UAF VOL 2

ULTIMATE ADVANCE FILE

P.O.W.E.R

PREPARATION OF ADC WITH WINSPERT EXPERT REVIEW

NOTES

PROSTHODONTICS

By Dr. Jigyasa Sharma

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R.A.S.H TECHNIQUE

R- RULE OUT
A-DOES IT ANSWER OUR QUESTION
S- SEQUENCE WISE WHAT COMES 1ST
H-WHAT IS GIVEN IN THE HISTORY

SOLVE ADC QUESTIONS AT
lightning speed!

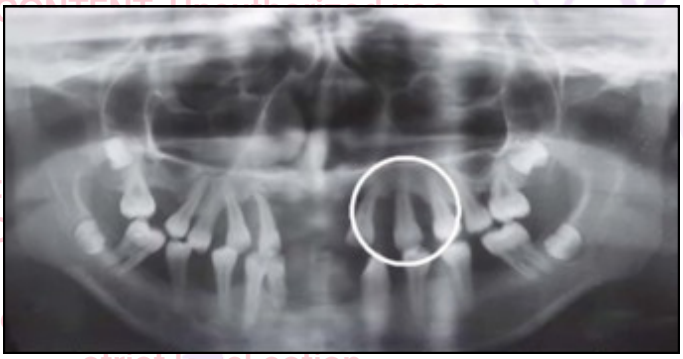
PROSTHODONTICS

SBQ 1

OPG GIVEN. ABSENT UPPER POSTERIORS FOR 5 YEARS AND SEVERE BONE LOSS. LOWER ANTERIOR TEETH SHOWED LESS BONE LOSS. UPPER ARCH SHOWED MORE RESORPTION THAN THE LOWER

I. What is the level of bone loss visible?

A. Mild
B. Mild with localised moderate
C. Moderate
D. Moderate with localised severe
E. Severe



II. What would be the reason for mobility of 25 ,25 in OPG showed somewhat similar bone loss (not supra erupted)

A. Severe bone loss
B. Supraeruption
C. Bone loss with attachment loss
D. Split root

III. Grade 3 mobility was seen in respect to 25. You plan to extract 25. What is the preferred impression material to obtain the final cast to fabricate prosthesis?

A. PVS
B. Alginate
C. ZnOE
D. Polyether

IV. You decide to give RPD to the patient. What's your choice of material to give the RPD?

A. Upper acrylic lower metal
B. Upper metal lower acrylic
C. Both metal
D. Both acrylic

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SBQ 1

V. You have decided to take occlusal registration. What is the use of facebow recording before doing it ?

A. Helps to orient maxillary cast to patients anatomical reference points
B. Helps to find the difference between CR and CO
C. For maxillary and mandibular relation establishment

VI. Impression material was initially washed in water and after that immersed in what for disinfection?

A. Saline
B. Glutaraldehyde,
C. Naocl
D. Diluted detergent

IV. When should you change the impression disinfection solution?

A Follow manufacturer instructions (not given in some centers)
B. When visibly soiled.
C. After every pt to avoid microbial contamination
D. Every day at least once
E. When it looks soiled or contaminated

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P.O.W.E.R NOTES SBQ 1

I. According to the OPG:

- There are multiple missing teeth due to periodontitis.
- Generalized attachment loss
- More than 30% bone loss in multiple teeth which is generalized.
- More than 30% teeth are affected.
- So, it's a severe, generalised condition.

		Disease Severity and Complexity of Management			
		Stage I: Initial periodontitis	Stage II: Moderate periodontitis	Stage III: Severe periodontitis with potential for additional tooth loss	Stage IV: Advanced periodontitis with extensive tooth loss and potential for loss of dentition
Evidence or risk of rapid progression, anticipated treatment response, and effects on systemic health	Grade A Grade B Grade C	Individual Stage and Grade Assignment			

