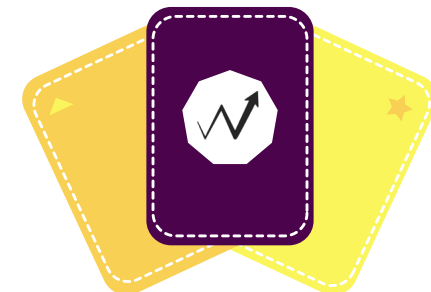


PROSTHODONTICS

COMBINATION SYNDROME



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA

WINSPERT MIND MAP

COMBINATION SYNDROME

Definition

- Definition: Characteristic features from edentulous maxilla opposed by natural mandibular anterior teeth
- Origin: Coined by Ellsworth Kelly after following 6 patients for 3 years.

Features of Combination Syndrome

- Bone Loss: Anterior maxillary ridge loss when opposed by mandibular anterior teeth.
- Key Features: Reduction of maxillary bone, enlargement of tuberosities, resorption under mandibular RPD.

Adaptation Issues

- Poor Fit: Poor adaptation of the prosthesis.
- Tissue Changes: Epulis fissuratum and periodontal changes may occur.

Partial Maxillary Edentulism

- Similar Symptoms: Signs and symptoms parallel combination syndrome.
- Preservation Effects: Presence of posterior maxillary teeth prevents hypertrophic changes.

Classification of Combination Syndrome

- Overview: Three classes with ten modifications based on maxillary condition.
- Key Feature: Anterior maxillary resorption from anterior mandibular teeth is consistent in all cases and modifications.

Class II Combination Syndrome

- Maxilla: Partially edentulous with anterior region edentulous, posterior regions present.
- Mandible Modifications: Same modifications as Class I (M1, M2, M3).

Additional maps

- Vertical Dimension: Loss of the vertical dimension of occlusion (VDO).
- Tooth Extrusion: Extrusion of lower natural teeth.
- Occlusal Discrepancy: Occlusal plane discrepancy present in patients.

Role of Mandible RED

- Negative Impact: Mandibular RPD contributes to early anterior maxillary bone
- Severe Resorption: Maxillary resorption is a dominant feature.

Residual Ridge Resorption

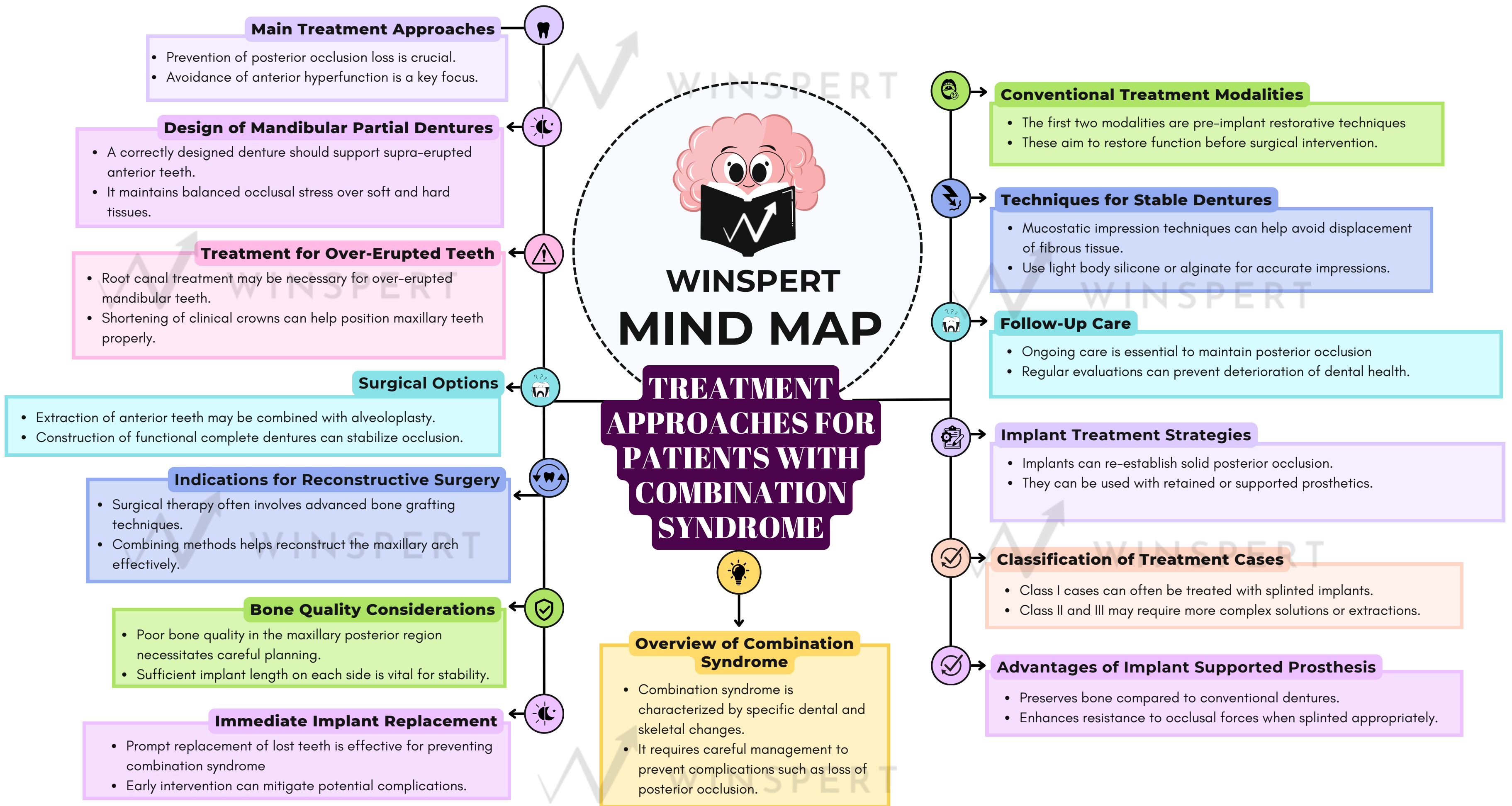
- Remodeling: Post-extraction remodeling includes bone resorption and contour change.
- Immediate Dentures: Reduce maxillary resorption initially but continuous resorption occurs under dentures.

Class I Combination Syndrome

- Maxilla: Completely edentulous alveolar ridge.
- Mandible Modifications: Modification 1 (M1): Partially edentulous. Modification 2 (M2): Fixed full dentition. Modification 3 (M3): Teeth in anterior and one posterior region.

Class I Combination Syndrome

- Maxilla: Partially edentulous with one posterior region present only; anterior region edentulous.
- Mandible Modifications: Consistent with Classes I and II (M1, M2, M3A, M3B).





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**COMBINATION
SYNDROME**

Question 1

**What is combination
syndrome?**



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**COMBINATION
SYNDROME**

Answer 1

Combination syndrome is defined as the characteristic features that occur when an edentulous maxilla is opposed by natural mandibular anterior teeth. It includes loss of bone from the anterior maxillary ridge, overgrowth of the tuberosities, papillary hyperplasia of the hard palatal mucosa, extrusion of mandibular anterior teeth, and loss of alveolar bone and ridge height beneath the mandibular removable partial denture bases.



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**COMBINATION
SYNDROME**

Question 2

What are the three key features of combination syndrome described by Ellsworth Kelly?



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**COMBINATION
SYNDROME**

Answer 2

The three key features of combination syndrome are reduction of anterior maxillary bone, enlargement of maxillary tuberosities, and bone resorption under mandibular RPD bases.



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**COMBINATION
SYNDROME**

Question 3

What secondary changes are associated with combination syndrome?



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**COMBINATION
SYNDROME**

Answer 3

Secondary changes associated with combination syndrome can include loss of vertical dimension of occlusion (VDO), extrusion of lower natural teeth, occlusal plane discrepancy, anterior spatial repositioning of the mandible, poor adaptation of the prosthesis, epulis fissuratum, and periodontal changes.

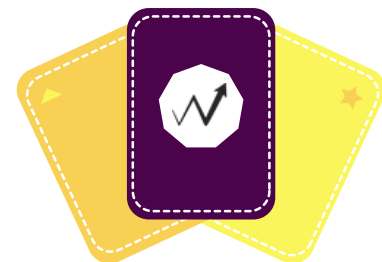


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**COMBINATION
SYNDROME**

Question 4

**What is the dominant feature
of combination syndrome?**



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**COMBINATION
SYNDROME**

Answer 4

The dominant feature of combination syndrome is severe maxillary resorption.



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**COMBINATION
SYNDROME**

Question 5

**How is combination
syndrome classified?**

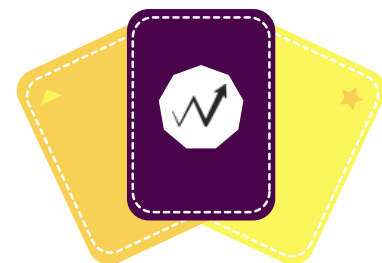


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**COMBINATION
SYNDROME**

Answer 5

Combination syndrome is classified into three classes based on the maxillary edentulous condition, with modifications based on the mandibular condition.



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**COMBINATION
SYNDROME**

Question 6

What is the treatment approach for patients with combination syndrome?

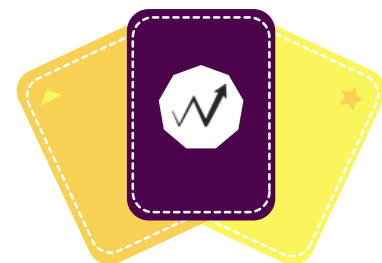


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**COMBINATION
SYNDROME**

Answer 6

The main treatment approaches for patients with combination syndrome include prevention of loss of posterior occlusion and avoidance of anterior hyperfunction through various treatment modalities, including conventional and surgical-prosthetic techniques.



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**COMBINATION
SYNDROME**

Question 7

What treatment options are available for Class I combination syndrome?



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**COMBINATION
SYNDROME**

Answer 7

Class I combination syndrome can be treated with implant-retained or supported maxillary prosthesis on 2 to 4 splinted implants placed in the posterior maxillary region, opposed by mandibular bilateral distal extension RPD.



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**COMBINATION
SYNDROME**

Question 8

What is the recommended treatment for Class II and Class III combination syndrome?



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**COMBINATION
SYNDROME**

Answer 8

Class II and Class III combination syndrome with partially edentulous maxilla and salvageable posterior teeth are best treated with a well-designed and maintained conventional RPD or, as an alternative, an implant prosthesis.



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**COMBINATION
SYNDROME**

Question 9

What is the impact of using implant-supported prostheses compared to conventional dentures for combination syndrome?



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**COMBINATION
SYNDROME**

Answer 9

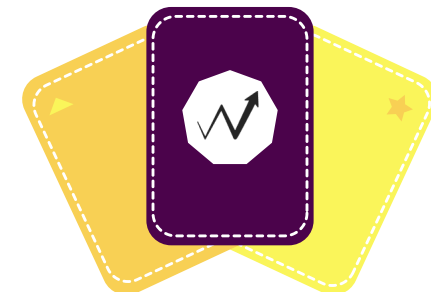
Implant-supported prostheses have a bone-preserving effect, while conventional denture treatment promotes continued ridge resorption.

PROSTHODONTICS

OCCLUSION SCHEMES, CANINE GUIDANCE, GROUP FUNCTION, BILATERALLY, BALANCED OCCLUSION



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA

WINSPERT MIND MAP

OCCLUSION SCHEMES IN RESTORATIVE TREATMENT

Centric Relation (CR)

- CR is the maxillomandibular relationship where condyles articulate optimally.
- It acts as a reliable reference point for recording maxilla and mandible relationships.

Mandibular Movements

- In the sagittal plane, involves rotational and translational movements around the terminal hinge axis.
- Horizontal plane movements include lateral excursions with specific interactions of working and non-working condyles.

Centric Occlusion (CO)

- CO is the occlusion of opposing teeth when in centric relation.
- Essential for prosthodontic treatments, marking critical reference points.

Types of Occlusion in Prosthodonties

- Bilaterally balanced occlusion allows maximum teeth contact in excursive positions.
- Unilateral balanced occlusion focuses on contact on the working side, with no contact on the non-working side.

Mutually Protected Occlusion

- Relationships emphasize anterior teeth guiding excursive movements to prevent posterior contact.
- Posterior teeth act as a vertical closure stop, minimizing horizontal loading.

Understanding Occlusal Contacts

- The goal is to establish stable occlusal contacts in posterior teeth.
- Avoid deflexive contacts that can destabilize the mandibular position.

Determining Centric Relation

- Clinically detectable through superior and anterior mandibular direction.
- Dependent on controlled jaw movements to locate the physiological transverse hinge axis.

Maximum Intercuspation (MI)

- Position of teeth during maximum contact, ideally aligning with centric relation.
- Discrepancies between MI and CR may necessitate corrective occlusal therapy.

Jaw Relations for Complete Dentures

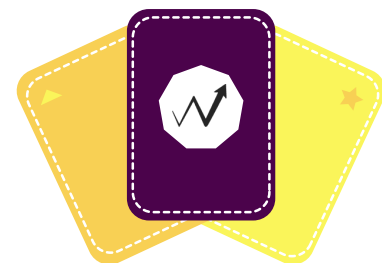
- Vertical Jaw Relation consists of VDR and VDO, assessed physiologically and mechanically.
- Horizontal Jaw Relation revolves around centric relation and its eccentric movements.

