

Indicators Surgical Methods of Treatment of Chronic Periodontitis

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The relevance of the study. The frequency of pulp and periodontal diseases in children and adults currently does not tend to decrease. Epidemiological data on the study of endodontic lesions of teeth show that out of 37 examined orthopantomograms in patients with no clinical manifestations of endodontic diseases, 78.9% revealed destructive changes at the root tip or root canal filling was observed. On average, there were 3 endodontic teeth per person. In the structure of the therapeutic reception, 35% are visits for pulpitis and periodontitis. Completed endodontic treatment is often mistaken for success. While, even with technically perfect root canal filling, the pathological focus in the periapical tissues persists for a long time, creating the risk of relapses and complications. The need for re-treatment of the canals of the teeth exceeds the need for their primary treatment.

Surgical treatment of chronic periodontitis consists in tooth extraction, replantation, transplantation, implantation, resection of the tip of the root of the tooth and sometimes hemisection, amputation of the root of the tooth.

Tooth extraction is carried out according to the rules set out in Chapter 6. After tooth extraction with granulating and granulomatous periodontitis, granulation growths or granulomas should be carefully scraped out. For the prevention of atrophy the bones of the alveoli are filled with biomaterial, the adjacent soft tissues are mobilized and the wound is sewn tightly. In the presence of a fistula on the gum, its revision and scraping of granulation along its entire length are necessary. In some cases, it is more expedient to excise the fistula and sew up the wound by applying 2-3 submerged catgut and 3-4 sutures to the mucous membrane. In chronic granulating periodontitis, complicated by submucosal, subcutaneous, and dermal granulomas, after tooth extraction, granulomatous growths are scraped out from under the mucous membrane, periosteum, subcutaneous tissue, and skin. When removing pathological tissues in the subcutaneous tissue and on the skin of the face, the weight is pre-dissected along the transitional fold and the resulting wound is tamponed with iodoform gauze for a long time for 3-4 weeks. The focus in the soft tissues is scraped out, the fistula is excised and the wound is sutured. For aesthetic purposes, especially with significant retraction of the fistula and cicatricial changes, after its excision, tissue plasty is performed by moving two counter triangular flaps. In the postoperative period, analgin, amidopyrin and other analgesics are prescribed, on the 3rd-4th day — physical methods of treatment.

More progressive interventions in the treatment of chronic periodontitis are replantation, root apical resection, hemi-section, root amputation, immediate implantation.

Tooth replantation is the return to the hole of the removed tooth. The operation is performed if conservative therapy is unsuccessful or impossible, and tooth extraction is undesirable (V.A. Kozlov). There are vital and devital replantation. During vital replantation, the pulp is preserved. Devital implantation consists in tooth extraction, scraping of pathological tissues from the alveoli and from the root surface. After filling the channels and resection of the tops of the roots, the tooth is inserted into the hole and fixed there. Replantation is performed mainly of many root teeth. With vital replantation, teeth can function longer, up to 10-12 years. The preservation of the circular ligament is of great importance for the success of replantation. The tooth is removed carefully, trying not to injure the tissues of the dental alveoli and adjacent soft tissues. They also carefully make

