

Catarrhal Gingivitis Testing Algorithms in Children with Disabilities

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Abstract: Despite certain achievements in the diagnosis of chronic catarrhal gingivitis in children with disabilities, as well as in improving the indicators of dental examination, treatment and prevention, the high level of this pathology, the trend of increasing morbidity is becoming one of the urgent problems. The frequency of chronic catarrhal gingivitis is due to its prevalence (80-98%), while the variety of clinical manifestations complicates diagnosis, treatment and prevention.

Keywords: Children with disabilities, catarrhal gingivitis of the larynx, periodontitis, oral mucosa.

Introduction

The causes of the most frequent occurrence of gingivitis in children with disabilities are the unsatisfactory state of hygiene in the oral cavity, the unsatisfactory attitude of parents to provide hygiene education in the child, the presence of dental-jawomalia, as well as an aggravating general somatic condition, and the combination of general and local factors for the development of marginal periodontinuous inflammatory diseases [3.5.9].

Gingivitis is an inflammatory disease of the mucous membrane of the gums, most often in children 98% gachauchray in adolescence. The development of the most effective methods of treating diseases of Parodont tissues, as well as its implementation in practice, has occupied one of the first places in the research of authors of scientists from Uzbekistan, Russia and abroad in the last decade. [1.2.3].

When the condition of the Parodont tissue was clinically assessed, attention was first paid to the condition of the mucous membrane in the gums:

1. There is inflammation
2. Inflammation accelerated
3. Spread of inflammation.

The sample is based on staining of areas where there is deep damage to the connective tissue in the presence of inflammation. It is associated with the accumulation of large amounts of glycogen in inflammatory sites.

For the characteristic of inflammation, the following grading has been adopted: 1 negative sample – is painted in straw-yellow; 2 positive samples – are painted in bright-brown; 3 positive samples – dark-brown color.

Execution technique. Milk slime is rubbed with a mixture with a changed appearance of Lucille (potassium iodine – 2 ml, Crystal iodine – 1 ml, distilled water – 4 ml) varies from bright-brown to dark-brown. There is no difference in gum staining when the Parodont is healthy.

The simplest criterion for assessing hygiene in the oral cavity is the tooth surfaces covered with dental Carache, expressed in numbers. The Green-Vermillon method was used for this.

G.Green and I.R. Wermillon (1964)proposed a simplified index of OGI-s (Oral Hygiene Indices-Simplified) oral hygiene. The following tooth surfaces are studied to determine OHI-S: face, tongue, and (6/6)/(6/6)lab1|1.

On all surfaces, tooth decay is determined first. The amount of carash on the surfaces of the teeth is determined in the following way: with a mixture with iodine, six permanent tooth surfaces are painted – the lip surfaces of the upper central incisors, the face surfaces of the Upper first permanent large root teeth, the tongue surfaces of the lower first permanent large root teeth.

The following dental Carache assessment system is used:

0-absence of dental Carache (no staining);

1-Dental Carache covers more than 1/3 of the area of the tooth surface;

2-dental Carache covers an area of more than 1/3 of the tooth surface, but less than 2/3;

3-dental Carache covers more than 2/3 of the area of the tooth surface.

On each tooth, the amount of points is added to the total amount and divided into six (number of teeth).

By the amount of carash detected on the surface of the teeth, three levels of hygiene in the oral cavity can be distinguished: good, satisfactory and bad.

As a good case, it is possible to assess the condition in which the stained Carache is detected on the necks of individual teeth (0-1 points). Satisfactory condition-carash covers the surface of the tooth crown 1/3 and slightly more than 1/3 of the individual teeth (1-2 points). The jaw covers almost the entire surface of the crown, that is, more than 2/3 of all teeth under examination (2-3 points). This index makes it possible to conclude about the hygienic condition of the oral cavity during the period of bite exchange in children.

In the absence of the first permanent teeth, to assess the hygiene condition of the oral cavity, we take yu.A. Fedorov and V.V. We used the Fedorov-Volodkina index proposed by Volodkina (1971), which is determined by staining the surface of the six lower frontal teeth with an iodine-containing mixture (iodine-potassium mixture).

Quantitative assessment is conducted in a five-point system:

1. Staining of the entire surface of the tooth crown-5 points

2. Staining the surface of the tooth crown $\frac{3}{4}$ - 4 points

3. Staining $\frac{1}{2}$ surface of the tooth crown-3 points

4. Staining $\frac{1}{4}$ surface of the tooth crown-2 points

5. No staining-1 point

$$K_{sr} = \left(\sum_{p=1}^n k_p \right) / n$$

Here KSR is the general hygienic index, KP is the hygiene index when cleaning a tooth, n is the number of teeth under study (in the norm, gi should not exceed 1).

Hygiene classes were held in the oral cavity, which included a course for teaching hygiene skills in the studied groups. At the time of the lesson, children were explained the rules for cleaning teeth in standard method in muliages.

