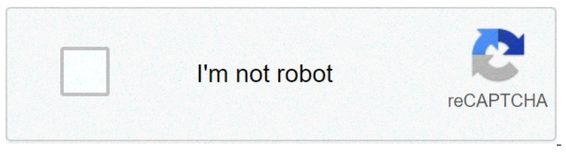

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Maxillary anatomical landmarks pdf

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Context: The maxillary artery can be injured during the procedures in the subconthylar part of the mandible. In-depth knowledge of this region is mandatory to avoid accidental puncture of maxillary artery, which can lead to abundant bleeding that is difficult to control. Methods: in 16 half of eight embalmed corpse heads, the maxillary artery has been dissected from the branch point to the point of entry of the maxillary breast. Its anatomical relationships with certain reference points were recorded numerically. RESULTS: The average distance of the ramification point of the maxillary artery to the sausage pointer was 16.2 mm (interval, 14.97 to 16.80 mm) in the horizontal plane and 21.4 mm (interval, 19.14 to 23, 53mm) in the vertical plane. The average vertical distance of the ramification point on the horizontal plane of Frankfurt 25.7 mm (interval, 24.86 to 27.47 mm). The average distance of the ramification point of the maxillary artery at the tip of the 22.4 mm condyle (interval, 21.66 to 23.99 mm). The average distance of the artery at the medial edge of the subconthylar portion of the jaw was 6.8 mm (interval, 4.06 to 8.47 mm). The average distance between the deepest point of the sigma notch and the junction of the jaw artery and sigma notch was 5.1 mm (range 4.97 to 5.95 millimeters). The average distance of the mascellar artery-sigma notch junction to the tragal pointer was 22.9 mm (interval, 20.95 to 25.05 mm). Conclusions: The maxillary artery can be wounded during surgical interventions performed in the temporary-mandibular region. Its relationship with the subconthylar portion of the varied mandible. Book Title: Textbook of Complete Prosthetic Prosthesis Author 1. DL SARANDHA ISBN 9.788.184,480894 MILLIONS DOI 10,5005 / JP / Books / Edition 10902_2 1 / E year of publication 2007 Pages 9 Author affiliations 1. Hasanamba Dental College Hospital e, Hassan, Karnataka Chapter Keywords Something went wrong. Wait a moment and try again. Volume 118, Issue 2, April 2017, Full Text Page 90-94View maxillary Anatomical Reference Points Coming SlideShare Load in a | 5 Ãƒ 1 Like this presentation? Because not sharing! 1. By-dr. Akanksha Narela PG 1 Â ° Anatomical maxillary year Reference points 2. Content - I Introduction Intraoral reference points Ã¯ meligated Arch I. Histology II. Support areas III. Peripheral / limitation areas I conclusion references 3. Introduction mm devan dictum A goal of a prosthodontist is not only the meticulous replacement of what is missing, but also perpetual conservation of what is presents a med must in harmony with i Fabrics that surround them and those who surround them support them. It is therefore the dentist must understand macroscopic as well as the microscopic anatomy of support and limiting prosthetic structures. 4. This knowledge helps determine - i. Selective positioning of forces from the prosthesis bases on support fabrics. II. The shape of the prosthesis edges that will be in harmony with the normal function of the limiting structures that surround them. 5. Intraoral landmarks 6. Intraoral Landmark supporting structures Limitation Structures in relief area Area stress Bearing 7. Stress Zone Stress bearing Primary Zone Secondary bearing Zone stress stress stress Zone bearing - 8. According to 9th edition of Boucher and 12 Â ° Edition of ZARB & BELENDER maxillary Arch stress Bearing Safety area Primary area: Secondary Ridge Residue: Pliche Incisive Papilla, Median Palatale Rafe, Fovea Palatini. 9. According to BoucherÃ ¢ s 13 maxillary edition Arch stress Bearing Safety area Primary area: Tuberosity firm, palate hard on both sides palatale cocks secondary: Pliche, alveolar ridge Palatal Torus, Median Palatale Rafe, Fovea Palatini. 