

CLINICAL ASPECTS OF COMPLEX ORAL REHABILITATION IN PATIENTS WITH DYSFUNCTIONAL SYNDROME OF THE STOMATOGNATH SYSTEM AND ITS INTERFERENCES WITH SCHIZOPHRENIA -diagnostic and treatment- PART 2

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Abstract

Dysfunctional syndromes of the stomatognathic system are interconnected with various pathologies, including complex psychiatric conditions. In these intricate cases, an interdisciplinary approach that integrates both dentistry and psychiatry is crucial. Effective oral rehabilitation demands strategic treatment plans designed to enhance quality of life and achieve optimal results for patients with schizophrenia.

Introduction

In the category of patients with multiple pathologies, which are of high frequency in our years, we can recognize as some how representative the rehabilitation and the complex treatment that intervenes to stabilize it in our case prosthetic treatment [1-7].

The typology of diagnosis has significant implications for the optimal resolution of each case. It is essential to minimize stress factors and create a stress-free environment to maintain patient confidence in the doctor. This approach ensures that the therapeutic interventions are both efficient and prompt [8-15].

It is a very important aim to establish a good diagnosis because this is the a optimal modalities for appropriate treatment [16-20].

Are a lot of methodology to obtain a fine evaluation of clinical morphological suport, in this direction, we start this direction with indexes cuantification [19-24].

Also, quantifying in terms of positive and negative support points, general, loco-regional and local clinical and biological indicators (Table 4. a, b, c), checking the consistency of the elements of the stomatognathic system.

Support	Positive	Negative
General	Good general health	
Loco-regional	ATM: condyles centered in glenoid cavities, asymmetric, asynergic, equal amplitude, condylar excursions; no pain. Muscles: normotonic, painless on palpation.	

Table 4a. clinic- biological indexes support

Table 4 b. clinic- biological indexes support

Support	Positive	Negative
Mucosa	Insertion of the alveolo-jugal envelopes and the braces at a distance from the ridge Medium sac bottoms Mucosa with normal resilience Mucosa firm, adherent, painless on palpation Passively mobile mucosa area wide enough to ensure good marginal closure Oblique palatal wave position	
Bone	Apophysis genil at a distance from the ridge Maxillary edentulous ridge III Atwood, high (7-8mm), broad, rounded Mandibular alveolar ridge, high (6-7mm) Non-retentive maxillary sides in quadrant 1 and slightly retentive in quadrant 2 Medium depth palatal arch Torus absent	

Table 4c. clinic- biological indexes support

Support	Positive	Negative
Odontal	Grouped distribution of teeth Coronal volume preserved in the teeth 1.1, 1.3, 2.1, 2.2, 2.5, 2.6 3.3, 3.6, 4.1, 4.3, 4.5, 4.7 Increased number of remaining teeth Increased retention of remaining teeth	Edentatia unfavorably positioned, biterminal Reduced coronal volume in teeth 3.4, 3.1, 4.4 Absence of contact points Non-recoverable root remnants (1.2) Generalised grade I-II abrasion in all teeth LOC (3.6, 4.7) Medium mechanical strength reduced implantation in bone
Parodontal	Absence of gum recession Absence of mobility in the teeth	Generalized deep chronic marginal periodontal disease Super- and subgingival tartar

Diagnosis:

-Diagnosis of general condition: the patient is in a compensated state of disease, which allows dental treatment.

-Dental integrity diagnosis: generalized grade 1-2 abrasion of maxillary and mandibular teeth resulting in slow progressing masticatory and facial disorders, favourable prognosis with

treatment, untreated. Coronal dental lesions in teeth 3.6, 4.7, of multifactorial aetiology, with masticatory disorders, slow evolution, favourable prognosis with treatment, untreated.

-Diagnosis of periodontal integrity: Deep chronic, generalized, chronic marginal periodontitis, sub and supragingival tartar deposits present on all odonto-periodontal units, of multifactorial aetiology (traumatic, microbial), with functional, physiognomic, masticatory disorders, slow evolution, prognosis reserved, untreated.

-Pulp integrity diagnosis:

-Arch integrity diagnosis Maxillary partial edentulousness class I Kennedy with 2 changes and mandibular partial edentulousness class I Kennedy with 4 changes, subclass C Lejoyeux, of multifactorial aetiology, causing masticatory, physiognomic, swallowing, phonetic disorders, with slow evolution, favourable prognosis by treatment, untreated.

-Diagnosis of occlusal integrity: Malocclusion by alteration of occlusal parameters, static and dynamic, following edentulousness.

-Bone integrity diagnosis Atrophy and bone resorption class II Schroder, class II Koller-Russov, with masticatory, physiognomic, phonetic, swallowing disorders, slow evolution, local and loco-regional complications, unfavourable prognosis, untreated

-Surgical diagnosis: root remnant 1.2, multifactorial aetiology, with masticatory, phonetic and physiognomic disorders, slow evolution, favourable prognosis with treatment, treated.

-Diagnosis of homeostatic and functional integrity dyshomeostasis, of local aetiology (odontal) and loco-regional aetiology (bone, muscle, and joint support), with masticatory, phonetic, physiognomic, swallowing disorders, with slow evolution, local and loco-regional complications, favourable prognosis with treatment, untreated.

-Diagnosis of hygiene Bacterial plaque, tartar, poor oral hygiene.

The results

We can take into discussion the therapeutic modalities criteria.

The therapeutic solution of choice, chosen mandibular:

Mixed prosthesis consisting of 3 mixed metal-acrylic sixes 3 acrylic teeth, medium-cuspid, anatomically shaped; Main connector: mandibular dento-mucosal plate; EMSS: 4 Ackers crossbones at level 3.6, 3.4, 4.5, 4.

