



artificial crowns. Therefore, an important rehabilitation stage for the patient should include a comprehensive approach consisting of orthodontic preparation (making space of a missing 1.1 tooth and simultaneous correction of II class) followed by a surgical stage of implantation and prosthetics by means of an artificial crown or its further replacement by means of dental bridge prosthesis.

After the braces were removed, a fixed retainer was applied on the lower frontal teeth from the lingual side. The patient rejected an offer to place an implant. She decided on dental bridge prosthesis on the basis of zirconium dioxide. Therefore, the following stage in the treatment was orthopedic preparation of 1.2, 2.1, and 2.2 teeth and making temporary dental bridge prosthesis. The final stage included adjustment and fixation of the orthopedic construction.

By means of a combined approach to an unusual clinical situation, esthetic of the smile and function of the dentition were restored, and the patient was satisfied with the treatment performed.

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**CASE REPORT: CLINICAL RESULT OF REVASCULARIZATION
OF A PERMANENT TOOTH**

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Earlier, it was believed that the regeneration of the pulpal tissue in the necrotized infected tooth with apical periodontitis (AP) is impossible. However, if the necessary conditions are created, regeneration is possible. Apexification is a method to induce a calcified barrier in a root with an open apex or the continued apical development of an incompletely formed root in teeth with necrotic pulps (American Association of Endodontists 2013). After apexification procedures, the immature permanent teeth are usually filled with root canal sealer and gutta-percha. The disadvantages of apexification procedures are that the canal walls remain thin and continued root development might not occur (Iwaya et al., 2001, Banchs, Trope, 2004), and such teeth are prone to fracture after root canal treatment. Recently, revascularization procedures have been recommended to treat immature permanent teeth with necrotic pulp tissue and/or apical periodontitis/abscess.

The aim was to implement revascularization of a permanent tooth with an unformed root apex with apical periodontitis in a child and evaluate clinical results after a follow-up examination.

In our case report, we evaluate the results of the revascularization of pulp tissue in an 11-years-old patient with the diagnosis: apical periodontitis of 4.5. Due to the opening of the 4 mm apex and the presence of thin dentin, walls prone to a possible fracture in the future, so it was decided to try to regenerate the pulp according to the method proposed by D.C. Rule, G.B. Winter, and S.I. Iwaya.

The root canal (RC) was disinfected with 20 ml of 5.25% sodium hypochlorite solution. After drying, a paste of ciprofloxacin, metronidazole, and minocycline (by Hoshimo method) was introduced at a depth of 8 mm. Tooth was closed with "Cavit". After 26 days, 4.5 was asymptomatic, fistula closed. After disinfection and cleaning, an endodontic probe was introduced into the RC at a depth of 15 mm to cause bleeding in the apex. MTA (Angelus) was carefully placed on a blood clot, and closed with a wet cotton ball and "Cavit". At the follow-up examination 6 months later, no symptoms were detected, no fistula signs, too. X-ray: complete radiographic healing. Control examinations one year later and then after 18 months showed that the symptoms were absent. The complicated formation of the root apex was observed.

Thus, this clinical case was followed up for a total of 18 months, and it can be considered a success that the walls acquired their normal thickness and strength, and the apex was further formed normally. Time will show whether the canal obliteration has occurred or apical periodontitis may develop at a later stage. Thus, if the canal is disinfected, a matrix has been created on which new tissue could sprout, crown sealing was provided, the regeneration is possible, even in teeth with unformed apex.