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Horizon Tracing is used to determine the Breadth of the Alveolar Ridges

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Description

Periodontal disease, periapical pathology, and mechanical trauma are all common causes of bone loss prior to tooth extraction. Furthermore, forceful extraction has been linked to further bone loss. As a result of the normal remodelling process, alveolar bone atrophys more during the healing phase following extraction. This starts immediately after extraction and can result in up to 50% resorption of the alveolar ridge width in as little as 3 months. Because sufficient vertical and horizontal volume of alveolar bone should ideally be present at the location of insertion, post-extraction AR resorption may have an influence on dental implant implantation [1]. Alveolar ridge preservation methods have been developed to preserve an appropriate ridge shape in regions of cosmetic importance, as well as to avoid alveolar ridge atrophy and retain suitable bone dimensions for implant implantation in prosthetically driven placements. In preclinical and clinical trials, several approaches for ARP have been examined, including socket grafting with autogenous bone, demineralized freeze-dried bone allograft, xenografts, such as deproteinized bovine-bone mineral, alloplasts, and bone morphogenic proteins. The use of guided bone regeneration with or without bone transplants has also been investigated. Despite the fact that several of the above bone replacements were capable of limiting post-extraction alveolar resorption ridge to some extent, the quality of the newThe tissue in the socket differed widely. The traces of In keeping with preclinical findings, the grafts frequently interfered with the natural healing process. An ARP review papers have been published in a lot of journals.

Throughout the previous decade, a comprehensive evaluation of the type and quality of the newly established tissue, as well as methodological quality and bias risk None of the studies have been completed [2]. Furthermore, as well as non-controlled prospective and retrospective studies as well as case studies were included in the majority of the past evaluations that did not provide a comparison to the control unassisted socket healing group. Therefore, the objective of the present systematic review was to investigate the effect of ridge preservation on the residual alveolar ridge dimensions and on histological characteristics, compared to unassisted socket healing.

Teeth are lost in adults for a variety of causes, including periodontal disease, trauma, periapical lesions, and other pathological consequences. Not only is the tooth extracted, but the alveolar socket undergoes extensive remodelling, which has been linked to further bone loss. Alveolar socket resorption causes around 3.87 mm of width loss and 1.67 to 2.03 mm of height loss in the first 3 months. This not only causes cosmetic issues, but it also restricts the viability of dental implants and fixed partial dentures. Multiple factors influence absorption, including extraction socket depth, mucosa thickness, metabolic parameters, and functional loads. Preventing these causes alone will not suffice to halt ridge resorption. As a result, additional procedures are required.

Many techniques, including as ultrasound treatment, sandwich osteotomy, and distraction osteogenesis, have been published in the literature to prevent or restore ridge resorption. None of them could meet the goal of presenting an appropriate ridge height and width for subsequent implant or prosthetic treatment with the least amount of effort. Alveolar socket and alveolar ridge preservation may appear to be a trustworthy option [3]. In terms of definition, ASP refers to a technique in which completely contained extraction sockets are filled with a bone substitute material and sealed with membranes, whereas ARP also includes damaged extraction sockets. From this point on, sockets with and without minor damage are covered in this page, and just ARP is mentioned. However, it should be noted that the word preservation does not imply that the original dimension of the alveolus may be preserved.

It is much more an attempt to keep the bone loss as low as possible. ARP has been demonstrated in several well-documented trials with various types of BSM. Autografts from the same patient, allografts from the same species, xenografts from another species, and alloplastic materials synthetic materials are the four types of BSM. Among the substitutes discussed in this article are autologous bone and bone marrow grafts, various allografts such as demineralized freeze-dried bone allograft mineralized freeze-dried bone allograft xenografts such as deproteinized bovine bone mineral, absorbable collagen sponges, or corticocancellous porcine bone alloplast materials such as bioactive glass particles; and various calcium phosphates and bioactive materials. Another benefit of ARP is the usage of membranes [4,5].

Conflict of Interest

None.

References

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