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Review Article

Preventive prosthodontics – An overview

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ABSTRACT

Preventive dental care is an important part of comprehensive dental care, preventive dental procedures are employed in the practice of dentistry and community dental health programs, that prevents the occurrence of oral diseases and oral abnormalities. It combines regular dental check-ups along with developing good oral hygiene habits. The effective prosthetic prophylaxis includes not only prevention of causes for alveolar bone loss leading to tooth loss but also preventing the defects of oral tissues. As a clinician our aim should not be just treating the area of interest, instead it should include the evaluation of mouth as a whole. This article brings out various concepts regarding preventive aspects of prosthetic dentistry such as prevention at every stage with special considerations in preventing alveolar bone loss.

1. Introduction

"*An ounce of prevention is worth a pound of cure*" - **Benjamin Franklin**

Preventive prosthodontics refers to prosthodontic practice that help to prevent the factors adversely affecting the orofacial tissues such as periodontium, alveolar bone, basal bone and surrounding musculoskeletal structures like muscles of mastication, TMJ and salivary glands. [1,2]

Preventive prosthodontics emphasizes the importance of any procedure that can delay or eliminate future prosthodontic problems. [1]

2. Aims of Preventive Prosthodontics

Patient's education and choosing evidence-based management options / prosthetic type of design to maintain the remaining teeth and their supporting tissues in a healthy state.

2.1. Goals [1,3,4]

1. To reduce ridge resorption.
2. Preservation of remaining structures.
3. Maintenance of surrounding structures.

3. Stages in Preventive Prosthodontics

3.1. Preventive stage

Any measures applied in the pre-pathogenic period before a preventable disease or disorder appears. It also includes regular care of the prosthesis, educating patient's on chewing habits, tongue posture for better maintenance of occlusion and maintenance of the prosthesis. [5]

3.2. Restorative / Corrective stage

This includes action which halter the progression of a disease at its incipient stage and prevents further

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complications.

It includes treatment for preventing or reducing the consequences of non-preventable diseases or disorders, such as restorative or rehabilitative treatment after surgery for oral cancer or orthodontic correction of malocclusion.

3.3. Recreative/ Rehabilitative stage

Aimed to improve the quality of life of people with disease by limiting disability and rehabilitation .

All measures available to limit impairment and disability, minimise suffering caused or existing departures from good health and to promote patients adjustment to irremediable conditions come under this stage.

Preventive Prosthodontics can be broadly divided into the following stages for our convenience,

Table 1:

Preventive Stage	**Restorative & Corrective Stage**	**Recreative & Rehabilitative Stage**
Diet Counseling	Elimination of plunger cusp	Preservation of stratergic tooth / teeth
Caries Preventive measures	Elimination of occlusal interferences	Interim/ Treatment Denture
Feeding plate	Management of Trauma From Occlusion	Immediate Dentures
Space maintainers	Provisional restoration	Sequelae of extraction in CD
Mouth guards	Restorative procedures on decayed tooth	Over dentures
Socket shielding	Management of Obstructive Sleep Apnea	Single CD/ Complete Denture
Radiation carrier devices	Management of Bruxism	Preventive Implant Therapy
Regular care of prosthesis		Maxillofacial Prosthesis

4. Preventive Stage

4.1. Diet counseling

Oral tissues, like all tissues in the body, are diet and nutrition-dependent. Knowledge of food sources, their properties, functions, requirements, optimal levels, and consequences of deficiences forms the basis for dietary counseling. The main objectives of diet and nutrition counseling are to screen for and correct food-related oral disturbances and to promote good dietary habits that prevent disease.[6]

4.2. Caries preventive measures

Dental caries management is a complex dynamic process, but if proper preventive strategies are followed at the right time, tooth structure can be preserved and extensive restorations can be avoided. Increased amount of techonology are aimed at promoting remineralization of the carious teeth, but based on clinical evidence fluoride remains the most preferred one. When fluoride alone is not sufficient, synergestic approach which promote saliva production, increasing intra-oral calcium and phosphate ion concentrations, antibiotic therapy, etc can be used to obtain better results.[7]

4.3. Space maintainers

Dental space maintainers are designed for a specific purposes. They may be removable, fixed or semi-fixed. They are very essential in cases of deciduous or permanent tooth loss to prevent malposition of teeth, supra eruption or crowding.[8]

4.4. Feeding plate

Cleft lip and palate (CLP) is a common congenital orofacial defect. Pathogenesis occurs during embroyonic development due to failure of fusion of various facial processes.[9] Children born with CLP are unable to generate the normal level of suction and compression required for bottle and/or breast feeding.[10] The prevailing condition results in severe nutritional deficiency. Prosthetic obturation of the defect is done temporarily with the help of a feeding plate until Rule of 10 criteria is met prior surgery.

