I Hate Love Complete Dentures Lecture
Dr. Ronnie Schnell

Friday, June 12, 2015
8:30 a.m. – 11:30 a.m.

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Friday June 12th
8:30-11:30 AM
Lecture

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Key to Successful Dentures

1. Knowledge of edentulous anatomy and their predicted effects on the outcome of the denture
2. Knowledge of the musculature is the key to successful denture borders and optimal impressions
3. Knowledge of optimal esthetics and how to achieve desirable results
4. Knowledge and skill to manage denture occlusion, which contrasts natural occlusion.

Sequence of Patient and Lab Visits

- Preliminary Impressions
  - Custom trays
- Final Impressions
  - Record bases & occlusion rims
- Intermaxillary records
  - Set up
- Trial denture
  - Processing & lab remount
- Insertion
  - Clinical (patient) remount

1st Clinical Visit: Initial Patient Exam

- Patient attitude
- Patient expectations (vs what you can deliver)
- Is there a “significant other” who play an important role in decisions?
- Chief complaint
  - Loose, sore, cannot chew, appearance, time to replace
- Snacks?
- Prescription meds?
- Smoker?
- How much water does the patient drink daily?
- How long has the patient been edentulous? U? L?
- Does the patient have an existing prosthesis?
  - How long ago was that made?
  - How many dentures were made in the patient’s lifetime?
- Esthetics and function: What does patient like and not like?
- What do you like and not like?
- The initial data gathering appointment is EXTREMELY important to the success of the case... Do not rush through it – especially the space analysis

Inter-arch Space

When natural teeth are in occlusion, ridge crests are approximately a minimum of 12 mm apart in the anterior

Inter-ridge Space?
Anterior - 12 mm minimum
Posterior - 1-2 mm minimum

Evaluate with a tongue blade during initial exam

1st Clinical Visit: Initial Patient Exam

- Saliva - Ropy, Viscous, Absent, Average
- Oral Tolerance - Average, Sensitive, Very sensitive, Gagger
- TMJ Status - Symptomatic, Asymptomatic
- Oral pathology review - WNL, Suspected Areas...
- Tongue size - Average, Large
- Throat form -
  - U-House I, II, III
  - L-Nell's Lateral I, II, III
Edentulous Maxillary Anatomy

Edentulous Mandibular Anatomy

Impressions

You’ll never get a second chance to make a great first impression...

- Will Rogers

Luckily for us we often do...!

Developing Our Goals

- What makes a “GREAT” edentulous impression?
- Types of materials available
- What is currently the “BEST” technique?
- What works best in the operators hands?
- Has it accomplished our goals?

Ref.

Denture Retention - Definitions

- **Adhesion** — attraction of different molecules to each other. Increase by increasing surface area of the tray/impression.
- **Cohesion** — attraction of the identical molecules to each other. Increase by increasing contact (closeness) of the tray/impression.
- **Atmospheric Pressure** — force per unit area exerted against a surface by the weight of air above that surface. Enhance with Posterior Palatal Seal (Post Dam).
Maxillary Preliminary Impression for Diagnostic Cast and/or Custom Tray

Captured are the incisive papilla, frenial attachments, folds, rugae, palate. Extended posteriorly to the hamular notches bilaterally and distal to the anterior vibrating line.

May be corrected with green or grey stick compound.

Upper and Lower Preliminary (1°) Alginate Impressions

Indications:
- Undercuts
- Existing dentition

Laboratory steps:
- Beading, Boxing and Pouring
  (alginate cannot be beaded and boxed)

2nd Clinical Visit: Final Impressions

Are BOTH mucostatic and mucodynamic

Where?
- Borders – Mucodynamic
- Intaglio – Mucostatic

Why border mold?
- The borders of the denture are formed by the muscle attachments
- We must capture the functional movements of the muscle attachment during impressioning
- This process is called border molding

General Preliminary (1°) Impression Objectives

- For Custom tray fabrication
- Surface adaptation for adhesion and cohesion
- Diagnose Patient
Clinical Hints for Impressions

