

THE MINISTRY OF HEALTH OF UKRAINE
THE HIGHER STATE EDUCATIONAL INSTITUTION OF UKRAINE
"UKRAINIAN MEDICAL STOMATOLOGICAL ACADEMY"

Approved at the meeting of orthodontics
« ____ » _____ 20 ____ y.
protocol № ____ by _____
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METHODICAL RECOMMENDATION
for independent work of students during the preparation
to practical lessons and on the lessons

Academic discipline	Orthodontics
Module № 3	
The theme of the lesson № 3	Clinical and biological substantiation of children's dentures. Types of prosthetics in children with malocclusion class III by Angle. Types of prosthetics in children with innate malformations of teeth and jaws.
Course	V
Faculty	Preparation of foreign students

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1. The relevance of the topic. Children's prosthetics is part of the planned sanitation of the oral cavity in children because early removal of temporary teeth disrupts the integrity of the dentition, which leads to a malfunction in the chewing and can lead to the malocclusion formation, as well as diseases of the digestive system. Therefore, the knowledge of the principles of orthopedic assistance, and the types of prosthesis designs will allow dentists to timely provide prosthetics for patients with dentition defects and prevent complex deformations of the dentition. In patients with congenital malformations, the restoration of a full-fledged chewing apparatus and face esthetics will allow them to fully adapt in our society.

2. Specific objectives:

To know the role of preventive measures in preventing early tooth extraction.

To know principles of child prosthetics.

To know the causes of defects in teeth and dentition in children of an innate nature.

To know tasks of child prosthetics.

To know classification of anomalies of individual teeth in children.

To know congenital malformations of the face and jaws accompanied by multiple or complete adentia.

To know stages of making full removable dentures.

3. Basic knowledge's, abilities, skills necessary for studying the topic (interdisciplinary integration)

Name of previous disciplines	Skills
1. Anatomy	to determine the deviation of the teeth hard tissues structure
2. Propaedeutics of orthopedic somatology	to know the classification and features of dentures for separate teeth and dental arches defects reconstruction
3. Orthodontics	to know classification of malocclusion by Angle

4. Tasks for independent work during preparation to the lesson and on the lesson

4.1. A list of the main terms, parameters, characteristics that need to learn by the student during the preparation to the lesson:

Terms	Definition
1. Congenital malformation	Anomaly of intrauterine organ development
2. Ectodermal dysplasia	A collective concept embracing more than 150 congenital diseases characterized by hypo- or aplasia of ectodermal structures: hair, nails, skin, sebaceous glands and teeth.
3. Krist-Siemens-Turen' syndrome	Anhydrite hereditary ectodermal dysplasia
4. Papiyon-Lefevre' syndrome	Progression of the vertical destruction of the alveolar bone and the mobility of the teeth

4.2. Theoretical questions to the lesson:

1. Clinical and biological substantiation of pediatric prosthetics.
2. Congenital malformations of the teeth.
3. Congenital malformations of the jaw (cleft of the upper lip, alveolar process and palate)
4. The nature of morphological, aesthetic, functional disorders in multiple and complete adentia.
5. Features of making complete removable dentures in children.
6. Stages of making complete removable dentures.
7. Orthopedic constructions, which are used in children with congenital malformations of the jaws (obturators).

4.3. Practical works (task) which are executed at the lesson:

To conduct a clinical examination.

To find out the age of the child, given the history.

To determine the period of bite formation.

To pay attention to the distinctive features of temporary and permanent teeth (color, crown size, erosion of tubercles, shape, etc.).

To define the defect of individual teeth based on an assessment of the patient's photo or clinical examination.

To diagnose according to the appropriate classification of anomalies of teeth.

To assign the appropriate design to replace the defect.

To draw a complete removable denture base on the models.

To draw up a treatment plan, to make the impression.

The content of the topic:

Anhydrite ectodermal dysplasia is an anomaly of development that arises from the genetic damage of the external embryonic leaf – ectoderm. Abnormalities of teeth; increased body temperature; abnormalities of hair (thin hair, sparse); sunken nose bridge; large forehead; sunken cheeks; dry, thin skin; deformed ears; full lips; hypoplasia of the wings of the nose; protruding superciliary arches lag in mental development (30-50% of cases).

