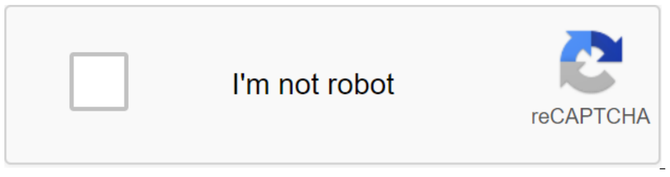
Biologic width violation



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This is important from a restorative point of view, because its impairment leads to complications like increased angle alveolar bone loss and improper recovery fit. it is necessary to maintain the health of the periodontal and to remove irritation that can damage periodontium (for example, the restoration of prostheses). The size of the biological width is not permanent, it depends on the location of the tooth in the alveoli, varies from tooth to tooth, as well as on the aspect of the tooth. His constancy (only one - he) can be found only in a healthy denture. The encroachment of biological width is of particular concern when considering the restoration of a tooth that has broken or has been tooth decay near the alveolar crest. The superficial physiological dimension is a free and attached gingival surrounding the tooth, while the curved physiological dimension is a gingival dimension from the glyval field to the joint epithelium. The sub-previcular physiological space is similar to the described biological width, consisting of connective epithelium and connective tissue. The authors argued that in order to prevent permanent calculus, marginal placement in the subcrevicular physiological space should be avoided. Radiographic interpretation can also be used to detect interaxyal disturbances of biological width, but they are not diagnostic due to tooth intentions. All patients with a low crest do not respond equally to the injury of attachment. Some patients with low crest are susceptible to vision decline, while others have a fairly stable attachment apparatus, the difference is based on the depth of the sling. The main purpose of treatment according to many doctors now days, is to mask the compound of the tooth with the recovery margin. Typically, doctors have 3 options for placing margins. Adv supragingival fields : 1. Preparing the tooth and finishing the edges is the easiest. 2. Dubbing fields with impressions that can be removed over the finish line without tearing 3. It is the easiest to finish the restoration and removal of excess material. 4. Checking the marginal integrity of recovery is the easiest. 5. Supragingival fields are the least irritated gum tissue. This measurement should be performed on teeth with a healthy gingiva and must be repeated on more than one tooth to provide an accurate assessment and reduce individual and site variations. Biological width disturbance occurred during the recovery of margin placement can be corrected by two methods: Ind: Short Clinical Crowns. In combination with a tooth requiring hemiseection or root resection. Teeth with excessive occlusion wear or wear cutters. A gingivectomy can be performed in the case of Figure 9: hyperplasia or pseudo-post-mapping sufficient amount of keratinized tissue. APF is done when there is no adequate width attached to gingiva, and there is a biological width of zgt;3 mm on several teeth haling: Nonesthetic areas- Re-eval. Aft 6 weeks after surg. Esthetic Areas- Req Longer Healing Period These six teeth have been probing depths of 2-3 mm and 4-7 mm attached gingiva on the labial side (Figure 1). There was no mobility on those teeth. Since the teeth had thick connective tissues of attachment and connective epithelium on the side of the palate, an APF with a submarginal incision was attempted. PD:2-3MM to taste. Ind : When a biological width violation is located on an inter-toxic surface. In an environment where biological width disruption across the entire facial surface, the level of glival is correct. Since acessy decline will lead to loss of bone mass on teeth Nos. 12 and 14 and poor ratio of crown to root on tooth No. 13, forced eruption was planned to expose the sound structure of tooth No. 13. The tooth erupted at about 4 mm for five weeks. How ostectomy will lead to anegate architecture Technique : Orthodontic braces are associated with the problem of the tooth and adjacent teeth and in combination with the archwire. The elastic elastic is tied from the bracket to the arch, which pulls the tooth coronal. If the sulsey probes are more than 1.5 mm, the recovery stock can be placed in half the depth of sulcus Reason for maintaining rules 1 and 2 : The margin is far enough below the tissue, so that it is still covered if the patient is at a higher risk of recession 1. BIOLOGICAL WIDTH PRESENTED BY BIBINA GEORGE GUIDED, DR. JAYASHRI A. MUDDA 2. CONTENT - Introduction - Intercontinental BW - Concept BW - Category / Profiles BW - Margin Placement - Assessment of BW violations - Signs of BW violation - Correction of BW violation - BW in implants - BW in restorative dentistry - Conclusion - References 3. INTERVIEWER - Biological width is defined as the size of soft tissues, which is attached to the part of the crown of the tooth to the crest of the alveolar bone. (Gargiulo et al. 1961) 4. The average histological width of connective tissue attachment is 1.07 mm. Average length of epithelial attachment - 0.97 mm Range: 0.71 mm-1.35 mm. Sulcus depth: 0.6 mm . . . . . When assessing the surfaces of cadaverous teeth ⚠, the most consistent measurement based on the average measurement of the depth of the sulcus ⚠ - 1.34 mm, epithelial attachment of the ⚠ - 1.14 mm and ⚠ connective attachment of tissues - 0.77 mm. Vacek et al 1994 - Further research of Newcombe (1974), Gunai et al (2000), and Wilson (1979), Tal et al (1986) and Nevins and Skurov (1984) show a violation of the biological width width be prevented. 