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DECAY OF PRIMARY TEETH: CAUSES AND CONSEQUENCES

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Treating young children poses one of the most complex challenges in practical dentistry. The difficulties are due to the child's psycho-emotional characteristics, parental behavior (parents often "catch" the child's anxiety during the appointment), as well as the specific structure of dental tissues, the nature of carious process spread, the physiological features of salivation, and the inability of a young patient to maintain a static posture for a prolonged period.

The earliest signs of pathology are observed in teeth that have not yet fully erupted, where destruction affects the incisal edge. After complete eruption, damage is most often localized on the vestibular surface.

The main reason parents seek dental care is caries, which can manifest in various ways. Typical forms include localized enamel defects on the vestibular surface of incisors (crescent-shaped or irregular), located in the cervical or middle third of the crown, with dentin pigmentation and overhanging edges of demineralized enamel, flat enamel defects on the palatal surface of incisors, defects on the occlusal surfaces of the first primary molars of both the upper and lower jaws, extensive crown defects without communication with the pulp chamber, with light or pigmented dentin of varying density. Parents often complain about the appearance of "non-removable plaque" after an illness. In such cases, areas of dull white enamel, light yellow or brownish spots and stripes on the crown surface are detected. The tooth surface may be either shiny or dull, while enamel defects are not detected upon probing.

A special category includes cases where fistulas appear on the gum in the projection of the roots of destroyed anterior teeth. Such teeth require mandatory radiographic examination and, as a rule, belong to a group of teeth united by a single formation period in the prenatal period, which allows this condition to be considered a developmental defect.

For a certain category of young patients, treatment in an outpatient setting is possible. This possibility is determined by the willingness of at least one parent to cooperate, the physician's ability to establish contact with the child, the availability of technologies, instruments, and medications that can halt caries progression through disinfection of altered tissues, creating conditions for mineralization and activating reparative potential.

In cases where the outpatient approach is impossible or ineffective, the problem is solved by providing dental care under general anesthesia, which is particularly relevant due to increasing aesthetic demands in treatment and advances in pediatric anesthesiology.

The set of therapeutic methods includes remineralizing therapy with controlled hygiene, fluoridation of enamel and dentin, laser therapy and ozone therapy, chemomechanical and ultrasonic preparation, filling with glass ionomer cements or compomers, prosthetics of primary molars and incisors with single crowns (standard metal crowns with composite facing, PvSC, or stainless steel crowns, SSC).

The decay of primary teeth is a multifactorial process, the successful treatment of which is impossible without a comprehensive approach. A key condition for the effectiveness of any intervention is the preliminary motivation of parents, correction of hygiene skills and diet, since achieving a lasting result is impossible without eliminating cariogenic factors. The modern strategy is minimally invasive, preventive, and family-centered to stop decay and preserve teeth until natural replacement.