1. Prior removal of old dentures and tissue conditioner to rest and or treat tissues - if contributing to problems
2. Tray selection
   - 1/4” larger or custom for thickness of impression material
3. Head position
   - Upright for safety / tissues vertical
4. Dentist position
5. Muscle movements
6. Saliva control – suction & astringent mouthwash
7. Syringe teeth for immediate/interim/partial denture impressions

Never Block Out Anterior Undercuts

1. Never block out Anterior undercuts!
2. Alter Path & block out Posterior undercuts

Dynamic Evaluation of Buccal Fold

- Over-extended
- At rest
- When evaluating folds...
- Pull out and up
- Do not pull down and away

Custom Tray Try-in: Evaluation and Adjustment of Borders for Intra-oral Anatomy

1. Intra oral Evaluation
2. Overextension
3. Relief of frenue

Border molding - Required Armamentarium: Gray or green stick compound (red stick if needed to extend custom tray), Bunsen Burner, Hanau torch, water bath @ 140 degrees

The Severely resorbed mandible

- Tray must not “rebound”
- Tray can be retentive!
- Border molded custom tray

Final Impression - PSR

Severely Resorbed Mandible
Tiny voids with sharp edges may be filled in with Physiologic Wax. Fill voids even with surface of impression. Wax softens at mouth temperature. Leave in mouth for 1 minute to establish contour.

Criteria for Success

We can create a successful impression if we know:

- What anatomical landmarks must be captured
- How to activate the muscles
- Materials and technique
- Patient management

Evaluation of Impressions

- Stability
- Border thickness
- Tissue detail
- Tray penetration
- Folds or creases
- Surface texture
- Voids
- Retention

Upper Y  Lower Y/N

LABORATORY STEP

Bead, Box, and Pouring the Final Cast

Rubber base adhesive painted 3 mm below height of border will facilitate Beading & Boxing. All-acrylic prostheses are poured with YELLOW stone. The Final Cast is critical. Formed by Beading Wax.
**Record Base Criteria**

- Border Extension - into the full width & depth of the fold

**Record Base Criteria**

- Stability during function
- Retention

If a record base is not all of the above, visits will be challenging to the Doctor and discouraging to the pt.

...revisit your final impression...

**How do we do it?**

- Information from the initial patient exam
  - Current denture
  - Patient experience
- What we already know
  - Patient landmarks / anatomy
  - Esthetics
  - Phonetics
  - Clinician experience

**Occlusion Rims**

- Locate guidelines on the final cast
- Fabricate occlusion rims
- Adjust rims according to guidelines and then intraorally

**Maxillary Tooth Position**

- Maxillary Centrals are ALWAYS anterior to the Incisive Papilla with the facial surface approximately 6 mm in front of the Papilla.
- The remainder of the Maxillary Anterior teeth generally follow the shape of the arch.
- Maxillary Posterior Teeth are generally set slightly labial to the crest of ridge....
- To prevent cheek biting maxillary teeth should be offset approx 2mm to the buccal of the mandibular teeth. If monoplane teeth are used, as in most cases, cross bites are also acceptable to prevent cheek biting.

**Locating Guidelines Helps Determine Tooth Position**

- Midline (from the face)
- Internal Land Line
- Incisive papilla line (upper)
- Posterior crest of ridge lines
- Tuberosity lines
- Hamular Notch Line
Mandibular Tooth Position

- Mandibular anterior teeth are centered over the anterior crest of ridge.
- Mandibular anterior ridge bone resorption happens posterior to anterior.
- Mandibular teeth are set on or slightly lingual to the lower ridge crest.

**To help stabilize lower denture** and to prevent cheek biting.

The Occlusal Plane

- The VERTICAL height of mandibular posterior teeth is determined relative to the retromolar pad.
- The distal of the second molar is generally 2/3 the vertical height of the Retromolar Pad.
- This requires a frontal view.
- All four lines should line up.

Comparison of Rims

Max ant @ 22 mm
Post parallel to residual ridge

Mandib ant @ 18 mm
Post = to 2/3 height RMP

Rims must be FLAT and FLUSH

Note: the RM Pad does not appear to be divided evenly in 1/3s. That is because both pads level off at different slopes and rates.

