



The University Of Jordan
Faculty of Dentistry
fourth Year
2016-2017



Prosthodontics 2

slides

handout

sheet

Website
:
<http://dentistry2018.weebly.com/>

LECTURE # :24

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DAY & DATE :

2018/4/26

PRICE :

مكتبة تلاع العلى – ABC Books

شارع الجامعة الأردنية – جسر كلية الزراعة
عمارة العساف – 235 داخل المجمع



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❖ Denture stomatitis

Last time we talked about **denture stomatitis** , which is inflammation and redness of the oral mucous membrane occurs beneath a denture. In about 90% of cases, Candida species are involved.

The Newton classification divides denture-related stomatitis into three types based on severity. Type one may represent an early stage of the condition, whilst type two is the most common and type three is uncommon.

Type 1 - Localized inflammation or pinpoint hyperemia.(fig A)

Type 2 - More diffuse erythema (redness) involving part or all of the mucosa which is covered by the denture.(fig B)

Type 3 - Inflammatory nodular/papillary hyperplasia(soft tissue overgrowth), usually on the central hard palate and the alveolar ridge.(fig C)



❖ Angular stomatitis:is inflammation of one or both corners of the mouth.

Often the corners are red with skin breakdown and crusting.



Angular cheilitis can be caused by systemic factors or local factors :

- systemic factors : as iron deficiency anemia or immunodeficiency disorders .
- local factors as : infection, irritation, or allergies.



Infections include by fungi such as **Candida albicans** and bacteria such as **Staph. Aureus** .
Irritants include poorly fitting dentures, licking the lips or drooling, overclosure of the mouth due to ***reduced vertical dimension and increased FWS***. Allergies may include substances like toothpaste, makeup, and food.

Management of angular cheilitis :

- 1- correct the cause first , ether increase the vertical dimension ,or correct the systemic factors as well .
- 2- ask the pt to improve his OH & describe dual (antifungal & antibiotic) medication ,as miconazole .

❖ overextension of denture borders :

we will see ulcers in the sulcus (lingual or buccal sulcus), following exactly the flanges of denture.

❖ Pressure area on the fitting surface :

here we will see redness or ulcers on another area rather than sulcus ,as palate , post dam area.

*if we over carve of post dam area ...what will happen ?

1- theoretically, the denture will dislodge ,because the denture will compress the tissue more than they can take, so the tissue will push the denture away as a reaction .

2-clinically , if the denture has a good retention , it will not dislodge , the tissue can't push it away , so the denture will cause pressure on posterior dam area causing ulceration in post dam area .

❖ Torus palatine :

Torus palatine are Usually present on the hard palate ,so we can manage the retention , without remove it surgically ,but if it extends posteriorly to soft palate(vibrating line) , it will break the periphery seal and compromise the retention , so we have to excise it surgically .

The torus palatine here is difficult to manage it , it extends to movable soft palate, it should be removed .



❖ Mandibular tori :

Mandibular tori are usually present near the premolars, on lingual side and they are bilaterally most of the time .

Most of the time they are near the lingual sulcus or within it, and that will break the seal , and compromise the retention .

Usually we remove the mandibular tori , except if they are very small we can leave them and relief the denture .



❖ Denture fissuratum :

Its soft tissue overgrowth , due to chronic irritation of that area .

It starts as ulcer due to overextended borders , but the pain threshold for that pt. is high , and will not feel it ,with time it becomes chronic irritation , and the ulcer will change to denture fissuratum .that's why we have to do post insertion appointment , to check the overextension from the beginning .

Viva Qu.

The scenario is : a pt. came to u and had a denture for 10 yrs. And the lesion starts to appear from last 3 yrs. What do u think the reason behind that ?

Bone resorption with time , that will lead to overextension of borders ,that will cause chronic irritation .

The Management :

1-thin fissuratum>> we relief the denture .

2-thick fissuratum>> surgical removal then construct a new denture .



❖ Cheek biting :

The cause is the lack of overjet posteriorly . the management is increasing the overjet by trimming the lower posterior teeth buccally, then polish the surfaces .



❖ Teeth clicking :

As a result of one of them :

- 1-decreased FWS .
- 2-loose denture(lack of retention).
- 3-porcelain teeth .(but we don't use it nowadays)

❖ Pain on the crest of the ridge :

1-if it's localized soreness : due to occlusal interference.

2-if it's Generalized soreness: increased vertical dimension
There is no FWS, the pt.is clenching on the teeth
all the time .

There is no pressure area on primary and secondary supporting areas .they are supposed to be pressured without causing pain , unless there was a sharp acrylic point on the fitting surface .

the scenario in the viva will be :

a pt. came to u , and had a generalized redness on the crest of the ridge ,& he also complains of teeth clicking >>the cause is increased vertical dimension and low FWS .

❖ Sore throat :

Due to overextended borders from disto-lingual flanges of lower denture .

❖ Pain while opening the mouth :

Due to overextended borders from disto-buccal flanges of upper denture (near the coronoid area).

❖ Denture falling while opening the mouth :

Due to overextended borders from disto-buccal flanges of upper denture (near the coronoid area).



✓ How to clean the denture ?