Periodontitis stage		Stage I	Stage II	Stage III	Stage IV
Severity	Interdental CAL at site of greatest loss	1 to 2 mm	3 to 4 mm	≥5 mm	≥5 mm
	Radiographic bone loss	Coronal third (<15%)	Coronal third (15% to 33%)	Extending to middle or apical third of the root	Extending to middle or apical third of the root
	Tooth loss	No tooth loss due to periodontitis		Tooth loss due to periodontitis of ≤4 teeth	Tooth loss due to periodontitis of ≥5 teeth
Complexity	Local	Maximum probing depth ≤4 mm Mostly horizontal bone loss	Maximum probing depth ≤5 mm Mostly horizontal bone loss	In addition to stage II complexity: Probing depth ≥6 mm Vertical bone loss ≥3 mm Furcation involvement Class II or III Moderate ridge defect	In addition to stage III complexity: Need for complex rehabilitation due to: Masticatory dysfunction Secondary occlusal trauma (tooth mobility degree ≥2) Severe ridge defect Bite collapse, drifting, flaring Less than 20 remaining teeth (10 opposing pairs)
Extent and distribution	Add to stage as descriptor	For each stage, describe extent as localized (<30% of teeth involved), generalized, or molar/incisor pattern			

II.

- Severe bone loss alone can not give rise to mobility.
- Bone loss with attachment loss can be the reason for the mobility.

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P.O.W.E.R NOTES SBQ 1

III. It's an impression for the immediate denture.
If there's a mobile tooth and we need to take an impression in such situation, FLOWABLE PVS is the best material. Because:

- Accurate
- It has a high tear strength- his strength helps ensure the material can withstand the forces involved in removing the impression from undercuts and around teeth without tearing or breaking.
- Not rigid
- Can be flexed around the tooth without putting any movement on the tooth which can lead to accidental extraction.

IV.
- This patient is diagnosed with severe periodontitis.
- In the future, we are not sure that the disease can be controlled or not.
- It can be in a transitional period.
- In such situations metal based RPD is not recommended as adding missing teeth would be a difficult task.
- Therefore, both acrylic dentures would be the best option.

V. There are 3 types of jaw relationships. (maxilla to mandible jaw relationship)
1. Vertical jaw relation
2. Horizontal jaw relation
3. Orientation jaw relation

- If anyone of them are recorded incorrectly it can lead to a faulty denture.
- FACE BOW is not used for centric or horizontal jaw relation.
- The difference between the centric relation (CR) and the centric occlusion (CO) is the horizontal relation. So, option (B) is ruled out.
- Option (C) is ruled out as it doesn't specifically mention about the type of the jaw relation.
- FACE BOW is used in orientation jaw relation. Orientation jaw relation is nothing but orienting the maxillary cast to the patient's anatomical reference points which is the hinge axis/condylar movement axis.
- Therefore, among the given (A) is the best answer.

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P.O.W.E.R NOTES SBQ 1

V. Reference:

METHOD OF ORIENTATION

Establishing the plane of orientation:
ARBITRARY METHOD OF ORIENTING THE CAST

- The casts are centered anteroposteriorly& laterally between upper & lower articulator members
- Occlusal plane is positioned to a determined average value which is marked on the articulator
- In Hanau articulator level of occlusal plane is marked by a groove in incisal pin
- This makes occlusal plane about 3.5mm below a horizontal plane passing through the intercondylar shafts (which is Balkwill's average value position)
- In this orientation individual variations are not taken into consideration

Face bow
The face bow is a caliper like device that is used to record the relationship of the jaws to the temporomandibular joints or the opening axis of the jaws and to orient the casts in the same relationship to the opening axis of the articulator. (Boucher)

Uses

- Records spatial relationship of maxilla to cranium by help of some anatomical refrence plane.
- Transfer this relation to articulator - facebow transfer.

Importance of facebow transfer

- Determines terminal hinge position
- Duplication of all arcs of closure on the instrument.
- Cusps can be tailored to harmonize with these arcs

VI. 1st preference of disinfection solution is "DILUTED DITERGENT".

Reference:

4. Impressions

To remove contamination from impressions, thoroughly rinse them with cold running water to remove saliva and traces of blood. Then apply a diluted detergent. This can be done by immersion in a solution of detergent or by spraying the diluted detergent onto the impression (e.g. in a plastic bag). The detergent will have a surfactant action which assists in removing the remaining microorganisms from the impression. Thorough rinsing is then undertaken to remove the detergent. This second rinsing step must continue until all visible contamination is removed. Once this is completed, the impression is deemed to be decontaminated.

