





























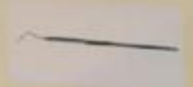


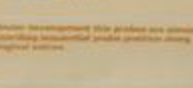





PG POSTERS

PERIODONTAL PROBES

PERIODONTAL PROBES

Definition:- Periodontal probe is a diagnostic instrument, which is tapered, rod like, calibrated in millimeters, with a blunt, rounded tip that is used to locate, measure and mark pockets as well as determine their course on individual tooth surface.

GENERATION	PROBES	BASIC DESIGN	ADVANTAGES	DISADVANTAGES
1 st (CONVENTIONAL)	 <p>Most common markings of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Simple & easy to use Accurate Low cost Wide availability 	<ul style="list-style-type: none"> Time consuming Subjective Operator dependent
2 nd (CONSTANT PRESSURE)	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Easy to use Low cost 	<ul style="list-style-type: none"> Time consuming Subjective
3 rd (AUTOMATED)	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Easy to use Low cost 	<ul style="list-style-type: none"> Time consuming Subjective
4 th (3 DIMENSIONAL PROBE)	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Easy to use Low cost 	<ul style="list-style-type: none"> Time consuming Subjective
5 th (ULTRASONIC)	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Easy to use Low cost 	<ul style="list-style-type: none"> Time consuming Subjective
DIAMOND PROBE	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Easy to use Low cost 	<ul style="list-style-type: none"> Time consuming Subjective
PERIOTEMP PROBE	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Easy to use Low cost 	<ul style="list-style-type: none"> Time consuming Subjective


PREPARED BY: RITU JOSHI, PARI JALAVADIA, HARDIK KACHHADIA, MONIKA JANI, AMI ALWANI, AMBARISH JETHWANI

DEPARTMENT OF PERIODONTOLOGY
3rd B.D.S. (2009-'10)

CURETTES

CURETTES

"INSTRUMENT USED FOR REMOVING DEEP SUBGINGIVAL CALCULUS, ROOT PLANING FOR ALTERED CEMENTUM AND REMOVING THE SOFT TISSUE LINING OF THE PERIODONTAL POCKET."
EACH WORKING END HAS A CUTTING EDGE ON BOTH SIDES OF THE BLADE AND A ROUNDED TOE.




Spoon shaped blade
Rounded tip

Basic characteristics of curettes

CLASSIFICATION

UNIVERSAL CURETTES


- Universal curettes have cutting edges that may be inserted in most areas of dentition by altering and adapting the finger rest, fulcrum and hand position of the operator
- The blade size and the angle and length of the shank may vary but the face of the blade of the every universal curette is at a 90 degree angle



AREA SPECIFIC CURETTES


GRACEY CURETTES

- They are designed and angled to specific anatomic areas of dentition
- Gracey #1-2: anterior teeth
- Gracey #3-4: anterior teeth facial & lingual
- Gracey #7-8: posterior teeth: mesial
- Gracey #11-12: posterior teeth: distal




AFTER FIVE CURETTES

- They are a modification of gracey curette which permits deeper periodontal pocket insertion and smoother sub-gingival insertion.
- The terminal shank 3mm longer allowing extension into deeper periodontal pockets of 5mm or more




MINI BLADED CURETTES (HU-FRIEDY MINI FIVE CURETTES)

- They are modification of extended shank curettes for easier insertion and adaptation in deep, narrow pockets, furcation, developmental grooves, line angles and developmental grooves.



LANGER AND MINI LANGER CURETTES

- They are combination of gracey and universal curettes design to allow the advantages of the area specific shank to be combined with the versatility of universal curettes



Gracey curettes	Universal curettes
They are designed for specific areas and surfaces.	They are designed for all areas and surfaces
One cutting edge used.	Both cutting edges used
Curved into two planes.	Curved into one plane.
Face of blade beveled at 60 to shank.	Face of blade beveled at 90 to shank.

DEPARTMENT OF PERIODONTOLOGY
3RD BDS
YEAR 2009-10

PREPARED BY:
KINJAL SHAH MANSI SHAH
KUSHAN SHAH JIQAR SHAH
PARTH SHAH ARJAV SHUKLA

FURCATION INVOLVEMENT

Furcation Involvement


- Furcation:** Furcation is an anatomical area of multi-rooted teeth where the roots divide.
- Furcation Involvement:** Furcation Involvement refers to invasion of bifurcation or trifurcation of multi-rooted teeth by periodontal disease.

Classification

Based up on "Horizontal Bone Loss" by Glickman


Grade I

- This is the earliest or early lesion.
- The period is supragingival throughout.
- There is slight bone loss in furcation area.
- The radiographic change occur about one mm below the crest.



Grade II

- In this type of lesion involvement, the horizontal level is completely absent but the hard & bony surface of the furcation are involved by original lesion.
- Therefore it is not visible clinically.
- There may be a crater like lesion in the area.
- Occular depression of apex or vertical probing with tendril or horizontal component of wire loop.



Based up on "Vertical Bone Loss" by Tarnow & Fletcher

Grade A

- It indicates a vertical height of 1-3 mm.

Grade B

- It indicates a vertical height of 4-6 mm.

Grade C

- It indicates a vertical height of more than 7 mm.


Signs & symptoms:

- The denuded bifurcation or trifurcation may be visible or may be obscured by the inflamed wall of the periodontal probe.
- The tooth may or may not be mobile & is usually symptom free, but there may be painful complication.
- This includes sensitivity to thermal change caused by caries or lacunar resorption of the root in the furcation area.
- Recurrent or constant throbbing pain caused by pulp changes and sensitivity to percussion caused by acute inflammatory involvement of periodontal ligament.


Diagnosis:

The diagnosis of furcation involvement is made by dental examination, radiographic examination & by careful probing by nabers probe.

Nabers probe:



Nabers probe in the furcation area:



Department Of Periodontia,
College of Dental Sciences & Research Centre,
Bopal,

3rd BDS
Year 2009-10

Prepared by:
Shapath Pujara, Mira Ramdevputra,
Urvi Patel, Niyati Raval,
Nirav Patel, Rahul Santoki

PERIODONTAL POCKET

THE PERIODONTAL POCKET

DEFINITION :- A periodontal pocket is a pathologically deepened gingival sulcus.

CLASSIFICATION :-

1) Depending upon the morphology:-

- Gingival pocket (False/Relative)** - It is formed by gingival enlargement without destruction of underlying periodontal tissue.
- Periodontal pocket (Absolute/True)** - It is formed by destruction of supporting periodontal tissue.
- Combined pocket** - It is formed by both type of pockets.

2) Depending upon its relationship to crestal bone:-

- Suprabony pocket (Supracrestal, Supraalveolar)** - The bottom of the pocket is coronal to underlying alveolar bone.
- Infrabony pocket (Infrabony, subcrestal)** - The bottom of the pocket is apical to level of adjacent alveolar bone.

3) Depending upon numbers of surfaces involved:-

- Simple pocket** - One tooth surface is involved.
- Compound pocket** - Two or more tooth surfaces, base of the pocket is in direct communication with gingival margin along each of surfaces.
- Complex pocket** - Spiral type of pocket, originates on one tooth surface & twist around tooth to involve one or more additional surfaces.

4) Depending upon the nature of soft tissue wall:-

- Fibrotic pocket**
- Edematous pocket**

5) Depending upon the disease activity:-

- Active pocket**
- Inactive pocket**

Clinical photographs :-

CLINICAL SIGNS OF PERIODONTAL POCKET :-

1. Enlarged bluish red marginal gingiva with a "Rolled" edge separated from tooth surface.
2. A reddish-blue vertical cone extending from the gingival margin to the attached gingiva and sometimes into the alveolar mucosa.
3. A break in the fasciolingual continuity of the interdental gingiva.
4. Shiny, discolored and puffy gingiva associated with exposed root surfaces.
5. Gingival bleeding.
6. Purulent exudates of gingival margin or its appearance in response to digital pressure on the lateral aspect of the gingival margin.
7. Looseness, extrusion and migration of teeth.
8. The development of diastemata where none had existed.

CLINICAL SYMPTOMS OF PERIODONTAL POCKET :-

Periodontal pockets are generally painless but gives following symptoms:-

1. Localized pain or a sensation of pressure after eating which gradually diminished.
2. A foul taste in localized areas.
3. A tendency to suck material from the interproximal spaces.
4. Radiating pain "Deep in the bone."
5. A "Gnawing" feeling or feeling of itchiness in the gums.
6. The urge to fit a pointed instrument into the gum with relief obtained from the resultant bleeding.
7. Complaints that food "sticks between the teeth" or teeth "feel loose" or a preference to "Eat on the other side."
8. Sensitivity to heat and cold, toothache in the absence of caries.