Long Centric Occlusion

- This concept allows freedom in anteroposterior direction with arbitrary lengths.
- Requires careful spacing for harmonious posterior disocclusion during movements

Conclusion

- The understanding of occlusion schemes is critical for effective restorative dentistry.
- Proper occlusal contacts can prevent complications and enhance treatment outcomes.



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 1

What is the primary goal of occlusal contacts in restorative treatment?



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 1

The primary goal is to create stable occlusal contacts in the posterior teeth, rather than deflective contacts that may destabilize the mandibular position.



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 2

What is centric relation?



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 2

Centric relation is defined as the maxillomandibular relationship where the condyles articulate with the thinnest avascular portion of their respective disks in the anterosuperior position, independent of tooth contact.



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 3

**Why is the determination of
centric relation important?**



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 3

Determining centric relation is essential for analyzing dental interarch, condylar position, and skeletal relationships.



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 4

**What movements are
included in the terminal
hinge axis determination?**



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 4

The terminal hinge axis is located through a series of controlled opening and closing movements of the jaw when the mandible is held in the most retruded position relative to the maxilla.

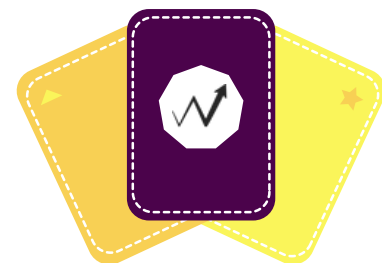


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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 5

**What are the three
recognized concepts of
occlusion in prosthodontics?**



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 5

The three recognized concepts are bilaterally balanced occlusion, unilateral balanced occlusion (group function occlusion), and mutually protected occlusion (canine-protected occlusion).



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 6

What is bilaterally balanced occlusion?



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 6

Bilaterally balanced occlusion dictates that the maximum number of teeth should contact in all excursive positions of the mandible, maintaining simultaneous contact in centric and eccentric positions on both sides.



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 7

**What characterizes unilateral
balanced occlusion?**



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 7

In unilateral balanced occlusion, occlusal contact occurs between all opposing posterior teeth on the working side only, while there is no contact on the non-working side until centric relation is reached.

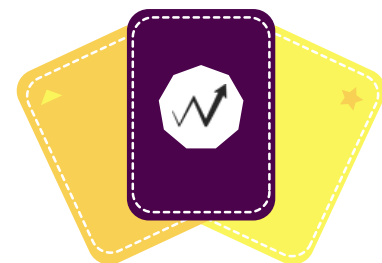


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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 8

**What is the significance of
long centric occlusion?**



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 8

Long centric occlusion allows for some freedom in anteroposterior direction when the mandible translates from centric relation to anterior tooth contact, promoting harmonious gliding contact among posterior teeth.



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 9

**What role do anterior teeth play
in mutually protected occlusion?**



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 9

In mutually protected occlusion, the anterior teeth guide excursive movements, and no posterior contact occurs during lateral or protrusive excursions, minimizing horizontal loading on the teeth.



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Question 10

**What is maximum intercuspation
(MI)?**



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**OCCLUSION SCHEMES, CANINE GUIDANCE,
GROUP FUNCTION, BILATERALLY,
BALANCED OCCLUSION**

Answer 10

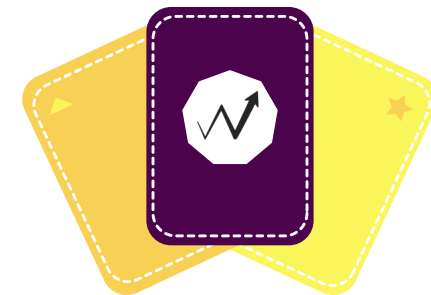
Maximum intercuspatation is the position of teeth when upper and lower teeth are in maximum contact and intercuspatation, ideally coinciding with centric relation.

PROSTHODONTICS

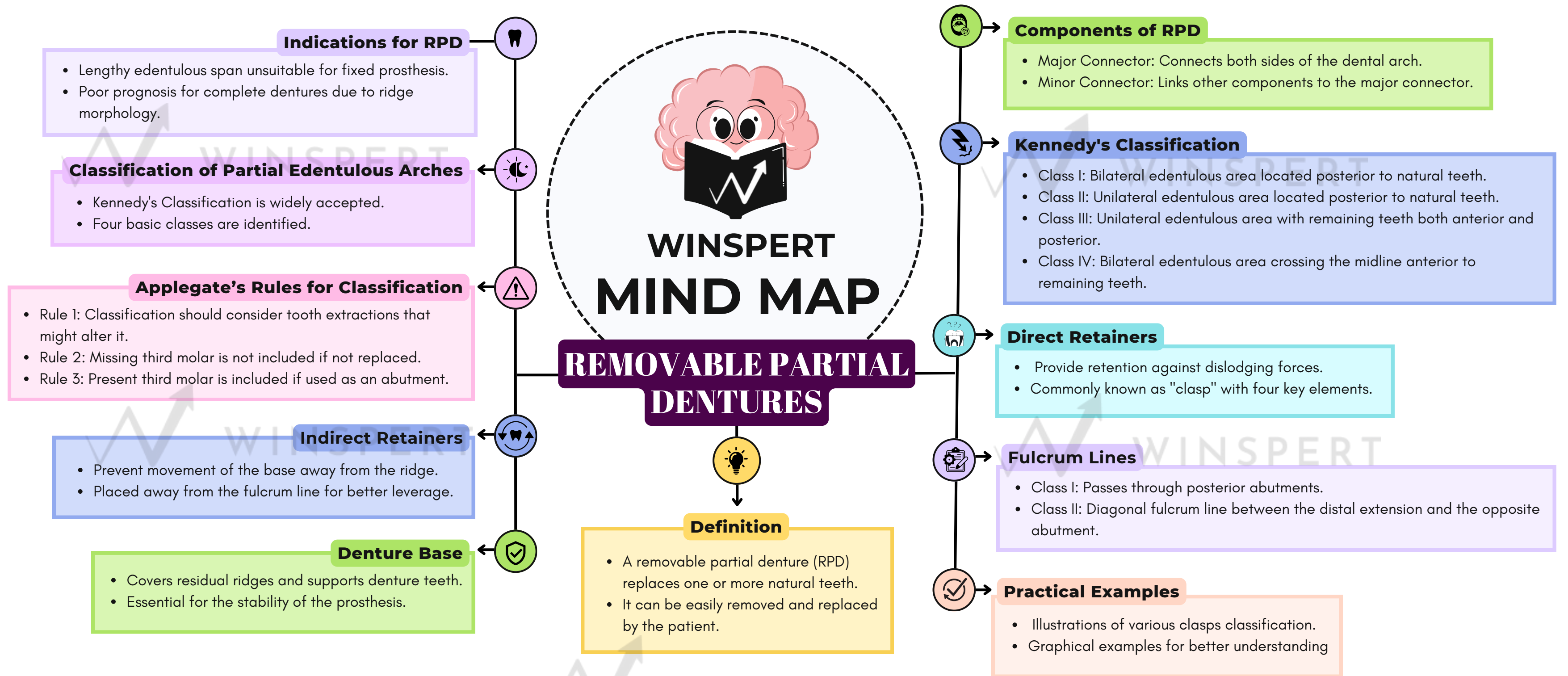
RPD PART CLASPS KENNEDY'S CLASSIFICATION



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA



WINSPERT MIND MAP

MAJOR CONNECTORS IN PARTIAL DENTURES

Guidelines for Designing Major Connectors

- Must avoid movable tissue and gingival impingement.
- Should have relief under connectors to prevent interference from tissue prominences.

Lingual Bars

- The superior border must be $\geq 4\text{mm}$ below the gingival margin to prevent impingement
- Adjustments may be required if the denture base moves tissue-ward during function.

Sublingual Bars Details

- Useful when floor of mouth height limits traditional bar placement.
- Contraindications include high lingual frenum or interfering tori.

Labial Bars Use Cases

- Utilized where remaining teeth's lingual inclination complicates normal bar use.
- Should be placed far from gingival tissue to ensure function.

Various Maxillary Connector Options

- Full palatal plate is indicated for long distal extensions or limited anterior teeth.
- U-shaped connectors should be avoided unless necessary due to biomechanical inefficiency.

Definition of Major Connectors

- A major connector connects parts of the prosthesis across the dental arch.
- It ensures stability against functional stresses in dentures.

Types of Mandibular Major Connectors

- The lingual bar is commonly used, requiring at least 8mm of vestibular depth.
- A lingual plate is used when a lingual bar is impractical due to high floor of mouth

Linguoplate (Lingual Plate) Specifics

- Engages anterior teeth to mitigate horizontal rotations in cases of vertical resorption.
- Used for stabilizing periodontally weakened teeth.

Lingual Bar with Cingulum Bar

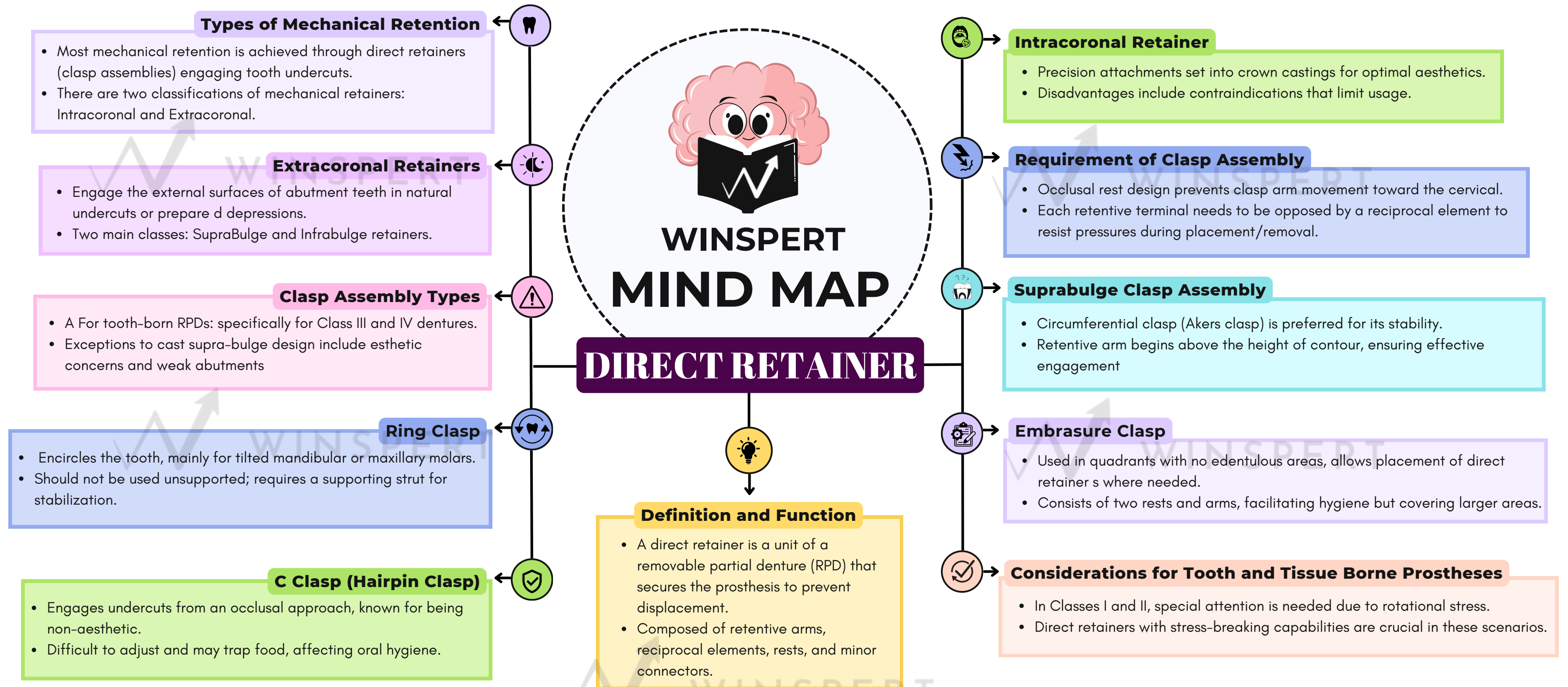
- Consists of a lingual bar plus additional bars above anterior teeth cingula.
- Controversial due to potential food traps and effectiveness for stabilization.

Types of Maxillary Major Connectors

- Single palatal strap is not suitable for distal extensions or anterior replacements
- Combination anterior and posterior palatal strap provides enhanced rigidity.

Considerations for Palatal Bars

- Single palatal bars are only for tooth-supported cases and can be too bulky.
- Anterior-posterior palatal bars have narrower elements, increasing bulk for rigidity.





WINSPERT MIND MAP

UNDERSTANDING BAR CLASPS IN DENTURES



What is Bar Clasp?

- A cast clasp emerging from the partial denture framework.
- Approaches the retentive undercut from a gingival direction.

