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Indications for the Elimination of Morpho-Functional Changes Caused by Pathological Tooth Extraction

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ABSTRACT
Dental examination and examination were carried out according to a generally accepted procedure using a set of standard dental equipment. When using elastic plastic mouth guards, which are recommended for stage 1 pathological tooth abrasion, it was possible to stop tooth abrasion at this level. Effective results were achieved in 90% of cases with electrophoresis with calcium and fluoride preparations to reduce tooth sensitivity.

KEYWORDS: pathological wear of teeth, height of bite, treatment of pathological wear of teeth.

Relevance of the study. The occurrence of pathological edirsia is caused by exogenous and endogenous etiological factors, which include a violation of metabolism, changes in the formation of tooth decay, dental changes, loss of lateral teeth, increased chewing pressure in certain teeth (traumatic nodes), disruption of the central nervous system, in the dental-jawomalar and professional harmful habits. In some patients, the process of pathological exhalation is slow, and in the head it is fast. Once it deepens in the places where the dentin opens and stops for a while in the places where the enamel is sagging, it is constantly strained. For this reason, edirish surfaces have the appearance of a flat polished area or The Shape of a crescent or cratersimon groove, which is bordered by the sharp ends of the enamel, which sometimes scar the tongue. The tooth pulp responds with a chemo reaction against editation. This reaction is manifested by the release of substituted dentin. Substitute dentin changes The Shape of the tooth cavity, sometimes completely enclosing it. In Pulp dystrophy, the rate of release of substituted dentin may lag behind the rate of tissue excision, the dentin floor becomes thinner, the dentin ducts open, and death blurring of the pulp is observed. Due to this, foci of inflammation (chronic periodontitis) appear near the tip of the tooth root in pathological exhalation. Enamelling may be accompanied by tooth decay and extreme sensitivity to chemical lambs.

Step-by-step treatment is carried out if the alveolar height is reduced at a distance of more than 6 mm (F.Shper, 2006; C.Rufenacht, 2000).

46 patients showed limited and 10 had diffuse pathological tooth extraction. Clinical manifestations in the above observations make it difficult to denture teeth. In the orthopedic treatment of patients, the following goals are set: to eliminate the jarochat of the oral mucosa, restore the bite height, restore the anatomical and functional state of the teeth, restore the chewing function (A.V.Tsimbalistov, 2005; C.Rufenacht, 2010).

Pathological tooth extraction is a complex dental disease, occurring in 23.1% of the population, polyethiological, with different clinical manifestations and Multi-Stage Complex Treatment. In pathological tooth extraction, along with the teeth, there will be changes in the pulp, parodont, chewing muscles and chakka-lower jaw (X.A.Kalamkarov, 2006; A.V.Bryukhanov, 2008).

Research objective: practicing modern methods of treatment, studying the degree of spread of pathological incontinence of teeth.

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Object and methods of research Subjective and objective examinations were carried out in 108 people aged 24-60 who applied for treatment at the dental Polyclinic of the Navoi mining and Metallurgical Combine medical and sanitary department (NKMK TSB). Examination of the oral organ and tissues in the sequence saw a tooth and tooth row, a pricus, a periodont state, the presence of dental fillings, dental prostheses, and attention was paid to their condition. Pathological edirations of a single tooth on the chewing or incision surface, the palate surface of the teeth of the upper jaw, the vertibular surface of the teeth of the lower jaw were diagnosed. Oral hygiene was investigated (Green,Vermillion, 1964).

Methods of electro-odonto-diagnostics (EOD), radiological (orthopantomagram), anthropometric measurement of bite height, study of diagnostic models were carried out. In diagnostic models, the condition of the tooth rows was subjected to their interaction and anthropometric examinations.

As we have already mentioned above, we have prepared plasticine Cappas in 52 patients with pathological edging of teeth of the 1st degree.

Statistical processing of the results from the study was carried out using the Microsoft Exsel special 2007 standard application package on the Pentium IV personal computer.

Research results: when patients were asked, most complained of a violation of their aesthetics, a decrease in the height of the tooth crown, difficulty disconnecting food, an increase in sensitivity to sweet, sour and salty, and a jarring of the bark of the gums.

The examiners were studied as 4 young gurukhi. The highest number of patients aged 45-54 were 40.