DEPARTMENT OF PERIODONTICS
3rd YEAR (2009-2010)

PREPARED BY: SHIOCHI SHAH BHATTI RIDDHI SANJAY AGRAWAL
BHADYADRA CHARJIE BUCH KAMYA DHIRUV CHAUHAN

GINGIVAL ENLARGEMENT



CLINICAL FEATURES OF GINGIVITIS

CLINICAL FEATURES OF GINGIVITIS

DEFINITION:- PRESENCE OF INFLAMMATION THAT IS CONFINED TO GINGIVA ONLY




ACCORDING TO COURSE AND DURATION :-

1. **ACUTE GINGIVITIS :-** SUDDEN ONSET & SHORT DURATION AND CAN BE PAINFUL
2. **CHRONIC GINGIVITIS :-** SLOW ONSET & LONG DURATION, GENERALLY PAINLESS
3. **RECURRENT GINGIVITIS :-** REAPPEARS AFTER HAVING BEEN ELIMINATED BY TREATMENT





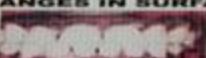







ACCORDING TO TOOTH OR GROUP OF TEETH INVOLVED :-

1. LOCALIZED
2. GENERALIZED

ACCORDING TO GINGIVAL AREA INVOLVED :-

1. **MARGINAL:-** CONFINED TO MARGINAL GINGIVA

2. **PAPPILARY:-** CONFINED TO ONE OR MORE INTERDENTAL SPACES

3. **DIFFUSE:-** EXTENDS FROM THE MARGINS TO THE MUCOBUCCAL FOLD


CLINICAL FEATURES OF GINGIVITIS

<p>1. GINGIVAL BLEEDING ON PROBING :-</p>   <p>- EARLIEST VISUAL SIGN OF INFLAMMATION - IT MAY BE CHRONIC, RECURRENT OR SPONTANEOUS</p>	<p>2. COLOR CHANGES IN GINGIVA :-</p>   <p>- NORMAL COLOR - CORAL PINK - IN ACUTE GINGIVITIS - BRIGHT RED OR REDDISH PINK - IN CHRONIC GINGIVITIS - BLuish RED OR PINKISH RED</p>
<p>3. CHANGES IN SURFACE TEXTURE :-</p>   <p>- LOSS OF STIPPLING IS AN EARLY SIGN OF GINGIVITIS - IN CHRONIC GINGIVITIS - IT MAY BE SMOOTH & SHINY OR FIRM & NODULAR</p>	<p>4. CHANGES IN CONSISTENCY OF GINGIVA :-</p>   <p>- NORMAL CONSISTENCY - FIRM AND RESILIENT - IN ACUTE GINGIVITIS - SOFTENING & DIFFUSE PUFFINESS - SLOUGHING MAY BE SEEN - IN CHRONIC GINGIVITIS - SOGGY PUFFINESS, MAY BE FIRM & LEATHERY</p>
<p>5. CHANGE IN CONTOUR OF GINGIVA :-</p>   <p>- NORMAL CONTOUR - SCALLOPED AND MARGINS ARE KNIFE EDGED - IN GINGIVITIS - MARGINAL GINGIVA BECOMES ROLLED OUT AND INTERDENTAL PAPPILA BECOMES BLUNT AND FLAT</p>	<p>6. CHANGE IN POSITION OF GINGIVA :-</p>   <p>- NORMALLY THE GINGIVAL MARGINS LIES AT OR SLIGHTLY CORONAL TO THE CEMENTO ENAMEL JUNCTION - IN RECESSION - THERE IS EXPOSURE OF ROOT SURFACE BY AN APICAL SHIFT IN POSITION OF GINGIVA</p>

COLLEGE OF DENTAL SCIENCES & RESEARCH CENTRE
DEPARTMENT OF PERIODONTOLOGY


NIMESH PATEL & VANDI PATEL
IIIRD B.D.S. 2008-09

CLINICAL FEATURES OF HEALTHY GINGIVA

CLINICAL FEATURES OF HEALTHY GINGIVA

GINGIVA: IT IS A PART OF ORAL MUCOSA THAT COVERS THE ALVEOLAR PROCESSES OF THE JAWS & SURROUNDS THE NECKS OF THE TEETH





INTERDENTAL GINGIVA
MARGINAL GINGIVA
ATTACHED GINGIVA



NORMAL GINGIVA
PARTS OF GINGIVA
SULCUS DEPTH

MARGINAL GINGIVA: IS TERMINAL EDGE OF THE GINGIVA SURROUNDING THE TEETH IN COLLARLIKE FASHION
ATTACHED GINGIVA: IS CONTINUOUS WITH THE MARGINAL GINGIVA, WHICH IS FIRM & RESILIENT
GINGIVAL SULCUS: IS 'V' SHAPED CREVICE BOUNDED BY TOOTH & EPITHELIUM LINING ON EACH SIDE
INTERDENTAL GINGIVA: OCCUPIES THE GINGIVAL EMBRASSURE & IT CAN BE PYRAMIDAL OR TENT SHAPED

CLINICAL FEATURES

COLOR	CONTOUR	CONSISTENCY	SURFACE	POSITION	
					
CORAL PINK	MELANIN PIGMENTATION	SCALLOPED & KNIFE EDGE MARGIN	FIRM & RESILIENT	STIPPLED	AT OR 1MM ABOVE THE CEJ

DEPARTMENT OF PERIODONTOLOGY RINAL PATEL, ANKITA PATEL (3RD YEAR, 2008-09)

DENTAL IMPLANTS

Do you avoid laughing aloud, smiling or eating in Public???

because

- Your denture may slip
- Space left by your missing teeth

If yes!!!

Dental IMPLANTS will give you CONFIDENCE

IMPLANTS Feel Like Natural Teeth

Your natural teeth are stable biting and chewing surfaces because they are supported by your jawbone. This will also be true of your dental implant. Successful dental implant becomes firmly embedded in the jaw, providing a chewing surface as secure that of natural teeth.

Natural Teeth
Roots Hold Crowns

The crown is the tooth's hard surface which is visible above the gum line.

The root is the supportive base of your tooth and is fixed in the jawbone.

The ligaments are tough fibers that fasten the root to the jawbone.

Dental Implants
Implants Hold a Prosthesis

The prosthesis is the artificial crown which is stable above the gumline.

The abutment is the small post-like metal that connects the prosthesis to the implant.

The implant is the supportive base of the prosthesis that becomes fixed in the jawbone under the gum line.

ORALTRONICS

**NOVO
Dental**

147 Parkway Avenue, Suite 101
 RR1, Linton, Ontario, Canada L0K 1S0
 Near H&W T.V. Off Hwy 10, Linton
 Australia (Ph): (08) 8388 2222 Fax: (08) 8388 2222
 Email: implant@oraltronics.com.au Web: www.oraltronics.com.au




POST OPERATIVE INSTRUCTIONS

DEPARTMENT OF PERIODONTOLOGY

ઓપરેશન પછીની સૂચનાઓ

POST OPERATIVE INSTRUCTIONS

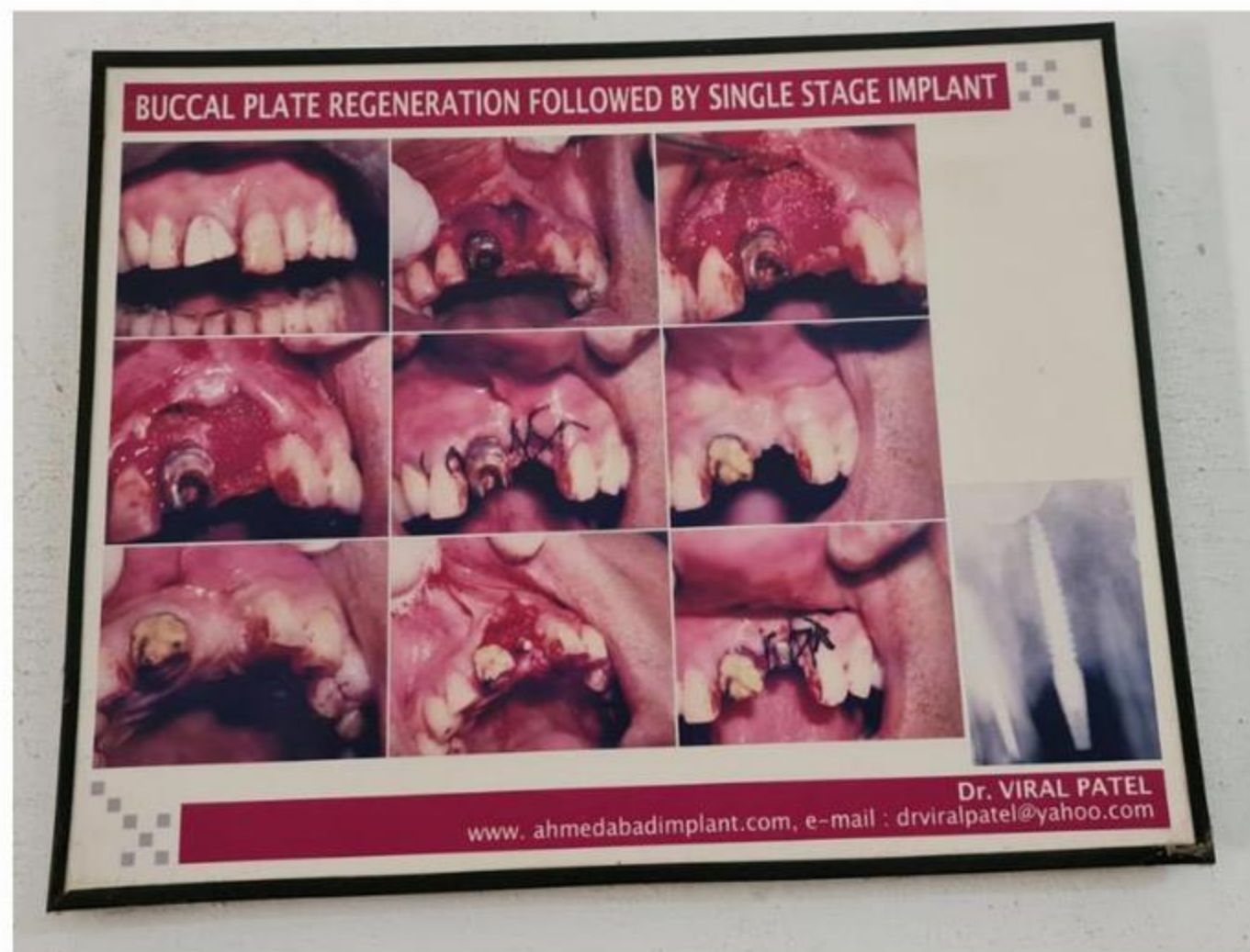
- You will experience numbness in the operated area for 1½ hrs due to the effect of anesthesia.
- Do not spit or gargle for the next 24 hrs.
- It is okay if your spit is streaked with blood for the next 4-5 hrs., but if it persists/increases, consult your doctor.
- Apply ice pack on operated area from outside for next 12 hrs.
- Post operative swelling will resolve within 3-4 days. Consult the doctor if it persists/increases.
- Do not brush teeth for next 24 hours. After 24 hrs., brush properly in all areas except the operated area, resume normal brushing after 2-3 days with 0.2% chlorhexidine mouthwash.
- Avoid hot and hard food for the next 24 hours, take care not to injure the operated area.
- Do not consume bidi/cigarette/pan masala after surgery.
- Follow up with your doctor after 7 days of surgery.