Etiology and pathogenesis.

Heterogeneous group of hereditary diseases caused by abnormal development of the ectoderm. There are anhydratic forms (dysplasia ectodermalis anhydrotica, s. Hypotrichotica, syndromum Christ-Siemens) and hydrodynamic (dysplasia ectodermalis hydrotica, s. Syndromum Clouston) forms, as well as a number of syndromes in which skin defects are associated with other congenital anomalies (Marchall syndrome, Helweg-Larsen syndrome, etc.).

Salomon and Kepeg believe that the term "ectodermal dysplasia" should refer to those conditions that are congenital, diffuse, do not progress, affect the epidermis and at least one of the appendages of the skin. Anhydratic form without congenital anomalies is inherited in most cases recessively-linked. With the X-chromosome or autosomal recessive. There are also data on variants inherited autosomal dominantly.

There is the possibility of developing dysplasia, at least in the opinion of Kuhlwein and Weiss, sporadic forms, under the influence of chemical compounds, X-rays, viral infections and other hazards.

Ectodermal dysplasia is a collective concept encompassing more than 150 congenital diseases characterized by hypo- or aplasia of ectodermal structures: hair, nails, skin, sebaceous glands and teeth. The most known hypohidrotic form is inherited by a recessive type, linked to the X chromosome. This means that women are carriers of a defective gene, and the disease manifests itself in men. Women described more rare forms with an autosomal dominant and an autosomal recessive type of inheritance. The prevalence of the anomaly is 1:50 000. The clinical picture of ectodermal dysplasia is characterized by smooth dry skin, hypodontism, hypotrichosis (rare hair) and hypohydrosis (complete or partial absence of sweat glands). Other clinical manifestations include sunken bridge of nose, massive super ciliary arches, eyelid pigmentation, reddish skin tone, thin rare hair and eyebrows, prominent lips, indistinct red lip rim, xerostomia. Often the absence of several teeth is noted, and the available teeth have a conical shape. Fangs are most often present, while incisors are usually absent. Molars, if any, differ in the small size of the crown. Sometimes they mark an adentia. Most patients have no sweating or decreased sweating, so they do not tolerate heat. Patients need care, genetic counseling, they should avoid overheating. To improve the function of chewing and for aesthetic reasons, partial or complete prosthesis or implantation of the teeth is resorted to. Prosthetics patients usually suffer well even at a young age. As the jaws grow, dentures should be replaced.

When examining the oral cavity, there is a complete absence of teeth. The mucous membrane of the oral cavity is dry, pale. The upper and lower jaws are significantly reduced with a pronounced underdevelopment of the alveolar processes. The ratio of toothless alveolar processes is normognathic.

Complete removable dentures are made for children with full adentia. The manufacturing rules are the same as for adults. Features of children's complete prostheses: - in the temporary bite on the prosthesis do not create, compensatory curves and put respectively 10 teeth on the jaw; - in connection with the growth of the jaw prostheses are changed every year; - the child is taken to a dispensary account to monitor the dynamics of jaw growth and the timely replacement of the prosthesis.

Congenital adentia of all temporary permanent teeth was observed only with HED (hydrotic ectodermal dysplasia) when the anatomical prerequisites for denture maxillary prosthesis are complex: the alveolar process is not developed; The mucosa is thin and mobile, in the region of the mandibular tubercles and the retromolar regions, it is sharply mobile along with the underlying tissues, and therefore it is difficult to obtain their natural mapping even with the help of a unloading impression. Difficulties are also observed with the fitting of removable plate prostheses of toothless jaws: saliva is secreted in insufficient quantity – the mouth is dry, the tongue is large. There are difficulties in fitting and developing prosthesis for the toothless mandible. Infringement of the mobile mucous membrane of the retro-molar region and on other sites causes pain. In these patients, up to the dento-alveolar prosthesis of the restoration, the shape of the face is sharply disturbed due to a significant shortening of its lower part, protrusion of the thickened lips, sagging of the bottom of the oral cavity as a result of the low position of the tongue. The toothless children are lagging behind in growth due to malnutrition, they suffer from their aesthetic flaws, they need a dental prosthesis from the age of 3. With the goal of improving the fixation of the prosthesis especially on the lower jaw, the use of implants is indicated. Replacement of congenital missing teeth with prosthetic restorations, based on implants, allows achieving optimal results. Protective treatment using implants as a support is recommended mainly after the completion of the growth of the maxillofacial part of the skull, as significant changes occurring during growth reduce the duration of implant use that must be removed. McNamara wrote about the early completion of the transversal growth of the mandible in her anterior section and the possibility of using implants for use in children with specific problems.

