**Oral Prophylaxis -** is a procedure done for teeth cleaning. It removes tartar and plaque build-up from the surfaces of the teeth as well as those hidden in between and under the gums. The dentist uses a scaler, a type of hand instrument, to remove the plaque and tartar.

Advantages -

**Advantages**

1. It minimizes the operator and patient fatigue.
2. It is time saving and effective.
3. Dentinal sensitivity is diminished following the use of prophy-jet, which may be explained by the fact that bicarbonate crystals may block the tubular opening
4. It removes plaque from areas that are otherwise difficult to reach like furcations, flutings and close root proximities.

#### Disadvantages

1. They should be cautiously used in patients with restricted sodium diets, respiratory, renal or metabolic disease, infectious disease, children, diuretics or long term steroid therapy, and those having titanium implants. Owing to the limitation of prophy-jet in individuals with sodium restricted diets, nonsodium prophy powder, containing aluminum trihydroxide (cavitron, jet-fresh) instead of sodium bicarbonate can be used
2. Another drawback is the aerosols generated by air-polishing may present an infection control hazard. Hence, a preprocedural rinse is always recommended along with aerosol reduction devices. Subcutaneous emphysema can also occur whenever compressed air is employed intra-orally. This highlights the iatrogenic potential and reinforces the need to follow manufacturer's instructions appropriately.[[19](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4555792/" \l "ref19)]

## CONCLUSION

Tooth polishing used to be a standard part of a dental cleaning appointment. The dentists used to smoothen teeth so that plaque and bacteria which cause gingivitis, periodontitis or cavities do not stick to the tooth easily. However, it is now known that within 30 min, the bacteria colonize on the tooth surface irrespective of whether teeth are polished or not. Also, polishing removes the outer layer of tooth enamel, which takes a period of 3 months to rebuild the fluoride-rich layer. Hence, selective polishing is recommended. Each patient should be assessed individually for polishing of teeth. Teeth are polished only if stains are present which scaling was unable to remove. This means that during cleaning procedures either some, all or none of the teeth may be polished.

Currently, the dentists and hygienists have varied options regarding the abrasive/polishing agents and type of polishers used. They can now use different polishers and abrasives based on the patients’ acceptance and condition, thereby providing good care by selectively designing the treatment according to the patients’ need and with minimum concern about the loss of tooth structure.

Tooth Coloured Restorations

Tooth Coloured Restorations A tooth coloured restoration (filling) is the composite resin used to repair a damaged tooth. If, for example, your dentist needs to treat your cavity, the decayed portion of the tooth will be removed and the area from which that material was taken will have this restorative resin placed in it instead. Tooth coloured restorations are also used to help repair cracked, broken or worn down teeth. This can be caused by trauma, nail biting, or tooth grinding, as but a few examples.

Why would I need a temporary tooth restoration?

You might need a temporary restoration in one of the following circumstances: After a root canal treatment. To settle down a tooth’s nerve; when the pulp, which contains the nerve and carries the blood, becomes irritated. In the event that emergency dental treatment is required. Restorations can often be used in the interim, before a permanent crown can be placed, in instances such as toothaches or broken teeth, for example.

What is involved in the restoration of a tooth?

Your dentist will first numb the area of the mouth using a local anesthetic. The decayed area of the tooth, if necessary, will be removed using dental hand pieces and diamond burs. Your dentist will check that all of the decay has been removed by probing the affected area during the removal procedure and staining it with a decay-detecting agent. Then your dentist will clean the cavity of additional bacteria and debris in order to prepare the area for the restoration. The tooth coloured material is then applied in layers, with a special light that “cures”/hardens each layer as it is applied. Once the layering process is completed, your dentist will shape the composite material, trimming off any excess material, and polishing it accordingly. Once the final restoration is applied, your bite will then be checked to ensure that it is functioning properly.