10. Maxilla tuberosity enterprise slopes of the Hard on both sides of the Palatal area Raphahe primary reforming - sectors that are able to resist the vertical occlusion forces. 11. Ridge alveolar jaw Rugae Secondary stress zone bearing areas - The areas that resist the lateral forces of occlusion and e help resistance to vertical forces. 12. Relevance Areas - The part of the prosthesis that is replaced to eliminate excessive pressure on the specific parts of the fabric support prosthesis. Jaw Incisive Papilla Mid Palatine Raphe Torus Palatinus Sharp Bone Prominences Fovea Palatinee 13. â ¢ Alveolar Ridge (Residual Dorsal) Ã ¢ â ¢ Hard palate Ã ¢ â ¢ Incisive Papilla Ã ¢ â ¢ Palatale Rugae Ã ¢ â ¢ Mediana Raphe Ã ¢ Â Â ¢ Ã ¢ maxillae tuberosity â ¢ Fovea Palatinee Area Supporting - 14. â ¢ Labial frenulo Ã ¢ Labial groove Ã ¢ Buccali Frenulo Ã ¢ Buccali Solco Ã ¢ â ¢ Distobuchale Space Ã ¢ â ¢ Hamular notch Ã ¢ PALATALE Rear Device seal / Areas Limiting - 15. Correlation of the Anatomical Reference Points - No. Reference Point on the Mouth Impression Limit 1 Labial Frenulo Labial Notch 2 Labial Vestibule Labial Flange 3 Buffal Breakfast Vestibular Notch 4 Buffal Buffal Buffal Flange 5 Coronoide Swiveling Coronoid Contour 6 Residual Ridge Alveolar alveolar groove 7 maxillary tuberosity maxillary tubercular pit 8 hamular pterigaxillary notch seal 9 rear palatale region rear seal palatale 10 foveae Palatinee Foveae Palatinee 11 Median Palatine Mediana Raphae Palatino Gorge 12 Incisive Papilla Effission Pit 13 Rugae Rubae Region 14 Soft Displacable & Palato Hard Butterfly Description of PPS 16. Mucose - Mucosa - Submucosa - Formed by Stratified Squamoso Epithelio and a Thin Subtle Layer Of Connective Fabric It is present called their own lamina. Composed of connective tissue ranging from dense to lose aeorose fabric. In eDentulous persons a mucosa that covers a hard palate + crest crest + residual gum = mucosa chewing. Various thickness and can contain glandular, fat or muscle cells and transmits blood and nerve intake to the mucosa. Featuring a well-defined keratinized layer on the most external surface. Attachment takes place between the submucosa and periostal covers of the bone and makes the mass of the mucosa. 17. Oral mucosa mucosa membrane - 18. The residue crest is the residue of the alveolar process that originally contained sockets for natural teeth. After natural teeth are extracted, the alveolar crest can be expected to get smaller (resorb). The reabsorption rate varies considerably from person to person. Alveolar Ridge (Residual Ridge) - 19. Histology of the mucosa covering the crest of the residual crest Ã ¢ â ¢ The submucosal layer is often sufficiently to provide resilience to support a complete prosthesis Ã ¢ the bone covering the crest of the Upper crest is often compact. Ã ¢ â ¢ so the crest is the primary stress bearing area. Sub-mucosa 20. Hard palate - Ã ¢ â ¢ The hard palate is constituted by the two-thirds front of the Palatina vault supported by bone (palatine processes of the maxillary and the horizontal plates of the Palatine bones). Ã ¢ â ¢ The Palatine process are joined together with the medial suture. 21. Hard palate configuration: - Hard palate was ranked by several authors: Nichols - Arched-sharp squares / plate Heartwell, Elinger Shay - based on different slopes V-shaped high media fabric plate 22. Gland TissueDipose anterolateral part Hard palate, with plenty of posterolateral adipose tissue part of the hard palate, with plenty of fabric gland 23. Ã ¢ â ¢ It is a fibrous connective tissue pad overly overlooking the nose-palatine channel orifice. Importance: 1. Stable point of reference and gives its relationship with incisive forames through which the neurovascular beam emerge and are located on the surface of the bone. Incisive Papille - 24. 