



LOWER MOLAR ANESTHESIA

SKIPPING THE BLOCK

What I wish I knew sooner as a dentist

CLINICAL APPLICATIONS

Routine restorative procedures, extractions, and endodontic treatment.

Exceptions: For a hot tooth or complex full-arch surgery cases, this technique alone would not be sufficient.

This approach is not intended to replace nerve blocks in every clinical situation. Please use your best clinical judgment when treating each case.

THE TECHNIQUE

STEP 1 | TOPICAL

Place topical anesthetic in the vestibule as you normally would.

STEP 2 | BUCCAL INFILTRATION

Anesthetic: 4% articaine with 1:100,000 epinephrine. Needle: Short.

Inject at the bottom of the vestibule, as you would with conventional infiltration.

For adult patients, administer a full cartridge. For younger patients (teenagers), approximately $\frac{2}{3}$ – $\frac{3}{4}$ of a cartridge is usually sufficient, depending on the patient.

STEP 3 | INTERDENTAL PAPILLA INFILTRATION

Switch to an extra-short needle. Bend the needle slightly at the base for easier access.

Yes, I know we're not supposed to bend the needle. 🤔😅

Inject at 90° into the center of each interdental papilla on either side of the treated tooth. A couple of drops per site.

WATCH FOR BLANCHING! That is your main cue.

STEP 4 | ONSET

No routine 15-minute wait like with blocks.

I generally use the next 5 minutes to walk the patient through the procedure, discuss anticipated challenges (if any), and answer questions. That is usually enough time for the anesthesia to kick in.

ADDITIONAL CLINICAL NOTES

Residual sensitivity? If needed, a supplemental lingual infiltration of approximately $\frac{1}{3}$ cartridge near the projected root apices of the mandibular second molar often helps address residual sensitivity (potentially associated with mylohyoid innervation).

A NOTE FROM EVERYDAY PRACTICE

A mentor shared this technique with me a few years ago, and it completely changed how I practice day to day. It has become my go-to approach for routine lower molar anesthesia.

In my experience, it has meant fewer repeat injections, faster onset compared with traditional IANB, and more efficient appointments.

I am simply sharing what has worked in my everyday practice, not claiming that one technique works for every patient or clinical situation.

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