Güncel Pedodonti Çalışmaları II

Editör
M. Cem DOĞAN

ISBN
978-605-258-603-7

Kitap Adı
Güncel Pedodonti Çalışmaları II

Editör
M. Cem DOĞAN

Yayın Koordinatörü
Yasin Dilmen

Sayfa ve Kapak Tasarımı
Akademisyen Dizgi Ünitesi

Yayıncı Sertifika No
25465

Baskı ve Cilt
Bizim Dijital Matbaa

Bisac Code
MED016000

DOI
10.37609/akya.883

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ÖNSÖZ

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Akademisyen Yayınevi A.Ş.

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Bölüm 1

ÇOCUK DİŞ HEKİMLİĞİNDE KULLANILAN GÜNCEL VE ALTERNATİF LOKAL ANESTEZİ YÖNTEMLERİ

Sema AYDINOĞLU[1]
İpek ARSLAN[2]

GİRİŞ

Çocuk diş hekimliğinde ağrı yönetimi kritik konular arasında yer almaktadır. İğne penetrasyonunu görme veya deneyimleme sonucu gelişen korku, yumuşak dokularda şişme hissi ve uzun süreli uyuşukluk kadar anestezik ilaçlara karşı gelişen alerjik reaksiyonlar, hasta ve hekimleri lokal anestezi kullanımı ile ilgili endişe duymaya sevk eden en yaygın faktörlerdir. Yeni alternatif ve atravmatik yöntemlerin keşfedilmesi ile birlikte çocuk diş hekimliğinde gerçekleştirilen dental tedavinin kalitesi artmaktadır.

Anestezik ajanlar, lokal anestezide kullanılan cihazlar ve teknikler ile ilgili son gelişmeler; artmış ağrı kontrolü, azaltılmış enjeksiyon ağrısı ve daha az yan etkinin görülmesini sağlamıştır. Bu konuda yaşanan mevcut ilerleme yeni ajan ve ekipmanların geliştirilmesine, tekniklerin modifiye edilmesine öncülük etmiştir.

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Bölüm 2

ÇOCUK HASTADA EROZİV DİŞ AŞINMASINA YOL AÇAN NEDENLER VE TEDAVİ YAKLAŞIMINA GÜNCEL BAKIŞ: BİR LİTERATÜR DERLEMESİ

Aslı SOĞUKPINAR[1]

GİRİŞ

Geçmiş yıllarda 'diş erozyon' tanımı yüzeyin yumuşamasıyla birlikte aynı zamanda mekanik etkeni de içeren diş aşınması olarak ifade edilmekteydi. Günümüzde ise 'diş erozyonu' demineralizasyon ve asitlere maruz kalmayla (kimyasal etki) diş yüzeyi kaybı olarak belirtilirken, 'eroziv diş aşınması' kimyasal-mekanik işlemlerin sonucuyla görülmektedir (1).

Dental erozyon diş çürüğünün aksine bakteri olmaksızın kimyasal faktörlerle dişteki geriye dönüşümsüz sert doku kaybı olarak tanımlanmıştır (2,3). Mineralize diş yapısında meydana gelen çözünme, iç ve dış kaynaklardan ağız boşluğuna gelen asitlerle ilişkilidir (4). Tekrarlayan asit atakları yalnızca diş yüzeyinde yumuşamaya yol açmayıp, diş yüzey kaybına da neden olmaktadır. Diğer taraftan dişlerin işlevsel kaybıyla sonuçlanan faktörler; atrizyon, abrazyon ve abfraksiyondur (5). Eroziv diş aşınması yetişkinleri olduğu kadar, adölesan ve çocukları da etkilemektedir. Diş yüzeyi kaybı sonrasında fonksiyonel, estetik, beslenme, dişte hassasiyet, ağrı ve psikolojik sorunlar gözlenmektedir. Bu nedenle eroziv diş aşınmasının çözümü için multidisipliner bir yaklaşım

