направленный на развитие навыков клинического мышления, решение вопросов индивидуальной фармакотерапии, взаимодействия лекарств между собой и с пищей, путей устранения полипрагмазии, снижение риска развития побочных реакций, коммуникативных умений будущих врачей. Освещены методики оформления работы, проанализированы типичные студенческие ошибки в процессе ее выполнения. Приведены особенности оценки данного вида самостоятельной работы.

Ключевые слова: кредитно-модульная система, клиническая фармакология, самостоятельная работа.

Belehai R.I.

"Protocol of Efficiency and Safety of the Drug" as a Type of Independent Work of Students in the Study of Clinical Pharmacology

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Abstract. The article is devoted to the organization of "Protocol of efficacy and safety of the drug" writing as a kind of independent work of students, which is one of the ways of intensification of training. The attention is paid to the importance of this form of activities in the training of future doctors, especially in the context of the Bologna process. The experience of this type of independent work of students at the department of clinical pharmacology and pharmacotherapy in SHEI "Ivano-Frankivsk National Medical University" aims to develop clinical thinking skills, issues of individual therapy, drug interactions among themselves and with food, ways to eliminate polypharmacy, reduce risk of adverse reactions, communicative skills of future doctors. We analyzed the method of work design, typical students errors during its execution. The peculiarities of this type of independent work were presented.

Key words: credit-modular system, clinical pharmacology, independent work.

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Creating a Distal Limited Defect by Surgical Exposure of an Impacted Third Molar. Prognosis and Treatment

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Restoration of occlusion, speech and aesthetics are the 3 basic problems in prosthetic dentistry. A various number of materials and different treatment methods are used for its perfect implementation, depending on the pathological alterations (7). In most of the clinical cases, when a distal unlimited defect is present, the treatment is limited to elaboration of some kind of a non-fixed denture (4, 13). However, non-fixed partial dentures and model-casted ones are preferred neither from dentists, because of their pathological transmission of the occlusal pressure and loss of bone, nor from patients, because of their mobility.

The great successes of dental implantology, practically allows the transformation of most distal unlimited defects in limited ones and their easier restoration. However, in a lot of the clinical cases this kind of treatment is impossible, because of severe bone loss and need of further bone grafting, close proximity to anatomical features such as the inferior alveolar nerve or the maxillary sinus; or just because of its unaffordable price for most of the patients (6). Fortunately, in some of the clinical cases the lower third molars are with well-formed crowns and radices, despite of the fact that they are impacted (semi-retained). That gives a possibility for including them in restorations, if a favorable ratio between the clinical crown and radix is developed by a surgical intervention (3, 10).

The retained (impacted) teeth are most common for the permanent dentition (highest % - 3rd molar). Sometimes there are no symptoms, and the impacted tooth is found by chance, when a X-ray is done. Clinically the impacted tooth could be placed entirely in the jaw(bone), could be covered with mucosa and periosteum, or a little part of it has erupted (5). In case of an impacted tooth, there are several well-known approaches of treatment:

1.Observation- divided in 2 periods: before and after the exposure. During this period of time no act is undertaken, but observing the germination of the tooth.

2. Intervention includes an orthodontic treatment for a short period of time or a surgical excision of the "holder/retainer", which the tooth cannot erupt.

3. Transposition of the tooth can be achieved by orthodontic methods or surgical ones, as well: re-implantation of the tooth.

4. Extraction – if there is no option for the tooth to be placed in a proper position in the dental arc (1, 2, 14).

CLINICAL CASE

Anamnesis morbi: Patient K.I., age 28, from Plovdiv (No:384) Seeks dental help due to a pain in left lower jaw while eating. He complains from bad breath, hard chewing and low aesthetics. The first inconvenience appeared about 2 years ago.

Anamnesis vitae: The patient does not report for any other illnesses or allergies.

Anamnesis familliae: The patient does not report for any hereditary dental diseases. **PICTURE (Fig. 1)**

Status presens generalis:

Patient is active, answers adequately the questions; pulse: 72; RR: 110/70.

Status localis extraoralis:

During the extra-oral inspection is not found any facial asymmetry. Skin's turgor is normal, without any alterations.

Palpation of the lymph nodes is done. Nothing pathological is found. TMJ- symmetric, without any alterations.

Status localis intraoralis:

Normal mouth opening; the buccal, vestibular, palatinal mucosa and tongue are without any alteration: faint pink, bright, well humidified, absence of oral lesions. The tongue has normal mobility.

