

Starting name Of Almighty Allah

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Assignment: Maxillofacial surgery

Submitted to:

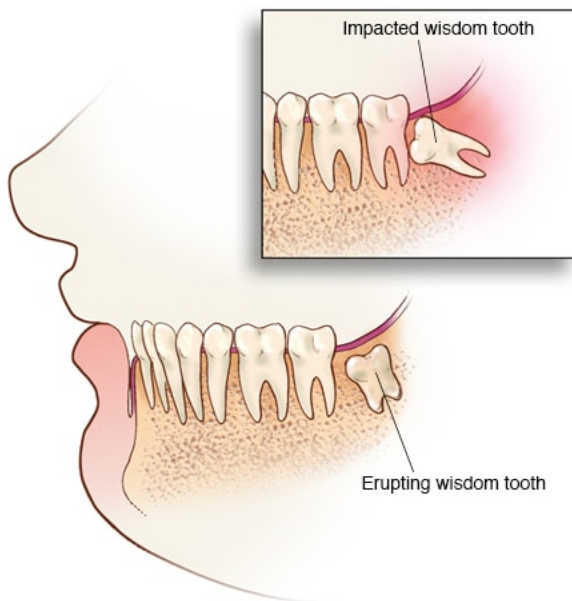
Mam Natasha

Answer the Following Questions:

Q1)which tooth is most Commonly involved in Impaction?

And

Which teeth are most often impacted?



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Wisdom teeth, which are usually the last teeth to grow in – typically between the ages of 17 to 21 – are most typically impacted.

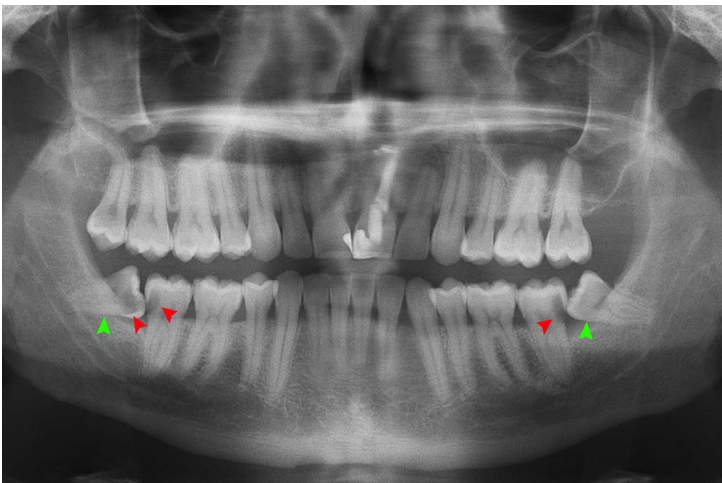
By the time that wisdom teeth – also known as “third molars” – come in, the jaw has often stopped growing. The mouth and jaw may thus be too small to accommodate them. Because there’s no real need for wisdom teeth anymore, they’re typically removed if they’re a problem. If you have a small jaw, you’re more likely to have impacted wisdom teeth.

The second most common teeth to be impacted are the maxillary canines, also referred to as the cuspid or upper eyeteeth. Because these teeth play a more important role in your mouth, your doctor is more likely to recommend treatments that encourage these teeth to erupt instead of removing them

How are impacted teeth treated?

If you suspect you have an impacted tooth, see your dentist as soon as possible. They can examine your teeth and take an X-ray of your mouth to determine if an impacted tooth is causing your symptoms. If it is, they can discuss the benefits and risks of treatment.

XRYs OPG



Treatment options may include

Waiting and monitoring

If your impacted tooth isn't causing any symptoms, your dentist may suggest a wait-and-see approach. With this approach, instead of surgically removing the tooth, your dentist will regularly monitor it so that they can see if any problems develop.

This will be easy to do if you go in for regular dental checkups.

Surgery

If you're experiencing pain and other unpleasant side effects from an impacted tooth, your dentist may recommend extraction surgery, particularly in the case of impacted wisdom teeth. They may also recommend extraction if the impacted tooth will have a negative effect on other teeth.