2. It is a biometric guide for information on the positional report for central incisors that are about 8-10 mm anteriorly incisive papilla. 3. Biometric guide that gives us information about the position of the mascellar canines (a perpendicular perpendicular rear Center of the incisive papilla on the sagittal floor passes through canines). 25. Clinical examination: during final impression procedure, be careful not to compress papilla. papilla. The incisive papilla should be relieved by a spacer. Reason: a. Compression of blood vessels Lumen obliteration Ã¯æ 'depriving tissue nutrition Ã¯æ' division of fabrics. B. The pressure on the nerve causes parashesia in the upper lip region. 26. N. N. NERVO NERVO AND DECALEZIONE NOXPAULATES Nerve and ships in the submucosa level 27. Areas of dense connective tissue radiates radiates from the average suture in front 1/3 of the palate are raised. Ã ¢ â,¬ â ¢ Á secondary secondary stress pad area. Meaning: 1.SAID to be worried about phonetics. 2. Increase the surface of the foundation and therefore completes the values of retention. 3. The stabilizing area of protesification in the maxillary foundation. Palatel Rugae - 28. Ã ¢ â,¬ â ¢ is the area that extends from the incisive papilla to the distal extremity of the hard palate. Meaning: 1. Sutural and covered joint area with mucous membrane firmly adhering to the underlying bone with little underwater fabric. 2.This sutural articulation is formed by the median melting of two mascellar processes and two horizontal plates of the palatine bone. Mid Palatine Suture - 29. 3. The function of the prevailing joint is the growth and sometimes there will be excessive growth of the bone at the suturial articulation with consequent Torus Palatinus. Clinical considerations: During the final impression procedure this raphe is raised to create a balance between resilient and non-resilient tissues. 30. PALATAL MEDIUM SUPLE SUBMOUSHOSE H / P showing the thin submucosal layer 31. Ã ¢ â,¬ â ¢ It is a narrow slot of loose areolary tissue which is about 2 mm to an anteriority. Ã ¢ â,¬ â ¢ is located between the distal surface of the tuberosity and the Hamulus of the medial pterigoid plate. Ã ¢ â,¬ â ¢ Located using T-Burnishher. Meaning: Ã ¢ â,¬ â ¢ constitutes the lateral limit of the rear palatal sealing area in the maxillary foundation. Ã ¢ â,¬ â ¢ The pterigo raphe sticks to Hamulus. Notch Hamular - 32. Clinical consideration: 1.Tenture should not extend beyond the Hamular notch, which will translate: a. A. Patrafomanda PatrafomandBular movement. B. When the mouth is wide open the prosthesis of the prosthesis. 33. Ã ¢ â,¬ â ¢ It is most of the residue of the residual alveolar crest and presents the reference points of the rigid tissues. Ã ¢ â,¬ â ¢ are the main stress bearing area. Meaning: The last rear tooth should not be placed on the tuberosity. Clinical meaning: Ã ¢ â,¬ â ¢ Often there is a lateral and vertical growth of tuberosity and the area takes importance when the maxillary antrum extends sideways with undercuts to the tuberosity region. Mascellari Tuberosity - 34. Ã ¢ â,¬â ¢ It is important to prevent the gold-anthral fistula so that it is important to have radiographed before the resection of tuberosity. Ã ¢ â,¬ â ¢ can be used for retention of the prosthesis. 