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STAGES OF SURGICAL PREPARATION ORAL CAVITY OF COMPOUND IAW PATIENTS

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ABOUT ARTICLE

Key words: Prosthetic manipulations, depulpation of intact teeth, excision of exostoses.

Received: 04.02.2024 **Accepted**: 09.02.2024 Published: 14.02.2024 Abstract: If a general practitioner has already cured and removed a diseased tooth that the surgeon considered unsuitable prosthetics, prosthetics are usually followed by

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oral care.

INTRODUCTION

However, there are situations when an orthopedist has to send a tooth that has just been cured of uncomplicated caries for depulpation or solve the problem of optimal fixation of the prosthesis due to the absence of remaining teeth. In addition, clinical "obstacles" may arise that complicate the preparation of the tooth, the removal of casts and other prosthetic manipulations. In our opinion, it is advisable to develop an orthopedic treatment plan before the start of oral rehabilitation in order to link it with future orthopedic treatment. This is especially important, since orthopedic rehabilitation of patients with complex jaw pathology is often problematic due to the complexity of manipulations in the oral cavity [1, 2]. Special preparation before orthopedic treatment is carried out in accordance with the orthopedic treatment plan drawn up for the patient. Preparatory procedures include therapeutic (depulpation of intact teeth), surgical (for example, excision of exostoses, removal of severely elongated or tilted teeth, dental transplantation), orthodontic (correction of occlusal disorders with dental deformities) and orthopedic (shortening of teeth and increasing interalveolar height to improve the

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occlusal surface by dissection). Special attention should be paid to special surgical preparation for prosthetics of toothless jaws. Surgical operations to correct the shape of the alveolar process (removal of the movable mucous membrane). (Operations to correct the shape of the alveolar process (removal of the movable mucosa of the alveolar process, removal of the ligament or scar of the oral mucosa, excision of exostoses, excision of part of the alveolar process), preparation of the hard palate (removal of the torus), removal of the ligament or scar of the mucous membrane of the prosthetic field, deepening of the vestibule and bottom of the oral cavity, alveoplasty, implants and etc.) [3]. We would like to share our experience on the example of clinical cases, believing that it will help practitioners in difficult situations.

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Clinical case 1. Patient S. (47 years old) complained of pain under the support of a soldered bridge fixed on teeth 2.3 and 2.6. When removing the bridge, it turned out that the crown of tooth 2.3 was completely destroyed, and the remaining root was hidden under a thickened gum (Fig. 1a). The first thought was to remove the roots of the tooth. However, the complex history of a patient with congenital left-sided cleft palate (sutured mucous membrane of the palate in childhood) served as a weighty argument in favor of preserving the root: in the area of the tooth 2.3, the mucous membrane is deepened along the transitional fold (recession into a bone defect). If you remove the root of the 2.3 tooth, located on the border of the bony palatine fissure, then most likely a large through defect will occur. Taking into account all this, as well as X-ray data (the roots were well passable, of sufficient length and there were no signs of chronic inflammation in the periapical tissues), it was decided to keep the gum in a different orientation (Fig. 1b). After surgical preparation and treatment, tooth 2.3 was restored with a cast insert followed by prosthetics (Fig. 1c). Clinical case 2. Patient S (68 years old) I wanted to get a prosthesis after resection of the right half of the lower jaw. Intraoperatively, the bone defect was replaced with a titanium plate. After the surgical wound was healed, a rough scar (about 10 cm long) formed on the inner surface of the right cheek, which squeezed the cheek and prevented opening the mouth. This caused problems with the manufacture and use of the prosthesis. After the removal of the rough sutures, the clinical situation improved markedly, and the patient underwent prosthetics.

CONCLUSION

The presented clinical case does not describe all surgical procedures that can improve the condition before prosthetics, but illustrates the relevance of this problem. This publication is intended to convey to dentists of all specialties the need for an integrated approach in the management of such patients, the need to consult with a number of specialists who will be able to correctly assess the situation and

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develop a treatment plan, as well as the need to warn patients against hasty tooth extraction in order to choose the most appropriate treatment option.

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