Maxillary & Mandibular
End of Occlusal Table and Posterior crest of ridge line

We do not set teeth over the Tuberosity or Retromolar Pads
Mandibular occlusion rim is low to stabilize denture.

Mandibular occlusion rim is short to distribute stress.

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**Posterior Palatal Seal**

AKA The Post Dam

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**Definitions:**

HNL = Hamular Notch Line
   An arbitrary line connecting R & L Hamular Notches

AVL = Anterior Vibrating Line
   Junction of movable and non-movable tissue

CTL = Compressible Tissue Line
   Junction of compressible and non-compressible tissue

PPS = Posterior Palatal Seal (Post Dam)
   A bead located posteriorly on the internal surface of the upper denture which completes the border seal

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**Post Dam Clinical Technique On Patient**

- Locate hamular notches with T-ball burnisher and mark with indelible pencil.
- Place a perpendicular line on palate with indelible pencil. Observe repeated phonetic "ah".
- Scribe "ah" line (AVL) with indelible pencil.
- Insert record base and transfer AVL pencil line.
- Cut record base back to AVL.
- Palpate outline of compressible tissue.
- Draw CTL on model.

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**Post Dam Clinical Technique On Cast**

1. Score AVL transfer through both Hamular notches to ½ depth measured.
2. Score CTL transfer just enough to break surface of cast.
3. Connect CTL and AVL by tapering from zero depth at the CTL to AVL depth.
4. Blend smoothly into cast.
Postdam outline transferred to cast

Note: IPS extends past hamular notch and is BLENDED into the DB fold

3rd Clinical Visit
Inter-Maxillary Records

- Occlusal Plane
- Vertical Dimension of Occlusion
- Facebow Registration
- Centric Relation Registration
- Tooth Selection

Occlusion Rims: Clinical Adjustment

- Facial midline
- Lip fullness
- Lip length
- Smile line
- Canine line
- Phonetics (sibilants, fricatives)
- Ridge relationship (I, II, III)
- VDO
- VDR
- Flush contact @ VDO

VDO & Space

- Inter-ridge Space
- Freeway Space
- Closest Speaking Space
- The Neutral Zone
- Space of Donders

Facial midline
Lip fullness
Lip length
Smile line
Canine line
Phonetics (sibilants, fricatives)
Ridge relationship (I, II, III)
VDO
VDR
Flush contact @ VDO

Freeway Space

The Freeway Space is the space between the teeth when the mandible is at rest (VDR)

VD occurs during swallowing
VD occurs at the end of swallowing
VD occurs at the end of the “M” sound or smiling

Closest Speaking Space

- The Closest Speaking Space is the small space between the occlusal surfaces during sibilant sounds
- Teeth should not contact during sibilant “S” sounds or “clicking” of the teeth together will result
- Clicking of teeth is NOT normal and if VDO is correct, even if the patient is wearing porcelain teeth, there will be none
The neutral zone is the area where the displacing forces of the lips, cheeks, and tongue are in balance. It is in this zone that the natural dentition and flanges lie, and this is where the denture teeth should be positioned so that conflict does not occur and the dentures remain in equilibrium.

The influence of tooth position and flange contour on denture stability is equal to or greater than any other factor. This is particularly critical in patients with atrophic ridges.

Additionally, and independent of VDO... if the palate is too thick... Space of Donders will be decreased and the patient will have trouble swallowing.

The occlusal plane is determined by areas "A" and "C". "A" = Esthetics + Phonetics, "C" = Anatomy of Retromolar Pad.

These areas should not be altered to change VDO.

The VDO is determined by "A" + "B" and "C" + "D". The VDO is altered by areas "B" and "D". "B" = Sibilants with "A" and "D" = Sibilants with "C".
A mounting with a Facebow Registration on a semi-adjustable articulator permits small changes in VDO +/- 3mm without having to remount.

Bow should reflect the plane of the adjusted wax rim which should be parallel to the interpupillary line.