Krist-Siemens-Turen' Syndrome - anhydrite hereditary ectodermal dysplasia. Dental status: tongue dry, hypoplasia of the glands of the oral mucosa. The frenum of the upper lip is attached low, the buccal folds of the mucous membrane are markedly expressed. The vestibule and the bottom of the mouth are small, the salivating is meager. Alveolar processes on the areas of missing teeth are not developed, the sky is flat with a pronounced torus. There is dysplasia of the facial skull, a decrease in the vertical dimensions, especially the lower part, the sharpening of the chin, the "saucer-like face". With multiple adentia, almost all teeth, especially the anterior ones, have a conical shape. Alveolar processes are low, hypoplastic. Use mainly removable structures of dentures. However, significant problems arise with their fixation. Complex conditions for prosthetics (hypoplasia and absence of alveolar processes, flat hard with a pronounced torus, short frenulum of the lips, small vestibules and the bottom of the oral cavity, absence of a large number of teeth or their complete absence) do not allow reliable fixation of removable dentures. In order to compensate for defects in the dental arches, a number of methods have been proposed in such patients: transplantation of tooth rudiments (G.E. Dranovsky, 1978), implantation (M.M. Ugrin, 2000, etc.). Nevertheless, their use is associated with certain difficulties, and so far they cannot be implemented in children's orthopedic practice. Therefore, to date, the main method remains dental prosthetics, and the main task is to find rational methods for fixing dentures.

Papiyon-Lefevre' syndrome. The first dental signs of the disease appear in 2-3 years. Milky teeth erupt at regular intervals and without special features. First, the mobility of the incisors with hyperemia and the release of pus is observed, and in the future the mobility of all the milk teeth. Gingival abscesses may form, vertical destruction of the alveolar bone progresses and the mobility of the teeth. Up to 4-6 years, children lose all their milk teeth, after which the inflammation stops in periodontium. On histology, premature resorption of the alveolar process is determined. Constant teeth also erupt in physiological terms. After eruption of permanent teeth, the disease recurs again and after 1-2 years the teeth become mobile. The pathological process in the periodontium rapidly progresses, dento-gingival pockets are formed, dental calculus is deposited, granulation tissue grows, and complete lysis of the alveolar process occurs. Up to 13-15 years, patients lose all permanent teeth, after which the process stops. When X-ray examination of the jaw bones, there is a generalized destruction of the alveolar bone, interalveolar and inter-root septa. Calcification of the medulla is described.

Individual features of the oral environment and infected parodontium pockets worsen the course of the disease. In 25% of patients, sensitivity to infection is increased, so they need to remove dairy and permanent teeth with a pronounced inflammatory destructive process in the periodontium, which will stabilize the inflammatory process in the oral cavity and stop further destruction of the alveolar bone (Yu. A. Belyakov, 2000; S.I. Doroshenko, 2007).

However, the response of antibodies in young patients can prevent generalized periodontal damage. Therefore, it is advisable, along with local symptomatic treatment, to prescribe thymus preparations thymalin, thymogen; N. Tinanoff et al., 1986).

Suspend the process by using antibiotics, in particular tetracycline (I. Preus, P. Gjermo, 1987). The effectiveness of the use of antibiotics, including tetracycline, in the treatment of patients with Papiyon-Lefevre syndrome is confirmed by other specialists (D. Bixler, D.K. Khartsfielcl, 2003).