Classification of Bar Clasp Arms

- Different shapes include T, modified T, I, Y, L, U,S.
- The shape is less critical than the mechanical and functional stability.

Soft Tissue Relief

- Achieved through 28- or 30-gauge wax under the approach arm.
- Prevents tissue impingement.

Vestubular Depth Requirement

- Minimum of 4mm is necessary for the clasp approach arm.
- This includes 3mm from the free gingival margin and 1mm for clasp thickness.

Components of the RPI Clasp Assembly

- "R" for rest usually present mesially on occlusal or lingual surfaces.
- "P" for proximal plate, providing stabilizing features, ideally positioned on guide planes.
- "I" for I-bar retentive arm, tapering to contact the tooth without food entrapment.

RPA Clasp Introduction

- Similar to RPI but uses a wrought wire circumferential clasp (Akers).
- Used when there is insufficient vestibular depth or severe tissue undercuts.

Importance of Clasp Design

- Covers minimal tooth structure and provides stability.
- T- and Y-shaped terminal ends are commonly misapplied, often needing less coverage than utilized.

Limitations of Bar Clasps

- Not suitable for deep cervical or severe soft tissue undercuts.
- Avoid areas with pronounced frenal attachments due to potential food traps.

RPI Clasp Assembly Overview

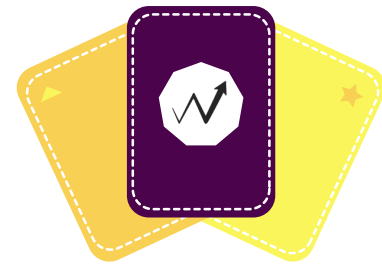
- The most common clasp assembly for tooth and tissue-borne prosthesis with stress release.
- Components include a mesio-occlusal rest and a distal guiding plane.

Contraindications for RPI Clasp

- Insufficient vestibular depth (less than 4mm).
- No labial or buccal undercuts present on the abutment.

Combination Clasp Design

- Similar to a cast circumferential clasp but features a round wrought wire retentive arm.
- Offers adjustable placement and improved esthetics with smaller diameter flexibility.

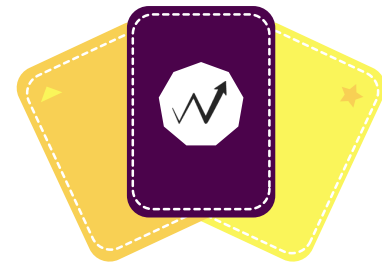


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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 1

**What is a removable
partial denture (RPD)?**



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RPD PART CLASPS KENNEDY'S CLASSIFICATION

Answer 1

A removable partial denture is a prosthesis that replaces one or more, but not all, natural teeth and supporting structures that can be removed and replaced in the mouth by the patient.



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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 2

**What are the indications
for a removable partial
denture?**



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RPD PART CLASPS KENNEDY'S CLASSIFICATION

Answer 2

Indications include lengthy edentulous spans, no posterior abutment for a fixed prosthesis, excessive alveolar bone loss, poor prognosis for complete dentures, reduced periodontal support, need for cross-arch stabilization, need for immediate replacement of extracted teeth, and cost/patient desire considerations.

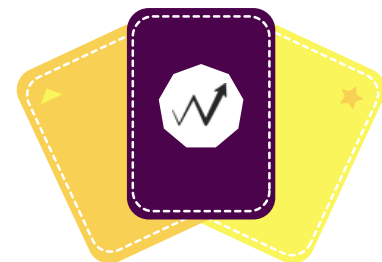


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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 3

**How did Kennedy classify
partially edentulous arches?**



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RPD PART CLASPS KENNEDY'S CLASSIFICATION

Answer 3

Kennedy classified partially edentulous arches into four basic classes:
Class I - bilateral edentulous area located posterior to natural teeth;
Class II - unilateral edentulous area located posterior to natural teeth;
Class III - unilateral edentulous area with natural teeth remaining both anterior and posterior;
Class IV - a single, bilateral edentulous area located anterior to remaining natural teeth.



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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 4

What is the function of a major connector in a removable partial denture?



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RPD PART CLASPS KENNEDY'S CLASSIFICATION

Answer 4

A major connector connects the parts of one side of the dental arch to those of the other side, providing unification and rigidity to the denture.



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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 5

What components make up a direct retainer for a partial denture?



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RPD PART CLASPS KENNEDY'S CLASSIFICATION

Answer 5

A direct retainer, commonly known as a clasp, is composed of four elements: a rest, a retentive arm, a reciprocal arm, and a minor connector.



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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 6

**What is an indirect retainer
and where is it usually
placed?**



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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Answer 6

An indirect retainer prevents or resists movement or rotation of the base(s) away from the residual ridge, typically taking the form of rests placed away from the fulcrum line.



**WINSPERT
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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 7

What are the requirements of a clasp assembly in a removable partial denture?



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RPD PART CLASPS KENNEDY'S CLASSIFICATION

Answer 7

Clasp assemblies must ensure that the occlusal rest prevents movement of the clasp arms toward the cervical, retentive terminals are opposed by reciprocal components, and they avoid direct transmission of tipping and rotational forces to the abutment.



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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 8

**What distinguishes the RPI
clasp assembly?**



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RPD PART CLASPS KENNEDY'S CLASSIFICATION

Answer 8

The RPI clasp assembly consists of a mesio-occlusal rest, a proximal plate, and an I-bar retentive arm, providing stress release during function, particularly for distal extension prostheses.



**WINSPERT
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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 9

What is the impact of the position of indirect retainers in maintaining prosthesis stability?



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**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Answer 9

Indirect retainers should be placed as far away from the distal extension base as possible to gain the best leverage advantage against lifting, enhancing the stability of the prosthesis during function.



**WINSPERT
CUE CARDS**

**RPD PART CLASPS
KENNEDY'S CLASSIFICATION**

Question 10

What is a contraindication for using the RPI clasp?



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RPD PART CLASPS KENNEDY'S CLASSIFICATION

Answer 10

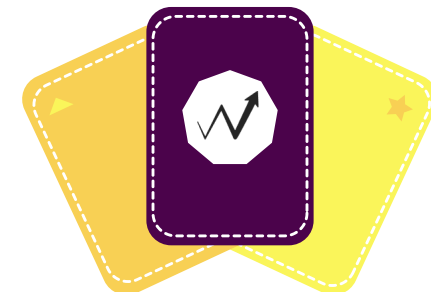
Contraindications for the RPI clasp include insufficient depth of the vestibule, lack of labial or buccal undercut on the abutment, severe soft tissue undercut, and a disto-buccal undercut.

PROSTHODONTICS

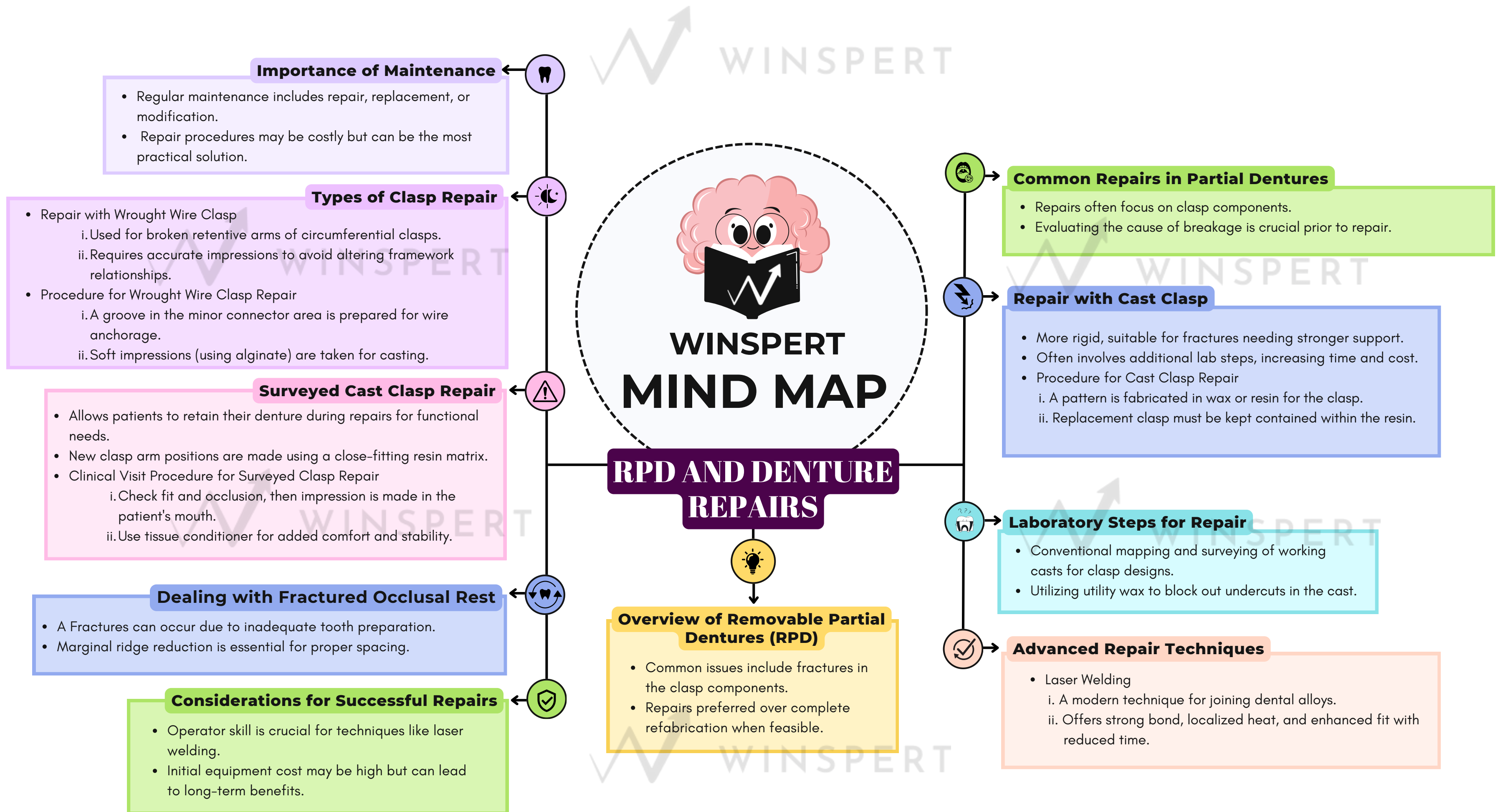
RPD AND DENTURE REPAIR



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA





**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Question 1

What is a commonly encountered problem when repairing removable partial dentures?



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**RPD AND DENTURE
REPAIR**

Answer 1

Fractures of the clasp component are a commonly encountered problem in dental offices.



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**RPD AND DENTURE
REPAIR**

Question 2

Why are repair procedures often preferred over refabrication of an entire prosthesis?

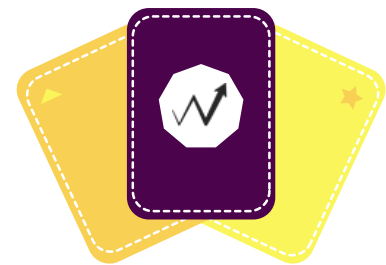


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**RPD AND DENTURE
REPAIR**

Answer 2

Repair procedures are preferred whenever possible because they are often more feasible than refabricating the entire prosthesis.



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**RPD AND DENTURE
REPAIR**

Question 3

**What should be evaluated
before commencing the
repair procedure of a broken
clasp?**



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**RPD AND DENTURE
REPAIR**

Answer 3

The cause of the breakage of the clasp must be evaluated prior to commencing the repair procedure.



**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Question 4

What condition of the metal at the fracture site necessitates mouth preparation for clasp repair?

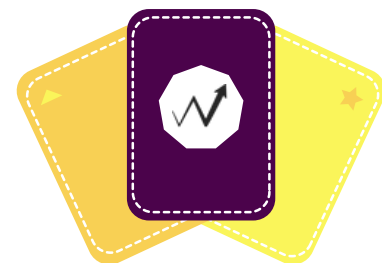


**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Answer 4

If the thickness of the metal at the fracture site is less than 1.2 mm, mouth preparation is required.



**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Question 5

What is the typical wire used in the repair with wrought wire clasp for broken retentive arms?



**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Answer 5

An 18-gauge wrought wire is typically used for the repair of broken retentive arms.



**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Question 6

What is a common disadvantage of using wrought wire for clasp repair?

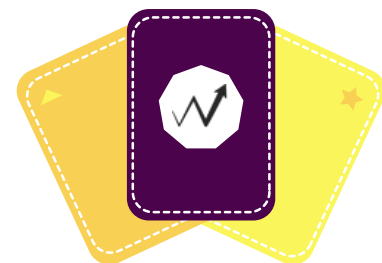


**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Answer 6

Although it is quick and simple, repairing with wrought wire may not yield the best results



**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Question 7

What is a crucial step in the laboratory procedure after producing a working cast?



**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Answer 7

Survey the full arch working cast and draw the design of the clasp on the cast.



**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Question 8

What unique advantage does laser welding have over traditional soldering in dental repairs?

