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REVIEW OF A CLINICAL CASE OF EXTRUSION DISLOCATION OF THE UPPER INCISORS IN A PATIENT WITH MESIAL OCCLUSION

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ABOUT ARTICLE

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Abstract: Dental treatment as a result of injury is not as common as carious lesions. However, in such cases, a comprehensive and qualified approach to solving the problem is very important. Injuries due to mechanical trauma most often occur in the front teeth of the oral cavity - according to various sources, about 80% [1]. Timely dental treatment and long-term management after injury can significantly reduce the risk of post-traumatic complications such as pulp necrosis, root resorption and dental ankylosis. Child and adolescent psychology is designed in such a way that patients with traumatic dental injuries are referred to a pediatric dentist for consultation more often than to an adult [3, 4].

INTRODUCTION

A 12-year-old patient was admitted complaining of injury to the maxillary incisors as a result of an impact during a car accident. According to his mother, the incisors were previously in the correct position, but now the teeth overlap each other in the opposite direction. She can't completely clench her teeth. Approximately 30 hours after the injury. Appearance: the face is symmetrical, straight in profile. Examination of the oral cavity: art.loz: hematoma of the mucous membrane of the upper lip, swelling and hyperbleeding of the mucous membrane of the upper incisors, tooth hematoma 2.2, 2.3,

overlap of retroincident teeth 1.1, 2.1, 2.2. Protrusion of teeth 1.1, 2.1, 2.2; mobility of teeth 1.1, 2.1, 2.2 in degree II. Occlusion: Class III closure in the area of the first molars and canines. Stenosis and shortening of the maxillary dentition, lateral contact of the canines. The overlap of the posterior incisors is about 3 mm. Rg-examination: enlarged periodontal gap at the tips of the roots of the teeth 1.1, 2.1 and 2.2, there are no root fractures. There are also no fractures of the alveolar process, bifurcation and articular process of the lower jaw, dislocation of teeth 1.1, 2.1 and 2.2, and hematoma of the upper lip and mucous membrane of the maxillary alveolar process. Dental diagnosis: mesiocclusion, stenosis and shortening of the maxillary dentition, overlap of the reverse incisors in sections 1.1, 2.1 and 2.2, vestibular position of the tooth 2.3. Skeletal diagnosis: skeletal classification III, mandibular gigantism, normal deviation, protrusion of the maxillary incisors, straight profile, enlarged nasolabial angle. Treatment plan: since more than 24 hours have passed since the injury, simultaneous reduction of dislocated teeth is impossible. Splinting is also difficult due to the overlap of the posterior incisors and the soreness of the front teeth in the bite. Non-removable orthodontic devices are used as splinting and repositioning devices. [1,4].

extraction of teeth 1.1, 2.1, 2.2 from the bite,

tooth reposition 1.1, 2.1, 2.2,

tooth intrusion 1.1, 2.1, 2.2,

removal of 1.1, 2.1, 2.2 into the correct incisor overlap, correction of vertical incisor overlap, correction of sagittale occlusion, installation of paid occlusal contacts, retention.

Devices: non-removable orthodontic devices, straight arc method. Non-removable retainer: flexwire 0.0175", removable: holley appliance Wound disinfection treatment with 0.006% chlorhexidine solution; Filtek occlusive pads fixed on teeth 3.7 and 4.7; bite separation to reduce the load on the front teeth. Orthodontic device Mini-splint (Forrestadent) for teeth 1.5 - 2.5, buccal tubes for teeth 1.6 and 2.6. Arc NiTi SE 0.014", arc ligatures. Antiseptic cleaning and mucosal treatment with Aekol solution are prescribed at home; upon examination, after 1 month, the mobility of the upper incisor of the first degree was preserved, its position was normalized, there was no root fracture along the Rg line, there was no root resorption; after 3 months, direct contact appeared on the incisors, tooth mobility 1.1, 2.1 and 2.2. Within normal limits; an edging arc of NiTi SE 0.016 was applied to the maxillary dentition"x 0.022", the occlusal patch has been removed. The occlusal contact is weakened. In the sagittal plane, class III. Repeated OPTG and targeted Rg revealed no changes in the area of the incisor root of the upper jaw. Five months after the start of treatment, the maxillary occlusion was completely completed. The

teeth 1.1, 2.1 and 2.2 were in the correct position, the overlap of the incisors was 1-1.5 mm, the position of the tooth 2.3 was normalized. The patient's parents suggested continuing orthodontic treatment with a completely non-removable device in order to correct intermediate occlusion and normalize occlusive contact. The parents agreed. Fixing braces on the lower teeth: braces 3.5-4.5 mini splint (Forestadent), buccal tubes for 3.6 and 4.6. Alignment of the lower dentition took another two months. To correct sagittal occlusion, the patient was prescribed a class III interdigital thrust (Fox, Ormco). The mode of use was approximately 18-20 hours per day. Anterior box traction (Fox, Ormco) was also prescribed to increase the overlap of the incisors. After 5 months of using the interdigital traction, the dynamics of correcting sagittal occlusion was weakly positive. Cooperation with the patient and parents deteriorated, the boy's hygiene deteriorated significantly, the interdigital traction was not worn enough, which made it difficult to carry out the stages of sagittal occlusion and vertical correction. The parents were satisfied with the position of the front teeth, were not interested in lateral orthodontics and insisted on removing the device (Fig. 4-6).

CONCLUSION

After 12 months of orthodontic treatment, the protruding dislocation of the maxillary incisors was successfully cured. The maxillary incisors were correctly positioned in relation to the mandibular incisors, with an overlap of about 2.5-3 mm. However, the ratio in the sagittal plane still corresponded to Engle class III, and the nodal occlusal ratio was maintained. OPTG and targeted dental radiographs 1.1, 2.1 and 2.2 showed that the periodontal cleft remained throughout the root. The tip of the root of teeth 1.1, 2.1 and 2.2 was slightly resorbed. Non-removable flexible clamps were fixed indefinitely on teeth 1.3 - 2.3 and 3.3 - 4.3 [2]. Removable Holly retainers were made for mandibular teeth and prescribed to be worn for 14-16 hours a day; the examination was carried out after 6 months, and then once a year until the end of skeletal growth.

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