Treatment of such patients should be comprehensive. Prescribe symptomatic local therapy and immune correction (thymus preparations). Orthodontic and orthopedic treatment consists of dental prosthetics, mainly removable structures, especially in childhood; Hardware correction of the position of individual teeth (according to indications) followed by splinting.

However, treatment is ineffective. There is still no alternative to dental prosthetics. Therefore, the search for more rational designs of dentures and more effective methods of treatment continues.

Chondrodystrophy is a hereditary disease. Anomalous transformation of cartilage into bone with predominant epiphysis lesion. The main dental symptom is the multiple or complete retention of both permanent and dental teeth, due to the consolidation of the alveolar process. Vibration and ultraphoresis are less effective for stimulation of teething, therefore, dentures are used with removable plate prostheses (with multiple retention) or complete with full retention.

Prosthetics at the cleft defects.

Prosthetics of children with defects of the palate are more difficult than prosthetics of adults suffering from palate defects, and requires another technique for closing the space. The fact is that the usual obturator is strengthened in the mouth with the help of clasps. These clasps cover the jaw from both sides and limit the growth of the developing baby's jaw. That's why they should be prosthetically performed with the help of no-smoking so-called floating obturators. The floating obturator was first proposed by Kez in 1902. It was constructed without a fixation part, usually located on the upper jaw, and consists only of the obturator. Its edges in the form of grooves accurately cover the edges of the defect. Due to this, the obturator is retained in the oral cavity. It has the form of a triangle, the base of which is turned to the posterior wall of the pharynx. To build such an obturator, thin edges of the defect and the integrity of the posterior edge of the palatine curtain are needed. The procedure for manufacturing a floating obturator is common, except for the removal of the impression. To remove the impression, according to Vankevich's method, proceed as follows. Soften a piece of the wall in hot water, give it the appearance of an oblong roller and apply it on the convex surface of a curved spatula. When using alginate and silicone impression masses, instead of the wall, it is necessary to create retention points in the form of holes or loops to fix the impression mass on the curved end of the spatula, which otherwise can easily separate from the spatula and enter the respiratory tract. Then put a spatula with the mass in the mouth so that it reaches the posterior pharyngeal wall and a slight movement from the bottom upwards and from the rear anteriorly move the wall into the crevice of the palate. Then the helper gives the wall a cold water and removes it from the mouth, moving backward towards the wall of the pharynx and down. On the impression, the nasal and palatal side walls adjacent to the edges of the defect, as well as the anterior surface of the posterior pharyngeal wall, should be well reflected.

When the finished obturator is delivered, it is necessary to use paraffin to detect the places to be corrected. The paraffin is heated and, when it comes to a liquid state, it is applied to the edges of the obturator, injected into the mouth and suggests that the patient speak, laugh, swallow saliva, etc. The solid places are cut on the paraffin. At first, the child is given an obturator with a thread attached to it; Thread attached to the teeth. The use of the obturator is important not only to restore the physiological role of the palate in adults and in older children. It is important in infants in connection with the violation of the act of sucking. Ilyina-Markosyan proposes to manufacture the obturator from elastic plastic EGMASS-12. During feeding, the obturator is tied with a string to a bottle or to another object outside the mouth. In the case of the appearance of teeth in the part of the plate corresponding to the teeth, make holes. In stating the issue of obturators, it should also be noted that the acquired defects of the palate usually appear at the age when patients already speak, and therefore, with the rapid closing of the defects of the palate with obturators, patients usually quickly get used to the latter and their distinct speech is restored. A different picture is observed in congenital defects of a hard or soft palate in children. Children with such anomalies never have a full speech. They suffer not only because of a defect in the palate, they have insufficiently developed neuromuscular apparatus. Such children need exercises to differentiate the mouth and nose, which is achieved by the gymnastics of the palatine and pharyngeal muscles, they need breathing exercises, the ability to properly use articulatory apparatus. Therefore, they do not correct speech right there after prosthetics. These patients, in addition to providing obturators, must also be taught correct speech, that is, the right articulatory movements of the palatines, labial, buccal, lingual and pharyngeal muscles, and only after that they master the complex reflex work that is necessary for normal word-pronunciation. The manufacture of obturators for the hard palate is very simple and differs little from the manufacture of a lamellar prosthesis. The impression is removed in the usual way, it is necessary only to close the defect of the palate with gauze before that, so that the gypsum does not get there, since after hardening it will be difficult to remove it from the defect. It is better to remove the impression with a thermoplastic mass. On the impression obtained by the impression, the prosthesis is manufactured in the usual way, which also replaces the missing teeth (if necessary) and closes the communication between the nasal and oral cavity. As for the shape of the base plate, some suggest that the part adjacent to the defect on the inner side of the plate should be convex, the convexity should play the role of a plug and close the defect tightly.