6. INTERDENTAL BIOLOGIC WIDTH Kois and Spear noted that the dentogingival complex is 3.0 mm facial and 4.5 mm to 5.5 mm interproxymal. They noted that the height of the interdental papygen can only be explained by an increase in the jagged bone. Becker and his colleagues (1970) defined the variation of scallop glyvalia as flat jagged and pronounced jagged. 7. Spear suggested that an additional 1.5 to 2.5 mm of interproxymal height of gingial tissue required the presence of adjacent teeth for coniferous interproxymal gum volume. Without a nearby tooth, the interproxymal gingival tissue is aligned, suggesting a normal biological width of 3.0 mm. Tarnow and his colleagues found that in order for gum tissue to take full control of the intersoal space, the distance from the point of contact to the alveolar crest should not exceed 5 mm to 5.5 mm. 8. CONCEPT OF BIOLOGIC WIDTH - Maynard and Wilson (1979) divided periodontium into three dimensions: - Surface Physiology - Crevicular Physiological and - Subcrevicular Physiological - Subcrevicular Physiological Space similar to the biological width described (Gargiulo et al 1961) 9. CATEGORIES / PROFILES OF B.W . 3 bio-width categories, based on the overall measurement of the attachment and the depth of the sulus after the measurements of bone sound : NORMAL CREST HIGH CREST LOW CREST MIDFAcial measurement of 3 mm zlt; 3 mm. zgt; 3 mm Proximal measuring range from 3 mm to 4.5 mm There is one area where the comb is seen more often, in the proximal surface adjacent to the edulous site. 4.5 mm. Appearance aptly 85% of the time. Gingival tissue is usually stable in patients. 2% of the time is aptly 13% of the time 11. The crown mark-up should be placed no closer than 2.5 mm from the alveolar bone. Thus, the crown margin, which is placed 0.5 mm subgingivally, is usually well tolerated gingiva Usually not possible to place an intracrevicular margin, because the margin will be too close to the alveolar bone, causing the biological width encroaches, and chronic inflammation more susceptible to recession secondary to the placement of intracrevicular crown margin. When refuted, the cord is placed after the crown is made; The attachment apparatus is usually traumatized. As the damaged attachment heals, it tends to heal back to the normal position of the crest, resulting in a 12 recession gingival. PLACING MARGINS 13. Supragingival Equigingival Subgingival Least effect on periodontium. More plaque accumulation than supragingival or sub gum margin as a result of desingivial inflammation More quantitative and qualitative changes in the microflora Application of non-ethical areas due to the noticeable contrast in color and opacity of traditional materials against Tooth Restorative fields can be aesthetically mixed with a tooth and finished to provide a sleek, polished interface on a gygapping margin. Elevated plaque index, gingiva index, slump, pocket depth and fluid ging. 14. The benefits of expanding recovery gingivally 1) to create adequate resistance and retentive form in the drug 2) make significant contour changes due to tooth decay or other tooth deficiencies 3) to mask the tooth/recovery int4 erface by placing it sublst. 15. EVALUATION OF BIOLOGICAL WIDTH VIOLATION - CLINICAL METHOD : - If a patient experiences discomfort in the tissues, when recovery margin levels are assessed by a periodontal probe - the margin has spread to attachment, and biological width disorder occurred 16. - BONE SOUNDING/TRANSGINGIVAL PROBING - Biological width can be identified by sensing under local anesthesia (called sounding to the bone) by subtracting the depth of the hole from the surrounding measurements. - If it is a distance of 2 mm in one or more places, the diagnosis of biological width disorder can be confirmed. Vavacek et al., 1994 17. RADIOGRAPHIC METHOD : - Can detect interproxymal disturbances of biological width. - However, on the mesophacial and distofacial corners of the teeth line, X-rays are not diagnostic due to tooth intentions. - A parallel profile X-ray technique has been developed that can be used to measure both the length and thickness of the dental glass with precision. 18. BIOLOGIC WIDTH - Signs of biological disturbance of biological width width: 1. Chronic progressive inflammation of the gums around recovery. 2. Bleeding during probing. 3. Localized gingiva hyperplasia with minimal bone loss. 4. Gingival Recession 5. Pocket education 6. Clinical loss of affection. 7. Alveolar bone loss. 19. CORRECTION BIOLOGIC WIDTH VIOLATION - Surgical removal of the bone from proximity to the recovery fields. Orthodontic tooth extrusion and then moving the edges away from the bone. The advantage of the surgical process: Fast method. Gives a more pleasant result if the crown lengthening is done. 20. SURGICAL CROWN LENGTHENING : INDICATIONS CONTRAINDICATIONS - Inadequate clinical crown for retention due to extensive carey, perforation of roots or root resorption in the cervical 1/3rd root in the teeth with adequate periodontal attachment. Unequal, excessive or non-aesthetic levels of desthetics. Teeth with insufficient interocclations for proper restorative procedures due to perlution. Restorations that break the biological width. Deep brownies or fractures requiring excessive bone removal. A tooth with insufficient crown root ratio (ideally 2: 1 ratio is preferred). Non-respced teeth. Tooth with risk of participating in a fur a leak. • • compromise aesthetic/adjacent alveolar bone support. 