It's seen radices of 36 and 37, on the gingival level. There is no pain during exploration, percussion and pressure. Hypertrophied mucosa over tooth 37's radices, 2nd degree mobility. Missing tooth 45.

Dental Status (Fig. 2):

Periodontal status:

- Gingiva: pink to redden, with mild consistency
- Gingival margin – swollen, at ECB's level, Papilla-swollen
- Attached gingival level – 3 mm
- Green Vermilion CI – 1,70 DI - 1, 75
- Bleeding – 78 %
- Periodontal "pockets" 3-4 mm – 17, 16, 15, 14, 13, 24, 25, 26, 37, 36, 35, 32, 41, 46, 47- (over 3-4 mm)
- Degree of furcation affection- 36, 37- IV degree
- Mobility (Miller) – 36 I degree ; 37 II degree

Paraclinical tests:

Ortopantomography and segment Ro-gr.(Dick)

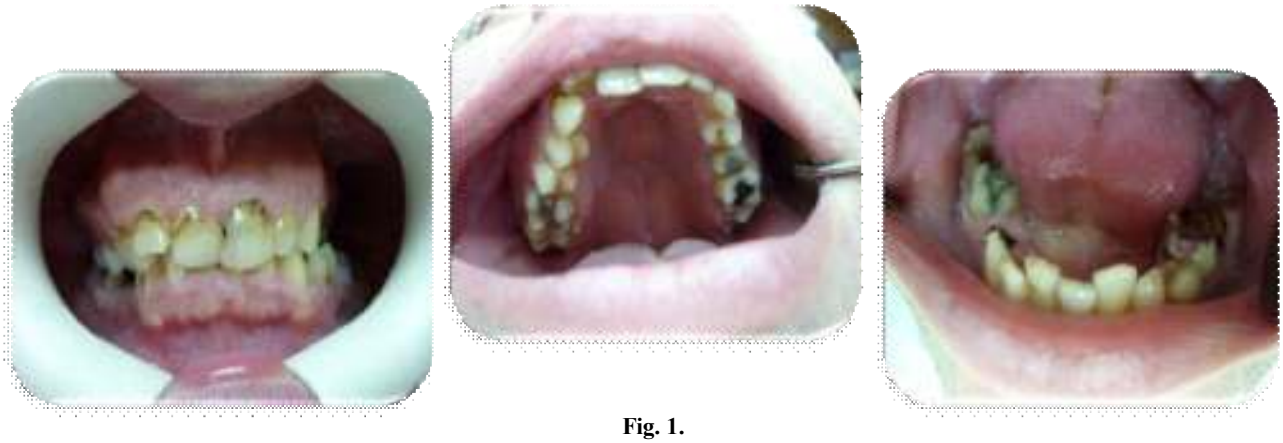

Fig. 1.

• Under 1/3 resorption of the interdental septum: 17,16,15,14,24,25,26,27,47

• Expanded periodontal slit (apical and/or marginal):

• 35, 36 and 37 – periapical alterations

• 36, 37 – affection of the furcation- IV degree.

• Missing 18,28,48

• Semi-retained 38 (Fig. 3)

Diagnoses:

✓ Periodontal diagnosis – Parodontitis chronica generalisata (1st to 2nd degree) ;

✓ Endodontic diagnoses – Pulpitis chr. ulcerosae 16, 27 ; Periodontitis chr. Fibrosa 35- за релечение; Caries secunda…Caries media

✓ Surgical diagnoses –Periodontitis periapicalis chronica granulomatosa localisata 36; Periodontitis totalis chronica granulomatosa progressiva s. diffusa 37; Radices gangraenosae 36, 37; Retentio dentis 38;

✓ Prosthetic diagnoses – Destructio totalis coronae dentes 36,37; Adentia partialis dentium permanentium mandibulae 45; Kennedy- class III,

✓ Orthodontic diagnoses - I-class Angle; Deep bite; Right-side crossed bite.

