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Gingival recession classification pdf

Reviewing these gum recession classifications can aid in evaluating the type of defect your patients may have. GUM RECESSION Mucogingival defects are very common defects seen in patients with or without periodontal disease. Gingival recession can occur on any tooth and can be found on buccal or lingual surfaces. The causes of gingival recession are well documented. Causes include frenums, gingival infection which may weaken the attachment of the tissue to the tooth and trauma which can cause tissue damage. Trauma can range from aggressive tooth brushing habits to lip or tongue piercing. There is also a correlation between gingival recession and past orthodontic therapy. Dr. P.D. Miller, a periodontist and fellow alumni from the University of Alabama, classified gingival recession. By reviewing these classifications, I hope it will aid you to diagnose the type of recession defects your patients may have. Having this classification system will also help in your knowledge of expected surgical root coverage results. Marginal tissue recession that does not extend to the mucogingival junction. Marginal tissue recession that extends to or beyond the mucogingival junction, with no periodontal attachment loss (bone or tissue) in the interdental area. Marginal tissue recession that extends to or beyond the mucogingival junction, with periodontal attachment loss in the interdental area or malpositioning of teeth. Marginal tissue recession that extends to or beyond the mucogingival junction, with periodontal attachment loss in the interdental area or malpositioning of teeth. Marginal tissue recession that extends to or beyond the mucogingival junction, with periodontal attachment loss in the interdental area or malpositioning of teeth. Class I and II defects can expect about 80-100% root coverage with soft tissue grafting Class III defects can expect less than 80% root coverage. Class IV defects can expect little to no root coverage. In future Newsletters, I will review soft tissue treatment options for root coverage and increasing attached gingiva. Should you have any questions regarding any periodontal or implant issues, please don't hesitate to call or email me. Joint Prophylaxis --- Pregnancy and Periodontics 1: Total loss of attachment (clinical attachment loss, CAL) is the sum of 2: Gingival recession, and 3: Probing depth Gingival recession, also known as receding gums, is the exposure in the roots of the teeth caused by a loss of gum tissue and/or retraction of the gingival margin from the crown of the teeth.[1] Gum recession is a common problem in adults over the age of 40, but it may also occur starting from the age of a teenager, or around the age of 10. It may exist with or without concomitant decrease in crown-to-root ratio (recession of alveolar bone). Classification Various classifications have been proposed to classify gingival recession, Miller's classification system[2] being the one that is most widely followed. Many cases which are encountered in daily clinical practice cannot be classified according to the criteria of the present classification systems. Kumar & Masamatti's classification system gives a comprehensive depiction of recession defect that can be used to include cases that cannot be classified according to present classifications. A separate classification system for palatal recessions (PR) has been given. A new comprehensive classification system classifies recession on the basis of the position of interdental papilla and buccal/lingual/palatal recessions. Kumar & Masamatti's classification system tries to overcome the limitations of Miller's classification.[3] Causes There are many possible causes for gingival recession: By far the most common cause is gum disease (periodontal disease).[1][failed verification] Overaggressive brushing is also cited to cause gum recession.[1] One systemic review of the literature concluded that "The data to support or refute the association between tooth brushing and gingival recession are inconclusive," although aggressive or forceful brushing was not specifically addressed.[4] A subsequent study found horizontal tooth brushing technique (versus Bass technique or circular methods), medium-hardness toothbrush use and brushing only once daily were associated with gingival recession.[5] Improper flossing (i.e., flossing too roughly or aggressively) which may cut into the gums.[6] Hereditary thin, fragile or insufficient gingival tissue predisposes to gingival recession.[1] Dipping tobacco, which affects the mucous membrane lining in the mouth and will cause receding gums over time Self-inflicted trauma, such as habits like digging a fingernail or pencil into the gum. This type of recession more commonly associated with children and persons with psychiatric disorders, Scurvy (lack of dietary vitamin C) Acute necrotizing ulcerative gingivitis Abnormal tooth position, such as tooth crowding, giving inadequate cover of one or more teeth by the jaw bone.