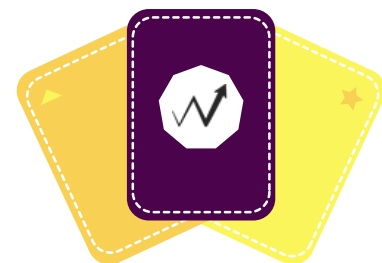


**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Answer 8

Laser welding is considered superior due to its high reproducible strength, localized heat production, and reduced working time.

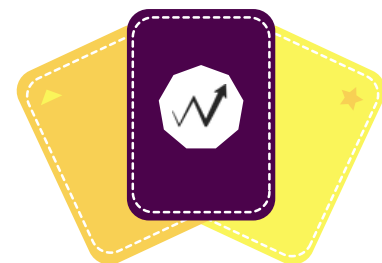


**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Question 9

In the context of repairing a fractured occlusal rest, what is a common cause of the fracture?

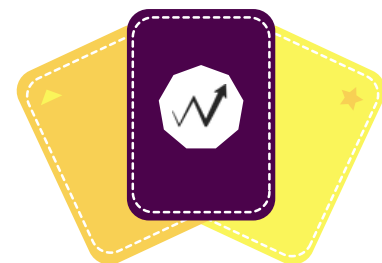


**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Answer 9

A fractured occlusal rest is often due to thin metal over the marginal ridge of the abutment tooth resulting from inadequate tooth preparation.



**WINSPERT
CUE CARDS**

**RPD AND DENTURE
REPAIR**

Question 10

What technique is recommended for attaching the retentive segment of the new clasp arm to the denture base?



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**RPD AND DENTURE
REPAIR**

Answer 10

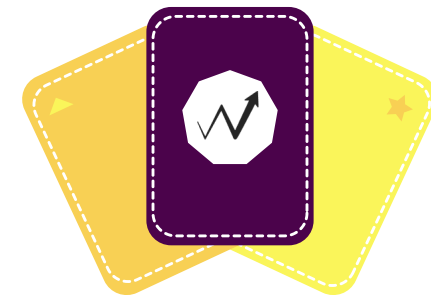
The retentive segment of the new clasp arm is typically attached to the denture base with auto polymerizing acrylic resin.

PROSTHODONTICS

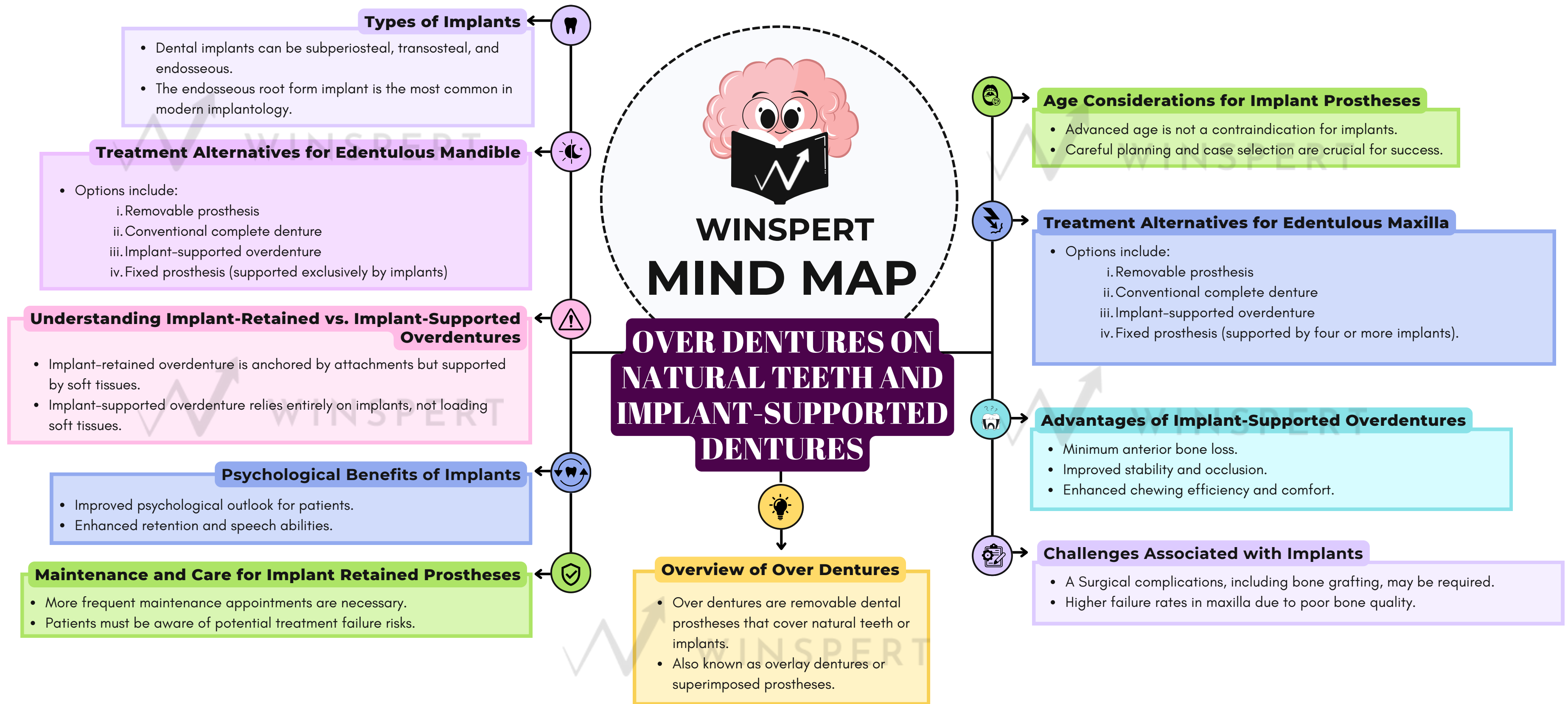
OVER DENTURE ON NATURAL TEETH AND OVER DENTURE ON IMPLANT SUPPORTED

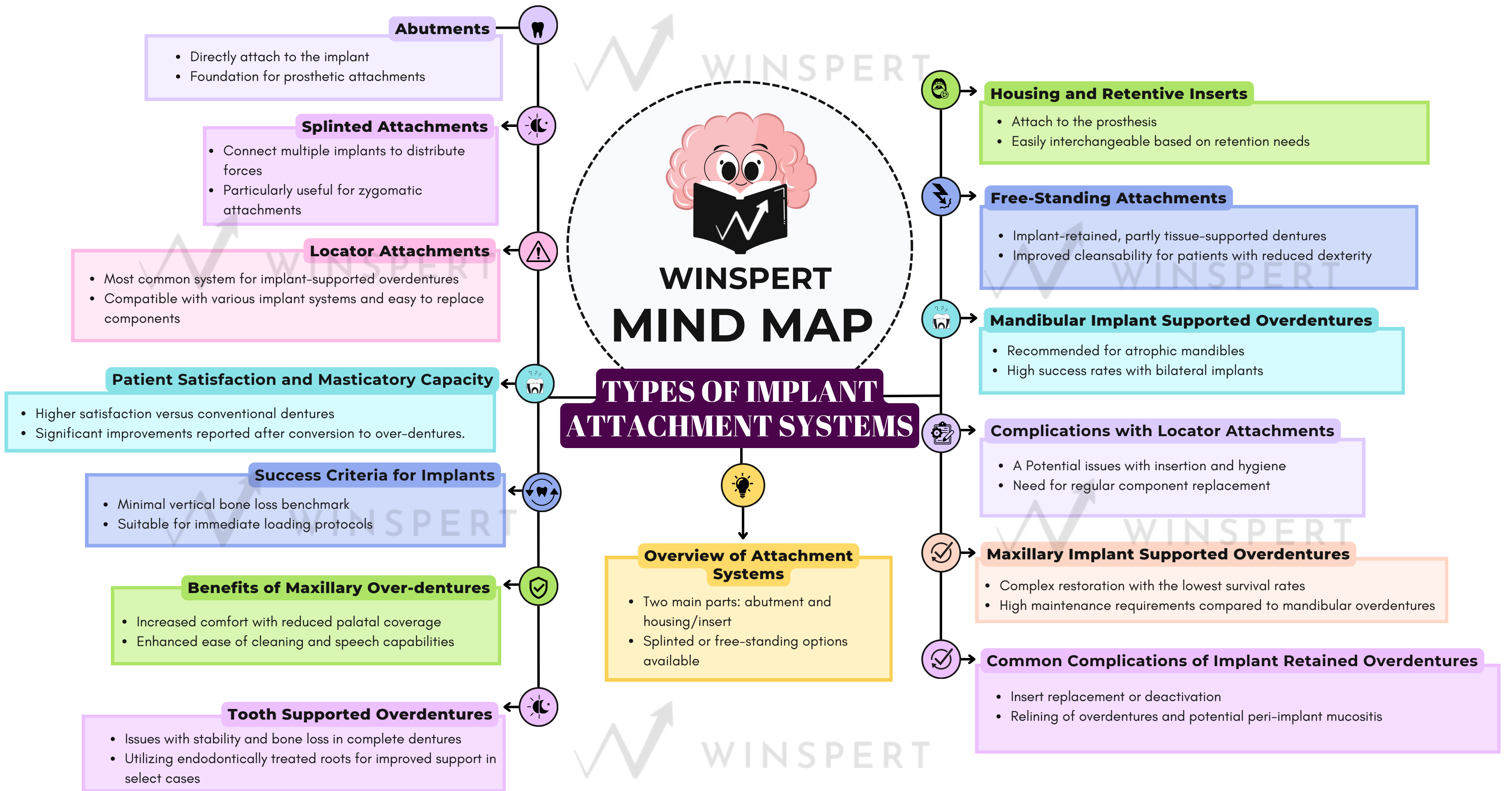


MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 1

What are overdentures in dentistry?

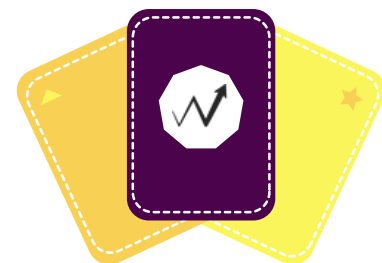


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CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 1

Overdentures are any removable dental prosthesis that covers and rests on one or more remaining natural teeth, the roots of natural teeth, and/or dental implants.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 2

**What is the main difference between
implant-retained and implant-supported
overdentures?**

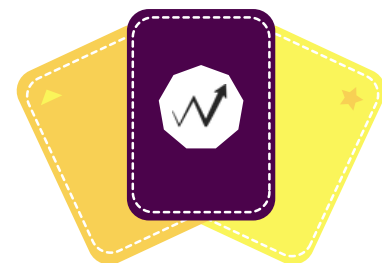


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**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 2

An implant-retained overdenture is retained by an attachment system but supported by underlying soft tissues, while an implant-supported overdenture is supported in its entirety by implants without loading the underlying soft tissues.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 3

**What are some advantages of
implant-supported/retained
overdentures over conventional
complete dentures?**



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 3

Advantages include minimal anterior bone loss, improved stability, increased chewing efficiency, better retention and speech, and enhanced comfort compared to conventional dentures.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 4

**What is the significance of
accurate impression taking for
implant-retained overdentures?**

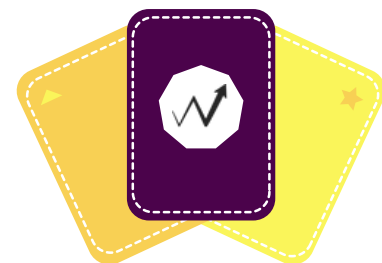


**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 4

Accurate impression taking is crucial for ensuring that the supporting soft tissue is recorded in a passive state, as inaccuracies can lead to rapid wear of implant components.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 5

**What are some challenges
associated with implant-
supported overdentures?**



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 5

Challenges include the need for implant surgery which may involve multiple procedures, potential treatment complications and failures, and increased maintenance appointments compared to conventional dentures.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 6

**How are implants classified
based on their morphology?**

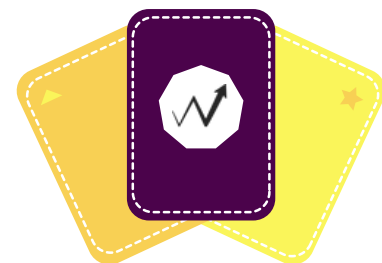


**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 6

Dental implant forms can be classified as subperiosteal, transosteal, endosseous plate (blade) forms, and endosseous root form implants, with the latter being the mainstay of modern implantology.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 7

What is the recommended number of implants for a mandibular implant-supported overdenture?



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**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 7

The recent consensus recommends the use of two implants placed bilaterally in the interforaminal region of the mandible as the first choice for restoration of an edentulous mandible.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 8

**Why are maxillary
overdentures considered
complex?**

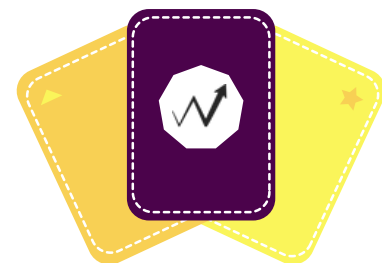


**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 8

Restoration of the edentulous maxilla is complex due to lower survival rates of maxillary implants, the need for meticulous planning, and higher maintenance requirements compared to mandibular implants.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 9

What are common complications associated with implant-retained overdentures?