This, however, should not be done, because such a convexity, densely adjacent to the edges of the defect, subsequently causes an increase in the latter, does not ensure a more tight fit of the obturator and irritates the surrounding tissues. V. Yu. Kurlyandsky proposes on the inner surface of the plate in a place corresponding to the boundaries of the defect to form a Goldstein cushion, which should increase the absorbability of the plate and the impermeability of the closure of the defect. This is also inadvisable, since the roller causes inflammatory phenomena on the mucosa of the palate, and with a good impression, a sufficient tightness of closure of the defect is achieved without it. True, in our clinic there were cases when patients, a month or more after manufacturing the obturator, complained of leakage of fluid and air passage. But the reason for this was a change in the prosthetic bed due to the continued scarring of tissues surrounding the defect of the sky. In these cases, the expansion of the gutta-percha and its subsequent replacement with plastics managed to completely cover the defect. As for methods of fixing obturators with the help of clamps, with a two-sided support it is possible to confine oneself to putting crowns with tufts on two supporting teeth, which limit the defect on both sides. Wire clamps introduced from both sides into the obturator, go to the tapping on the crowns of the supporting teeth and firmly hold it. With one-sided support, the first to defect and the most distant from the defect teeth should be selected as the supporting ones. These teeth are covered with crowns with taps and on them the obturator is strengthened with the help of retaining clasps covering the supporting teeth - the front teeth with the mesial teeth and the posterior teeth on the distal side. This method of fixation is more reliable. In particularly difficult cases, it is sometimes necessary to use more complicated methods of fixation (Pales, Z. Ya. Shur, etc.), for example, crowns can be worn on the supporting teeth, provided with tie-offs from the vestibular side, and on the tongue side soldered to the crowns by a vertical tube. A pin is inserted into the obturator, which enters when the obturator is put into the tube. Manufacture of obturators for the soft palate. Making the obturator for the soft palate is more difficult. The obturator for the soft palate, as it is said, consists of two parts: fixative and obturating. First remove the impression from the hard palate, which is pre-prepared spoon in such a way that its posterior edge goes far beyond the line A. The impression is cast model, on which a wax base with a roller and clasps is made. At the back edge of the basis, a metal rod with cuts must be attached; He goes in the middle of the defect of the soft palate towards the posterior wall of the pharynx. The base is tried on in the oral cavity, while checking the correctness of the production of the clasps, the direction and length of the rod. After fitting, the wax is replaced with plastic and thus, a fixing part is provided, equipped with a rod at the distal end. Then, a large amount of softened thermoplastic mass or wax is applied to the rod, which is held on the stem due to the cuttings on it, and the plate is inserted into the mouth. Mass or wax should fill the entire defect of the soft palate. The patient is offered to do swallowing movements, speak and loudly read and take out the plate from the oral cavity. Musculature of the palate and pharynx, contracting during functional movements, leaves the corresponding traces on the plastic impression mass. In places where there is a surplus of mass, they are cut off, and in places that do not come in contact with the tissues surrounding the defect, it is added, the plate is reintroduced

into the mouth and the patient is offered to perform functional movements again.