Pt. photo courtesy of Dr. Shervin Tabeshfar

CR vs. CO

1. For a denture patient* the first contact must be the full and final contact.
2. Although CR is defined at least 7 different ways in the Glossary of Prostodontic Terms, one thing that is agreed upon is that the position is difficult to define anatomically but is determined clinically by assessing when the jaw can hinge on a fixed terminal axis. This summary suggests that the CR position is therefore reproducible.
3. We therefore strive to mount all cases of unknown "centric"* in CR because of its reproducibility and continue to adjust ongoing cases to maintain CO=CR.
4. Key is reproducibility
5. * no habitual natural posterior stops

Discrepancy in denture occlusion will cause:

- Denture movement
- Denture displacement
- Pain
- Bone loss

95% of problem dentures have an undiagnosed occlusal discrepancy

Natural Dentition: the chin can be held during retrusion. If teeth are in dentures: the dentures must be held during retrusion.

Natural Dentition – OK
Denture – NOT OK

Index finger on buccal shelf
Thum under mandible

Always Re-Verify CR in and out of Patient’s mouth

Check for stability of bite registration
Ensure there is 1mm space in anterior

Check for Heel interference
Check for impression of notch

Tooth Selection & Arrangement

Rim Guidelines = Your RX

- Midline
- High smile line
- Canine lines
- Inter-pupillary line
- Incisal Edge Contour
Patient Analysis - Anterior

- Face Shape
- Smile Line (length)
- Canine Distance (width)
- Gender (Masculine/Feminine tooth set-up)
- Complexion (shade)
- Old Denture (likes/dislikes)
- Old Photos (graduation/wedding)
- Old Xrays
- Old Casts
- Patent Opinion / Significant Other

Then evaluate your selections intra-orally

Trubyte Rim Selector Kit

Denture Base and Custom Denture Base Shade Mixes

CLASSIFICATION OF COMPLETE DENTURE OCCLUSION

Combination

Lingual Contact Occlusion

- Anatomical (lingualized) vs Lingual Contact

Eliminate Maxillary Buccal Cusp Interferences
To eliminate additional lateral forces
The Occlusal Scheme

- Rules of Denture Occlusion:
  - No Anterior Contact in CR
  - No incisal guidance in protrusive
  - No canine guidance in lateral
  - CR=CO
- Occlusal Plane = 1/2 to 2/3 height RMP
- NO porcelain teeth unless the opposing is fixed (and even then, use caution)
- Lingual Contact Occlusion

Natural vs. Denture

- Anterior contact in CO
- Incisal guidance
- Canine guidance
- CO ≠ CR
- No anterior contact in CO
- No incisal guidance
- No canine guidance
- CO = CR
- Bilateral Balance (if anatomical)

Natural Dentition in Protrusion: Mutually Protected Occlusion or...

Complete Denture in Protrusion: Guidance

Complete Denture in Protrusion: Balance

4th Clinical Visit: Trial denture

- Verify VDO
- Verify CR
- Does CR (or CO) in patients mouth match with CR (or CO) on Articulator? (They MUST match or lower MUST be remounted to match the patient!)
- Esthetics
- Phonetics
- Patient Approval Signature (EDR)

5th Clinical Visit: Insertion

Sequence:

- Adjust upper alone
- Adjust lower alone
- Insert U/L w/o occluding
- Rehearse/record CR
- Mount lower
- Perform Patient remount- refine occlusion
- Re-polish
- Review home care instructions
- Reappoint for 1st adjustment

Complete Denture in Protrusion: Guidance

Leads to denture instability, movement and bone loss
Note “show through” in area of overextension

Using pastes @ insertion or for Ds/adjustment of sore spots

Objectives of Equilibration
- To have CO = CR
- To maintain VDO
- To distribute stress
- To retain cusp shape
- To achieve balanced occlusion
- To smooth contacting surfaces

Adjusting Monoplane Occlusion*
- Perfect lower Plane to 2/3 RMP (Area “C” & “B”)
- Adjust Maxillary (Area “D”)
- If significant adjustment is needed or to reduce VDO adjust both.
- Remember: flat adjustments. Do not create inclines or cusps!
- If incisal or canine guidance, create wear facets

