REVIEW

WHY DENTURES FAIL (Part I)

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Dentures fail because they are made by some people for the personal use of others are therefore the object of all the variables found in human beings.

The construction of dentures, like the writing and producing of a play, is a creative efforts which is offered for use and exhibition in an intimate environment for all to see. The star of the show is the patient, who is chiefly responsible for the success of the effort. Everyone is a critic. Dentists are fortunate that, because of the need and adaptability of the average denture wearer, the mortality rate for dentures in not as high as that of most plays on Indian TV and Bollywood movies.

As with all endeavors involving human beings, no positive criteria for success are valid for everyone. The problems presented by individuals who wear complete dentures vary from person to person. Often the reasons for failure quite obvious, and frequently a case will be unsatisfactory for a patient for no discernible cause. The art and science of full denture construction is so full of subtleties and delicate combination of resourcefulness that truly successful restoration are not routine occurrence.

Many discontented denture patients are more than justified in their complaints because certain fundamentals of denture construction had been disregarded in the fabrication of their dentures.

CRITERIA FOR EVALUATING DENTURE FAILURES

What is an "unsuccessful" denture and how does it differ from a "successful" one? In order to decide this question it would be wise to identify one's objectives in the construction of dentures for our patients.

Complete dentures should: (1) restore the "lost natural dentition and associated structures of the maxillae or mandible"; (2) maintain the health of the tissues of the mouth; (3) help to restore function, phonetics and esthetics; (4) be comfortable and not intrude upon the consciousness of the wearer.

Definition:- An unsuccessful denture may be defined as one which fails to fulfill any or all of the above criteria to the satisfaction of the doctor or his patient.

These objectives are not always achieved. For example, many dentists have treated patients whose physical image of themselves is different from the dentist's appraisal of them. The result may be an appearance which greatly pleases the patient and his family but leaves the dentist dissatisfied.

Often the reverse is true. The doctor feels that he has achieved all the criteria necessary for a successful denture but the patient thinks differently and a failure results for the patient and, of course, for the doctor.

Denture failures results most often from dissatisfaction on the part of the patient. Of greater importance are the failures of which patient may not be aware, such as denture which violate certain basic principles of denture construction. These may permanently damage the supporting oral structure.

This article will discus some of the sources of error in denture construction and offer certain suggestions which may be helpful in the management of denture patients. For the purpose of clarity, this outline of reasons for denture failures is offered as a guide for the discussion which follows:-

I. Inadequate Patient Evaluation
A. Failure to recognize the psychological limitations imposed by the patient.
B. Failure to identify the physical limitations of the patients.
1. Structural
2. Systemic
3. Neuromuscular
4. Post surgical and radiation squeal
II. Failure of the Dentist to understand his own limitations
A. Personality conflicts with the patient
B. Insufficient professional skill
III. Failure to prepare the patient for Dentures
A. Physical preparation
B. Emotional preparation
C. Limit the expectations of the patient
i. For function
ii. For appearance

D. Failure to explain the treatment plan and fee.
IV. Failure in Denture Construction.
V. Failure to seek consultation when indicated.
VI. Lack of proper aftercare.

I. INADEQUATE EVALUATION OF THE PATIENT

The initial most frequent point of failure occurs because of inadequate evaluation and diagnostic procedures. No examination can be too comprehensive. Although the skillful interview and the trained observer can learn much about a person in a relatively short period of time, enough time must be spent between both parties to allow the patient to react with the doctor so that they may become knowledgeable of one another. Often this inability to feel comfortable or to communicate with the doctor becomes so frustrating that the patient becomes resentful and uncooperative From the evaluation procedure the practitioner must draw certain conclusion about his patient, which guide his course of treatment.

In addition to accumulating positive objective findings regarding his patient, he must become highly sensitive to the limitations his patients imposes upon him.

A. FAILURE TO RECOGNIZE THE PSYCHOLOGICAL LIMITATIONS IMPOSED BY THE PATIENT. Many failures occur because patients cannot accept the reality of dentures or because they have emotion which interface with their adaptive capabilities. Often these are readily indentified and can be overcome with patience and careful management by a dentist with insight and understanding. there are some individuals, however, who are so mentally ill that nothing the dentist can do will allow them to wear dentures successfully. Numerous examples of these emotional hazards to successful dental prosthesis are available. These are the desperate clenchers, the constant grinders, the persistent gaggers, the people who over salivate with dentures, those who are equipped physically in every way for dentures but must demonstrate their ability to conquer and defeat the dentist, to name a few. These unfortunate individuals often are very disarming and mask their difficulties quite successfully at the beginning of their adventure with the dentist. They constitute an important hazard to the conscientious practitioner's longevity and should be recognized early if possible, and referred to someone who can treat their emotional maladies.

