
FULL-MOUTH REHABILITATION—LABORATORY PROCEDURES

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ABSTRACT

To generate highly aesthetic results, as well as the most precise interaction between gums, bones, muscles, and teeth, full-mouth rehabilitation and complete arch reconstruction need the use of very specific lab protocols and techniques. Confirmation of tolerance to changes in the vertical dimension occlusion (VDO) is of paramount importance. A diagnostic wax-up and articulated study castings can give information for the assessment of treatment alternatives. The intermediate interval may be altered in accordance with the patient's circumstances and ability for adaptation. This article aims at providing a literary review of the treatment planning of full-mouth rehabilitation that will assist clinicians in the therapeutic plan. Observing the final result before starting therapy is essential for long-term success. Full-mouth rehabilitation entails the performance of all the procedures necessary to produce an aesthetic, well-functioning and self-maintaining masticatory system.

Keywords: *full-mouth rehabilitation, occlusion, laboratory protocol*

INTRODUCTION

As a dynamic functional activity, full-mouth rehabilitation entails the coordination and integration of all component elements into a single working unit. The shape and function of masticatory apparatus should be restored as close to normal as possible. Full-mouth rehabilitation can be categorized into three groups based on clinical and laboratory techniques when both arches are restored at the same time (1). Simultaneous restoration of both arches is done (2). Restoration of each quadrant is carried out according to a programmed manner (3). A combination of both can be done (1).

Prior to initiating a reconstructive procedure, the clinician must decide upon the occlusal approach and appropriate occlusal scheme, after having evaluated and classified the patient's existing clinical situation (2).

Occlusal approach for restorative therapy can be either conformative approach (often advisable) or a reorganized approach. In a conformative approach, the occlusion is reconstructed according to the patient's existing intercuspal position. In a reorganized approach, a new occlusion scheme is established around a suitable condylar position, which serves as the centric relation (CR) position.

It is used when just a minimal quantity of intervention is needed. If the intercuspal position is currently unacceptable and needs to be changed, or if extensive treatment is required to improve the patient's occlusion, it may be reorganized. Loss of vertical dimension occlusion (VDO), severe bruxism, occlusion-related trauma, lack of interocclusal space for restorations, repeated fracture/failure of teeth or restorations, unacceptable function and aesthetics,

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presence of temporomandibular joint disorders or developmental anomalies are all signs that a new approach needs to be taken (3,4,5). Furthermore, one of the most significant aspects to take into consideration is whether or not an increase of the vertical dimension is necessary (6,7).

MATERIALS AND METHODS

The searches were performed in the databases of Google Scholar, PubMed, and ScienceDirect. Several articles from a prosthodontics textbook were also taken into consideration. The information included in the research was chosen due to its topical significance.

DISCUSSION

The searches were performed in the databases of Google Scholar, PubMed, and ScienceDirect. Several articles from a prosthodontics textbook were also taken into consideration. The information included in the research was chosen due to its topical significance.

CONCLUSION

Optimal oral health is the ultimate objective of all dental procedures. Observing the end result before starting therapy is essential for long-term success. Full-mouth rehabilitation entails the performance of all the procedures necessary to produce an aesthetic, well-functioning and self-maintaining masticatory system. In the procedures listed above, proper diagnosis and execution of the treatment plan are critical to success.

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