Anatomical Occlusal Equilibration

Interferences
- Only one side contacts
- Posterials not in CR
- Only one side contacts
- Only one side contacts
- Only one tooth contacts
- Only anterior contacts
- Only some teeth contact or anterior are too far apart
Equilibration Sequence

1st Centric interferences
2nd Lateral interferences
3rd Protrusive interferences

Ground Rules

Maxilla is stationery - 1°
Mandible is movable - 2°

Curve of Wilson

Supporting Cusps

1º Supporting Cusps do not move
2º Supporting Cusps are movable

Grinding supporting cusps will result in loss of CO & VDO

Centric Occlusion

- Before grinding…
- Check excursions
  Right lateral
  Left lateral
  Protrusion

If Right Lateral excursion has no interference and...

If Left Lateral excursion has no interference and...
If Protrusive excursion has no interference then grind Fossa

Centric interference: grind Fossa if interference occurs only in Centric

But…

If Centric & Right Lateral excursion have interferences or…

Centric Occlusion

If Centric & Left Lateral excursion have interferences or…

Centric Occlusion

If Centric & Protrusive excursions have interferences then grind Cusp

Centric Occlusion

Centric interference grind Cusp if interference occurs in Centric & Eccentric
Centric Occlusion

Centric interference: grind Cusp or Fossa?

Centric Occlusion

Maxilla is stationary

Mandible is movable

Curve of Spee

Grinding supporting cusps can change CR or VDO

Centric Occlusion

Centric Interference Rules

Centric only: Fossa
Centric & Eccentric: Cusp

Centric Occlusion

Centric Occlusion

Centric Interference Rules

• Vertical direction:
  Centric only: Fossa
  Centric & Eccentric: Cusp

• Horizontal direction: MUDL

MUDL (Mesial of Upper, Distal of Lower Buccal cusps)
DUML (Distal of Upper, Mesial of Lower Buccal cusps)

For Horizontal interferences: MUDL

Centric Occlusion

Centric Interference Rules

• Vertical direction:
  Centric only: Fossa
  Centric & Eccentric: Cusp

• Horizontal direction: MUDL

MUDL (Mesial of Upper, Distal of Lower Buccal cusps)
Left Working (Right Balancing)

1º Supporting Cusps do not move
2º Supporting Cusps are movable

Each Supporting Cusp opposes a non-supporting cusp

Working Side

Grinding a non-supporting cusp will not change CR or VDO

Lateral

For Working interference: grind BULL
(Buccal of Upper or Lingual of Lower)

Restoration of bilateral balance
Lateral

● = centric stops
No loss of CO or VDO

Right Balancing (Left Working)

1º Supporting Cusps do not move
2º Supporting Cusps are movable

Balancing Side

There is a pair of contacting supporting cusps on the balancing side
Grinding a Supporting Cusp will change CR or VDO

Balancing Side

To maintain CR & VDO, grind only the inner incline of the Secondary Supporting cusp

Lateral

● = centric stops
● = eccentric contacts

For Balancing interference: grind only incline of BL
(Buccal of Lower)
Removal of lateral interference using 2 colors of articulating paper

● = centric stops
No loss of CO or VDO following grinding

Reason for posterior disclusion in Lateral?

Canine Guidance in Lateral

Lateral Interference Rules

- Working side: BULL
- Balancing side: BL inclines only (buccal cusp – lingual incline only)
- Canine: 1st lower canine, 2nd lower premolar, 3rd upper canine

For Canine Guidance in Lateral: grind lowers (1>2>3)
Equilibration Sequence

1\textsuperscript{st} Centric interferences
2\textsuperscript{nd} Lateral interferences
3\textsuperscript{rd} Protrusive interferences

Contact between Supporting and non-supporting cusp inclines
Buccal cusps only – There is no lingual cusp contact in protrusion

Grind non-supporting cusp inclines whenever possible
In MOST cases – 99+% - Buccal cusps only

For Protrusive interferences: grind DUML

Anterior & Posterior Balance in Protrusion
Protrusion

Reason for posterior discclusion?