Treatment plan:

1. Periodontal treatment: dental hygiene, motivation, instructions and control of the personal dental hygiene.

2. Extraction of 36 and 37.

3. Operation – disclosure of 38 and osteotomy. Jodoformal drainage with Indextol.

4. Re-treatment of 35 and placement of model-casted post.

5. Endodontic treatments of 16, 27. Fillings- 14, 11, 21, 25, 26.

6. Preparation of 34, 35 and 38, taking an impression, bridge 34, 35-38.

7. Bridge 44-46- prospective .

8. Preparation of 13, 12, 11, 21 and 22 for veneers and all-ceramic crowns – prospective.

1. Periodontal treatment

Initial phase:

Dental hygiene – ultrasound, teeth polishing; trimming the enamel pearls with Perio-red-set; instructions for teeth brushing; curettage;

Before treatment: DI= 2; Bleeding- 86%

After treatment: DI= 0.64;Bleeding - 39%;

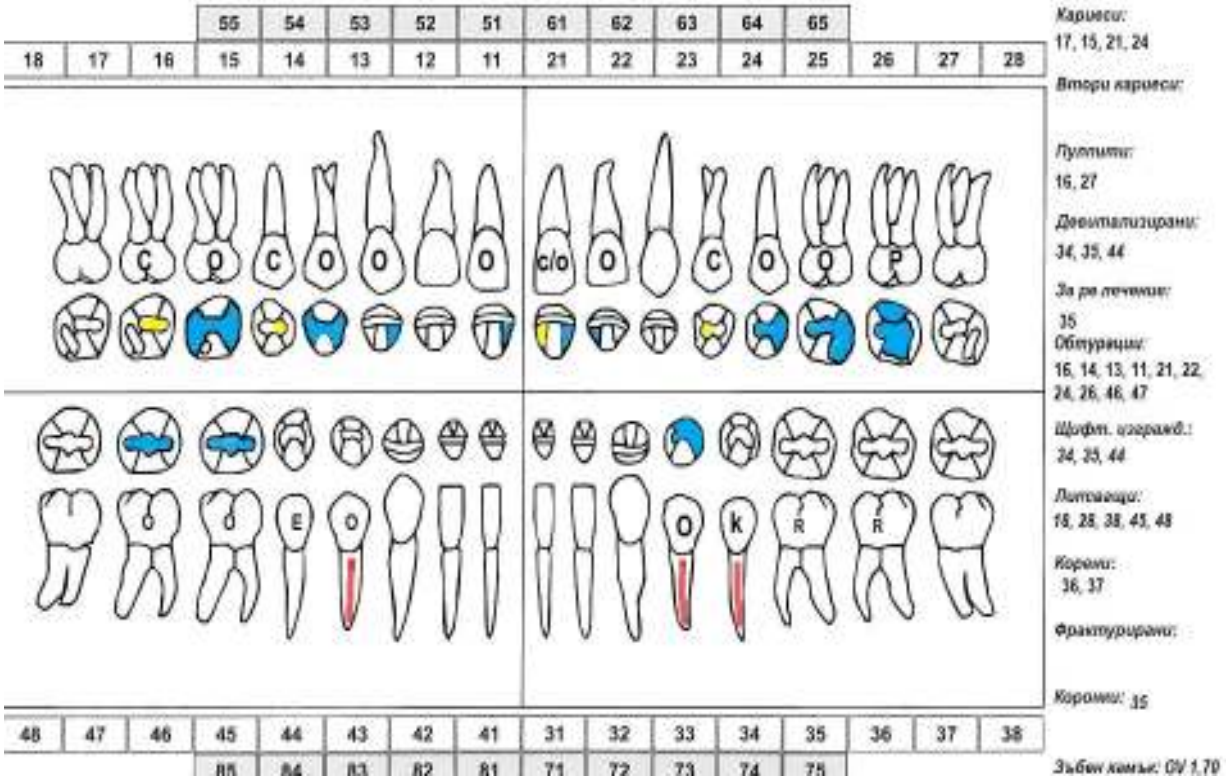

Fig. 2.