This is done until a full imprint of all the edges of the defect is obtained, as well as the entrance openings of the Eustachian tubes and the Passavan roller, which is formed during swallowing and pronunciation of sounds. It is very important to obtain an impression of the Passavan bead, since this roller, being reflected on the obturating part of the impression, creates the possibility of forming an interval of 0.5 cm between the obturator and the posterior pharyngeal wall during the transition of the upper pharyngeal compressor to a calm state. Such a gap is necessary for nasal breathing and clear pronunciation of sounds possible with the free passage of an air wave through the nose. After receiving the reflection of the platen, Passavana is replaced by the impression mass with plastic. Thus, a soft-palate obturator with a stable connection is manufactured. The obturator with a movable joint is made almost the same way. The only difference is that the obturating part is located farther from the hard palate and between the fixing and obturating parts is a ribbon or spiral spring. Il'ina-Markosyan proposes a more simplified obturator design. She suggests to make the fixing part in the usual way from plastic AKR-7, and the obturating part – from EGMASS-12. The palatine part, therefore, consists of two sheets. The lower leaf, less elastic, constitutes the continuation of the fixing part, covers the cleft of the posterior third of the solid and part of the soft palate on the side of the oral cavity. The upper is more elastic and thin, covers the cleft of the soft palate from the side of the nasal cavity and, when the muscles of the soft palate contract, reach the posterior pharyngeal wall. Both sheets are interconnected by a button. In plastic operations, a celluloid or plastic plate is used to cover the cracks in the palate. This plate protects tampons and the seam line from contamination from the oral cavity, immobilizes the patches of the palate in a new position and creates a support for the injected tampons. For the production of a protective plate, it is necessary to prepare the model accordingly. On the model, an additional plaster of gypsum should be made in order to not only fill the indentation in place of the defect of the palate, but also cover it at a considerable height of the surface of the latter. Due to the thickening of the surface of the palate, the plate produced does not fit tightly to the palate and there is room for tampons. The plate should be made in such a way that it covers the teeth with the cheek and tongue in the form of a tooth-jaw, as a result of which it is fixed in the oral cavity. For better fixation, you need to engrave the cervical teeth on the model. With proper engraving of the necks, the celluloid plate, due to elasticity, after some effort, slips through the convex sections of the crown to the neck of the teeth. If the finished plate fits freely to the neck of the teeth and is therefore poorly fixed, this defect can be corrected by bending the edges, the celluloid plate to the necks. Such bending is performed with the help of heated pliers. After applying the pliers, wait 4-5 seconds for the celluloid to warm up and then bend. Engraving of the neck of the teeth ensures the fixation of protective celluloid plates usually only with a large number of teeth or high crowns. At low crowns or other reasons for poor fixation of the plates, a metal lever of A. A. Limberg's design is used. The ends of this lever are connected by rubber rings to the hooks on the orthopedic head cap, and thus, this extra-oral and intraoral traction retains the protective plate. This method of protecting the palate requires the presence of a dental laboratory and participation in the manufacture of a plate of dental equipment. Ya. M. Zbarzh proposes to make a protective plate of fast-

hardening plastic. In these cases, he applies two methods: intraoral and extra-oral. The intra-oral method has the disadvantage that the patient feels the unpleasant odor of the monomer and the slight burn of the mucous membrane during the polymerization of the plastic in the oral cavity. Therefore, we describe the extra-oral way. According to this method, a few gauze napkins covering the cleft of the palate are introduced into the patient's mouth and allow leaving the necessary space for future tampons. Then the impression is taken, the model is cast and, noting the boundaries of the future plate, a part of the plate that covers the alveolar process and teeth, and also the part covering the sky, are modeled from the dough-like mass of AKR-100 (fast-hardening). After plastic hardens, the plate is removed from the model and mechanically processed. For easy separation of the plate from the model, the latter is smeared with office glue, which must dry before applying AKR-100. For better fixation of the plate in the oral cavity, after machining the plate, grooves are made between the teeth by a dough-like mass AKR-100, insert the plate and hold it in the mouth until it hardens. AE Rofe suggests using for use in manufacturing protective plates an impression spoon made of new plastic AKP-n. The impression spoons from AKP-n (plasticized acrylate) are used as follows. The plate is heated in hot water or over the flame of the burner to the required degree of softening, laid on the model prepared by the described method, press it to the middle part, alveolar bone and teeth. Then the excess is cut off. Most dentures in children are temporary, subject to replacement in 6-12 months, sometimes - a little more, depending on the age of the child. Therefore, they should be simple in their construction.