Tooth extraction surgery is usually done as an outpatient procedure at an oral surgeon's office, meaning you can go home the same day you have the procedure. The procedure usually takes 45 to 60 minutes, and you'll likely be put under local anesthesia. Recovery may take 7 to 10 days, but you should be able to return to work or school within a few days of having the procedure

More information

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Identifying and Treating Impacted Teeth

Medically reviewed by Christine Frank, DDS – Written by Julie Ryan Evans – Updated on May 22, 2018

Symptoms

Causes

Treatment

Complications

Pain relief

Outlook

What are impacted teeth?

An impacted tooth is a tooth that, for some reason, has been blocked from breaking through the gum. Sometimes a tooth may be only partially impacted, meaning it has started to break through.

Oftentimes, impacted teeth cause no obvious symptoms and are only discovered during a routine X-ray at the dentist's office.

Read on to learn more about impacted teeth and when you need to do something about them.

Symptoms of impacted teeth

You may not experience any symptoms in some cases. In other cases, an impacted tooth may cause:

red, swollen, or bleeding gums

bad breath

a bad taste in your mouth

difficulty opening your mouth

pain when opening your mouth, or when chewing and biting

Symptoms may come and go over weeks or months.

What causes an impacted tooth?

In general, a tooth becomes impacted when your mouth doesn't have enough space for it. This can be the result of genetics or orthodontic treatment.

Which teeth are most often impacted?

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By the time that wisdom teeth – also known as “third molars” – come in, the jaw has often stopped growing. The mouth and jaw may thus be too small to accommodate them. Because there's no real need for wisdom teeth anymore, they're typically removed if they're a problem. If you have a small jaw, you're more likely to have impacted wisdom teeth.

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Eruption aids

When the canine teeth are impacted, eruption aids may be used to get the tooth to erupt properly. Eruption aids may include braces, brackets, or by extracting baby or adult teeth that may be blocking the canines. These methods are most effective when performed on younger people.

If eruption can't be achieved, then the impacted tooth will need to be removed and replaced with a dental implant or bridge.

Complications of impacted teeth

Since fully impacted teeth never break through the gums, you won't be able to clean or care for

them. But if your tooth or teeth are partially impacted, they'll be more difficult to clean properly. This puts them at a higher risk for dental problems, including:

cavities

decay

infection

crowding of nearby teeth

cysts, which can damage roots of nearby teeth or destroy bone

absorption of bone or adjacent teeth

gum disease.

Q2) Name the local anesthetic agent and vasoconstrictor used in local anesthesia.

And) Local anesthetic agent:

Commonly used amino amides include lidocaine, mepivacaine, prilocaine, bupivacaine, etidocaine, and ropivacaine and levobupivacaine. Commonly used amino esters include cocaine, procaine, tetracaine, chlorprocaine, and benzocaine.

vasoconstrictor use in Local Anesthesia

Addition of a vasoconstrictor to a local anesthetic may have several beneficial effects: a decrease in the peak plasma concentration of the local anesthetic agent, increase in the duration and the quality of anesthesia, reduction of the minimum concentration of anesthetic needed for nerve block, and decrease of blood loss during surgical procedures. The addition of a vasoconstrictor to a local anesthetic may also have detrimental effects. A review of the literature indicates that vasoconstrictor concentrations in local anesthetics marketed for dental use in the United States are not always optimal to achieve the purposes for which they are added. In most cases, a reduced concentration of vasoconstrictor could achieve the same goal



as the marketed higher concentration, with less side-effect

Q3)what is the management of root displacement?

Ans)INTRODUCTION

An iatrogenically displaced tooth during extraction is one of seldom anticipated complication of oral surgery.

This is challenging for both the primary practitioner and the subsequent surgeon.¹

This complication most often occurs during removal of impacted 3rd molars.

Common spaces for displacement of teeth include maxillary sinus, temporal space, infratemporal space, lateral pharyngeal space, sub mandibular space and buccal space.²

There are many factors that increase the chance of tooth displacement. These include anatomic considerations, such as distolingual angulation of the tooth or dehiscence in lingual cortical plate, excessive or uncontrolled force, improper manipulation and inadequate clinical and radiographic examination.

