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Dentistry

Commentary

Association Between Periodontitis and the Quantity of Prosthetic Crowns

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ABOUT THE STUDY

Periodontitis is a term used to describe bacterial biofilm-induced host-mediated inflammation that results in the loss of periodontal attachment. The ecological changes brought on by the dysbiosis of microorganisms, which emerge as anti-bacterial mechanisms and induce inflammation and tissue death in the gingival sulcus, are what determine the beginning and progression of periodontitis. Inflammatory mediators cause loss of attachment and crestal bone resorption when periodontitis worsens, and the depth of the periodontal pocket deepens as well.

Plaque accumulation and consequent gingivitis and periodontitis are related to the presence of prosthetics as well as the structure, position, and connections of the teeth with one another. Additionally, by inflicting trauma or as a result of allergic reactions to dental materials, the production and delivery of tooth-supported prosthesis may have an adverse effect on periodontal tissues. According to certain reports, the gingival inflammation is worse the deeper the subgingival crown margin is positioned in the gingival sulcus. Furthermore, after putting subgingival restorations, long-term observations have demonstrated that loss of attachment rapidly advances one to three years later. Other investigations have shown that gingival recession and bleeding on probing are two effects of the subgingival margin design of prostheses on the neighbouring periodontal tissue. It is also well recognised that overhanging restorations result in interproximal bone loss and gingival irritation. These findings are inferred from the notion that it is challenging to control plaque around the overhanging prosthesis and the subgingival margin.

However, there have been no significant epidemiological studies that offer reliable proof of the link between periodontitis and prosthetic crowns. Every year 7,000 people participate in the Korea National Health and Nutrition Survey (KNHANES), which compiles data on diseases and nutrition to produce national statistics every three years. The World Health Organization (WHO) survey guidelines were followed for performing oral examinations on the tooth surface for the seventh edition of the KNHANES survey, which also counted how many prosthetic crowns each participant had. The Community Periodontal Index (CPI) was also measured to determine the state of the periodontium.

Several articles have previously reviewed the theory that the size, shape, and border of a dental prosthesis may contribute to periodontal inflammation. It is well recognised that plaque retention and loss of clinical attachment are related to the fabrication process, along with the design and material of the tooth-retained replacement. However, it is already understood that good restoration margins within the gingival sulcus do not result in gingival inflammation if the patient is able to execute adequate plaque management independently and with regular supportive periodontal care.

In comparison to regular teeth, prosthetic teeth require more extensive dental care and management techniques to prevent illness. In addition, plaque buildup under the prosthesis and poor oral health care make it easy for periodontal disease and secondary caries to develop. Depending on the type of prosthesis, different oral care products and particular brushing techniques are advised to prevent periodontal disease. When analysing the results of our study, there are a few restrictions to take into account. Due to the cross-sectional nature of this study, it is not possible to demonstrate a causal relationship between the incidence of periodontitis and the quantity of prosthetic crowns.

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