Rule of 10

1. 10 Weeks old
2. 10 Pounds of weight
3. 10 Grams of Hb

4.5. Mouth guards

Other Names: Gum Shield, Mouth protector, Sport Guard.

Introduced by Woolf Krause, a London dentist for protecting boxers from lip lacerations. It is a prosthesis that covers the teeth and supporting structures with the aim of preventing or reducing trauma to the teeth, gingival tissue, lips, and jaws.

Usually worn on the maxillary arch and works by separating the upper and lower dentition, from the surrounding soft tissue, by absorbing or redistributing shock and or stabilising the mandible during traumatic jaw closure.[11]

It is classified into three categories (By American Society for testing and materials).[12]

1. Prefabricated/ Ready made/ Stock mouth guards.
2. Mouth formed/ Boil and bite type.

3. Custom made.

These devices can be made of various materials like rubber, vinyl laminate, polyurethane, silicone rubber, urethane rubber, arylic resin, polyvinyl acetate, polyethylene etc.

4.6. Socket shielding

This technique is used to preserve the residual ridges by preventing alveolar bone loss. After extraction,the alveolar bone undergoes a process of horizontal and vertical bone loss. This complicates dental rehabilitation, especially in case of implant treatment. Various Guided Bone Regeneration (GBR) techniques like the use of filler materials and membranes have been used to retain the original dimension of bone after extraction. Leaving a segment of the uninflammed buccal root in place (Socket shield technique, Root Submerge Technique)[13] and thereby preserving the natural periodontium eventually prevents bone loss. Davarpanah and Szmukler[14] did a 2 year follow up of five patients showing that immediately placed implants in contact with tooth fragements preserved buccal bone without any signs of abnormal changes.

4.7. Radiological stents

Radiation stents/ shields are the ones which protect the adjacent tissues from scattered and secondary radiation during radiotherapy.

Importance of intra – oral radiotherapy stents[15]

1. Proper projection of radiation
2. Protects healthy tissues
3. Reduces the side effects of the treatment
4. Increases the accuracy of the radiation source.

Types of radiation stents[15]

1. Fluoride carrier (fluoride stent)
2. Positioning stent (prosthesis to displace the tissues)
3. Peri oral cone positioning devices/ beam locator or beam director (Docking device)
4. Positioning radioactive sources/ carrier/ applicator.
5. Shielding/ Tongue protectors.

Inspite of the advancement of radiation techniques, this procedure is frequently associated with a wide variety of oral complications such as erythema, mucositis, loss of taste, xerostomia, radiation caries, trismus and osteoradionecrosis with significant impairment of the patient's quality of life.[16]

Materials used in fabricating radiation stents includes heat cure acrylic resin (most commonly used), alloys (cerroband, cerrosafe, cereolow,cerrotru & lipowitz). Cerrobend is the most commonly used.

Radiation docking devices are utilized for directing the radiation cones to a particular area of the oral cavity. Docking device help in the proper orientation of the radiation cones and protects the adjacent soft tissue by deflecting them out of the radiation path, when other areas of the oral cavity are irradiated, the tongue needs to be protected. This is done with the tongue shielding radiation stent.[17–19]

4.8. Regular care of prosthesis

Many safe and effective commercial cleaning solutions are available for the hygienic maintenance of oral prosthesis. Patients should be encouraged to thoroughly clean their dentures with a soft brush and non-abrasive paste or denture cleansing tablets or soaps can be used. Over night soaking of the prosthesis is recommended to give adequate rest to the underlying tissues. Dentures should be left overnight in plain water with teeth facing downwards. If the dentures are lined with soft temporary lining materials, then the inner portion should be gently washed under cold running water with soft cotton and the external surface can be brushed in a normal manner. Apart from all these, tissues and tongue brushing is also recommended for complete oral hygiene of prosthodontic patients.

5. Corrective Stage

5.1. Eliminating occlusal interference

Any tooth contact that inhibits the remaining occluding surface from achieving stable and harmonious contact is an occlusal interference that produces mandibular deviation during closure to the maximum intercuspation (MIC) position. The interference may be also be present during latero-trusive and protrusive movements.[20]

If the occlusal interference exceed the adaptive capacity, it leads to muscle spasm, headache, muscle fatigue, wear facets, fractured cusps, tooth mobility, muscle hypertrophy, and cranio – mandibular dysfunction syndrome. Therefore correction of interference is recommended at early stages, which is achieved by means of occlusal adjustment.