Where a risk assessment indicates that additional treatment may be needed (e.g. a patient known or suspected to be colonised with multi-resistant organisms such as MRSA), additional chemical treatments may be undertaken. A common protocol for additional treatment is immersion in a weak (0.5%) sodium hypochlorite solution for 3 to 15 minutes, as this does not cause deterioration of the impression material. Note that higher concentrations or longer exposure times will degrade the quality of the impression and the resulting cast. Other commercial solutions designed for impression disinfection can also be used, as per the instructions for use.

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P.O.W.E.R NOTES SBQ 1

VII. Disinfection solutions which are most used in dentistry are:

- **Sodium hypochlorite**
- **Benzalkonium chloride**

Impression disinfection solution should be changed on daily basis.

Reference:

1. Clinical implications

The present study demonstrates the importance of having a second level disinfection protocol in dental laboratories to ensure the highest levels of impression disinfection and the absence of spores and/or uncommon bacterial species. Furthermore, following the manufacturer's instructions in terms of pre-rinsing impressions for 3 min before disinfection is an important factor in maintaining the efficacy of the disinfecting solution. Finally, dental personnel's level of experience as well as the daily impression number/load affected the efficacy of the disinfecting solution. The present study informs clinicians that the Cavex Impresafe disinfecting solution needs to be changed more frequently (daily rather than weekly) in larger dental facilities with higher impression turnover per day.

Antimicrobial disinfection has been a critical step in clinical dentistry and dental research aiming to ensure the health and safety of patients and practitioners as well as improving the quality of treatment outcomes [1,2]. Prevention of transmission of pathogens from patients to the dental team is at the cornerstone of practicing dentistry. Studies have shown that dental impressions can harbor various pathogenic microorganisms [[3], [4], [5]]. Benzalkonium chloride (BAC) is a common solution used in the dental office to disinfect dental impressions and prevent the transfer of microorganisms from patients to dental and laboratory personnel. One advantage of detergent-like active agents -such as BAC- over oxidising active agents - such as sodium hypochlorite-is that the latter lose disinfectant power over time (even if not used) whereas the former do not degrade over time [6]. However, despite the low degradability of BAC, disinfectant solutions using BAC still lose power with repeated use owing to three main reasons. First, the more times a solution is used the more dead bacteria are left in the solution [7]. Accumulation of dead bacteria creates turbidity and reduces disinfectant power. Second, the active molecules of BAC have a negative charge, some impression materials neutralise this charge reducing the disinfectant power faster. Finally, the surfaces of some impression materials absorb active molecules of BAC whenever an impression is submerged for effective disinfection to take place. Hence, the more the solution is used, the fewer active molecules are left, and the less disinfectant power remains [8].

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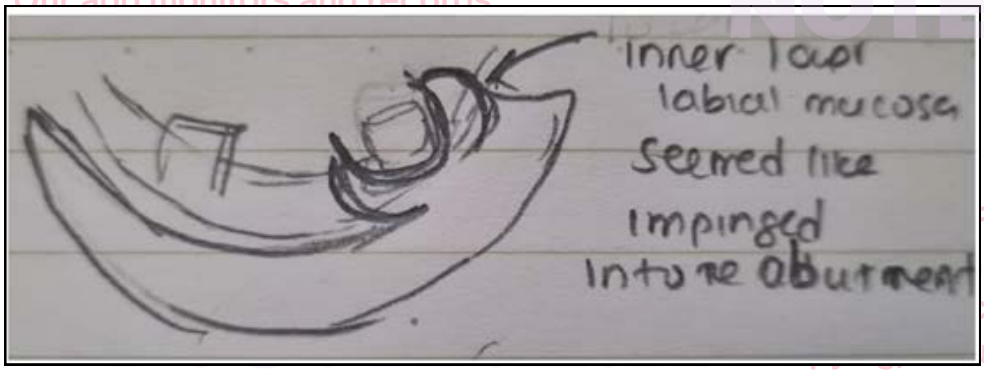
PROSTHODONTICS

SBQ 2

(UAF VARIATION LOCATOR ATTACHMENT MANDIBULAR OVERDENTURE)

A 70 YEAR OLD PATIENT NAMED VALERIE STAYS IN AN OLD AGE HOME. THE PATIENT CAME TO THE CLINIC WITH HER DAUGHTER SALLY.PATIENT HAD GOT AN IMPLANT-SUPPORTED UPPER AND LOWER DENTURE A FEW YEARS BACK, SHE LOST HER DENTURES. PATIENT WAS ON IV DENOSUMAB INJECTIONS TAKEN SIX MONTHLY TO TREAT OSTEOPOROSIS. SHE HAD A HISTORY OF DEMENTIA, POORLY CONTROLLED DIABETES. PHOTOGRAPH WAS GIVEN. THERE WAS INFLAMMATION AROUND THE IMPLANT AND OVERGROWTH OF TISSUE AROUND THE IMPLANT. SHE IS ANXIOUS AND DOESN'T WANT TO LEAVE THE CARE HOME.

