual border of mesial marginal ridge, developmental depression mesiolingually and leads to mesiolingual development groove.

⇒ Below the contact area, surface is concave above cervical line.

⇒ Root outline from cervix to apex is relatively in line tip of buccal cusp.

⇒ marginal ridge is confluent with lingual cusp ridge.

⇒ Distal contact area is broader than mesial and the center at a point.

* Distal Aspect

⇒ Distal marginal ridge is higher above cervix and have extreme lingual slope of mesial marginal ridge.

⇒ Distal contact area is broader than mesial and the centre is at a point midway b/w buccal and lingual crest of curvature.

⇒ curvature of cervical line distally in same as mesially with less curvature.

⇒ surface of root exhibits more convexity than found mesially.

* Occlusal surface

⇒ mandibular premolar exhibit more variations occlusally than maxillary premolars.

⇒ occlusal outline is roughly diamond shaped.

⇒ middle buccal lobe makes up major bulk of tooth crown.

⇒ buccal ridge is prominent.

⇒ mesiobuccal and distobuccal line angles are prominent although round.

⇒ Has 2 depression, mesial and distal fossa.

⇒ mesiolingual developmental depression & grooves are present.

⇒ lingual cusp is small,

Arch traits that of Mandibular Premolars.

Buccal ⟹ * Buccal ridge is less prominent
* Crown exhibited slight distal tilt on root due to greater distal bulge.

Lingual ⟹ more difference between heights of buccal and lingual cusps.

Proximal ⟹ * Crown tilts to lingual so buccal cusp tip almost centered over root.
* Lingual cusp is much shorter than buccal

Occlusal ⟹ * Crown shape closer to square or round.
* Crown less oblong.

Buccal

Lingual

occlusal

Mesial

Distal

② Classify salivary glands. Describe the histology of submandibular gland. Add a note on clinical consideration of salivary gland.

The salivary glands have been classified in a variety of ways,

① size and location, namely major and minor gland, and based on location lingual and labial.

② histochemical nature of secretory product namely serous and mucous.

Major salivary glands

* Parotid gland
⇒ largest major salivary gland.
⇒ It is located subcutaneously lying in front of the external ear and its deeper portion lies behind the ramus of mandible.
⇒ It is pure serous gland.

* Submandibular gland
⇒ The submandibular gland is the second largest salivary gland and also called submaxillary salivary gland.
⇒ The submandibular gland is on the medial aspect of the body of mandible in submandibular triangle.
⇒ The main excretory duct is Wharton's duct.

* Sublingual gland
⇒ sublingual gland is the smallest of major salivary gland.
⇒ It is in "almond shape.
⇒ It lies b/w the floor of the mouth, below the mucosa.

⇒ The main duct Bartholin's duct opens with or near the submandibular duct.

Minor salivary glands

⇒ The minor salivary glands are located beneath the epithelium in almost all parts of the oral cavity

⇒ It usaly These glands usually consis of several small groups of secretory units of opening.

⇒ They lack a distinct capsule.

⇒ The minor salivary glands are classified according to their anatomic location.

- ⇒ labial glands
- ⇒ buccal glands
- ⇒ lingual glands
- ⇒ Palatine glands
- ⇒ glosopalatine glands.

* Labial and buccal glands

⇒ The glands of the lips and cheeks classically have been described as mixed.

⇒ Intercellular canaliculi have also been described b/w the mucous cells

* Glossopalatine glands

⇒ These are Pure mucous.

⇒ They consist of several hundres glandular aggregates in the lamina propria of the posterolateral region

⇒ The opning of the ducts on the Palatal mucosa are often large and easly recognizable.

* Lingual glands

⇒ The glands of the tongue can be divided into several grups.

⇒ The anterior lingual glands known as gland of nuhn.

⇒ The Posterior lingual are located later and Posterior to the

Vallat papillae and association with their ducts lingual tonsil.

⇒ They are known as von Ebner's gland.

⇒ The submandibular gland is a mixed gland, with both serous and mucous secretory units.

⇒ The serous units predominate, but the proportions may vary.

⇒ The mucous terminal portions are capped by demilunes of serous cells.

⇒ The basal and lateral plasma membranes are thrown into numerous folds.

→ Demilunes of gianuzzi

→ Adipose tissue

→ Mucous Acini

→ Intratubular duct

→ Serous Acini

→ CT septa

Mixed gland

→ In the mixed glands the proportion of serous and mucous cells may vary from predominantly serous in the human submandibular gland to predominantly mucous as in human sublingual gland.