[1] Piercings in the lip or tongue that wear away the gum by rubbing against it. Intentional gingival retraction. For example, the adult tooth may not grow out of the gum, and to remedy this, a procedure called an exposure is done. It involves the gum tissue being cut open to allow the adult tooth to grow out. This is a less common cause of gum recession. Symptoms Gum recession is generally not an acute condition. In most cases, receding of gums is a progressive condition that occurs gradually over the years. This is one reason that it is common over the age of 40. Because the changes in the condition of the gums from one day to another are minimal, patients get used to the gums' appearance and tend not to notice the recession visually. Receding gums may remain unnoticed until the condition starts to cause symptoms. Advanced gingival recession. Note particularly severe recession on leftmost incisor. The following signs and symptoms may indicate gum recession: Tooth mobility Dentin hypersensitivity (over-sensitive teeth) - short, sharp pain is triggered by hot, cold, sweet, sour, or spicy food and drink. If the cementum covering the root is not protected anymore by the gums, it is easily abraded exposing the dentin tubules to external stimuli. Teeth may also appear longer than normal (a larger part of the root is visible if gums are receding) The roots of the tooth are exposed and visible The tooth feels notched at the gum line Change in the tooth's color (due to the color difference between enamel and cementum) Spaces between teeth seem to grow (the space is the same, but it seems larger because the gums do not fill it any more) Cavities below the gum line If the gum recession is caused by gingivitis, the following symptoms may also be present: Puffy, red, or swollen (inflamed) gums Gum bleeding while brushing or flossing Bad breath (halitosis) In some cases, it is the treatment of gingivitis that reveals a gum recession problem, that was previously masked by the gums swelling. Gingival grafting Main article: gum graft Depending on the shape of gum recession and the levels of bone around the teeth, areas of gum recession can be regenerated with new gum tissue using a variety of gum grafting "periodontal plastic surgery" procedures performed by a specialist in periodontics (a periodontist). These procedures are typically completed under local anesthesia with or without conscious sedation, as the patient prefers. This may involve repositioning of adjacent gum tissue to cover the recession (called a pedicle graft) or use of a free graft of gingival or connective tissue from the roof of the mouth (called a free gingival graft or a Subepithelial connective tissue graft). Alternatively, a material called acellular dermal matrix (processed donated human skin allograft) may be used instead of tissue from the patient's own palate. Growth-factor techniques Recent advances have seen the introduction of platelet-derived growth factor (PDGF) infused bone graft material. This material is usually combined with the cellular matrix to form a soft bone paste that is then covered by the allograft. The development of this type of bone and tissue cellular matrix (also known as ortho filler) results in greater osseointegration with the patient's healthy bone and soft tissue. Healing from such procedures requires 2-4 weeks. After a few months the results can be evaluated and in some cases the new tissue needs to be reshaped in a very minor procedure to get an optimal result. In cases where recession is not accompanied by periodontal bone loss, complete or near complete coverage of the recession area is achievable[citation needed]. References ^ a b c d e Gingival Recession - Causes and treatment Archived 2010-09-17 at the Wayback Machine JADA, Vol 138. . Oct 2007. American Dental Association ^ Miller PD Jr. A classification of marginal tissue recession. Int J Periodontics Restorative Dent 1985;5:8-13. ^ Kumar A, Masamatti SS. 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Therefore, an effort is made to review most commonly used classification systems for gingival recession, and their drawbacks further come up with a proposal of new classification system for gingival recession.Keywords: Cementoenamel junction, classification, gingival recession, Miller's classification How to cite this article:Guttigannur N, Aspalli S, Sanikop MV, Desai A, Gaddale R, Devanoorkar A. Classification systems for gingival recession and suggestion of a new classification system. Indian J Dent Res [serial online] 2018 [cited 2021 Jul 25];29:233-7. Available from: Exposure of the tooth through apical migration of the gingiva is called gingival recession or atrophy.[1] It is a commonly occurring condition with varying etiologies such as anatomical, pathological, and physiological factors.[2] Gingival recession can either be localized or generalized; it may be a feature of periodontitis as depicted in the definition of periodontitis which is "as an inflammatory disease of the supporting tissues of the teeth caused by specific microorganisms or groups of specific microorganisms, resulting in progressive destruction of the periodontal ligament and alveolar bone with increased probing depth formation, recession, or both."[3] In addition, other common etiologic factors for recession are chronic mechanical trauma from toothbrushing, iatrogenic damage from unfavorable restorations, and repeated scaling and root planing. Although it rarely results in tooth loss, marginal tissue recession is associated with thermal and tactile sensitivity, esthetic concerns/complaints, and a tendency toward root caries.