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THE PLACE OF THE PSYCHIC FACTOR IN THE PROTETICAL REHABILITATION OF THE TOTAL EDENTATE

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ABSTRACT

The human personality is structured under the action of hereditary factors, internal and external factors which demand, under the conditions of modern civilization, an increasing power of adaptation on the part of the body .After the ontogenetic and phylogenetic evolution, however, the adaptive capacity decresed, as man has reached a stage with a superior organization .The psychic, seen as a new type of reaction of the organism to its environment, is strongly influenced by the external environment and in particular is merely stress. Under its action, the value of the psychic as an element of regulation and adaptation in the environment diminishes, too. It is known that the morphological and functional integrity of the stomatognathic system, the health and the vigor, is conferred for the individual "a state of well-being" that influences his somatic and mental health, as any disturbance at this level leads to repercussions in psychic and social behavior. Such a disruptive disorder is the total edentation that severely alters not only the system but the whole organism, posing various biological and psycho-social problems.**Material and method**: The study included 43 patients, 24 of whom were men and 19 women, with total uni- or bimaxillary edentation. **Results and discussions:**It can be concluded that the total edentation can be and is responsible for somatopsychic alterations, along with other general, local, social factors, which can sometimes take a dramatic turn, converting, where the land is favorable, a pure somatic disease. **Conclusions:** Psychiatric disorders frequently accompany the total edentation and may condition both the doctor-patient collaboration during the treatment and the possibilities of adaptation of the patients to the mobile prosthetic devices.

Keywords:
Oral rehabilitation, diagnosis, treatment, healing, prosthesis.

INTRODUCTION

Total edentation represents not only a physical but also a psychological disability at an advanced age. The psychological shock caused by the loss of teeth can lead to a lack of respect and mistrust both in oneself and in others, making cooperation with the dentist difficult in the rehabilitation process[1,2,3].

If, at the psychological changes that occur with age, we also associate those determined by the total edentation, we realize the amplitude of the actual, cognitive and volitional changes that are installed and at the same time the complexity of the prosthetic therapeutic act. For the entire course of the treatment, at the moment of the pre-prosthetic, - as well as of the post-prosthetic one, often results in biological failures, for which the therapeutic act cannot be reproached[4,5,6].

Noting that the somatic changes in the total edentation negatively influence the psychic processionality, it should be noted

that it reverberates in the activity of the entire organism corresponding to its functioning state and its interactions with the environment[7,8,9].

Oral rehabilitation consists in diagnosing and treating the entire pathology from the level of the oral cavity, from the articular, muscular, bone level, by correcting the changes that have occurred as a result of the loss of teeth, abrasions, dental malpositions or following removal of tumor formations from the face. After the clinical-paraclinical examination and the diagnosis, the patient will be included in the database and the evaluation will be performed in the long term, being at European standards, the patient going through a new era in dental medicine, there is a much greater interest for the health of the body. The healing of the oral cavity, the correction of the loco-regional pathology and the development of provisional prostheses are the initial stages of the treatment, followed by the definitive prosthesis, when there are sufficient financial sources[10,11,12].

Total edentation is a clinical condition characterized by the absence, lack of teeth (ontoparodontal units) on the arch after the normal eruption period, lack accompanied by impairment of the essential functions of the stomatognathic system as: mimicry, phonation, swallowing, mastication, self-maintenance, self-stimulation.

Oral atrophy of the buccal mucosa involves the indication of the non-compressive impression, the prosthesis having the mucosal face covered with a resilient material, and the crushing surfaces are reduced. Moreover, it involves periodic checks at least three times a year, regarding adaptation and occlusion. As a frequency, the total edentation is high, with all the relative progress registered by the dental and periodontological therapy, by the improvement of the therapeutic means but also due to the increase of the average life. There are no precise data on the frequency of total edentation in adulthood, but it is specified that it affects mainly the female sex, also, the population in the rural area compared to the urban one.

The etiology of total edentation was and is considered to be the expression of a state of involution, imputed to the phenomenon of aging. This fact is corroborated by the geriatric research that attests that the beginning of aging is a period that cannot be clearly defined[13,14,15].

The etiology of total edentation summarizes the following causes: congenital causes → total anodontia through the agnosis of the permanent buds; apparent causes → dental inclusions; acquired causes → represented by the final effect of the action in time of the multiple factors that add up as follows: dental caries and its complications followed by multiple extractions, executed abusively and without medical discernment that generates partial edentations, occlusion-articular imbalances that evolve through the exhaustion of the periodontal teeth total edentation, chronic evolutionary marginal periodontopathies, inflammatory diseases of the maxillary bones, oro-maxillofacial tumor formations, maxillofacial trauma.

