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**FEATURES OF ETIOPATHOGENETIC TREATMENT INFLAMMATORY PERIODONTAL
DISEASES*****Sadriyev Nizom****Samarkand State Medical University, Uzbekistan****Axmadjonov Dostonjon****Samarkand State Medical University, Uzbekistan****Bobonazarov Sarvar****Samarkand State Medical University, Uzbekistan****Bo'riyev Sardor****Samarkand State Medical University, Uzbekistan****Xolmo'minova Zarnigor****Samarkand State Medical University, Uzbekistan***ABOUT ARTICLE****Key words:** Localized periodontitis, splinting, orthopedic treatment of periodontitis.**Received:** 20.01.2024**Accepted:** 25.01.2024**Published:** 30.01.2024**Abstract:** Epidemiological studies show that only 12% of people have healthy periodontal tissues, 53% have early inflammatory changes in the supporting tissues of the teeth and 23% have destructive changes. Of these, 12% of patients have moderate to severe changes. These figures also apply to patients without orthopedic dental treatment, however, the presence of dentures in the oral cavity contributes to the emergence and development of inflammatory and destructive processes in periodontal tissues due to poor oral hygiene [2]. Most periodontal diseases are inflammatory in nature. Inflammation occurs under the influence of microbial plaque products, but at the same time, the role of local trauma, including iatrogenic causes, should be noted. According to statistics, endodontic lesions are the cause of premature removal of denture crowns in 17% of cases, mechanical destruction of cermet crowns and abutment teeth occurs in 27% of cases, and aesthetic deficiency due to destructive

changes in the periodontal ligament occurs in 64% [3]. To date, most non-removable dentures are made using prepared teeth as abutments without bite, which naturally leads to chronic injury and a sharp decrease in hygiene due to the preservation of food residues and dental deposits at the edges of non-removable elements (crowns, linings, etc.).

INTRODUCTION

Incorrect modeling of occlusal surfaces and the formation of non-functional occlusion can lead to overload of the supporting and antagonistic teeth, violation of limbal attachment and integrity of the orthopedic structure (inlays, onlays, veneers and metal-free crowns at the edges), which often leads to the development of caries on the supporting teeth. This is due to the exposure of highly permeable dentin after enamel removal. Currently, techniques for preparing supporting teeth by forming ledges are used, which reduces the likelihood of periodontal injury and improves hygiene in accordance with the principle of minimal invasion. Micro- and macro-sealing techniques (filtration with fluorinated compounds and surface coating with photopolymer sealants) are used to increase the resistance of the hard tissues of the supporting teeth to microbiological and aseptic demineralization. The main difference between deep fluorination (micro-hermetics) is that the size of CaF₂ crystals is only 50 Å. This allows them to penetrate into the pores of loose enamel at a distance of up to 100 Å and create a concentration of fluoride ions about five times higher than that of simply fluorinated (macrofluorinated) calcium fluoride. To cover the prepared tooth surface, a composition is used in which fluorine microcrystals are immersed in a silicate gel to form and protect against mechanical impact. This creates an optimal environment for fluorine ions, which, together with saliva mineral salts, lead to prolonged remineralization and a 100-fold increase in the rate of remineralization. Copper ions in the composition of remineralizing drugs contribute to protection from microorganisms due to alkaline copper fluoride (Cu(OH)F). The bactericidal power of copper compounds is constantly being restored due to their interaction with oxygen in an aqueous solution. Deep fluoridation does not damage the mineral tissue of the teeth, since calcium is not removed from them [4]. The role of oxidation by free radicals Experimental and clinical results have shown that overload of periodontal tissues leads to complex pathological changes, mainly inflammation and dystrophic phenomena [6]. This, combined with risk factors, leads to the first background - the relative insufficiency of the physiological antioxidant system. Firstly, this is due to the leakage of superoxide anion radicals during the "respiratory explosion" of phagocytized leukemic cells. The latter, under the influence of local factors

