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DECISION MAKING FOR ROOT COVERAGE: PREDETRMINIG THE OUTCOME BEFORE SURGERY

The attainment of complete success is one of the most important goals in everyday practice. Sometimes patient's expectations are different from that of the clinician. Periodontal plastic surgery aims "to prevent or correct anatomical, developmental, traumatic or plaque disease-induced defects of gingiva, alveolar mucosa or bone" (AAP 1996) improving, if possible, the patient's self-esteem. It means that even periodontal procedures have to satisfy aesthetic requirements respecting the patient's psychological sphere. Concerning recession-type defects the literature reports many studies dealing with different root coverage techniques such as coronally advance flap (CAF) alone or in association with subpedicle connective tissue graft (SCTG), enamel matrix derivate (EMD), acellular dermal matrix (ADM) or purified recombinant platelet-derived growth factors (rhPDGF-BB). In spite of the multitude of articles the results are at times contradictory, technique sensitive or unpredictable. Little attention is paid to tooth position, type of crown and/or root lesion and, more importantly, to the harmony of the outcomes considering the specific gingival morphology and patient's personal satisfaction. After a careful review of available international literature, a clinical decision-making chart was realized considering gingival thickness, Miller classification, tooth anatomy, presence of root abrasions or caries, flap design and the use of EMD or SCTG as appraisal parameters. The ADM and rhPDGF-BB were not included in our evaluation because they are not yet available in Italy. The chart presents 5 categories: 1) thick gingival biotype: class I recessions; 2) thin gingival biotype: class I recessions with open cleft or class II recessions: marginal keratinized tissue smaller than 2 mm; 3) wide recessions: marginal keratinized tissue smaller than 2 mm and root abrasions deeper than 1.5mm; 4) class III and IV recessions 5) complex combined defects. In particular, in terms of surgical approach, a number of principles - like avoiding vertical incisions in favour of enveloped flaps, using sutures to encourage flap stabilization, or choosing a more coronal position whenever possible - have been applied to all cases regardless of individual differences. Step by step surgical techniques and long-term results are discussed. In conclusion the purpose of "modern" periodontal plastic surgery should be the recreation, in the best predictable way, of a dento-gingival architecture that blends harmoniously with the patient biotype. This goal should be achieved in a single surgical step, through a team approach (perio-restorative-ortho), aimed at satisfying the patient's desires and with minimum discomfort.

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