Comprehensive treatment - Full Mouth Rehabilitation case

By

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Personal Data

Name: A. N. A
Age: 60 years (30/03/1958)
Gender: Female
Nationally: Libyan
Occupation: house wife
Material & Society: mother
Chief complaint & History of Chief complaint

Chief complaint :-
pain in the lower front left side since 2 days

History of Chief Complaint:-
moderate to severe , continues throbbing pain in the lower anterior left side since 2 days , exacerbated by sweet and cold drink , pain grade 7 from 10 cause sleep disturbance and relief by ketofan 4 tab per day , headache , no swelling , no sins , no associated phenomena .
Medical history : N.O.S
Drug history : N.O.S
Allergic history : N.O.S
Family history : her mother was diabetic
Social history : married, Mother of six daughters and four sons, Not smoker neither alcohol drinker or drug abuser.
Dental history

last visit 1 year ago for extraction, without complication

Oral hygiene practice:
Brushing: once a day regularly
Brushing method: horizontal and vertical
Extra-oral examinations

Lips: competent.
No swelling or sinus.
Symmetrical face with no facial deformity
Skin: NAD.
TMJ status:
  examination reveals no clicking, crepititation, limitation or deviation of mouth opening, with no masticatory muscles tenderness.
Lymph nodes:
  not palpable, neither tender.
Intra-Oral Examination:

- No halitosis
- Fair oral hygiene
- Tongue : NAD
- Cheeck : NAD
- Floor of the mouth : NAD
- Oral mucosa and tongue : NAD
Clinical examination for the offending tooth revealed badly decayed tooth. Which is not tender to vertical percussion, but sensitive to ethylene cold test and not tender to palpation.
Differential Diagnosis of Chief Complaint:

- Acute irreversible pulpitis
- reversible pulpitis
Intraoral Periapical radiograph:-

IOPA on the lower left 4 showe large radiolucent area in the crown proximal to the pulp, normal per apical area and slightly waidding in PDL space
Periodontal health

- Normal gingival reddish pink color, with normal scalloped margin and There is normal stippled gingivae, exhibit some gingival oedema with blunt IDP.
- There is generalized bleeding on probing.
- Probing depth with a range from 0.5 to 3.
- Lose of attachment 1 to 3 mm.
- There is a recession.
- No mobility.
Final diagnosis : -

1. Acute irreversible pulpitis

1. dentinal caries

1. 3- generalized mild to moderate chronic periodontitis with generalized horizontal bone lose

2. 4- cannady class 2 M (1) in lower, class3 M (1) in upper
Treatment plan

Emergency phase: pulp extirpation

Phase I: O.H instruction, scaling & root planning
Reevaluation of phase I

Phase II: 75421 | 457
Phase III: restoration | 7 | 4, RCT | 4

Post core and PFM Crown | 4, RPD | 6 54 | 567
Phase IV: reevaluation
Emergency phase:

- Pulp extirpation and estimation of working length
Phase I

- O.H instruction, full prio chart, scaling & root planning, Reevaluation of phase I, diet sheet
Reevaluation of phase I
P.t was satisfied and the inflamed gingiva is decreased.
No plaque or calculus present.
Probing depth is decreased.
Attachment loss decreased with in 0.5 to 1 mm gaining attachment.
Phase II

- Surgical phase which is Not indicated in this case
Phase III

Part 1 Restoration of carious teeth.

- RCT for the complaining tooth 4
- Final working length (23mm) – cleaning and shaping with pro taper file
- Obturation with (F2 GP) and G.I.C resoration
- Restoring of decayed teeth
part 2 transient RPD for upper and lower

- Primary alginate impression of upper and lower arch
Final impression for the lower arch
- jaw relation, bit registration, shade A2
Try in
Insertion
Part 3 Post core crown for the RCT tooth
Post preparation
Cementation of fiber post
Core build up
Crown preparation
Temper crown
Final impression

- using double mix.
- one step technic
Metal try in
Shade selection

- Was A2
Incomplete setting of the crown

- due to over contour of the proximal contact
After the adjustment

- The crown was completely setting
Trial cementation
Final cementation
Phase IV

- recall and Follow up for maintenance
- Reevaluation
- Gingival health within normal, no signs of inflammation or active disease.
Thank You