It can be achieved by selective tooth grinding/ through the use of restorative materials. The aim of such an intervention is to obtain a stable occlusal relationship, with no premature contacts or mandibular excursion.[21]

5.2. Eliminating plunger cusps

The cusps which wedge the food forcefully into the interdental spaces of the opposing arch are called plunger cusp. These plunger cusps are usually the functional cusp (palatal cusp of the maxillary arch and buccal cusp of the mandibular arch) and sometimes the palatal incline of the maxillary buccal cusp and buccal incline of the mandibular lingual cusp.

Plunger cusps can be treated by roundening and shortening of the plunger cusps, and the opposing

interproximal space is protected by splinting the adjacent teeth. Furthermore, extrusion is associated with a discrepancy in the marginal ridge relationship. If the extrusion is less, it can be managed by simple grinding. However, if it is greater, a prosthesis should be made to correct marginal ridge discrepancy.[22,23]

5.3. Provisional restoration

According to GPT, "Provisional or interim prosthesis or restoration is a fixed or removable dental or maxillofacial prosthesis designed to enhance esthetics stabilization and/or function for a limited period of time, after which it is to be replaced by a definitive dental or maxillofacial prosthesis.[24]

It mainly focuses on protecting pulp and periodontal health, promoting guided tissue healing to achieve an acceptable emergence profile, evaluating hygiene procedures, preventing abutment migration, providing an adequate occlusal scheme and evaluating maxillo-mandibular relationships.[25]

5.4. Management of trauma from occlusion

When occlusal force exceed the adaptive capacity of the perioditum, tissue injury results, this is called as Trauma From Occlusion. It is a reversible condition and it may be acute or chronic, primary or secondary.

Acute TFO is due to sudden heavy force where as chronic TFO is due to continuous and long duration damaging occlusal forces, Eg: Bruxism. Primary TFO is caused due to high occlusal forces, whereas the main cause of secondary TFO is a low threshold or low resistance of the periodontium. TFO can be treated by Occlusal Corrections.[26]

5.5. Restorative procedures on decayed tooth

Restorative procedure depend upon the extent of tooth damage. Restorative dentistry includes any dental procedure that focuses on repairing or restoring damaged oral structures. This includes a wide variety of treatments ranging from simple fillings, inlays, onlays, crowns, bridges, veneers to complex procedures like implants and so on.

The goal of restorative dentistry is to restore the function and integrity of the tooth structure, function, and health, without disrupting the natural appearance.

5.6. Management of bruxism

Common terms : Grinding/ clenching/ Gnashing of the teeth.

Bruxism is defined as a parafunctional grinding of teeth/ oral habit consisting of involuntary rhythmic/ spasmodic non-finctional gnashing, grinding/ clenching of teeth in other than chewing movements of the mandible which may lead to occlusal trauma. (GPT 9) It occurs during both sleep and wakefulness.

It has a multifactorial etiologies - stress, anxiety, sleep apnoea, cracked tooth syndrome, periodontitis, CNS disturbances, and alcohol consumption. Bruxism leads to attrition, mobility, muscle hypertrophy, occlusal facets, alveolar bone loss, and TMJ disorders.

Signs and symptoms include muscle soreness, muscle fatigue (early in the morning), hypermobility, hypercementosis, cusp fractures, pulpitis, break in the lamina dura, furcation involvement.

Treatment includes controlling psychological stress, occlusal correction, coronoplasty, occlusal splints or intra oral orthoses.[27,28]

5.7. Management of obstructive sleep apnoea

The role of dentistry in sleep disorders is becoming more significant, especially in co-managing patients with simple snoring and mild to moderate obstructive sleep apnea.

It is characterized by cessation of the airway while diaphragm movement continues. Sleep apnea is a problem that may be first recognized in the dental office. Serious health problems have been associated with obstructive sleep apnea, which includes cardiovascular and respiratory diseases. It may be due to enlarged tonsils, enlarged soft palate, enlarged tongue, retrognathism, etc.

Prosthetic management includes advancement appliances, soft palate lifters, tongue retainers, mandibular repositioners, snore guards, etc. The other treatment modality is surgery to remove the portions of soft palate and uvula.[29,30]

6. Restorative/ Rehabilitative Stage

6.1. Preservation of stratergic tooth/ teeth - thoughtful timing of extraction

Timing of extraction plays an important role in the preservation of alveolar ridges. Extraction of the maxillary third molars is delayed until middle age, as third molars have their influence on the growth of tuberosity and helps in anteroposterior development of alveolar ridge.[31]

If antagonists are not present, supra eruption of the opposing dentition leads to contact between teeth and mucosa of the opposing arches resulting in loss of arch stability, eventually leading to severe resorption of the alveolar ridge in the edentulous arch.