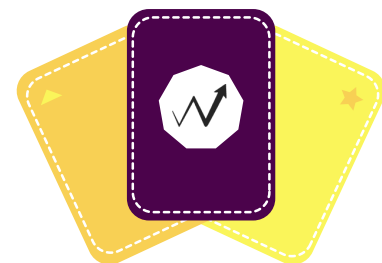


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CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 9

Common complications include deactivation or replacement of inserts, loosening of abutment screws, fracture of denture teeth, and peri-implant mucositis or tissue hyperplasia.



**WINSPERT
CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Question 10

**Why might tooth-supported
overdentures be beneficial for
certain patients?**



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CUE CARDS**

**OVER DENTURE ON NATURAL
TEETH AND OVER DENTURE
ON IMPLANT SUPPORTED**

Answer 10

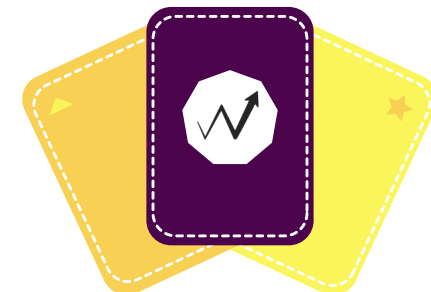
**Tooth-supported overdentures can help
preserve the residual alve**

PROSTHODONTICS

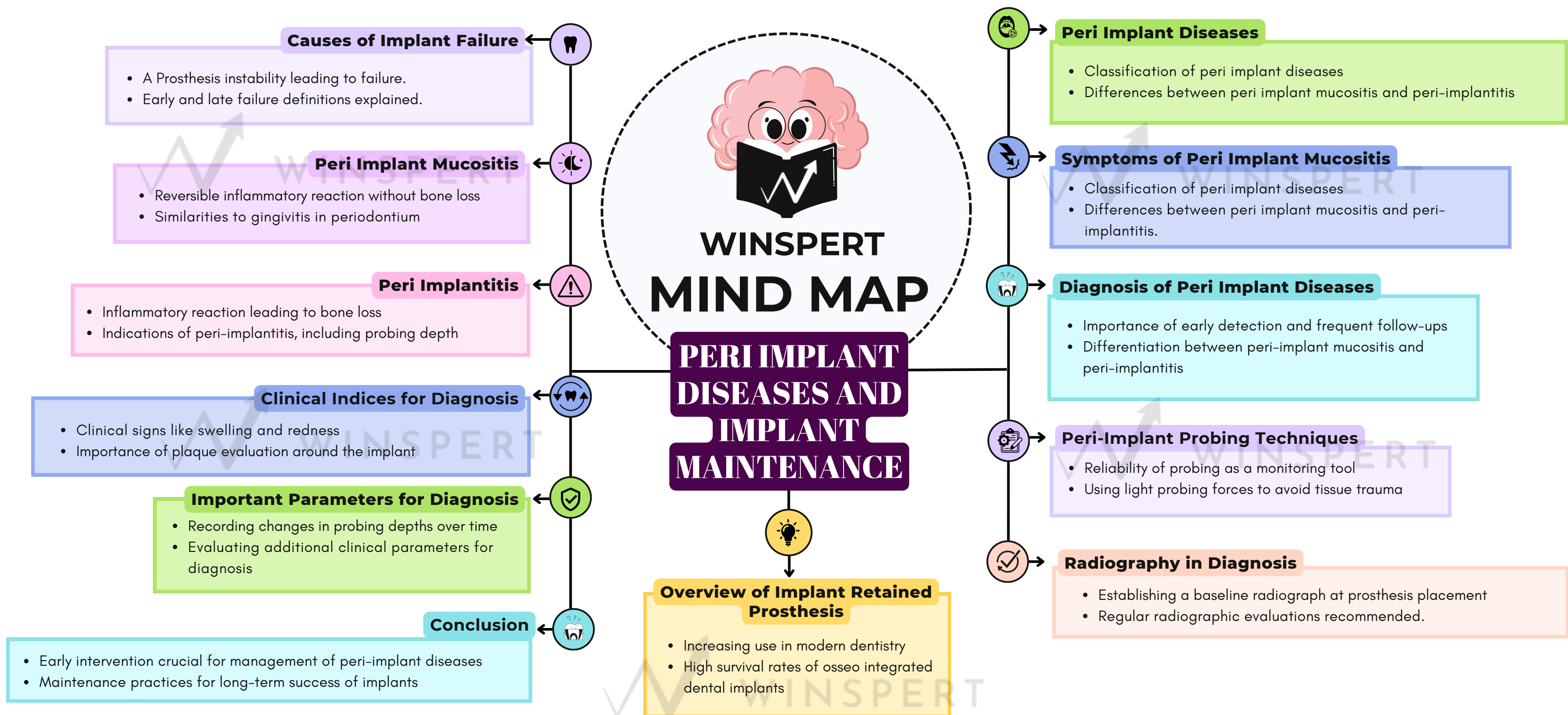
PERI IMPLANTS AND PERI MUCOSITIS AND IMPLANT MAINTENANCE



MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







**WINSPERT
CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 1

**What is peri-implant
mucositis?**



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 1

Peri-implant mucositis is defined as a reversible inflammatory reaction in the soft tissues surrounding an implant without bone loss.



**WINSPERT
CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 2

**What is the major cause
of late implant failure?**



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 2

The major cause of late implant failure is peri-implant diseases, particularly peri-implantitis.



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 3

**What factors increase the
likelihood of developing
peri-implant disease?**



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 3

Factors that increase the likelihood of developing peri-implant disease include lack of professional maintenance, smoking, history of periodontitis, poor oral hygiene, and difficulties in cleaning the implant.



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 4

**How can peri-implant
mucositis be managed?**



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 4

Peri-implant mucositis can be managed by assessing plaque presence, bleeding on probing, and pocket depth, and by reinforcing proper oral hygiene measures. Cleaning the implant using soft instruments is also recommended.



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CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 5

**What is the clinical
significance of probing depth
in diagnosing peri-implantitis?**



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 5

Probing depths of 6mm or more, alongside profuse bleeding and suppuration, indicate peri-implantitis, and differentiation from peri-implant mucositis is crucial for diagnosis.



**WINSPERT
CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 6

What treatment is indicated for peri-implantitis when probing depths are greater than 5mm?

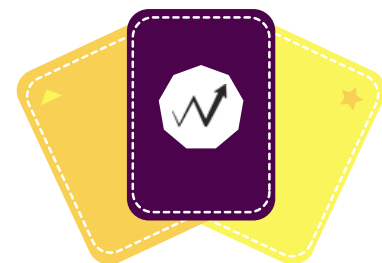


**WINSPERT
CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 6

When probing depths are greater than 5mm and there's significant bone loss, surgical intervention is required to improve the condition of the soft and hard tissues around the implant.



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 7

What type of cleaning instruments are recommended for professional cleaning of implant surfaces?



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**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 7

Recommended cleaning instruments for implant surfaces include titanium, carbon fiber, or plastic reinforced with graphite curettes or scalers, as they will not damage the titanium surfaces.



**WINSPERT
CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 8

**What is the role of oral
hygiene in the maintenance
of dental implants?**

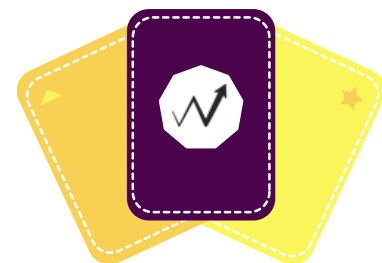


**WINSPERT
CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 8

Good oral hygiene is critical for maintaining dental implants, involving the use of toothbrushes, floss, and specially designed tools like super floss or tufted brushes to reduce plaque biofilm.



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CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 9

**What should be recorded during
the initial maintenance program
for implants?**



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CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 9

Baseline data such as probing pocket depth, mucosal margin position, and radiographic crestal bone level should be established and recorded in the maintenance program for implants.



**WINSPERT
CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Question 10

**Why is it important to detect
peri-implant diseases early?**



**WINSPERT
CUE CARDS**

**PERI IMPLANTS AND PERI
MUCOSITIS AND IMPLANT
MAINTENANCE**

Answer 10

Early detection of peri-implant diseases is vital because it allows clinicians to modify oral hygiene practices and manage the disease at an initial stage, potentially preventing further complications.