What should I expect after a restoration? Initially, you will experience numbness in the restored area for about 2 to 3 hours. During this time, take care not to bite or chew on the numb tissue. If your restoration is a bit high you may experience some pain or discomfort. This can be adjusted with a 5-minute appointment with your dentist, during which the high point will simply be adjusted. Depending on the situation, the tooth may be sensitive for anything from a single day to a few months. The reason for this is because of the composite contracting during the curing process. This will settle down in most instances; however, if it does not and the restoration is deep, then the nerve may die, meaning that a root canal treatment may then be required.

 What is Dental Amalgam (Silver Fillings)

Most people recognize dental amalgams as silver fillings. Dental amalgam is a mixture of mercury, silver, tin and copper. Mercury, which makes up about 50 percent of the compound, is used to bind the metals together and to provide a strong, hard, durable filling. After years of research, mercury has been found to be the only element that will bind these metals together in such a way that can be easily manipulated into a tooth cavity.

Is mercury in dental amalgam safe?

Mercury in dental amalgam is not poisonous. When mercury is combined with other materials in dental amalgam, its chemical nature changes, so it is essentially harmless. The amount of mercury released in the mouth under the pressure of chewing and grinding is extremely small and no cause for alarm. In fact, it is less than what patients are exposed to in food, air and water. Ongoing scientific studies conducted over the past 100 years continue to prove that amalgam is not harmful. Claims of diseases caused by mercury in amalgam are anecdotal, as are claims of miraculous cures achieved by removing amalgam. These claims have not been proven scientifically.

What about patients allergic to mercury? The incidence of allergy to mercury is far less than one percent of the population. People suspected of having an allergy to mercury should be tested by qualified physicians, and, when necessary, seek appropriate alternatives. Should patients have amalgam removed? No. To do so, without need, would result in unnecessary expense and potential injury to teeth.

**How do Crowns Work?**  
A crown is used to entirely cover or "cap" a damaged tooth. Besides strengthening a damaged tooth, a crown can be used to improve its appearance, shape or alignment. A crown can also be placed on top of an implant to provide a tooth-like shape and structure for function. Porcelain or ceramic crowns can be matched to the color of your natural teeth. Other materials include gold and metal alloys, acrylic and ceramic. These alloys are generally stronger than porcelain and may be recommended for back teeth. Porcelain bonded to a metal shell is often used because it is both strong and attractive.

Your dentist may recommend a crown to:

* Replace a large filling when there isn't enough tooth remaining
* Protect a weak tooth from fracturing
* Restore a fractured tooth
* Attach a bridge
* Cover a dental implant
* Cover a discolored or poorly shaped tooth
* Cover a tooth that has had root canal treatment
* **How are Crowns and Bridges Made?**  
  Before either a crown or a bridge can be made, the tooth (or teeth) must be reduced in size so that the crown or bridge will fit over it properly. After reducing the tooth/teeth, your dentist will take an impression to provide an exact mold for the crown or bridge. If porcelain is to be used, your dentist will determine the correct shade for the crown or bridge to match the color of your existing teeth.
* Using this impression, a dental lab then makes your crown or bridge, in the material your dentist specifies. A temporary crown or bridge will be put in place to cover the prepared tooth while the permanent crown or bridge is being made. When the permanent crown or bridge is ready, the temporary crown or bridge is removed, and the new crown or bridge is cemented over your prepared tooth or teeth.
* **How Long do Crowns and Bridges Last?**  
  While crowns and bridges can last a lifetime, they do sometimes come loose or fall out. The most important step you can take to ensure the longevity of your crown or bridge is to practice good oral hygiene. A bridge can lose its support if the teeth or bone holding it in place are damaged by dental disease. Keep your gums and teeth healthy by Brushing with fluoride toothpaste twice a day and flossing daily. Also see your dentist and hygienist regularly for checkups and professional cleanings.
* To prevent damage to your new crown or bridge, avoid chewing hard foods, ice or other hard objects.