6.2. Timely insertion of interim / treatment denture

Interim denture is indicated in cases where definitive treatment cannot be done for various reasons. They may act as space maintainers, prevent migration / drifting, prevents supra eruption, prevents contact between teeth and alveolar bone, restore function esthetics, restore muscular tonicity,

restore vertical height, jaw health and avoids abnormal jaw habits.

6.3. Immediate denture

An immediate denture is a denture that is made prior to the extraction of the natural teeth, which is inserted into the mouth immediately after the extraction of the natural teeth. If the dentition is much compromised and indicated for extraction, then immediate dentures are planned to promote better healing (immediate dentures act as surgical stents), protect the blood clot and aid early healing and promote better ridge form. Immediate dentures also prevent the facial musculature from collapsing, provide a guide for the vertical dimension, esthetic, easy adaptation to the dentures, and provides psychological comfort.[32]

6.4. Overdentures

In the practice of removable prosthodontics, much attention is given to the preservation of the residual ridges. Extraction of teeth leads to bone resorption. Denture pressure on a residual ridge also causes bone resorption. However, when tensile stresses are received by bone, additional bone is formed.[33]

Retaining root stumps beneath the artificial denture teeth helps in maintaining alveolar bone bone health and height. This can be advantageous in terms of conserving the natural teeth, reducing the rate of residual ridge resorption, proprioceptive feedback by existing periodontal ligaments, and thus controlling the occlusive forces thereby eliminating rapid alveolar resorption.[34]

6.5. Single complete denture / complete denture

When the teeth are completely absent in any one of the arches, fabrication of a single complete denture is highly recommended to prevent the contact of the teeth and alveolar ridge, restoration of function, vertical dimensions, esthetics and prevents the development of parafunctional habits.[35] Complete dentures are provided with various occlusal schemes like balanced occlusion, lingualized occlusion, neutrocentric concept and others depending upon the condition of the patients.

6.6. Preventive implant therapy

Preventive implantology is concerned with the preservation of the alveolar ridges. After extraction of the tooth, atrophy of the edentulous lower jaw can be prevented or delayed by using implants supporting an overdenture or a fixed mandibular prosthesis. Studies have shown that the mandibular ridge shows a slower resportion pattern when compared to the maxilla because of the presence of a large composition of cancellous bone in the maxilla. Kalk et al., proposed the resorption stages of the residual ridges which are used in preventive implantology.[36]

6.6.1. Preventive stage I

Anatomic situation immediately after tooth extraction. Further resorption can be prevented by implantation of the bone substituents. Eg: Non resorbable hydroxy apatite.

6.6.2. Preventive stage II

After initial resorption has occurred, further resorption can be prevented by placing cylindrical endosteal implants to maintain adequate width and height.

6.6.3. Preventive stage III

Knife edged ridge. Here, bone removal is necessary for implant placement.

6.6.4. Preventive stage IV

Severe resorption of the alveolar ridge has occurred. Only basal bone is present. Implants are placed directly into the basal bone to prevent total loss of function of the arches.

6.7. Obturators

Obturators are used to close congenital or acquired tissue opening, primarily of the hard palate and / alveolar structures. Prosthetic restoration of the defect often includes the use of a surgical or immediate obturators, an interim obturator, and definitive obturators. (GPT)

Immediate obturators are placed immediately after surgery, which acts as a surgical stent with or without surgical packing. It can be retained by screws or wires. It helps in re-establishing the oral contours, prevents regurgitation of oral fluids into the nasopharynx, protects wounds, helps in uneventful wound healing, and prevents cicatrisation or shrinkage.[37]

The interim obturator is retained up to three months with repeated checking and relining with the help of tissue conditioners and reliners, which is followed by definitive obturator.[38]

7. Summary

Preventive prosthodontic procedures should be employed at every dental visit as a standard operating procedure with emphasis on Devan's dictum "Prevention of what is remaining rather than meticulous replacement of what is lost". Comprehensive care with focus on the entire mouth, stomatognathic system, and whole body should be considered rather than looking and solving patients immediate complaints.

8. Conclusion

Although prosthodontics has evolved as a specialized field in the replacement of missing teeth and associated

structures, the involvement with other aspects of preventive dentistry cannot be ignored. Potential problems can be avoided & resolved by properly instituting preventive prosthodontic measures according to the degree or level of prevention needed to correct it.

Every extra minute spent in a thorough clinical evaluation eliminates future prosthodontic problems.

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10. Conflicts of Interest

The authors of this manuscript declare that they have no conflicts of interest, real or perceived, financial or non-financial in this article.

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