- 1-brush the denture before soaking it in cleanser .
- 2-Soak the denture in NaHCl(5%) solution 1:3 with water ,for 5 min .
- 3-Soak the denture in cold water all the night .

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Now we will talk about **clinical remount** and **laboratory remount** :

Laboratory remount : done by technician in the lab .

The technician will do it to correct the flasking process errors and shrinkage.

Purpose of lab remount :

- 1-to correct errors in occlusion that have occurred during processing .
- 2-To return the denture to the correct vertical dimension of occlusion .by putting the master casts on the articulator and return the pen to the zero .



2nd part:

Now the clinical remount is the remount which the dentist should do it when he finds excessive occlusion errors during insertion, so in order to avoid excessive adjustment of the denture in front of patient which is time consuming, less accurate and makes him feels that the denture is cheap product, you go for clinical remount.

Firstly you should put soft Aluwax (aluminum reinforced wax) on the lower teeth and guide the patient to the centric relation without perforating the wax so only cusp tips' indentation will appear on the wax, and then you will go for remounting and start occlusal adjustment.

It is so important not to perforate the wax during centric relation recording, because if you do so the guidance of the cusps will change the relation. "Cusps will touch each other and guide you away from centric relation".

Partial dentures:

The doctor will go over this topic briefly because it was covered in details previously.

He also mentioned that in Prostho VIVA exam keep in your mind all treatment option not only the removable prosthesis, you should mention all fixed and removable treatment options.

In VIVA exam they want to know if you are a safe dentist so for example they may ask you about the drawbacks of RPDs and how does it affect your patients?

You have to say that you have to improve their oral hygiene, you have to do regular maintenance for distal extension due to bone resorption which will cause sinking of the RPD and which in turn move the clasps downward to the gingiva leading to ulcers, recession and root caries.

You have to know all the consequences of poor oral hygiene, poor RPD design and poor maintenance from the dentist and poor designing from the technician.

There is no need to repeat the classification because you already know them, however don't forget that class IV is without modifications. "That's a common mistake in VIVA exam"

You know the rules of classification also so why to talk about them again and again :p .

Steps of treatment planning: start with data collection, diagnosis list, stabilization phase which include primary caries, endo problem, extraction of hopeless teeth, perio treatment, control any surface loss by diet modification or splint if he was bruxer. And then you mention if you want to reorganize or to confirm his current occlusion, then you go for treatment option of the case.

Al doctor shalfag alf slide l2no kolhom bn3rfhom .



Challenges in RPD designing for Class I and Class II:

1. Difference in support “compressibility” between teeth and soft tissues. So you have more movement toward the tissues compared with the teeth in class I/II.

To overcome:

a. functional impression. “Altered cast technique”

they ask a lot about it in VIVA exam.

You should make sure that metal framework is probably done and fitting well then you need to send it to the lab to put special tray on the distal extension. When you come to take the impression you start with border molding.

Regarding the design of the special tray, you will have spacer on the crest of the ridge but there is no spacer in the buccal shelf because it is primary supporting area and we mainly want to compress it. “Dr Kifah loves this kind of questions”.

Usually we choose mucocompressive impression material such as ZnO-Eugenol with closely-fitted non-perforated tray.

You put the RPD fully seated without any finger pressure on the distal extension. If you exert finger pressure there the rest will be lifted up and errors can happen.

Then cut the distal extension part of the cast and pour the impression, so you end up with altered cast with compressed distal extension.

However, there is other ways for doing it, for example during making the secondary impression you can use ZnO-Eugenol with closely-fitting tray distally without perforation and alginate on the anterior dentate segment and by this you will get mucocompressive impression posteriorly without the need for altered cast technique.

B. Remove the second molar from the RPD design to decrease the load on the distal area.

c. reduce the teeth size to decrease the load necessary to penetrate the food.

2. Stressing of the distal abutment

To overcome:

RPI system which consists of mesial rest, guiding plate and I-bar.

A student asked about stress breaking but I didn't hear it well, however, the doctor answered that the guiding plate does not extend to the full length of the tooth but it has to set in the cervical lower third of the middle third of the tooth to be able to disengage, and this comes in the middle of the tooth on the most bulbous part.

So stress breaking means when you bite down the stresses that usually will be on the abutment will not be on the abutment anymore because these components disengage from



the tooth so it will keep the tooth safe from distal tilting “distal forces” and extraction forceps effect.

In some cases you cannot use RPI system like in shallow sulcus, existence of frenum and soft tissue undercut which becomes food impaction area. In these cases we can use combination clasp which is wrought-wire C clasp with cast reciprocal arm.

A student asked about the location of the rest on the tooth if we use combination clasp, the doctor answered it doesn't matter but if they asked you in the exam say it depends on the location of the undercut or to stay in the safe side you can answer that you will put the rest mesially and wrought-wire clasp distally.

Another student asked why don't we use it usually instead of I-bar and the doctor answered that I-bar is more esthetic and has minimal contact with the tooth because in combination clasp we have 2 arms one buccal and the other lingually/palatal contacting the tooth make it more difficult to clean.

Moath Shaqar

3. Movement away from the tissues in class I/II because of lacking of distal clasp.