A **removable partial denture (RPD)**

 is a [denture](https://en.wikipedia.org/wiki/Dentures) for a partially [edentulous](https://en.wikipedia.org/wiki/Edentulism) patient who desires to have replacement teeth for functional or aesthetic reasons and who cannot have a [bridge](https://en.wikipedia.org/wiki/Bridge_(dentistry)) (a [fixed partial denture](https://en.wikipedia.org/wiki/Fixed_prosthodontics)) for any number of reasons, such as a lack of required teeth to serve as support for a bridge (i.e. distal abutments) or financial limitations.

This type of prosthesis is referred to as a *removable partial denture* because patients can remove and reinsert it when required without professional help. Conversely, a "fixed" prosthesis can and should be removed only by a dental professional.

Depending on where in the mouth teeth are missing, edentulous situations can be grouped under four different categories, as defined by Dr. Edward Kennedy[[1]](https://en.wikipedia.org/wiki/Removable_partial_denture#cite_note-1) in his classification of partially edentulous arches.

* Class I (bilateral free ended partially edentulous)
* Class II (unilateral free ended partially edentulous)
* Class III (unilateral bounded partially edentulous)
* Class IV (bilateral bounded anterior partially edentulous)

**Kennedy Class I** RPDs are fabricated for people who are missing some or all of their posterior teeth **on both sides (left *and* right)** in a single arch (either [mandibular](https://en.wikipedia.org/wiki/Human_mandible) or [maxillary](https://en.wikipedia.org/wiki/Maxilla)), and there are no teeth [posterior to](https://en.wikipedia.org/wiki/Commonly_used_terms_of_relationship_and_comparison_in_dentistry)the [edentulous](https://en.wikipedia.org/wiki/Edentulous) area. In other words, Class I RPDs clasp onto teeth that are more towards the front of the mouth, while replacing the missing posterior teeth **on both sides** with false [denture](https://en.wikipedia.org/wiki/Denture) teeth. The denture teeth are composed of either [plastic](https://en.wikipedia.org/wiki/Plastic) or [porcelain](https://en.wikipedia.org/wiki/Porcelain).

**Class II** RPDs are fabricated for people who are missing some or all of their posterior teeth **on one side (left *or* right)** in a single arch, and there are no teeth behind the edentulous area. Thus, Class II RPDs clasp onto teeth that are more towards the front of the mouth, as well as on teeth that are more towards the back of the mouth of the side on which teeth are not missing, while replacing the missing more-back-of-the-mouth teeth **on one side** with false denture teeth.

**Class III** RPDs are fabricated for people who are missing some teeth in such a way that the edentulous area has teeth remaining both [posterior and anterior](https://en.wikipedia.org/wiki/Commonly_used_terms_of_relationship_and_comparison_in_dentistry) to it. Unlike Class I and Class II RPDs which are both tooth-and-tissue-borne (meaning they both clasp onto teeth, as well as rest on the posterior edentulous area for support), Class III RPDs are strictly tooth-borne, which means they only clasp onto teeth and do not need to rest on the tissue for added support. This makes Class III RPDs exceedingly more secure as per the three rules of removable prostheses that will be mentioned later, namely: **support,** **stability** and **retention.** (See the article on [dentures](https://en.wikipedia.org/wiki/Denture) for a more thorough review of these three fundamentals of removable prosthodontics.)

However, if the edentulous area described in the previous paragraph crosses the anterior [midline](https://en.wikipedia.org/wiki/Dental_midline) (that is, at least both [central incisors](https://en.wikipedia.org/wiki/Central_incisor) are missing), the RPD is classified as a **Class IV** RPD. By definition, a Kennedy Class IV RPD design will possess only one edentulous area.

