



## A Brief Note on Gingival and its Treatment

Maxim Babiner\*

Department of Conservative Dentistry, Universidade Federal do Rio Grande do Sul, Romania

### DESCRIPTION

Gingival downturns are outlined as the apical migration of the marginal gingiva and are related to mucogingival deformities that indicate anatomically functional irregularities resulting from a detrimental correlation within the mucogingival complex that consists of epithelium, fur, cementum, and alveolar bone. The multicausality of their etiological causes is a reflection of the uniqueness of gingival recessions. Recessions typically appear for a variety of causes, but the most common ones are poor brushing methods, high frenal attachment, an insufficient zone of keratinized gingiva, a thin biotype of the soft tissue (less than 2 mm), and bone dehiscence. In nearly 90% of instances with this anomaly, orthodontic therapy has lately been described as the most prevalent cause.

Epidemiologically, the prevalence of GR is significantly influenced by the patient's age, as well as a few favourable variables. Thus, it was found that 58% of younger individuals and nearly 100% of adults had gingival recessions (on one or more teeth). These qualities clearly convey their significance. The categorization of gingival recessions is crucial because it greatly facilitates our ability to make a prognosis before beginning therapy. There are many distinct categories in use today, with Miller's from 1986 being the most well-known. According to the position of the gingival edge in relation to the mucogingival line, the existence of an interdental septum, and the frequency, it is classified into four groups.

The first and second classes of recessions are almost always treatable, whereas the third and particularly the fourth classes indicate significant damage and are linked to subpar procedural results. The categorization of gingival regression put forth by Cairo in 2011 is one of the most commonly used ones today. It is categorized into three groups based on how well the CEJ is functioning and how much of the basal bone has been lost at the buccal and interproximal locations. Type 1 is clinically undetectable and exhibits no lack of interproximal adhesion.

Interproximal connection loss is a symptom of type 2.

Interproximal attachment loss is either equivalent to or less than mandibular attachment loss. Interproximal connection loss is connected to type 3 decline. Compared to the attachment loss on the afflicted tooth's buccal side, the interproximal attachment loss is higher. Clinicians face difficulties treating mucogingival issues with gingival recession in the maxillary anterior teeth, one of the orthodontic treatment's consequences. Dental cleaning discomfort, thermal hypersensitivity, cosmetic deficiencies, and challenging plaque management can all be caused by mucogingival issues. Here, we show the case of a 16-year-old female who underwent orthodontic therapy and developed gingival recession in the left mandibular central incisor.

A slender soft tissue biotype with root prominence was seen in the mandibular anterior region according to prior clinical observations. An interdental depression could be seen. Following reflection of the full-thickness flap, root covering was carried out using an artificial bone transplant and sub-epithelial connective tissue taken from the palatal mucosa. Clinical results at 6 months and 5 years after surgery revealed better soft tissue histology. Five years after the procedure, the maxillary incisors had a well-maintained labial bone plate, according to cross-sectional CBCT images. According to the constraints of this case report, patients who underwent orthodontic therapy and then developed gingival recession in their mandibular incisors may benefit from a combined operation that combines sub-epithelial connective tissue grafting with artificial bone grafts to successfully modify their biotype.

For widening the keratinized mucosa or filling the denuded root surface, several methods have been developed, including a free gingival graft, a sub-epithelial connective tissue graft, and a coronally advanced flap. The gold standard for root coverage treatments for people with gingival recession is a coronally progressed flap with a sub-epithelial connective tissue transplant.

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**Corresponding author** Maxim Babiner, Department of Conservative Dentistry, Universidade Federal do Rio Grande do Sul, Romania, E-mail: maximbabiner@gmail.com

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There have also been reports of guided tissue regrowth, tunnel method, and partially epithelized connective tissue grafts. Acellular cutaneous matrix and collagen matrix are also used in place of autogenous soft tissue grafts.

Within the constraints of the existing case report, for patients with thin soft and hard tissue phenotype of the mandibular anterior region and gingival recession that happens due to adverse effects of orthodontic treatment, an effective periodontal phenotype transformation can be attained with a combined method using a sub-epithelial connective tissue graft with bone graft substitutes. Additionally, the lower incisors' interdental concavities were enhanced. In terms of the full regeneration of

the supporting dental mechanism, it is possible to accomplish both cosmetic and practical outcomes by using contemporary techniques, which include the use of connective tissue grafts, a regard for tissue biology, and the use of bio-mediators. By doing this, we guarantee steady remission and stop recessions from happening again.

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## **CONFLICT OF INTEREST**

There are no conflicts of interest.