(LOWER-TWO IMPLANT SUPPORTED OVER DENTURE)- PATIENT LOST IT ONE OR THREE MONTHS AGO.(IN THE PROVIDED PICTURE U CAN 2 ABUTMENTS ONLY AS GIVEN BELOW AND YOU FIND SEVERE INFLAMMATION AROUND ABUTMENTS AND ULCER ON LOWER LABIAL MUCOSA).GINGIVA WAS ENLARGED LOOSELY ENCIRCLING THE ABUTMENT AND IMPLANT ABUTMENT WAS LINGUALLY POSITIONED.



I. What may be the cause of inflammation and ulceration around the abutment?

A. Patient did not wear denture for a long time
B. Lingually placed abutments
C. Abutment placed too high

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PROSTHODONTICS

SBQ 2

II. What can be the complication in her case when you plan to change the implant abutment to healing abutment?

A. Type I diabetes
B. Osteoporosis
C. Smoking

III. What will you tell Sally (the daughter) before commencing treatment?

A. To get control of the poorly controlled diabetes before starting the treatment.
B. Construct new dentures.

P.O.W.E.R NOTES SBQ 2

I.
- When there's no adequate width of the bone to place the implants, it's better to use implants with narrow diameter rather than placing implants too labially or lingually. Because later it can affect the soft tissues, attached gingiva, can irritate the soft tissue around the implant, if can affect the phenotype, it can lead to peri-implant mucositis.
- Giving higher abutments are beneficial rather than giving submerged abutments, because submerged abutments can irritate the gingiva more. So, option (C) is ruled out.
- Soft tissue irritation will not happen when the patient is not wearing the denture, it can happen when patient is wearing the denture. So, option (A) is ruled out.
- Among the given the best option is (B).

Reference:

placement of the prostheses and up to the 1-year follow-up visit. To avoid soft-tissue problems in mandibular overdenture treatment with ball attachments, the amount of attached gingiva, as well as the pressure of the lip and the grade of alveolar atrophy, should be carefully assessed during treatment planning. Although the problem can be solved by placing the implants higher or by adding mucosal cylinders, it may be worthwhile to consider mucosal soft-tissue grafting (e.g., from the palate) with or without bar retention, in which case the shoulder of the implant would be covered by the coping of the bar. After this study was completed, the component manufacturer introduced a set of ball anchors in which the shoulder is 1, 3 or 5 mm high. Using these components would naturally be recommended in cases where an elevated shoulder is indicated.

PROSTHODONTICS

P.O.W.E.R NOTES SBQ 2

II.
- It's better not to remove this implant and replace it because of several reasons. They are:
- It's a healthy implant. It's a well Osseo integrated implanted and there's only soft tissue irritation.
- Patient is on DENOSUMAB. So, need to plan the surgery very meticulously to avoid MRONJ.
- Patient has poor controlled DM.
- She's in an old aged home care. Follow up visits will be too hard for them.
- If we are not doing any surgical procedure, denosumab, MRONJ and osteoporosis are not risk factors.So, option (B) is ruled out.
- In the history it's not mentioned that the patient has a habit of smoking. So, option (C) is ruled out.
- Uncontrolled DM and smoking both delays wound healing. So, the best option is (A)

III.
- Giving the patient a healing abutment and letting the soft tissue heal 1st. cylindrical abutments will be the choice in this case.
- Unless she controls diabetes, healing abutments won't be enough. So, option (A) is the best answer.

