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Hand Out

Slide

* Sheet



Designed by: Hind Alabbadi

Immediate Denture

Immediate Denture means that a ptn. comes into the clinic, his teeth will be extracted and the denture is inserted immediately at the same time. This means that the denture has to be prepared and ready before the teeth extraction.

The ptn. prefers this procedure because:
1.It helps the aesthetic \*\*here there’s no time where the ptn has no teeth at all; the time he loses his teeth, the new teeth are inserted immediately. This is the main objective.

2.the ptn doesn’t have to go through the period of edentulism that is occurred after tooth extraction ^\*the time required after tooth extraction for the socket healing takes weeks to few months. Usually we ask the ptn to come after 4-6 months after extraction. Only after 6 months the ptn will be presented clinically with his ridges being in a stable condition\*^.

~~Bone resorption is a continuous process, it doesn’t end, nothing to stop the bone resorption and remodeling, it stops only by death \*.\*

--the first 2 months after extraction has a high rate of bone resorption, here the amount of bone loss is significant. Then it slows gradually and finally going into platue, for the rest of 4 months \*\*the time here of bone loss is not clinically significant\*\* meaning we can rely on the extracted side by saying it’s completely healed by the end of 4-6 months (AVg 5 months).

In immediate dentures we don’t have to wait all that time, especially for the people who are really in need of their teeth like politician, teacher….etc. not only for aesthetic reasons but also for phontics.

Indications:
-what happens while the ptn is wearing the immediate denture?
the bone continues to resorp, through over the time the denture base will become loose and we need the ptn comes into the clinic for relining and rebasing his denture, until finishing the 6months the case will be stable. The whole procedure is considered temporary for 6months only. After 6 months where everything in oral cavity is stable and then you can do a permanent prosthesis.

why do people lose their teeth???

@Caries and periodontal diseases are the very strong reasons.
 \*There’s a pic.\* Most of the teeth are non-vital, others are missing, anterior teeth mobility and only to preserve the speak pattern and aesthetic we constrict what we called an immediately performed prosthesis.
@Malocclusion, skeletal malformation between and the lower jaw that is beyond orthodontic or orthognathic treatment, we have to get the teeth out and replace them by an immediate denture. \*There’s a pic.\* the ptn presents with poor oral hygiene, front teeth are missing, remaining roots, caries as well. The mandible is advanced in front of maxilla, upper teeth are mobile, vertical bone resorption, we have to extract the teeth and replace them by an immediate denture and an osseous surgery; we have to readjust the alignment of the bone

@poor aesthetic, \*there’s a pic.\* a ptn has mobile teeth, class 5s, RR, she has a habit of lip sucking ((sucking of the lower lip exaggerated the relation of anterior segment)) the teeth are removed, osseous surgery is performed to get the pre whole pre-maxilla slightly backward and then construct an immediate denture.

$$The patient indicated for immediate denture **must end up as a complete denture ptn.**
a ptn. with extracted anterior teeth (still has posterior teeth) and replaced immediately, here the ptn is still partially edentulous. This is NOT an immediate denture ptn, this is an addition to an existed partial denture $$.

<>**Advantages:**
1.aesthetic, ptn concern, anterior sextant are just the case of an immediate denture, if we replace a molar this NOT an immediate replacement, just the anterior sextant of the upper or lower jaws.
2. get the ptn to bypass the 6 months period of bone resorption and edontulism

3.precise reproduction of vertical dimension

Since the teeth are still in the mouth & the pt. has some occluding contact between U&L teeth which means that the intraoral dimension already there so **we can preserve it & use the same vertical dimension (VD) without interfering with it which is a big advantage for the pt. (good adaptation)** so we don’t have to guess how much freeway space we have to give to the pt.

 Not only VD but also **the position of teeth** (related to V & H plane), where exactly they should be in relation to the neighboring soft tissue (facial muscle of cheeks, lips).the tooth position is

Very important in horizontal plane (HP) so **we can preserve the exact position of teeth on HP & in natural status, we don’t have to start guessing where to estimate the neutral zone of teeth.**

In complete denture as we did in the last year the pt. is edentulous & there is nothing tell u what kind of VD they had before they lose their teeth so we have to measure VD at rest then u decide to give that patient 4 ,5,2,3 mm freeway space (according to the case).

Q: would we take into account the amount of bone resorption?
yes, we do, the bone is resorping and when there’s functional contact on the incision the rate of bone resorption will be increased. That’s why we need the ptn to come back for follow up for relining and rebasing to compensate for the amount of bone resorping.

