Denture Cleansers and Post Delivery problems

Dec, 23, 2015
Dec, 30, 2015

Introduction

- There is a wide range of denture cleansers available over the counter.
- Surveys showed that elderly patient face difficulty cleaning his denture and find it easier to continue wearing a dirty denture.
- Misuse or abuse of approved cleaning methods or the use of alternative regimes e.g. prolonged or frequent soaking in household bleach might deteriorate the denture mechanical properties.

Requirements of Denture Cleansers

1. Non-toxic, non-irritant.
2. Easy to apply and remove without residues.
3. Remove the organic portion of denture deposits.
4. Remove the inorganic portion of denture deposits (mainly calcium phosphate and calcium carbonate).

Types of Denture Cleansers

1. Mechanical action denture cleansers.

These include:

1. Abrasive pastes used with brushes (Dentucreme, Boots Denture Paste).
   Hard brushes + pressure → abrasion.
2. Ultrasonic cleaners:
   Suitable for handicapped patients or patients with impaired manual dexterity.

Types of Denture Cleansers

2. Chemical action denture cleansers.

These include:

1. Effervescent perioxides (Steradent).
2. Alkaline hypochlorite (Dentural, Milton).
3. Acids (Denclen, Deepclean).
4. Disinfectants (chlorhexidine).
5. Enzymes (Kobayashi, Polident).

Effervescent peroxides

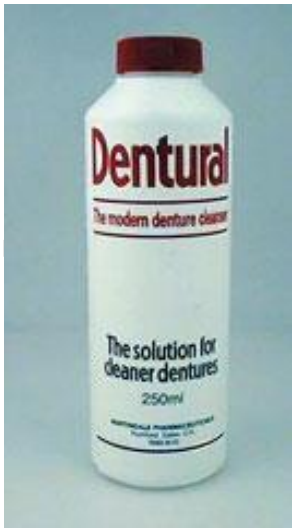
- Powder or tablet releases oxygen on mixing with water.
- Can be acidic, alkaline or neutral.
- Simple to handle and effective with low to medium stain and calculus accumulations.
- Use of very hot water and prolonged exposure may lead to bleeching of acrylic resin.
- Have possible mechanical effect through oxygen release.

Effervescent peroxides

- Limited antibacterial effect.
- Will not remove calculus.
- Some brands are mixed with proteolytic and yeastlytic enzymes that degrade the proteins in the plaque increasing its effectiveness.

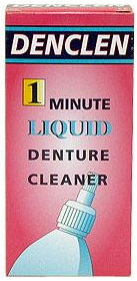
Alkaline Hypochlorite

- Superior cleaning properties.
- Dissolves plaque and inhibits plaque formation.
- Superior stain removal properties.
- Some bactericidal and fungicidal prope
- Disadvantage: excessive bleaching is possible and corrosion of metals, residual taste and odor.



Acids

- Less popular.
- Useful for stubborn stains and calcified deposits.
- Disadvantage: cause corrosion to metals.

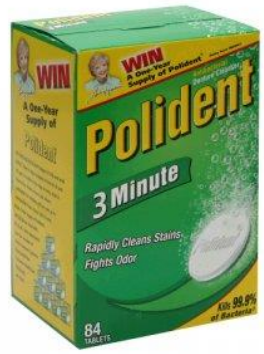


Disinfectants

- Chlorhexidine is recommended as adjunct in denture induced stomatitis, denture should then be soaked 15 minutes twice daily.
- Disadvantage: Brown staining.

Enzymes

- When incorporated with other cleansers the proteolytic and yeastlytic effect increase action.



Recommendations

- After each meal, denture should be rinsed and gently brushed with soap and water.

Recommendations

- For acrylic resin dentures:
  Alkaline hypochlorite solution should be used by soaking the denture for 20 minutes in the evening and then rinsed and soaked in cold water overnight.
  Occasional use of acid cleaners helps against stubborn stains and calculus.

