



DEVELOPMENT OF EARLY DIAGNOSIS AND PREVENTIVE MEASURES OF PATHOLOGICAL EDIRISM OF TEETH AMONG WORKERS

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Abstract: Relevance of the study. Pathological tooth extraction is a polyethiological process that is accompanied by pathological changes in the dentition. Increased tooth hard tissue edging leads to impaired and brittle enamel and dentin tissue histogenesis, meaning that mineralization is not a complete dressing on enamel and dentin floors. As a result of this, the hard tissue of the tooth is resistant to chewing pressure, and pathological edging is rapid. Due to this, the normal shape of the teeth is disturbed, the stamens, the edges of the incision are loaded, the height of the tooth crown decreases. In the case of a strong exacerbation of pathological edirsia, only the root of the teeth will coalesce, the surface of which will be located on the surface of the edges of the gums. Dental hard tissue pathological editation in the form of a rapidly undergoing decompensator leads to functional and morphological changes in the face-jaw, chewing muscles, lower jaw of the chakra, moving to the border of enamel dentin.

It should be said that the occurrence of pathological edirsia is caused by exogenous and endogenous etiological factors, which include impaired metabolism, changes in the formation of tooth decay, tooth changes, loss of side teeth, increased chewing pressure in certain teeth (traumatic nodes), disorders of the central nervous system, in dental-jawomalogy and professional harmful habits. In some patients, the process of pathological exhalation is slow, and in the head it is fast. Once it deepens in the places where the dentin opens and stops for a while in the places where the enamel is sagging, it is constantly strained.

The tooth pulp responds with a chemo reaction against editation. This reaction is manifested by

the release of substituted dentin. Substitute dentin changes The Shape of the tooth cavity, sometimes completely enclosing it. In Pulp dystrophy, the rate of release of substituted dentin may lag behind the rate of tissue excision, the dentin floor becomes thinner, the dentin ducts open, and death blurring of the pulp is observed. Due to this, foci of inflammation (chronic periodontitis) appear near the tip of the tooth root in pathological exhalation. Enamel etching can be accompanied by the extreme sensitivity of the teeth to charorat and chemical lambs (F.Shper, 2006; C.Rufenacht, 2000).

When the teeth are pathological, the pulp shows a response reaction to self-defense, that

is, the secondary dentin is dressing as a result of which the pulp becomes smaller and the tooth cavity undergoes obliteration. Due to the bite, it becomes sensitive to traumatic and chemical influences. Hyperesthesia disappears rapidly due to the preservation of the plasticity of the pulp. This is caused by the formation of a secondary dentin floor, which acts as a barre between the outer and middle pulp floors (K.Lemani, 1999; L.A.Lobovkina 2009).

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The purpose of the study is to improve treatment and prevention methods by studying the degree of prevalence of pathological tooth decay among workers of Navoi mining and Metallurgical Combine.

Object of study

During the research, 210 workers of the Navoi mining and Metallurgical Combine were examined. The main criteria for selecting patients to the group under study are clinical – laboratory. affirmations serve.

Research methods.

The examination program consists of traditional and special clinical examination methods and dental examination methods at all stages.

- clinical-dental examination methods
- anthropometric
- X-rayolok
- biochemical and microbiological

Research results: Pathological exertion of a vertical appearance is observed on the palate surface of the teeth in the upper jaw and on the vestibular surface of the teeth in the lower jaw. 25-34 age gurukhi in the upper jaw 6.6%+0.6 in the lower jaw 3.3%+0.3 ; 35-44 age gurukhi in the upper jaw 18.9%+0.9 in the lower jaw 3.4%+0.4; 45-54 age gurukhi in the upper jaw 26.5%+1.0 in the lower jaw 4.0%+0.4; 55-60 age gurukhi in the upper jaw 26.4%+1.0 and in the lower jaw was 2.9%+0.4.

When checking the electrical excitability of the dental pulp, 1and Level 2 teeth are pathological in 60% of patients with increased electrical excitability 1.2-1.8 mkA. Level 3 teeth are pathological making in 40 of those examined, it was observed that the electrical excitability of the pulp decreased by 14.2 mkA [1.3.5.7.9.11].

Before the restoration of the Frontal tooth crown kompazision, we determined the dimensions of the central shovel teeth. Frontal tooth guru this size has aesthetic acuity. The central cranial teeth in the upper jaw stand out between all the upper and lower teeth. These teeth are more pronounced when they speak and laugh. The medial angle of the central cranial teeth is prominent earlier, the distal angle less prominent. The medial angle of the tooth crown is acute angle, distal angle rounded. The Frontal central teeth are ovate, rectangular and triangular in appearance.

The size of the central teeth has been determined in teeth pulled in one nechata examination (a.V. Salova, 2004; A Friedman, 2008) and the central cranial teeth were found to be 8.3-9.3 in width and 10.4-11.2 mm in height. The width of the teeth does not change at all times, while the height of the teeth shrinks. Among the examiners, we determined the size of the central incisors (60 teeth of 30 patients). Patients with pathological exacerbation of Grade 1-2 have aniclated that

the central incisors are 8.2-9.2 mm wide and 8.2 - 8.7 mm high (Tablisa-2 , Figure-2). Patients with pathological edirsia of the 3rd degree had a central cranial tooth width of 8.2-9.2 mm, and a height of 3.2-5.4 mm. In the pathological development of teeth of the 1st and 2nd degree, the central incisors decreased in height by 2.2-2.5 mm, and in the third degree pathological exudation-by 5.8-7.2 mm (in the norm, the width is 8.3-9.3 mm and the height is 10.4-11.2 mm).