curettage of the alveoli, removing granulation growths or granuloma, trying to preserve the periodontal fibers along the lateral surface of the alveoli and the circular ligament. The wound is washed with a warm isotonic sodium chloride solution with the addition of antibiotics (gramicidin, lincomycin, etc.) and loosely tamponed with sterile gauze. The removed tooth is temporarily placed in a container containing a warm (36.6 ° C) isotonic sodium chloride solution with the addition of antibiotics or a chlorhexidine solution. The tooth cavity and channels are sealed with cement or quick-curing plastic, but it is better with chemical-cured glass-polymer cement, which creates better adhesion and does not affect the bone tissue toxically. The tops of its roots are sawed off. Sometimes the roots of the teeth are not resected, but only widen the channels and carry out drug treatment and their filling. During these manipulations, the tooth is carefully held with a sterile napkin and necessarily placed in a preservative solution (isotonic sodium chloride solution, preservative "Vicon"). After the toilet of the bone, the tooth is placed in the alveolus and fixed with a wire splint, a protective plate made of fast-hardening plastic, a wire-composite fixation, a mouth guard for 2-3 weeks. In some cases, after tooth extraction, significant changes are detected in the area of one of the roots. It is amputated, the top of the remaining root is resected, and then the tooth is replanted. In other cases, tooth hemisection and replantation of only part of it may be required. In both cases, biomaterial — ostim-100, colapol, collapan, hydroxia-pol, bioimplant and their combinations are used, including with the inclusion of enzymes, disinfectants, antibiotics to fill the alveoli and the space at the resected tip of the tooth. Improve bone regeneration by mixing biomaterials with blood from the alveoli and most effectively with platelet-enriched blood plasma (T.G. Robustova).

The chronic focus of inflammation in periodontitis promotes constant antigenic stimulation. Like any other long-term inflammatory process, chronic periodontitis contributes to a decrease in the overall immunological reactivity and nonspecific resistance of the body, which increases the risk of purulent-inflammatory complications. In chronic periodontitis, there are violations of both humoral and cellular immunity, while there are 2 types of immunological reactions: immunocomplex damage, carried out by the formation of an antigen - antibody complex (the Arthus reaction) and delayed hypersensitivity. According to Bazhanov N. N. (1995), the cause of phlegmon of the maxillofacial region in 98-99% of cases is chronic periodontitis. The main causes of periodontitis include: infectious, traumatic and chemical effects on the periodontium. The leading role in the development of apical periodontitis is assigned to the infectious factor.

The aim of the study. For the treatment of chronic apical periodontitis, conservative (therapeutic), surgical and combined methods are used. The main object of influence in the treatment of chronic periodontitis is an infected root canal with its numerous branches, dentine tubules, as well as periodontal tissue that is in a state of acute or chronic inflammation. The variety of anatomical variations in the shape and number of root canals is a big problem when cleaning the entire root canal system. According to the results of recent studies, it is mechanically impossible to completely clean all the internal surfaces of the root canal, leaving untreated areas of various lengths with remnants of fibers and a "dirty layer". No more than 70% of the walls of the passable channels are processed qualitatively, mainly at the point of contact with the tool. The narrow, sinuous, non-circular macrochannels and the main part of the microchannels remain almost unprocessed. Excessive fascination with the mechanical treatment of the root canal significantly weakens the strength of the tooth. Therefore, special attention should be paid to antimicrobial drugs for intra-channel use. The choice of means for medical treatment of root canals is quite large, but it is quite difficult to choose the optimal means in a particular case, since the methods that allow identifying the microflora of the root canal and periapical tissues are laborious, and most importantly long, so the choice of antimicrobial drugs is almost always empirical.

Conclusions: The use of delayed root canal filling technology can significantly improve the long-term results of treatment of both granulating and granulomatous forms of chronic periodontitis. After 12 months, the frequency of complete obliteration of the focus of periapical destruction significantly increases by 16.1% in the granulating form, and by 14.5% in the granulomatous form, compared with traditional treatment.