Class I, II and III RPDs that have multiple edentulous areas in which replacement teeth are being placed are further classified with modification states that were defined by Oliver C. Applegate.[[2]](https://en.wikipedia.org/wiki/Removable_partial_denture#cite_note-2) Kennedy classification is governed by the most posterior edentulous area that is being restored. Thus if, for example, a maxillary arch is missing teeth #1, 3, 7-10 and 16, the RPD would be Kennedy Class III mod 1. It would not be Class I, because missing third molars are generally not restored in an RPD (although if they were, the classification would indeed be Class I), and it would not be Class IV, because modification spaces are not allowed for Kennedy Class IV.[[3]](https://en.wikipedia.org/wiki/Removable_partial_denture#cite_note-3)

The results of a study conducted in Saudi Arabia, showed that the occurrence of Kennedy Class III partial edentulism was 67.2 % in the maxillary arch and 64.1% in the mandibular arch. Followed by Class II in both maxillary and mandibular arch with an average of 16.3 % in maxillary arch and14.8% in the mandibular arch. Based on these results, class III has the highest prevalence in younger group of patient (31- 40 years). Class I and class II have the highest incidence among older group of Patients (41-50 years).[[4]](https://en.wikipedia.org/wiki/Removable_partial_denture#cite_note-4)

**Dentures**

, (also known as **false teeth**), are [prosthetic](https://en.wikipedia.org/wiki/Dental_prosthesis) devices constructed to replace missing [teeth](https://en.wikipedia.org/wiki/Tooth); they are supported by the surrounding soft and hard tissues of the [oral cavity](https://en.wikipedia.org/wiki/Oral_cavity). Conventional dentures are removable ([removable partial denture](https://en.wikipedia.org/wiki/Removable_partial_denture) or complete denture). However, there are many denture designs, some which rely on bonding or clasping onto teeth or [dental implants](https://en.wikipedia.org/wiki/Dental_implant) ([fixed prosthodontics](https://en.wikipedia.org/wiki/Fixed_prosthodontics)). There are two main categories of dentures, the distinction being whether they are used to replace missing teeth on the [mandibular arch](https://en.wikipedia.org/wiki/Human_mandible) or on the [maxillary arch](https://en.wikipedia.org/wiki/Maxilla).

Causes of tooth loss

Patients can become entirely edentulous (without teeth) for many reasons, the most prevalent being removal due to dental disease typically relating to oral flora control, i.e., periodontal disease and tooth decay. Other reasons include pregnancy, tooth developmental defects caused by severe malnutrition, genetic defects such as dentinogenesis imperfecta, trauma, or drug use.

Advantages

Dentures can help patients through: • Mastication or chewing ability is improved by replacing edentulous areas with denture teeth. • Aesthetics, because the presence of teeth gives a natural appearance to the face, and wearing a denture to replace missing teeth provides support for the lips and cheeks and corrects the collapsed appearance that results from the loss of teeth. Pronunciation, because replacing missing teeth, especially the anteriors, enables patients to speak better. There is especially improvement in pronouncing words containing sibilants or fricatives. Self-esteem, because improved looks and speech boost confidence in the ability to interact socially.

# Tooth Extraction

Surgery Overview Gum disease can loosen or severely damage a tooth. A tooth that is severely damaged may need to be removed. Your dentist or a surgeon who specializes in surgeries of the mouth (oral and maxillofacial surgeon) can remove a tooth. Before removing your tooth, your dentist will give you a local anesthetic to numb the area where the tooth will be removed. A stronger, general anesthetic may be used, especially if several or all of your teeth need to be removed. General anesthetic prevents pain in the whole body and will make you sleep through the procedure. After the tooth is removed, you may need stitches. You can gently bite down on a cotton gauze pad placed over the wound to help stop the bleeding. The removed tooth can be replaced with an implant, a denture, or a bridge. A bridge camera.gif is a replacement for one or more (but not all) of the teeth and may be permanent or removable.