PROSTHODONTICS

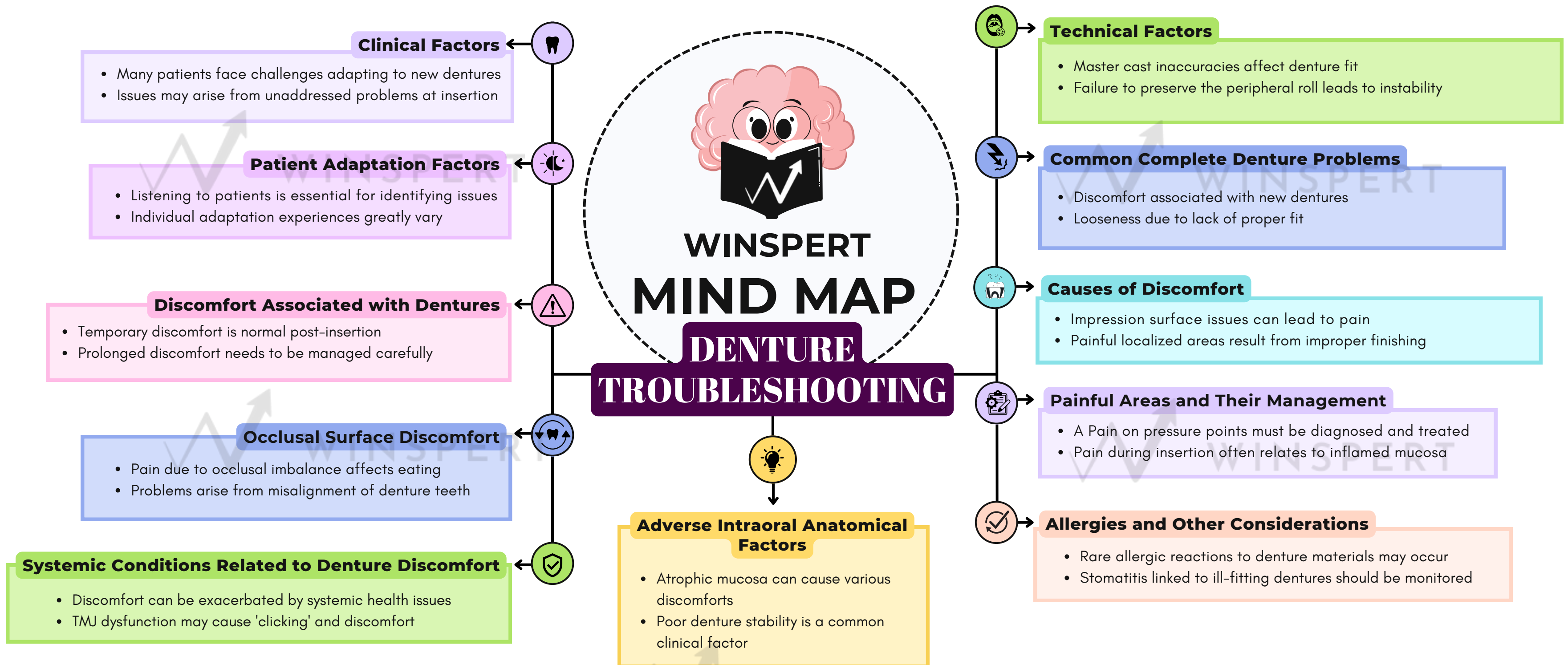
DENTURE TROUBLESHOOTING

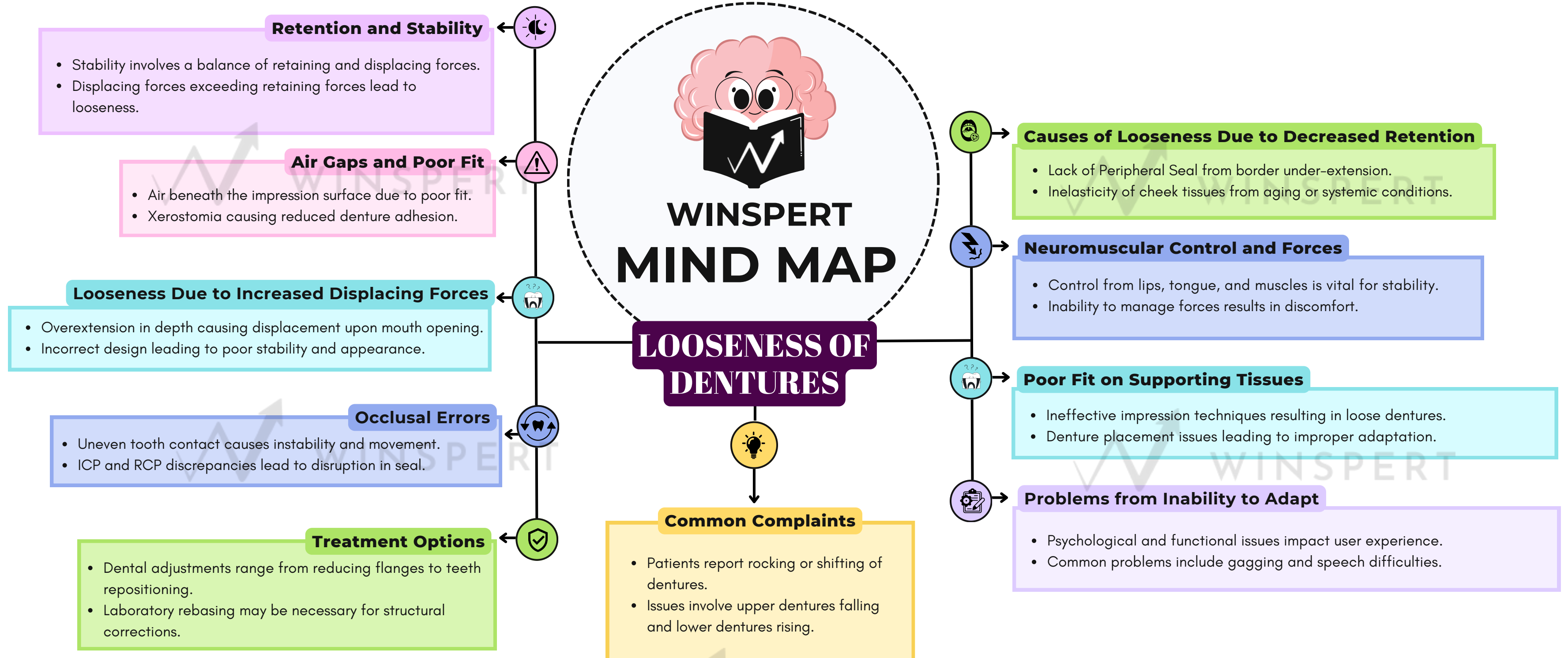


MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 1

What are the common factors that contribute to problems with complete dentures?



**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 1

Factors causing denture problems can be grouped into adverse intraoral anatomical factors, clinical factors, technical factors, and patient adaptational factors.



**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 2

**What should be the first step
when addressing a
denture-wearing problem?**

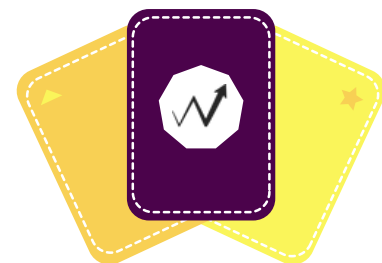


**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 2

The first step should be listening to the patient to understand how they describe their difficulties.



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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 3

**What common discomfort
can patients experience with
new dentures immediately
after insertion?**



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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 3

Many patients experience discomfort for a short period (up to a few days) after receiving new or replacement dentures.



**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 4

What is one type of discomfort associated with the impression surface of the denture?

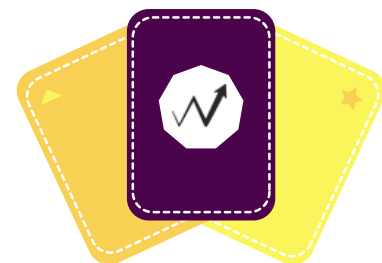


**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 4

Discomfort can occur due to discrete painful areas caused by sharp ridges of acrylic on the fitting surface due to lack of laboratory finishing.



**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 5

What is a common cause of denture looseness?



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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 5

A common cause of denture looseness is a lack of peripheral seal due to border under-extension in depth or width.



**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 6

**What can lead to discomfort
due to occlusal imbalance
when wearing dentures?**



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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 6

Pain on eating due to occlusal imbalance typically occurs from premature contacts between denture teeth or lack of harmony in occlusion.



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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 7

What factor contributes to diminished retention of a complete denture?



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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 7

Xerostomia, or reduced ability to form a suitable seal due to dry mouth, can cause insufficient adhesion between the denture base and the mucosa.



**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 8

**What symptoms may arise
due to a lack of adaptation to
dentures?**

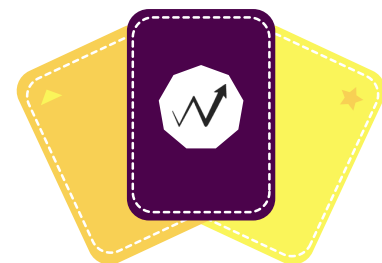


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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 8

Symptoms can be functionally related (like difficulty in eating or speaking) or psychologically related, manifesting as discomfort or anxiety.



**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 9

What correction can be made for immediate gagging after denture insertion?

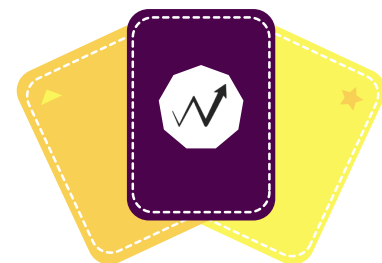


**WINSPERT
CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 9

Immediate gagging can be corrected by reducing the posterior dam area or lowering the thickness of the lower lingual flange.



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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Question 10

What adjustments can solve the issue of a whistle sound on the "S" sound during speech with dentures?



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CUE CARDS**

**DENTURE
TROUBLESHOOTING**

Answer 10

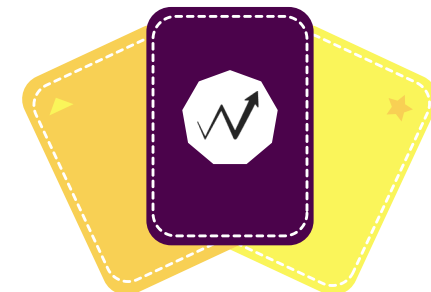
The issue can be corrected by either repositioning the bicuspids more buccally or grinding out more space for the tongue if there is not enough space in the bicuspid area.

PROSTHODONTICS

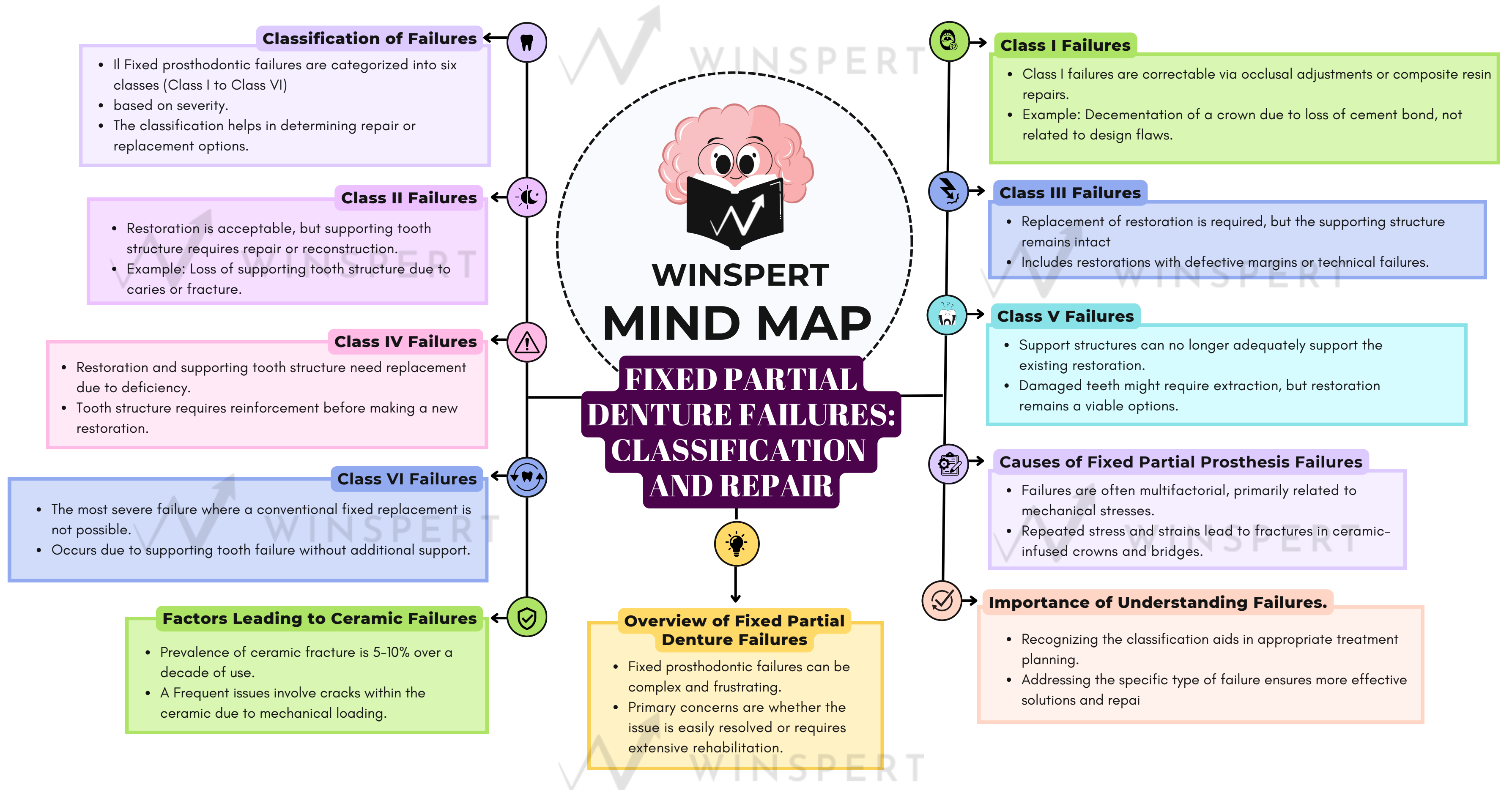
RPD FAILURES, CHINNINGS AND REPAIRS

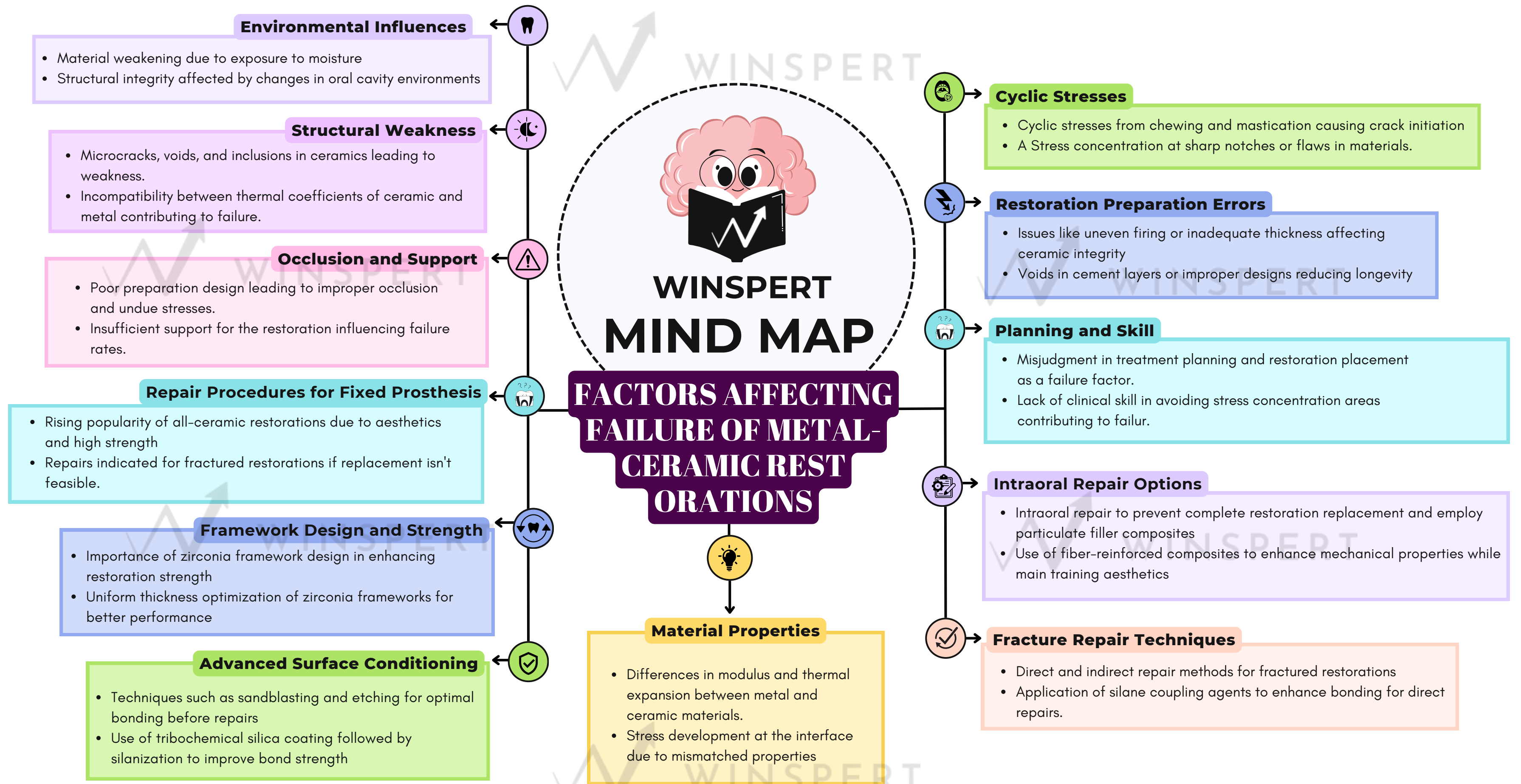


MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







**WINSPERT
CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 1

**What are the primary types
of failures in fixed
prosthodontics?**



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 1

Fixed prosthodontic failures can be classified into six categories based on severity, ranging from Class I to Class VI.