The complications of total edentation can be systematized into three groups: local, regional, general[16,17,18].

Local complications are those of the oral cavity and concern the two prosthetic fields. Important changes occur at the level of the alveolar ridges, apophyses, tuberosities, pyriform tubercles. They can have different aspects: exaggerated hypertrophy of the apophyses; exaggerated hypertrophy to atrophy consisting in the reduction of volume of the alveolar apophyses; osteoporosis, which consists in the enlargement of the areolar spaces, the thinning of the bone cortex, the widening of the Havers channels;

the osteomalacia or the senile rickets which accompany a devolution and fine formation) that does not mineralize, osteoporomalacia, where histological and radiological aspects similar to the two entities described above are encountered[19,20,21].

Complications of the oral mucosa occur as a result of the decrease in the thickness of the mucosa which is accompanied by a decrease in the number of desmosomes from the deep epithelial layers, which makes the microbial flora penetrate the oral mucosa more easily. Due to this atrophy of the covering epithelium, submucosa connective tissue is more easily traumatized, eventually leading to fibroblastic degeneration, thinning and dehydration with atrophic changes of the mucosa and submucosa. Hypokeratinization processes appear, sometimes leading to decreased resistance to infections and pressures with an increased number of papillary ridges[22,23,24].

Often by excessive growth of mucosal tissue and submucosa it leads to increased resilience of the mucosa. This increase in mucosal clogging can also be explained by a faster resorption of the underlying bone than the covering mucosa.

The increased resilience of the mucosa produces the instability of the prosthesis both horizontally and vertically, which leads to an intense demand of the bone that suffers the most harmful action of the pressure forces, thus accentuating the atrophy of the bone as the thickness increases of the submucosa layer, realizing thus a true vicious circle.Complications at the level of the salivary glands occur due to the absence of functional stimuli associated with involuntary changes due to aging processes, the glandular mobile tissue, in particular the secretory tissues are gradually replaced by a connective tissue.This replacement has the effect of hypertrophic salivary gland, apparent hypertrophy, only morphological, because functionally the activity of the glands is diminished.

An obvious decrease in salivary secretion, until asialie, has consequences on the stability of the prostheses and on the integrity of the mucous membranes; reduction of the space between the arches, anterior sliding of the mandible with the opening of the gonad angle and changes atthe ATM level; it is not advisable to start the prosthetic rehabilitation treatment until the family doctor, a geriatric specialist has been consulted and caution is advised in promises[25].

If the dental losses have occurred almost simultaneously, the edentulous alveolar relief will have a symmetrical appearance. If the dental loss has occurred at large intervals, the alveolar arch will have an asymmetrical form.

Comparing the ratio of the intact dental arches with the ratio of the edentulous alveolar ridges, we will find that through total edentation the mandibular alveolar ridge is usually eccentric with respect to the maxillary ridge, while the situation is the reverse.

The longitudinal axes of the upper teeth are oblique, apically converging, and print the character of alveolar resorption. Thus the circumference of the maxillary edentulous ridge decreases, and the palatal vault reduces its depth and a centripetal atrophy occurs.

In the case of total edentation, not only the alveolar apophyses undergo changes, but the entire body of the maxillary bones, producing a considerable reduction in the ADM volume.

The wearing of the mobile prosthesis is constantly accompanied by bone resorption, which varies greatly from case to case. Occasionally, asymptomatic bone defects such as Stafne defects may appear on the inside of the mandible body. They can be used in prosthetics.

Regarding the strategy of gerontostomatology, problems related to chewing are first, then the aesthetic and phonetic function.

Paraclinical examinations, x-rays of the maxillary area, CT scans, complete the clinical picture and facilitate decision making.

Oral changes sometimes have a characteristic aspect: dental wear, which consists of the slow (physiological) or rapid (pathological) disappearance of the hard dental tissues (wear is the loss of hard substance during the course of the physiological act of mastication). Atheria is natural, normal, physiological wear; abrasion is a rapid natural wear through very hard foods or parafunctions; physiological abrasion refers to the reduced, gradual denial wear that occurs after the chewing process; pathological abrasion refers to a marked wear, through the tooth-tooth contact, generated by the functional deviations such as parafunctions (occlusal interference, premature contact, bruxism, tics, interposition of objects between dental arches, etc.).