⇒ Separate serous and mucous units may exist.

⇒ In addition to secretory units composed of both cell types.

⇒ The mucous cells form a typical tubular portion.

⇒ The secretion of serous Demilune cells reaches the lumen through the intercellular canaliculi.

Clincial consideration

⇒ saliva regulates the oral environment and has wide spread distribution of the salivary gland in oral cavity.

⇒ The salivary glands are subject to a number of Pathologic conditions

⇒ These include inflamatory infective diseases such as viral, bacterial or allegic sialadenitis, a variety of benign and malignant tumour.

⇒ Another lesions associated with salivary gland is a nicotinic stomatitis.

→ The salivary sal gland may also affected by a variety of systemic and metabolic diseases.

⇒ Age changes in salivary glands, particularly prominent to in the Parotid, consist of a gradual replacement of Parenchmya with fatty tissues.

8

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Sl. No.: 4616

INTERNAL ASSESSMENT EXAMINATION

ADDITIONAL ANSWER BOOK

Reg. No. : ________ Invigilator's Signature : ________

Ans.

③ Histology of PDL.

⇒ It is a connective tissue organ coverd by epithelum that attaches the teeth to the bones of the Jaws.

⇒ It provides a continually adapting apparatus for support of the teeth during function.

⇒ The Periodontium comprises cementum, Periodontal ligament, bone lining the tooth

⇒ The Principal cells of the healthy, functioning, Periodontal ligament are concerned with the synthesis and resorption of alveolar bone and the fibrous connective tissue of the ligament and cementum.

3½

⇒ The cells of periodontal ~~ligmame~~ ligament may be divided into

① synthetic cells

→ fibroblasts

osteoblasts

cementoblasts

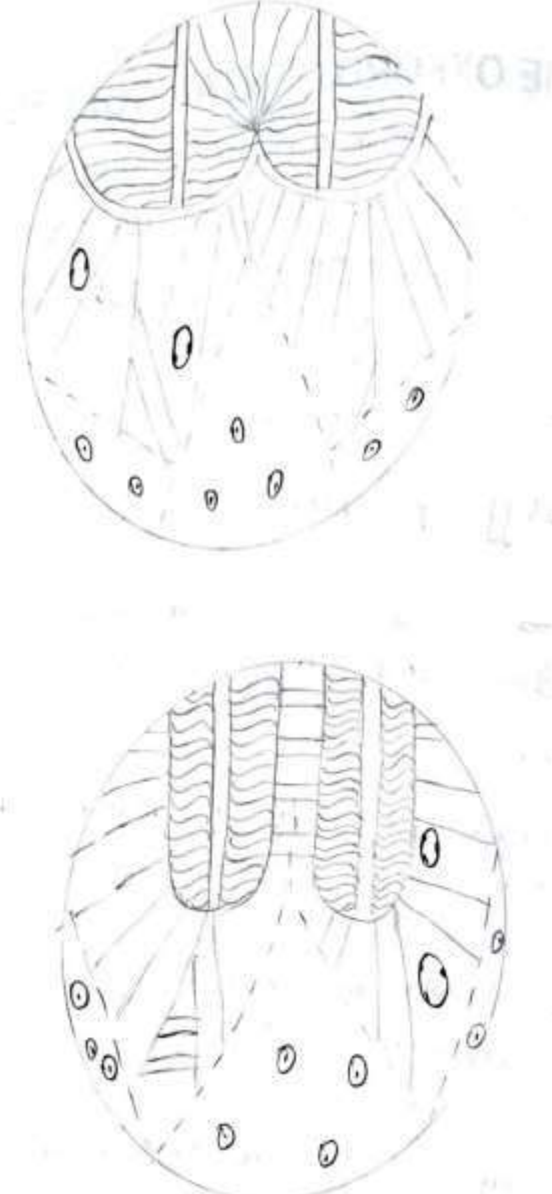
Describe?

② Resorptive cells

→ osteoclasts

⇒ fibroblasts

⇒ cementoclasts.



3. Progenitor cells.

4. Epithelial rests of malassez

5. Defense cells

⇒ mast cells
⇒ macrophages
⇒ Eosinophils.

④ Functions of Pulp.

⇒ The dental pulp occupies the center of each tooth and consists of soft connective tissue.

⇒ The pulp is housed in the pulp chamber of the crown and in the root canal of the root.