‘’’If there’s one tooth remaining in the arch or any numbered of teeth but not opposed, or there’s no interdigitation between the opposed teeth (scissors bite). There are nothing here to preserve the VD in this case we consider the ptn as edentulous and we have to take the VD by phontics, metric measurement or when lips are completely relaxed (the same as a complete denture ptn.).
‘’’Any tooth contacting it’s opposing with an acceptable VD we preserve it and we fit our denture according to it wither anterior or posterior.

4. copy the shape of exciting teeth, size and position, sometimes we might change the shape especially for anterior, if they were non-vital, discolored, so we choose the teeth matching the ptn profile, color of the skin and so forth….

5. Maintaining the whole function, (particularly the function that is affected by the position of anterior teeth & relation of the 2 jaw together, no speech therapy, no lisping, because we maintain the position of teeth & VD so the function will not be affected at all).

In the same visit we get the ptn to the oral surgery clinic during the prosthetic clinic session, put the ptn under L.A, extract the teeth and while the ptn is still under LA we transfer him to the prosthetic clinic and we insert the denture. We might need some minor adjustments and tissue conditioner to relief the denture. After extraction and insertion immediately, the denture itself will help minimize the amount of bleeding it acts as pressure pack.

<**>Disadvantage:**

1. The ptn has to be recalled for follow up visits, this might be costly to the ptn so we have to discuss this with, before extraction.

2. Medical problems, contraindication of extraction because of the medical history.

**^^Impression Making:**Remember we make the primary impression and the secondary one while the ptn still has teeth.

We use a partial denture tray to make the primary impression, the tray should fit the anterior teeth and the areas where no teeth like roof of the palate or distal end saddle, our special tray should be large. Our impression should be muco-compression on the edentulous part and mucostatic over the teeth.

so the partial denture tray has to be modified for each individual cases, we put compound inside the tray on areas where no teeth; saddle, roof of the palate, we made an impression, cut the excess that is in the teeth area, outside the vestibule and peripheries of the tray and then we apply an adhesive layer over all the tray; on compound as well, we put alginate over the whole tray and over the teeth and saddle and take the impression, the result is an alginate impression that is mucostatic where the tray is spaced anteriorly around the teeth and compressed impression over the compound posteriorly around the saddle and roof of the palate.

Now we can get our study cast.

**<>Steps:**

1-soften the compound & add it to stock tray

2-make the imp. then take it out

3-remove the excess

4-apply the adhesive spray on top of the compound & the tray

5-full over all alginate imp.

6-pour the imp. to have the study model

Master impression has many technique: \*\*we still have the teeth :D \*\*

our special tray should be

\*\*in edentulous area & roof >> must be close fitting

\*\*around the teeth>>double spaced

1. **Single imp. Technique**: we use medium body silicon (not available in our clinic) over all the tray this material is good as ZOE and the beauty of this material that whenever the tray is closed-fitted it produces a muco-displasive (muco-compressive) impression and where the tray is doubly- spaced the same material will produce a mucostatic impression at the same time, so we take a single impression.
2. **Two materials in one tray:**  we use ZOE over the areas where the tray is closed-fitted after border molding and take the impression take it out cut the excess, put an alginate over all the tray (like the first impression) and take the impression. ZOE and alginate will bond to gather
3. **Split tray; Two tray, two materials**: we make a special tray just to fit over the areas where no teeth, this tray will be used to make one impression with ZOE. We took the impression take it out, check the accuracy (no bubbles, no pressure areas), we cut the handle of the tray (our doctor prefers to hold the tray with green stick since it’s easier to be removed), transfer the tray back to the ptn mouth fit it tightly, then we put a large size tray with alginate and take the impression to the whole arch while the first tray is still inside.

 \*\*We do master impression to fit the particular part, to get more precise and accurate impression.

\*\*We can use bone graft inside the socket after extraction, but it will undergo resorption because osteoclast activity is very high. This is why we need to wait until the time when this kind of activity is almost diminished and we’ll have a stable condition, so even if we fill the socket with any type of bone graft we still have the osteoclast activity, so the bone graft will be failed unfortunately.

\*\* when we do an implant, sometimes we try to save time rather than waiting 6months, so we use the same socket and put the implant directly, still we are facing osteoclast.

\*\*References:

Michael McEntee: The Complete Denture- A Clinical Pathway, Chapter 11, Page:99.
AND Dean L. Johnson, Russell Stratton; Fundamentals of Removable Prosthodontics; Page 457-81.

**The Best Is Yet To Come,,,,**

**The End**