

DENTAL REHABILITATION OF DENTAL IMPLANT PATIENTS WITH COMPLEX MAXILLOFACIAL PATHOLOGY AFTER CANCER OF THE LOWER JAW

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Abstract:

Introduction. The frequency of malignant diseases in maxillofacial area in the world and in Ukraine is growing. This issue includes mandatory orthopedic rehabilitation. In practice, doctors, dentists, orthopedists face, with well-known problems in prosthetic toothless lower jaws. That arise through no fault or low qualifications dentist, podiatrist, and because of local anatomic conditions prevailing in the patient due to age or aggressive course that periodontal, periodontal disease or tooth decay complicated and sometimes injury. Also, the cause of tooth loss, alveolar height or body of the mandible is malignant processes. After treatment, there are significant atrophy in need of significant cosmetic corrections, namely epitezu the loss of soft tissue face. Results. When prosthesis after resection of half of the mandible in violation of the continuity of dentition, as a complication after surgery have difficulty in fixing dentures. This solves the problem, known modeling basis prosthesis with a long outside in the distal, making hypoglossal rollers partially eliminates deformation of the face. Denture - hard. Weight bearing causes loosening of teeth, uneven chewing pressure accelerates the process of atrophy of the prosthetic bed tissues that have lost the basis for bone surgery. Hence, the loss of plots and their fixation in the maxillofacial area. But the point where the latch mechanism and that the efficiency of fixation? How to securely fix dentures made of atrophied alveolar part or body of the mandible? The answer provides a method of implantation, which improves the quality of fixation of dentures in atrophied mandible. Currently, the only effective way that allows the patient to obtain positive, predictable over time, long-term effect of the dental treatment. In severe cases mizhmentalnomu space set four endoosalni implants for single or dvohetapoviy method, followed by manufacturing prosthetic or conditionally removable denture. Conclusion. This design offers advantages: - The ability to respond in terms of relapse - Prosthesis is easier to repair and correct - Easier to take care stranger when the status of cancer patients is much worse because of unfavorable development of the underlying disease.

ANATOMICAL VARIATIONS IN THE MORPHOLOGY OF THE MAXILLARY SECOND MOLAR

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Abstract

Introduction : There are various anatomical variations in the morphology of the second maxillary molar. Described are six variations. Liebfield reported a presence of two separate root and two separate canals in the second maxillary molar in 0.4% and Peikoff et al to 1.4%. The purpose of the present study is to report a clinical case of maxillary second molar with two separate palatal canals, a rare entity. Clinical case: 23- years- old female presented a complaint of having a fistula in the maxillary right second molar, which expires in exudate for 6 months. Clinical examinations revealed that the tooth had an obturation on the occlusal surface, had no tender to the vertical percussion and palpation. Radiographic examination disclosed bone loss in the furcation of the maxillary right second molar. We did another x-ray with gutta-percha cone № 15, placed in the fistula that led to the distal root. The outline on root morphology were vague, and therefore require the use of cone-beam computed tomography (CBCT) for more accurate diagnosis. The tooth respond on the vitality test examination to the value 6 - 8?A. Following local anesthesia, an endodontic access opening was made and the pulp chamber was exposed clearly. (Initially conventional triangular access was prepared and three canals (MB, DB, P) were negotiated. As the palatal canal was located more distally (DP) and a hemorrhagic spot was visible towards the mesial side, with a groove joining both mesial and distal palatal canals, confirming two palatal canals [MP,DP] and access cavity was then modified to trapezoidal form. Examination of the chamber floor revealed four canal orifices, mesiobuccal canal (MB), mesiopalatal canal (MP), distopalatal canal (DP) and distobuccal canal (DB).The working length of each of them was determined by using electronic apex locator Raypex 5 and radiographic method separately for vestibular and palatal root. The root canals were cleaned and shaped by stainless steel K-files using step back technique and were copiously irrigated with 0,5% sodium hypochlorite and 3% hydrogen peroxid. The root canals were obturated with cold lateral condensation. The patient was directed to the surgeon for curettage of granulation tissue in the furcation. Patient was recalled after one week for post endodontic restoration and permanent adhesive composite restoration was done. At the three-month recall examination, the patient was comfortable without any symptoms. The inflammation is controlled, there was no fistula. Conclusion: Knowledge of root-canal anatomy, accurate diagnosis and proper preparation of the endodontic access is an important prerequisite for the success of endodontic treatment.