

Bölüm 11

AĞIZ İÇİ MOLAR DISTALİZASYON YÖNTEMLERİ

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GİRİŞ

Sınıf II kapanış bozuklukları, ortodonti pratığında klinisyenlerin yaygın olarak karşılaşıkları iskeletsel ve/veya dental nedenlerden kaynaklanan uyumsuzluklardır. Bishara dişsel Sınıf II kapanış bozukluğunun etiyolojisini, dentoalveolar bir uyumsuzluğa bağlı olarak maksiller dişlerin onde konumlanması veya süt dişinin konjenital eksikliği ya da erken kaybı nedeniyle maksiller birinci büyük ağız dişlerinin daha fazla meziale doğru hareket etmesinden kaynaklandığını belirtmektedir. İskeletsel uyumsuzluğu olmayan dental Sınıf II kapanış bozukluğu olan bireylerde tedavi, üst posterior dişlerin distalizasyonu veya diş çekimli bir tedaviyi içermektedir. Günümüz ortodontik tedavi pratığında eğilim, diş çekimli ortodontik tedaviden diş çekimi içermeyen ortodontik tedavilere doğru evrilmekte, bu doğrultuda yeni tedavi modelleri geliştirmektedir.

Molar distalizasyon yöntemlerinden ilki, Kingsley ve Angle tarafından kullanılan headgearlerdir. Ağız dışı distalizasyon apareylerinin en önemli sınırlılıkları hasta uyumu gerektirmeleri, estetik olmayan görüntüleri, kuvvetin aralıklı olması nedeniyle diş hareketinin daha yavaş olması ve distalizasyonun daha uzun sürede gerçekleşmesidir. Bu olumsuz faktörler nedeniyle hasta uyumu gerektirmeyen, sürekli kuvvet uygulayan, kısa sürede distalizasyon sağlayan ağız içi distalizasyon yöntemleri gün geçikçe daha çok plana çıkmaktadır.

İntrooral molar distalizasyon yöntemlerinde temel prensip bir bölgeden ankray sağlanarak hedef bölgedeki dişleri hareket ettirmektir. Ancak üst molar dişlerin distalizasyonu sırasında bazı istenmeyen sonuçlar meydana gelmiş, bunları ortadan kaldırmak için de birbirini takip eden yeni uygulamalar ortodonti literatürüne kazandırılmıştır. Kitabımızın bu bölümünde mevcut literatür

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4.3.9. Zigomatik Mini Vida/Mini Plak Destekli Molar Distalizasyonu

Maksillada mini vida ve mini plak yerleştirmek amacıyla tavsiye edilen en stabililitesi yüksek ve anatomik olarak güvenli alanlardan biri zigomatik butress bölgesidir. Karma dişlenme döneminde olan hastalarda süren dişleri zararlı olmayacağı konumda ve kortikal kemik yapısının kalın olması sebebiyle ankray almak için tercih edilebilir. Fakat zigomatik bölgeye mini vida veya mini plak uygulamalarının gerektirdiği cerrahi prosedür, anatomik lokasyonun zor olması nedeniyle, tercihi kısıtlıdır.

Mostafa ve ark. (110) araştırmalarında, 20 hastaya Zigomatik Buttress'e mini vida uygulamış ve büyük azıların distal hareketini gerçekleştirmiştir. Üst dişlere kalın köşeli ve devamlı ark teli uygulaması yapılmıştır. Arkın üzerine lateralın distali ve moların mesialı arasına jig bükülmüştür. Mini vida ve jik arasına close coil asılmıştır ve 300 gram distal kuvvet elde edilmiştir. Tedavi sonucuna göre molar dişlerde 2,92 mm distale hareket ve üst keserlerde 1,89 mm vertikal gömülme gözlenmiştir. Ayrıca maksillada 2,08° saat yönünün tersine rotasyon görülmüştür.

SONUÇ

Ağız dışı distalizasyon yöntemlerinin estetik olmaması ve hasta uyumu gerektirmesi ağız içi distalizasyon yöntemlerinin gelişmesine yönlendirmiştir. Ağız içi molar distalizasyon yöntemleri estetik sorun yaratmaması, hasta uyumu gerektirmemesi, sürekli kuvvet uygulayarak tedavi süresini kısaltması gibi avantajlara sahiptir. Bunun yanında vaka seçiminde göz önünde bulundurulması gereken bazı dezavantajları da mevcuttur. Maksiler molar dişlerde rotasyon ve distale devrilme, ankray alınan küçük azılarda mezial hareket ve tipping, kesicilerde protrüzyon, overjet artışı ve overbite azalması, premolar ve molar dişlerde ekstrüzyon; ankray için alt arktan destek alındığında alt dişlerde mezializasyon ve protrüzyon oluşmaktadır. Bu dezavantajların önüne geçmek için son yıllarda minividə destekli ağız içi distalizasyon aygıtları popüler olmuştur. En isabetli tedavi yöntemi seçimi, vakının ihtiyaçları göz önünde bulundurularak yapılan tedavi olacaktır.

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