Peads sheet 7

The doctor just read the slides and said few notes

Slide notes :

Slide 4\* if the 3rd molars are missing we don't call it hypodontia , also when we talk about hyodontia we mean the developmental absence not the environmental such as loss due to trauma , so hypodontia means that the tooth was not formed

Slide 6\* genetic in certain families due to the gene that is responsible for tooth formation is defective, so you will see members in the family have hypodontia

Slide 7\* false positive means : when you do clinical examination and the you say certain tooth is missing while it is impacted or the tooth not formed yet , for example ; a 6 years old patient took an OPG and the clinician founds there is no 2nd premolar was formed , then after 2 years , he took another OPG and he found that the 2nd premolar is formed

The most tooth that we think it is missing is the 2nd premolar , because it is the last that formed in the jaw , so you have to wait until age 7-8 years until you decide that tooth is missing

Slide 15\* patient with hyodontia expected to have infra occluded teeth

Bridges and veneers are rare to be done

Slide 16\* hyperdontia in primary teeth is underestimated , because not all the patient with hyperdontia has been examined in this period " primary dentition " , and might be due to the space between the teeth , the extra tooth is well accommodated in the arch , the parents won't notice that or the dentist sometimes won't notice

Slide 18\* dental lamina hyperactivity theory : dental lamina is the structure that formed the teeth , so when the dental lamina is hyperactive it might produce a higher number than the normal

Slide 20\* tuberculate most commonly found in the anterior maxilla

Slide 21\* wide diastema more than 3 mm , you should consider the presence of supernumerary tooth

Slide 24\* if the supernumerary not causing any problem , you can leave it without extraction and just follow up

Complication that consider the extraction of supernumerary tooth such as : preventing eruption of a permanent tooth , causing root resorption , rotation or displacement

Slide 25\* supernumerary tooth on the right

Slide 26\* missing 2nd premolars in the lower jaw , and mesiodens in the upper

Slide 27\* the patient has a tuberculate in the upper jaw above the centrals

Slide 28\* microdontia could be generalized or localized ( peg shaped lateral )

Slide 32\* localized such as turner tooth that caused by trauma or infection , most anterior tooth is affected is the central , and most posterior teeth are affected are the premolars due to infection of the Ds and Es , the first molar cannot be affected because it doesn't has a preccesor (primary tooth) , so to have a turner tooth it should has a precceser

Slide 33\* in the generalized form the distribution on the teeth allow you to determine at what age the infection was happened

slide 37\* the radiographs shows you a different contrast in enamel which look much closer to the density of dentin ( in the normal pattern the enamel more radio opaque than dentine ) , so this is AI , some cases the enamel already not formed as in hypoplastic type , the teeth will look very thin

Slide 38\* hypoplastic : the enamel was not formed ( deficient enamel ) ,

 hypomaturation the least sever form

slide 39\* hypoplastic type could be with smooth or rough surface

slide 40\* in the hypomineralized form the enamel shipped off easily , the teeth are yellowish in color due to hypocalcified teeth which make the enamel more translucent

slide 42\* sensitivity due to exposed dentin , gingivitis due to rough surface of the tooth ,

slide 46\* the prevalence is 3.6-25% and there is another studies say that it reach up to 40 % , (FPM : first permanent molars) ,

slide 47\* post eruption breakdown means that when you look at the tooth , some of its structures are missing . Atypical restoration means that it is not only a restoration due to fissure caries or groove , it is more extended to the buccal and palatal/ lingual surface , involving the cusp tips .

slide 49\* post eruption break down caused by subsurface porosity

slide 52\* amoxicillin maybe one of the causes of MIH or might be the illness that we treated by amoxicillin that caused MIH ,but to be certain it is unknown etiology

slide 53\* explanation to parents that the only affected teeth are just the FPMs almost

slide 55\* desensitization : to reduce the sensitivity by applying topical fluoride .

tooth mousse it decrease the sensitivity too , and if it applied on the anterior teeth it will improve the esthetic too

slide 57\* difficulties : 1. Difficult to achieve the anesthesia ( the pulp is highly innervated ), 2. Management of child behavior will be difficult due to multiple visits , or they might had a bad experience with some doctors , 3. Determine how much enamel to remove ( affected enamel ) , it is even hard to an experienced dentist to determine that

slide 59\* GIC provide : 1. Easily placed , 2. Release fluoride , 3. Mechanical attachment to tooth structure

RMGI : superior to GIC , but both are not recommended as definitive treatment

amalgam : it cannot be used at all in MIH because the tooth doesn't have good structure , it needs sound enamel to get its retentive form

slide 65\* pt with sever MIH ,radiographically not that sever but on clinical examination it is much worse

slide 66\* they decide to extract the affected teeth , you can noticed the closer of space in the upper much better than the lower

slide 67\* a better alignment noticed when the pt get 10 years old

slide 68\* perfect space closer at age 13

studies shows that space closer in the maxilla is up to 96% after the extraction of the 6s , but in the mandible it is much less and it needs sometimes the eruption of 8 and the good alignment of 5 " not distally tipped "to get better results