

Day. MTWTFSS ✓

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Babar Paper Product

Checked By:.....Parents:.....Excellent Good Need Improvement

QNO: 4

Demonstrate the recent trend modification of oral screening?

ANSWER:-

MODIFICATION OF ORAL SCREENING:-

Oral screen is a myofunctional appliance introduced by Newell in 1912. It is a thin of acrylic base material which is fit into the buccal or labial vestibule of the mouth which acts as a screen between the teeth & the surrounding musculature. It is also known as vestibular screen.

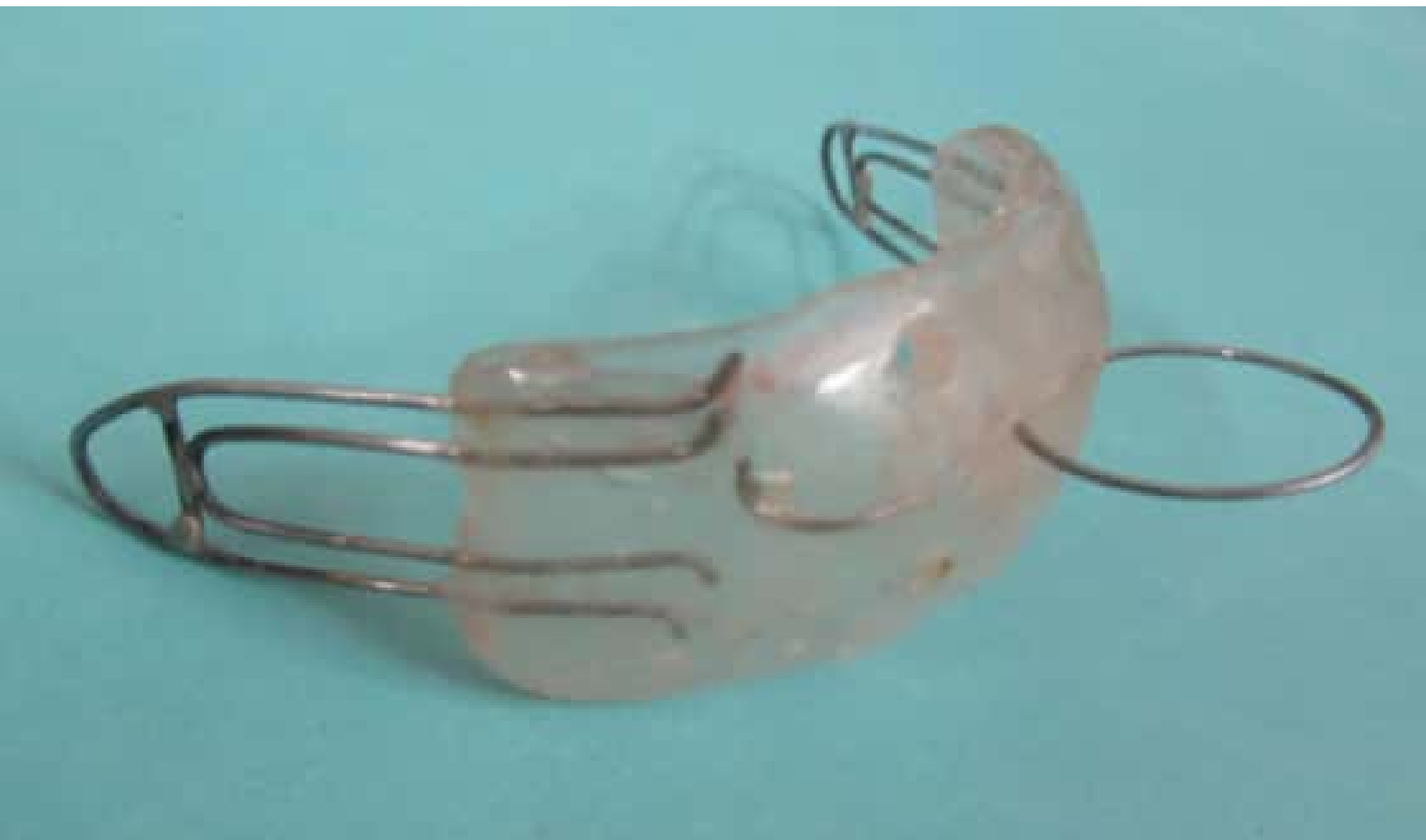




MODIFICATION:-

- 1- The oral screening can be fabricated by a metal ring projecting between the upper and the lower lip. This ring can be use to carry out various muscles exercises.
- 2- In patient who has tongue thrust habit and additional screen is placed to the lingual aspect the teeth.
- 3- In case of mouth breather the vestibular screen should be fabricated with a number of hole that are gradually closed in a phased manner.

