Periodontal diseases are currently one of the

the most important and complex problems in dentistry.

 The current level of scientific knowledge allows quite completely

characterize the main nosological forms of diseases, their etiology and

pathogenesis, pathomorphological changes in periodontal tissues.

 In our country, much attention is paid to improving

organizational forms of treatment and preventive care for patients with pathology

periodontal disease, development and implementation of treatment methods and means for

based on fundamental research into the role and significance of leading etiological

factors, prevalence of diseases among different age groups.

 Examination of a patient with periodontal pathology allows not only

correctly diagnose the disease, its severity, features

clinical course, but also to determine etiological factors and

pathogenetic mechanisms of the inflammatory or dystrophic process in

periodontitis. In this case, it is possible to clarify the role of genetic factors, the influence

nutrition, ecology, occupational hazards etc..

 All these survey results provide the basis for compiling

adequate, comprehensive treatment plan using products

etiotropic, pathogenetic and symptomatic therapy.

 Basic requirements for the treatment of periodontal diseases:

1. Treatment must be comprehensive. This means that in terms of treatment

methods and means should be provided to eliminate

symptoms of the disease, normalization of the condition of periodontal tissues and

impact on the patient’s body as a whole, i.e. the right combination

local and general treatment.

2. It is necessary to individualize complex therapy, taking into account

type, severity of the disease and characteristics of the clinical course, and

also the general condition of the patient.

3. Justified choice of methods and means of influencing the focus in

periodontal disease and the patient’s body as a whole.

4. Maintaining the correct sequence of application of various

methods and means of complex therapy.

5. During the period of remission, carry out repeated courses of treatment in order to

prevention of exacerbation of the chronic process.

6. Provide for rehabilitation measures.

7. Organization of medical examination.

 Among the methods used in orthopedic dentistry it is necessary

indicate the following:

 1.Selective grinding.

 2. Temporary splinting.

 3. Orthopedic techniques.

 4.Use of permanent splinting devices and prostheses.

 5. Direct prosthetics and splinting.

 Orthopedic methods used to treat periodontal diseases,

allow you to relieve inflammation, improve blood circulation and trophism

tissues by eliminating pathological mobility, normalizing

occlusal relationships, removing the traumatic effect of chewing

pressure.

The theoretical basis for the application of these methods, confirmed

Clinical observations are as follows:

1. With periodontitis, there is a violation of histofunctional correlation

tooth with surrounding tissues. Destruction of periodontal tissue leads to a decrease in

the area of the ligamentous apparatus and the walls of the alveoli, changes in the topography of the zones

compression and stretching under load, increase in specific pressure on tissue,

changing the nature of deformation of fibers and bone tissue due to changes

directions of spatial displacement of the tooth root.

2.Dynamic chewing function is modified but optional

factor of the influence of the external environment on periodontal tissue.

3.There is a close connection between the function of chewing and blood circulation in

periodontal tissues.

4. Changes in chewing functions cause disruption

histofunctional correlations in the tooth-periodontal system, manifested

circulatory disorders due to changes in vascular tone, development

reactive and then congestive hyperemia.

 5.Under the term “trauma”, “overload” of the periodontium and “traumatic

occlusion" should be understood as such a change in chewing functions when a tooth or

a group of teeth is subject to frequent, time-drawn, same type

the effects of chewing pressure causing perversion of vascular

reactions.

 6.Pathological mobility of teeth in the initial stage of the disease

is caused by tissue edema and is aggravated by the destruction of the fiber apparatus and

periodontal bone tissue.

 7. Destruction of periodontal tissues significantly reduces their resistance to

the action of a vertical load directed at an angle to the long axis of the tooth,

reduces the level of adaptation and compensation.

 Jenkelson selective grinding method.

 Indications:

 1. Supercontacts for:

 1) secondary deformation of the dentition with secondary partial

 edentulism;

 2) pathological abrasion;

 3) periodontal disease with tilted teeth

by turning your teeth around

 axis, formation of diastemas and three.

 2. Syndrome of painful dysfunction of the mandibular joint.

 3. Lack of physiological abrasion.

Selective grinding is indicated:

1. After curettage, drug treatment and temporary splinting.

 2. Before flap surgery and open curettage (i.e. before

 surgical intervention).