Currently, new raw materials have appeared on dental practice-compasites, compomers, nanotechnology - based raw materials, as well as improvements in adgesive system tools are achieving high results in the restoration of teeth and their reconstruction. With modern restorative raw materials, the tooth hard tissue fully meets the requirements from aesthetic design when restored.

We used maxillary infiltration and conductive anesthesia methods. It is known to us that the correct determination of the color of composite raw materials leads to the fact that the restoration turns out to be excellent. Saliva and blood reduces the adhesion of composite material to the hard tissue of the tooth. In the process of working in the oral cavity, the effective method of distinguishing from saliva is the use of cofferdam. So that there is no cofferdam, we worked with an alternative method of laying cotton swabs and pulling a straw with a straw puller. We used an air-water cooling system when choking tooth hard tissue. During anesthesia, pulp can burn if the tooth is sharpened without the use of a continuous cooling system, and pulpitis disease is caused. We used those with diamonds when sharpening teeth. When sharpening, kiya slopes were dressing at the edges of the enamel, which ensures that the enamel and the composite material are not separated from each other optically. 37% orthophosphatic acid is applied to the surface of the sharpened tooth to make Micra puncture dressing for 20 seconds, washed with water and dried and an adgesive agent is applied. After that, the selected composite by color is laid out in a hole no

thicker than 2mm from the raw materials, photopolymerization on the opposite side is carried out for 20-40 seconds. We used solidifying restoration raw material 3m Filtek Z250 using microfil beam. Finishing and grinding are abrasive, held using a disc and rubber headboard. In a composite restoration, there will be small blemishes and blemishes that are invisible to the eye. Therefore, after finishing, a thin layer of composite is photopolymerized by applying hermetic (adhesive). Removes excess parts of the hermetic over the gums and on the tooth contact surfaces [2.3.4.6.8.10].

After the infiltration was anesthetized, the teeth were cleaned of caraches. The bite and occlusion contact were sharpened taking into account and dressing kiya slope at the enamel border. The adhesive was restored using the a2, a3 colors of the curing 3m Filtek Z250 composite using light after application of the agent.

In the second degree of diffuse pathological exertion, the Sox of molar teeth were restored with cast coatings. The frontal tooth socket, on the other hand, was restored with ceramic Winders. For this restoration, the tooth is first depulped and the tooth sharpened. Prior to sharpening, attention should be paid to the aloxia of the prikus and occlusive cipslaing. After that, the height, shape, color and anatomical shape of the vestibular surface of the vinir, which is prepared with the patient, were explained. Before sharpening the teeth, the tooth surfaces were cleaned, the tooth color was determined. Previously treated teeth are X-ray-controlled to determine if there is a change in the parodont tissue. If the tooth has pathological processes in the surrounding tissue should be treated until restoration. The tooth was then insulated with cotton swabs and a saliva puller was placed in the mouth. We used fissur, straight Diamond bores to sharpen the tooth surface. The tooth was attached to a not deep 2mm zina on the neck. The depth of the Zina and how much tissue is taken from the vestibular surface of the tooth depends on how much the tooth is made. After the formation of

the neck part of the vestibular surface of the tooth, the medial and distal borders are sharpened. After sharpening, the enamel edges with a thin fissur boron were aligned obliquely, and an elastic mold was obtained with a two-layer mold with a silicone grouse of raw materials.

The mold was sent to the laboratory to prepare the wine. In the laboratory, ceramic vinir was prepared with incineration wool and sent to kelinika. In the clinic, we saw ceramic Viner adapted to the mouth of the patient, and the permanent fixation was made with shishaionomer cement. After the cement hardening, the excess was removed, the teeth were checked for tightness, and the final finishing was carried out with rubber heads and finishing pastes [11.12.13.14].

For the preparation of Kappa, patients were first sanitized oral cavity. An anatomical main and auxiliary mold was obtained from the upper and lower jaw. In the laboratory, a model was poured from supergips, and the boundary of the future kappa was drawn. A special elastic plastic plate was formed under pressure on the model under the influence of high heat.

For a year, patients were taken into dispensary control and examined. Of our 52 patients, 45 used elastic Cappas. 5 did not use it. There were different reasons for this: feeling discomfort in oneself, losing Kappa, lack of hoax.

Conclusion: It was found that teeth are more susceptible to pathological edging of the chewing surface and the incision edge, that is, the horizontal appearance compared to the vertical. It has been found that pathological exertion in the vertical view occurs in the upper jaw in comparison with the lower jaw.

When teeth apply elastic plastic Cappas, which are recommended at the 1st level of pathological edirsia, the edirsia stops to such an extent. Effective results were achieved in 90% of cases when electrophoresis was performed with calcium and fluorine preparations to reduce tooth sensitivity.

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