

## 1: Télécharger Dental Erosion Livre PDF Online Français - telechargeqjx8livre

*Dental Erosion (Quintessentials of clinical Practice) [R Graham Chadwick, Nairn H F Wilson] on www.enganchecubano.com \*FREE\* shipping on qualifying offers. Concentrating on key issues of immediate practical relevance, Chadwick (restorative dentistry, Dundee Dental School and Hospital.*

Dental Erosion Key Points Erosion is the loss or wear of dental hard tissue by acids not caused by bacteria. Erosion may be caused by intrinsic e. Soft drinks, particularly carbonated sodas and sports drinks, appear to be the most significant extrinsic cause of erosion. Drinks containing high concentrations of calcium, like milk, may reduce risk of erosion. Introduction Dental erosion has been defined as the irreversible loss of dental hard tissue from acids, without the involvement of bacteria. Dental Erosion Intrinsic Causes Intrinsic erosion results from the introduction of gastric acids into the oral cavity at a frequency exceeding the ability of the buffering capacity of saliva or other oral health measures to prevent it, usually several times a week for a number of years. The regurgitation of stomach acids following meals, especially after overeating, is considered normal<sup>7, 11</sup> for up to about 1 hour a day. Bulimia nervosa is an eating disorder that is characterized by intentional vomiting as a means to maintain a desired weight. Bulimia is contrasted with anorexia nervosa, in which weight gain is controlled by excessive restriction of diet,<sup>17</sup> and non-purging bulimia which is characterized by periods of fasting and excessive exercise. Photos courtesy of Craig Mabrito, D. The increase in intra-abdominal pressure during pregnancy may result in an increase in reflux, but dental erosion is rare unless vomiting is chronic, as in the case of hyperemesis gravidarum. Arguably the most significant cause of extrinsic dental erosion<sup>1, 3, 11</sup> are soft drinks and fruit juices which have low pH values <sup>2</sup>. More frequent consumption of highly acidic fruit and sport drinks in combination with decreases of salivary flow and dehydration from athletic or strenuous activity may increase erosion risk. Airborne industrial acids have been implicated in dental erosion among factory workers,<sup>1, 2</sup> particularly in munitions, battery, and fertilizer plants. Calcium supplemented to acidic beverages, and other calcium-enriched products, have been suggested but not well studied as to their efficacy. Patient Information Avoid acidic beverages, particularly swishing or holding the liquid in the mouth. Drink milk along with acidic meals or beverages, which contributes to remineralization and helps neutralize acids. Avoid brushing teeth immediately after eating or drinking acidic beverages. ADA Seal of Acceptance: A company earns the ADA Seal for a product to help prevent or reduce enamel erosion from dietary acids by providing scientific evidence demonstrating the safety and efficacy of its product, which is evaluated according to the objective requirements related to their claims. Definition, classification and links. Eur J Oral Sci ; 2 Pt 2: Etiology of dental erosion--extrinsic factors. Schlossman M, Montana M. Prevention Across the Lifespan: Professional Audience Communications, Inc. Dental erosion due to wine consumption. The Journal of the American Dental Association ; 1: Pathogenesis and modifying factors of dental erosion. The Journal of the American Dental Association; 7: Etiology of dental erosion--intrinsic factors. The evidence base for professional and self-care prevention--caries, erosion and sensitivity. BMC oral health ;<sup>15</sup> 1: European Journal of Oral Sciences ; 2: Acta Stomatologica Croatica ;<sup>46</sup> 4. Diet influenced tooth erosion prevalence in children and adolescents: Results of a meta-analysis and meta-regression. J Dent ;<sup>43</sup> 8: Clinical Oral Investigations ;<sup>19</sup> 7: Curr Opin Pulm Med ;<sup>19</sup> 1: Gastroesophageal reflux disease in COPD: Comorbidities in idiopathic pulmonary fibrosis patients: Eur Respir J ;<sup>46</sup> 4: Oral complications in anorexia nervosa. Scand J Dent Res ;<sup>85</sup> 1: Etiology of dental erosion "intrinsic factors. Dental erosion in alcoholic patients under addiction rehabilitation therapy. Clinical studies of dental erosion and erosive wear. Caries Res ;<sup>45</sup> Suppl 1 Suppl. European journal of oral sciences ; 2: Meurman JH, Vesterinen M. Wine, alcohol, and oral health, with special emphasis on dental erosion. Quintessence Int ;<sup>31</sup> The pH of beverages in the United States. J Am Dent Assoc ; 4: Dietary factors associated with dental erosion: PLoS One ;<sup>7</sup> 8: Zipkin I, McClure F. Salivary citrate and dental erosion: J Dent Res ;<sup>28</sup> 6: Linkosalo E, Markkanen H. Dental erosions in relation to lactovegetarian diet. Scand J Dent Res ;<sup>93</sup> 5: Periodontal conditions in vegetarians: Eur J Clin Nutr ;<sup>67</sup> 8: A randomised clinical study to measure the anti-erosion benefits of a stannous-containing sodium fluoride dentifrice. J Indian Soc Periodontol ;<sup>19</sup> 2: In situ clinical evaluation of a stabilised, stannous fluoride