[4]A condition deviated from normal need to be diagnosed, with determination of prognosis and requires treatment planning for which a classification is required. Various classifications of gingival recessions have been put forward since decades starting from Sullivan and Atkins in 1968,[5] Milnek et al. in 1973,[6] Miller in 1985,[7] Smith in 1997,[8] and Mahajan in 2010.[9] Among the various classification systems, Miller's classification system is the most widely used and currently followed classification systems and various drawbacks have been noted in this classification. Classifications, defined as "systematic arrangements in groups or categories according to established criteria,"[10] have been conceived to facilitate the comprehension of the great amount of factors and information involved in complex systems. Classifications have proved useful and indispensable in many fields of knowledge, particularly in medicine.[11] In periodontology, classifications are widely used to categorize defects due to periodontitis according to their etiology, diagnosis, treatment, and prognosis. Classification of gingival recession is necessary for diagnosis, prognosis, treatment planning, and as well as for communication between academicians and clinicians.Hence, an attempt is made in this article to overcome the drawbacks of various classification systems by presenting a new classification system for gingival recession.Classification systems are necessary to provide a framework to scientifically study the etiology, pathogenesis, and treatment of diseases in an orderly fashion. In addition, such systems give clinicians a way to organize the health care needs of their patients. Since era, several classifications have been proposed in the literature to facilitate the diagnosis of gingival recessions which are discussed as follows:Way back in 1968, Sullivan and Atkins classified soft-tissue defects at mandibular incisors into four classes: "narrow," "wide," "shallow," and "deep," and better root coverage outcomes following a gingival graft procedure for narrow-shallow defects were reported.[5]In 1973, Milnek et al. identified "shallow-narrow" defects as recession 3 mm.[6]Miller in 1985 proposed four classes of marginal tissue recessions which are based on the level of gingival margin with respect to the mucogingival junction (MGJ) and the underlying alveolar bone. Class I: Marginal tissue recession not extending to the MGJ. No loss of interdental bone or soft tissue. Class II: Marginal recession extending to or beyond the MGJ. No loss of interdental bone or soft tissue. Class III: Marginal tissue recession extends to or beyond the MGJ, but coronal to the apical extent of the marginal tissue recession. Class IV: Marginal tissue recession extends to or beyond the MGJ. Loss of interdental bone extends to a level apical to the extent of the marginal tissue recession [Figure 1]. [7]Smith in 1997 proposed classification to assess both vertical and horizontal extent of the defect. The degree of horizontal component was expressed as a value ranging from 0 to 5 depending on the severity of CEJ exposure, while the vertical extent of the recession was measured in millimeters using a periodontal probe on a 0-9 range.[8]In 2010, Mahajan proposed a modification of Miller's classification into four classes Class I: Gingival recession defects not extending to MGJ. Class II: Gingival recession defects extending to MGJ or beyond it. Class III: Gingival recession defects with bone or soft-tissue loss in the interdental area up to cervical one-third of the root surfaces and/or malpositioning of the teeth. Class IV: Gingival recession defects with severe bone or soft-tissue loss in interdental area greater than cervical one-third of the root surface and/or severe malpositioning of teeth.[9]Among all the classification systems, Miller's classification is still the most widely used, but various drawbacks have been noted which are as follows:[11]Difficulty in locating MGJ]This classification does not provide information about keratinized tissue and its components. He refers to the MGJ only, and it is difficult to identify the MGJ which makes tough to distinguish between Class I and II. Due to the fact that a tooth with gingival recession always presents a certain amount of keratinized tissue, the marginal tissue recession cannot extend to or beyond the MGJ. Therefore, Class II could never exist and Classes I and II would represent a single category. With regard to Class III and IV, the bone or soft-tissue losses in the interdental areas are considered the strategic issues to identify these categories. On the other hand, the amount and characteristics of bone loss (horizontal or vertical) are not reportedClass III considered tooth malpositioning as an alternative criterion to bone or soft-tissue loss without a comprehensive explanation as it is unclear when it comes to establishing the degree of malposition for including a recession in one or the other class. Therefore, the inclusion of a recession in a precise class may be difficultFrom the prognostic standpoint, Classes I and II cannot be distinguished from each other as they both anticipate 100% root coverageAs regards Class III, partial root coverage is anticipated while some recent studies demonstrate that root coverage can be unpredictable in treating Class III recession-type defects.