PLI karash index (Sylnex, Loe H., 1964) allows the study of all teeth, or only some, depending on the wishes of the researcher. Using visual or flute without staining, the presence of soft tooth separations on the four surfaces of the tooth is studied (vestibular, oral, distal and medial). The amount of carash on the surface of the tooth is assessed on a scale: 0 points – carash does not have in the area of the gum Aldi; 1 point – a thin film of carash is determined using only a flute in the area of the gum Aldi; 2 points – carash is visible in the area of the gum arrig and neck Aldi; 3 points – carash occupies a large part

Dental PLI is calculated by the following formula:

$$PLI = (\sum \text{〔four hundred points〕}) / 4$$

In the oral cavity, PLI is defined as the average size from PLI in all examined teeth.

OHI-S (Green J.C., Vermillion J.R., 1964) a simplified index of oral hygiene was proposed by the same authors in 1960, based on the Oral Hygiene Index Index, which provides a quantitative estimate of gum-top and under-tooth separation, evaluating results on segments (quadrants) on the face and tongue surfaces of all permanent teeth except third molars.

The OHI – s index six indicators were proposed to assess the state of hygiene in the oral cavity according to the condition of the teeth: the first molars in the upper and lower jaw (26 and 46 adjacent second molars when they were not) and two central incisors (11 and 31, when they were not-central incisors on the other side). Only one surface of the teeth is examined: the molars of the upper jaw, and in all incisors – the vestibular, in the lower jaw – the tongue. The surfaces listed at the same time should not be damaged by caries and hypoplasia.

Each surface is used to the presence of soft tooth decay and tartar with the help of a flute. On the surface under examination (tongue, face), the flute is placed parallel to the axis of the tooth, zigzagged from the occlusion surface of the tooth towards the neck, the level of the tooth is determined, in which tooth separations accumulate in the flute. The OHI-s V dental index is calculated as the sum of the karash index.

Karash index scale (Debris Index, DI-s): 0 points – no carash or pigment; 1 point – soft carash occupies less than 1/3 of the crown height, or any area of the surface has non – dental pigmentation with invisible soft carash (pristine carash); 2 points – soft carash covers more than 1/3 of the tooth crown, but less than 2/3 of the area; 3 points-soft carash occupies more than 2/3 of the tooth surface.

Toothpaste index scale (Callculus Index, CI-S): 0ball – no stone; 1 point – a tartar that occupies less than 1/3 of the surface under study; 2 points – the presence of a tartar or individual parts of the tartar that occupies more than 1/3 of the surface being examined, but less than 2/3 of the area; 3 points – a tartar that occupies more than 2/3 of the surface.

It is believed that the disease occurs in children living in ecologically unfavorable regions [10]. The article presents the results of studying the amount of leukocytes in the tsitokin profile and oral fluid when comparing children living in an ecologically polluted region with children with chronic catarrhal gingivitis with children living in an ecologically clean region with this diagnosis. A detailed analysis of Leukocyte levels and cytokine spectrum changes in oral fluid has been given, depending on the severity of chronic catarrhal gingivitis in children in the studied groups. An analysis of the amount of leukocytes and cytokines in oral fluid (OS) of children with chronic catarrhal gingivitis (SKG), depending on age and place of residence, showed that the level of leukocytes in OS of 7-year-olds living in an ecologically polluted region (eim) was $(198.19 \pm 4.11) \cdot 10^6 / l$, 1.4 times higher than the results of their peers living in a conditionally clean region (SHTM), $(141.09 \pm 4.10) \cdot 10^6 / l$, ($r < 0.01$). Analysis of the tsitokin profile in this age group showed that the amount of IL-6 inflammatory tsitokin in children living in an ecologically unfavorable region was 11.22% higher than that of children living in a conditionally "clean" region (13.78 ± 0.38 PG/ml versus 12.39 ± 0.50 PG/ml, $r < 0.05$).

In children with disabilities, a number of epidemiological studies have been carried out that indicate a correlation between the pathological condition of the oral organs and some systemic diseases of the body. The presence of common somatic diseases in children can cause the development of structure-function changes in the jaw-facial area, including increasing the risk of developing periodontic diseases and greatly affecting the course and prognosis of these diseases.

Functional and morphological insufficiency of the periodont structure in children is a factor that determines the course of the inflammatory process [13.14.15].

As local factors leading to the development of catarrhal gingivitis in children with limited capacity, tooth damage (Crown fracture, tooth dislocation, etc.), neck caries, improper bite, dental (dystopia, tightness) and oral soft tissue abnormalities (short extension of the lips, small access); unsatisfactory Dental Care, Tartar, fillers, dental prostheses, defects in the installation of aesthetic wines or [15.16].

Conclusion. Diagnosis of surinkal catarrhal gingivitis in children with limited capacity of mucous membrane of the oral cavity of sick children and periodont diseases with the help of dental examination methods, side diseases are diagnosed with consideration. However, the character of these changes is very diverse, depending on the etiology, individual identities of the organism, age, physical condition, genetic status, etc. For this reason, the diagnostic value of the symptoms of mucous membrane changes, as well as the treatment and preventive tactics of the doctor, will vary.

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