dentifrice. Int Dent J ;64 Suppl 1: Protective benefits of a stabilised stannous-containing fluoride dentifrice against erosive acid damage.

## 2: Ebooks Quintessentials

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Received Nov 1; Accepted Dec This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. This article has been cited by other articles in PMC. Abstract Since the mids, the focus of studies on tooth wear has steadily shifted from the general condition towards the more specific area of dental erosion; equally, a shift has occurred from studies in adults to those in children and adolescents. During this time, understanding of the condition has increased greatly. This paper attempts to provide a critical overview of the development of this body of knowledge, from earlier perceptions to the present. It is accepted that dental erosion has a multifactorial background, in which individual and lifestyle factors have great significance. Notwithstanding methodological differences across studies, data from many countries confirm that dental erosion is common in children and young people, and that, when present, it progresses rapidly. That the condition, and its ramifications, warrants serious consideration in clinical dentistry, is clear. It is important for the oral healthcare team to be able to recognize its early signs and symptoms and to understand its pathogenesis. Preventive strategies are essential ingredients in the management of patients with dental erosion. When necessary, treatment aimed at correcting or improving its effects might best be of a minimally invasive nature. Still, there remains a need for further research to forge better understanding of the subject. Introduction Interest in dental erosion and its role in tooth wear increased considerably since the mids. Early studies on tooth wear in humans were, in the main, based on teeth from archeologically obtained skulls. In later studies, contemporary adult populations were examined, but in neither the early nor the later periods of study, erosion was rarely, if ever, mentioned as a possible etiological factor [ 1 ] Figure 1. The definition and diagnosis of dental erosion have not been agreed upon among researchers and clinicians, which can explain some of the confusion and perhaps the earlier lack of interest in the subject [ 2 ]. The diet of our ancestors was often tough and contained coarse particles, which required heavy chewing. The resulting wear facets were further influenced by the abrasive components of the food. Modern diets would appear to lack such abrasives but can contain acids, which can demineralize enamel and potentiate attrition and abrasion. Nevertheless, there are findings supporting the existence of dental erosion even in medieval populations [ 3 , 4 ].

### 3: - Dental Erosion (Quintessentials of clinical Practice) by R. Graham Chadwick

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The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of dental erosion. When the dentist considers it necessary, an other health care professional s should be consulted to acquire additional information. In developing a treatment plan, the dentist should consider that dental erosion may be the result of one or many factors and can be in combination with other dental conditions, such as dental abrasion and microfractures of tooth structure associated with occlusal forces. In developing a treatment plan, the dentist should consider that dental erosion can be generalized or site-specific, progressive and predisposing to other conditions. The behavioral, psychological, anatomical, developmental and physiological status of the patient should be considered by the dentist in developing the treatment plan. The dentist should consult with the prescribing health care professional s before modifying medications being taken by the patient for known conditions. After consideration of the individual circumstances, the dentist should decide whether the dental erosion should be monitored or treated. The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, prognosis, limitations and risks associated with treatment, and the probable consequences of no treatment. Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment. Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions. The dentist should refer the patient to an other health professional s when the dentist determines that it is in the best interest of the patient. Relevant and appropriate information about the patient and any coordinated treatment should be communicated and coordinated between the referring dentist and the health professional s accepting the referral. The dentist may take this opportunity to emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions. The dentist should consider the characteristics and requirements of each patient in selecting material s and treatment s. The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance. Transitional or provisional restorations may be utilized by the dentist to facilitate treatment. Placement of restorations, or modification or replacement of restorations may be performed to facilitate treatment or reduce symptoms resulting from lost tooth structure. Pulpal tissue should be protected by the dentist when indicated. Endodontic therapy may be performed by the dentist. Periodontal procedures, including surgery, may be performed by the dentist to facilitate treatment. The dentist should communicate by prescription the necessary information and authorization for fabrication of the prosthesis es to the dental laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the accuracy of the prosthesis es.