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 2

What is Class I FPD Failure?



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 2

Class I failures are correctable through occlusal adjustment or composite resin repairs without needing to replace the restoration, such as decementation of a crown or FPD due to loss of cement bond.



**WINSPERT
CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 3

**What defines a Class II FPD
Failure?**



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 3

In Class II failure, while the restoration itself is acceptable, the supporting tooth structure or foundation requires repair or reconstruction. Examples include foundation failures or supporting tooth structure loss due to caries or fracture.



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 4

**What is the requirement for a
Class III FPD failure?**



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 4

For Class III failure, replacement of the restoration is required, but the supporting tooth structure remains intact and can provide acceptable support for the new restoration.



**WINSPERT
CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 5

**What happens in a Class IV
FPD failure situation?**



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 5

In Class IV failures, the restoration requires replacement, and the supporting tooth structure or foundation is deficient, necessitating reinforcement or reconstruction before a new restoration can be made.



**WINSPERT
CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 6

**What characterizes Class V
FPD failure?**



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 6

In a Class V failure, the support structures can no longer provide adequate support due to extensive fractures, carious destruction, or periodontal problems, which may even require tooth extraction.



**WINSPERT
CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 7

**What is the most severe type
of FPD failure?**



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CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 7

Class VI failure is the most severe, where a conventional fixed replacement is no longer possible due to supporting tooth failure and a lack of additional support for a redesigned restoration.



**WINSPERT
CUE CARDS**

**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 8

What are some common causes of fixed partial prosthesis failures?



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**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 8

Common causes include multifactorial issues such as repeated stress and strains from chewing, cracks within the ceramic due to environmental loads, and differences in thermal expansion between metal and ceramic materials.



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**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 9

**What are the common methods
used for repairing fixed
prostheses?**

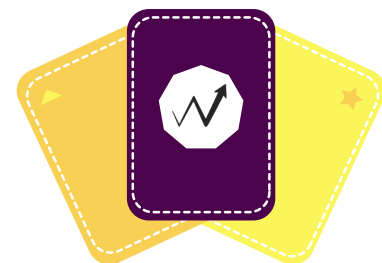


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**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 9

Common repair methods include intraoral repairs using composites and indirect repairs using porcelain applied as a laboratory procedure, often employing mechanical roughening and silane coupling agents to enhance bonding.



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**RPD FAILURES,
CHINNINGS AND REPAIRS**

Question 10

What is a key consideration when repairing zirconia bridges?



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**RPD FAILURES,
CHINNINGS AND REPAIRS**

Answer 10

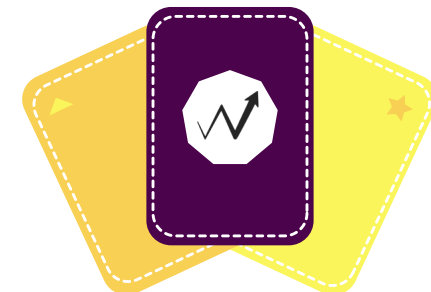
When repairing zirconia bridges, a cavity is prepared, and techniques such as etching, sandblasting, and silanizing are used, followed by applying dual-adhesive resin cement and glass-fibre-reinforced composite for support.

PROSTHODONTICS

IMPRESSION, TECHNIQUES AND MATERIALS

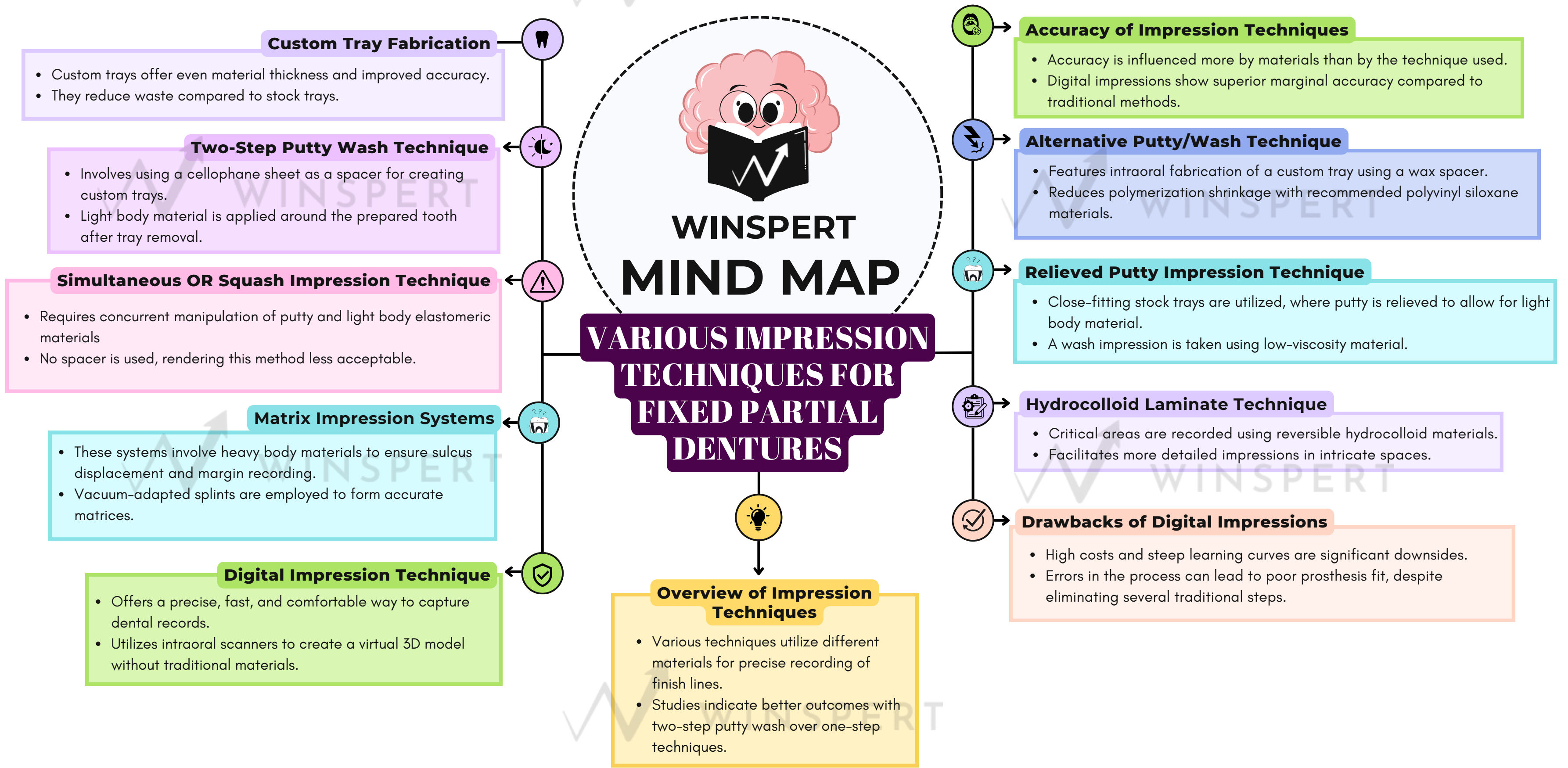


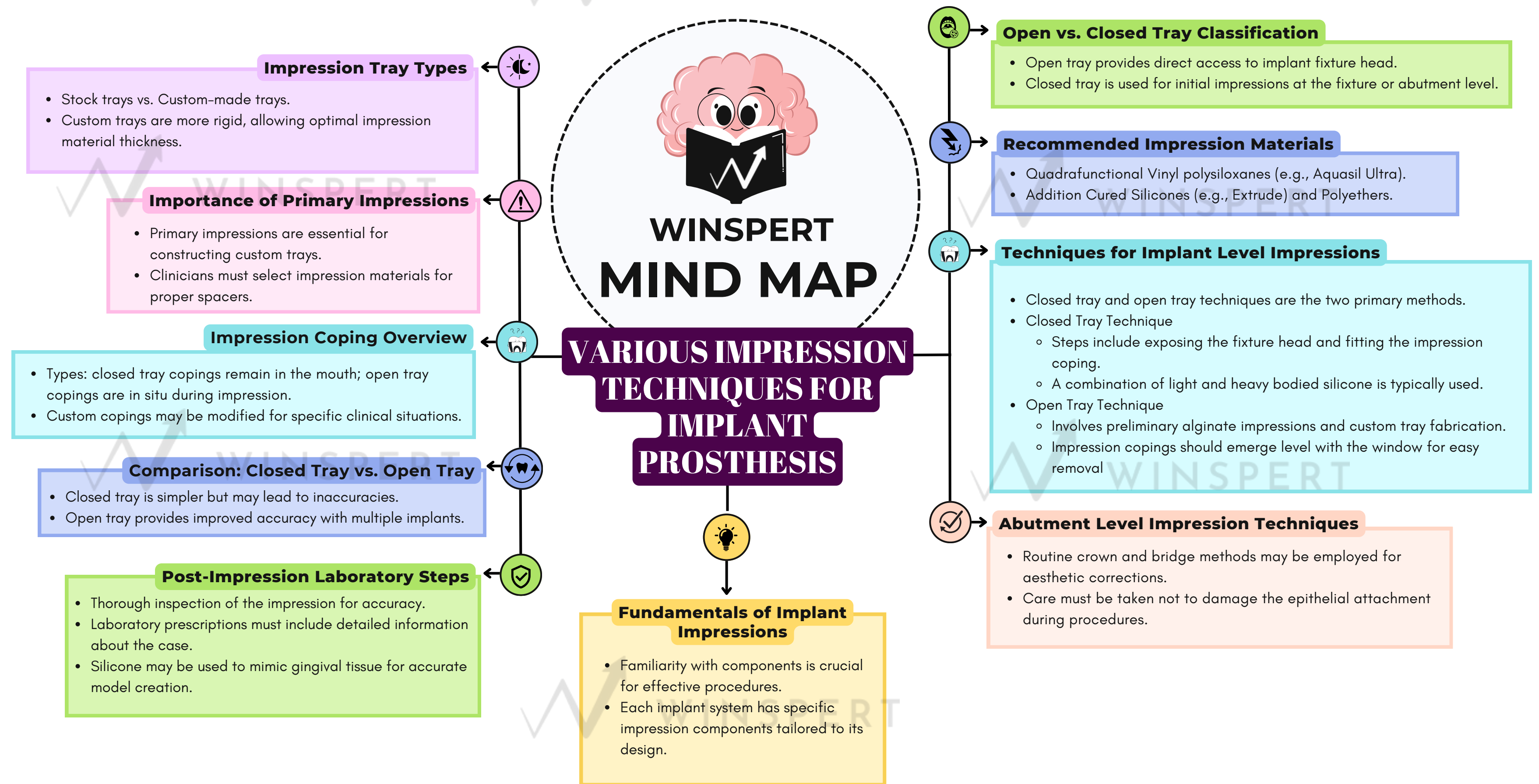
MIND MAP & CUE CARDS

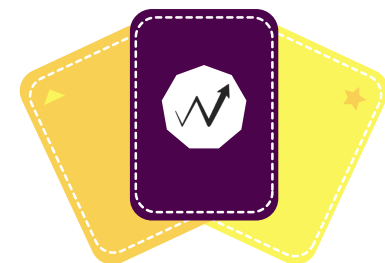


BY DR. JIGYASA SHARMA







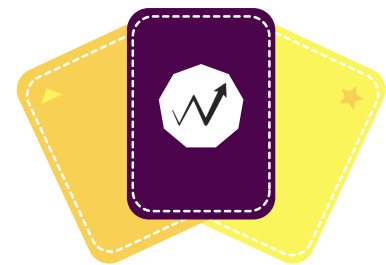


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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 1

**What is an impression in
dentistry?**

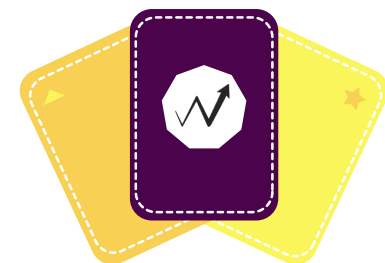


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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 1

An impression is an imprint or negative likeness of the mouth, used to create a positive reproduction or cast of the teeth and surrounding structures.

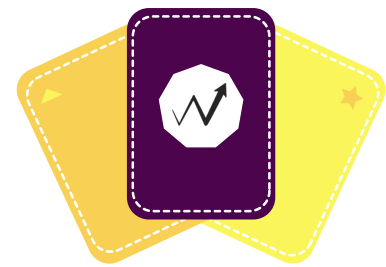


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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 2

What are impression materials?