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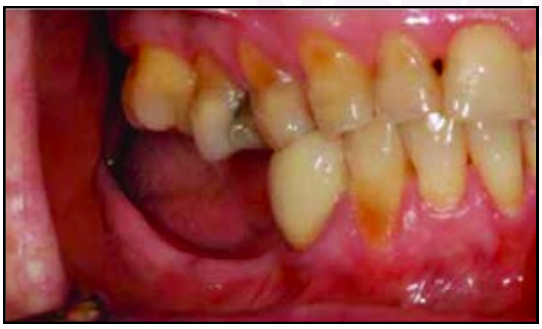
SBQ 3

SOMEWHAT SIMILAR PIC AS BELOW.PATIENT CAME TO YOU WITH A COMPLAINT OF DISCOMFORT ON THE UPPER RIGHT QUADRANT. UPON EXAMINATION YOU FIND A VERTICAL ROOT FRACTURE IN RELATION TO 15 SO YOU PLAN TO EXTRACT 15. AFTER DISCUSSING WITH THE PATIENT, SHE ASKS FOR A BRIDGE AS THE OPTION FOR REPLACING 15.



I. What will contraindicate bridge in this patient?

A. Supraeruption of 16
B. Perio condition of patient
C. Lack of opposing teeth
D. Biological compromise of the abutment teeth.

II. Patient wants RPD for the lower jaw and she asks you whether a lower removable partial denture will be beneficial. What will you tell her?

A. Yeah it provides some benefit
B. It will not provide any benefit
C. Implant replacement will be more beneficial
D. No replacement is necessary

III. What is the benefit of replacing the lower edentulous area?

A. Prevent supraeruption of 16
B. Improves self esteem
C. Restore masticatory function

IV. Patient came with loose denture on the left distal extension, 4 weeks post insertion. How will you manage?

A. Adjust the clasps tight so you can't move the denture during chewing
B. Reline with tissue conditioner on one side
C. Construct a new denture

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PROSTHODONTICS

SBQ 3

V. In the same patient, on examination you noticed a small amalgam filling on 25 with mesial and distal marginal ridge cracks. Patient is asymptomatic. How will you manage?(picture was not given)

A. Remove amalgam and restore with bonded composite
B. Keep under observation
C. Stainless steel Band
D. Intentional RCT and crown

VI. Which type of fracture originates from the root and goes to the crown of the tooth?

A. VRF
B. Cracked tooth

VII. What group of muscles will have an effect on making a lower impression?

A. Orbicularis oris
B. Geniohyoid
C. Mylohyoid

P.O.W.E.R NOTES SBQ 3

I.
- Periodontal condition has an impact on any type of tooth replacement, whether it 's RPD, FPD or implant.
- If there is attachment loss and teeth are periodontally compromised, it will affect on teeth replacement.
- Supra eruption of teeth is not a contraindication as prophylactic RCT can be done in complicated situations. Option (A) is ruled out.
- Lack of opposing teeth is not a contraindication as opposing teeth can be replaced if needed. Option (C) is ruled out.
- In crown preparation very minimal amount of tooth reduction is done. So, there's no biological compromising of the abutment teeth. option (D) is ruled out.

II.
- Lower removable partial denture will be beneficial. It will be helpful in masticatory function. And it will replace the missing teeth.
- Ridge is excessively resorbed and distal extension. So, RPD will be the better option.

III.
- It will prevent supra eruption.
- It will boost self-esteem. But not that effective in the posterior teeth region.
- Will be helpful in masticatory function. Posterior teeth are more important in mastication.
- All these options are correct. Best is option (C).

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P.O.W.E.R NOTES SBQ 3

IV.
- It's not an immediate denture. So, there's no immediate bone resorption. So, no need of doing the relining. Option (B) is ruled out.
- The looseness is seen only in one side. patient started experiencing it after 4 weeks.
- Stability might have been affected due to the changes in the clasp. Adjustments of the clasps should be done 1st.
- Constructing a new denture is not the best practical approach. Option (C) is ruled out.

REFERENCE: BDJ- RPD article

Prosthodontic opinion on clasp design

Statement 1 — A clasp should always be supported by a rest

A clasp should be supported to maintain its vertical relationship to the tooth. Without such support the clasp will tend to move gingivally with the following detrimental effects:

- The retentive tip of the clasp will lose contact with the tooth. It will not therefore provide retention for the denture until there has been sufficient movement of the denture in an occlusal direction to re-establish contact of the clasp with the tooth. The denture may therefore seem loose to the patient.
- The tip of the clasp may sink into and damage the gingivae.

This statement is not universally applicable. For example, acrylic mucosally supported RPDs often employ wrought wire clasps without tooth support. However, even in this situation tooth support for clasps can sometimes usefully be obtained by wrought wire rests or clasp arms extending onto the occlusal surfaces.

