CONNECTIVE TISSUES, GINGIVAL GRAFTING, AND TIME.

I LOVE soft tissue grafting. I love it for covering exposed roots, thickening tissues to prevent recession, or bulking tissues to mimic root prominences apical to implants or under bridges.

Palatal connective tissue is particularly special. It acts as a living bandaid over open areas like extraction sockets, or deep narrow root exposure defects, to regenerate tissues that can not form there on their own. Cadaver allograft materials are non-living sources of connective tissue limited in their ability to regenerate tissues by requiring a living cover of host soft tissues.



Both graft types, palatal or allograft, can be used to cover exposed roots with shallow caries or non-carious cervical lesions. Root coverage procedures have predictable long term prognosis provided graft tissues are thick enough, host biotype is thick enough, and any habits causing the root exposure are terminated. However, <u>exposed dentin where enamel used to be can't be</u> <u>covered with gingiva as the gingiva never was present there</u>, as we will see with the case below.

The case is a full mouth connective tissue grafting case with long term follow up. Financial limitations dictated treatment of one sextant per year starting in 2013, and ending in 2018. The patient was re-referred this year for further gingival grafting. The case demonstrates the utility of several graft materials (both palatal and allograft), and their stability over time. The graft tissues and host biotype were thick enough. However, the case highlights the surprisingly deleterious effects of negative habits on the enamel and dentin especially in certain individuals over time. The cause of the initial severe recession and abrasion was due to aggressive brushing. I would have expected the gingiva to suffer more from continued bad habits, but the <u>enamel of the maxillary canines and premolars has been alarmingly damaged most significantly</u>. Because the gingival margins are relatively unchanged post initial grafting and it is the enamel that is missing, further grafting can not bring the gingiva any further coronally over areas of missing enamel.

This patient was instructed to use a Sonicare toothbrush, a non-abrasive toothpaste (a list is available on my website <u>www.nicoaraperio.com</u> in the middle of the Patient Information page), not to brush more than 2 minutes at a time or more than 3 times per day, and to wait at least 30 minutes to brush after eating particularly if the food consumed was more acidic in nature to allow saliva to buffer acids. Fluoride varnish at each maintenance visit, and a fluoride tray for home use will also strengthen the enamel and dentin. Because occlusal stress can not be ruled out as a contributing factor, an occlusal guard was also recommended.

Since further gingival grafting is not beneficial, class V restorations could be considered if esthetics were a concern. The patient prefers not to worry about possible recurrent caries under composites or loss of composites over time.

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Connective Tissue Grafting: Long Term Follow Up