## 4: Dental Erosion and Its Growing Importance in Clinical Practice: From Past to Present

*This book explores the interface between clinical dentistry and the management of a modern dental practice. It covers a range of business areas, including the principles of financial management and the use of financial ratios and indicators in relation to practice profitability.*

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**Abstract** Since the mids, the focus of studies on tooth wear has steadily shifted from the general condition towards the more specific area of dental erosion; equally, a shift has occurred from studies in adults to those in children and adolescents. During this time, understanding of the condition has increased greatly. This paper attempts to provide a critical overview of the development of this body of knowledge, from earlier perceptions to the present. It is accepted that dental erosion has a multifactorial background, in which individual and lifestyle factors have great significance. Notwithstanding methodological differences across studies, data from many countries confirm that dental erosion is common in children and young people, and that, when present, it progresses rapidly. That the condition, and its ramifications, warrants serious consideration in clinical dentistry, is clear. It is important for the oral healthcare team to be able to recognize its early signs and symptoms and to understand its pathogenesis. Preventive strategies are essential ingredients in the management of patients with dental erosion. When necessary, treatment aimed at correcting or improving its effects might best be of a minimally invasive nature. Still, there remains a need for further research to forge better understanding of the subject.

**Introduction** Interest in dental erosion and its role in tooth wear increased considerably since the mids. Early studies on tooth wear in humans were, in the main, based on teeth from archeologically obtained skulls. In later studies, contemporary adult populations were examined, but in neither the early nor the later periods of study, erosion was rarely, if ever, mentioned as a possible etiological factor [ 1 ] Figure 1. The definition and diagnosis of dental erosion have not been agreed upon among researchers and clinicians, which can explain some of the confusion and perhaps the earlier lack of interest in the subject [ 2 ]. The diet of our ancestors was often tough and contained coarse particles, which required heavy chewing. The resulting wear facets were further influenced by the abrasive components of the food. Modern diets would appear to lack such abrasives but can contain acids, which can demineralize enamel and potentiate attrition and abrasion. Nevertheless, there are findings supporting the existence of dental erosion even in medieval populations [ 3 , 4 ]. Extensive tooth wear of maxillary teeth in a medieval man estimated to be 35 to 45 years old. The loss of the first right molar was most likely caused by wear penetrating into the pulp subsequently leading to an inflammatory process in the periapical jawbone [ 6 ]. Although the terms attrition, erosion, and abrasion are the commonly accepted nomenclature used in dentistry to characterize tooth wear, the terms do not explain the wear process. Neither do they imply causation, instead describing clinical outcomes of a number of underlying events. In this regard, the science of tribology may more accurately characterize the process of tooth wear. Tooth wear in archeological material was, from an anthropological point of view, considered pathologic only if the function of the tooth was lost [ 7 ]. This may be one reason why dental erosion may have been overlooked as a possible cause in studies of tooth wear in those populations even though its morphological features sometimes have similarities with what we see today Figure 2. Severe tooth wear on the mandibular first molars in an approximately year-old individual from the 16th century third molars are impacted. Looking carefully, NCCLs can be seen indicating either abrasive or erosive influences, which, in combination with the wear seen on the first molars, resembles the pattern seen in modern erosive wear [ 11 ]. A further change in emphasis regarding the subject occurred in the mids: Recent studies from a large number of countries all over the world have confirmed that the prevalence of erosive wear, especially among children and adolescents, is high Table 1. Besides this, some longitudinal studies show that the occurrence of erosion is increasing and that erosive lesions that are already present progress rapidly [ 8 &€” 10 ]. Even if the prevalence rates vary substantially, it is evident that dental erosion is a common finding in populations from all over the world, especially among children and adolescents Table 1. During the past few

