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Perspective

Effect of Orthodontic Therapy on Gingival Recessions

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ABOUT THE STUDY

The term Gingival Recession (GR) refers to gingival atrophy that causes the gingival margin to shift apically and expose the tooth's root. In the adult population, the prevalence of GR affecting at least one tooth ranges from 11% to 90%, with those 50 and older experiencing the condition more frequently. Age has been found to worsen the severity of GR. On vestibular surfaces and in mandibular teeth, GR is more common. Although it often affects one or a few teeth, GR can affect more teeth when the gingiva of several teeth is compromised. There are various predisposing and precipitating reasons for gingival recession, including coronally connected frenulum and muscles, aberrant tooth position, and periodontal disease. Thin mandibular alveolar bone or traumas, overhanging restorations, proclination of teeth, fenestration, dehiscence Another factor contributing to GR has been identified as Orthodontic Treatment (OT), which was linked to transverse/labial enlargement and problems controlling plaque during treatment. It has been discovered that with each year that passes following OT, the likelihood of GR appearing increases by 9.7%. The maxilla's canines, first premolars, and first molars are most susceptible to GR after OT, whereas the mandible's central incisors and first premolars have the highest risk of developing GR. Tooth sensitivity, root caries, hypermobility of the affected tooth, and poor aesthetics are all effects of GR. The hardest ones are those that take place in the aesthetic zone.

It is critical to determine if orthodontic treatment may have an impact on the improvement in Gingival Recession (GR) given the growing emphasis on mucogingival variables in the Orthodontic Literature (OL). In earlier research, the influence of variables that contribute to the onset of recessions was given greater attention than modifications. The current retrospective study's objective was to assess how the GRs that existed prior to OT had changed. Only 5.1% of the 12 years' worth of clinical data from two orthodontists' patients had pre-existing GR. The variety of malocclusion, number of recessions, and other factors among the included patients contributed to the existing paucity of prospective research. The included patients' average age was relatively high (28.7 years), which is consistent with other reports in the literature and suggests that GRs are more common in adult patients. According to reports, GRs in teenagers are linked to unusual tooth location. The alteration of 114 gingival recessions in 37 patients following OT was examined in the current study. The findings showed that OT had a favourable effect on the change in GR (62.3% GRs improved). The average change in GRs at the patient (0.4 mm) and tooth (0.5 mm) levels was comparable, demonstrating the beneficial effects of OT. The high number of improved GRs may have been impacted by gingival expansion during OT. Although this study largely included adults with adequate oral hygiene, gingival expansion is more common in youth with poor oral hygiene, so the impact of this issue is not examined. In GR alterations, tooth group was discovered to be significant. The maxillary incisors and maxillary premolars demonstrated the biggest GR improvement in millimetres in the current study. According to the study, gingival recessions both improved and deteriorated equally (42.3%). Notably, these authors only looked at recessions on mandibular incisors, which did not get better in our study. Because mandibular incisors have the largest prevalence of new GRs on their labial surfaces following OT, they may be characterised the most frequently.

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