PARKER PERIO PRESENTS

The goal of our e-newsletter is simple:
Take cases that seem ***impossible***
and show you how Parker Periodontics makes them ***possible***.

PRE-ORTHODONTIC GINGIVAL GRAFTING

THE BACK STORY

Stephanie presented with receding gingival tissue in the mandibular anterior that has been sensitive to cold and hot for the last few years. Recently, she has noticed food getting trapped at the sites as well as increased bleeding and inflammation. Stephanie decided it was time to have it addressed as she was hoping to pursue orthodontic treatment due to esthetic concerns with her smile.

THE FINDINGS

Periodontal charting revealed #24 had 6mm of recession and #25 had 7mm of recession. There was 1mm of keratinized tissue at each site but with a probing depth of 2mm mid-facial there was no attached tissue. All other sites in the mouth were periodontally healthy. A small mandibular midline frenum was present as well as a deep vestibule. Calculus was present on the root surface due to sensitivity when brushing.

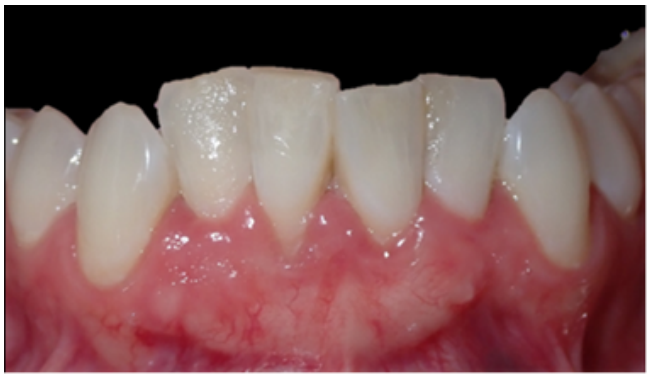
THE OBSTACLE

The mandibular anterior is a common area for mucogingival defects due to aberrant frena, thin tissue, shallow vestibule, and a lack of attached tissue. The temperature sensitivity amplifies the need to achieve complete root coverage. A free gingival graft is typically chosen for this site but it does not always achieve great root coverage. Therefore, at times we need to think outside the box to achieve an optimal result.

THE PROCEDURE

The laterally closed tunnel was selected to achieve increased root coverage and keratinized tissue at #24-25. After intravenous sedation and local anesthesia was delivered, the teeth were scaled and root planed. Sulcular incisions were made on the facial of #24-25. Tunneling instruments were used to create a full thickness tunnel extending from the gingival margins and past the mucogingival junction for #23-26. This allowed for internal release of the frenum attachment. A connective tissue graft was taken from the palate and threaded under the tunnel and midline papilla. The CTG was stabilized in place with simple interrupted and sling sutures. Finally, the lateral borders of the recession were closed tension free to completely cover the CTG. Sutures used were 6-0 Glycolon, a slow-resorbing monofilament suture. A stent was placed in the maxillary arch for protection of the graft donor site.

THE OUTCOME



Sutures were removed after 3 weeks of healing. Initial healing showed complete root coverage with increased tissue thickness at the site. Further tissue maturation occurred after 6 months of healing with excellent root coverage and tissue thickness and no temperature sensitivity. Orthodontic movement can be safely performed now that the soft tissue concerns have been addressed. With straightening of the teeth, it is expected the graft will continue to improve as access to hygiene is improved.

LIKE IT? LOVE IT?
WANT TO KNOW MORE ABOUT IT?
HAVE A CASE YOU'D LIKE US TO DISCUSS?

FEEL FREE TO CONTACT US AT WWW.PARKERPERIO.COM TO REVIEW MORE CASES LIKE THIS ONE!

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PERIODONTICS & IMPLANT DENTISTRY