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Wonders of Semilunar Flap in Gingival Recession – A Case Report

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ABSTRACT:- Gingival recession is one of the most common problem faced in periodontal practice. Several Root coverage procedure can be performed for the treatment of gingival recession among which semilunar coronally positioned flap is one of the most accepted for the root coverage procedure. So,in this article we are presenting a case report of a semilunar coronally positioned flap at its shining results.

Keywords- Gingival recession, Semilunar Coronally positioned flap.

I. INTRODUCTION

Gingival recession is defined as an apical displacement of gingival margins from the cementoenamel junction which result is root exposure.[(1)]Gingival recession occur due to multiple factors mainly anatomy of bone,smoking, position of the teeth, orthodontic movement, improper tooth brushing methods and periodontitis.[(2)]Sulivian and atkins were the first who classified the gingival recession but the most accepted one is given by Miller,he classified gingival recession into 4 classes,In Class I recession the marginal tissue recession does not extend above mucogingival junction with no interdental bone loss and soft tissue loss,In Class II recession marginal tissue recession extend upto or beyond mucogingival junction but no interdental bone and soft tissue loss is present,In class III recession extends upto or beyond the mucogingival junction along with loss of bone and soft tissue apically to CEJ but coronal to the recession defect while in class IV loss of bone and soft tissue occur apical to the level of recession defect.[(3,4)]This case report shows a case of gingival recession treated with semilunar coronally advanced flap with 3 months of follow up.

II. SURGICAL PROCEDURE

Tarnow's original technique was followed in this surgical procedure. A semilunar incision, which is 3mm greater than depth of recession, is given from gingival margin (Fig.1). The incision is extended into the papilla region on each side of the tooth. An intracrevicular incision is given extending apically to the level of the semilunar incision(Fig.2) and soft tissue graft is coronally repositioned to the level of the cementoenamel junction and stabilized by light pressure for around 5 minutes(Fig.3). Periodontal dressing was given for the protection of the wound.

III. CASE REPORT

A 48 year old male reported the department of periodontology, kd dental college with complaint of sensitivity with respect to upper left teeth. Patient had no medical history with deleterious habbit of chewing betelnut two packs a day. Patient was using horizontal brushing technique. On examination teeth number 23 had Miller class 1 recession with a depth of 2.5 mm and cervical abrasion. After the surgical root coverage patient was adviced to change the brushing habit to vertical rolled out along with withdrawing the habit of betle nut chewing. Periodontal dressing was placed and analgesic was given for 3 days.Patient was recall after 1 week(Fig.4) , 1 month(Fig.5)and 3 months(Fig.6) patient has shown no history of relapse.

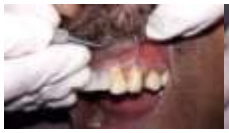
Figure.1


Figure.2


Figure.3


Figure.4


Figure.5


Figure.6

IV. DISCUSSION

Semilunar coronal advanced flap is one of the minimally invasive technique for root coverage.In this case report we have achieved a successful root coverage of the respective teeth.In 2006 Haghighat K had introduced a modification of semilunar flap for coverage of multiple tooth recession[5], semilunar flap is minimum invasive technique this technique also come with some drawbacks as this technique can only be performed in maxillary arch it is not recommended in mandibular arch so the use of this technique is restricted one more drawback of it is it can be only be performed in miller class 1 recession.It is also technique sensitive as if not properly executed it can lead to tissue necrosis.

V. CONCLUSION

In this case report it is justified that semilunar coronally repositioned flap if performed accurately with proper case selection can lead to full coverage of the millers class 1 gingival recession in maxillary arch.

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