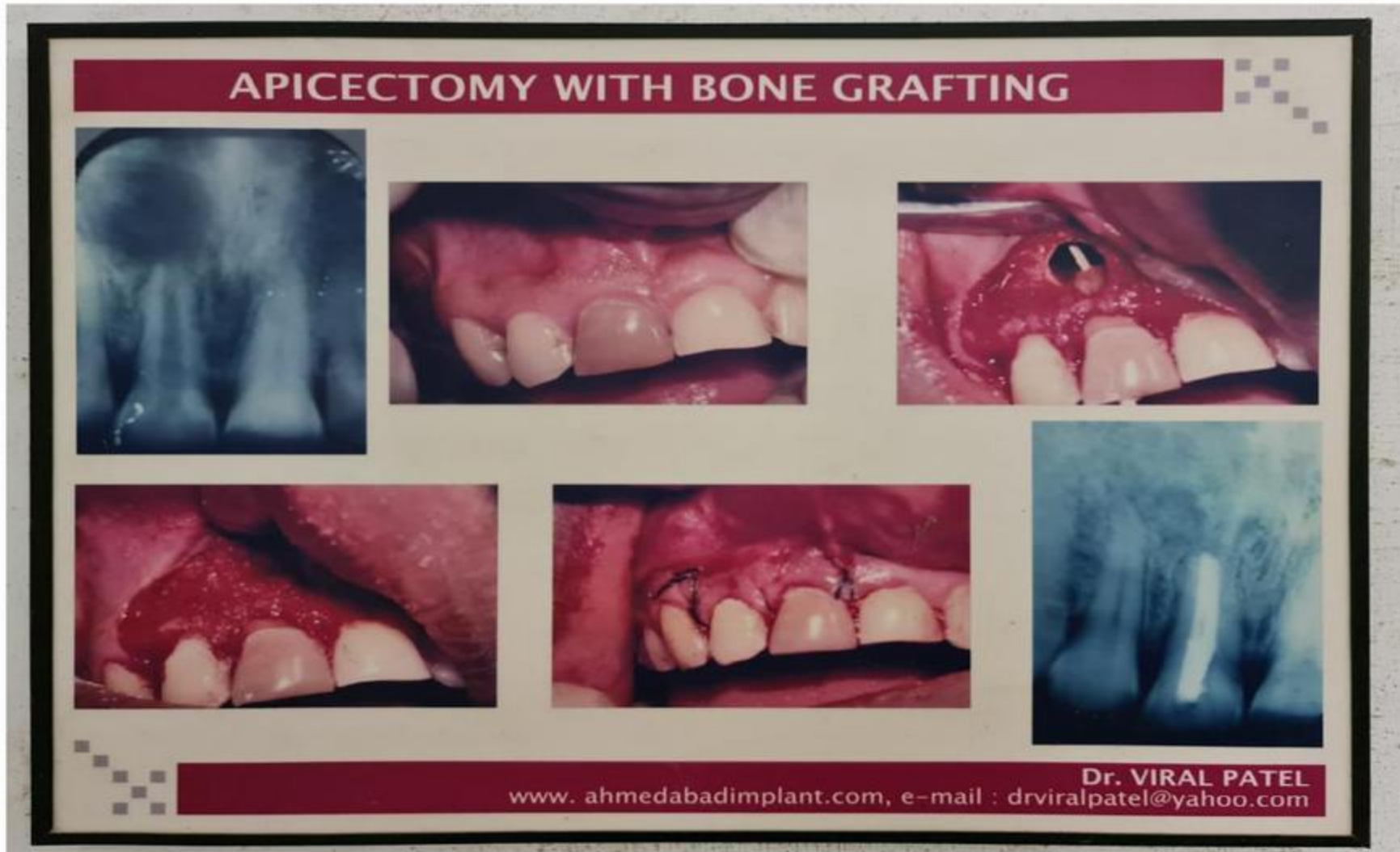
- આપને સારવારના ભાગમાં 1 કલાક સુધી ભારી ભારી લાગશે.
- ૨૪ કલાક સુધી થૂંકવું નહિ. થૂંક આવે તો ગળી જવું.
- શરૂઆતમાં ૪-૫ કલાક સુધી પીતું થૂંક કે લોહી આવશે જો વધારે રહે તો ડોક્ટરનો સંપર્ક કરવો.
- પહેલાં ૧૨ કલાક સુધી બહારની બાજુ થી બરફ લગાડવો.
- ૧-૨ દિવસ સુધી સર્જરી કરેલા ભાગમાં સોજો રહેશે.
- પહેલાં ૨૪ કલાક બ્રશ કરવું નહિ. ૨૪ કલાક બાદ બીજા બધા ભાગમાં બ્રશ કરવું ૨-૩ દિવસ પછી આખા મોઝામાં હળવેથી બ્રશ કરવું. ૦.૨% ક્લોરહેક્ઝીડીન થી કોગળા કરવા.
- થોડા દિવસ સુધી શ્રમ પડે એવું કામ કરવું નહિ.
- ઠંડો અને પોચો ખોરાક જ ખાવો.
- સારવાર કર્યા પછી બીડી/સિગરેટ/મસાલા નું સેવન કરવું નહિ.
- ટાંકા ખોલાવવા ૭ દિવસ પછી જરૂર આવવું.

By: **Aastha Harne** (Intern 2017-18)
Guided by:
Dr. Anita Panchal Dr. Bhaumik Nanavati
Dr. Rahul Shah Dr. Riddhi Gandhi
Dr. Khoobi Shah

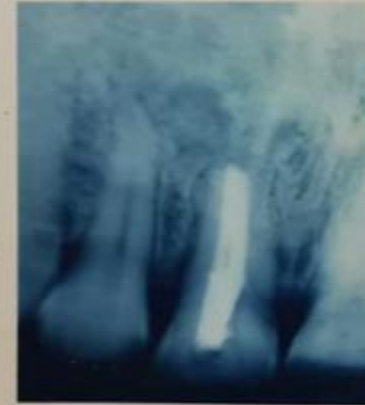
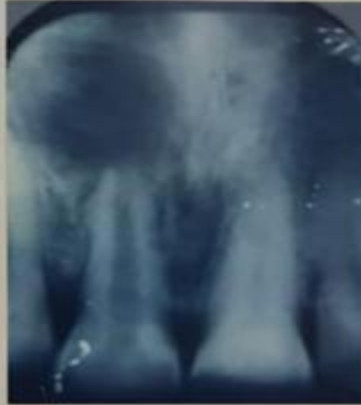
BUCCAL PLATE REGENERATION FOLLOWED BY SINGLE STAGE IMPLANT