 There are three classes of surfaces:

1st - buccal surfaces of the vestibular tubercles of the lower jaw,

vestibular - cutting surfaces of incisors and canines;

2nd - oral surfaces of the palatine tubercles of the upper jaw;

3rd - buccal surfaces of the palatine tubercles of the upper jaw.

Selective grinding is carried out in 4-5 visits depending on the size of the supercontacts: if the contact is 2.5 mm in area, then 5 visits.

 1 visit

 Articulating paper is applied to the occlusal surfaces of the teeth of the upper jaw, while the patient is asked to move the lower jaw posteriorly

to the position of distal occlusion.

Grinding is carried out according to class 3 with a drop-shaped or flame-shaped head, i.e. sharpen the bump, but do not grind it off. After this, remineralizing therapy, fluoride varnish, and protective pastes are carried out.

 2nd visit

 In 3-5 days to a week. Determine the supracontacts of the teeth of the lower jaw in

central occlusion according to class 1, do not remove the cusps, but grind them to 45

degrees, increase the circumference of the equator. Then - the canine and incisors with

vestibular side. Along the cutting edge you can remove hard tissues,

height only in one case, if one tooth is clearly lower than the other teeth. If

If you shorten a tooth, it will still go into supercontact.

 3 visit

 After 10 days, check the upper teeth in central occlusion 2

class.

 4 visit

 After 5-7 days, check the contacts in the central occlusion according to class 3.

5 visit

 After 10-14 all three classes are checked. Polish hard fabrics

always retherapy.

 TIRES

A splint is a device for immobilization (complete immobility or

significantly reduced mobility) of a group of teeth or the entire dentition.

Tire requirements:

 1) create a strong block from a group of teeth, limiting their movements in

 three directions: vertical, vestibulo-oral, medio-

 lateral (for anterior) and anteroposterior (for lateral);

 2) be rigid and firmly fixed to the teeth;

 3) do not irritate the marginal periodontium;

 4) do not interfere with medical and surgical therapy of gingival

 pocket;

 5) do not have retention points for food retention;

 6) do not create blocking moments with your occlusal surface

 movement of the lower jaw;

 7) do not interfere with the patient’s speech;

 8) not cause gross disturbances in the patient’s appearance;

 9) making a tire should not involve removing a large layer

 hard tissues of tooth crowns.

The decision on the need for splinting is made based on mobility assessment

teeth, which characterizes the functional state of the periodontium. At loss

for 1/2 the length of the tooth root, the splinting plane is horizontal

(mesiodistal and transversal directions). With a decrease of 3/4 length

horizontal and vertical splinting of the tooth root. After defining

splinting plane, you should choose the type of stabilization - sagittal (in

within the lateral portion of the dentition), frontal (front portion);

fronto-sagittal, parasagittal, along the arc, along the arc in combination with

parasagittal.

Periodontal diseases complicate treatment to varying degrees.

orthopedic treatment. Even in simple cases, for example, when

uncomplicated deformations of dentition defects, periodontal diseases

lead to difficulties in choosing teeth for supporting and

retention function of fixing elements of prostheses. While maintaining full

dentition with weakened periodontium, orthopedic treatment involves

splinting mobile teeth, combining them into a single block. More often it happens

simultaneously splinting and restoring the anatomical shape of the dentition.

Orthopedic structures used during complex

treatment of periodontal diseases are presented:

1) Designs manufactured before therapeutic and

surgical treatment - temporary;

2) Permanent or long-term prostheses.

 Temporary splinting

 Temporary dentures are made to restore the anatomical shape of the dentition and splint the remaining teeth.

 The temporary splinting method is used in the advanced stage

generalized and focal chronic periodontitis, less often during

exacerbation at the initial stage.

 Temporary tires approx.

taken during the entire period of complex treatment

until a permanent splint is applied. Temporary

splinting eliminates the traumatic effects of pathological

mobility and chewing function, i.e. eliminate one of the pathogenetic

mechanisms supporting hemodynamic disturbances in periodontitis. Tire

ensures uniform distribution of chewing pressure between

periodontium of the teeth included in the splint, creates rest for the affected tissues and

helps to increase the effectiveness of pathogenetic and symptomatic

therapy.