(plaque, plaque, microbiota), accumulate in the gingival fluid and gingival tissue [1]. Free radicals damage lipids of cell membranes, proteins, enzymes, nucleic acids and other compounds in periodontal tissues. Antioxidant mechanisms protect cells from damage. One of the natural antioxidants is reduced glutathione (GSH). This substance makes a significant contribution to the functioning of the antioxidant system. Glutathione helps to maintain the spontaneity and integrity of membranes, the normal course of various membrane processes, affects the biosynthesis of nucleic acids and proteins and plays an important role in protecting against xenobiotics. In general, the glutathione system is an important protective mechanism of cells, increasing their resistance to both chemical and physical factors. Cells respond to many undesirable effects that reduce GSH levels by increasing GSH production [5]. The normal concentration of glutathione in the oral fluid is 717 nanomoles/ml [7]. It is natural to assume that with periodontal inflammation, this concentration increases. If this position is proven, it will expand our understanding of the pathogenesis and will be of great importance in the comprehensive diagnosis of periodontal inflammation. Therefore, there is an urgent need to study changes in the glutathione system in the oral fluid of patients diagnosed with periodontitis of the supporting teeth before and after treatment. The purpose of this study was to determine the periodontal status of the supporting teeth in patients with non-removable dentures in the mouth, which is the initial stage necessary for further clinical and laboratory studies of changes in the glutathione system in the oral fluid.

MATERIALS AND METHODS

A study of the periodontal status of 38 patients (18 women and 20 men) who sought restorative treatment after 6-8 years of using a non-removable metal-ceramic bridge prosthesis was conducted in the clinic of the Department of Orthopedic Dentistry of the Samarkand State Medical University. The age of the examined patients ranged from 27 to 68 years.

RESULTS AND DISCUSSION

During examination, 44.7% of patients showed symptoms of gingivitis localized on the teeth of the abutment, with stasis hyperemia of the gingival margin, thickening of the gingival papillae and bleeding during probing. Destructive changes in periodontal tissues of molars characteristic of localized periodontitis (depth of periodontal pockets up to 3.5 mm, mainly in the interdental space, X-ray signs of resorption of the alveolar gap up to 1/4 of the root length, mobility of molars up to grade I II after removal of the prosthesis, induced bleeding) were detected in 18.4% of patients. Generalized periodontitis was detected in 5.2% of patients. After removal of the prosthesis, foci of demineralization

of hard tissues were found in 65% of the supporting teeth of the studied group of patients. We conducted a comprehensive treatment, which can be divided into general and local. Since it is very important to increase the restorative (restorative) ability of tissues, general restorative therapy was used according to indications. Vitamin therapy and phytotherapy were used for this purpose. Local treatment was used to prepare for re-reconstruction. At first, the oral cavity was disinfected to reduce inflammatory phenomena. The oral cavity was treated with aseptics and disinfectants. Ultrasonic curettage of periodontal pockets was performed with polishing of root surfaces and excision of granulation tissue. Restorative treatment included local physiotherapy and the use of keratostimulating jelly ("Solcoseryl"). Physical therapy included massage, electrophoresis with vitamins and pain relief. Combined therapeutic measures for the relief of inflammatory changes, removal of a damaged bridge and temporary splinting of teeth, carried out jointly by a periodontist, a dental surgeon and a therapist, led to good clinical stability. Then, the patient underwent a re-molding of the non-removable prosthesis in accordance with clinical requirements. A total of 43 ceramic-metal prostheses were made. In this group of patients, indentation of hard tissues was used. To reduce postoperative sensitivity and prevent demineralization of hard dental tissues, deep fluoridation of the hard tissues of the prepared abutment teeth was performed twice: after tooth preparation and during installation of the frame. Inflammatory changes in periodontal tissues were caused by non-compliance with the rules of modern periodontal preparation, non-functional occlusal relationships between the prosthesis and opposite teeth, neglect of the possibilities of sealants and deep fluoridation, untimely detection of the formation of pathological processes. Along with the observance of modern methods of preparing supporting teeth for prosthetics, early diagnosis of inflammatory periodontal diseases is necessary.

CONCLUSION

Therefore, it is necessary to develop new opportunities for early diagnosis of inflammation of the tissues surrounding the supporting teeth, which is to study changes in the oral fluid glutathione system before and after treatment of patients diagnosed with periodontitis of the supporting teeth.

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