It might be preferable to omit tooth support when, as shown in Fig. 1a, there are very few teeth remaining and rests on them would produce a support axis that approximately bisects the denture. In this situation tooth support can contribute to instability of an RPD because the denture tends to rock about the support axis.

If however, there are very few teeth remaining, but rests on them would produce a support axis which forms a tangent to the residual ridge, tooth support can usually be employed to advantage and the denture remain acceptably stable (Fig. 1b).

Tissue-conditioning materials are soft, resilient, temporary relining materials which, by reducing and evenly distributing stresses on the mucosa of the basal seat, have a rehabilitating effect on unhealthy tissue and allow reversible conditions to return to normal states of health.[1] In addition to tissue conditioning, its use has been advocated in impression making procedure or as a final impression material. In the past, there was little agreement about the best method of using them as functional impression materials and their use in complete denture impressions was even controversial.[2–5] The study on the physical properties of tissue conditioners revealed that these materials do have the essential properties of a satisfactory impression material if working casts are poured promptly.[1,6,7]

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PROSTHODONTICS

P.O.W.E.R NOTES SBQ 3

IV.

Instability

Instability	*Causes*	*Solutions*
When not occluding	1. Overextension of borders and posterior limits 2. Under extended borders 3. Loss of post dam seal a. Post dam on hard palate b. Post dam not over hamular notches c. Insufficient post dam 4. Dehydration of tissue due to alcoholism or medication. 5. Flabby tissues displaced when taking impression due to improper tray.	In all cases a new impression is necessary. Best to grind out the tissue side and take a wash impression, using compound where necessary to extend impression to include post dam area. Rebase entire denture.
When chewing food	1. Loss of post dam seal 2. Anterior teeth too far labially 3. Flabby anterior tissue 4. Improper incising habits 5. Lower posteriors set off ridge	1. Same as above. 2. Remount and reset bringing anteriors back lingually. 3. Surgery to remove poor denture foundation and rebase. 4. Patient education is the answer. 5. Reset and correct posterior alignment.
When occluding in centric	1. Malocclusion a. Premature individual teeth hitting b. High occlusion on one side of arch c. Bicuspid area premature contact 2. Upper denture "riding" on hard palate surface 3. Flabby tissues over ridge 4. Teeth set too far bucally 5. Centric occlusion not in harmony with centric relationship	1. a. Remount grind, and mill-in selective teeth. b. Remount and reset. c. Try chairside mill-in or remount and set. 2. Relieve pressure area 3. Remove flabby tissue with surgery and rebase. 4. Remount and reset lingual. 5. Remake one denture.

V. The treatment decision in cracked teeth appeared to be more influenced by symptoms rather than by the amount of remaining tooth structure

Symptomatic cracked tooth can be of 2 types.

- Reversible – two stage approach is done. 1st band is placed and reviewed. Then the definitive treatment will be decided.
- Irreversible- RCT is required.

Asymptomatic cracked tooth

- definitive treatment is done
- Either direct technique with cuspal coverage or indirect technique with crowns.

In the scenario it's an asymptomatic tooth. so, we need to do a direct cuspal coverage. Among the given option (A) is the best.

REFERENCE: Diagnostic and treatment preferences for cracked posterior teeth

- Scenario 1: symptomatic crack tooth with a cold sensitivity
- Scenario 2: symptomatic crack tooth with a cold sensitivity, biting pain and tenderness to percussion
- Scenario 3: asymptomatic cracked tooth initially discovered during restoration replacement.
- Scenario 4: asymptomatic apical periodontitis in cracked tooth with a 5mm distal probing defect discovered during RCT

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P.O.W.E.R NOTES SBQ 3

V.

confidence to prefer single-stage definitive treatment.[24] This approach was likely driven by the circumferential bracing effect and high success rates of cuspal coverage indirect restorations in cracked teeth.[2,37]

Symptoms, structural loss and treatment decisions (Scenario 1, 2 & 3)

The presence or absence of symptoms seems to be a significant determinant among the respondents in choosing definitive single-stage treatment. Generally, a multi-stage approach, such as placement of an orthodontic band was chosen in the symptomatic cracked tooth as suggested in a recent review.[24] On the other hand, more definitive treatment, such as indirect cuspal-coverage was preferred for an asymptomatic cracked tooth. These findings reflect those of the NPBRN reports that cited presence of symptoms as a reason to commence restorative treatment.[14] The choice of direct cuspal coverage in both scenarios 1 (68.9%) & 2 (48.0%) is supported by the literature both as an interim and as a long-term measure.[35]