Based on the vascular-biomechanical hypothesis, the use of temporary

tires allow you to break the pathogenetic chain of inflammation-blood supply-

dystrophy - chewing function, which helps improve tissue trophism

periodontal, relieving the inflammatory process.

Carrying out gingivotomy and gingivectomy without prior

making a temporary splint is unacceptable.

 In case of generalized periodontitis, all teeth are included in the splint, providing

immobilization along the arc. For focal periodontitis, the length of the splint

due to the localization of the lesion and its relationship with the teeth, in

which the periodontium is not affected: the splint must include teeth with

unaffected periodontal disease.

Temporary splints are made of plastic. There are mouthguard tires,

oral and vestibulo-oral multi-unit.

 Mouthguard splints cover the occlusal part of the tooth crowns, their

application is associated with an overestimation of the occlusal height.

 Plastic splints - mouthguards reinforced with metal or

non-metallic reinforcement and temporarily fixed, provide the best

splinting effect, at the same time allowing to restore dental defects

and improve the patient's appearance.

 Vestibular-oral splints (circular) cover only part of

vestibular surface of the tooth, do not interfere with the closure of antagonists and do not

push back the gingival margin.

 The design often chosen is a partial removable laminar denture with

bent wire clasps. Such a prosthesis loosens the teeth with clasps,

does not eliminate occlusal trauma, injures the marginal periodontium and mucous membrane

shell of the prosthetic bed. But such a prosthesis is cheap and easy to make

and can be repaired; various medicinal elements can be added to it

structures - orthodontic elements, occlusal platforms, etc. Such

dentures are indicated in cases where the bite height is reliably fixed

several pairs of stable antagonist teeth and no signs

reflected traumatic node.

 The emergence of modern materials based on the use of adhesive

technology, allows you to solve the problems of splinting areas of the dentition with

compliance with modern aesthetic requirements and directly during

reception of the patient, without involving a long laboratory stage. In a number

cases, new systems make it possible to solve the problem of replacing single

defects.

 They use 2 types of materials depending on their chemical

composition:

- based on inorganic matrix Glaspan (USA) and Fiber Splint

(Switzerland).

- based on the organic matrix of polyethylene Ribbond (USA) and Connect

(USA),

made of many finest fibers D = 3-5 microns, woven between

yourself. It is quite difficult to answer unequivocally which of the fittings is better.

There is evidence that polyethylene tires have better adhesion due to

special plasma treatment - activation and better impregnation

composite, which is important because allows the composite to create more

durable single unit; they have better biocompatibility with tissues

human body, because consist of bioinert glass, not

plates

The advantage is that their modification is available in the form

hollow flagellum, which significantly expands the scope of application: flagellum

optimal for splinting lateral teeth using the creation technique

grooves, to restore a single defect in the dentition or as

an alternative to intraradicular pins.

 Application of the Fiber-Splint system in the treatment of diseases

 periodontal disease and the presence of single dentition defects

 The basis of the "Fiber-Splint" system is a microfiber quartz tape with a width of

4 mm, 0.06 mm thick and light-curing unfilled bonding "Fiber-

Bond". Thanks to the microfiber structure "Fiber-Splint", impregnated

light-curing bonding, after illumination with a halogen lamp for

polymerization, forms a durable structure with internal spatial

frame.

 In patients with periodontal diseases, the first stage is

removal of all supra- and subgingival deposits followed by polishing

surfaces of teeth and the use of drug therapy. For the second -

the third day from the oral surface, and sometimes from the vestibular,

A Fiber-Splint splint was applied.

Splinting technology:

1.Preliminary abrasive treatment of the surface of the teeth to create

retention points.

2.Etching the surface of the teeth.

3.Applying bond to the surface of the teeth.

4. Step-by-step application of the tape to the dentition with insertion into

interdental spaces and surface exposure.

 Finally, the tire is covered with a thin layer of composite, followed by

polishing When making a tire, for hygienic reasons, it is necessary

leave the gingival spaces between the teeth open.

