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| 5, part 2Dent-2011.weebly.com | Lecture No. |
| 1/11/2015 | Date: |
| Dr.Nicola  | Doctor: |
| Luma issam jalham  | Done by: |



Periodontics II

**University of Jordan**

**Faculty of Dentistry**

**5th year(2015-2016)**

Price &Date of printing:

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Designed by: HindAlabbadi

**Management of osseous defects**

**Osseous Surgery**

**Applications of osseous surgery** "objectives of osseous surgery " :

1. Crown lengthening :
* Removal of excessive tissue due to gingival hyperplasia that may caused by drug induced gingival hyperplasia or by long standing inflammatory tissues ,,, the tissue become inflames from resilience form
* If there is no excessive tissues crown lengthening its used for fitting the crown without cause violation in the biological width .
1. To permit primary wound closure:
* Allow the rapid healing through the primary intention
1. To create contours that will parallel the contours of the gingival tissue after healing.
2. To create contours that permit patient to accomplish effective plaque control.

**Choices for resolving osseous defects:**

1. Elimination of the bony defect by osteoplasty or osteoctomy:
2. **Osteoplasty** : removal of the excessive bone , the non supporting bone that don't cover by connective tissue "periodontal ligaments " ,, means removal of bone only
3. **Osteoctomy** : there is no excessive bone , the bone supported by connective tissue ,, means removal of both connective tissue and bone .
4. Induce or promote re-growth and regeneration of bone "bone graft"
* Loss of bone and the horizontal connective tissue attachment .
* The type of flap that can be used is conventional flap >>> used to recontoure the bone and removal of the bone to have it at same level .
* The bone graft acts as a template ,, which play role as osteogenetic , osteoconductive , and osteoinduction to enhance the production of bone and support it .
1. Amputate a root in case of inter-radicular involvement or divide the tooth in half to eliminate the defect.
2. Frequent scaling, root planning and local drug delivery

Not all patient capable for treatment or have the standard of oral hygiene levels so should had scaling and polishing first then doing osseous surgery to rule out any failiar during and after the procedure .

1. the procedures that done on surgery clinics is a destructive procedure

***the biological width:***

* is a depth not a width
* It’s the distance between the crest of the alveolar bone and the base of the junctional epithelium.
* It’s the normal relation of the gingival to the tooth .
* The gingival behavior following the periodontal surgery
* Osseous resective Surgery, osteoplasty and/or osteoctomy are techniques to achieve physiologic contours in the bone during surgery that parallel the anticipated post surgical gingival form.
* \* gingival covering tooth structure and the root

\* constant contoure of the gingival following the convexity of the crown ,concavity of the crown and convexity of the root .

\* scalloping of the gingival following CEJ.

\* the bone level following the CEJ.

" if any of these relation is incorrect its mean violation in the biological width.

* The relation :
1. In relation to the gingiva :

Connective tissue is 1.07 mm

Junctional epithelium is 0.97 mm

Sulcus depth is 0.69 mm

>> so the biological width is = 1.07+0.97+0.69 =2.04mm

>> in some books : Connective tissue is 1 mm

 Junctional epithelium is 1 mm

 Sulcus depth is 1 mm

 << so her the biological width = 3mm which is not wrong.

1. In relation to the underlying bone :
* 1- Lingual gingiva

2- Fascial gingiva

3- interdental papilla

* If there is a narrow jaw means there is a narrow scalloping and long interdental papilla coronally
* Shape of the gingiva follows the shape of the bone ,, and the shape of the bone follows the shape of CEJ.
* after the procedure we should return the flap to the original place ,, we should anticipate this place and it should be parallel to the scalloping of sextant and the bone whatever the flap type is used

\* there is conventional flap ,, at the same level of bone because less bone and connective tissue are lost

\* apical ,, apical to bone level

\* coronal ,, coronal to bone level

* if the flap not parallel ,, the gum try to heal itself << called inverse healing ,, healing inside toward the gingival

gingival try to heal itself ,, means that gingival try to maintain the biological width

* anteriorly the biological width return normal by doing correct procedure ,,

posteriorly the biological width never return back to normal level although using correct procedure and correct anticipation of flap position

* posteriorly the wrong becoming from increasing the levels of epithelium " sulcular and junctional epithelium " not from connective tissue that doesn't change ,, so we have pocket and difficulty in cleaning
* Frequent scaling, root planning and local drug delivery :

Local drug delivery :

1. Before 30 years Guston make a trial ,,, bring chlorohixidine , amoclane , amoxicillin , and metronidazole .

Put them in the pocket and found that the drugs completely release from the pocket in the first 24 hours then the rest days no drugs so no sterilization and the bacteria repopulate

1. After that the use acrylic strips " same acrylic that used for dentures " and impregnate it with mixture of " chlorohixidine ,metronidazole , and amoxicillin ." >>> put it in syringe and inject it in the pocket ,, and the found that the drug released 50% in the first 24 hours and the rest still released in next days and weeks .
2. Microchips : found as pills 1 mm

 Composed of chlorohixidine gluconate and put it in the pocket .

**Good luck**

**Sorry for any mistake ☺**