35. Ã ¢ â,¬ â ¢ are the remains of coalescence ducts. Ã ¢ â,¬ â ¢ usually two in number on both sides of the median line. Ã ¢ â,¬ â ¢ indicate the proximity of the rear palatine sealing area. Ã ¢ â,¬ â ¢ its position also affects the position of the rear edge of the prosthesis. Ã ¢ â,¬ â ¢ The denture prosthesis can extend 1-2 mm through it. Ã ¢ â,¬ â ¢ In patients with thick saliva, the Fovea Palatine should be left discovery or thick saliva flows between the fabric and increases hydrostatic pressure and thus lead to displacement of prosthesis. Fovea Palatine - 36. Peripheral / limiting areas 37. Ã ¢ â,¬ â ¢ It seems a fold of mucous membrane that extends from the mucous lip liner to the crest of the residual crest on the labial surface. Ã ¢ â,¬ â ¢ could be single. Ã ¢ â,¬ â ¢ could be tight / wide. Ã ¢ â,¬ â ¢ does not contain muscle fibers of significant. Ã ¢ â,¬ â ¢ begins superorly as a fan form and converges as it descends to its terminal attack on the labial side of the ridge. BRENUM LABIAL 38. Clinical consideration: 1. The survey of conditions must be given during the final impression procedure and in the completed prosthesis because the main brake function will cause pain and disposal of the prosthesis. 2. Configuration impression procedure The lip should be stretched horizontal to the outside for the correct correct of the frenulo. 3.If Frenulo is attached to the crest frenectomy is made, bankruptcy that will lead to the border prosthesis to be placed on the bone tissue that will cause a decrease border gasket. 39. Ã ¢ â ¢ extends on both sides of the median line from Labial Frenum before the rear vestibular frenulum. Ã ¢ â ¢ 'Delimited sideways from the labial mucosa, medially by a maxillary ridge residual ridge. Ã ¢ â ¢ Ã flanked by linig mucosa. Ã ¢ â ¢ Reflection of the mucosa reflects the height above. The mucous reflection area has no muscle. Clinical examination: For an effective contact border between prostheses and fabrics, vestibule should be completely filled with impression material. Labial vestibule - 40. Ã ¢ â â ¢ bending or mucosa folds extending from the mucosa reflection area at the slope or crest of the residual ridge. Ã ¢ â ¢ It constitutes the line of demarcation between the labial and the buccal vestibule. Meaning: Ã, â ¢ Angulioris elevator (muscular caninus) is located under it and the frenulo position affect. Ã, â ¢ Orbicularis Oris pulls muscle frenulo ahead. Ã ¢ â ¢ Buccinator muscles pull backward frenulo. BUCCALE Frenulo - 41. Clinic Consideration: 1. During final impression procedure and in the final prosthesis sufficient relief should be given to the movement of the frenulum because besides a horse of the frenum function it will cause pain and the dislocation of the prostheses. 2.During cheek impression procedure should reflect laterally and backwards. 3.If Frenulo is attached to the ridge of the alveolar crest, frenectomy is required. 42. Borders: Ã ¢ â ¢ is bounded before the vestibular frenulum, sideways from the buccal mucosa and medially from the residual alveolar crest. Ã, â ¢ size of the vestibule varies with the contraction of the buccinator muscle, mandible position and quantity of jaw loss bone. BUCCALE Vestibule - 43. Clinic Consideration: 1. During vestibule impression procedure must be completely filled with impression material for the correct contact border between prostheses and fabrics. 2. When the vestibular space that is distal and lateral tubercles alveolari is filled with the dental prosthesis flange the stability and the retention of the maxillary prosthesis is greatly improved. 44. 3. The buccal border flange depend on the mandible branch movement at the distal end of the buccal vestibule and therefore the patient must move the mandible sideways and Protrusively to make sure the mandible does not interfere with these functions. 4.To RECORD EFFECTIVELY BUCELLE BUCCALE SUPERO Mouth should be half-closed road due to a wide opening of the mouth narrowing the space and does not allow a correct contours of the groove because the coronoid process of the mandibla is approaching the groove. 