**Sheet no. : 13**

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“ post delivery complains “

1. “ pain and discomfort “

First cause of pain : occlusal problems.

\_ The Occlusal faults/problems could be : 1.Wrong antero-posterior relationship.

2.Uneven pressure.

3. Excessive vertical dimension.

4.Insufficient vertical dimension.

5. Cuspal interference.

**- Cuspal interference:**

How would cuspal interference cause pain?

Upon cuspal interference : The dragging action of the teeth against each other

so if the denture was retentive with good peripheral seal, this will be translated as pain on the mucosa but if the denture doesn’t have enough seal or retention, this cuspal interference will be translated as dislodgement.

* So one of the DDx when the patient comes with unretentive denture is occlusal faults.
* -**Treatment:**
* If Slight: chair side grinding or clinical remount.
* If Gross: new dentures with balanced occlusion.
* \_ The **second** cause of pain is : teeth being ( too buccal to the ridge )  
   but why this happens ?

For ex; a pt with class 3 has a small maxilla compared to the mandible so upon making our setup in class 1 then the upper teeth will be placed way out of the ridge buccally and upon functioning/eating, the upper denture will tilt and dig in the peripheries into the mucosa on the working side while on the balancing side it will pull the denture away to end up with a dragging effect against the tubrosity of the maxilla.

In this situation, the pt comes complainig of pain in the sulcus on one side posteriorly and at the tubrosity on the other side which is the balancing side so this must draw your attention that the setting was done in a wrong way ( out of the ridge )

**- Treatment:**

• Remove last four molar teeth and reduce the bulk of acrylic over the tuberosities to give more tongue space posteriorly to control upper denture. (temporary solution to relieve pain )

• New dentures with above faults corrected. ( definite treatment ).

**\*\* So if your pt is class 3 skeletal relationship, do your setting class 3 relationship**

* The **third** cause of pain is: Retained root or unerupted tooth   
     
  that was not recognized before the denture placement, could be immediate impacted tooth that is very close to the gum , denture directly pressurize on the soft tissue . or

delayed complain , resorbtion making this remaing piece of root close to the crest

**-Treatment** ( depending on the severity of the case ) :

• Extraction of the root or tooth, followed by relining of the denture in that site.

• Or easing the fitting surface over it if extraction is not indicated ( only relief the denture ).

* The **forth** cause of pain is: Narrow resorbed ridge

This usually happens with the lower ridge

**-Treatment**

* simply: relief over the sharp irregular ridge.
* If the complain continues then we do Alveolectomy to smoothen the sharp areas of the crest of the ridge followed by either relining the denture or making a new one.
* The **fifth** cause of pain is: Mental foramen

With resorption, it becomes over the crest of ridge

This pain characterizes by being electric pain ( burning sensation ) because it is nerve related.

**-Treatment:**

• Relief the denture at the mental foramen in order not to cause any pressure but in advanced cases relief alone might not give us the desired results so we do surgical procedure for nerve tarnspositiong into a more apical position which is very aggressive procedure that we try to avoid.

* The **sixth** cause of pain is: Irregular resorption

It happens as a result of different time of extraction so we end up with resorption in one area of the ridge more than other areas. This can cause pain over the area of interference.

Similar to the pain due to narrow resorbed ridge, where the pt comes complaning that the pain is getting worse after eating or functioning but the pain is localized.

**-Treatment:**

* At the beginning : just relieve the denture and if it doesn’t work ;

• Surgical smoothing of the affected irregular area followed by relining the denture.

\_ The **seventh** cause of pain is: Rough fitting surface

relieve with an acrylic bur.

\_ The **eighth** cause of pain is: Swallowing and sore throat

in such situation we have to think that the denture might be over-extended in **certain** areas.

* For the upper denture: it could be extended over the soft palate or pressing over either the hamular notch or the postdam region, this can cause difficulty in swallowing and the feeling of having tonsillitis.
* For the lower denture: if it is over-extended in the lingual pouch distally, again it can give them such feeling.

-There will be an area of slight redness or ulceration.

pt also complains of having unretentive denture since it extends beyond the postdam area so everytime he talks, the soft palate moves and the seal will be broken and the denture will fall down.

**- Treatment**:

• Reduction of the over-extension.

\_ The **last** cause of pain is: Undercuts

Most probably in the upper denture the undercuts are located posteriorly at the maxillary tubrosity

**Treatment:**

Depending on how severe is the undercut; we can either relieve the denture around it or go for alveolplastic surgery and reconstruct the denture.

The best method of insertion of a denture in the presence of undercuts is rotational way

**Categories of Complete Denture Complaints:**

Pain and discomfort.

Appearance.

Inability to eat.

