Perspective

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Identifying the Space Restrictions for Implant Attachments inside a Complete Denture

Serge Feroz*

Department of Pediatric Maxillofacial Surgery, University of Michigan Health System, Texas, USA

***Corresponding author**: Serge Feroz, Department of Pediatric Maxillofacial Surgery, University of Michigan Health System, Texas, USA, E-mail: Feroz_S@sf.us

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Description

Alveoplasty is a surgical pre-prosthetic procedure performed to facilitate tooth removal and to flatten or reshape the jawbone for prosthetic and cosmetic purposes. This procedure smoothes, redesigns, or recontours the bony margins of the alveolar ridge and surrounding structures to create well-fitting, comfortable and aesthetic prostheses or implants, can surgically placed. This pre-prosthetic surgery may include bone grafting, which improves the condition and quality of the support structure so that it is ready to receive the prosthesis or implant, supports the prosthesis, and provides better support and stability. Make it possible after tooth extraction, any remaining ridge irregularities, undercuts, or bone needles may interfere with placement of the prosthetic restoration and should be removed. Recontouring can be done during or after extraction. The primary goal of alveoloplasty is to contour and reconstruct the alveolar bone to establish a functional skeletal relationship. However, indications for alveolarplasty should include alveolar bone reshaping or remodeling during tooth extraction surgery. For example, if the alveolar bone has sharp edges after tooth extraction, the bone surface should be smoothed to facilitate the healing process of the tooth cavity and avoid complications such as pain and long-standing open wounds. The following indications for alveoloplasty usually involve stand-alone procedures performed prior to prosthetic treatment planning, such as the insertion of fixed or removable prosthetic devices.

Healing Process of the Tooth Cavity

Concerning the first instruction point of the procedure, bone contouring after tooth extraction also helps prepare for prosthetic rehabilitation. This is an important procedure because sharp bony ridges under removable appliances such as dentures cause discomfort and pain when patients perform chewing functions. The main essence of prosthetic rehabilitation related to alveoplasty is to maintain the width and height of the alveolar ridge to provide stability and support for prostheses such as prostheses and dental implants. Alveolar mucosa and alveolar crest from another perspective, alveoloplasty also acts as a weight-loss procedure for jawbone morbidity. Alveoplasty is contraindicated in situations where vital structures such as nerve bundles, blood vessels and/or vital teeth are damaged during removal of bony structures. Nerve injury is undesirable due to the risk of complications such as paresthesia, neuropathic pain, and allodynia. Additionally, it uses existing reduced volumes or atypical bone structures. Alveoplasty is also not a recommended procedure. Some important contraindications to consider for alveoloplasty are those who have undergone radiation therapy to the head and neck, or certain medical conditions such as uncontrolled or excessive bleeding, poor healing response, or compromised immune system. People with medical conditions that lead to complications. For reference, patients with underlying bleeding disorders or who are currently taking anticoagulants are at risk of uncontrolled bleeding. On the other hand, people with uncontrolled diabetes or infections have a poor healing response after procedures. Irregular alveolar bone may be noted at the time of tooth extraction or after healing and bone remodeling. The goal of alveoplasty is to achieve optimal tissue support of the planned prosthesis while preserving as much bone and soft tissue as possible. A simple alveolarplasty can be done at the same time as or after tooth extraction. Gross irregularities in bone contour are usually seen in the post-excision area. Sharp edges, bony prominences, or undercuts usually need to be removed prior to prosthesis rehabilitation. The degree of bone abnormality determines the most effective method of alveoloplasty. Minor irregularities in the extraction site may only require digital compression of the socket wall. Larger bone defects may need to be removed by lifting the flap to expose the bone area that needs recontouring. A mucoperiosteal incision is made along the crest to obtain proper access and visualization of the alveolar ridge. The maxillary tubercle is a rounded ridge that appears after the eruption of the third molar. The maxillary tubercle is important for the stability of the upper total prosthesis. A reduction in the maxillary tubercle may be soft or hard tissue due to the thick alveolar mucosa in the area. There may be a vertical or lateral excess of the maxillary tubercle. Proper alignment of occlusal surfaces and teeth can be hampered by vertical overshoot. The lateral excess limits the thickness of the buccal prosthesis flange between itself and the uncinate process and also causes insertion problems. Examination of the assembled diagnostic model is mandatory to assess the extent of elimination. When augmenting the tuberosity, undercuts are often found on the

buccal aspect of the maxillary tuberosity, making it difficult to successfully manufacture an upper total prosthesis. Enlarged nodules can complicate the posterior palate seal and compromise the stability of the upper prosthesis. Reconstruction of the maxillary tubercle may be necessary to remove bony undercuts or to ensure sufficient space between the arches for good construction of the posterior region prosthesis. The most common complications of any surgery are pain, swelling, infection and bleeding. Additionally, if the surgical site approaches critical structures such as nerve bundles, clinicians may need access to nerve injuries at the time of surgery and/or further evaluation of these patients to assess and treat the condition. However, sequestration can occur due to excessively thin bone that cannot be revascularized, ultimately leading to delayed wound healing, infection and pain. If prosthesis rehabilitation is included in the treatment plan, adequate tissue healing must be achieved before creating a removable prosthesis. If immediate dentures are indicated, your doctor may consider immediate denture lining options to allow adequate soft tissue healing.

Fixed or Removable Prosthetic Devices

The easiest type of alveoloplasty can be as a computerized pressure on the sidelong walls of bone after straightforward tooth extraction, given that there are no gross bone inconsistencies. At the point when more abnormalities exist, different strategies can be embraced, like the moderate method, interseptal alveoloplasty after post extraction and the alveoloplasty performed on edentulous edges. In situations where there are serious undermines, revolutionary alveoloplasty is required. This includes the expulsion of the entire buccal or labial plate after extraction. Also, optional alveoloplasty in some cases happens after the underlying strategy to take out any gross bone abnormalities. A full thickness fold is normally raised to a point apical to the ideal region to be shaped and as per how much bone should have been eliminated, a bone document, or a burr under plentiful water system can be utilized to give the ideal form. Taking in thought that absence of water system can prompt bone corruption. At the point when gotten done, the fold is repositioned and stitched. The alveolar mucosa covering bone ought to have uniform thickness, thickness and compressibility to equally disseminate the masticatory powers to the fundamental bone.