Increased abrasions can induce obliteration of the dental carcasses and sclerosis of the pulp connective tissue, which makes endodontic treatments difficult[26].

Prosthetic stomatitis may be present due to old prosthetic works, biologically and medically inadequate; Candida infections located on the jugal mucosa, tongue or in the form of an angular cheilitis; premalignant or even malignant lesions with various locations in the soft oral parts; due to hyposalgia the mucous membranes may have atrophy accompanied by drying of the surfaces → xerostomia, which leads to the hardening of the mastication.

Criteria for oral rehabilitation

The food of the modern man consists mainly of food that is well prepared thermally, so it requires a little masticatory effort, a situation in which the shortened arches face satisfactory.

It has been shown that there is good compensation at the articular level, and the mandibular-cranial dysfunction appears much less often than one would expect.

Compared to the good adaptation of the ADM in time to the maxillary or mandibular edentation, the elderly patients hardly adapt to a new prosthetic work, having a reduced neuro-muscular reactivity. Paradoxically, failure can also occur in the case of traditional mobile prostheses, correctly executed and adapted[27].

Elderly patients, especially women, require from the dentist an improvement of the physiognomic function - an unaltered smile, a reduction of wrinkles - while the doctor is mainly looking for functional occlusal rehabilitation.

There are clinical situations (lack of functional disorders, easy acceptance of complex treatment, advanced degree of senility, etc.) in which, after a careful analysis of the case, the patient is helped more if nothing is done, than if he is subjected to clinical maneuvers, large-scale restorations.

If the decision is in favor of the complex treatment of oral rehabilitation, in the first phase it is decided to evaluate the sustainability of the measures taken: *provisional treatments*, where the general state promises an improvement or cure, after which a definitive solution can be devised; *palliative treatments*, in cases with a lower chance of longevity, where the general state would not allow a larger prosthetic therapy. It always starts with a preprotective treatment: the healing consists of removing the deposits of tartar, of the bacterial plaque, the reduction of the gingival-bone bags, the extraction of the root residues and of the teeth

without prosthetic value; the prostheses are made as soon as possible, to prevent the unfavorable evolution of the temporo-mandibular dysfunction; the existing prosthetic works are carefully examined, because it is known that the elderly become accustomed to them after a longer period of use, and hardly give up, accepting with difficulty a large oral rehabilitation, preferring to keep the old prosthetic works, possibly reconditioned; the transition from partially edentulous to full edent is for a good part of the patients an awareness of the psycho-emotional disability. Extraction of the last tooth is in fact an irreversible slope of the decline. The application of a total or subtotal mobile restoration is inevitably accompanied by adaptive biological, psychological, physical, family and social reactions[28].

The biggest problem with total edentation, due to advanced atrophies, is and remains, the stability of prosthetic parts. For this reason, in the elderly it is much more important than in other patients that the success in restorative treatments is supported by a good mental training and motivation. If the patient is prevented from the initial drawbacks of the prosthesis, he will accept the adaptation period more easily. It is advisable not to give firm assurances on the duration of the difficulties of adaptation, since they are variable depending on the treatment solutions, but also on the degree of psycho-neuro-muscular adaptability of the patient.

MATERIAL AND METHOD

The study included 43 patients, of whom 24 were men and 19 women, with total uni- or bimaxillary education.

RESULTS AND DISCUSSIONS

Modern dentistry involves addressing the sufferings of the patient who is seen in the complexity of its determinants: biological, mental, social.

The individualization of the treatment as well as the complete recovery of the patient, having as a final aim and the reintegration in the society can be done only by addressing the morphofunctional disorders of the stomatognate system affected by the edentation as well as the psychic aspects that his disease implies.

In the conditions of the medicalization of the dentistry, the medical specialist must have a thorough knowledge of psychology and psychiatry for the correct resolution of the case law they are facing.

The psychotherapy that can be achieved in the dental offices does not require a special equipment, it is within the reach of everyone, but it implies the existence of a very well trained dental team.

The complex dental and psychological treatment is compulsory in any patient, but especially in the elderly in whom recovery is more difficult, to the specific disorders of the disease, adding those of senescence. Thus, a humanistic medicine is performed for patients of all ages, but especially for elders who raise a particular problem, long neglected.

CONCLUSIONS

The connection between the organic and the psychic is indestructible. Thus the disease is understood as a drama in which the somatic process has a psychic value, and the psychic one has a bodily value.

The place of the psychic factor in the current dental therapy is more and more important, considering that its purpose is to fully recover the patients, reintegrating them into the social environment to which they belong.

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