Functions

① Inductive

⇒ The Primary role of the pulp analage is to interact with the oral epithelial cells, which leads to defferentiation of dental lamina and enamel organ formation.

⇒ The pulp analage also interacts with the developing enamel organ.

② Formative

⇒ The pulp organ cells produce the dentin that surrounds and protects the pulp.

⇒ The pulpal odontoblasts develop the organic matrix and functions in calcification.

⇒ Dentin is formed along the tubule wall as well as the pulp-predentin front.

③ Nutritive

⇒ The pulp nourishes the dentin through the odontoblasts and their processes and by means of blood vascular system.

④ Protective

⇒ The sensory nerves in the tooth respond with pain to all stimuli such as heat, cold, pressure etc..

⇒ The nerves also initiate reflexes that control circulation

⇒ The symphathetic function is a reflex, providing stimulation to visceral motors.

⑤ Defensive or reparative

⇒ The pulp is an organ with remarkable reparative ability

⇒ It responds to irritation, whether mechanical, thermal, chemical or bacterial. by producing reparative dentin.

4½

⑤ Difference between cementum and bone.

Cementum	Bone
⇒ In areas of Tension, cementoblasts increase secretion of cementum to fill space left.	⇒ In areas of compression osteoclasts Resorb bone to accomodate tooth movement
⇒ In areas of compression cementum is Resorbed.	⇒ In areas of Tention osteoblasts secrets bone to fill space lefts.
⇒ Cementum is not vascularized	⇒ It is vascularised
⇒ Cementum has minor ability to remodel.	⇒ more ability.

2½

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Estd.1974

INTERNAL ASSESSMENT EXAMINATION Sl. No. : 1400

MAIN ANSWER BOOK

Reg. No. : ______ No. of Additional Sheets : ______

Name : Milga Maria C.D Subject : ______

Course : ______ Date : ______

Examination : ______ Invigilator's Signature : ______

Ans.

Cementum contains 46 % of inorganic salts. 70 % bone is made by inorganic salts.

(7) Difference between Primary and Permanent Dentition.

Features	Primary	Permanent
(1) No: of teeth	20 in number, 5 in each quadrant.	32 in number, 8 in each quadrant
(2) Type of teeth	$I\ 2/2\ C\ 1/1\ m\ 2/2$	$I\ 2/2\ C\ 1/2\ P\ 2/2\ m\ 3/3$
(3) colour	White in colour due to more opaque enamel resulting from less mineral content	Yellowish white in colour, lesser white due to translucent enamel.
(5) Interdental	Natural specify exists	less or no spacing b/w them.

5	Orientation	Primary Incisors have got upright orientation	Teeth are labi[ally] Inclined
6	Attrition	undergo attrition to great extent.	undergo attrition b[ut] to lesser extent
7	Shape	Teeth are more bulbous an more consistent shape.	lesser bulbous and shapes less consistent.

33

8) Histology of Alveolar Bone.

outer fibrous layer
Inner circular layer
outer circumferential lamella
osteocytes
Haversian system
Concentric lamellae
Interstitial lamella

Haversian system

4

⇒ Haversian system is also called osteons.

⇒ They are seen in compact bone ie adjacent to periodontal ligament in bundle of bone.

⇒ These consists central channel the Haversian canal.

⇒ The Haversian canal is surrounded by 4-20 concentrically arranged Haversian lamellae.

⇒ Harversian canal communicate with adjusant canals with the periosteum and marrow cavity by tranverase

⇒ The contents of volkmann's canal is same as Haversian canal.

⇒ Irregular shaped lamellar groups located b/w Haversian system called Interstial lamellae.

⑩ Difference between maxillary and mandibular canine.

	Maxillary canine	Mandibular canine
①	They are found on the upper jaw between the maxillary lateral incisors & premolary	They are found on the lower jaw b/w the mandibular lateral incisors and premolars.
②	The right maxillary canine is numbered as 13 and left one is 23.	The right mandibular canine is numbered as 43. The left is 33.

③ They have no long roots	They also have [illegible] [illegible] [illegible] [illegible]
④ The permanent [illegible] canine develop around the age of 11-13	[illegible] around the [illegible]

⑨ Cementogenesis

→ Cementum formation occurs during [illegible] the whole root surface

→ However at the beginning the bottom edge of the deposit margin of Hertwig's epithelial [illegible]

→ During development of the [illegible] dentin is [illegible] from mesenchymal cell of [illegible] dental follicle by Hertwig's epithelial root sheath

→ The inner layer of epithelial sheath consist of modified ameloblasts secreting no enamel, but [illegible]

→ During eruption, the proliferation of Hertwig's epithelial sheath cells is not [illegible] [illegible].