years, definitions of diagnosis and grading of the erosive lesions have been highlighted, and it is to be hoped that such moves towards greater standardization may lead to greater concordance between studies conducted and the methods used. As a result of these findings, dental erosion deserves serious consideration in clinical dentistry today. Despite the common finding of an increase of tooth wear, especially in the younger population during the last decade, the number of publications in PubMed dealing with, for example, dental caries, surpasses studies on dental erosion by a factor of over 10. Prevalence of dental erosion, according to studies from different countries. Prevalences, as listed, refer to erosion that reaches to the dentin or deeper. This paper is not a systematic review, which would have needed a more focused aim than is presently the case. Given that, many of the selected articles present valuable findings that add to the body of knowledge on dental erosion. It is, therefore, the purpose of this paper to give an overview of current knowledge of dental erosion, based on a scrutiny of the literature. There has been a considerable increase in the intake of soft drinks in recent decades, and these often are high in acidic content [ 41 ]. It is clear that, in children and adolescents today, the dominant causative factor for erosion is soft drinks [ 25 , 42 – 44 ] Figures 3 and 4. Published with permission from the Swedish Dental Journal [ 2 ]. A year-old boy who has a high intake of cola. In these cases, for example in patients suffering from eating disorders and gastroesophageal reflux disease GERD , vomiting and regurgitation, there is an increased risk for erosion [ 45 – 49 ] Figures 5 and 6. Rumination is a special form of gastric disease which is believed to affect mainly intellectually disabled patients, although its occurrence in the normal population may have been underestimated [ 51 ]. The condition involves GERD in combination with voluntary or involuntary regurgitation of swallowed solid food which is then rechewed and reswallowed; the erosive damage might well be severe Figure 7. A year-old woman who had suffered from Bulimia Nervosa since she was a teenager. Frequent vomiting followed by intense and meticulous toothbrushing in combination with a high intake of light cola-type soft drinks have resulted in severe erosive tooth wear. At the time that these photographs were taken, she had for a long time been free of her eating disorder but suffers a lot from tooth sensitivity [ 11 ]. A year-old woman with inoperable hiatus hernia, and despite long-term antireflux medication developed severe damage on her posterior teeth. Very severe erosive damage in an intellectually disabled year-old boy with a habit of frequent rumination. In addition to rumination he also suffers from GERD [ 11 ]. A large number of diseases and syndromes are associated with dental erosion. One consequence of the modern lifestyle and the various lifestyle-related diseases of today is that the dentition is more frequently than earlier times, exposed to acidic challenges and the consequent increased risk for dental erosion [ 56 ]. This somewhat sudden change in lifestyle, resulting in more acidic challenges for the dentition than earlier, can be compared with the lifestyle change following the 2nd World War that caused a large increase in sugar consumption, which was associated with the subsequent increase in the incidence of dental caries [ 34 ]. Although knowledge about dental erosion has improved in recent years, there is an urgent need for further research in order to better and more fundamentally understand its occurrence. It occurs as a result of acidic attacks during simultaneous unsaturation of both hydroxyl- and fluor-apatite in saliva, causing loss of dental hard tissue, layer by layer [ 58 ]. In addition, any patient symptoms, in these early stages, are often absent or very limited. More pronounced changes in macromorphology occur when the erosive damage is more severe. The condition will then be easier to recognize and more likely to present symptoms [ 2 ] as well as affecting the oral health-related quality of life of patients [ 33 ]. Earlier it was stated that an eroded surface always gave the impression of being a matt surface [ 59 ]. It was also stated that dental erosion only could be diagnosed on teeth that had no opposing occlusal contacts [ 60 ]. Today it is understood that the surface appearance of an erosive lesion is either blank or matt and that erosion can be diagnosed even if the tooth surfaces have opposing occluding contacts. The erosive lesion can be uneven and produce small concavities. Proximal erosive lesions are difficult to diagnose but are probably rare, whereas a cervical shoulder formation Figures 4 a and 8 b , as well as the reversed V-sign incisally on maxillary central incisors are more common Figure 8 a. Cuppings are strongly correlated with dental erosion and should be carefully looked for as it has been stated that they can be regarded as an indicator of the onset of erosion [ 62 ]. In advanced cases of erosion, the pulp can be visible through the remaining tooth substance. This is especially the case in the maxillary central incisors in the primary dentition but can also be seen in the permanent dentition Figures 3 and A year-old girl