Lack of retention and instability.

Clicking of teeth.

Nausea.

Inability to tolerate dentures.

Altered speech.

Biting the cheek and tongue.

Food under the denture.

Inability to keep denture clean.

**2 - Appearance:**

The main cause of such complain is that the pt was not given enough time to evaluate the appearance or pt being indifferent or hysterical type of pt.

Appearance complains might be due to:

1. **Facial appearance:**

* May complain: his nose and chin approximating due to failure to restore the OVD correctly the complaint is delayed, it will be due to alveolar resorption.
* May complain: that the lips and cheeks are falling in. teeth have been set too far lingually insufficient width to the buccal and labial flanges that was taken during border molding adaptation of the wax rims.

1. **Dissatisfaction with teeth:**

Could be due to :

• Colour

• Shape

• Position

**3 \_ Inability to eat:**

* This most probably happens with new denture wearer. reassure the pt instruct small bites, soft food and try to eat on both sides to stabilize the denture then see what happens with time.
* Cusp teeth vs low-cusp or zero-cusp teeth: a denture with zero cusp teeth we don’t expect from the pt to be able to chew everything.
* Lack of interdigitation of posterior teeth and Unbalanced occlusion: can be fixed by chairside or clinical remount and if severe then remake the denture.
* Locked occlusion (plane line articulator): this usually happens when we use hinge type articulator since it is only capable of doing single movement which is opening and closing and is not capable of doing lateral movement.
* Restricted tongue space: can be due to either the teeth setup is too lingually or the borders of the flanges of the lower denture are too thick.

\_ If the teeth setup is too lingually then reset the teeth.

\_ If the borders of the flanges of the lower denture are too thick then reduce the thickness,

* Over-extension of periphery: feeling of sore throat, the pt inability to eat.
* Habit of eating on anterior teeth only: because the pt loses his posterior teeth first and starts to use the anterior ones for eating and functioning this tend to dislodge the denture from its place causing him the inability to eat.

**4\_ Lack of retention and instability:**

* forget opening one of the freni.

– Low (or defensive) tongue position : so if the tongue is defensive or retracted then we have to inform the pt immediately not to expect a retentive denture the pt either use adhesive or try to change this habit.

– Over-extension: if it was slight then it will affect the retention, if severe then it can cause pain also.

– tight lips and hyperactive mentalis muscle that tends to dislodge the lower denture

– Restricted tongue space: Trim lingual cusps altogether.

– Under-extension and lack of peripheral seal

– Lack of saliva: The pt should be informed the lacking of saliva has a huge effect on compromising the stability and retention of the denture

he should be instructed to use artificial saliva.

* When coughing or sneezing: no way to overcome such a problem
* **5- Clicking of teeth**: due to

• Excessive vertical dimension: It is due to the lack of FWS that allow teeth to move freely

• Movement of lower denture.

• Cuspal interference and lack of balanced occlusion.

• Excessive incisal guidance angle and low overjet : proper balanced occlusion and the anterior teeth meet prematurely while the posterior teeth are separated. This can cause clicking.

. • Porcelain teeth

* **6- Nausea**: due to
* Upper denture slightly over-extended on the soft palate:
* Denture under-extended: unretentive causing slight movement against the soft mucosa
* Thick posterior border:
* Protrusive imbalance: upper denture to dislodge posteriorly
* **7- Inability to tolerate dentures:** due to
* Cramped tongue space
* Altered vertical height: So, the change in the vertical dimension should be always gradual.
* Altered occlusal plane
* Unemployed ridge
* Changes in shape

**8 \_ Altered speech:** is a matter of time

**-Treatment:**

reassure the pt , can be enhanced by exercise, otherwise remake.

**9 \_ Biting the cheek and tongue:**

• Cheek biting:

1– Insufficient buccal overjet

**-Treatment**:

we solve this problem by recreating the OJ. It depends on the case for ex. If the pt was class 1 relationship then we reduce the buccal surfaces of the **lower** buccal cusps but if your pt was class 3 relationship ( which means we have to do our setup in crossbite relation but we place them edge to edge ) then we reduce the buccal surfaces of the **upper** buccal cusps.

2 – Reduced vertical height: remake at the proper VDO.

• Biting the tongue: due to decreased tongue space or decreased VDO.

**10 \_ Food under the denture:**

the lack of peripheral seal of the lower denture

**11 \_ Inability to keep denture clean:** duo to

• any rough areas will collect plaque and interfere with the cleaning process. The pt should be instructed to brush his denture as much as he can.

• Use of hard abrasives

• Failure to clean dentures regularly

• Incorrect use of denture cleansers

• Reduced manual dexterity of the elderly (or ill) patient.