The [illegible]
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→ Heithwig epithelial sheath is responsible for root morphology.

⇒ The developing predentin is covered by 10 um thick, hylin like layer.

... amelogenin of enamel matrix protein.

Estd. 1974

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Bommanahalli, Hosur Road, Bengaluru 560 068, Karnataka, India
Tel.: + 91-80-6175 4682 Fax No.: 080 6175 4680

MENTOR - MENTEE PERFORMANCE CARD

STUDENT DETAILS:
STUDENT NAME: ANIKET CHANDRAMOULI
REGISTER NUMBER: 18D0370
BATCH: 2018
DATE OF BIRTH: 07/06/2000
CONTACT (MOBILE /LANDLINE) NUMBER: 8310865625
STUDENT'S EMAIL ID: aniket.veb@gmail.com
NATIONALITY: INDIAN
STATE: KARNATAKA
DAY SCHOLAR / HOSTELITE: DAY SCHOLAR
BLOOD GROUP: O POSITIVE
ALLERGIES TO: –
HEALTH ISSUES: –
ON ANY MEDICATIONS: –

PARENT DETAILS:
MOTHER/FATHER/GUARDIAN NAME: CHANDRAMOULI RV
RESIDENCE ADDRESS: 48, 2nd main, amarjyothi layout, Sanjaynagar, Blore-94
CONTACT (MOBILE /LANDLINE) NUMBER: 9845136429
EMAIL ID: prabha.chandramouli@gmail.com

CHILDREN'S EDUCATION SOCIETY (Regd.)
C.A Site No.40, 1st Phase, J.P Nagar, Bengaluru 560 078, Karnataka, India
TEL : +91-80-6175 4501 / 502 FAX: 080-2654 8658
EMAIL :info@theoxford.edu
WEBSITE : www.theoxford.org.edu

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Bommanahalli, Hosur Road, Bangalore – 560 068.
Ph: 080-61754680 Fax : 080 – 61754693E-mail:deandirectortodc@gmail.com
Website: www.theoxford.edu

YEAR : I BDS

NAME OF THE MENTOR: Dr. usha ? (General anatomy)

SUBJECT		I INTERNAL ASSESSMENT						II INTERNAL ASSESSMENT						III INTERNAL ASSESSMENT					
General Anatomy Including Embryology & Histology	ATTENDANCE	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		26	24	23	19	88	73												
	MARKS	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
														70	90	56	57	80	63
General Human Physiology & Biochemistry Nutrition & Dietics	ATTENDANCE PHYSIOLOGY	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
														120	60	105	55	88	91
	MARKS PHYSIOLOGY	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		35	55	30	47	85	85												
	ATTENDANCE BIOCHEMISTRY	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
														76	25	65	20	85	76
	MARKS BIOCHEMISTRY	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		35	20	15	13	5	65												
Dental Anatomy & Histology	ATTENDANCE	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
														105	250	99	196	94	78
	MARKS	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		70	30	33	12														

CO-CURRICULAR ACTIVITIES

PROJECT WORK	
PRESENTATIONS	
CONFERENCES / CDE PROGRAMS / WORKSHOPS / HANDS ON COURSE	
INTERDISCIPLINARY / ADD ON / VALUE ADDED COURSES	Covid online classes
FIELD & INDUSTRY VISITS / HOSPITAL & COMMUNITY POSTINGS	
SCHOLARSHIP	

YEAR : I BDS

NAME OF THE MENTOR: Dr .usha ? (General anatomy)

SUBJECT		I INTERNAL ASSESSMENT						II INTERNAL ASSESSMENT						III INTERNAL ASSESSMENT					
General Anatomy Including Embryology & Histology	ATTENDANCE	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		26	24	23	19	88	73												
	MARKS	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
														70	90	56	57	80	63

SUBJECT		I INTERNAL ASSESSMENT						II INTERNAL ASSESSMENT						III INTERNAL ASSESSMENT					
General Human Physiology & Biochemistry Nutrition & Dietics	ATTENDANCE PHYSIOLOGY	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
														120	60	105	55	88	91
	MARKS PHYSIOLOGY	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		35	55	30	47	85	85												
	ATTENDANCE BIOCHEMISTRY	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
														76	25	65	20	85	76
	MARKS BIOCHEMISTRY	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		35	20	15	13	5	65												