APICECTOMY WITH BONE GRAFTING



APICECTOMY WITH BONE GRAFTING

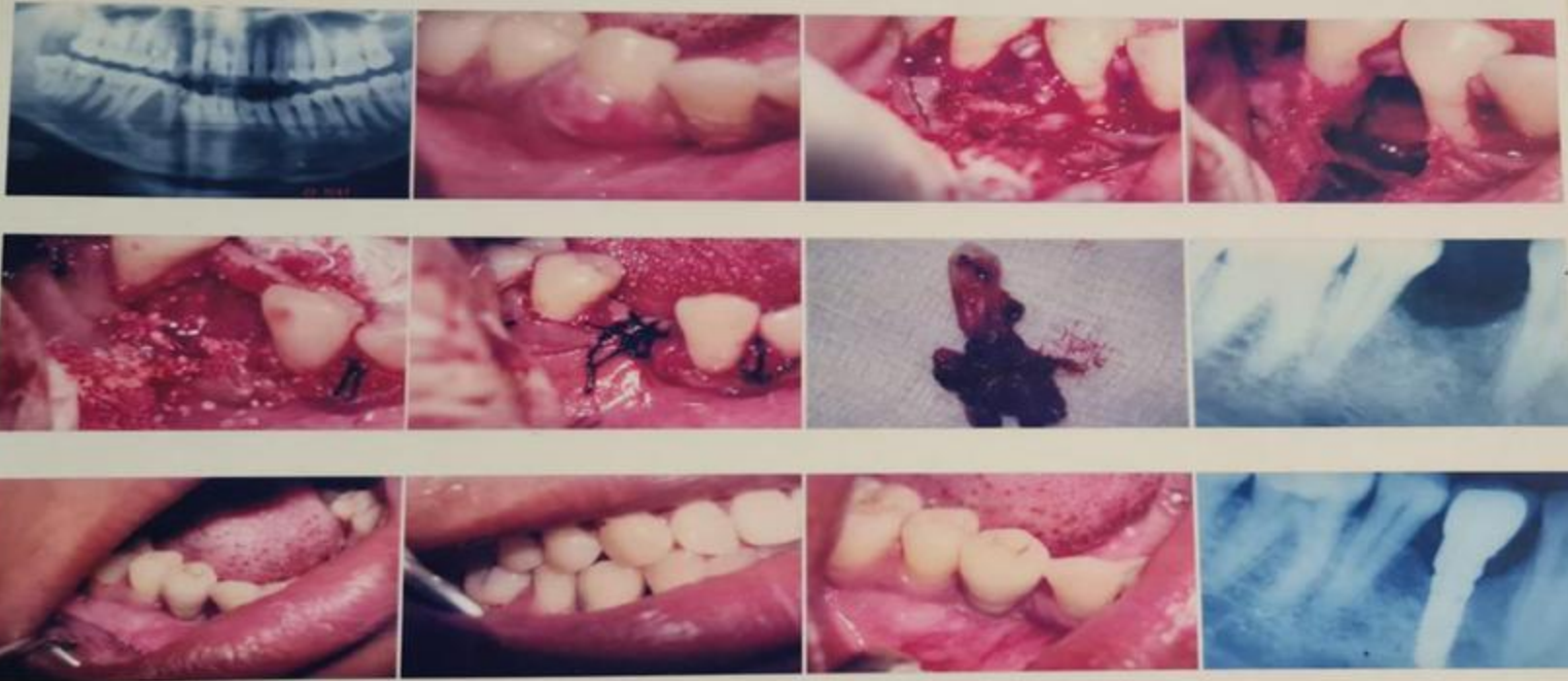


Dr. VIRAL PATEL

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IMPLANT IN REGENERATED CYSTIC DEFECT

IMPLANT IN REGENERATED CYSTIC DEFECT



Dr. VIRAL PATEL


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RIDGE AUGMENTATION



FULL MOUTH REHABILITATION WITH IMPLANTS

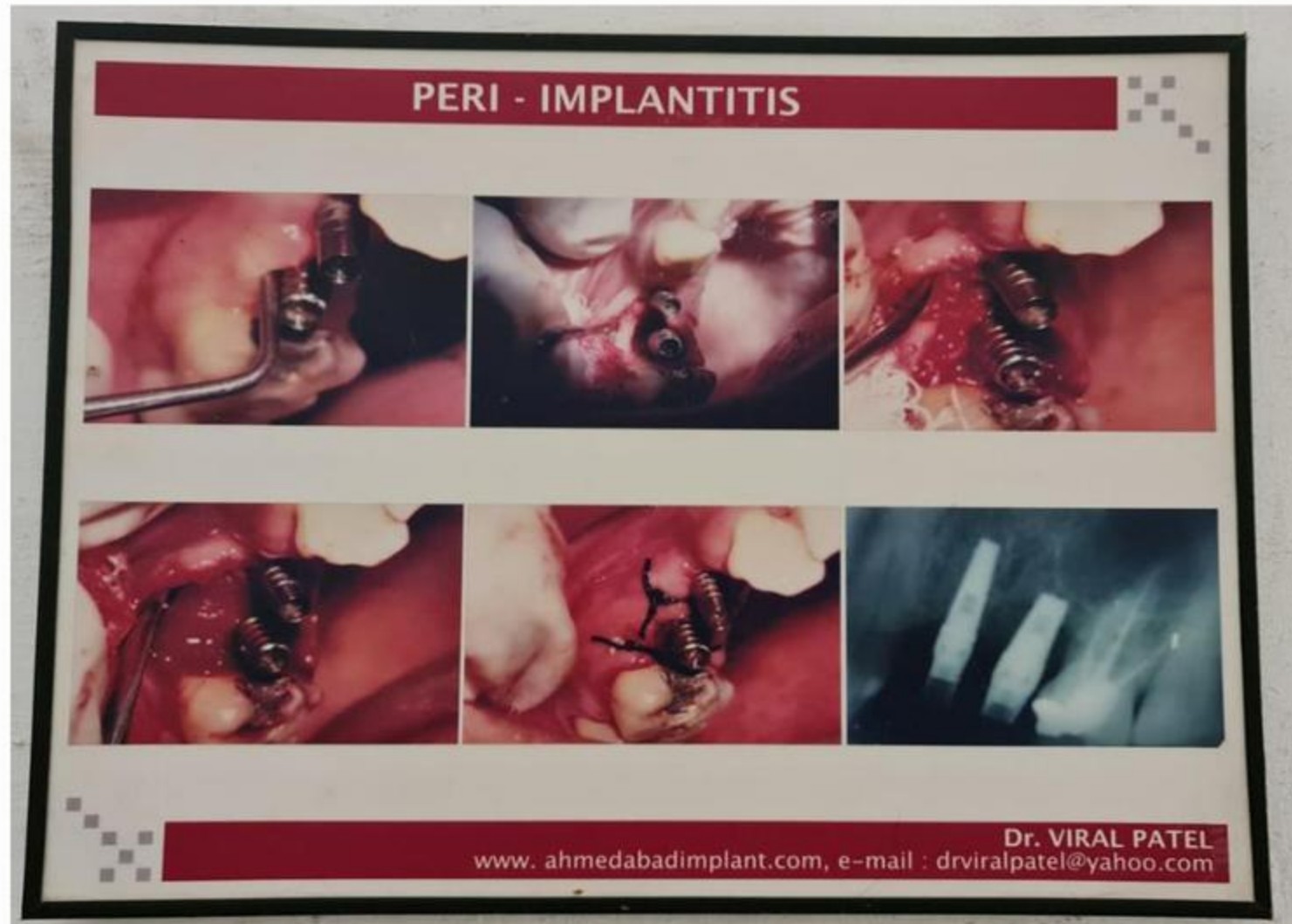
FULL MOUTH REHABILITATION WITH IMPLANTS



The collage consists of six photographs arranged in a 2x3 grid. The top-left photo shows a close-up of the patient's upper teeth with several dental implants visible. The top-right photo shows the patient's lower teeth. The middle photo is a profile view of the patient's face, showing the overall appearance. The bottom-left and bottom-right photos show the patient smiling, displaying the final dental work.

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PERI-IMPLANTITIS



IMTEC MDI-ULTRATHIN MINI IMPLANTS

IMTEC MDI - ULTRATHIN MINI IMPLANTS

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INTERDENTAL AIDS

INTERDENTAL AIDS

DEFINITION:- Interdental aids are adjunctive devices that are used to remove plaque from interproximal tooth surfaces thus preventing Dental & Periodontal Disease Which Originates In The Interdental Area. *

Types Of Embrasures	Condition Of The Gingiva In The Embrasures	Cleaning Aids Recommended For The Embrasure Cleansing
1	Embrasures Are Completely Occupied By Healthy Interdental Papilla	Superfloss & Thin Dental Floss, Used Only For Clearing Subline
2	About 75% Of The Embrasure Is Occupied By The Gingiva	Thin To Medium & Thick Dental Floss
3	About 50% Of The Embrasure Is Occupied By The Gingiva	Thin Fine Pointed Small Spine Interdental Brushes
4	About 25% Of The Embrasure Is Occupied By The Gingiva	Thick - 1.5mm Interdental Brushes & Fine Bristle Liquid Unbuffered Brushes
5	Complete Loss Of Interdental Papilla And Gingiva From The Embrasures. The Level Of The Gingiva In The Interdental Space Is Same As The Buccal & Lingual Gingiva On Teeth.	Bristle & Liquid Unbuffered Brushes & Thick Spine Interdental Brushes.

TYPES OF INTERDENTAL AIDS :-

- EQ Dental floss
- EQ Triangular tooth picks: a) wooden and b) plastic
- EQ Interdental tooth brushes: a) proxabrush system; b) bottle brushes and c) single tufted brushes
- EQ Yam
- EQ Superfloss
- EQ Perio-aids

DENTAL FLOSS


AVAILABLE AS:

multifilament	-bonded	-thick	-waxed
-twisted	-non bonded	-thin	-unwaxed
-non twisted			


FUNCTION:

- Removal of adherent plaque & food debris
- Polishing of tooth surface during removal of plaque & debris
- Improving oral hygiene
- Reducing oral bleeding
- V...