Recommendations

- For metal based dentures:
  Alkaline peroxides are suitable for use (15 minutes soaking).
  Alkaline hypochlorites can be used for short periods (10 minutes) otherwise metals will get discolored and corroded.
  Acid cleaners are contraindicated.

Recommendations

- For Dentures with temporary soft liners (like Viscogel and CoeComfort):
  No brushing is allowed.
  Effervescent peroxides should not be used as these cause bubbling.
  Rinse denture and soak daily for 20 minutes in hypochlorite cleaner.
  Material should be replaced frequently.
  Hypochlorite use results in prolonged taste and odor.

Recommendations

- For Dentures with permanent resilient soft liners (like the silicon Molloplast B or KG or the acrylic Coe super soft):
  Brush lightly with soft brush and use same regime as for temporary soft liners.
  If a metal strengthener is incorporated, don't soak for more than 10 minutes.

Recommendations

- For Dentures with denture fixatives:
  Repeated use of the denture without the use of denture cleaners will produce mal odor and enhance plaque and calculus accumulations resulting in stomatitis.
  It is essential to remove fixatives and clean denture fresh material is used.

Advantages of denture cleanliness

- Prevent mal odor.
- Produce better esthetics.
- Prevent plaque and calculus accumulations and prevent damage to mucosa.

- **Care of:**

DenturesPlastic dentures

Dentures should always be cleaned over a basin of water to minimise to risk of breakage should they be dropped.

- Rinse denture after every meal and remove debris by brushing with a soft brush, soap and cold water.
- Soak denture in an alkaline hypochlorite soaking solution e.g. baby bottle sterilizing solution, "Milton" or "Dentural" for 20 minutes in the evening.
- Rinse thoroughly with cold water and soak in cold water overnight.

Metal and plastic

Rinse denture after every meal and remove debris by brushing with a soft brush, soap and cold water.

- Soak denture in an alkaline peroxide solution (e.g. "Steradent") for 15 minutes or an alkaline hypochlorite solution ("Dentural" or "Milton") for 10 minutes in the evening. Rinse denture thoroughly with cold water and soak in cold water overnight. Do not use acid cleansers.

Temporary soft linings

Rinse denture after every meal with cold water.

- Soak denture in an alkaline hypochlorite solution ("Dentural" or "Milton") for 20 minutes.
- Rinse thoroughly with cold water.
- Do not use alkaline peroxide cleansers.

Permanent soft linings

Rinse denture after every meal and remove debris by brushing with a soft brush, soap and cold water.

- Soak denture in an alkaline hypochlorite solution ("Dentural" or "Milton") for 20 minutes in the evening.
- Rinse denture thoroughly with cold water and soak in cold water overnight.
- Advice provided by the Britsh Dental Association

Denture Complaints in relation to time of delivery

- Immediate complaints.
- Delayed complaints.
- Problems with no complaints !!!

Presentation of patient with complaints

- Informed patient of possible problems.
- Un-informed patient:
  - Sense of pain.
  - Sense of loss (waste of time and money).
  - Sense of deceit.

Categories of Complete Denture Complaints

- Pain and discomfort.
- Appearance.
- Inability to eat.
- Lack of retention and instability.
- Clicking of teeth.
- Nausea.
- Inability to tolerate dentures.
- Altered speech.
- Biting the cheek and tongue.
- Food under the denture.
- Inability to keep denture clean.

Pain and Discomfort

Causes:

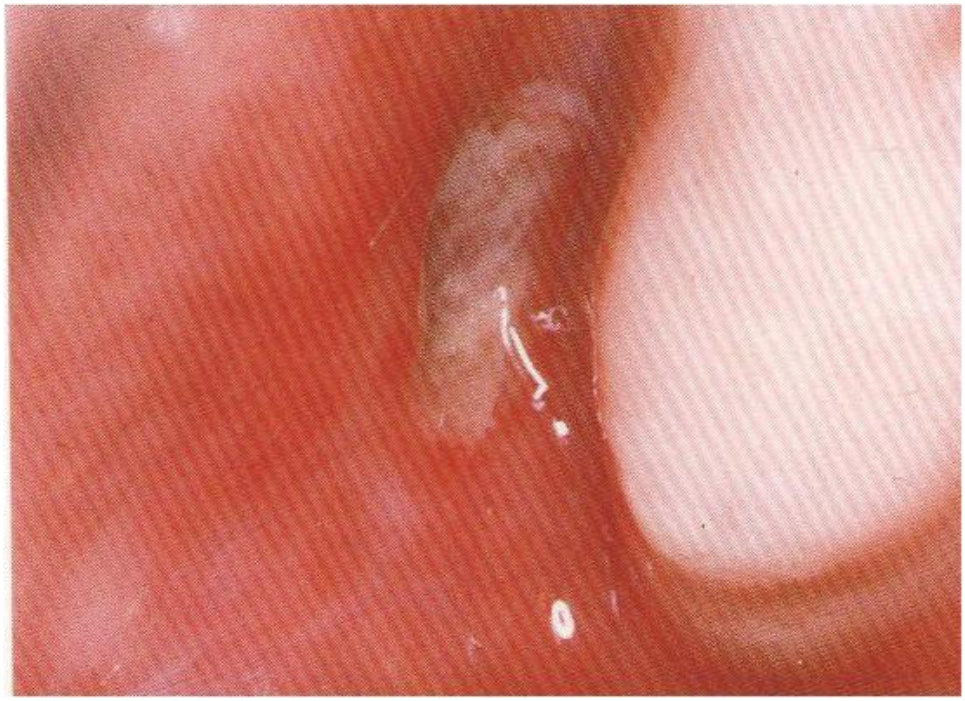
- Over-extension of the periphery.
- Poor fit.
- Insufficient relief.
- Occlusal faults:
  - Wrong antero-posterior relationship.
  - Uneven pressure.
  - Excessive vertical dimension.
  - Insufficient vertical dimension.
  - Cuspal interference.
- Teeth off the ridge.
- Retained root or unerupted tooth.
- Narrow resorbed ridge.
- Mental foramen.
- Irregular resorption.
- Rough contact or fitting surface.
- Swallowing and sore throat.
- Undercuts.

