Prostho. Lec.#6

PLEASE REFER TO SLIDES >> because the doctor mention ONLY FEW NOTES ! ☺

We will begin discussing the **(Ridge irregularities) :**

***-Feather ridge : (**scalloped appearance**)**

Diagnosis: by palpation , and x-rays show radiolucent cancellous bone.

Management: is reshaping and recountouring these irregularities by bone file.

When examining a patient with a feather ridge , we palpate on the elevated (not depressed) part of the ridge and ask the patient if there is any pain , some male patients say it is painless even if they feel pain , so to confirm his answer observe his eyes ; if he closes his eyes when you palpate,this means it is a painful procedure.

Q : why do we remove these elevations ? because these are bony spicules that will act as pressure areas when wearing the denture leading to ulcers formation and causing pain to the patient.

***-knife-edge ridge :**

Is the ridge where the length is good but the width is narrow . it is found more in the mandible and it is painful to pressure & it appears thin and smooth .

Management : relieve the fitting surface of the denture and if the discomfort persists and there are recurrent sores and ulcers,surgery should be performed to smoothen the area.

***-Torus palatinus :**

Notes: 1- there is no submucosa in the palate ; the bone lies directly below the mucosa.

2-Torus palatinus MAINLY affects the **stability** of the denture by acting as a fulcrum leading to rocking of the denture .

Management : if it is small and not interfering within the stability of the denture , relive the fitting surface of the denture, but of it is large and affecting the stability of the denture or interfering with the speech or the patient is phobic of being a cancerous mass,**you have to interfere surgically**,but take care of the anatomy at that area where we have the greater palatine artery and nerve.

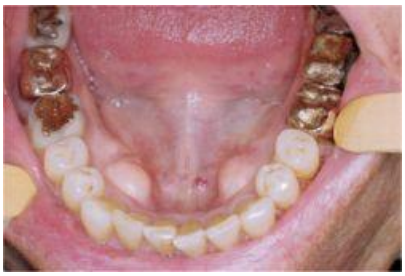
**PICTURES NOTES:

1- when removing the bone by chisel,the chisel bevel should be toward the bone .

2- at the past a retainer composed of gutta percha and adam clasps on the sixes was used to decrease the pressure at the jaw to accelerate the healing (shock absorber) ,but nowadays we use tissue conditioner material.

*-Torus mandibularis :

it affects **retention** if it extends in the area of the lingual flanges **;** if it is small you relieve the denture at that area (its near the tongue so you under extend the denture that area) , but if it was large you have to remove it surgically.



*-Prominent mylohyoid ridge :

Mylohyoid ridge is distal to the 7, the way you examine it is by palpation with the index finger perpendicular, you rub your finger up and down you might feel that there is prominence and you might feel catch then there is an undercut AND WE SHOULD RELEIF IT, so we don't interfere surgically because lingual nerve, mandibular canal is there very dangerous area may cause paraesthesia so shorten the flanges in that area is better than damaging the critical structures .

If the undercut was deep and the patient can't use a denture we have to take care of the lingual nerve surgical procedure : open a flap with w the use of a chisel, round bur then you smooth it take the bone out .

NOTE : when you do a surgery take care of floor of the mouth >> oedema! ☺

*there are 5 structures that can't be resorbed throughout life ?

1. genial tubercle

2.mylohyoid ridge

3.lower border of the zygomatic arch

4. external oblique ridge (buccal shelf)

5. lower border of the mandible

***-pressure on the mental nerve :**

a patient denture wearer complains of numbness and burning sensation so he takes it off and can't put it again .

With age the mental foramen moves occlusally to the crest of the ridge because of bone resorption on an OPG, you can see that due to advanced resorption the mental foramen's location became very close to the ridge (it's more superior in postion) we either :

1) relieve the area.

2) some surgeons go to the extremes (transposition to the mental nerve itself).

3) implant overdenture mental between 4 , 5 so we put 2 implants in the canine area, and relieve the denture at that area so less pressure is exerted on the nerve.

***-Undercuts :**

Management :

_ try to relief the area of the undercut

_ if deep and large you have to remove it surgically not recommended in :

1) The mandible because of the high rate of resorption in the mandible 4 times higher than maxilla so we try to avoid it as much as we can.

2) IF we have 2 posterior left and right undercuts in the maxilla very deep and one anteriorly so regarding the posterior undercuts we remove one and leave the other for mechanical retention.

3) anterior undercut we remove the two posteriors and leave the anterior and the path of insertion of the denture will be anterioposterior engaging the undercut first then rotate it posteriorly.

**PICTUERS NOTES:

Pic1* The way we insert the denture in the presence of an insert the denture in the undercut and then rotate it to the other side where there is no undercut,this undercut act as a mechanical lock.

Pic2* Well developed ridge nice and not compromised so undercut; we remove both posterior undercuts.(theoretically we remove only one but clinically we remove both in this situation).

*-Conditions that require major surgical procedure :

before constructing a denture include skeletal discrepancies; skeletal class II and class III, these require orthognathic surgery,with general anesthesia .

** Orthognathic : we do ortho :13yr , gnathic surgery :after 19yr to ensure the stop of bone growth **.**

** Orthognathic surgery includes the **sandwich technique** that is done for the mandible.

An elderly patient came to you with a protruded mandible and class lll relation and you told him we have to cut part of the mandible from each side to bring the normal relation back .(we don't do that for elderly patients)

So what we will do is:

In elderly patients we never do this surgery (for edentulous patient) so we can make the occlusion as close as possible to class I or edge to edge at least by manipulating teeth setting.

*-How to know if the class lll is habitual or actual?

1) Old pictures.
2) Old casts.
3) History; you do the relation with your hand and ask him which one was his relation.
4) Family history.

THE END

BEST OF LUCK

We used last year sheet as guideline to write this sheet ☺

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