who has a high intake of soft drinks. Mandibular incisors are relatively intact. Erosion in the primary dentition in a 6-year-old girl who has high intake of juice, fruit drink, cola, and fruit. On the basis of archeological data, populations from the past experienced endodontic complications that were mostly related to tooth wear, whereas today they are most often related to dental caries [ 63 ]. It will be evident that the loss of tooth substance brought about by dental erosion may at some stage present dissatisfaction for patients; it is to be hoped that at an early enough stage the attending dentist will have identified the matter, informed the patient and implemented an initial preventive strategy. Other Types of Tooth Wear and Their Relation to Dental Erosion Tooth wear has a multifactorial etiology and is usually a result of more than a single mechanism [ 67 ]. In addition to erosion, other types of wear can occur in parallel. Today, there is evidence that a key element in a severely worn dentition is erosion, and that attrition and abrasion are of lesser importance [ 1 , 69 – 71 ]. There is no strong support for the previously common belief that bruxism is the main cause of tooth wear. It has been shown that in individuals with tooth wear and simultaneous bruxism, erosion, and not attrition bruxism is the dominant etiological factor related to the loss of tooth substance [ 72 ]. If strict diagnostic assessment of bruxism is carried out e. Whether the tongue might also act as a reservoir for acid after an acidic challenge has been discussed. This may not be the case after intake of an acidic drink since the pH on the tongue surface recovers very quickly after drinking [ 66 ]. However, research has shown that the cause of these injuries cannot be blamed on intense or improper brushing techniques alone, as they may occur subgingivally, in individuals who seldom brush their teeth, in archeologically recovered material clearly before the toothbrush era , and even in animals [ 25 , 75 – 80 ]. Definitions of the various forms of NCCL are often imprecise which may be one explanation for the wide range of prevalences reported. The most common NCCL is the shallow cervical erosion. NCCLs appear to develop with age from a shallow lesion into the other types mentioned, with wedge-shaped lesions being most prevalent in older adults. NCCLs are common on the facial and buccal surfaces of the maxillary anterior and premolar teeth and the mandibular premolar teeth. Significant correlations have been found between NCCLs and the presence of occlusal erosive lesions as well as occlusal attrition [ 2 , 81 ]. Wedge-shaped NCCLs have been called abfractions, assumed to be caused by heavy stress on the teeth namely, due to heavy chewing or bruxism , or in combination with an acidic challenge which will result in strain microfractures along the buccal cemento-enamel junction, making the area more prone to substance loss when stressed [ 76 , 82 , 83 ]. On the other hand, wedge-shaped cervical lesions have also been identified on teeth without occlusal contacts. The theory has, not surprisingly, received criticism due to lack of robustness of the evidence [ 84 ]. A review concluded that toothbrushing, with or without toothpaste, only minimally contributes to the development of wear of enamel, whereas toothbrushing in combination with an acidic diet may be linked to dentin wear and hypersensitivity [ 85 ]. It is likely that NCCLs not only have a multifactorial aetiology, including many factors besides toothbrushing [ 86 ], but also that toothbrushing in the presence of acid may contribute to a more rapid development of NCCLs [ 85 , 87 ]. As there is near consensus today that the most important etiological factor for NCCLs is erosion, preventive measures to reduce acidic challenges on the teeth is essential in managing patients with NCCLs. Diagnosis and Grading of Dental Erosion in the Clinic For the purposes of appropriate clinical decision making, it is necessary to quantify the severity of erosion at a certain point of time, as well as the progression of erosion during a specific time interval. Different techniques are available, ranging from sophisticated optical or laser scanning methods to relatively simple ordinal scales [ 88 ]. The latter scales are mostly designed for epidemiological studies, but can be appropriately adapted for clinical use. Examples of such scales are shown in Tables 2 [ 25 ] and 3 [ 1 ]. More recently, digital scanning systems, now on the market, may offer great opportunities as scanning can be performed intraorally, on study casts and impressions.

### 5: DENTAL EROSION | DENTODONTICS

*knowledge of the aetiology of dental erosion and its management, Dental Erosion is a timely and valuable addition to the popular Quintessentials of Dental Practice series. In common with the other carefully targeted books in the series, a modern, evidence-based.*

### 6: Making Sense of Dental Practice Finance by Bright Mervyn, Li Sau-Kee Paperback

*Quintessentials of dental practice; 34, Clinical practice; 4 RK Concentrating on "key issues of immediate practical relevance," Chadwick (restorative dentistry, Dundee Dental School and Hospital, UK) seeks to distill the essence of the diagnosis and management of dental erosion.*

### 7: Series: QuintEssentials of Dental Practice - Quintessence Publishing Deutschland

*Erosion is the irreversible loss of tooth substance brought about by a chemical process that does not involve bacterial action.. There have been some disagreements in dental field pertaining to "Dental Erosion".*

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