Much has been written and said about maintaining a leading position of "control" of the patient during the fabrication of dentures. This is admittedly of much importance, but I doctor cannot be the leader unless the understands mush of the patient's reactions to his suggestions. Often the relationship between the doctor and his patient gets so confused that it is difficult to determine who is in control.

It is interesting to note the recurring diagnosis of "psychotic" for patients who cannot wear the dentures made for them by their dentist. The unfortunate thing is that this observation is made after the dentures are finished. It does much to restore the confidence to the dentist, however, and relieves him of the task of searching for other possible reasons for this failures.

B. Failure to identify the physical limitations he patients: An adequate evaluation of the patient may be often disclose structural abnormalities or systemic deficiencies in a prospective patient.

Neuromuscular inadequacies, post surgical sequelae and radiation of the oral tissues are additional sources of difficulty for the prosthodontist. A few of the more frequently encountered examples illustrate these findings.

1. Structural Abnormalities: anatomic inadequacies such as severely resorbed alveolar ridges, a diminutive maxilla or mandible, or congenital deformities can be the source of much difficulty for the dentist.

Bony overgrowths such as large, pendulous maxillary tuberosities inhibit proper seating of the denture and may prevent adequate closure of the mandible. Lingual or palatal tori and buccal or labial exostoses often cause undercuts which are responsible for much discomfort during and after denture construction.

The relationship of the ridges to the ridges to one another often indicates an unusual situation which requires special attention.

A tongue can be massive or immovable or hyperactive.

The tissue surrounding the denture seating areas may attach themselves in a manner which makes an adequate seal impossible; the vibrating line of the soft palate may extend so far anteriorly that the maxillary denture space is very restricted.

2. SYSTEMIC ILLNESS: Systemic illnesses are reflected in the tissues of the mouth by poor tone, tissue fragility, low pain threshold, slow healing inability to withstand pressure, bizarre sensitivities and allergies.

3.LACK OF NEUROMUSCLUAR

Coordination: important is the lack of neuromuscular coordination which some patients exhibit. This is a severe limitation on the ability of the patient to help the dentist make adequate dentures because it makes more difficult the many intricate steps involved in denture construction. Later these patients find it extremely difficult to adapt themselves to dentures and to use them properly.

4.POST SURGICAL AND RADIATION SEQUELAE: The physical limitations imposed by individuals who have undergone major maxillofacial surgery to correct congenital defects or as the result of malignancy or accident vary with each case. These unfortunate people are often plagued with the additional emotional stress and burdens of disfigurement. Many have swallowing and speaking difficulties which make it almost impossible to cope with a prosthetic restoration even it can be fabricated for them.

Radiation of the denture seating areas of the mouth often results in lessened ability of these tissues to tolerate dentures. They are painful, slough readily and repair very slowly.

II. Failure of the dentist to understand his own limitations

It is important that the dentist realistically appraise himself in relation to the needs of his prospective dentures patients so that he may know whether or not he is prepared to treat this individual. He must take whatever time is necessary to learn all he can about how he reacts with him.

With are his limitations professionally and as a human being?

The two most common limitations possessed by the dentist are the interpersonal emotional conflicts, either overtly recognized or subconsciously sensed, which cause discomfort or even open hostility between himself and his patient and insufficient professional skill to handle the problems of a given case.

A.The limitations of Emotional Conflicts: The most successful practitioners are those who can recognize irreconcilable personality conflicts between themselves and an occasional patient. It may be a tone of voice, an attitude, certain modes of dress or a causal word that immediately sets off alarm and resistances on the part of the doctor. He should refer this patient elsewhere for treatment. All dentist learn sooner or late that they cannot treat successfully everyone who comes to them.

B.The Limitations of Insufficient **Experience or Knowledge:**

The second limitation is the hardest on the ego but must face if the dentist wishes to add serenity to his life and his practice. No one can be prepared to every situation and challenges presented by the patients and if an objective appraisal convinces the doctor that his patient needs special care, the successful way to treat this patient is to refer him to someone properly prepared to provide this treatment. this may be another dentist or it may be an internist or psychiatrist or a neurologist or an endocrinologist.

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