21. SURGICAL PROCESS - TIPS: - Gingivoplasty - Gingivectomy - Amicalized valve with bone reconcation - In such situations, the bone should be removed from the edge at a measured distance of ideal biological width, with an additional 0.5 mm as a safety zone. 22. Lack 1. Gingival recession after bone removal 2. Papillary decline (interproxymal removal) 3. Creating a non-astic triangle of space under interproxymal contacts. (Black Triangles) 23. APF without Osseous reduction 24. APF with Osseous reduction 25. ORTHODONTIC PROCEDURES : Slow extrusion rapid extrusion - slowly brings the alveolar bone and gleivial from the tissue to the ideal bone level at 0.5 mm. The tooth stabilizes in this new position and is then surgically treated to correct bone and gingillary tissue. Ends in a few weeks. During this period, supracral fibrootomy is performed weekly to prevent tissue and bone after the tooth. The tooth is then stabilized for at least 12 weeks to confirm the position of the tissue and bone - any coronal creep can be corrected surgically. 26. FORCED ERUPTION WITH OSSEOUS SURGERY 27. FORCED TOOTH ERUPTION INDICATIONS CONTRAINDICATIONS - Cases where the traditional lengthening of the crown with ostectomy cannot be achieved, both in the front, and remove bones from adjacent teeth, which can jeopardize the function of these teeth - inadequate crown-to-root ratio. No occlusion gap for the required amount of eruption. Possible periodontial complications. 28. FORCED TOOTH ERUPTION WITH FIBROTOMY TECHNIQUE CONTRAINDICATIONS - Fibrotomy is performed with a scalpel at intervals of 7-10 days to break the over-cross fibers, thereby preventing the shape of the rowing bone, following the root in the coronal direction. Crestal bones, and gingal margins are extracted on their pre-treatment spot and tooth-gingiva interface as adjacent teeth are backless. - Angular bone defects and ectopic teething. 29. BIOLOGIC WIDTH AND IMPLANT - The most important difference between periodontal and periimplant tissue - periodontal fiber structure pass perpendicular to the long axis of the tooth - In the tissue of the implant fibers from the crest run parallel to the surface of the implant. The peri-implantic biological width consists of sulcus, supracral epithelium and a component of connective tissue. 30. - The influence of five different factors on the biological width of the implant is assessed: - Surgical technique, - Loading time, - Abutted material, - Structure and position of the implant, - Immediate insertion after extraction. On the implant: Linked epithelium connective tissue biological width 1.88 mm 1.05 mm 3.08 mm 31. BIOLOGICAL IN IMPLANT - Implantation-adjoining-adjoining Placing - - At the level of gingival supracrestal to the alveolar bone, the biological width measurement was similar to a natural denture. - At a deeper level, the biological width has increased accordingly. - Far below the crest of the gum tissue, it will encroach on the gingiva and permanent inflammation is created. - Highly jagged, thin gingiva is more prone to recession than flat periodontium with thick fibrous tissue. The level of the implant should always be placed subgingivally to develop the desired profile and aesthetics. 32. BIOLOGICAL WIDTH IN RESTORATIVE DENTISTRY If there were no signs of inflammation prior to recovery, you can follow the following rules: If the sulcus gingival is ≤ 1.5 mm, place the margin at 0.5 mm below the crest of the gum tissue. If gingiva sulcus is 2 mm, the recovery fields are being prepared 0.7 mm subgingivally. If the gingalting sulcus is 2 mm, in the etonic zone with the vestibular side. Gingivectomy is recommended - Recovery fields are prepared 0.5 mm subgingivally 33. FINAL : - The health of periodontal tissue depends on a well-designed recovery. Incorrectly placed restoration stock and unadapted restoration violate the biological width. If the margin needs to be placed subgingivally, the other factors that need to be taken into account are: 1. Correct crown outline in gingival third. 2. Proper polishing and finishing of the field. 3. A sufficient area of the attached gingival and no biological width violation by subgingival by margin. Repeated visits to maintenance, cooperation with patients and motivation are an important factor to improve the success of the recovery procedure with positive periodontal health. 34. DETAILS: - Carranza, 10th and 11th edition - Malathi K, Arjun singh. Biological width: Understanding and preserving it. Int J Med and Dent Sci 2014; 3(1):363-368. Linkevicius T et al. Stomatologija, Baltic Dental and Maxillofacial Journal, 2008;10(1):27-35. Sharma A, Rahul GR, Gupta B, Hafiz M. Biological Width: No violation zone. Eur J Gen Dent 2012;1:137-41. Srjak KJ et al. Periodontal and Prosthetic Aspect of Biological Width Part I: Violation of Biological Width. Acta Stomatol Horvath,2000;34(2):195-7. Nugala B, Santos Kumar BB, Sahitya S, Krishna PM. Biological width and its importance in periodontal and restorative dentistry. J Conserv Dent 2012;15:12-7. Dhir S. 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