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Sonuç

Süt dişlenme dönemindeki çocuklarda görülen erozyon daimi dentisyon için risk faktörü olup, dişlerin zarar görmesini önlemek amacıyla erken tanı ve tedavi önemlidir. Çocuklarda görülen eroziv diş aşınması; diş hassasiyeti, ağrı, okluzyonda değişiklik, beslenme problemleri, estetik, pulpa perforasyonu veya abse bulgusuna kadar birçok klinik probleme neden olabilmektedir (3,10). Eroziv diş aşınması kimyasal, mekanik ve davranışsal faktörlerin neden olduğu multifaktöriyel etkenlerin sonucu görülen bir rahatsızlıktır. Bu amaçla çocuk hastanın erozyona yol açan faktörleri dikkatli bir şekilde değerlendirilmeli, ailelerin farkındalığı özellikle arttırılmalı, beslenme alışkanlıkları düzenlenmeli, koruyucu önlemler alınmalı, ağız ve diş sağlığı bakımı düzenli kontrollerle gerçekleştirilmelidir. Koruyucu önlemler arasında diyet alışkanlıkları düzenlenmelidir. Hastanın asidik yiyecek ve içecekleri tüketim sıklığı azaltılarak, ana yemeklerle birlikte tüketilmesi önerilmektedir. Hastanın aldığı öğünü ağız içinde tutma alışkanlığından vazgeçirmeye teşvik edilmeli, asidik gıdadan sonra ağız suyla çalkalanmalı ya da su tüketilmeli, ağız içindeki asidik pH'ı nötralize etmek amacıyla peynir gibi alkalen yiyecekler tercih edilmeli, hastanın kullandığı ilaçlardan tablet formunda olanlar ağızda bekletilmeden direkt yutulmalı, gece uyumadan önce asidik gıdaların tüketilmesinden kaçınılmalıdır. Yukarıda saydığımız etkenler ölçüsünde ailelere, çocuk doktorlarına ve çocuk diş hekimlerine büyük görev düşmektedir.

Anahtar Kelimeler: Reflü, eroziv diş aşınması, çocuk diş hekimliği

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Bölüm 3

DİŞ HEKİMLİĞİNDE ZİRKONYA

Zekiye EFE[1]

ZİRKONYA

Zirkonyum, periyodik cetvelde 4B grubunda bulunan sembolü 'Zr' olan atom numarası 40, atomik ağırlığı ise 91.22 olan geçiş metallerindendir. 1789 yılında Martin Heinrich Klaproth tarafından bulunmuş olup 1824' de Jons Jakob Berzelius tarafından izole edilmiştir (1, 2).

Doğada saf halde bulunmayan zirkonyumun en çok bilinen bileşikleri arasında zirkonyum silikat (Zirkon) ve zirkonyum oksit (Zirkonya) bulunmaktadır. Bu bileşiklerin çeşitli işlemler sonucunda ayrıştırılıp saf zirkonyumun elde edilmesinin ardından biyomateryal olarak kullanılabilmektedirler. Zirkonyanın, kimyasal - boyutsal stabilitesinin yanı sıra fiziksel dayanımı ve sertliğinin oldukça iyi olması, paslanmaz çelik alaşımlarına benzer elastik modülünün olması ve biyouyumlu olması biyomateryal olarak tercih edilmesini sağlamaktadır (2, 3). Tıbbi amaçla ilk kez 1969 yılında ortopedi alanında kalça protezlerinde titanyum ve alüminyumun yerine kullanılmıştır. (2). Aşınmaya karşı olan direnci, sertliği, üstün estetik ve optik özellikleriyle birlikte biyouyumlu olması 1990' lardan itibaren diş hekimliği alanında da kullanımı yeri bulmasını sağlamıştır (4).

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lacak olan çalışmalar, zirkonyanın kullanım alanının ve şeklinin daha iyi belirlemesine katkı sağlayacaktır.

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Bölüm 4

KRON KÖK KIRIKLARI

Tuğba YİĞİT[1]

TERMİNOLOJİ, PREVELANS VE ETİYOLOJİ

Kron kök kırıkları mine, dentin ve sementi içermektedir. Kırıklar pulpayı içerme durumuna göre komplike olmayan ve komplike olarak ikiye ayrılmaktadır. Bazı araştırmacılar, sadece kron veya kök kırığına dahil edebilmektedir. Bu nedenle, kron kök kırığı, daimi dişlerde %5 süt dişlerinde %2 oranında görülmektedir. En sık karşılaşılan etiyolojik faktörler düşme, bisiklet ve otomobil kazaları, yabancı cisim yaralanmalarıdır.(1)

Ön bölgede direkt travmalar, arka bölgede indirekt travmalar nedeni ile kron kök kırıkları oluşabilmektedir. Arka bölgede bukkal veya oral tüberküllerde fraktür meydana gelebilmekte, sıklıkla pulpa içermeden gingival ataçmanın altına kadar uzanmaktadır. Etkileyen kuvvetin doğrultusu kırık tipini belirlemektedir.(2)