Materials for self-control:

A. Tasks for self-control (tables, diagrams, drawings, graphs):

- to sketch in the album different types of obturators.

B. Tasks for self-control:

1. The maxillofacial area is formed from:

the first branchial arches pair

the second branchial arches pair

the third branchial arches pair

the fourth branchial arches pair

all answers are correct

2. The face formation and fusion of the processes that constitute it, ends on the following dates:

7 weeks

on the 6th week

5 week

on the 8 week

9 week

3. From primary palate tissues are formed:

the middle part of the upper lip and upper jaw

the nasal septum

the lateral part of the upper lip and upper jaw
the wings of the nose
the root of the nose

4. From the secondary palate tissues are formed:
the soft palate
the middle part of the upper lip and upper jaw
the lateral part of the upper lip and upper jaw
the wings of the nose
incisal bone

5. The birth of a child with innate defects you must send the message to the following institution:
center for the treatment of children with innate maxillofacial defects
the department regional hospital
city children's clinic
regional children's hospital
regional dental clinic

6. At birth the child with upper lip and palate cleft defect to the hospital are invited:
surgeon-dentist and orthodontist
surgeon-dentist and therapeutic-dentist
dentist and cosmetic dentist
cosmetic dentist and therapeutic-dentist
cosmetic dentist and orthodontist

7. At birth the child with upper lip and palate cleft defect should address the following issues:
all answers are correct
stages of treatment
the timing of surgical interventions
the place of surgical interventions
breast feeding

8. Classification of morphological, functional and aesthetic disorders in congenital cleft defects proposed:
F. Khoroshilkina and G. Granchuk
L. Ilyina-Markosian and A. Kibkalo
Ziebert-Malygin
F. Khoroshilkina and L. Zubkova
T. Sharova and G. Rogozhnikov

9. Functional abnormalities in the hard and soft palate cleft defects are as follows:
all answers are correct
the impaired chewing function and swallowing

the breathing disorders
tension of facial muscles and swallowing
snuffling during the speech

10. Morphological disorders at the hard and soft palate cleft defects are as follows:

all answers are correct
deformation of the upper dentition
anomalies of the frontal teeth location
deep incisal overlapping
a defect or scarring in the palate

11. Aesthetic disorders at the at the hard and soft palate cleft defects are as follows:

all answers are correct
flattening of the lips
violation of the contour of the vermillion border
deformation of the wing of the nose
postoperative scar, residual defects

12. Depending on the extent of anatomical changes there are the following forms of the upper lip cleft defect:

a hidden, incomplete and complete
symmetrical, asymmetrical
median, lateral
congenital, acquired
hidden, clear

13. Dysfunction of sucking in the newborn with isolated upper lip cleft defect caused by:

all answers are correct
violation of the closing of the lips
the leakage of the oral cavity
trouble swallowing
the lips shortening

14. Floating obturator is made in the following cases:

when the soft palate cleft defect
when the soft and 1/3 hard palate cleft defect
with the full hard palate cleft defect
the upper lip and palate cleft defect
when alveolar bone cleft defect

15. Ilyina-Markosyan obturator applies in the following cases:

when hard and soft palate cleft defect
when the upper lip cleft defect
when alveolar bone cleft defect

when unilateral cross non-complete upper lip and palate cleft defect
when bilateral non-complete upper lip and palate cleft defect