 When replacing single defects, it is possible to make a tooth from

photocomposite, fixed on a splint between adjacent teeth. Given this

type of work, it is necessary to manufacture tires in such a way that the load-bearing part

was pushed forward and passed through the thickness of the artificially manufactured

tooth It is recommended to strengthen the middle part of the tire with additional layers.

"Fiber-Splinta".

 During the splinting, a number of conclusions were made that can be

recommend to all doctors:

- the width of mobile teeth with 1 degree of mobility does not require

creating a special groove (puncture), and with grades 2-3 -

requires.

- parodon is not tal splinting for patients with

low level of compliance with personal hygiene rules. Observations

show that when a patient has high hygiene indices,

the likelihood of tire failure increases significantly, because

the design will already be an additional factor

retention for dental plaque;

- it is important to check that the splint leaves the interdental spaces open

intervals to allow the patient to maintain proper hygiene

oral cavity. A special point in subsequent hygienic care

behind the splint is the use of superflosses or brushes.

Finally, an X-ray assessment of the results is carried out before

splinting and 6 months after it. According to the level of bone location

tissue in relation to the tooth root, the effect of splinting is clearly visible.

 If preparation of splinted teeth is planned, then effective

An alternative to non-metallic reinforcement can be a wire busbar,

made from ligature or clasp wire. Gives a good effect

additional fixation of the wire splint to the hard tissues of the teeth using

parapulpal pins. There is a Splint-lock System kit, including

braided wire splint with holes for parapulpal pins, set

pins.

 Another promising and highly effective temporary structure is

this is a tire made on vacuum forming machines, a Biostar tire or

Mini Star made from rigid, transparent Imprelon S polycarboxylate material.

It is removable, easy to manufacture and fit in the oral cavity,

provides reliable fixation both horizontally and vertically

planes, has a satisfactory appearance, can restore end and

included dentition defects. Sometimes at the preliminary stage

orthopedic treatment, you can use complex biogenic splints

prostheses, when the process is generalized and uniform, and

bone destruction does not exceed 1/2 the length of the tooth roots. To the final

orthopedic interventions are transferred when reparative processes in

periodontal disease after surgery are completed.

 In case of an unfavorable prognosis, long-term

structures with a service life of 2-3 years (temporary - for 2-6 months). TO

long-term non-removable structures include temporary built-in splints,

integrated into the hard tissues of the tooth. Satisfies these criteria

Splint-lock system described above, or long-term - transcoronal

wire tire according to Komari.

 Removable long-term structures are represented by “overlapping

structures." Morphologically, "overlapping prosthetic structures"

are complete removable dentures, under the base of which are preserved

roots of some teeth. Such designs have a number of positive

properties compared to full removable structures. They:

 - better fixed on the prosthetic bed;

 - preserve the natural path of chewing pressure transmission;

 - have greater occlusal stability.

The negative side of overdentures is the high frequency

root caries, gingivitis in the area of preserved roots.

 The service life when using overdentures is

approximately 3 years. During this time, the patient gets used to the prosthesis.

 Permanent splinting

 Permanent splints are used as therapeutic devices for immobilization

teeth for a long time. The patient uses such splints constantly.

 Depending on the topography of the dentition defect, prevalence and

degree of periodontal destruction, permanent structures can be removable,

non-removable and combined.

 Fixed tires

 Fixed dentures are better than removable ones because... fix teeth in

horizontal and vertical planes.

 They provide reliable strengthening of mobile teeth, forming them into

block capable of withstanding as a single unit horizontal and

vertical forces developing during chewing. They interfere little with speech, and

patients quickly get used to them.

 The main problem in manufacturing is ensuring reliable fixation of the tire

or a prosthetic splint to the splinted tooth. The design must be sufficient

rigid and fit exactly to the prosthetic bed, which also has sufficient

contact area. Increase the contact area and improve resistance to

lateral shift is possible by introducing parapulpal or

intracanal pins. The most reliable non-removable design should be

recognize one, the fixing element of which is a solid cast

lined or unveneered crown (“solid, non-removable splints”).