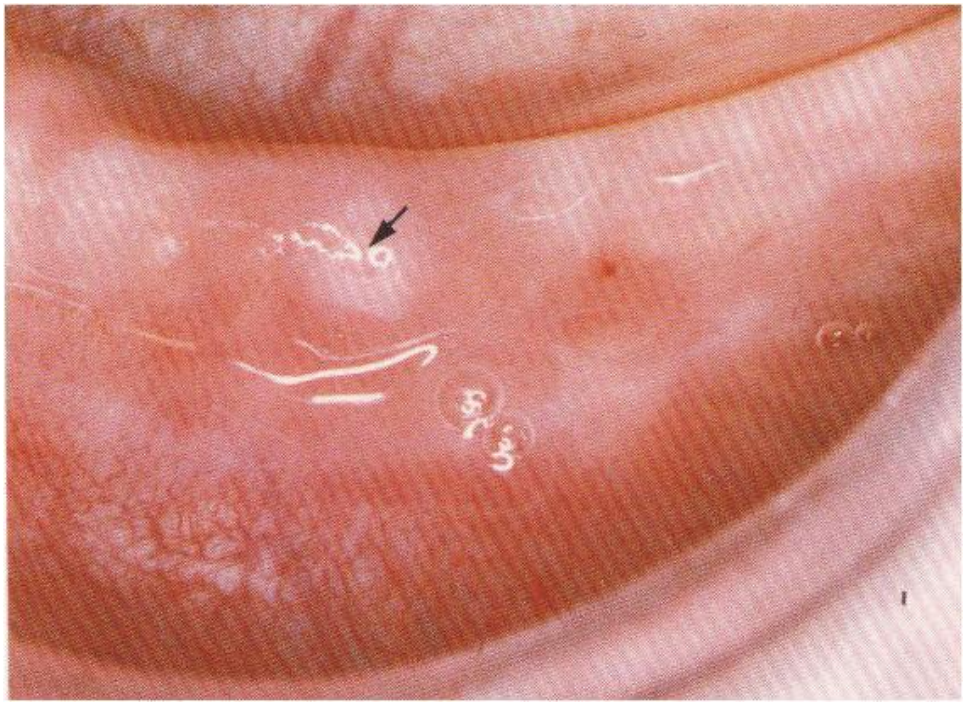
Over-extension of the periphery

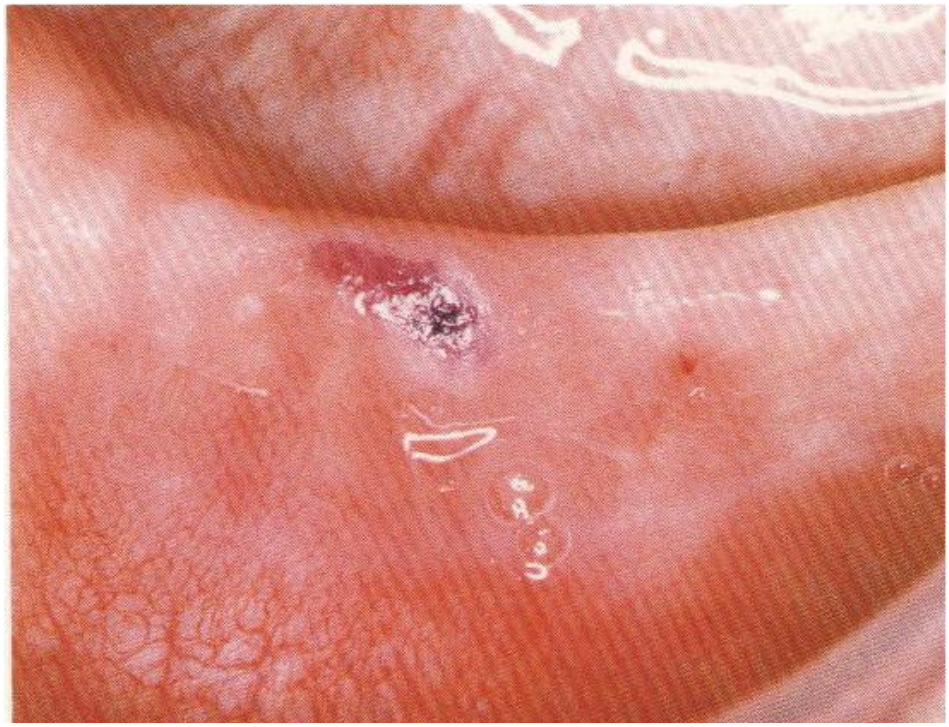
- The most common cause of pain.
- Impression errors.
- Corresponds to hyperaemic area or ulcer.

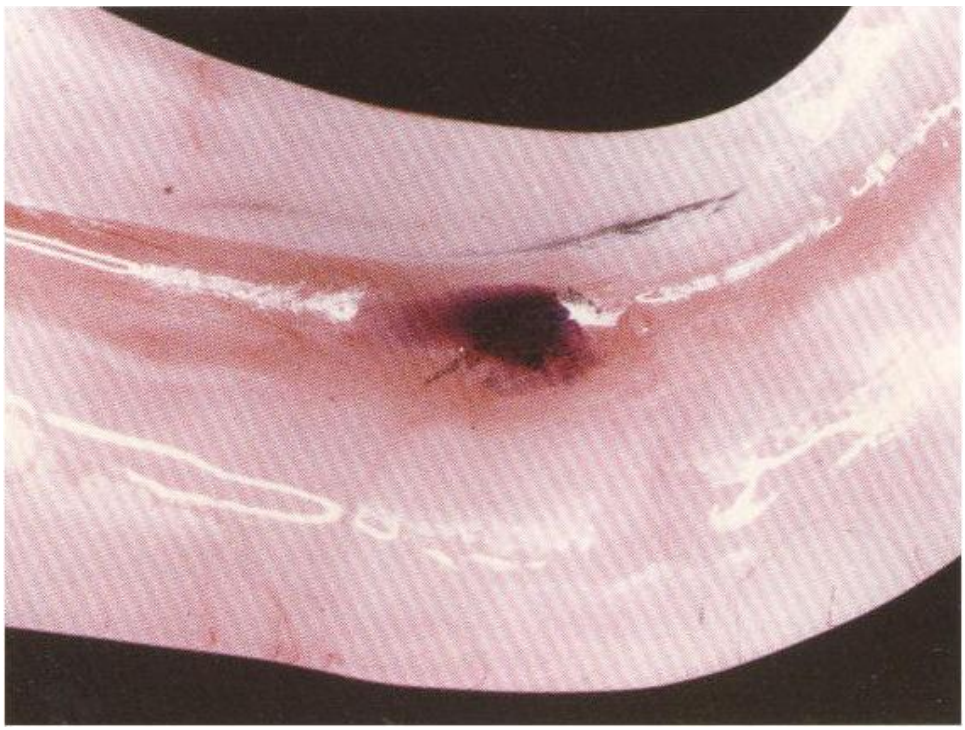
Treatment:

- Pressure indicating paste to periphery of denture or:
- Methylene blue or indelible pencil to injured mucosa.
- Ease periphery with a bur, and polish it.
- The complaint might be delayed: here it is due to ridge resorption and often it is accompanied by hyperplasia. In this case the cut back denture should be lined with tissue conditioner. When the hyperplastic region has been reduced a new denture should be constructed.









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Poor fit

- Poor denture retention, rocking unseating in any position.
- Denture movement over the mucosa will cause pain and areas of inflammation might be present.

Treatment:

- Tissue conditioner to existing denture.
- Construct a new denture.

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Insufficient relief

- Areas to be relieved of the denture:
  - Prominent bony areas (buccal canine region).
  - Bony tori (maxillary or mandibular).

Treatment:

- Apply pressure indicating paste to demarcate the area and ease the fitting surface of the denture.

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Wrong anteroposterior relationship

- Mismatch of ICP and RCP.
- Interdigitation of teeth locks the dentures together, while the patient will not feel comfortable in that situation. Trials to retrude the mandible will rub the denture against the mucosa. This will cause pain and looseness .

Treatment:

- Slight error: check record, remounting, and grinding of teeth.
- Gross: place occlusal pivots to reposition lower dentures. Remake lower denture.

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Uneven pressure

- Error in setting artificial teeth, resulting in the tilting of dentures.
- Pain is confined to the crest of the ridge on one side, and may be related to buccal aspect of the ridge on one side and lingual aspect of the ridge on the other side as the problem causes tilting of the denture (it is mainly the lower).
- Diagnosis: by using a mylar strip on either side with the patient closing just to hold it without reaching the tilting point of the denture bases.

Uneven pressure

Treatment:

- Slight error: chair side occlusal grinding.
- Moderate errors: clinical remount.
- Severe errors: add tooth colored self-cured acrylic resin over posterior teeth in area of light occlusion, then either remake denture or replace posterior teeth.

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Excessive vertical dimension

- Error during registration stage or incomplete closure of the denture flasks.
- Pain on crest of lower ridge.
- Easing gives immediate temporary relief of pain that will come back few days later at a different site.
- Complaint: teeth jar, clatter, too high or in the way.

Treatment:

- If occlusal plane of upper denture is acceptable, replace teeth on lower denture or make a new lower denture.
- Otherwise: new upper and lower denture.

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Insufficient vertical dimension

- This condition is often a delayed one not immediate.
- Results from the alveolar ridge resorption and/or acrylic teeth attrition.
- Indefinite location of pain.
- May be associated with temporomandibular joint dysfunction.

Treatment:

- Use of occlusal pivots to stabilize the occlusion, followed by new dentures.

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Cuspal interference

- Dragging action will be exerted on both dentures during lateral and protrusive movements with teeth in contact if cusped posterior teeth are used or if excessive incisal guidance angle has been used.
- Dragging will cause pain on retentive dentures or instability with loose ones.
- Pain is widely distributed, and only experienced on eating.
- Sore areas on buccal or lingual surfaces of ridges.