TECHNIQUE:-




INTERDENTAL BRUSHES



TECHNIQUE:-


Interdental brushes of any type are inserted through interproximal space & moved back and front between the teeth with short strokes.



single tufted brushes provide access to furcation areas or isolated areas of deep recession & work well on the lingual surface of mandibular molars & pre molars

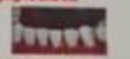
TRIANGULAR TOOTHPICKS

Woodenpicks Plasticpicks




TECHNIQUE:-

Toothpicks are placed in the interdental space with the base of the triangle resting on the gingiva and the sides in contact with the proximal tooth surfaces then repeatedly moved in and out of the embrasure to remove plaque.



SUPER FLOSS

It contains segments of stiffened thread, spongy floss and regular floss.



Soft thread can make it easier for you to slide the superfloss between teeth.

Spongy floss cleans between wide spaces

Regular floss remove plaque from the adjacent tooth surfaces

Dep. of Periodontology 3rd year BDS Created by:- Pandya Pratik Nayakpara Vinay
 College of Science & Research Centre (2009 - 2010) Pandya Krupa Bhavik Mavani
 Patel Falgun

UG POSTER


PERIODONTAL INSTRUMENTS

PERIODONTAL INSTRUMENTS

DEFINITION: A periodontal instrument is a device used to render tooth surface clean, smooth, hard and biologically acceptable by removal of plaque, calculus, altered cementum and debris in order to attain and maintain healthy gingival and periodontal tissues.

CLINICAL DESIGN OF INSTRUMENTS:
The parts of each instruments referred to as...

- The handle
- The shank
- The working end.



CLASSIFICATION OF PERIODONTAL INSTRUMENTS

1 Periodontal Diagnostics instruments

- Periodontal Probes
- Explorers
- Mouth mirrors

2 Scaling, Root planing and Curettage instruments

- Sickle scalars
- Curettes
- Hoe, chisel and file
- Ultrasonic and sonic instruments

3 Cleansing and polishing instruments

- Rubber cup and brushes
- Dental tape
- Air powder

4 Surgical instruments

- Excisional and Incisional
- Surgical curettes and sickles
- Periosteal elevators
- Surgical chisels
- Surgical files
- Scissors
- Hemostats and tissue forceps

PERIODONTAL PROBES:
The periodontal probe is a periodontal instrument that is marked in millimeters increments and is used to evaluate the periodontal tissue health.

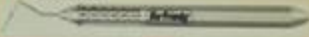
USES:

- To measure sulcus and pocket depths
- To measure clinical attachment levels
- To determine width of attached gingiva

TYPES OF PERIODONTAL PROBES:

- William probe - Markings: 1-2-3-4-5-7-8-9-10 mm.
- Goldman Fur probe - Markings: 1-2-3-5-7-8-9-10 mm.
- University of North Carolina (UNC-15) probe - Markings as 1 to 15, at 5, 10 and 15 mm are darker
- WHO probe - Markings 0.5mm ball tip, markings at 1.5, 5.5, 8.5 and 11.5 mm & color coding from 3.5 to 5.5 mm.
- Community periodontal Index for treatment needs (CPTN) probe - Markings at 3.5mm, 5.5mm, 8.5mm and 11.5mm
- Nabors's probe - Markings at 3mm interval as 3, 6, 9, 12mm.

PROBING TECHNIQUE:
The probe should be inserted parallel to the vertical axis of the tooth and "walked" circumferentially around each surface of each tooth to detect areas of the deepest penetration.




EXPLORERS:
An explorer is an instrument with a flexible wirelike working end.

USES:

- To examine tooth surface for carious, decalcified and carious lesion and anatomic features such as grooves, or root furcation.

TYPES OF EXPLORERS:

- spheruloid hook explorer
- straight explorer
- curved explorer
- pigtail and cowhorn explorer
- orbital type explorer
- 11/12 type explorer




DENTAL MOUTH MIRROR:
A dental mouth mirror is a multifactorial instrument that is used in almost every instrumentation procedure.

USES:

- Indirect vision
- retraction
- Indirect illumination
- transillumination

TYPES OF DENTAL MIRROR:

- front surface mirror: reflecting surface is on front surface glass produces clear image without distortion
- concave surface mirror: reflecting surface is on the front surface mirror lens produces magnified image which can distort
- plane (flat) surface mirror: reflecting surface is on back surface of mirror lens produces double image (ghost image), double image is distracting.




SICKLE SCALAR:
A sickle scalar is a periodontal instrument used to remove supragingival calculus deposits from the supragingival & subgingival surface of the tooth.

USES: the primary function of sickle scalar is removal of medium to large sized supragingival & subgingival calculus deposits. Excellent for calculus removed on the proximal surfaces of anterior crowns

- Enamel surfaces of apical to contact areas posterior teeth

TYPES:

- Universal sickle scalar
- U 1520 scalar
- Jacquet's sickle scalar
- Morse sickle scalar




UNIVERSAL CURETTE:
This is one of the periodontal instrument used to remove deep subgingival calculus, curette - necessary and removing & used to remove lining of the periodontal pocket.

PRINCIPAL FUNCTION:
Debridement of crown and root surfaces.

TYPES OF CURETTE:

- Universal curette
- Area specific curette

	SIMPLE CURETTE	UNIVERSAL CURETTE
AREA OF USE	Set of many curvettes designed for specific areas of surface.	One curvette designed to fit areas of all surfaces.
USE	One cutting edge associated with other side of the edge only.	Both cutting edges associated with other side of the edge only.
CONSTRUCTION	Curved to the gingivocervical margin up to 1/2 to the apex.	Curved to one gingivocervical margin up to 1/2 to the apex.
BLADE ANGLE	UPPER blade, back of blade bent at 90 degree to shank	Blade set 120° - back of blade bent at 90 degree to shank
EXAMPLES	<ul style="list-style-type: none"> Shirley curette Universal curette Black modified curette Wood's large tapered curette Depositor curette Langens curette 	<ul style="list-style-type: none"> Universal curette # 1, 2, 3, 4 Curved curette # 15-12, 16-12, 20-12, 24-12 Orange Wood # 1, 2 McCart's # 17-10 Ballou's curette # 17-10



HOE SCALAR: is the periodontal instrument used for scaling of ridges or rings of calculus.

ANGULATION: The sickle has 90° angle. The cutting edge is beveled at 45°.

A CHISEL SCALAR: is designed for the proximal surface of teeth too closely spaced to permit the use of other scalars, is usually used in the anterior part of the mouth.

ANGULATION: Double ended blade, beveled at 40°

A PERIODONTAL FILE is a periodontal instrument that is used to prepare the calculus deposits before removal with another instrument.

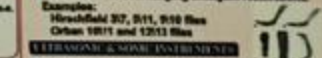
ANGULATION: The working end has a series of cutting edges at 90° to 100° angle.

USES OF FILE:

- To crush large, tenacious subgingival calculus deposits.
- To roughen the surface of the burrished calculus deposits.
- To smoothen overhanging amalgam restorations.

Examples:

- Hirschfeld 307, 311, 310 files
- Orban 1811 and 12513 files



ULTRASONIC & SONIC INSTRUMENTS:
Ultrasonic and sonic instruments are electronically powered instruments for the removal of calculus deposits and plaque biofilms. There are two types of electronically powered devices

- Sonic
- ULTRASONIC: Two types of ultrasonic devices are:
 - Magnetostrictive
 - Piezoelectric

CLINICAL PREPARATION INSTRUMENTS:

- Rubber cups
- Dental tape
- Brillo brushes
- Air powder polishing

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COLLEGE OF DENTAL SCIENCES & RESEARCH CENTRE, ARAD

ULTRASONIC SONIC INSTRUMENTS

ULTRASONIC & SONIC INSTRUMENTS

Definition: Ultrasonic & Sonic Instruments Are Electronically Powered Instruments For The Removal Of Calculus Deposits & Plaque Bio Films.
Goal: These Devices Are Developed With The Goal Of Making Calculus Removal Easier & Faster With Less Patient's Discomfort And Clinician's Fatigue.
Basic Design: These Devices Are Composed Of Portable Unit That Contain An Electronic Generator, a Hand Piece & Interchangeable Instrument Tips.