Kron kök kırıkları iatrojenik nedenlerle de oluşabilmektedir. Özellikle premolar, molar bölgelerinde, kök kanal dolgusu sonucu oluşan lateral basınç, post simantasyonu, post korozyonu ve uygun olmayan dolgular vertikal kron kök kırıkları oluşturabilmektedir. Bu nedenle radyolojik ve klinik semptomlar iyi bir şekilde tanımlanmalıdır.(3)

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Dişe 3-4 hafta sonra endodontik tedavi, 1-2 ay sonra post destekli kron planlanabilmektedir.[16]

Cerrahi ekstrüzyon uygulanmış 5 yıl takipli çalışmalarda, kök rezorpsiyonu görülmemiş veya sınırlı boyutta tamir ile ilişkili rezorpsiyona rastlanmıştır.[17] Başka bir çalışmada, 19 cerrahi ekstrüze dişin 10 yıl takibi yapılmış, sadece bir dişte servikal rezorpsiyon görülmüştür.[18] Yapılan bazı çalışmalarda ve iki sistematik derlemede, yöntemin hızlı ve güvenli olduğu vurgulanmıştır. Ancak pulpa vitalitesi korunamamaktadır.[19,20]

5. VİTAL KÖKÜN BIRAKILMASI

Restorasyonun uygun olmadığı vakalarda, apikal parçanın çekilmesi alveol kemiğin genişliği ve yüksekliğinde önemli kayıplara neden olmaktadır.[4] Büyüme ve gelişimi devam eden hastalarda, dental implantların çenelerin büyümesine bağlı olarak yer değiştirebileceği ve uygulandığı bölgedeki büyümeyi olumsuz etkileyeceği nedeni ile kullanımı uygun olmadığı için[21] vital kökün bırakılması alveol hacminin korunması açısından ideal bir tedavi yöntemi olarak görülmektedir.[4]

6. DİŞİN ÇEKİMİ

Çekim sonrası alveol kemiğin hızlı bir şekilde rezorbe olacağı unutulmamalıdır. Vital kökün bırakılması daha iyi bir alternatiftir. Büyüme gelişimin devam ettiği hastalarda, ortodontik olarak yerin kapatılması[4] veya ototransplantasyon[4,22] çekim sonrası planlanabilmektedir.

Anahtar Kelimeler: Dental travma, kron kök kırıkları

KAYNAKÇA

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Bölüm 5

SENDROMİK OLMAYAN DİŞ AGENEZİSİNİN GENETİK ETİYOLOJİSİ

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GİRİŞ

Diş agenezisi en sık görülen konjenital dental anomalilerden biridir ve diş hekimliği için multidisipliner yaklaşım açısından önemlidir. Diş agenezisinin etiyolojisinde radyoterapi, ilaç uygulamaları, enfeksiyon hastalıkları, travmalar, endokrin ve intrauterin rahatsızlıkları ve genetik yatkınlık gibi birçok etkenin rol oynadığına inanılmaktadır (1). Diş agenezisi olguları genetik olarak, "sendromla ilişkili olmayan" ya da "sendromla ilişkili" olarak sınıflandırılmıştır (2,3).

Sendromik olmayan diş agenezisi vakalarının genetik olarak incelemelerinde Wingless-tip MMTV İntegrasyon Ailesi (WNT) yolağında; Dickkopf WNT Sinyal Yolu Inhibitörü 1 (DKK1), Kringle Transmembran Proteini 1 (KREMEN1), WNT Üyesi 10A (WNT10A), WNT Üyesi 10B (WNT 10B), Düşük Yoğunluklu Lipoprotein Reseptörü ile İlişkili Protein 6 (LRP6), Axis İnhibitör Protein 2 (AXIN2), Msh Homeobox 1 (MSX1) genlerinde, Transforming Growth Factor- β (TGFβ) yolağında; Paired Box 9 (PAX9), Gremlin 2 (GREM2), Kemik morfogenetik proteini 4 (BMP4), Latent transforme edici büyüme faktörü beta bağlayıcı protein 3 (LTBP3) genlerinde, Ektodisplazin A (EDA) yolağında;

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bilmektedir. Bundan yola çıkarak, diş hekimlerinin diş agenezisi olgularında hastanın oral rehabilitasyonunun yanı sıra, ilişkili genler vasıtasıyla diş agenezisine eşlik edebilecek olası patolojilere odaklanmaları da önem arz etmektedir.

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