SUBJECT		I INTERNAL ASSESSMENT						II INTERNAL ASSESSMENT						III INTERNAL ASSESSMENT					
Dental Anatomy & Histology	ATTENDANCE	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
														105	250	99	196	94	78
	MARKS	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		70	30	33	12														

CO-CURRICULAR ACTIVITIES

PROJECT WORK	
PRESENTATIONS	
CONFERENCES / CDE PROGRAMS / WORKSHOPS / HANDS ON COURSE	
INTERDISCIPLINARY / ADD ON / VALUE ADDED COURSES	Covid online classes
FIELD & INDUSTRY VISITS / HOSPITAL & COMMUNITY POSTINGS	
SCHOLARSHIP	

EXTRA-CURRICULAR ACTIVITIES	
SPORTS	—
CULTURAL ACTIVTIES	—
AWARDS / MEDALS / RECOGNITION	—

INTERACTIVE SESSION	FIRST INTERNAL	SECOND INTERNAL	THIRD INTERNAL
GRADE			
ADVICE GIVEN			
ACTION TAKEN			
OUTCOME			
STUDENT'S GRIEVANCES			
INTIMATION TO PARENTS (DATE/MODE OF COMMUNICATION)			
Student's Signature :			
Mentor's Signature:			

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Ph: 080-61754680 Fax : 080 – 61754693E-mail:deandirectortodc@gmail.com
Website: www.theoxford.edu

YEAR : II BDS

NAME OF THE MENTOR: Dr. Ravi Kumar.

SUBJECT		I INTERNAL ASSESSMENT						II INTERNAL ASSESSMENT						III INTERNAL ASSESSMENT					
		TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
General Dental Pharmacology & Therapeutics	ATTENDANCE	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		26	24	24	22	92	91							26	24	20	22	76	91
	MARKS	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		70	90	61	82	87	91							70	90	62	81	88	90
General Human Pathology & Microbiology	ATTENDANCE ~~PATHOLOGY~~ Microbiology	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		22	20	20	16	90	80	–	–	–	–	–	–	22	20	20	16	90	80
	MARKS ~~PATHOLOGY~~ Microbiology	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		35	55	20	42	57	76	-	-	-	-	-	-	35	55	25	41	71	73
	ATTENDANCE PATHOLOGY	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		22	20	19	15	86	75							22	20	17	17	77	85
	MARKS PATHOLOGY	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		33	45	26	32	80	71							35	45	29	34	82	75
Dental Materials	ATTENDANCE	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		10	9	9	7	90%	77	11	9	9	7	81%	77%	11	10	9	7	81%	70%
	MARKS	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		70	100	62	70	88%	70%	70	100	62	72	88%	72%	70	100	65	80	92%	80%
Pre-Clinical Conservative Dentistry (PCC) (PRACTICALS)	ATTENDANCE PCC	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		15	20	13	13	86	65	15	20	11	15	73	75	50	65	42	57	80	87
	MARKS PCC	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		50		30		68		50						50		35		70	
Pre-Clinical Prosthodontics (PCP) (PRACTICALS)	ATTENDANCE PCP	TCC		TCA		%		TCC		TCA		%		TCC		TCA		%	
		T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P	T	P
		9	20	8	18	88%	90%	9	20	8	18	88%	90%	10	21	8	19	80%	90%
	MARKS PCP	Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%		Max. Marks		Marks Obtained		%	
		20		15		75%		20		14		70%		20		16		80%	

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SPORTS	—
CULTURAL ACTIVTIES	—
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INTERACTIVE SESSION	FIRST INTERNAL	SECOND INTERNAL	THIRD INTERNAL
GRADE			
ADVICE GIVEN			
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OUTCOME			
STUDENT'S GRIEVANCES			
INTIMATION TO PARENTS (DATE/MODE OF COMMUNICATION)			
Student's Signature:			
Mentor's Signature:			

THE OXFORD DENTAL COLLEGE

Bommanahalli, Hosur Road, Bengaluru 560 068, Karnataka, India
Tel.: + 91-80-6175 4682 Fax No.: 080 6175 4680

MENTOR - MENTEE PERFORMANCE CARD

STUDENT DETAILS:

STUDENT NAME: PRANAMI BARUAH
REGISTER NUMBER: 17D4862
BATCH: 2017
DATE OF BIRTH: 01/10/1998
CONTACT (MOBILE /LANDLINE) NUMBER: 9148015001
STUDENT'S EMAIL ID: baruah.pranami7@gmail.com
NATIONALITY: INDIAN
STATE: ASSAM
DAY SCHOLAR / HOSTELITE: HOSTELITE
BLOOD GROUP: A+'ve
ALLERGIES TO: None
HEALTH ISSUES: None
ON ANY MEDICATIONS: None

PARENT DETAILS:

MOTHER/FATHER/GUARDIAN NAME: MUKUT CHANDRA BARUAH
RESIDENCE ADDRESS: NAKARI, WARD no. 3, NORTH LAKHIMPUR, ASSAM, PIN: 78700[illegible]
CONTACT (MOBILE /LANDLINE) NUMBER: 9435387619
EMAIL ID: dr.mukut_chandra@rediffmail.com

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The CPA (Continuous Performance Assessment) Card are the progress sheets that record each candidate's performance, proficiency and improvement to assess the progression of practical as well as theoretical knowledge academically periodic intervals. CPA cards are maintained in each department for regular assessment of the student's progress in terms of academic and extracurricular activities.

Each student is guided by a mentor for future development and scores are given at the end of the term to assess the performance development.

The student's progress report is maintained for each batch for particular academic year by the CPA Card. This progress report is then sent to parents so that they are aware and can assess the student's annual performance.

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Tel. : **+91-80- 3021 9701** Fax No. : **080-25734656**

Continuous Performance Assessment Card for Department of Oral and Maxillofacial Surgery Bachelor of Dental Surgery

Name : Kushala G.

Register Number : 18D0411

Year : IVth BDS , 2021-2022.

Scheme : RS3

Batch : Regular

Children's Education Society (Regd.)

C.A. Site No. 40, 1st Phase, J.P. Nagar, Bangalore, Karnataka, India - 560 078.

Tel.: **+91-80- 3041 0501 / 02** Fax: **080-2654 8658**

E-mail : **info@theoxford.edu**

Website : www.theoxford.org.edu, www.theoxford.net

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Website: www.theoxford.edu

THEORY CLASSES				
III YEAR		IV YEAR		TOTAL PERCENTAGE
CONDUCTED	ATTENDED	CONDUCTED	ATTENDED	
35	35	50	50	100%

CLINICALS				
III YEAR		IV YEAR		TOTAL PERCENTAGE
CONDUCTED	ATTENDED	CONDUCTED	ATTENDED	
25	24	30	27	96.36%

INTERNAL MARKS (FINAL YEAR)

	I	II	III	AVERAGE
THEORY	7	8	9	80%
CLINICAL	9	9	9	90%

REMARKS :

Dr. HARISH KUMAR A
Professor & H.O.D. Department of Oral Maxillofacial Surgery & Implantology
The Oxford Dental College & Hospital
Bangalore

SIGNATURE OF THE CANDIDATE

SIGNATURE OF HEAD OF THE DEPARTMENT

DATE :

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Bommanahalli, Hosur Road, Bangalore, Karnataka, India - 560 068.
Tel. : +91-80- 3021 9701 Fax No. : 080-25734656

Continuous Performance Assessment Card for Department of Oral and Maxillofacial Surgery Bachelor of Dental Surgery

Dept of Oral & Maxillofacial Surgery • The Oxford Dental College, Bangalore •

Name : Roopashree H S.

Register Number : 1800427

Year : IVth BDS, 2021-2022.

Scheme : RS3

Batch : Regular

Children's Education Society (Regd.)

C.A. Site No. 40, 1st Phase, J.P. Nagar, Bangalore, Karnataka, India - 560 078.
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THEORY CLASSES				
III YEAR		IV YEAR		TOTAL PERCENTAGE
CONDUCTED	ATTENDED	CONDUCTED	ATTENDED	
35	32	50	48	94.11%

CLINICALS				
III YEAR		IV YEAR		TOTAL PERCENTAGE
CONDUCTED	ATTENDED	CONDUCTED	ATTENDED	
25	24	30	29	96.36%

INTERNAL MARKS (FINAL YEAR)

	I	II	III	AVERAGE
THEORY	9	9	9	90%
CLINICAL	8	7	9	80%

REMARKS :

Dr. HARISH KUMAR .A BDS, MDS.
Professor & H.O.D. Department of Oral, Maxillofacial Surgery & Implantology
The Oxford Dental College & Hospital, Bangalore

SIGNATURE OF THE CANDIDATE
DATE :

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