TYPES OF POWER DRIVEN INSTRUMENTS

SONIC



- Attach To Dental Unit
- They Are Air Driven Scalers In Which Frequency Produces Vibrations Of The Insert Tip
- They Operate At Frequency Of 2000 To 8000 Cps
- So It Displaces The A+L In Distal Area & Moves It To The Right Stroke Pattern In Cervical O-Cervical

ULTRA SONIC

PIEZOELECTRIC



- Ceramic Disc Located In The Handpiece, They Change In Dimension As Electrical Energy Is Applied To The Tip
- Tips Move In A Linear Pattern, Giving The Tip Two Active Surfaces
- Frequency Range 18000 - 50000 Cps

MAGNETROSTRICTIVE



- Metal Stocks, That Change In Dimension As Electrical Energy Is Applied To Tip
- Tips Move In Elliptical Or Orbital Stroke Pattern, Giving The Tip Four Active Surfaces
- Frequency Range 18000 - 50000 Cps



Universal Scaling Tip



Tip For Root Planing



Square shaped And Subgingival Scaling Tip For Posterior



Tip To Remove Scale

Mechanism of Action

Several Mechanical Factors Play A Role In The Mechanism Of Power Scalers

- Frequency:** Frequency Is Defined As The Number Of Times Per Second An Insert Tip Move Back And Forth During One Cycle In An Orbital Elliptical Or Linear Stroke Path. It is Important Because It Determines The Area Of Insert Tip That Is Considered Active.
 - Higher The Frequency → Smaller The Active Area
 - Lower The Frequency → Bigger The Active Area
- Stroke:** Stroke Is The Maximum Distance, The Insert Tip Travels During One Cycle Or Stroke Path. The Power Knob On An Ultrasonic Unit Controls The Stroke Length Of The Insert Tip During One Cycle.
 - Higher The Power → Longer The Stroke Pattern
 - Lower The Power → Shorter The Stroke Pattern
- Water:** Power Ultrasonic Scaling Devices Contain A Water Knob, This Controls The Volume Of Water Being Delivered To Insert Tip. Water Contributes To 3 Physiological Effects That Enhance The Efficacy Of Power Scalers.
 - **Acoustic Streaming:** It Is A Unidirectional Fluid Flow Caused By Ultrasound Waves.
 - **Acoustic Cavitation:** It Is Created When The Movement Of The Tip Causes The Coolant To Accelerate Producing An Intensified Swirling Effect.
 - **Cavitation:** It Is The Formation Of Bubbles In Water Caused By The High Turbulence.

Indications:

1. Medium Or Heavy Tenacious Deposits / Calculus
2. Tenacious & Heavy Extensive Stains
3. Microleak Seal Surfaces
4. Orthodontic Cement After Bond Placement Removal.

Contraindications:

1. Communicable Diseases Et. TB & Hepatitis.
2. Heart Individual Can Disseminate Contaminated Aerosols.
3. High Susceptibility To Infection.
4. Respiratory Risk In Patients With Respiratory Diseases As They Can Aspirate Specific Material Or Micro Organism From Dental Dental Plaque To The Lungs.

Advantages:

1. Less time consuming
2. Less tissue manipulation.
3. Less patient fatigue.
4. Less operator fatigue.

Disadvantages:

1. Electro microscopic studies have shown highly irregular surfaces and deep gouges & cavitation with ultrasonic scaling.
2. Reduced visibility owing to difficult to control spray of water & possible damage to hard and soft tissue by incorrect use.
3. The weight and bulk of instruments can cause fatigue & decrease tactile sensitivity.
4. The temp. Of the coolant spray is often a source of discomfort.

Department Of Periodontia
III Year

Viprat Joshi • Kaval Trivedi • Eva Shah • Anisha Malik • Tejas Barot • Jayneel Patal

LOCAL ANESTHESIA

LOCAL ANAESTHESIA


CLASSIFICATION OF LOCAL ANAESTHESIA

Based on chemical composition:


		Amides	Quinoline
Esters of benzoic acid:	Esters of paraaminobenzoic acid:	Articaine	Centbuclidine
Butacain	Chlorbutacaine	Bupivacaine	
Cocaine	Procaine	Lidocaine	
Benzocaine	Propoxycaïne	Dibucaine	
Tetracaine		Etidocaine	
Hexylcaine		Mepivacaine	
Piperocaine		Prilocaine	
		Ropivacaine	

Short acting (pulpal anaesthesia approx 30 mins)	Intermediate duration (pulpal anaesthesia approx 60 mins)	Long duration (pulpal duration approx 90 mins)
Lidocaine Hcl 2%	Articaine Hcl 4% + epinephrine 1:100000	Bupivacaine Hcl 0.5% + Epinephrine 1:200000
Prilocaine Hcl 4%	Articaine Hcl 4% + epinephrine 1:200000	
	Lidocaine Hcl 2% + epinephrine 1:50000	
	Lidocaine Hcl 2% + epinephrine 1:100000	
	Mepivacaine Hcl 2% + epinephrine 1:100000	
	Prilocaine Hcl 4% + epinephrine 1:200000	


MANDIBULAR ANAESTHETIC TECHNIQUES




INFERIOR ALVEOLAR NERVE BLOCK
Nerve anaesthetized:
Inferior alveolar, mental, incisive, lingual
Area anaesthetized:
Mandibular teeth to midline, body of mandible, inferior ramus, buccal mucosa anterior to mental foramen, anterior 2/3 tongue & floor of the mouth, lingual soft tissue and periosteum.
Landmarks:
coronoid notch, pterygomandibular raphe, occlusal plane of mandibular posteriors.
Target area:
Inferior alveolar nerve as it passes downwards to the mandibular foramen
Indication:
Multiple mandibular teeth, Buccal anterior soft tissue, Lingual anaesthesia.
Contraindications:
1. Infection/inflammation at injection site
2. Patient at risk of self injury.



BUCCAL NERVE BLOCK
Nerve anaesthetized:
Buccal nerve
Area anaesthetized:
Soft tissues and periosteum buccal to the mandibular molar teeth.
Landmarks:
Mandibular molars, mucobuccal fold.
Target area:
Buccal nerve as it passes over the anterior border of the ramus.
Indications:
When anaesthesia required- mucoperiosteum buccal to mandibular molars.
Contraindications:
Infection/inflammation at injection site



MENTAL NERVE BLOCK
Nerve anaesthetized:
Mental nerve
Area anaesthetized:
Buccal mucous membranes anterior to the mental foramen to the midline and skin of the lower lip and chin.
Landmarks:
Mandibular premolars and mucobuccal fold.
Target area:
Mental nerve as it exists the mental foramen.
Indications:
Need for anaesthesia in innervated area.
Contraindications:
Infection/inflammation at the injection site.



INCISIVE NERVE BLOCK
Nerve anaesthetized:
Incisive, mental nerves
Area anaesthetized:
mandibular labial mucous membrane, lower lip/skin of chin, incisor, cuspid and bicuspids.
Landmarks:
mandibular premolars and mucobuccal fold.
Target area:
mental foramen, through which the mental nerve exits and inside of which the incisive nerve is located.
Indications:
dental procedures requiring pulpal anaesthesia on mandibular teeth anterior to mental foramen.
Contraindications:
Infection/inflammation at the injection site.

College of dental sciences and research center Department of periodontology

Presented by: 1st year PG (2012 batch)

LOCAL ANESTHESIA

LOCAL ANESTHESIA

DEFINITIONS: Local anesthesia is defined as loss of sensation in a circumscribed area of the body caused by a cessation of the flow of nerve energy or inhibition of the conduction process in an afferent pathway.

DIFFUSION: In local infiltration, small terminal nerve endings in the area of the surgery are flooded with local anesthetic solution - rendering them incapable of pain or preventing them from becoming stimulated and creating an impulse.

FIELD BLOCK: The field block method of using topical anesthetic is an excellent method of anesthetizing the area to be anesthetized in order to allow the patient the same degree of effectiveness.

INDICATIONS: The use of local anesthesia is indicated in all types of dental surgery, including the extraction of teeth, the preparation of teeth for restorations, the placement of crowns, bridges, and dentures, and the treatment of periodontal disease.

