

CRDTs Review

4/2/13

- 2 pencils w/ erasers
- 3 min. @ station, 3 questions
- 15-20 stations

- Models &/or pictures, Articulators

- 8 removable } out of the ones fixed
- 3 fixed
- 1 implant

- Evaluate amalgam prep. - too wide, too deep, etc

Complete Denture Cases:

- Types of occlusion - Green book from Obrez

Fig 4 - setting teeth based on ave overlap 2-4mm (horizontal)

- Monoplane - flat setup. 0°, everything set back due to condylar inclination with movements have opening pos. bite

- Anatomical occlusion

- Compensating curve

- Unbalanced occlusion

- flat lower teeth, max teeth > 0°
- palatal cusp down, buccal cusp ↑
- one big func. cusp.

Advant: little lat. stress to ridges

better efficiency & can be modified to individuals

* Good post. menopausal women closing bone. helps prevent interferences, better esthetics than monoplane.

* Hanau Quint:

Guiding factors - dictated by pt. ("Guide")

- Incusal guidance - adjusted but esthetics may dictate

- Condylar " " - recorded by protrusive

Controlling - dentist has control

- Occlusal plane
- Compensating Curve
- Cusp Height.

$$\text{Balanced Occlusion} = \frac{IG \times CG}{OP \times CC \times CH} \quad (\text{Thellmans Formula})$$

ex) if ↑ IG, need to ↑ something below to keep balance

Potential Questions:

1. Greater ~~axial~~ condylar path, > separation of pos teeth during protrusive. to provide balance
 - need to ↑ OP, CC, OR CH
2. > incisal guidance, greater sep. of ant. & pos. teeth to provide balance would
 - ↑ CC,
 - ↑ CH
 - ↑ OP
3. Cuspless - correct Centric jaw. Relations. In a straight protrusive excursion incisal guidance should be 0°
 - ← Should be no vertical overlap.
4. pos. teeth w/ no compensating curve. there should be no vertical overlap.
5. Cuspless balancing side contacts achieved by incorp. compensating curve
6. Common areas of irritation or interference
 - ~~mandibular process~~, coronoid process
7. Denture processed in acrylic resin, finished & polished returned for insertion from lab. check
 1. properly trimmed borders.
 2. tissue surface imperfections
 3. Accurately attach max Remount Cost to your articulation

Do NOT polish plastic teeth.

Standard of Care - Clinical Remount.
8. Pt. Remount superior to lab. Remount b/c lab Remount will not correct for
 - clinical errors in recording maxilloman. Relations

lab will correct processing areas, shrinkage of acrylic, vertical changes due to polymerization shrinkage
9. Selective Grinding order
 - Adjust centric relation, working, balancing protrusive. then milling post

Denture set ↑ probs.

- Retromolar pad - 1/2 way to 2/3 ↑ pad (Comp curve)
- Fox plane relates to OP to interpup line and Ala Tragus. also parallel to Camper's plane

- pos^{tion} of post. teeth in relation to ridge:
- lower post. Central grooves almost always over ridge crest 3 to preserve ridge.
 - Max. post. teeth
Barrier beyond depth of vestibules, would have to place in crossbite.

Phonetics:

- S → Sibilants - closest speaking space
if ant. teeth touch, vertical too much, close some
- F → dentolabial - incisal edge to touch wet/dry line of lower ^{lip} ~~teeth~~
horizontal plane
- M → bilabial - lip to lip - resting position
vertical relationship

Ant. tooth position

- almost always set facial to mand. ridge, but no further than vestibule
- Max. ant - set ant to incisive papilla, except severe CI II overbite that wants it corrected

Ip. planning -

- diagnostic casts -
- Free end Kennedy Classifications I + II
- large max. tuberosities - need reduction
- undercut in both tuberosities, but no labial undercut, only get rid of the undercut & use the other for retention
- Immediate dentures (need soft + relined cpl. weeks.
hard relined - 3-6mo

Denture teeth set up

- ♀ - round / ovoid
- ♂ - square

Angular cheilitis caused by: - overclosed, moisture pool in corners of mouth, vit. def.

Combination Syndrome

- max. ridge floppy in front & tub. enlarged / drop ↓ usually when only man. ant teeth and no IP against F/
- selective pressure impression - a lot of wax space in ant. region - less viscous impression material use Rubber base OR?
- main issue to do tub. reduction

Impressions

- Anatomical / Mucostate
 - tissue @ rest
- Functional
 - allend cast

records needed for dentures:

- Face bow and CR record - All need
- of protrusive record for ?

post. palatal seal

- mechanical = Empirical -> carved uni
- functional = Physiological -> pressed ↑ w/wax

lastic vs. Porcelain

If pt. wants porcelain ant teeth, then must use post. porcelain teeth to avoid Combination Syndrome due to wear

Anatomic 30-33°
 Non anatomic 0°

Semi - 1/4 bit the 2 above

lip support max teeth & supports man. lip.

