

A randomised clinical trial comparing anatomic, lingualised and zero-degree posterior occlusal forms for complete dentures

Sutton, A.F., McCord, J.F.

Statement of problem

There is a lack of evidence to recommend a particular type of posterior occlusal form for conventional complete dentures.

Purpose

The purpose of this study was to compare subject satisfaction with three types of posterior occlusal forms for complete dentures in a randomised crossover controlled trial.

Material and methods

For each participant (n=45), three sets of complete dentures were fabricated, each of which had a different posterior occlusal form (0-degree, anatomic and lingualised). Each set was worn for eight weeks in a randomised order. Subjective data were collected using the Oral Health Impact Profile 20-EDENT (OHIP-EDENT). The Wilcoxon statistical test was used to compare differences between the groups ($\alpha=0.05$).

Results

Lingualised posterior occlusal forms were perceived to be significantly superior in terms of painful aching in the mouth ($P=0.01$), sore spots ($P<0.001$), eating ability ($P=0.02$) and meal interruptions ($P=0.008$), compared with 0-degree posterior occlusal forms. Subjects with anatomic posterior occlusal forms had significantly fewer problems eating ($P=0.05$) compared with 0-degree posterior occlusal forms. There was no significant difference found between the lingualised and anatomic posterior occlusal forms.

Conclusions

Participants provided with complete dentures having lingualised or anatomic posterior occlusal forms exhibited significantly higher levels of self-perceived satisfaction compared to those with 0-degree posterior occlusal forms.

The Journal of Prosthetic Dentistry 2007; 97 (5): 292-298.

Guidelines for the management of traumatic dental injuries. II. Avulsion of permanent teeth

Flores, T.M., Andersson, L., Andreasen, J.O., et al.

Avulsion of permanent teeth is the most serious of all dental injuries. The prognosis depends on the measures taken at the place of accident or the time immediately after the avulsion. Replantation is the treatment of choice, but cannot always be carried out immediately. An appropriate emergency management and treatment

plan is important for a good prognosis. Guidelines are useful for delivering the best care possible in an efficient manner. The International Association of Dental Traumatology (IADT) has developed a consensus statement after a review of the dental literature and group discussions. Experienced researchers and clinicians from various specialties were included in the group. In cases in which the data did not appear conclusive, recommendations were based on the consensus opinion of the IADT board members. The guidelines represent the current best evidence based on literature research and professional opinion. In this second article of three, the IADT guidelines for management of avulsed permanent teeth are presented.

Dental Traumatology 2007; 23 (3): 130-136.

Impact of local and systemic factors on the incidence of oral implant failures, up to abutment connection

Alsaadi, G., Quirynen, M., Komárek, A., van Steenberghe, D.

Aim

The aim of this retrospective study was to assess the influence of systemic and local bone and intra-oral factors on the occurrence of early implant failures, i.e., up to the abutment connection.

Material and methods

The surgical records of 2,004 consecutive patients from the total patient population who had been treated in the period 1982-2003 (with a total of 6,946 Brånemark system® implants) at the Department of Periodontology of the Catholic University Leuven, were evaluated. For each patient the medical history was carefully checked. Data collection and analysis mainly focused on endogenous factors such as hypertension, coagulation problems, osteoporosis, hypo-hyperthyroidy, chemotherapy, diabetes type I or II, Crohn's disease, some local factors (e.g., bone quality and quantity, implant [length, diameter, location], type of edentulism, Periotest® value at implant insertion, radiotherapy), smoking habits and breach of sterility during surgery.

Results

A global failure rate of 3.6% was recorded. Osteoporosis, Crohn's disease, smoking habits, implant (length, diameter and location) and vicinity with the natural dentition were all significantly associated with early implant failures ($p<0.05$).

Conclusion

The indication for the use of oral implants should sometimes be reconsidered when alternative prosthetic treatments are available in the presence of possibly interfering systemic or local factors.

Journal of Clinical Periodontology 2007; 34 (7): 610-617.

ABSTRACTS

Tongue pain: burning mouth syndrome vs. Candida-associated lesion

Terai, H., Shimahara, M.

Objective

We investigated patients with tongue pain to examine whether the differential diagnosis of burning mouth syndrome and Candida-associated lesion was possible.

Patients and methods

A total of 60 patients with tongue pain were divided into three groups according to the intensity of pain at rest and that when eating using the visual analogue scale: Group A: Functional pain group; Group B: Non-functional pain group; and, Group C: Mixed pain group. Antifungal treatment was scheduled for patients suspected clinically, mycologically or cytologically as having candidal infection.

Results

The results of the culture test and direct examination indicated that group A was different from the others by its high positivity for Candida, and a good response to the antifungal treatment was

obtained. On the other hand, antifungal treatment was not useful in group B, and the low possibility of Candida infection in the direct examination supported the result in this group. In group C, the positivity of Candida and the effect of the antifungal treatment were between those of groups A and B.

Conclusion

These results may suggest that tongue pain in group A is Candida-associated, that in group B it is burning mouth syndrome-induced, and that in group C it is caused by mixed conditions.

Oral Diseases 2007; 13 (4): 440-442.

QUIZ answers (from page 117)

1. She was diagnosed with cyclic neutropenia.
2. When possible, periodontal treatment should be done during periods of disease remission. At such times, treatment should be as conservative as possible while reducing potential sources of systemic infection. After physician consultation, severely affected teeth should be extracted. Oral hygiene instruction should include use of chlorhexidine rinses twice daily. Scaling and root planing should be performed carefully under antibiotic protection.

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