Used literature

1. Eronov Yo. K. Disease incidence and statistical indicators in children with cerebral palsy // International engineering journal for research development .Vol. 5 Issue 4.2020. - P 31-32
2. Eronov Yo. K. Implementation of comprehensive prevention of dental caries in children with cerebral palsy // International Journal of Human Computing Studies Vol2 № 6 2020. JHCS - P 22-24
3. Eronov Yo.K. Indications for oral hygiene in stch children with cerebral palsy // International Journal of teguated Education Vol 3, Issue VI, June, 2020.-P. 26-27
4. EronovYo. K.Evaluationofstomatologicalinvestications in children diagnosed with cerebral palsy. “Актуальные вызовы современной науки” Украина выпуск 4(48) Часть-1.-P. 45
5. Eronov E.K.Criteria forevaluation of oral hygiene behaviorin children withcerebral palsy //“Актуальные вызовы современной науки” Украина выпуск 4(48) Часть-1.- P.45
6. EronovYo. K. Oral hygiene in sick children with cerebral palsy // “Actual problems of children’s denristry” India 22 may 2020.-P.19-20
7. EronovYo. K. Caries and stastical indicators in children with cerebral palsy. “Actual problems of children’s dentistry” // “Actual problems of childrens denristry” India 22 may 2020. - P.26-27
8. Мирсалихова Ф.Л. Минимально инвазивный метод лечения кариеса зубов у детей. //«Стоматология детского возраста и профилактика» Москва. 2018 2-70.С 9-12
9. Мирсалихова Ф.Л.Отстроченное пломбирование при кариесе постоянных зубов у детей с несформированными корнями. // «Клиническая стоматология» Москва, 2018 1/85/ январь-март. С 4-7
10. Мирсалихова Ф.Л.Минимально щадящий подход к лечению кариеса зубов у детей. // Материалы межрегиональной заочной научно-практической конференции с международным участием, посвященной 85-летию профессора В.Ю.Миликевича «Актуальные вопросы стоматологии». Волгоград.29 апреля 2017 г. С- 238-241.
11. Камалова Ф.Р. Изменение микрофлоры и неспецифических факторов защиты у детей при воспалительных заболеваниях челюстно-лицевой области. «Актуальные вопросы стоматологии детского возраста»// Вторая Всероссийская научно-практическая конференция, посвященная 90-летию со дня рождения профессора СайфуллинойХалимыМухлисовны. Сборник научных статей. – 2019. – С. 70-74.
12. Камалова Ф.Р. Изучение важных аспектов в развитии гнойно-воспалительных процессов челюстно-лицевой области у детей// Проблемы биологии и медицины. - 2017. - № 4,1 (98). – С. 69.
13. Камалова Ф.Р. Изучение стоматологического статуса у детей с сахарным диабетом в Бухарской области// Новый день в медицине. - 2020. - №1(29). - С. 216-218.
14. Камалова Ф.Р. Лечебно-профилактические мероприятия стоматологических заболеваний у детей с сахарным диабетом// Новый день в медицине. – 2019. - №2 (30/2). - С. 223-226.

15. Камалова Ф.Р. Первичная профилактика стоматологических заболеваний у детей// Новый день в медицине. - 2020. - №2 (30/2). - С. 383.
16. Yarieva O.O. The grade of damage to hard tissues of teeth of noncarious and carious among children and teenagers of the Bukhara region// World Journal of Pharmaceutical Research. - 2020. Vol. 3. - P. 345-350.
17. Yariyeva O.O. Clinic, Early Diagnosis and Treatment of Dental Caries in Children// International journal of Bio-Science and Bio-Technology. – India. – 2019. Vol. 6. – P. 15-23.
18. Yariyeva O.O. Importance of medical and social factors in etiology of carious and non-carious diseases of children// «International journal of pharmaceutical». - 2019. Vol. 7. – P. 456-461.
19. Яриева О.О. Алгоритм ранней диагностики и профилактики кариеса зубов у детей// «Образование, наука и практика стоматологии XXI века» VI-го международного конгресса стоматологов. - 2019. - С 12-13.
20. Яриева О.О. Болаларорасида кариес ванокариозкасаликларнингэтиологиясидатиббий-ижтимоийомилларнингхамияти// Доктор ахборотномаси. - 2019. - №3. - Б. 45-50.
21. Яриева О.О. Болалартишкарисеэтиологиясиниэртаташхислаш, даволашвапрофилактикасидасамарадорликни клиник асослаш// Журнал. Тиббиётдаянги кун. - 2020. - №2 (30). – Б. 343-347.