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Program. bs (D.T)

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Paper operative Dentistry

Exam final

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(1)

Q No(1)

AMS

(A) possible outcome for mixed root
Carot.

- Apical periodontitis.
- Infection will continue
- formation of painful abscess.
- Tenderness
- Swelling of the gum overlapping the roots.
- Increase mobility.
- Presence of pus in sinus.
- Sensitivity.

(b) procedure of broken file
in the canal.

Management:-

- Remove the fragment.
- Bypass the fragment.
- Cleaning & Shaping root canal up to the level of fragment.

⇒ use of chemical solvent like

EDTA → to achieve intentional corrosion of metal objects.

→ use of mini forceps.

→ Steiglitig forcep

→ peet silver point.

→ endo forcep.

→ use of wire loops

→ use of hypodermic surgical needles

→ binding of endodontic files.

→ use of endo extractor

→ use of endo extractor kit

→ Endo - Rescue.

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① No ②

Axis History Diagnosis.

Clinical Steps →

- Administration of local Anesthesia.
- placement of Rubber dam (Isolated)
- Access the Cavity - Remove carious lesion.
- Shaping of the Root Canal.
- the diseased & dead pulp tissue should be remove.
- Irrigation → NaOCl, EDTA, CHX, MTAD, IICJ
- Disinfection & clean.
- obturation → gutta percha, silver cones.
- A Temporary & or permanent filling should be placed.
- Medication.
- Crowning of tooth.
- Cavity preparation.

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Q No 3(3)

Ans:→

if there is an open apex
i.e immature tooth first thing
first you have to know
the pulp status, if the
pulp is reversibly inflamed
we perform vital pulp therapy
like pulp capping direct/
indirect or more so pulpotomy
but if pulp is irreversibly
inflamed or necrotic then we
perform apexification or revas-
cularization.

you just cant skip to apex
apexification with out knowing
the pulp status.

there are two steps to
perform this procedure:→

the first step is to disinfect
the canal space & the 2nd
is to stimulate the apical
barrier formation. disinfection is
achieve by placing a
relatively thin mixture
less than tooth past thick
of calcium hydroxide powder
mixed with 0.12% chlorhexidine
solution.

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Used for material-

→ Calcium hydroxide.

→ Collagen calcium phosphate gel.

→ Mineral Trioxide Aggregate.

→ osteogenic protein 1 & 11.

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Q No (4)

Ans.

Types of partial:

(1) mucosal Contact.

→ Ridge lap.

→ modified ridge lap

→ ovate

→ conical

(2) Non mucosal Contact.

→ Sensation (hygienic)

→ modified sensitivity

* Ridge lap:

The saddle or ridge lap partial has a concave fitting surface that overlaps the residual ridge buccolingually simulating the ~~continuous~~ contours & emergence profile of the missing tooth on both side of the residual ridge.

* Modified ridge lap partial.

The modified ridge lap partial combines the best features

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of hygienic & saddle pontic design
Combining esthetic with
Easy cleaning.

→ the modified ridge lap design
overlap the residual ridge on
the facial to achieve the
appearance of a tooth.

* Ovate pontic.

The ovate pontic is the most
esthetically appealing pontic design
its convex incisal surface
residence in a soft tissue depression
or hollow in the residual ridges
which make it appear that
a tooth is laterally emerging
from the gingival. Careful treatment
planning is necessary for successful
result.

* Conical pontic.

→ often called egg shaped,
bullet shape or heart shaped.
The conical pontic is easy
for the posterior to keep
clean. It should be
made as convex as
possible with only one point
of contact at the contact.

(8)

of the residual ridge. This design is recommended for the replacement of mandibular posterior teeth.

* ~~A~~ Non mucosal Contact :->

(1) Sanitary or hygienic pontic :->

⇒ Zero tissue contact
⇒ ~~occlusal gingival thickness~~ should be at least
⇒ occlusal gingival thickness should be at least 3mm.

⇒ Convex mesiodistally & faciolingually.

⇒ space beneath the pontic 2mm (bebe)
⇒ 3mm (Ty/nen)

(2) Modified Sanitary Pontic :->

gingival portion is shaped like a concave archway mesiodistally between the retainer & convex faciolingually.

⇒ Allow increase connector size while decrease the stress contracted in the pontic & connectors

⇒ Recommended for mandibular posterior.

Q No (5)

Ans of bridge.

A bridge is a fixed dental restoration used to replace one or more missing teeth by joining an artificial tooth definitively to adjacent teeth or dental implants.

Types of bridge:-(1) Fixed bridge:-

A fixed bridge is refers to a pontic which is attached to a retainer at both side of the space which is only one path of insertion this type of a design has a rigid connector at each end which connects the abutment to the pontic. As the abutment are connected together rigidly it is critical that during tooth preparation the proximal surface of the abutment tooth must be prepared so they are parallel to each other.

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* fixed movible bridge.

it has a ridge connector usually at the distal end of the pontic & a movable connector that allows some vertical movement of the mesial abutment tooth. This enables a more conservative approach as the abutment do not need to be prepared so that are parallel to one & other

→ Ideally the ~~rigid~~ rigid connector should attach the pontic to the more distal abutment.

* Conflivier bridge :-

it is the kind of minimal preparation bridge it provided support for the pontic at one end only, the pontic may be attached so a single retainer splinted together.
e.g. Maryland bridge, rockle bridge.

* Spring Conflivier bridge :-

they are restricted to the replacement of upper incisor only one pontic could be support by a spring conflivier bridge.