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 2

Impression materials are substances or combinations of substances used for making an impression, which is a negative reproduction.



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 3

**What are the two main
classifications of impression
materials?**



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 3

The two main classifications are non-elastic impression materials and elastic impression materials.



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 4

**What is the mucostatic
impression technique?**



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 4

The mucostatic impression technique aims to record the oral soft tissues in their resting state with minimal pressure, often used with low-density materials in relaxed conditions.



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 5

**What is the purpose of the
two-stage impression
technique?**



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 5

The two-stage impression technique involves taking multiple impressions with different viscosities of the same material, often used for complex cases to achieve greater accuracy.



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 6

What materials are commonly used for irreversible hydrocolloid impressions?

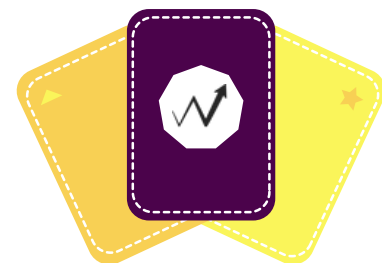


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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 6

Common materials used for irreversible hydrocolloid impressions include alginate, which is primarily used for primary impressions.



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 7

**What is the difference
between closed tray and open
tray impression techniques?**



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 7

The closed tray technique involves taking an impression with the impression coping retained in the mouth, while the open tray technique allows for direct access to the implant fixture head.



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 8

**What is the dynamic
impression technique?**

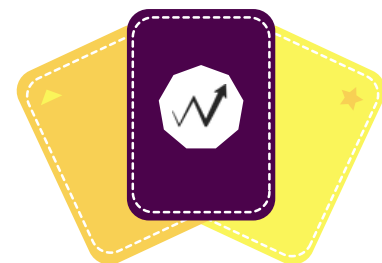


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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 8

The dynamic impression technique is used for extremely resorbed ridges, capturing the active muscle movements to ensure an accurate representation of the denture fit.

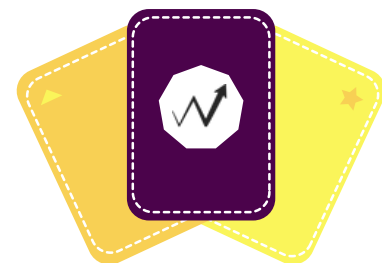


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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 9

**What are the recommended
impression materials in implant
prosthodontics?**



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 9

**Recommended materials include
Quadrafunctional Vinyl Polysiloxanes, Addition
Cured Silicones, and Polyethers.**

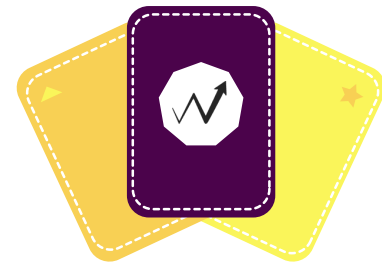


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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Question 10

How do digital impression techniques improve the impression-making process?



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**IMPRESSION,
TECHNIQUES AND
MATERIALS**

Answer 10

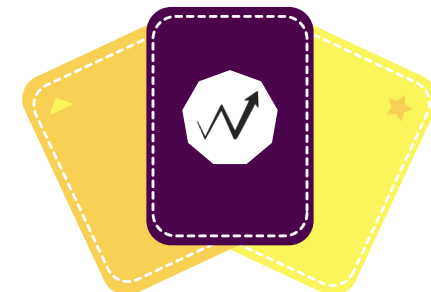
Digital impression techniques allow for more precise and faster capturing of records, eliminating many steps involved in conventional methods, although they come with higher costs and learning curves.

PROSTHODONTICS

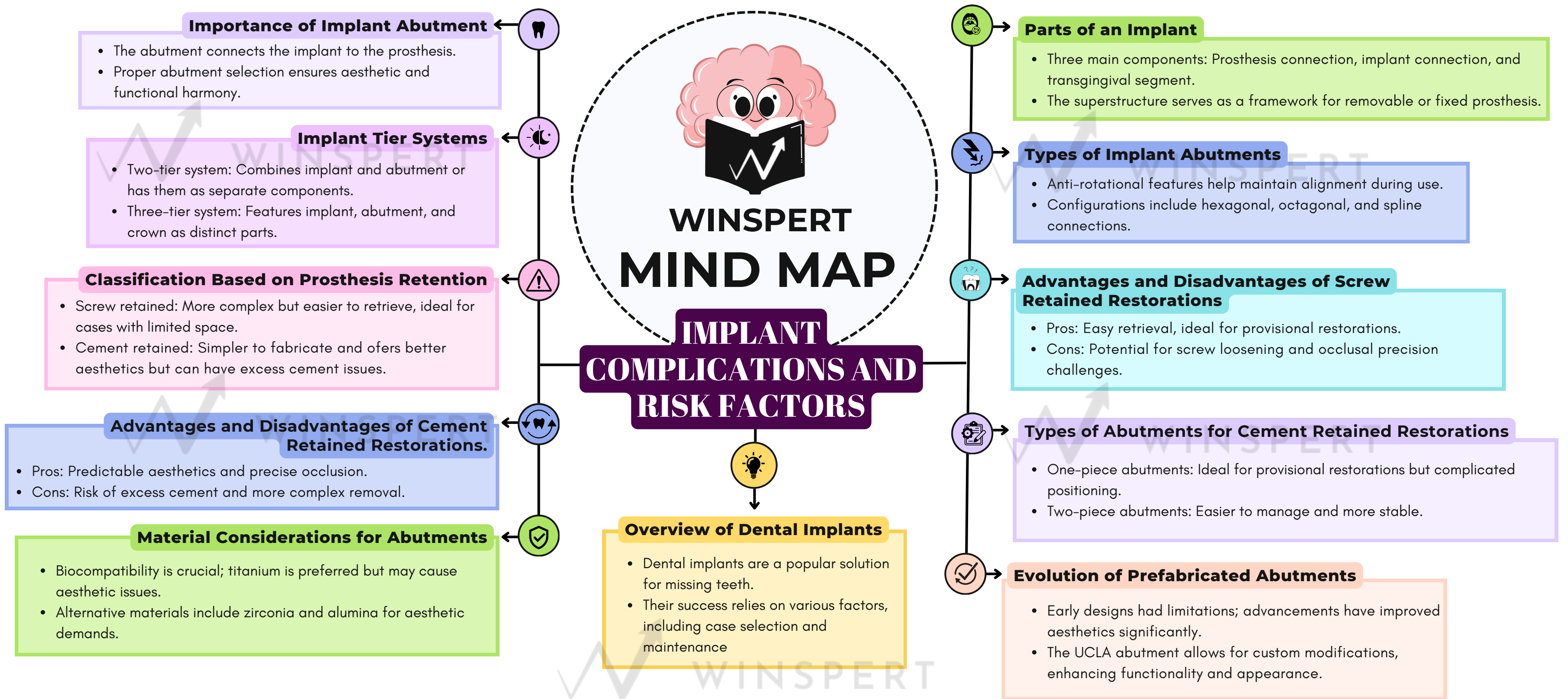
IMPLANT COMPLICATIONS AND RISK FACTORS

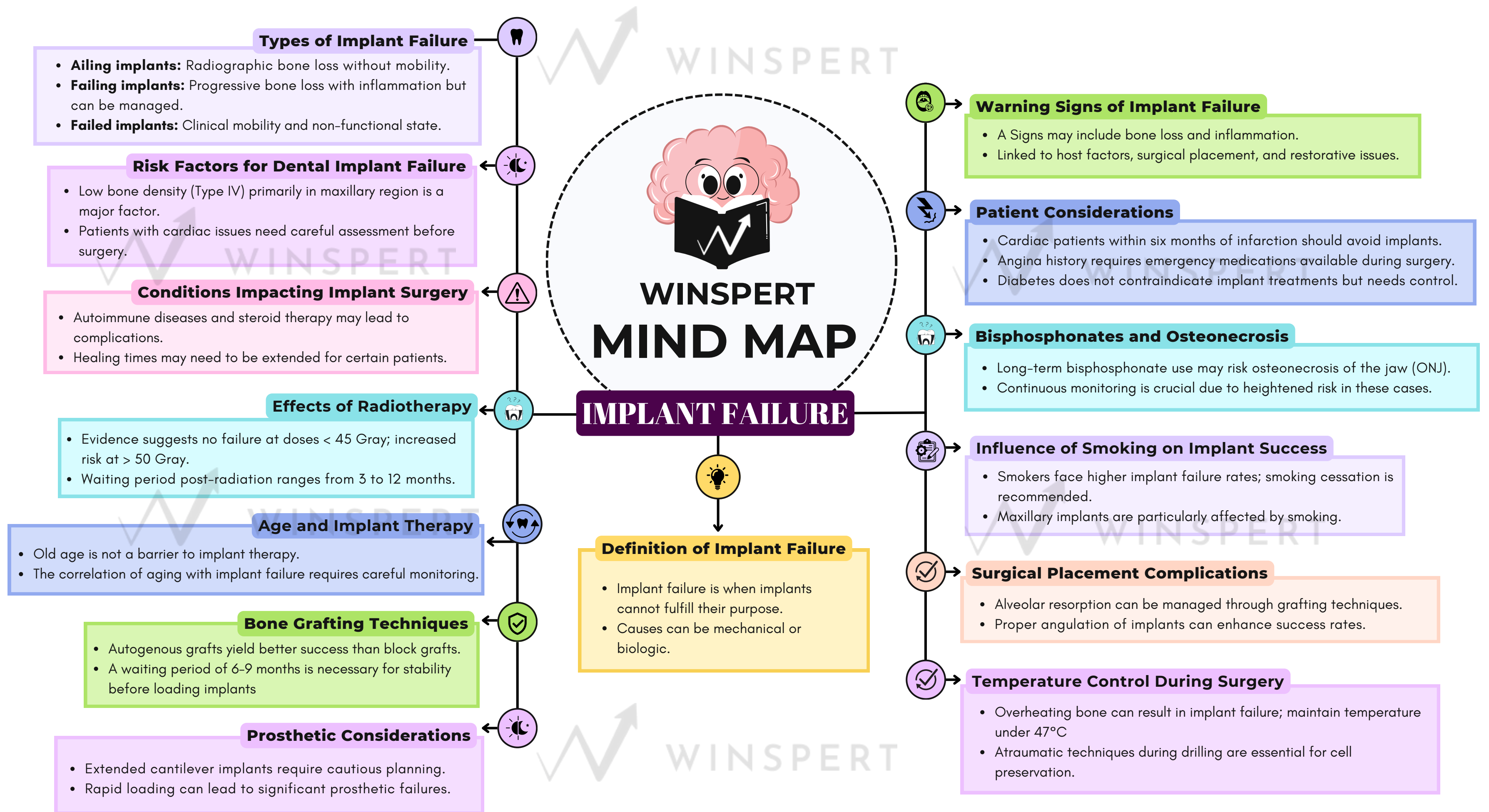


MIND MAP & CUE CARDS



BY DR. JIGYASA SHARMA







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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 1

What are the key factors that contribute to the success of dental implant restoration?



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 1

Successful implant restoration depends on various factors including case selection, implant placement, osseointegration, abutment selection, and maintenance.



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 2

**What are the three parts
of an implant abutment?**



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 2

The abutment consists of the prosthesis connection segment, the implant connection segment, and the transgingival segment.



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 3

How can implants be classified based on the number of components in their connection system?



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 3

Implants can be classified as either a two-tier system (comprising two components or two separate components for abutment and crown) or a three-tier system (where implant, abutment, and crown are individual components).



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 4

What are the types of retention options for implant restorations?



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 4

Implant restorations can be screw retained or cement retained. Screw retained restorations involve direct connection without an intermediate abutment, while cement retained restorations require an abutment and cement for securing the prosthesis.



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 5

What is the primary risk factor associated with dental implant failure?



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 5

The primary risk factor for dental implant failure is low bone density, particularly Type IV bone quality, which is commonly found in the maxillary premolar region.



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 6

**How does smoking affect
dental implant outcomes?**



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 6

Smoking is a recognized risk factor for wound healing, significantly increasing the failure rate of implants, especially in the maxilla. However, cessation at least one week before surgery can mitigate risks.



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 7

What complications can arise from surgical placement of implants?



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 7

Complications from surgical placement can include alveolar process resorption, which can be managed by grafting the area, angling the implant, or using an angulated abutment.



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 8

What different retention strategies exist for cement retained restorations?



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Answer 8

Cement retained restorations can utilize either provisional or definitive cementation, with provisional being easier to retrieve but having a higher risk of microleakage compared to definitive cementation.



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 9

What warning signs indicate the potential failure of an implant?



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 9

The warning signs of implant failure include progressive bone loss, signs of inflammation, and clinical mobility of the implant.



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**IMPLANT
COMPLICATIONS AND
RISK FACTORS**

Question 10

Which materials are currently used for customized implant abutments, and what are their advantages?



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IMPLANT COMPLICATIONS AND RISK FACTORS

Answer 10

Common materials for customized implant abutments include titanium, zirconia, alumina, Peek, and gold alloys. Titanium is ideal for mechanical properties, while zirconia is preferred for aesthetics in anterior regions due to less visibility of a greyish hue.