Symptoms arising due to displaced teeth vary. Patient may remain asymptomatic or may present with infection, pain, trismus, psychological distress and medicological problem.

Management Of tooth Displacement:

Root Displacement.

The tooth root that is most commonly displaced into unfavorable anatomic spaces is the maxillary molar root, which is forced into the maxillary sinus. If a root of a maxillary molar is being removed, with a straight elevator being used with excess apical pressure ~s a wedge in the periodontal ligament space, the tooth root can be displaced into the maxillary sinus. If this occurs, the surgeon must make several assessments to prescribe the appropriate treatment. First, the surgeon must identify the size of the 'root lost into the sinus. It may be a root tip of several millimeters, an entire tooth root, or the entire tooth. The surgeon must next assess if there has been any infection of the tooth or periapical tissues. If the tooth is not infected, [management](#) is easier tharr if the tooth has been acutely infected. Finally, the surgeon must assess the preoperative condition of the maxillary sinus. For the patient who .has a healthy maxillary sinus, it is easier to manage a displaced root than if the sinus has been chronically infected. If the displaced tooth fragment is a small (2 or 3 mm) root tip and the tooth and sinus have no.preexisting infection, the surgeon should make a minimal attempt at removing the root. First, a radio graph of the fractured tooth root should be taken to document its position and. size. Once that has been accomplished, the surgeon should irrigate through the small opening in the socket' apex and then suction the irrigating solution from the sinus via the socket. This occasionally flushes the root apex from the sinus through the socket. The surgeon should check the suction solution and confirm radio graphically

that the root has been removed. If this technique is not successful, no additional surgical procedure should be performed through the socket, and the root tip should be left in the sinus. The small, non infected root tip can

be left in place, because it is quite unlikely that it will cause any troublesome sequelae. Additional surgery in this situation will cause more patient than leaving the root tip in situ. If the root tip is 'left in the sinus, measures should be taken similar to those taken when leaving any root tip in place. The patient' must be informed of the decision and given proper follow-up Instructions. The oroantral communication should be managed as discussed later, with a figure-of-eight suture over the socket, sinus precautions, antibiotics, and a nasal spray to prevent infection and keep the ostium open. The most likely occurrence is that the root apex will fibrose onto the sinus membrane with no subsequent problems. If the' tooth root is infected or the patient has chronic sinusitis, the patient should be referred to an oral and maxillofacial surgeon for removal of the root tip If a large root fragment or the entire tooth is displaced into the maxillary sinus, it should be removed . The usual method is a Caldwell-Luc approach into the' maxillary sinus in the canine fossa region and then removal of the tooth. The oral and maxillofacial surgeon (to whom the patient should' be referred) performs this procedure . Impacted maxillary third molars are occasionally displaced into the maxillary sinus (from which they are removed via a Caldwell-Luc approach) or posteriorly into the infratemporal space. During elevation of the tooth,

the elevator may force the tooth posteriorly through the periosteum into the infratemporal fossa. The tooth is usually lateral to the lateral pterygoid plate and inferior to the lateral pterygoid muscle. If good access and light are available, the surgeon should make a single cautious effort to retrieve the tooth with a hemostat. The tooth. is usually not visible, and blind probing will result in further displacement. If the tooth is not retrieved after a single effort, the incision should be closed and the operation stopped.

The patient should be informed that the tooth has been displaced and will be removed and will be removed later. Antibiotics should be given to help decrease the possibility of an infection, and routine postoperative care should be provided. During the initial healing time, fibrosis occurs and stabilizes the tooth in a rather firm position. The tooth is removed 4 to 6



weeks later by an oral and maxillofacial surgeon. The displaced tooth lies medial to the ramus of the mandible and may interfere with wide opening of the mouth. In addition, the occurrence of a late infection is possible. Although possible, it is very unlikely that the tooth will migrate after initial fibrosis has occurred. If no mandibular restriction exists, the patient may elect not to have the tooth removed. If this decision is made, the surgeon must document that the patient understands the situation and the potential complications. Fractured mandibular molar roots that are being removed