[12]Sullivan and Atkins - this classification, although simple, is subjected to open interpretation of the examiner and interexaminer variability and is therefore not reproducible.[5][13]Milnek et al. - this classification does not specify the landmark for horizontal measurement as variable measurement may be present at variable distances.[6]Smith in 1990 - the author proposed that in cases of extensive vertical component, further horizontal component may be allotted at an intermediate distance between CEJ and base of the defect, which is not clearly specified. Furthermore, separate values can be assigned for multirooted teeth, which make it more complex. It may lead to overestimation of the condition as it utilizes subjective awareness of sensitivity. It is also difficult to detect the midpoints of mesial and distal surfaces, in the presence of intact interdental papilla.[8]In 2010, Mahajan proposed a modification of Miller's classification. This modification still does not accommodate all clinical conditions. For example, a tooth with gingival recession not extending up to MGJ but with interdental soft and hard tissue loss can neither be placed in Class I nor in Class III since there is no mention of the involvement of MGJ in Class III.[9]Considering the above limitations, a new classification system is being proposed which is more informative and lucid which is based on Miller's classification. This new classification can be applied for facial surfaces of maxillary teeth and facial and lingual surfaces of mandibular teeth, and interdental papilla recession can also be classified. This proposed classification system allows for easy means to assess progressive degrees of gingival recession using readily observed anatomical landmarks for reference. It provides a description of the extent of gingival recession. The use of such a system should assist future communication among clinicians and researchers.It is classified into four classes with subdivisions a and b,Class I - Apical shift in the crest of marginal gingiva 1-2 mm from CEJ] a - without any interproximal tissue loss clinically [Figure 2]] b - with interproximal tissue loss coronal to interproximal CEJ clinically [Figure 3]Figure 2: Class I - apical shift in the crest of marginal gingiva 1-2 mm from cementoenamel junction.] a - without any interproximal tissue loss clinicallyClick here to viewFigure 3: Class I b - with interproximal tissue loss coronal to interproximal cementoenamel junctionClick here to viewClass II - Apical shift in the crest of marginal gingiva >2 mm 3 mm from cementoenamel junction. III a - without any interproximal tissue lossClick here to viewFigure 7: Class III b - with interproximal tissue loss apical to interproximal cementoenamel junctionClick here to viewClass IV - Apical shift in the crest of marginal gingiva >3 mm from CEJ] with severe malposed tooth. IV a - without any interproximal tissue lossClick here to viewFigure 9: Class IV b - with interproximal tissue loss apical to interproximal cementoenamel junctionClick here to viewUndetectable or missing CEJ in some situations because of restorations, abrasion, and abfraction creates difficulty to classify recession, as CEJ is the landmark used in this proposed classification.Prognosis for root coverage procedures is not mentioned.When compared with various classification systems for gingival recession, the new system has the advantages summarized in Table 1]. This current classification system is user-friendly, there is no confusion, it is more precise, and it requires less time to be understood which is described in [Table 1]. (Table 1) Various classification systems have been put forward which have certain drawbacks; hence, here is an effort to combat those drawbacks and frame a new classification system for gingival recession which considers all clinical situations of gingival recession. This new classification system is more of a diagnostic classification which is simple to use, more convenient to record, easy to understand, and it reduces miscommunications. This system can be used routinely by periodontists, as well as general dentists worldwide. Financial support and sponsorshipNil Conflicts of interestThere are no conflicts of interest. 1.Newman MG, Takei HH, Carranza FA. Biologic basis of periodontology. Carranza's Clinical Periodontology. 12th ed. St. Louis, Missouri: Saunders; 2015. p. 22. 2.Kassab MM, Cohen RE. 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Correspondence Address:Dr. Nagappa GuttigannurDepartment of Periodontics and Oral Implantology, AME's Dental College, Raichur - 584 103, Karnataka IndiaSource of Support: None, Conflict of Interest: NoneCheck3DOI: 10.4103/ijdr.IJDR_207_17 [Figure 1], [Figure 2], [Figure 3], [Figure 4], [Figure 5], [Figure 6], [Figure 7], [Figure 8], [Figure 9]Page 2 Login Full text access is free in HTML pages; however the Journal allows PDF access only to users from INDIA and paid subscribers and allows ePub access only to paid subscribers. To access the article in PDF format, you should be a subscriber to Indian Journal of Dental Research. You can subscribe online for a year. If you are already a subscriber you can login to access the articles. You could recommend your institution's library to subscribe the journal so that you can have unrestricted access. Click here to recommend the journal.

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