The rigidity of a solid coronal prosthetic splint depends on the material, from

which the structure is made. Cross section of the structure (ex.recommended

pit

proportional) and its length (inversely proportional). Promote

structural rigidity can be achieved by increasing the cross-section, e.g.

by creating a garland from the palatal (lingual) surface. To provide

required rigidity, the design is complemented by a palatal clasp reinforced

on T-valves. Grooves for the latches are formed in the area of the second premolars or

first molars. The structure is placed on temporary cement for up to 3

months, and if during this period it turns out that the structure is not rigid enough

(this is manifested by chipping of the cladding, de-cementing, aggravation of

inflammatory process in the periodontium), then it is necessary to redo

design.

 Currently, the indications for the use of metal-ceramic

structures are expanding and metal-ceramic prostheses can be used for

mild to moderate periodontitis. For metal-ceramic prostheses

A number of positive properties have been noted:

- biological inertness of ceramics (unlike plastic)

eliminates injury to the marginal periodontium;

- on the glazed surface of metal-ceramic dentures

significantly less favorable conditions for plaque formation.

The scope of application of fixed structures is limited to those included

defects. The abutment tooth must be sufficiently stable and have sufficient

bone support. Otherwise, the manufacture of a removable splint is indicated

construction (clasp). It reliably splints the dentition in a horizontal

plane and provides any type of stabilization of the dentition. Open

marginal periodontium of existing teeth avoids injury

gums while using the prosthesis. The disadvantage is that for

fixation of the tooth in the vertical direction using one-piece clasps

not enough. This problem can be solved with the help of hybrid prostheses,

those. prostheses, the design of which contains both clasp

fixing elements, as well as locking ones (for example, rigid latches, i.e.

telescopes).

 Clasp dentures with claspless fixation require manufacturing

anchor crowns, thanks to which the entire structure becomes

combined removable (fixed) dentures.

 Removable tires

 The splinting properties of removable tires are provided by various combinations

continuous support-retaining and reversible clasps, as well as various

shapes of occlusal pads. Their spread was facilitated by the development

parallelometry techniques, precision casting on refractory models, application

chromium-cobalt alloys and alloys of precious metals.

 Removable splints can be used to splint one particular group

teeth or the entire dentition. When immobilizing the front teeth, a splint

It is advisable to bring it to the premolars, and when splinting the lateral ones - to the canines.

 Removable splints can be included in the design of the arch prosthesis as its

constituent part. These are prosthetic splints:

 1) continuous clasp type tire;

 2) splint-guard;

 3) a single splint for the entire dentition.

 Comparative assessment of removable and non-removable tires

 Both types of tires have positive and negative properties.

 The positive properties of non-removable tires include:

1) the ability to provide blocking of the system in three

directions: vertical, transversal, mediodistal;

2) leave the gum pockets open (exception - a block of full

crowns), make it accessible for medical and surgical

(curettage) therapy;

4) patients quickly get used to non-removable splints, and phonetic

violations occur rarely and are quickly eliminated without the help of a doctor.

Negative properties of non-removable tires:

1) the need for tooth preparation, accompanied by rough

trauma to enamel and dentin;

2) the use of pin splints involves the removal of pulp, which when

filling the canals creates a risk of developing apical

periodontitis;

3) fixed splints are difficult to apply when there is a fan-shaped discrepancy

teeth;

4) the designs of cap busbars are fragile and break along the soldering line,

de-cementing occurs;

5) non-removable splints worsen oral hygiene.

The splinting properties of permanent splints are ensured by clasps,

claw-shaped processes and occlusal linings. They create

immobilization in only two directions: vestibulo-oral, mediolateral

(for anterior teeth) or mesiodistal (for lateral teeth). These tires are not

always create fixation in the vertical direction.

Removable splints are easy to clean and less disruptive to cavity hygiene

mouth Violations of aesthetics are minimal.

The advantage is the ability to use them for prevention

functional overload of the periodontium, with defects in the dentition with signs

periodontal disease, but without pathological tooth mobility.

Manufacturing of removable tires

снятия шины возможна перегрузка пародонта отдельных зубов.