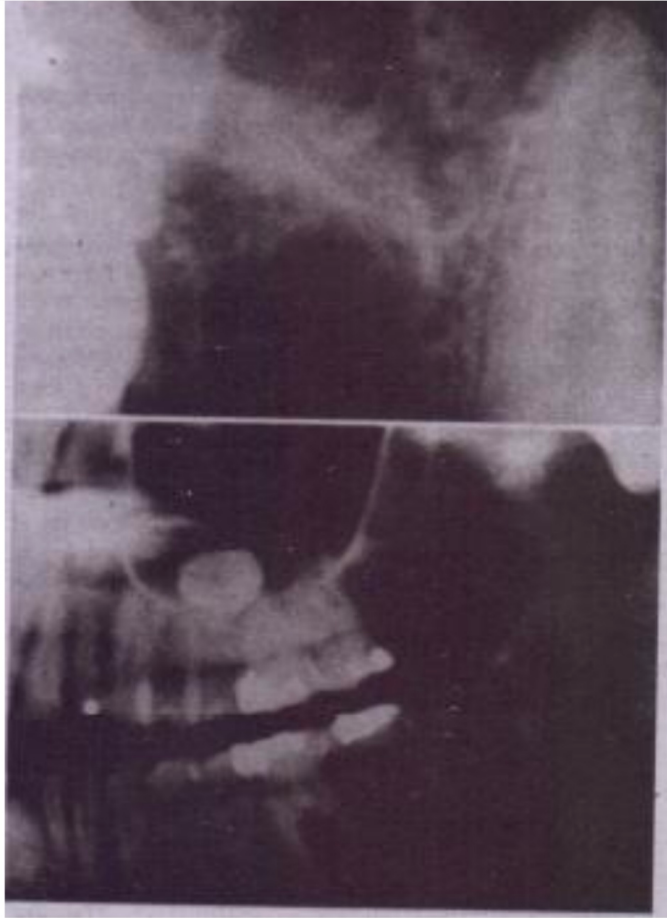
with apical pressures may be displaced through the lingual cortical plate and into the submandibular space. The lingual cortical bone over the roots of the molars becomes thinner as it progresses posteriorly.

Mandibular third molars, for example, frequently have dehiscence in the overlying lingual bone and may be actually sitting in the submandibular space preoperatively. Even small amounts of apical pressure result in displacement of the root into that space. Prevention of displacement

into the submandibular space is primarily achieved by avoiding all apical pressures when removing the mandibular roots. Pennant-shaped elevators, such as the Cryer, are used to elevate the broken tooth root. If the root disappears during the root removal, the dentist should make a single

effort to remove it. The index finger of the left hand is inserted onto the lingual aspect of the floor of the mouth in an attempt to place pressure against the lingual aspect of the mandible and force the root back into the socket. If this works, the surgeon may be able to tease the root out of the socket with a root tip pick. If this effort is not successful on the initial attempt, the dentist should abandon the procedure and refer the patient to an oral and maxillofacial surgeon. The usual, definitive procedure of

removing such a root tip is to reflect a soft tissue flap on the lingual aspect of the mandible and gently dissect the



, LARGE ROOT FRAGMENT DISPLACED INTO MAXILLARY SINUS.

FRAGMENT SHOULD BE REMOVED WITH CALDWELL-LUC APPROACH. 8,
TOOTH

IN MAXILLARY SINUS IS MAXILLARY THIRD MOLAR THAT WAS
DISPLACED INTO SINUS

DURING ELEVATION OF TOOTH. THIS TOOTH MUST BE REMOVED FROM



SINUS,

PROBABLY VIA A CALDWELL-LUC APPROACH.

overlying mucoperiosteum until the root tip can be found. As with teeth that are displaced into the maxillary sinus, if the root fragment is small and was not infected . preoperatively, the oral and maxillofacial surgeon may

elect to leave the root in its position, because surgical retrieval of the root may be an extensive procedure.