ORAL SCREEN APPLIANCE:-



USES OF ORAL SCREENING:-

- The oral screen can be used for the correction of the following conditions
- 1- Thumb sucking, tongue thrusting and lip biting.
 - 2- Mouth breathing.
 - 3- Open bites in deciduous and mixed dentition.
 - 4- Incompetent Lips.

^AMANGEMENT:-

The patient should be asked to wear appliance at night and 2 to 3 hours during the day.

- Patient is instructed to maintain lip seal during the first day the patient may show the certain area.
- Breathing hole should be gradually reduced in size.





Q NO: 5

What is finger Springs?
Why Z spring is called
double cantilever spring?

ANSWER:-

FINGER SPRING:-

Palatal
finger springs are often used
in removable orthodontic
appliances to tip teeth in a
mesiodistal direction. The
purpose of this report is
to establish the magnitude
of forces for finger
springs made from differ-
ent types of wire (ie those
from different manufacturers
and to different diameters
and lengths).

Finger spring is also called
single cantilever spring as
one end is fixed in acrylic.

and the other end is free. It is constructed using 0.6mm wire. It consists of active arm of 12-15mm length, a helix of 3mm internal diameter and retentive arm 4-5mm length. It is used for mesio distal tooth movement with when teeth are located correctly in buccolingual direction. It is activated by moving active arm toward the teeth intended to be moved.



ACTIVATION OF PALATAL FINGER SPRING:-

Activation is achieved by pulling the spring away from the baseplate at an angle of approximately 45° ; which will tend to displace the appliance away from the palate; good anterior retention is therefore important.

Why Z spring is called double cantilever spring?

Z SPRING:-

The Z spring is also called double cantilever spring. It is made up of 0.5mm wire. The spring consist of two coil of very small internal diameter. It should be placed perpendicular to palatal surface of tooth.

QNO: 1

Describe the procedure for mandibular and maxillary uses of acrylic in activator.

ANSWER:-

USES OF ACRYLIC IN ACTIVATOR:-

It was first developed by William Clark in 1977. Originally, it was made of acrylic. Blocks cut at 45 degrees to the occlusal plane; this has since been modified to 70 degrees to provide better engagement of the blocks and more positive forward positioning. Forces are not applied directly to the upper incisors. Retention of the upper appliance is achieved by Adams corks on the maxillary

first premolars and first molars, typically made from 0.7mm stainless steel. Additional retention afforded by ball clasps on the lower incisors.

Activator appliance initially started out as one block of acrylic which fit in both maxillary and mandibular arch. The lower arch would see the horseshoe shaped lingual plate acrylic extending from distal of the last erupted molar.

In the upper arch, initially the anterior portion is covered from canine to canine, but that was later modified, as seen with appliances such as bionator appliance which is placed its emphasis on the tongue function.

Wire.

The wire components.

of activator included a labial bow which was usually placed 1mm away from the front incisors and extended from canine to canine. The bow would be 0.9-0.8mm thick.

Additional wire elements were later added to stabilize the appliance.

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QNO: 3

Summarize the division 1 and division 2 of the class II malocclusion?

ANSWER:-

CLASS II MALOCCLUSION:-
ON:-

A deep bite (also known as a type II malocclusion) is a condition in which the upper teeth overlap the lower teeth, which can

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result in hard and soft tissue trauma, in addition to an effect of appearance. It has been found in 15-20% of the US population.

OR:-

Class 2 malocclusion, called retrognathism or overbite, occurs when the upper jaw and teeth severely overlap the bottom jaw and teeth.

The mesiobuccal cusp of the lower first permanent molar occludes distal to the class I position.

CLASS II DIVISION 1

Condition when Class II molar relationship is present with proclined upper central incisors.

- There is an increase in overjet

Class II malocclusion



CLASS II DIVISION 1:

DENTAL FEATURES:-

Class II molar, canine and incisor relations

- Proclined maxillary incisors or normally inclined
- Increased overjet
- Open bite, normal overbite or deep bite.

Low-to moderate quality evidence suggests that providing early orthodontic treatment for children with prominent upper front teeth (class II division 1) is more effective for reducing the incidence of incisal trauma than providing one course of orthodontic treatment in adolescence. There do not appear to be any other advantages

of providing early treatment when compared to late treatment. Low quality evidence suggests that, compared to no treatment, late treatment in adolescence with functional appliances is effective for reducing the prominence of upper front teeth.





