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FEATURES OF PROSTHETICS DURING THE PERIOD OF EXCHANGE OCCLUSION IN CHILDREN

Qodirov Muhammadali Maxamatsoli ugli

Assistant at the Department of Orthopedic Dentistry and Orthodontics, Andijan State Medical Institute

Abstract: Features compensation of dentition defects in children leads to the occurrence of maxillodental anomalies, functional and structural disorders of the maxillofacial area. Rational prosthetics of dental defects in children prevents the formation of maxillodental anomalies and creates favorable conditions for the full development of the child's body.

Keywords: Defects, anomalies, prosthetics.

In accordance with the average time for the eruption of permanent teeth, a permanent bite is formed by the age of fourteen. According to most authors and our own observations, it should be noted that after the eruption of the second permanent molar and the formation of its roots, the growth of the jaw bones practically stops. During this period, there is still a slight increase in the size of the jaw bones due to oppositional growth, which does not lead to a significant change in the overall size of the jaw bones and the relationship of the dentition in the bite. Therefore, from 14 to 15 years of age, it is possible to carry out prosthetics of teeth and dentition according to generally accepted rules. To more accurately determine the degree of formation and maturity of the dental system, and therefore, determine possible changes in the size of the jaw bones due to their growth, it is necessary to conduct an x-ray examination of the bones of the hand and wrist, and, by analyzing the degree of their ossification, decide on the correctness and rationality of the choice of denture design in each specific case [1].

Preventive examinations of children of various ages indicate that defects in the crowns of teeth and dentition occur already in the first year of life, that is, long before the formation of the bite is completed. Untimely compensation of dental defects in children leads to the occurrence of dental anomalies, functional and other disorders, the severity of which depends on the age of the defects. Structural and functional changes in the dental system develop in a short time due to the growth of children and adolescents. These deviations are irreversible and cannot be self-regulated, since all links of the articulatory chain are involved in the pathological process. The lack of a proper prevention system leads to the development of dental anomalies, the treatment of which takes years [2].

For orthopedic treatment, 14 children with a primary malocclusion were accepted, 9 with a temporary malocclusion, and 3 with a permanent malocclusion. Before the start of treatment, all children underwent clinical, biometric and radiological examination methods. This made it possible to objectively assess the size of the dentition defect, predict the size of unerupted anterior teeth, the depth of their occurrence, the position and presence of rotation of the rudiments of the anterior teeth, changes occurring during therapeutic replacement of the defect, the degree of formation of the roots of the teeth limiting the defect. During the clinical study, the following was assessed: the condition of the dentition; position of individual teeth in the sagittal, vertical and transversal planes; type of swallowing; character of speech and presence of bad habits [3].

Biometric measurements were carried out on control models and directly in the oral cavity (length of the dentition according to Nance, width - according to Pont, ratio of segments of the dental arches - according to Gerlach) [4].

It was found that out of 26 children taken for treatment with defects in the dentition in the anterior region, only two did not have deviations in the formation of the bite and dentition. Defects in the anterior dentition in 7 children contributed to the formation of an open bite (especially in preschoolers). This is due to the infantile type of swallowing or the addition of other etiological factors, in particular “bad habits” such as sucking fingers or other objects [18]. In 3 children, as a result of a defect in the anterior region, dentoalveolar protrusion of antagonists and the formation of a deep traumatic bite occurred. All children with defects in the anterior dentition complained of speech impairment, inability to bite off food, and aesthetic defects [19]. The absence of anterior teeth in the upper jaw is often manifested as a symptom of retraction of the upper lip. Aden-tia on both jaws in 2 people. accompanied by the development of angular cheilitis. In addition, we found that during the period of temporary occlusion, the most common cause of defects was premature tooth extraction due to complicated caries and traumatic injuries. The roots of the primary teeth limiting the defect are at various stages of development.[5] Therefore, bridges in this age period are not practical for prosthetics of a defect in the dentition in the anterior part of the dental arch. In this case, we use removable dentures that have high functional, aesthetic and hygienic indicators, and it is most advisable to use a planar fastening system, which is recognized as more rational in orthopedic dentistry. In this regard, clasps are placed on temporary canines and second temporary molars [6]. After children adapt to the prosthesis, it is recommended to remove the two clasps and convert the planar fastening system into a linear one (usually diagonal). This makes the clasp system more labile and does not inhibit jaw growth. To ensure an aesthetic optimum and prevent jaw growth retardation, artificial teeth are installed “on the edge”. The replacement of the prosthesis is carried out if its fixation is poor, regardless of the period of use [6, 7].

In children, defects in the dentition in the anterior section, limited to permanent teeth with formed roots, are rare, since even with traumatic injuries, as a rule, a fracture of the tooth occurs, and not its complete dislocation. In addition, in case of complete dislocation of permanent teeth with formed roots, their replantation is carried out. For prosthetic restoration of dentition defects in this age period, bridge-like prostheses with bilateral rigid fixation were used. Since the mesial-distal dimensions of teeth do not change with age, there is no need to use sliding structures. Intact abutment teeth are not prepared. Crowns are made with an open vestibular surface for aesthetic reasons.[7, 8, 9, 10]

Thus, we can conclude that the proposed treatment and prophylactic designs are multifunctional, increase the effectiveness of treatment, and allow an individualized approach to prosthetics in each specific case. Timely rational prosthetics of defects in the dentition in the anterior region in children prevents the formation of dentoalveolar anomalies and creates favorable conditions for the full development of the child’s body [11, 12, 13, 14, 15, 16, 17, 20, 21].

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