Treatment

- Slight: chair side grinding or clinical remount.
- Gross: new dentures with balanced occlusion.

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Teeth off the ridge

- Pain in upper buccal sulci and tuberosities.
- Upper teeth are often too far buccally (to meet occlusion in cases of skeletal class III).
- During function, upper denture will tilt, digging the periphery into the mucosa on the working side, and pulling it down the tuberosity on the opposite side.

Treatment:

- Remove last four molar teeth and reduce the bulk of acrylic over the tuberosities to give more tongue space posteriorly to control upper denture.
- New dentures with above faults corrected.

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Retained root or unerupted tooth

- Pain results from direct pressure on an area already tender.
- Well fitting denture may obstruct undetected sinus.

Treatment:

- Extraction of the root or tooth, followed by relining of the denture in that site.
- Or easing the fitting surface over it if extraction is not indicated.

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Narrow resorbed ridge

- Often the lower ridge. The denture squeezes the mucosa against the sharp bony ridge.
- Pain may be accompanied with burning sensation. Worst after meals.

Treatment:

- Alveolectomy followed by relining the denture, or simply: relief over the sharp irregular ridge.

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Mental foramen

- Normally it is situated below the alveolar ridge. With resorption, it becomes over the crest of ridge.
- Pressure from denture may elicit localized or referred pain.

Treatment:

- Relief.

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Irregular resorption

- This results in rough area of the crest of ridge with sharp specules of bone.
- Pain will be elicited when the intervening mucosa is pressurized.
- Similar to pain due to narrow resorbed ridge, but pain is localized.

Treatment:

- Surgical smoothing of the affected area followed by relining the denture or; just relieve the denture.

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Rough contact or fitting surface

- Small pimples or blebs of acrylic over the fitting surface due to inaccuracies of the surface of the cast.

Treatment:

- Remove roughness by acrylic bur.

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Swallowing and sore throat

- "Pain on swallowing" or "sore throat" are indicative of over-extension of the denture.
- The upper will be over-extended over the soft palate or pressing over the hamular notch or the postdam region.
- The lower will be over-extended distally in the lingual pouch.
- There will be an area of slight redness or ulceration.

Treatment:

- Reduction of the over-extension.

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Undercuts

- Often used by dentist to aid in denture retention.
- Associated with redness and ulceration.
- Treatment:
- Teach the patient how to insert the denture painlessly. If not successful, relief fitting surface. Or alveolectomy then, construction of new buccal or lingual flange.

Summary

Localized painful areas with ulceration

- Blebs and surface irregularities.
- Periphery too sharp
- Postdam too deep
- Edges of relief areas
- Lack of relief
- Occlusal error
- Excess periphery
- Tissue displacement by impression
  - Pterygomaxillary notch
  - Frenum
  - Pear-shaped pad.

Localized painful areas without ulceration

- Upper displaceable ridge
- Rough bony alveolar ridge
- Dental remnant
- Mental foramen
- Mylohyoid ridge
- Buccal prominence of tuberosity.
- Lack of relief e.g. incisive papilla
- Occlusal error
- Excessive vertical dimension
- Denture into undercuts
- Cramped tongue space
- Mucosal displacement

Categories of Complete Denture Complaints

- Pain and discomfort.
- **Appearance.**
- Inability to eat.
- Lack of retention and instability.
- Clicking of teeth.
- Nausea.
- Inability to tolerate dentures.
- Altered speech.
- Biting the cheek and tongue.
- Food under the denture.
- Inability to keep denture clean.

Appearance

- It is difficult for some patients to formulate a decision regarding aesthetics at the try-in stage.
- The presence of a friend, spouse or relative at the try-in stage will help the patient make such a decision and accept it.
- The patient might accept the trial denture and still remain unsatisfied with the finished denture.
- Final esthetics can be assessed only 4-6 weeks after the insertion of the denture due to adaptation of lips and muscles.