CLASS II DIVISION 2

Condition when class II molar relationship is present with retroclined upper central incisors, upper lateral incisors may be proclined or normally inclined.

- Overjet is usually minimal or may be increased.

- The upper central incisors show a lingual inclination and the lateral incisors overlap the central incisors.

Treatment can be undertaken using orthodontic treatments using dental braces. While treatment is carried out, there is no evidence from clinical trials to recommend or discourage any type of orthodontic treatment in children. A

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2018 Cochrane systematic review ~~anticip~~ anticipated that the evidence base supporting treatment approaches is not likely to improve occlusion due to low prevalence of the condition and the ethical difficulties in recruiting people to participate in a randomized controlled trials for treating this condition.

Q NO: 2

Illustrate the management of anterior cross bite?

ANSWER:-

ANTERIOR CROSS BITE:-

Anterior crossbite is defined as a malocclusion resulting from the lingual positioning of the maxillary anterior teeth in relationship to the mandibular anterior teeth.

- This condition is also referred to a "under-bite" or reversed overjet.

EXAMPLE OF CROSSBITE.-



MANAGEMENT OF ANTERIOR CROSSBITE:-

- The period of mixed dentition offers the greatest opportunity for occlusal guidance and interception of malocclusion.
- If delayed to a later stage of maturity treatment may become more complicated.

MANAGEMENT:-

① SKELETAL:-

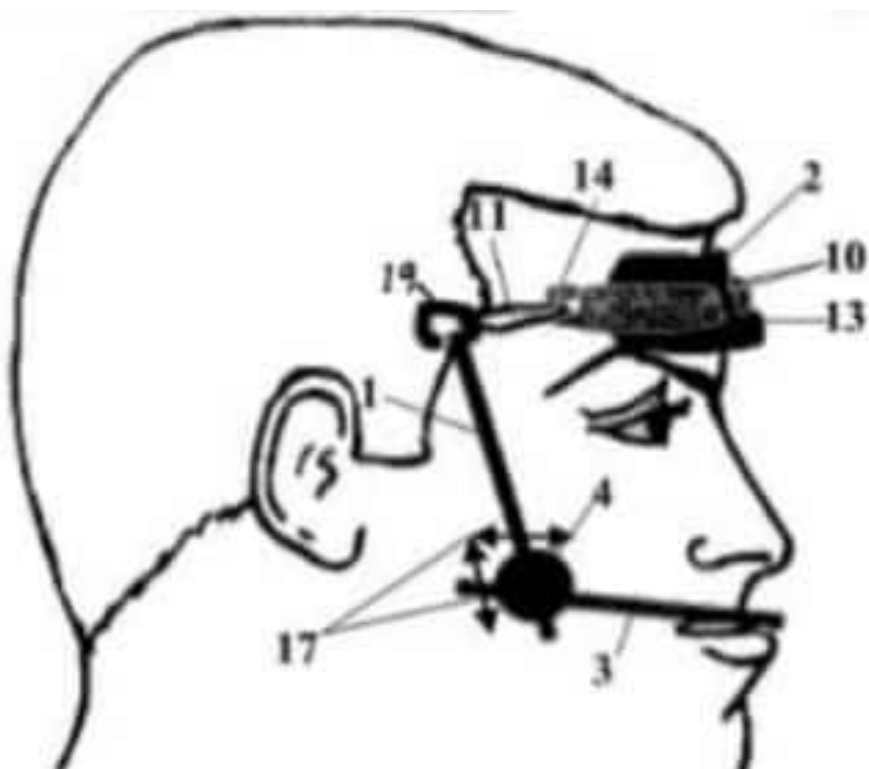
- Choice of treatment depends upon the cause:
- ① Skeletal: Can be controlled during growth by growth modification appliances, such as Protraction facemasks. Protraction facemasks therapy has advocated in the treatment of class III patients with maxillary deficiency.

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In skeletal factors were not managed during the growth period, an orthognathic surgery will need to be the alternative treatment modality.



MANAGEMENT:

2- DENTAL & FUNCTIONAL:-

Dental and Habitual Acts

- Bonded resin composite slopes.



MANAGEMENT:-

2- DENTAL & FUNCTIONAL:-

• REVERSED STAINLESS STEEL CROWNS:-

The chief disadvantages of this method is the difficulty in adapting a preformed crown to fit the tooth in crossbite.

• Furthermore, the reversed stainless steel crown is an unaesthetic treatment that is often rejected by children and their relatives.

• Removable acrylic appliances with posterior bite opening platforms and anterior finger springs for labial tipping of maxillary teeth.