Emergency (provisional) mandibular therapeutic solution:

Mandibular mobilizable acrylic partial denture consisting of main connector lingual plate with dento-mucosal contact; 3 acrylic saddles 3 anatomically shaped acrylic teeth, half cuspid; EMSS: 4 cervico-alveolar open edentulous clasps at the level of 4.7, 4.5, 3.4, and 3.6.

Other therapeutic solutions: Mixed prosthesis consisting of 3 mixed metal-acrylic sixes 3 acrylic teeth, medium-cuspid, anatomically shaped; Main connector: mandibular dento-mucosal plate; EMSS: - ring cusp at tooth level 4.7.

-T-notch at 4.5 and 3.4 level- Ackers' cusp at the 3.6 level.

Mixed prosthesis consisting of 3 mixed metal-acrylic sixes, 3 acrylic teeth, medium-cuspid, anatomically shaped, main connector: mandibular lingual bar, EMSS: T-cross at 4.5 and 3.4 level, Ackers crossbite at level 4.7 and 3.6.

Hybrid prosthesis consisting of 3 mixed metal-acrylic sixes; 3 acrylic teeth, medium-cuspid, anatomically shaped; Main connector: mandibular dento-mucosal plate; EMSS: -Gilmore bar at level 4.6 and 3.5; Ackers' crossbones at level 3.6.

Fixed semi-vision metal-ceramic prosthesis with aggregation elements at level 4.7, 4.5, 3.4, 3.6.

Semi-visionary metal-ceramic fixed prosthesis with aggregation elements at 4.7, 4.5, 4.4, 4.3, 4.1, 3.1, 3.3, 3.4 and 3.6 levels; Deck body at level 4.6, 4.2, 3.2, 3.5.

The therapeutic results can be enlarged also, in the following stadialisation.

Pre- and pro-protetic preparation:

1. Health education

Correct oral hygiene techniques; Training on plaque self-management techniques; Teaching Bass brushing technique; Use of a medium toothbrush and interdental brush; Use of interdental floss; Using toothpaste; Oral rinses with anti-plaque solutions.

2. Local preparation- Nonspecific preparation (prophylaxis):

-Preparation of the dental support: Manual and ultrasonic extraction; Professional brushing; Polishing of dental and root surfaces; Oral cavity cleaning- extraction 1.2.

-Preparation of mucous membranes: Massages practiced with the thumb index finger, percussion on the mucosa, Oral douches.

-Specific preparation (proprotetics): Bio-pulpectomies for prosthetic purposes (at 1.3., 1.1, 2.1, 2.2 and 3.6). Definitive root filling. Preparation of organic substructures (1.3., 1.1, 2.1, 2.2) for shaft delivery, parallelization of proximal faces and preparation for future fixed prosthetic work. Preparation of organic substructures (3.6,3.4,4.5,4.7) for making occlusal spur sockets.

-Protein preparation itself:



Figure 11. Maxillary and mandibular preliminary and functional impression for adjunct prosthesis management treatment stadialization.

-Maxillary functional impression:

Gingival sulcus spreading, impression of organic substructures for fixed restorations. Recording mandible-cranial relationships. Metal skeleton sample for fixed prosthesis fitting, colour registration with colour key; provisional cementation; preliminary impression.

Obtaining the preliminary model and the individual impression tray. Peripheral and central functional impression. Recording of mandibulo-cranial relationships (centric relation- Lauritzen - Barell) with occlusion models. Checking and fitting of the metal skeleton of the future partially mobile prosthesis. Final cementing of the fixed prosthesis. Fitting of the definitive prosthesis- immediate, primary, secondary, and tertiary fitting (Figure 11-14).

Mandible treatment:

Skeletal prosthesis consisting of a main metal connector represented by a dento-mucosal metal plate with 3 mixed metal-acrylic posts supporting 3 anatomically moulded acrylic medium-stiffened teeth and elements of maintenance, support, and stability: Ackers brackets 3.4, 3.6, 4.5, 4.7.

- Preliminary imprint:

Preliminary prints, for the study models

Temporary cementing of fixed maxillary work:

Functional

-Mandibular impression:



Figure 12. Maxillary and mandibular impression for conjunct management treatment stadialisation.

-Recording of mandible-cranial relationships:
Checking occlusion patterns. Checking and adapting occlusion models. Determination of the centric relationship- Lauritzen-Barrelle method. Solidarity of occlusion models. Establishment of landmarks for the selection and fitting of artificial teeth.

-Fitting mobile prostheses:
Immediate fitting: patient's first contact with the prosthesis. Primary fitting: 7-10 days after insertion of the appliance on the field. Secondary fitting: 30 days after insertion of the appliance on the field, or the late fitting-one, depending on the condition, intraoral parameters and health states.



Figure 13. Stages in adjunct prosthesis management treatment- machete in cire.



Figure14. Final presentation of patient prosthetic treatment.

We value the restoration of the phisionomic function in the first place as a mitigating and stabilizing force, as well as all functions of the dental system for self-acceptance and for easier social integration [21].
The outcomes of all intervention aspects in clinical dentistry show a 65% modification rate,comform DASS 21 results indicating opportunities to continue treatments and evaluate for improved results in the field.

Conclusion

This clinical case described the diagnosis and treatment sequence in a patient with psychiatric disorders, schizophrenia, who required full-mouth rehabilitation and a therapeutic algorithm established so that we may have a minimum loss of healthy tissues and the preservation of the existing functions to stabilized and a good prevention.

Both the psychiatrist and the dentist have the role of reintegrating the mentally ill in

society when this situation is possible and both sides are implicated.

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