16. What is the Passavan cushion?

muscle roller, which is formed by the contraction of the pharyngeal constrictor
transverse palatine folds

muscle roller, which is formed by the contraction of the muscles of the tongue

cushion mucous in the palatal and lingual arches

cushion mucous in the palate-pharyngeal arches

17. In the manufacture of which design it is important to get a print Passavan cushion?

the obturator

nipples for feeding

protective plate

reforming plate

all answers are correct

18. Which function is not peculiar to the protective plate?

separation of oral and nasal cavity

protection of the tissues of the palate after uranoplasty

the formation of the palate arch

fixation of dressings

all answers are correct

19. Due to some properties for the production of prints for the cleft defects of the upper lip and palate use thermoplastic materials?

less risk of aspiration

the speed of hardening

does not shrink

pleasant taste

the absence of contraindications to the use

20. With what age children with developmental disabilities are subject to dispensary observation?

from the moment of birth

6 months

1 year

3 years

6 years

21. What are the deadlines for completed follow-up of children with upper lip cleft defect at the orthodontist?

after the completion of the permanent dentition

after nose correction

after changing the frontal teeth
after cheiloplasty
after conducting uranoplasty

22. Orthopedic prosthesis with double dentition is used in:
the permanent dentition
the period of formed temporary occlusion
the late period of the mixed occlusion
the early period of the mixed occlusion
the period of involution of temporary occlusion

23. What are the most significant factors leading to the development of congenital defects of the facial skeleton:
all answers are correct
toxemia of pregnancy
influenza, respiratory viral infections, rubella in a pregnant
the use of drugs during pregnancy
smoking, alcoholism

24. Which aesthetic typical violations at the upper lip cleft defect?
the defect of the upper lip
concave facial profile
upper lip protruding
a wide nasal base
convex facial profile

25. The child of 2 years congenital hard and soft palate cleft defect, which achieves the cutting of the hole. What is the most likely diagnosis?
complete hard palate cleft defect
isolated hard palate cleft defect
partial hard palate cleft defect
the correct answer is missing
hidden hard palate cleft defect

26. Determine the timing of uranoplasty with incomplete cleft palate.
12-18 months
5-7 months
8-10 months
11-12 months
3-6 months

27. In the maternity ward invited the orthodontist. A newborn child full hard and soft palate cleft defect. What should the orthodontist in this case?
to prime south preformative Sharova plate
to make a palatal plate

to make the Kez' obturator
to make the Ilyina-Markosyan' obturator
to make the Chusovskaya' obturator

28. Treatment of patients with congenital the upper lip and palate cleft defects should be:

integrated
speech therapy, orthodontic
surgical, orthodontic
orthodontic, orthopedic,
orthodontic

29. The use of any design until it is expedient in 9-month-old child with congenital the upper lip and palate cleft defect? Cheiloplasty conducted at 8 months of age.

Chusovskaya
Ilyina - Markosyan
Rubeznaya
Sharova
Mac-Neil

30. Select a rational design of the prosthesis for a 4-year old child diagnosed with incomplete hard and soft palate cleft defect.

Ilyina-Markosyan' obturator
preformative Sharova plate
protective plate
Kez' obturator
Chusovskaya' obturator

31. For taking impressions children 2 years through left-side the upper lip and palate cleft defect to produce the floating obturator is necessary to apply:

S - shaped spatula
individual spoon
standard metal spoon
standard plastic spoon
straight spatula

32. What impression material is required for making prints the child with non-complete upper lip and palate cleft defect to produce the floating obturator?

stens
stomalgin
Repin
gypsum
syelast

33. A child born with incomplete the hard palate cleft defect, shows the fabrication of the obturator. What is the optimal timing of the use of the obturator?

2-3 years

3-4 years

5-6 years

at any age

in the nursing home

34. Select rational treatment design child's 12 years with adentia 12 and 22 teeth and a complete treatment of malocclusions, which arose due to bilateral complete upper lip and palate cleft defect.

sliding laminar partial removable denture

adhesive bridge prosthesis

cantilever bridge

bridge with two pillars

denture

35. An appliance should make 4-year old child with the alveolar process and palate cleft defect for dental prosthetics after veloplasty for defect closure of the hard palate?

obturator

plate with screw

Bynkin kappa

the Ainsworth appliance

the Andresen appliance

Literature

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