MAXILLARY ANESTHETIC TECHNIQUES MAINLY USED IN DENTISTRY

LOCUS ANESTHESIA	POSTERIOR SUPERIOR ALVEOLAR NERVE BLOCK	ALVEOLAR NERVE BLOCK	ALVEOLAR NERVE BLOCK	ALVEOLAR NERVE BLOCK	ALVEOLAR NERVE BLOCK
<p>LOCUS ANESTHESIA</p> <p>Indications: Maxillary teeth.</p> <p>Enter region innervated by the large terminal branches of the trigeminal nerve (Plexus) and root area of the tooth, but not periodontal connective tissue, mucous membrane.</p> <p>Indications:</p> <ol style="list-style-type: none"> 1. Maxillary teeth. 2. Crown fitting. 3. Root canal of teeth. <p>Technique:</p> <p>Apical region of tooth to be anesthetized.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Palpate anesthesia of maxillary teeth inserted into 1 or 2 tooth. 2. Soft tissue anesthesia in circumferential area. <p>Contraindications:</p> <ol style="list-style-type: none"> 1. Infection or acute inflammation in the area of injection. 2. Dental work covering the apex of the tooth. 	<p>POSTERIOR SUPERIOR ALVEOLAR NERVE BLOCK</p> <p>Indications: Posterior superior alveolar nerve and branches.</p> <p>Indications:</p> <ol style="list-style-type: none"> 1. Pulp, buccal periodontium and some maxillary 1st, 2nd, 3rd molars. <p>Technique:</p> <p>Maxillary 4th above maxillary 2nd molar.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. When treatment involves root or crown teeth. 2. When topographical condition contraindicated in buccal lip. <p>Contraindications:</p> <ol style="list-style-type: none"> 1. Risk of hemorrhage to the gland. 	<p>ALVEOLAR NERVE BLOCK</p> <p>Indications: Alveolar nerve and branches.</p> <p>Indications:</p> <ol style="list-style-type: none"> 1. Pulp of the maxillary 1st and 2nd premolars, mandibular root of 1st molar. <p>Technique:</p> <p>Maxillary 4th above maxillary 2nd molar.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. When the alveolar nerve is 3-4 mm, be prior to anesthesia to teeth distal to the maxillary nerve. 2. Maxillary 4th above maxillary 2nd molar. <p>Contraindications:</p> <ol style="list-style-type: none"> 1. Infection or acute inflammation in the area of injection. 2. When MIA is placed the patient is not anesthetized and if necessary 2nd molar is anesthetized by MIA. 	<p>ALVEOLAR NERVE BLOCK</p> <p>Indications: Alveolar nerve and branches.</p> <p>Indications:</p> <ol style="list-style-type: none"> 1. Pulp and buccal periodontium and base of the root of 1st molar. 2. 2/3 of patients have periodontal involvement up to 1st molar level. <p>Technique:</p> <p>Maxillary 4th above maxillary 2nd molar.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. When the alveolar nerve is 3-4 mm, be prior to anesthesia to teeth distal to the maxillary nerve. 2. Maxillary 4th above maxillary 2nd molar. <p>Contraindications:</p> <ol style="list-style-type: none"> 1. Infection or acute inflammation in the area of injection. 2. When MIA is placed the patient is not anesthetized and if necessary 2nd molar is anesthetized by MIA. 	<p>ALVEOLAR NERVE BLOCK</p> <p>Indications: Alveolar nerve and branches.</p> <p>Indications:</p> <ol style="list-style-type: none"> 1. Pulp and buccal periodontium and base of the root of 1st molar. 2. 2/3 of patients have periodontal involvement up to 1st molar level. <p>Technique:</p> <p>Maxillary 4th above maxillary 2nd molar.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. When the alveolar nerve is 3-4 mm, be prior to anesthesia to teeth distal to the maxillary nerve. 2. Maxillary 4th above maxillary 2nd molar. <p>Contraindications:</p> <ol style="list-style-type: none"> 1. Infection or acute inflammation in the area of injection. 2. When MIA is placed the patient is not anesthetized and if necessary 2nd molar is anesthetized by MIA. 	<p>ALVEOLAR NERVE BLOCK</p> <p>Indications: Alveolar nerve and branches.</p> <p>Indications:</p> <ol style="list-style-type: none"> 1. Pulp and buccal periodontium and base of the root of 1st molar. 2. 2/3 of patients have periodontal involvement up to 1st molar level. <p>Technique:</p> <p>Maxillary 4th above maxillary 2nd molar.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. When the alveolar nerve is 3-4 mm, be prior to anesthesia to teeth distal to the maxillary nerve. 2. Maxillary 4th above maxillary 2nd molar. <p>Contraindications:</p> <ol style="list-style-type: none"> 1. Infection or acute inflammation in the area of injection. 2. When MIA is placed the patient is not anesthetized and if necessary 2nd molar is anesthetized by MIA.

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STERILIZATION



TOOTH BRUSHING TECHNIQUE

TOOTH BRUSHING TECHNIQUES				
<p>BASS TECHNIQUE</p> <p>INDICATIONS</p> <ul style="list-style-type: none"> • The patient has dental plaque control advised & is unable to grasp the proper technique. • The patient has gingivitis, periodontitis, or recession and needs the help of a dentist to learn the correct brushing technique. • Recommended for most patients with or without periodontitis. 	<p>TECHNIQUE</p> <ul style="list-style-type: none"> • Bristles are placed at 45° angle to the gingiva & pressure is applied in a circular motion. • Bristles are applied around all teeth & brush in a circular motion. • The distal aspect of upper tooth, the brush is positioned vertically to prevent the bristles from slipping against the gum & then later along the tooth. 	<p>ADVANTAGES</p> <ul style="list-style-type: none"> • Effective method for removing plaque adjacent to the gingiva margins & sulcus. • Low gingival inflammation. • Patient easy. • Bristles recommended. 	<p>DISADVANTAGES</p> <ul style="list-style-type: none"> • It is not recommended for patients with recession. • It is not recommended for patients with periodontitis. • It is not recommended for patients with gingivitis. 	
<p>MODIFIED STILLMAN'S TECHNIQUE</p> <p>INDICATIONS</p> <ul style="list-style-type: none"> • The patient has dental plaque control advised & is unable to grasp the proper technique. • The patient has gingivitis, periodontitis, or recession and needs the help of a dentist to learn the correct brushing technique. • Recommended for most patients with or without periodontitis. 	<p>TECHNIQUE</p> <ul style="list-style-type: none"> • Bristles are placed against the tooth with the handle of the brush at 45° to the gingiva. • The bristles are applied in a circular motion. • The bristles are applied in a circular motion. 	<p>ADVANTAGES</p> <ul style="list-style-type: none"> • Superior bristle distribution can be achieved. • It is a good technique for patients with recession. 	<p>DISADVANTAGES</p> <ul style="list-style-type: none"> • It is not recommended for patients with recession. • It is not recommended for patients with periodontitis. • It is not recommended for patients with gingivitis. 	
<p>CHARTER'S TECHNIQUE</p> <p>INDICATIONS</p> <ul style="list-style-type: none"> • The patient has dental plaque control advised & is unable to grasp the proper technique. • The patient has gingivitis, periodontitis, or recession and needs the help of a dentist to learn the correct brushing technique. • Recommended for most patients with or without periodontitis. 	<p>TECHNIQUE</p> <ul style="list-style-type: none"> • The bristles are placed at 45° to the gingiva with the handle of the brush at 45° to the gingiva. • The bristles are applied in a circular motion. • The bristles are applied in a circular motion. 	<p>ADVANTAGES</p> <ul style="list-style-type: none"> • Provides optimum plaque removal efficiency. • It is a good technique for patients with recession. 	<p>DISADVANTAGES</p> <ul style="list-style-type: none"> • It is not recommended for patients with recession. • It is not recommended for patients with periodontitis. • It is not recommended for patients with gingivitis. 	
<p>ROLL TECHNIQUE</p> <p>INDICATIONS</p> <ul style="list-style-type: none"> • The patient has dental plaque control advised & is unable to grasp the proper technique. • The patient has gingivitis, periodontitis, or recession and needs the help of a dentist to learn the correct brushing technique. • Recommended for most patients with or without periodontitis. 	<p>TECHNIQUE</p> <ul style="list-style-type: none"> • The bristles are placed at 45° to the gingiva with the handle of the brush at 45° to the gingiva. • The bristles are applied in a circular motion. • The bristles are applied in a circular motion. 	<p>ADVANTAGES</p> <ul style="list-style-type: none"> • Good for patients with recession. • It is a good technique for patients with recession. 	<p>DISADVANTAGES</p> <ul style="list-style-type: none"> • It is not recommended for patients with recession. • It is not recommended for patients with periodontitis. • It is not recommended for patients with gingivitis. 	
<p>FONES TECHNIQUE</p> <p>INDICATIONS</p> <ul style="list-style-type: none"> • The patient has dental plaque control advised & is unable to grasp the proper technique. • The patient has gingivitis, periodontitis, or recession and needs the help of a dentist to learn the correct brushing technique. • Recommended for most patients with or without periodontitis. 	<p>TECHNIQUE</p> <ul style="list-style-type: none"> • The bristles are placed at 45° to the gingiva with the handle of the brush at 45° to the gingiva. • The bristles are applied in a circular motion. • The bristles are applied in a circular motion. 	<p>ADVANTAGES</p> <ul style="list-style-type: none"> • It is a good technique for patients with recession. • It is a good technique for patients with recession. 	<p>DISADVANTAGES</p> <ul style="list-style-type: none"> • It is not recommended for patients with recession. • It is not recommended for patients with periodontitis. • It is not recommended for patients with gingivitis. 	

FLAP SURGERY

Colgate

Flap Surgery

A procedure recommended for people with moderate or advanced Periodontitis. The gums are separated from the teeth and folded back temporarily to allow your dentist to reach the root of the tooth and the bone.

- 

1. Supporting bone around the root is removed and partially restored.
- 

2. Under local anesthesia, a scalpel is used to separate the gums from the tooth. The gum is then lifted or folded in the form of a flap. Plaque and tartar are removed from the infected pocket.
- 

3. The bone is smoothed and reshaped, reducing spaces where bacteria can grow.
- 

4. The gum is then closed over the reshaped bone at or below the original gumline. After the gum has healed, stitches dissolve or are removed.

Your dentist may recommend these steps for post surgical oral care:

- Brush twice a day with a toothpaste providing 12 hr protection such as Colgate Total Toothpaste
- Rinse twice daily for 30 seconds after brushing with an anti-bacterial rinse such as Colgate PerioGard Rinse
- Clean between the teeth daily with Colgate Floss or Colgate Interdental Brush
- Visit your dentist regularly



Colgate Total 12

Colgate PerioGard Rinse

Colgate Your Partner in Oral Health

BRUSHING TECHNIQUE



GUIDE TO ORAL HEALTH

Colgate

Guide to Good Oral Health

DECAY OF TEETH

Enamel and dentin are wearing away at their natural rate but can be protected.

When decay reaches the dentin, the enamel and the rest of the tooth are damaged.

A composite resin can be applied to the tooth, filling the hole and making the tooth look like it was never there.

KNOW YOUR TEETH

GUM DISEASE

THE 11-11-11 RULE

NON-DENTINE CLEANING

CARE FOR YOUR TEETH

1. Brush your teeth twice a day for two minutes. Use a soft-bristled toothbrush and fluoride toothpaste.
2. Floss daily. Flossing removes plaque and food particles from between your teeth and under the gum line.
3. Rinse with water after brushing and flossing.
4. Use the tip of your tongue to clean your teeth each day.
5. Use a fluoride mouthwash to help protect your teeth.