What may cause

- clicking -> vertical dimension problems
- gagging -> over extension in palate, pos. palatal seal
- speech probs -> palatal form, tongue position
- looseness -> not completely seated, deep pos palatal dam

Never adjust centre unless high in all eccentric movements.

- Chronic soreness over ridges = high in occlusion
- do clinical remount

- Resket partial - Unilat. Removable partial replaces modification
 - NOT standard of care - Asprated by pts.

Indication:
Metal backed facing - deep overbite where incisal guidance is
 so heavy would likely have ant. teeth breakage.

Metal pontic or "dummy pontic" - non-esthetic pos. have only 3mm of space & not enough room to get a tooth, ask lab wax ↑ tooth & cost in metal

both supported - rests as close to edent. space as can

Issue supported Rests away from edent. area

Wrought wire of Distal rest on free end.

Standard of care 1 bar - mesial rest

↳ can't use of severe undercut

Major connectors

- bar vs. plate need min. of 6mm, 8mm is desirable
- palatal torus - not AP straps 8-10mm wide
- lateral 7-9mm

To planning

- adjust contours & guide planes before rest seats.
- final impressum, frame try-in, altered cast, jaw relation, tooth selection, wax try-in, delivery, adjust

Kennedy Classifications:

- Class IV no modifications spaces

~~Arrangements~~ - most post space determines classification

~~margin~~

Mount on articulator w/ out interocclusal records - still need facebow.

Indirect Retainers - needed if free ended Partial

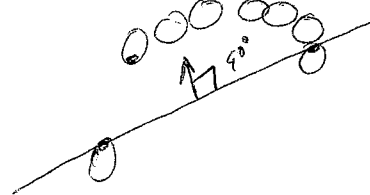
- Kennedy Class I & II

- prevents PIP from lifting ↑

- Fulcrum runs thru post.

Rest seats & indirect Retainer is @ 90°

- usually not on lat or Centrals.



Fixed

- pics of bur blocks - which Bur is best to make chamfer
- pics of tooth prep - ex) short ~~en~~ crown, effect retention & resistance form, to fix = Buccal Groove, proximal boxes

- Over tapered prep - effects resistance form
- up on B-L, Resist w/ Box on M or D
- up on M-D, then Box or L groove

Pier abutments - in fix handout



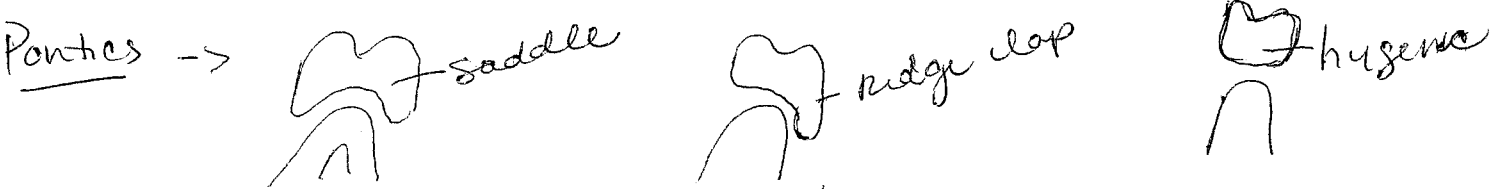
∴ this tooth will usually have movement of 5 unit bridge

- ∴ place key (on distal) and keyway
- don't put on mesial b/c teeth may drift mesial and then unseat
- * Keyway in distal of pontic, Key on molar

- C:R
- minimum 1:1
- Optimum 2:3
- Ideal 1:2

Root surface of abutment teeth should equal or surpass that of teeth being replaced.

Rather roots broader labiolingually than mesiodistally



- minimal contact w/ soft tissue / passive

Porcelain
Smother surface = larger size appearance
Contours

Implants

- Subperiosteal - on top of bone
- Intraosseous - thru mand. cortex
- Endosteal - into bone but not into mand. cortex.

Know Immunology

- healing cap?
- part into bone called?
- Screws?
- Abutment?
- fixture?

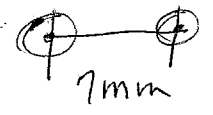
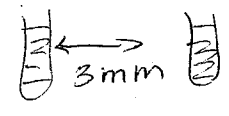
Quantity & Quality of Bone

Multiple teeth missing

- need to know space to determine how many implants can place

Single missing tooth

- 1mm of space
- Standard diameter of implant 4mm
- Space from 2 implants 3mm - if from center 7mm



Anatomical Limitations

- involve canal, bone width, max sinus.