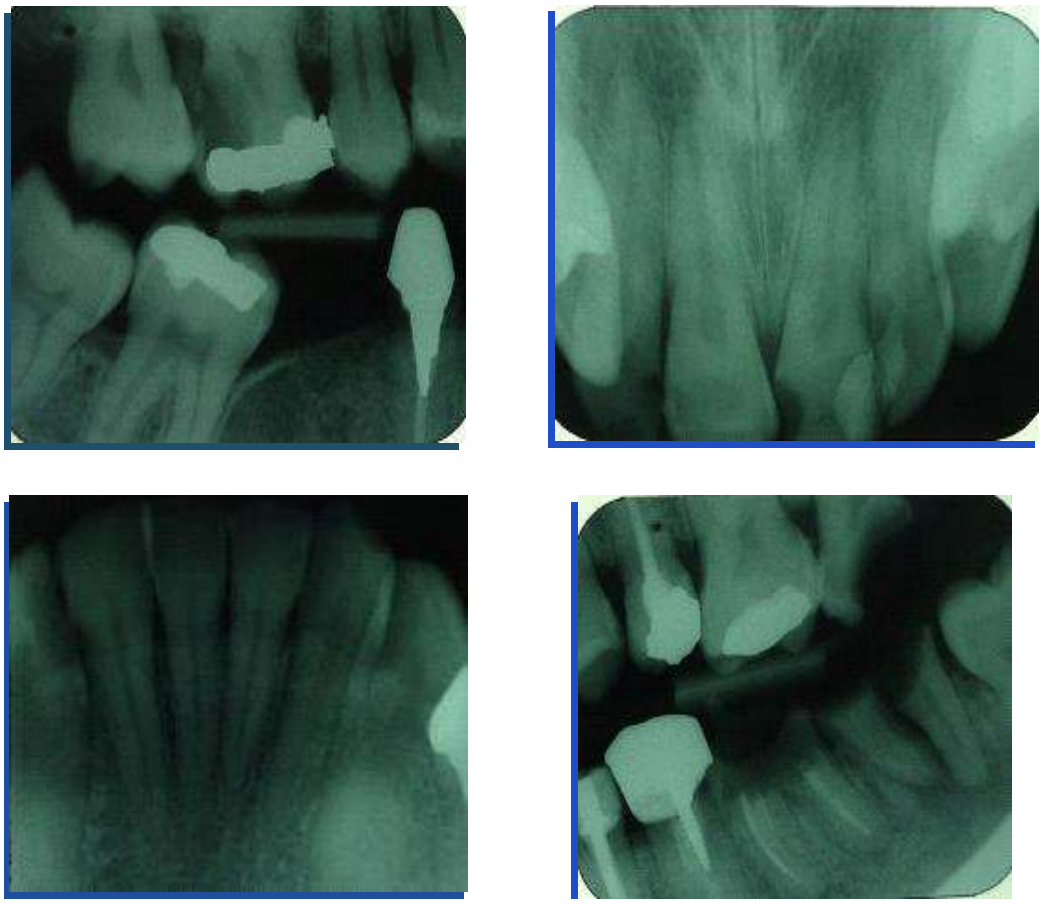

Fig. 3.

Fig. 4.

Corrective phase: surgical and prosthetic treatment;

Supporting phase: Eludril-2 weeks/ Sandrin every day;

Prophylactic examinations- every 4 months; re-motivation and re-treatment, if needed (Fig. 4);

2. Extractio dentes 36, 37;

Anesthesia: Mandibullar block

Medicament: Ubistesin e4%

Instruments: Straight and left levers

3. Surgical intervention

disclosure of the impacted third molar (Fig 5)

4. Re-treatment of 35, placement of model-casted post.

The reason for falling of 35's metal-ceramic crown is the corrosion of the golden-brassy post and it's continuous humid infiltration on the bound between the tooth and the composite. Due to which under the restoration is developed a carious process and after a period of time the crown falls together with the post and the composite (12) (Fig. 6).

Periodontitis chr. fibrosa

Re-treatment 35 (Fig. 7.)

Fixing of an indirect post – 35 (11) (Fig. 8)

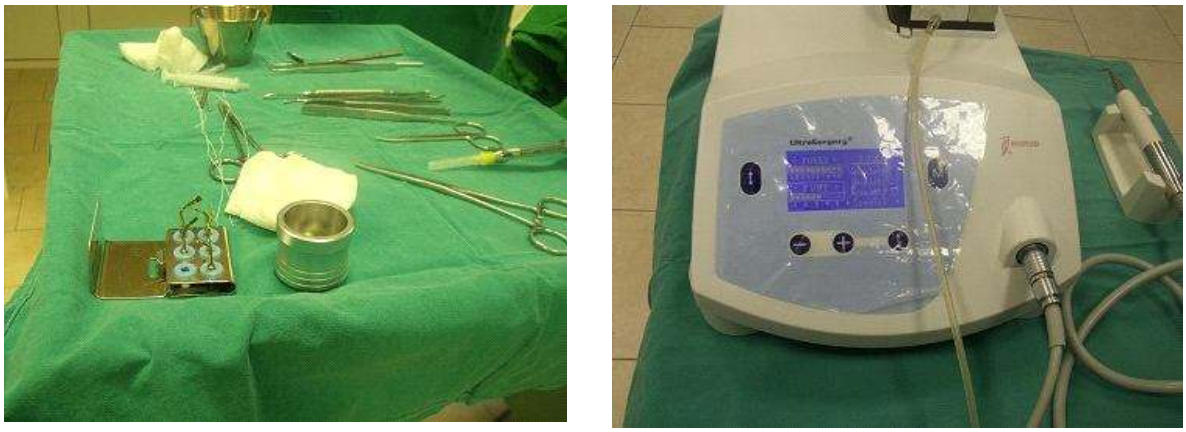

Fig. 5.