45. NS Arbree, DDS, * AA Yurkstas, DMD, MS, ** and JH Kronman, DDS, PhD. *** tufts university, school of dental medicine, boston, mass also known as Ã¯ buccal space or vestibule, Ã¯ pocket buccale, ã¯ tuberosity furrow, ã ã ã ã ã ã ã ã ã ã Ã¯ angle distenibble of the buccal vestibule, ã Ã¯ buccale furrow ã¯ buccale bag , Ã¯ buccale mucosa region Reflection I Postmalar Zone 46. The Coronomaxillary space: Review of literature and anatomical description Ã¯ space Coronomaxillary is that anatomical region that is media of the coronoid process and sideways to maxillary tuberosity. Ã¯ "Delimited prior-to the base of the zygomatic process. Rear boundary-pterigamascolor or hamular lower border notch - crest of the residual ridge. It is the coronomaxillary flange of the maxillary prosthesis is that part of the vestibular flange that extends from the zygomatic eminence to the Hamular notch 47. Muscle influence muscles affecting the interaction Disto-Buccale space b / w Buccinator & Superior Massereter Superior Moldsmarry Pharynx Rendering Pterygoid muscle, Muscle PteryGomandibular Raphae 48. The coronoid process can be relatively simple or vertical in some individuals. For these patients mandible opening can cause cause of space. It is, in some individuals, however, the coronoid process seems to flare sideways at its height with a stronger insertion of the temporal muscle, this flare can be increased. Ã¯, if the individual with a side flare of the coronoid process is observed during the opening, the space often remains the same or becomes wider. 49. Ã¯, - Various studies demonstrate alteration in the coronomasyllary space on the wide opening of the mouth, and some do not say any change in the opening. Ã¯, if the coronomasillary space extends or remains the same size when the opening, the functional filling of this space with the prosthesis flange becomes important. Â »Ã¯, if the space is not completely filled or even slightly filled, Ã, ~ Ã ¢ â,¬ â" ¢ Maximum retention can be lost. Ã¯, in this case, it is advisable not to have the patient wide open, protrudes or moving laterally during border stamping or impression procedures or imprint procedures. Â »Ã‚Â» ã, Â »Ã‚Â» ã, Â »Ã‚Â» ã, Â »Ã‚Â» ã, Â »Ã‚Â» ã, Â »Ã‚Â» ã, Â » Ã‚Â »ã, Â» Ã‚Â »ã, Â» Ã‚Â »ã, Â» ã, Â », a delicate molding of the region pulling out the cheek, down, and in succeeded 50. Area of Rear Palatale Tenut - Ã ¢ â,¬ â ¢ is also called as a postal dam, post palatal seal. Ã ¢ â,¬ â ¢ defined as Ã ¢ â,¬ "The area of soft fabric AO beyond the junction of the hard and soft palates on which pressure, within the physiological limits, can be applied by a prosthesis to help in the His retention. (GPT -7) Ã ¢ â,¬ â â ¢ Hardy and Kapur stated that the retention and stability obtained by accession, cohesion and superficial interface tension are able to withstand those sloged forces that are perpendicular to Base of the prosthesis. The horizontal and lateral discourage of the polyillaria prosthesis can only be resisted by an adequate border seal. 51. Ã ¢ â,¬ â â â â â â ¢ borders of the rear Palatale area is Ã ¢ â,¬ "I. Anteriority Ã ¢ â,¬ "The vibrating line II Located at the intersection of the attacked fabrics that overlooked the hard palate and the mobile tissues of the adjacent hard palate. Ã ¢ â,¬ â ¢ shape Ã ¢ â,¬ "The arc shaped prior, sometimes indicated as Ã ¢ â,¬ Ã ¢ â,¬ Ã ¢ â,¬ of the bow ". Ã ¢ â,¬ â ¢ Located at Ã ¢ â,¬" a) Maneuver Valsalva - Both nostrils are held firmly while the patient blows gently through the nose. This positions the soft palate down to its intersection with the hard palate. B) the patient is asked to say Ã ¢ â,¬ "ahÃ ¢ â,¬ â,¬ with short vigorous gusts.. 53. Rear vibrating line Ã ¢ â,¬" Ã ¢ â,¬ â â â ¢ an imaginary line to Tensor aponorosis junction PalaTini veils and the muscular portion of the soft palate. Ã ¢ â,¬ â â ¢ Located in - can be viewed when the patient says "ahÃ ¢ â,¬ â,¬ in a normal exaggerated fashion 54. Meaning: 1) keeps the contact of the prosthesis with soft fabric during functional movements of the Stomatognathogen (chewing, swallowing and phonation, etc.) 2) Decreases the reflection of the GAG. 3) Reduces the food accumulation with adequate compressibility of the fabric. 