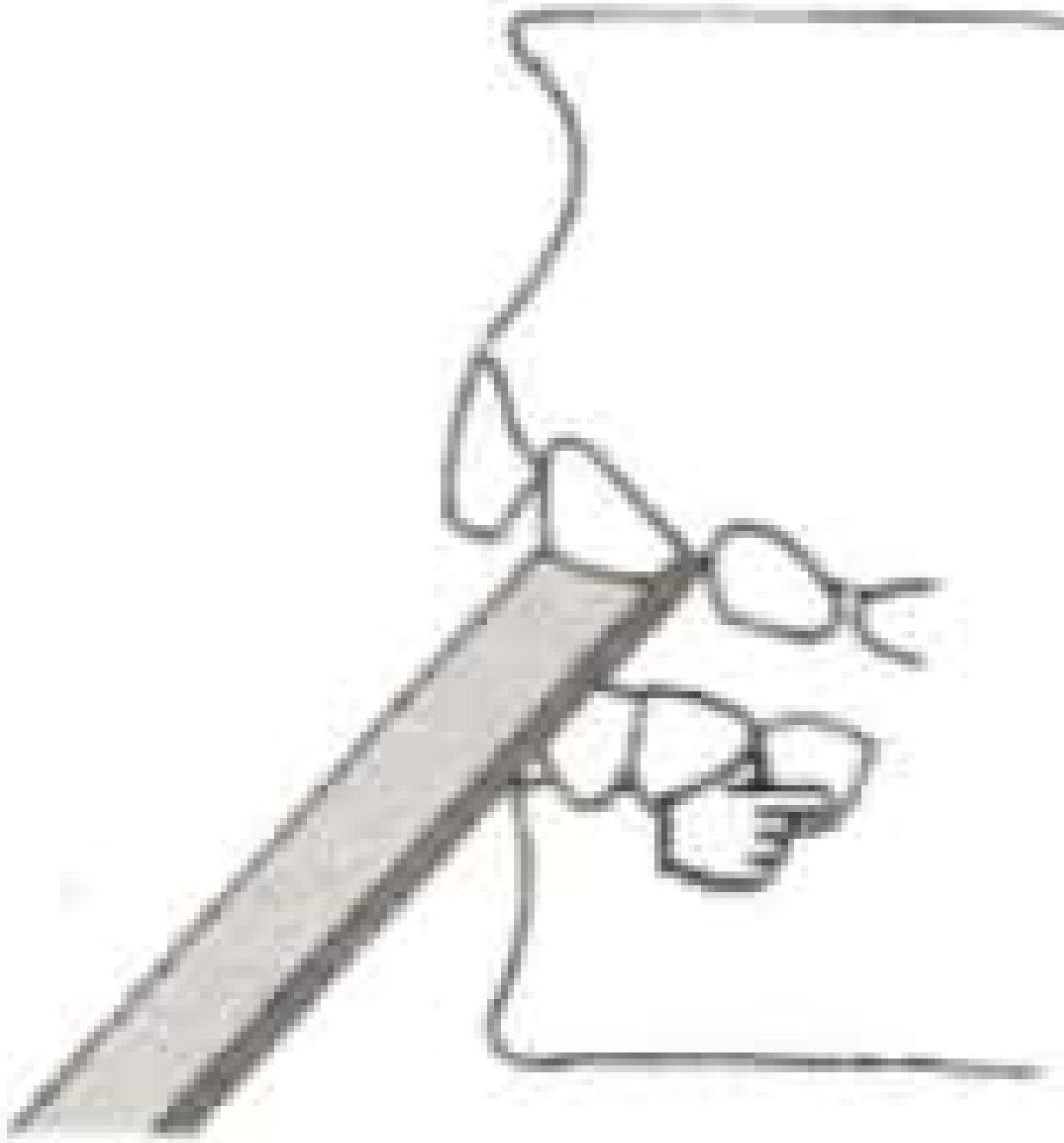


• TONGUE BLADE / DEPRESSOR

The tongue blade can also be an effective method of treatment during the early phase of eruption; however, however, it requires total cooperation from the patient, which in most ~~most~~ most cases is difficult to obtain.

~~LOWER~~





• LOWER ACRYLIC INCLINED BITE PLANE:-

It is another effective treatment method; however, it requires a laboratory phase, which increases the price of treatment, and the cement used with this type of appliance may cause gingivitis.

- Conventional orthodontics
- Screw appliances
- Removal of occlusal discrepancies.
- Extraction of supernumerary teeth.