The treatment decision in cracked teeth appeared to be more influenced by symptoms rather than by the amount of remaining tooth structure. This is evident by the reduction in choice of direct cuspal coverage restorations (26.9%) in scenario 3 despite there being more tooth structure when compared to the other two scenarios. The choice of indirect restoration by around half the dentists in scenario 3 was similar to the reports from the USA, where 44% of the crowns were placed purportedly to prevent complete fracture.[36] The lack of symptoms coupled with a vital pulp probably may have given dentists more

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P.O.W.E.R NOTES SBQ 3

VI. VRF

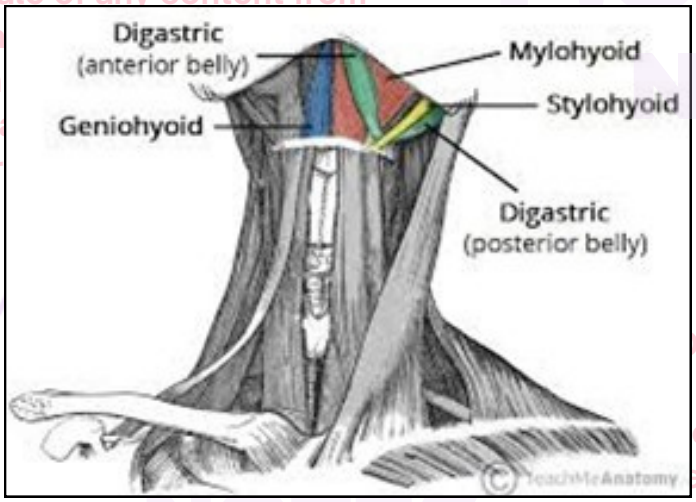
- Originates from root and progressed towards crowns
- Bucco-lingually

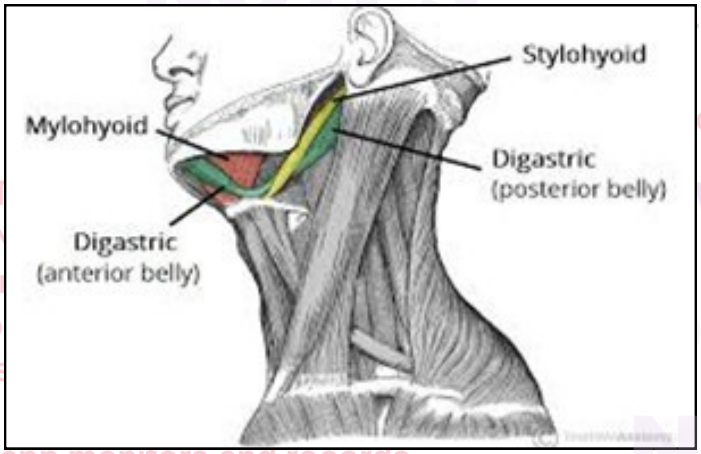
CRACKED TOOTH

- Originates from crown and progressed towards roots
- mesio-distally

VII.

- Patient has all the anterior teeth.
- Genioyoid and orbicularis oris will not have any effect. These muscles will play a role when we are making complete dentures.
- In this case we are making a lower denture with a distal extension. So, mylohyoid will influence making a lower denture.





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SBQ 4

THEY GAVE AN ARTICULATION PAPER MARK (BOTH LATERAL EXCURSIONS AND OTHERS) PICTURE WAS SIMILAR BUT IN MAXILLARY ARCH.

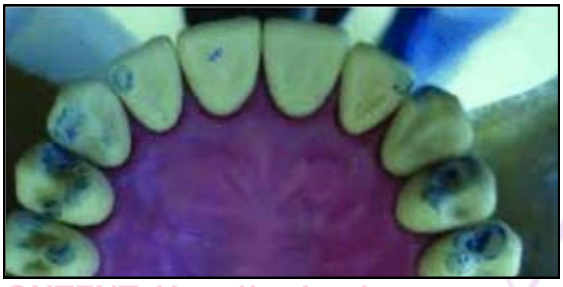
I. What type of occlusion did the presentation indicate?