4) Decrease the discomfort of the language patient with back of the prosthesis 55 . 5) Compensation of volumetric shrinkage that occurs during the polymerization of the PMMA. 6) Allows the normal movement of muscles and ligaments. 7) Increases retention and the stability by creating a partial vacuum. 8) increase in the strength of the maxillary dental base. 56. Classification of PPS based on the configuration of the soft palate (Bernard Levin) - Ã¯, Class I: - Exceed 5 mm of mobile fabric available for post damming. It is ideal for retention. It is usually è is usually The basis of the thin prosthesis is recommended. Ã¯, - Class II: - 1-5 mm of mobile fabric available for post damming, good retention is usually possible. A half thickness of the Prosthetics' prosthesis is quite adequate. 57. Factors that influence PPS The accuracy of reproduction of PPS in the complete prosthesis depends on various factors: - Ã¯, - configuration of the hard palate. Ã¯, - Investing mediums Ã¯, factors involved in the processing of acrylic resin. Ã¯, - thickness of the dental base. Ã¯, - Position position 58. The methods of determining PPS can be widely classified according to the phase of the construction of the prosthesis as follows: Ã¯, - PPS determination in the final impression phase. TO ,- ,- Determination or design on the cast master. Ã¯, recording PPS in the methods of the secondary phase of fingerprint appointments to record PPS 59. Ã¯, - Determine PPS on Cast Master 1. Boucher's Technique 2. Bernard Levin Technique 3. Swenson's Technique 4. Calomeni, Feldman, Technique of Kuebker 5. Kuebker technique. . Apple Baum 7. Winkler Technique 8. Winkler Technique 8. Silverman Technique 9. Hardy Technique and Kapur 60. Ã ¢ â,¬ ¢ The basic goal of a complete successful prosthesis therapy is reaching the expectations of Patients in fulfillment of the best charming capacity, of the unalterous speech and a better extension. Ã ¢ â,¬ â ¢ The extensions of the borders to obtain a good seal facilitates the clinician to obtain the compromised treatment approach. The clinician should have anatomical knowledge to manufacture the prosthesis that integrates that AIDS in adequate maintenance of the stomatognathogen system. Conclusion - 61. Ã ¢ â,¬ â ¢ The knowledge of oral, microscopic and macroscopic anatomy gives us better as prosthetic A - i. Decide how to make the impression. II. What material do you use? III. How to plan treatment? Ã ¢ â,¬ â ¢ everything will result in a successful prosthetic treatment 62. 1. Zarb, bolender, carlson Ã ¢ â,¬ "prosthetic treatment of boucher for edentulous patients, 12th edition 2. sharry jj Ã ¢ â,¬ "Prosthodontics of complete protestura; Ed.3.New York, 1974 3.Heartwell Charles Ã ¢ â,¬ "Syllabus for complete prosthesis Ed.4, Philadelphia 4 .Sheldon Winkler Ã ¢ â,¬" Essentials of Complete Denture Protosthodics, Ed.2 5. or Boucher Ã ¢ â,¬ "Complete Prosthodontics of the Swenson prosthesis, Ed.6 63. 11.Benard Lynn, Detriot, Mich - Meaning of anatomical reference points in the complete prosthesis service, JPD, 1964.14: 456-459 12. HRKOLB -Variable Denturing Limiting edentula mouth structures, part 1, Maxillary border areas, JPD 1966.16: 194-204 13.Colie H Millsap-The Palatale Rear Teaproof area for complete prosthesis. DCNA, Nov.1964,663 14 Ã, Â € .nocolswamy-Worker of Protesthodontics, ed. 1 15.Sermerbir Singh-Word-Wbard of human histology with color Atlas, Ed.3 17. Corban-oral histology and embryology, Ed.10 16.elinger-synopsis of the complete prosthesis, Ed.1 18.N. S. Arbree, DDS, * AA Yurkstas, DMD, MS, ** and JH Kronman, DDS, Ph.D. *** Tufts University, School of Dental Medicine, Boston , Mass Mass

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