 **Показания к включению зубов в шину**

 Показания к включению зубов в шину зависят от величины атрофии зубной

альвеолы и формы заболевания пародонта. Зубы с подвижностью III степени

подлежат удалению. Необходимо удалить зубы с подвижностью II степени, если

имеется атрофия более 2/3 лунки. Зубы с подвижностью I степени при атрофии

лунки более чем на половину при пародонтитах удаляют, а при пародонтозе их

нужно включить в шину. При хронических периапикальных изменениях зубы с

подвижностью I степени и с хорошо пломбированными корневыми каналами

подлежат шинированию. При плохой обтурации корневого канала зуб может быть

включен в шину только при отсутствии изменений верхушечного периодонта и

спокойного клинического течения (отсутствие болей до лечения и через 3-4

недели после него). В случае обострения хронического периодонтита, зуб не

включается в шину. Зубы с подвижностью II степени и хроническими

околоверхушечными очагами, даже если каналы хорошо пломбированы,

шинированию не подлежат. Наличие свищевого хода является противопоказанием

к включению зуба в шинирующий блок, даже если канал запломбирован.

 **Основные виды шинирования**

 Направление патологической подвижности любого зуба всегда определенно

и зависит от расположения его в зубной дуге. Для моляров и премоляров линии

их подвижности лежат почти в параллельных плоскостях, для резцов и клыков -

в плоскостях, расположенных под углом друг к другу. Наилучший результат при

шинировании достигается, если шина объединяет зубы, линии подвижности

которых лежат в пересекающихся плоскостях. Для передней группы зубов

применяется шина, объединяющая резцы и клыки. Это передняя иммобилизация.

Она удобна потому, что, во-первых, пародонт клыков менее поражен и

принимает на себя часть давления, разгружая ослабленный пародонт резцов; во-

вторых, восстанавливается единство группы зубов, имеющих одинаковую

функцию; в-третьих, зубы расположены по дуге, в связи с этим шина

приобретает большую устойчивость.

 Иммобилизация зубов, при которой шина располагается в переднезаднем

направлении, называется боковой (сагиттальной). Боковая иммобилизация

позволяет создать блок зубов, устойчивых к усилиям, развивающимся в

вертикальном, поперечном и переднезаднем направлениях. При определенной

степени атрофии лунок этого бывает достаточно, чтобы уменьшить

функциональную нагрузку и получить терапевтический эффект.

 **Особенности ортопедического лечения больных при заболеваниях пародонта, осложненных дефектами зубных рядов**

 К особенностям клинической картины пародонта, осложненной потерей

зубов, следует отнести появление дополнительной функциональной нагрузки,

обусловленной уменьшением числа зубов. Большое значение для развития

болезни в этих условиях имеет количество утраченных зубов, расположение

дефекта, вид прикуса, степень атрофии альвеолярной части. При утрате

боковых зубов передние получают дополнительную нагрузку. В связи с этим

увеличивается подвижность зубов, верхние резцы и клыки веерообразно

расходятся, выдвигаясь вперед, промежутки между ними увеличиваются,

уменьшается межальвеолярная высота, и как следствие уменьшается нижняя

треть лица. Одновременно изменяется положение нижней головки нижней челюсти

в суставной ямке, возникает опасность функциональной перегрузки сустава.

 Все указанные особенности течения пародонтоза и пародонтита при

частичной потере зубов определяют характер ортопедической терапии. Она

заключается в шинировании сохранившихся зубов и протезировании дефекта.

 Пациентов с заболеваниями пародонта и нарушением непрерывности зубных

рядов модно разделить на три группы. К первой группе относятся больные с

включенными, ко второй - с концевыми (односторонними и двусторонними)

дефектами зубной дуги; третью группу составляют больные с множественными

дефектами и небольшими (по 2-3) группами зубов.

 При расположении дефекта в переднем отделе зубного ряда протезирование

осуществляется при помощи различных видов мостовидных протезов. Опорами

являются оставшиеся зубы. Мостовидный протез является шиной. Если дефект

большой (потеря клыков, премоляров), оставшиеся корневые зубы шинируют

несъемной шиной, а дефект замещают съемным протезом.

 При односторонних и двусторонних включенных дефектах, образующихся при

удалении 1-2 моляров и премоляров, шинирование осуществляется мостовидными

протезами, опорными элементами которых являются экваторные и полные

коронки.