A. Canine guided occlusion
B. Balanced occlusion
C. Group function
D. Some options about malocclusion

P.O.W.E.R NOTES SBQ 4

I. How to identify teeth are in maximum intercuspation?
- You would be able to appreciate point on the tooth surface.

How to identify lateral exertion?
- Lateral exertion articulating points are in the form of lines.



- In the 1st picture, some narrow points and some wide points are marked. These are maximal intercuspation markings.
- These narrow points- denote higher impacted forces. Patient might complain of pain on biting in these area as more pressure is applied on these areas.
- The wider points -denote lower impacted forces. Lower impacted points are the preferred points.

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P.O.W.E.R NOTES SBQ 4

I.
- When we take maximal intercuspation articulation, we expect to see the wider points and not the narrow sharp points. Narrow points may lead to instability as they are causing interference and there are areas with high forces.
- There are no lateral exertion markings on the 1st picture.
- In the 2nd picture, there are red lines and they indicate the lateral exertion markings.
- In dentures we prefer bilateral balanced occlusion in bother centric and lateral exertions.
- Even in maximum intercuspation we prefer meeting of both anterior and posteriors.
- In balanced occlusion you would be able to appreciate points on all teeth.
- In 1st picture you can appreciate points on all the teeth, which means there is bilateral balanced occlusion in maximum intercuspation.
- In canine guide occlusion and group function, the anterior will not meet. So, there won't be points in anterior in maximum intercuspation.
- In case of bilateral balanced occlusion in lateral exertion, you would be able to appreciate lines in both R/S and L/S canines.

How to differentiate canine guidance and group function?

When the articulating lines are present only on the canine in one side is known to be canine guided occlusion.

When the articulating lines are present not only on the canine but also on the other posterior teeth in one side is known to be group function occlusion.

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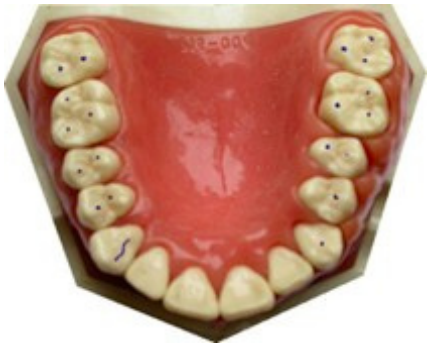
P.O.W.E.R NOTES SBQ 4

I.

TYPE OF OCCLUSION	DURING MAXIMU INTERCUSPATI ON (CENTRIC RELATION)	DURING LATERAL EXERTION (ECENTRIC RELATION)	DIAGRAM
01. BILATERAL BALANCED OCCLUSION Bilateral balanced occlusion refers to a specific type of dental occlusion where there is simultaneous contact of teeth on both sides of the jaw (bilateral) during both centric (closed) and eccentric (sliding or chewing) movements.	Able to appreciate dots on both anterior and posterior teeth	Able to appreciate lines on both anterior and posterior in both sides	
02. CANINE GUIDED OCCLUSION Canine guided occlusion, also known as canine guidance, is a type of dental occlusion where the canine teeth (the pointed teeth next to the incisors) play a primary role in guiding the jaw during lateral (side-to-side) and protrusive (forward) movements. In this system, when the jaw moves sideways, the canine teeth on the working side disengage the posterior teeth (premolars and molars), preventing them from touching. This disengagement is meant to protect the posterior teeth from excessive lateral forces that could lead to wear, damage, or even fractures.	Able to appreciate dot only on posterior teeth.	Able to appreciate a line only on the canine of the working side. (only on one side)	

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PROSTHODONTICS

P.O.W.E.R NOTES SBQ 4

I.

TYPE OF OCCLUSION	DURING MAXIMU INTERCUSPATION (CENTRIC RELATION)	DURING LATERAL EXERTION (ECENTRIC RELATION)	DIAGRAM
03. GROUP FUNCTION Group Function Occlusion (GFO) is a dental concept where multiple teeth on the working side of the jaw make contact during lateral (sideways) movements, distributing the chewing forces more evenly. This is in contrast to other occlusal schemes like Canine Guided Occlusion, where only the canines touch during these movements.	Able to appreciate dot only on posterior teeth.	Able to appreciate a lines on the canine and posteriors of the working side. (only on one side)