FIVE GOLDEN RULES FOR HEALTHY TEETH




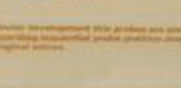



1. Brush 2 times a day.
2. Floss daily.
3. Use fluoride toothpaste.
4. Visit your dentist for a checkup and cleaning every 6 months.
5. Eat a healthy diet with lots of fruits and vegetables.

Colgate Your Partner in Oral Health

PERIODONTAL PROBES

PERIODONTAL PROBES

Definition:- Periodontal probe is a diagnostic instrument, which is tapered, rod like, calibrated in millimeters, with a blunt, rounded tip that is used to locate, measure and mark pockets as well as determine their course on individual tooth surface.

GENERATION	PROBES	BASIC DESIGN	ADVANTAGES	DISADVANTAGES
1 st (CONVENTIONAL)	 <p>Most common markings of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Simple & easy to use Accurate Low cost Wide availability 	<ul style="list-style-type: none"> Time consuming Operator dependent Not suitable for large scale studies
2 nd (CONSTANT PRESSURE)	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Operator independent Low cost 	<ul style="list-style-type: none"> Time consuming Operator dependent
3 rd (AUTOMATED)	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Operator independent Low cost 	<ul style="list-style-type: none"> Time consuming Operator dependent
4 th (3 DIMENSIONAL PROBE)	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Operator independent Low cost 	<ul style="list-style-type: none"> Time consuming Operator dependent
5 th (ULTRASONIC)	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Operator independent Low cost 	<ul style="list-style-type: none"> Time consuming Operator dependent
DIAMOND PROBE	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Operator independent Low cost 	<ul style="list-style-type: none"> Time consuming Operator dependent
PERIOTEMP PROBE	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	 <p>Measuring pressure 20 gms. 1 mm = 1 mm 2 mm = 2 mm 3 mm = 3 mm 4 mm = 4 mm 5 mm = 5 mm 6 mm = 6 mm 7 mm = 7 mm 8 mm = 8 mm 9 mm = 9 mm 10 mm = 10 mm</p>	<ul style="list-style-type: none"> Accurate Operator independent Low cost 	<ul style="list-style-type: none"> Time consuming Operator dependent


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DEPARTMENT OF PERIODONTOLOGY
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CURETTES

CURETTES

"INSTRUMENT USED FOR REMOVING DEEP SUBGINGIVAL CALCULUS, ROOT PLANING FOR ALTERED CEMENTUM AND REMOVING THE SOFT TISSUE LINING OF THE PERIODONTAL POCKET."
EACH WORKING END HAS A CUTTING EDGE ON BOTH SIDES OF THE BLADE AND A ROUNDED TOE.




Spoon shaped blade
Rounded tip

Basic characteristics of curettes

CLASSIFICATION

UNIVERSAL CURETTES


- Universal curettes have cutting edges that may be inserted in most areas of dentition by altering and adapting the finger rest, fulcrum and hand position of the operator
- The blade size and the angle and length of the shank may vary but the face of the blade of the every universal curette is at a 90 degree angle



AREA SPECIFIC CURETTES


GRACEY CURETTES

- They are designed and angled to specific anatomic areas of dentition
- Gracey #1-2: anterior teeth
- Gracey #3-4: anterior teeth facial & lingual
- Gracey #7-8: posterior teeth: mesial
- Gracey #11-12: posterior teeth: distal




AFTER FIVE CURETTES

- They are a modification of gracey curette which permits deeper periodontal pocket insertion and smoother sub-gingival insertion.
- The terminal shank 3mm longer allowing extension into deeper periodontal pockets of 5mm or more




MINI BLADED CURETTES (HU-FRIEDY MINI FIVE CURETTES)

- They are modification of extended shank curettes for easier insertion and adaptation in deep, narrow pockets, furcation, developmental grooves, line angles and developmental grooves.



LANGER AND MINI LANGER CURETTES

- They are combination of gracey and universal curettes design to allow the advantages of the areas specific shank to be combined with the versatility of universal curettes



Gracey curettes	Universal curettes
They are designed for specific areas and surfaces.	They are designed for all areas and surfaces
One cutting edge used.	Both cutting edges used
Curved into two planes.	Curved into one plane.
Face of blade beveled at 60 to shank.	Face of blade beveled at 90 to shank.

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GINGIVAL ENLARGEMENT




CLINICAL FEATURES OF HEALTHY GINGIVA

CLINICAL FEATURES OF HEALTHY GINGIVA

GINGIVA: IT IS A PART OF ORAL MUCOSA THAT COVERS THE ALVEOLAR PROCESSES OF THE JAWS & SURROUNDS THE NECKS OF THE TEETH

INTERDENTAL GINGIVA
MARGINAL GINGIVA
ATTACHED GINGIVA




NORMAL GINGIVA **PARTS OF GINGIVA** **SULCUS DEPTH**

PARTS OF GINGIVA

MARGINAL GINGIVA: IS TERMINAL EDGE OF THE GINGIVA SURROUNDING THE TEETH IN COLLARLIKE FASHION
ATTACHED GINGIVA: IS CONTINUOUS WITH THE MARGINAL GINGIVA, WHICH IS FIRM & RESILIENT
GINGIVAL SULCUS: IS 'V' SHAPED CREVICE BOUNDED BY TOOTH & EPITHELIUM LINING ON EACH SIDE
INTERDENTAL GINGIVA: OCCUPIES THE GINGIVAL EMBRASSURE & IT CAN BE PYRAMIDAL OR TENT SHAPED

CLINICAL FEATURES

COLOR	CONTOUR	CONSISTENCY	SURFACE	POSITION	
					
CORAL PINK	MELANIN PIGMENTATION	SCALLOPED & KNIFE EDGE MARGIN	FIRM & RESILIENT	STIPPLED	AT OR 1MM ABOVE THE CEJ

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CLINICAL FEATURES OF GINGIVITIS

CLINICAL FEATURES OF GINGIVITIS

DEFINITION:- PRESENCE OF INFLAMMATION THAT IS CONFINED TO GINGIVA ONLY




ACCORDING TO COURSE AND DURATION :-

1. ACUTE GINGIVITIS :- SUDDEN ONSET & SHORT DURATION AND CAN BE PAINFUL
2. CHRONIC GINGIVITIS :- SLOW ONSET & LONG DURATION, GENERALLY PAINLESS
3. RECURRENT GINGIVITIS :- REAPPEARS AFTER HAVING BEEN ELIMINATED BY TREATMENT





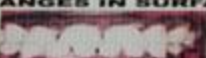







ACCORDING TO TOOTH OR GROUP OF TEETH INVOLVED :-

1. LOCALIZED
2. GENERALIZED

ACCORDING TO GINGIVAL AREA INVOLVED :-

1. MARGINAL:- CONFINED TO MARGINAL GINGIVA

2. PAPPILARY:- CONFINED TO ONE OR MORE INTERDENTAL SPACES

3. DIFFUSE:- EXTENDS FROM THE MARGINS TO THE MUCOBUCCAL FOLD


CLINICAL FEATURES OF GINGIVITIS

<p>1. GINGIVAL BLEEDING ON PROBING :-</p>   <p>- EARLIEST VISUAL SIGN OF INFLAMMATION - IT MAY BE CHRONIC, RECURRENT OR SPONTANEOUS</p>	<p>2. COLOR CHANGES IN GINGIVA :-</p>   <p>- NORMAL COLOR - CORAL PINK - IN ACUTE GINGIVITIS - BRIGHT RED OR REDDISH PINK - IN CHRONIC GINGIVITIS - BLuish RED OR PINKISH RED</p>
<p>3. CHANGES IN SURFACE TEXTURE :-</p>   <p>- LOSS OF STIPPLING IS AN EARLY SIGN OF GINGIVITIS - IN CHRONIC GINGIVITIS - IT MAY BE SMOOTH & SHINY OR FIRM & NODULAR</p>	<p>4. CHANGES IN CONSISTENCY OF GINGIVA :-</p>   <p>- NORMAL CONSISTENCY - FIRM AND RESILIENT - IN ACUTE GINGIVITIS - SOFTENING & DIFFUSE PUFFINESS - SLOUGHING MAY BE SEEN - IN CHRONIC GINGIVITIS - SOGGY PUFFINESS, MAY BE FIRM & LEATHERY</p>
<p>5. CHANGE IN CONTOUR OF GINGIVA :-</p>   <p>- NORMAL CONTOUR - SCALLOPED AND MARGINS ARE KNIFE EDGED - IN GINGIVITIS - MARGINAL GINGIVA BECOMES ROLLED OUT AND INTERDENTAL PAPPILA BECOMES BLUNT AND FLAT</p>	<p>6. CHANGE IN POSITION OF GINGIVA:-</p>   <p>- NORMALLY THE GINGIVAL MARGINS LIES AT OR SLIGHTLY CORONAL TO THE CEMENTO ENAMEL JUNCTION - IN RECESSION - THERE IS EXPOSURE OF ROOT SURFACE BY AN APICAL SHIFT IN POSITION OF GINGIVA</p>

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