 Понижение высоты тела мостовидного протеза ведет к уменьшению площади

спайки его с коронкой, что вызывает поломку протезов. В этих случаях

применяют литые конструкции или малые седловидные протезы с кламмерами на

зубы, блокированные несъемными шинами. Мостовидные протезы противопоказаны,

если дистально расположенный зуб подвижен. Для этого применяют шинирование

дуговым протезом с непрерывным кламмером и когтевидными отростками при

подвижности передних зубов.

 Съемные шинирующие протезы показаны при больших включенных дефектах,

значительном поражении пародонта или отсутствии достаточно прочной

дистальной опоры. Применяют дуговой протез, который позволяет осуществить

поперечную стабилизацию.

 Передняя группа зубов шинируется несъемными шинами. При большой

подвижности зубов шинирование может быть усилено путем включения в нижний

дуговой протез многозвеньевого кламмера, благодаря чему передние зубы

получают дополнительную поддержку с язычной стороны. Можно создать и

круговую фиксацию. Для этого многозвеньевой кламмер снабжают когтевидными

отростками. Лучшая круговая фиксация достигается при взаимном сочетании

несъемных шин и шинирующего съемного протеза.

 Шинирование остаточного зубного ряда возможно тремя способами:

несъемными шинами, шинирующими приспособлениями, включенными в конструкцию

съемного протеза и путем комбинации этих способов. Конструкция несъемной

шины зависит от положения шинированных зубов. Предпочтение отдается шинам,

покрывающим окклюзионную поверхность.

 При пародонтопатиях, осложненных концевыми (односторонними или

двусторонними) дефектами, протезирование производится съемными протезами.

Показания к применению определяются величиной дефекта, состоянием пародонта

сохранившихся зубов, выраженностью альвеолярных отростков и твердого неба.

 При комбинированных дефектах протезированию предшествует шинирование

каждой группы зубов несъемными протезами. Дистально расположенные зубы

блокируют экваторными, а зубы, видимые при улыбке - комбинированными

коронками. Границы протезов у таких больных должны быть максимально

полными, чтобы с одной стороны, сделать протез устойчивым, а с другой -

разгрузить оставшиеся зубы путем передачи давления на небе и беззубые

альвеолярные части.

 Правильно подобранный и проведенный комплекс ортопедических

вмешательств, направленный не только на восстановление дефектов зубного

ряда, но и на надежную стабилизацию оставшихся зубов, способствует

нормализации окклюзионных нагрузок, трофики пародонта и репаративным

процессам в его тканях, повышая тем самым эффективность лечения заболеваний

пародонта.

**Список рекомендованной литературы:**

1. Акулович А.В. "Применение современных материалов для шинирования"/

Стоматология, Материалы IV съезда Стомат. Ассоциации России, 1998 .

2. Акулович А.В., Орехова Л.Ю. "Современные методики шинирования

подвижных зубов в комплексном лечении заболеваний пародонта" / "Новое

в стоматологии" №4 - 1999 .

3. Барер Г.М., Лемецкая Т.И. "Болезни пародонта. Клиника, диагностика,

лечение", 1996 .

4. Вебер Г. "Ортопедическое лечение обширных дефектов зубного ряда с

применением имплантов и без них"

5. Гаврилов Е.И., Щербаков "Ортопедическая стоматология"

6. Каламкаров Х.А. "Ортопедическое лечение заболеваний пародонта"

7. Копейкин В.Н., Понамарева В.А., Миргазизов М.З., Миликевич В.Ю.,

Большаков Г.В., Воронов А.П., Троянский Г.Н., Гожая Л.Д.

"Ортопедическая стоматология", 1988 .

8. Кулаков О.Б., Шамшина А.В., Супрунов С.Н. "Опыт применения системы

Фибер-Сплинт производства Швейцарии при лечении заболеваний пародонта

и замещении одиночных дефектов зубного ряда" / "Вестник стоматологии"

№6 -1999.

9. Щербаков А.С., Гаврилов Е.И., Трезубов В.Н., Жулев Е.Н.

"Ортопедическа