Teeth pathological exhalation, we studied horizontal and vertical manifestations in aloxia. Horizontal appearance of pathological features of teeth 25-34 age gurukhi in the upper jaw 3.3%+0.8 in the lower jaw 10.0 %+1.7 ; 35-44 age gurukhi in the upper jaw 17.3%+1.7 in the lower jaw 22.4%+2.3 ; 45-54 age gurukhi in the upper jaw 2%+0.5 in the lower jaw 29.5%+2.1; 55-60 age gurukhi in the upper jaw 20.5%+1.8 in the lower jaw, while 39.2%+2.2.

Pathological exertion of a vertical appearance is observed on the palate surface of the teeth in the upper jaw and on the vestibular surface of the teeth in the lower jaw. 25-34 age gurukhi in the upper jaw 6.6%+0.6 in the lower jaw 3.3%+0.3 ; 35-44 age gurukhi in the upper jaw 18.9%+0.9 in the lower jaw 3.4%+0.4 ; 45-54 age gurukhi in the upper jaw 26.5%+1.0 in the lower jaw 4.0%+0.4; 55-60 age gurukhi in the upper jaw 26.4%+1.0 and in the lower jaw was 2.9%+0.4.

When checking the electrical excitability of the dental pulp, 1and Level 2 teeth are pathological in 60% of patients with increased electrical excitability 1.2-1.8 mkA. Level 3 teeth are pathological making in 40 of those examined, it was observed that the electrical excitability of the pulp decreased by 14.2 mkA [1.3.5.7.9.11].

Before the restoration of the Frontal tooth crown kompazision, we determined the dimensions of the central shovel teeth. Frontal tooth guru this size has aesthetic acuity. The central cranial teeth in the upper jaw stand out between all the upper and lower teeth. These teeth are more pronounced when they speak and laugh. The medial angle of the central cranial teeth is prominent earlier, the distal angle less prominent. The medial angle of the tooth crown is acute angle, distal angle rounded. The Frontal central teeth are ovate, rectangular and triangular in appearance.

The size of the central teeth has been determined in teeth pulled in one nechata examination (a.V. Salova, 2004; A Friedman, 2008) and the central cranial teeth were found to be 8.3-9.3 in width and 10.4-11.2 mm in height. The width of the teeth does not change at all times, while the height of the teeth shrinks. Among the examiners, we determined the size of the central incisors (60 teeth of 30 patients). Patients with pathological exacerbation of Grade 1-2 have aniclated that the central incisors are 8.2-9.2 mm wide and 8.2 - 8.7 mm high (Tablisa-2 , Figure-2). Patients with pathological edirsia of the 3rd degree had a central cranial

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tooth width of 8.2-9.2 mm, and a height of 3.2-5.4 mm. In the pathological development of teeth of the 1st and 2nd degree, the central incisors decreased in height by 2.2-2.5 mm, and in the third degree pathological exudation-by 5.8-7.2 mm (in the norm, the width is 8.3-9.3 mm and the height is 10.4-11.2 mm).

Until the beginning of the 21st century, when there was pathological edging in the socket of the frontal teeth, mainly orthopedic treatments were carried out (full cast coating, porcelain coating), restoration of the tooth crown with composite raw materials was not used much, this is due to the fact that restoration materials do not have sufficient properties. Currently, new raw materials have appeared on dental practice-compasites, compomers, nanotechnology - based raw materials, as well as improvements in adgesive system tools are achieving high results in the restoration of teeth and their reconstruction. With modern restorative raw materials, the tooth hard tissue fully meets the requirements from aesthetic design when restored.