Appearance – Facial appearance

- May complain: nose and chin are prominent or are approximating. This is due to failure to restore the OVD correctly. Or if the complaint is delayed, it will be due to alveolar resorption.
- May complain: that the lips and cheeks are falling in. This is because teeth have been set too far lingually or having insufficient width to the buccal and labial flanges.

Appearance – Dissatisfaction with teeth

- Colour
- Shape
- Position

Appearance – Dissatisfaction with teeth

Colour

- Usually the complaint is that teeth are too dark or too yellow. The dentist should explain the colour does get darker and yellower with age.

Treatment: Change the colour to the colour you both finally agreed to. If you think the wanted colour will look absurd, delay treatment or refer to colleague to convince him more.

Appearance – Dissatisfaction with teeth

Shape

- Complaint: " They don't look right".

Treatment: remove teeth, mount other new teeth of different or shape in wax until suitable ones are obtained.

Appearance – Dissatisfaction with teeth

Position

- Complaint: " Teeth too far back" or "too far forward". Reason: the setting has been left to the technician who sets teeth onto crest of ridge (but remember there is upper labial resorption, making the teeth too far lingually).
- Complaint: "Teeth too low and show too much". Anterior teeth may be removed and replaced at a higher level or better by remaking the denture

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Inability to eat

- Usually, new denture wearer.
- Certain food stuffs are more difficult to consume.
- Cusp teeth vs low-cusp or zero-cusp teeth.
- Lack of interdigitation of posterior teeth.
- Unbalanced occlusion.
- Locked occlusion (plane line articulator).
- Restricted tongue space.
- Over-extension of periphery.
- Habit of eating on anterior teeth only

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Lack of retention and instability

- When mouth is opened:
  - Low (or defensive) tongue position
  - Over-extension: if slight affects retention, if severe causes pain also.
  - Tight lips: exerts unseating pressure on lower denture
  - Restricted tongue space: Trim lingual cusps altogether.
  - Under-extension and lack of peripheral seal: very common, check by adding tracing compound, then reline.
  - Lack of saliva: artificial saliva.
- When coughing or sneezing:

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Clicking of teeth

- Excessive vertical dimension especially with sibilant sounds.
- Movement of lower denture.
- Cuspal interference and lack of balanced occlusion.
- Excessive incisal guidance angle and low overjet.
- Porcelain teeth.

Categories of Complete Denture Complaints

- Pain and discomfort.
- Appearance.
- Inability to eat.
- Lack of retention and instability.
- Clicking of teeth.
- **Nausea**.
- Inability to tolerate dentures.
- Altered speech.
- Biting the cheek and tongue.
- Food under the denture.
- Inability to keep denture clean.

Nausea

- Upper denture slightly over-extended: remove over-extension and readapt post dam.
- Denture under-extended: this causes intermittent contact with the tissues.
- Thick posterior border: irritates dorsum of the tongue.
- Protrusive imbalance: this will cause upper denture to dislodge posteriorly and tickle tissues there.

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Inability to tolerate dentures

It would help in this case to compare it to the old denture

- Cramped tongue space: as the ridges have resorbed with failure to set the teeth in neutral zone.
- Altered vertical height.
- Altered occlusal plane.
- Unemployed ridge: difficult to wear lower denture.
- Changes in shape: unless the patient can accept the change in shape after some time, remake preferably with the copy denture technique.

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Altered speech

- Can be enhanced by exercise, otherwise remake.

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Biting the cheek and tongue

- Cheek biting:
  - Insufficient buccal overjet: reduce buccal surfaces of buccal cusps.
  - Reduced vertical height: remake at the proper VDO.
- Biting the tongue: due to decreased tongue space or decreased VDO.

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- Inability to keep denture clean.

Food under the denture

- Due to lack of peripheral seal of the lower denture. This can be treated by maximum lower denture coverage with maximum peripheral seal.

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- **Inability to keep denture clean**.

Inability to keep denture clean

- Inadequate finishing of denture especially interdentally.
- Use of hard abrasives.
- Failure to clean dentures regularly.
- Incorrect use of denture cleansers.
- Reduced manual dexterity of the elderly (or ill) patient.