Fig. 6.

Fig.7.

Fig. 8.

Endodontic treatment 16 (Fig. 9)
Caries media 24 (Fig. 10)
Old fillings change (Fig. 11)

5. Preparation of 34, 35 u 38, taking an impression, fixing the bridge 34, 35-38 (8, 9)

- 34 and 35 – using wide shoulder margins, reduction of 1,5-1,8mm;
- 38-preparation for an inlay (Fig. 12);

References

1.Atanasov, D. Oral surgery, Plovdiv, Tafprint, 2011
2.Atanasov, D. Periodontal surgery, Quintessence BG, 1995
3.Bakardjiev, A. Surgery in dental practice – Plovidv, Dental Commerce, 1998, 190 p.
4.Boyanov, Б. Prosthetic treatment of the dental arc defects, Med. and ph., 1973, 341p.
5.Georgieva, K. Clinical oral surgery, 1992
6.Degors, T. Examination of patients before treatment with implants, SDK NUS, 1, 2002, 1, 8-21.
7.Ivanov, St. Oral surgery, Med.ph., 1988, 288 p.
8.Kissov, Chr. Dental ceramics, Index, 1997
9.Kissov, Chr. Preparation of teeth for all-ceramic crowns, Index, 2000, 183 p.
10.Kissov, Chr. Bakardjiev, A. Making a limited defect from an unlimited one by surgical disclosure of impacted third molar – SDK NUS, 1, 2002, 2, 28-30.
11.Kissov, Chr. Dental cements and fixing techniques, SDK NUS, 2008,
12.Kissov, Chr. Vlahova, A. Necessity of indirect restorations – study. SDK NUS, 2009
13.Popov, N. Prosthetic dentistry. 2nd Edition., Med and ph., 1996, 262 p.
14.Charles A. Frank, DMD, Treatment options for impacted teeth, JADA , May 2000
15.Overweg AW.,Utilization of an impacted third molar as a fixed bridge abutment, PubMed.com
16.Rosenthal RL , Extrusion of an impacted third molar for use as a fixed partial denture abutment, The Open Dentistry Journal, 2009, 3, 173-176
17. Seberg DC., Use of an unerupted third molar for a prosthetic abutment, Journal of Prosthetic Dentistry, February 2006

Fig. 9.

Fig.10.

Fig. 11.

Fig. 12.

Ірина Бєлєва, Христо Кіссов

Створення дистального обмеженого дефекту за допомогою хірургічного впливу на вражений третій моляр. Прогноз та лікування

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Резюме. Відновлення оклюзії, мови і естетики – це 3 основні проблеми в ортопедичній стоматології. Різна кількість матеріалів та різних методів лікування використовуються для її ідеальної реалізації, залежно від патологічних змін. У більшості клінічних випадків, коли присутній дистальний необмежений дефект, лікування обмежується розробкою якогось виду нефіксованого протезу. Тим не менше, нефіксованим частковим та вилитим із моделей протезам не надають перевагу ані стоматологи, через їх патологічний вплив на прикус та втрату кісткової тканини, ані пацієнти, через їх рухомість.

Великі успіхи стоматологічної імплантології практично дозволяють перетворити більшість дистальних необмежених дефектів на обмежені та полегшують їх відновлення. Тим не менш, у багатьох клінічних випадках цей вид лікування є неможливим через виражену втрату кісткової тканини та необхідність подальшої кісткової пластики, безпосередню близькість до анатомічних особливих структур, таких як нижнього альвеолярного нерва або верхньощелепної пазухи; або просто через його недоступну ціну для більшості пацієнтів. На щастя, в деяких клінічних випадках, нижні треті моляри – з добре сформованими коронками та коренями, не зважаючи на той факт, що вони вражені (напівзбережені). Це дає можливість для їх відновлення, якщо за допомогою хірургічного втручання розроблено сприятливе співвідношення клінічної коронки та кореня.

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