We used maxillary infiltration and conductive anesthesia methods. It is known to us that the correct determination of the color of composite raw materials leads to the fact that the restoration turns out to be excellent. Saliva and blood reduces the adhesion of composite material to the hard tissue of the tooth. In the process of working in the oral cavity, the effective method of distinguishing from saliva is the use of cofferdam. So that there is no cofferdam, we worked with an alternative method of laying cotton swabs and pulling a straw with a straw puller. We used an air-water cooling system when choking tooth hard tissue. During anesthesia, pulp can burn if the tooth is sharpened without the use of a continuous cooling system, and pulpitis disease is caused. We used those with diamonds when sharpening teeth. When sharpening, kiya slopes were dressing at the edges of the enamel, which ensures that the enamel and the composite material are not separated from each other optically. 37% orthophosphatic acid is applied to the surface of the sharpened tooth to make Micra puncture dressing for 20 seconds, washed with water and dried and an adgesive agent is applied. After that, the selected composite by color is laid out in a hole no thicker than 2mm from the raw materials, photopolymerization on the opposite side is carried out for 20-40 seconds. We used solidifying restoration raw material 3m Filtek Z250 using microfil beam. Finishing and grinding are abrasive, held using a disc and rubber headboard. In a composite restoration, there will be small blemishes and blemishes that are invisible to the eye. Therefore, after finishing, a thin layer of compasite is photopolymerized by applying hermetic (adgesive). Removes excess parts of the hermetic over the gums and on the tooth contact surfaces [2.3.4.6.8.10].

The patient restored the teeth with a composite material to restore the color and shape of the tooth, as well as to restore its aesthetics. After the infiltration was anesthetized, the teeth were cleaned of caraches. The bite and occlusion contact were sharpened taking into account and dressing kiya slope at the enamel border. The adgesive was restored using the a2, a3 colors of the curing 3m Filtek Z250 composite using light after application of the agent.

In the second degree of diffuse pathological exertion, the Sox of molar teeth were restored with cast coatings. The frontal tooth socket, on the other hand, was restored with ceramic Winders. For this restoration, the tooth is first depulpated and the tooth sharpened. Prior to sharpening, attention should be paid to the aloxia of the prikus and occlusive cipslaing. After that, the height, shape, color and anatomical shape of the vestibular surface of the vinir, which is prepared with the patient, were explained. Before sharpening the teeth, the tooth surfaces were cleaned, the tooth color was determined. Previously treated teeth are X-ray-controlled to determine if there is a change in the parodont tissue. If the tooth has pathological processes in the surrounding tissue should be treated until restoration. The tooth was then insulated with cotton swabs and a saliva puller was placed in the mouth. We used fissur, straight Diamond bores to sharpen the tooth surface. The tooth was attached to a not deep 2mm zina on the neck. The depth of the Zina and how much tissue is taken from the vestibular surface of the tooth depends on how much the tooth is made. After the formation of the neck part of the vestibular surface of the tooth, the medial and distal borders are sharpened. After sharpening, the enamel edges with a thin fissur boron were aligned

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obliquely, and an elastic mold was obtained with a two-layer mold with a silicone grouse of raw materials. The mold was sent to the laboratory to prepare the wine. In the laboratory, ceramic vinir was prepared with incineration wool and sent to kelinika. In the clinic, we saw ceramic Viner adapted to the mouth of the patient, and the permanent fixation was made with shishaionomer cement. After the cement hardening, the excess was removed, the teeth were checked for tightness, and the final finishing was carried out with rubber heads and finishing pastes [11.12.13.14].

As we have already mentioned above, we have prepared plasticine Cappas in 52 patients with pathological edging of teeth of the 1st degree. For the preparation of Kappa, patients were first sanitized oral cavity. An anatomical main and auxiliary mold was obtained from the upper and lower jaw. In the laboratory, a model was poured from supergips, and the boundary of the future kappa was drawn. A special elastic plastic plate was formed under pressure on the model under the influence of high heat.

For a year, patients were taken into dispensary control and examined. Of our 52 patients, 45 used elastic Cappas. 5 did not use it. There were different reasons for this: feeling discomfort in oneself, losing Kappa, lack of hoax.

Conclusion: according to our results of the examination, it was found that the pathological edirsia of the teeth increases in the correct proportion of patients to the age group, and the patient is weakly attached to the sex.

It was found that teeth are more susceptible to pathological edging of the chewing surface and the incision edge, that is, the horizontal appearance compared to the vertical. It has been found that pathological exertion in the vertical view occurs in the upper jaw in comparison with the lower jaw.

When teeth apply elastic plastic Cappas, which are recommended at the 1st level of pathological edirsia, the edirsia stops to such an extent. Effective results were achieved in 90% of cases when electrophoresis was performed with calcium and fluorine preparations to reduce tooth sensitivity.

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