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Q3.

Ans:⇒ Division 1 of class II mal-occlusion :⇒

⇒ The class II, division-I malocclusion is characterized by proclined upper incisors with a resultant increase in overjet

⇒ A deep incisor overbite can occure in the anterior region. A characteristic feature of this malocclusion is the presence of abnormal muscle activity.

⇒ The upper lip is usually hypotonic, short and fail to form a lip seal.

⇒ The lower lip cushions the palatal aspect of the upper teeth, a feature typical of a class II, division I referred to as 'lip trap'.

⇒ The Tongue occupies a lower posture Thereby failing to countrect the buccinator activity.

⇒ The unrestrained buccinator activity result in narrowing of the upper arch at the premolar and canine region Thereby producing a V-shaped upper arch. Another muscle - aberration is a hyperactive mentalis activity.

⇒ The muscle imbalance is produced by a hyperactive buccinator and mentalis and an altered tongue position The accentuates the narrowing of the upper dental arch.

* Class II division 2 :-

↳ As in Class II, division 1 malocclusion, the division 2 also exhibits a class-II molar relationship.

⇒ The classic feature of this malocclusion is the presence of lingually inclined upper central incisors and labially tripped upper lateral incisors overlapping the central incisors.

⇒ Variations of this form are lingually inclined central and lateral incisors with the canines labially tripped.

⇒ The patient exhibits a deep anterior overbite.

⇒ The lingually inclined upper centrals give the arch a squarish apperance, unlike the narrow V-shaped arch

(4)

Seen in division 1.

⇒ The mandibular labial gingival tissue is often traumatized by the excessively tripped upper central incisors.

⇒ The patient exhibits normal backward path of closure may also be present due to the excessively tripped central incisors.

Q5

Ans :- Finger Spring :-

↳ Finger spring 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 different types of wire ie those from different manufacturers and of 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 consist of active arm of 12-15 mm length, a helix of 3mm internal diameter and retentive arm of 4-5 mm

length. It is used for mesio-distal tooth movement when teeth are located correctly in bucco lingual direction.

⇒ it is activated by moving active arm toward the teeth intended to be moved.

* Why Z Spring is called double cantilever spring :⇒

⇒ Z Spring the Z Spring is also called a cantilever spring.

⇒ It is made up of 0.5 mm wire.

⇒ The Spring consist of two coil of very small internal diameter.

⇒ it should be placed — perpendicular to palatal surface of tooth.

⇒ The spring can be made for movement of single —

incisor or two incisor.

⇒ It is activated by opening helices by about 2-3 mm at a time.

Q2

Ans:- Management of Anterior - cross bite :⇒

⇒ The period of mixed dention offers the greatest opportunity for occlusal guidance and interception of malocclusion.

⇒ If delayed to a later stage of maturity, treatment may become more complicated.

① Skeletal :⇒

Choice of treatment depends upon the cause :⇒

* Skeletal :⇒

↳ Can be Controlled - during growth by growth - modification appliance such as protraction facemasks.

⇒ protraction Facemask therapy has been advocated in the treatment of class III palient with maxillary deficiency.

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

(2) Dental and Functional :⇒

* Dental and Habitual Acts :⇒

⇒ Bonded resin - composite - slopes.

- Removable acrylic appliances :⇒ with posterior bite opening -

platform and anterior finger-springs for labial tipping of maxillary teeth.

~~Focus~~

* Tongue Blade / Depressor :⇒

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

* Lower acrylic inclined bite plane 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.

Q1

Ans:⇒ Procedure of mandibule and maxilla of acrylic-activator:⇒

⇒ 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, intially the anterior portion is covered from canine to canine, but that was later modified, as seen with appliances such as

Bionator appliance which placed its emphasis on the tongue function.

Q4:-

Ans:- * Modification of oral screen :-

⇒ The oral screen can be fabricated with metal ring projecting between the upper and lower lip.

⇒ This ring can be used to carry out various muscle exercise.

⇒ In the patient who have tongue thrast bite and additional screen is attached to the vastibular screen should be by meant of

a Thick wire that runs throughbit in the leteral incisor region.

⇒ In case of mouth breather the vestibular screen should be fabricated with a number of holes that are gradully closed in a phased — manner.

⇒ Correction of mouth breathing

⇒ correction of tumb Sucking tongue thrusting, lip biting cheek biting.

⇒ mild protrusion of upper anterior with spacing and incomplete bite.

⇒ Disto - occlusion with premaxillary protrusion and

open bite in deciduous and mixed dentition.

⇒ In the presence of fluid hypotonic orofacial musculature as muscle excersire.

⇒ To correct mild anterior proclination.