هناء محمد على

شبكة المعلومات الجامعية

بسم اللّه الرحمن الرحيم

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التوثيق الالكتروني والميكروفيلم

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جامعة عين شمس

التوثيق الإلكتروني والميكروفيلم

قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها علي هذه الأقراص المدمجة قد أعدت دون أية تغيرات

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بالرسالة صفحات لم ترد بالأصل

CLINICAL EVALUATION OF ENAMEL MATRIX DERIVATIVE USED IN CONJUNCTION WITH SUBEPITHELIAL CONNECTIVE TISSUE GRAFT FOR THE MANAGEMENT OF CLASS II MARGINAL TISSUE RECESSION

Thesis

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Abbreviations

CEJ : Cemento-enamel junction.

LSF : Lateral sliding flap.

CPF : Coronally positioned flap.

GTR : Guided tissue regeneration.

e-PTFE : expanded polytetrafluoroethyle

RD : Recession Depth.

CAL : Clinical Attachment Level.

EMD : Enamel Matrix Derivative.

PDL : Periodontal Ligament.

PD : Probing Depth.

Contents

INTRODUCTION

The first discussion of "Mucogingival Surgery" was proposed in 1957 by Friedman[1] who introduced this term in order to correct problems such as pockets extending apical to the mucogingival junction, malpositioned frenum or muscle attachment and inadequate depth of the vestibule. As the pendulum swung toward more attached gingiva, the term "Periodontal Plastic Surgery" was introduced by Miller[2] designating "the surgical procedures performed to correct or eliminate anatomic, developmental, or traumatic deformities of the gingiva or the alveolar mucosa". This has further expanded the objective of the surgery from creating an adequate zone of attached gingiva to correction of ridge form, exposure of unerupted teeth for orthodontic treatment, esthetic surgery for crown lengthening and frenal surgery. The term of "Mucogingival Surgery" was defined according to the Glossary of Periodontal Terms[3] as "a periodontal surgical procedure to correct defects in the morphology, position and/or the amount of gingiva". However, removal of the frenum and deepening of the vestibule failed to correct these problems because the primary cause, the lack of attached gingiva, was overlooked[4].

Any mucogingival problem occurring will demonstrate itself via two ways: either as a closed disruption of the mucogingival complex resulting in pocket formation, or as an open disruption resulting in periodontal clefts and recessions[5]. Recession of the marginal periodontal tissues over mainly the facial root surfaces is a fairly common finding. From an epidemiological point of view, localized buccal gingival recessions occur in more than 60% of individuals[6], and account for a significant amount of periodontal attachment loss in subjects with good oral hygiene[7]. The primary causes of gingival recessions are improper oral hygiene measures[8], and periodontal disease[6], which result in root sensitivity, impaired esthetic appearance, and root caries[9].

Covering exposed root surfaces has become an integral part of surgical periodontal practice. The increasing interest in esthetics and the subsequent need to solve related problems such as hypersensitivity have favored the development of many surgical techniques that permit the coverage of exposed roots with varying degrees of success. These include laterally positioned pedicle flap[10], oblique positioned pedicle graft[11], double papilla graft[12], free gingival graft followed by a coronally positioned flap[13], coronally repositioned flap[14], and free autogenous gingival graft[15]. Each one of these techniques has its strengths, weaknesses, indications, and contraindications.

The use of subepithelial connective tissue graft technique[16] represented a major breakthrough in root coverage grafting. Healing of such graft occurs via a long junctional epithelium with only minimal signs of new cementum-like tissue formation in the apical portion of the recession site[17].

The goal of periodontal therapy however, has long been the regeneration of the periodontal attachment apparatus with new bone, cementum, and periodontal ligament. Thus, guided tissue regenerative procedures have been introduced in the treatment of gingival recession[18]. Although successful results were obtained with this technique, many technical difficulties have been encountered with guided tissue regeneration including primary wound closure, secondary membrane exposure, and additional cost[19].

In an evidence-based analysis, it was stated that "sufficient evidence exists to warrant and support the use of regenerative therapies