What To Expect After Surgery In most cases, the recovery period lasts only a few days. The following will help speed recovery: Take painkillers as prescribed by your dentist or oral surgeon. To help relieve pain and swelling, apply an ice or cold pack to the outside of your mouth for 10 to 20 minutes at a time. Put a thin cloth between the ice and your skin. After 24 hours, rinse your mouth gently with warm salt water several times a day to reduce swelling and relieve pain. Make your own salt water by mixing 1 tsp (5 g) of salt in a medium-sized glass [8 fl oz (240 mL)] of warm water. Do not rinse hard. This can loosen the blood clot and delay healing. Change gauze pads before they become soaked with blood. Relax after surgery. Physical activity may increase bleeding. Avoid smoking. Eat soft foods, such as gelatin, pudding, or a thin soup. Gradually add solid foods to your diet as healing progresses. Do not lie flat. This may prolong bleeding. Prop up your head with pillows. Avoid rubbing the area with your tongue. Do not use sucking motions, such as when using a straw to drink. Continue to carefully brush your teeth and tongue. After the tooth is removed, you may need stitches. Some stitches dissolve over time, and some have to be removed after a few days. Your dentist will tell you whether your stitches need to be removed.

Why It Is Done Removing

a tooth is necessary when decay or an abscessed tooth is so severe that no other treatment will cure the infection.

How Well It Works

Removing the tooth can help keep infection from spreading to other areas of your mouth.

## Symptoms & diagnosis

Wisdom teeth either produces no symptoms or causes these problems:

* Pain
* Tooth decay
* Cysts
* Swollen, red, tender or bleeding gums
* Swelling around the jaw
* Gum infection
* Damage to other teeth
* Bad breath
* An unpleasant taste in the mouth near the affected area
* Food to be trapped behind the tooth
* Headache or jaw ache
* Occasional difficulty opening the mouth
* Occasional swollen lymph nodes in the neck

To diagnose impacted wisdom teeth, dentists look for swollen gums or signs of infection such as tenderness, redness and drainage, according to the [National Institutes of Health](http://www.nlm.nih.gov/medlineplus/ency/article/001057.htm) (NIH). They also inquire about symptoms and regular oral cleaning habits. A diagnosis can be confirmed only with dental X-rays, which may also indicate damage to other teeth or the jawbone.

X-rays are needed because they show the exact positions of the wisdom teeth, and help surgeons decide the best strategy for removal, said Lee Carrasco, an associate professor of oral and maxillofacial surgery at the University of Pennsylvania in Philadelphia.

## After surgery

Patients are sent home with instructions for diet modifications and other measures to help manage the expected postsurgical pain and swelling. Complications are unusual, but may include:

* Infection of the tooth or gums due to bacteria or trapped food
* Sinus damage near upper wisdom teeth
* Dry tooth socket or bone exposure
* Weakened lower jawbone
* Nerve damage to the lower lip, chin or tongue

Patients who develop any postsurgical complications should contact their doctors immediately.

Complications are rare, but dry socket typically has the highest prevalence, occurring in about 5 to 10 percent of patients, Carrasco said. After the surgeon removes a molar, the body forms a clot to stop the bleeding. The clot initially has the texture of pudding, but it forms a scab within a few days.

"That sometimes doesn't happen," Carrasco said. "The clot sometimes washes away, leaving bare bone."

Dry sockets often lead to pain and inflammation, and doctors treat it with a sedative dressing. "Almost always, over a period of the next few days, it starts to feel better," Carrasco said.

The anesthesia may also cause some people to feel nauseous, he added. "Everyone has some seepage or oozing within the first 24 to 48 hours," he added.

But after eating soft foods for a few days, people are typically ready to eat regular foods again.

Patients can also take prescription painkillers following surgery. Carrasco encouraged people with leftover medication to return the pills to a pharmacist or dispose of them in another safe way. Parents who monitor their medicine cabinet and their children's medications can help stop [painkiller addiction](https://www.livescience.com/18523-prescription-drug-addiction-growing-teens.html), he said.

## Risk on non-removal

Because bone is more flexible in people under 30, wisdom tooth removal may be simpler before then, according to the NIH. Some impacted wisdom teeth never need removal if they don't cause dental problems.

Impacted teeth that are not removed may lead to serious complications, including:

* Cyst development around the tooth that may gouge the jawbone and damage adjacent teeth
* Infection of the tooth or gums
* Chronic mouth discomfort
* Misalignment of teeth
* Plaque caught between teeth and gums

Orthodontics › Orthodontic treatment