Incisal Guidance

↑ Horizontal Overlap or ↓ Vertical Overlap

Cut – if denture

OR Move – if in wax

“Wear Facets”

Before

During

a = 1/2 overlap
b = 1/2 overlap
c = 1/2 bevel
d = full bevel

After

If full bevel of Lower incisal is insufficient then Upper lingual may be ground as a last resort

Protrusive Interference Rules

• Anterior: Lower wear facets
• Posterior: DUML

Final Balanced Occlusion

Post Insertion Adjustments When?

a. Whenever the patient needs you!

b. First adjustment within 48 hours

c. Follow ups 1 week, 1 month and PRN

d. Immediate denture wearers: 24, 48 and either 72 hours to 1 week. 24 hour Is REQUIRED!!!

e. Follow up adjustments depend on individual and difficulty of case
Diagnosis of Post-insertion Problems

- Sore spots
- Burning sensation
- Tongue & cheek biting
- Tissue redness
- TMJ pain
- Instability
- Interferences
- Esthetics
- Phonetics

Soreness

Complaint
- In vestibule
- At posterior of upper
- Single sore on ridge
- Generalized on ridge
- At lower lingual border
- At lower labial border

Cause
- Overextended border
- Occlusal/heel interference
- Post dam too deep
- Post dam too sharp
- Occlusal extension CO ≠ CR
- Malocclusion
- Inaccurate denture base
- Blister on tissue surface
- Excessive VDO
- Inaccurate denture base
- CO ≠ CR
- Overextended lingual border
- Excessive overbite
- Deficient guidance heel or
- Occlusal interference
- Overextended labial border

Burning Sensation

Complaint
- Anterior palate or ridge
- Bicuspid to molar
- Lower anterior ridge
- Generalized Burning sensation, not defined

Pressure on:
- Anterior Palatine foramen
- Posterior Palatine foramen
- Mental foramen
- Burning mouth syndrome?

Cause
- Excessive VDO
- Poorly fitting denture
- Failure to remove denture
- Avitaminosis
- Fungal infection

*Torn by severe resorption*

Tongue & Cheek Biting

Complaint
- Cheek biting
- Tongue biting

Cause
- Posteriors edg-to-edge
- Deficient VDO (overclosure)
- Posteriors too buccal
- Posteriors too lingual

Tissue Redness

Complaint
- Denture bearing tissue only
- Overall tissue redness

Cause
- Excessive VDO
- Poorly fitting denture
- Failure to remove denture
- Avitaminosis
- Fungal infection

Acrylic allergy (extremely rare)

TMJ

Complaint
- Pain
- Clicking
- Limitation of movement

Cause
- Excessive VDO
- Deficient VDO
- CO ≠ CR
- Arthritis
- Trauma
Instability

Complaint

- When not occluding
- When incising
- When occluding in centric

Cause

- Border overextension
- Border underextension
- Loss of posterior palatal seal
- Tissue dehydration
- Flabby tissue displacement
- Loss of posterior palatal seal
- Anteriors too labial
- Poor denture foundation
- Improper incising habits
- Malocclusion
- Flabby tissues
- Teeth too buccal
- CO ≠ CR

Interferences

Complaint

- Swallowing
- Gagging
- Clicking
- Deafness
- Muscle fatigue
- General uneasy feeling

Cause

- U posterior too long or thick
- L lingual too long or thick
- Posteriors too lingual
- Excessive VDO
- Too long or thick or moving
- Excessive VDO
- Unstable denture
- Deficient VDO
- Excessive VDO
- Malocclusion
- Incorrect VDO
- CO ≠ CR

Esthetics

Complaint

- Fullness under nose
- Depressed filtrum
- Sunken upper lip
- Shows too much teeth
- Artificial appearance

Cause

- Labial border too thick or long
- Labial border too thin or short
- Upper anteriors too lingual
- Excessive VDO
- Incisal plane too low
- Cuspid, laterals too prominent
- Poor set up
- Lack of wear facets
- Lack of custom gingiva

Phonetics

Complaint

- Whistle on “S” sound
- Lisp on “S” sound
- Indistinct “T” and “Th”

Cause

- Anterior palate too narrow
- Anterior palate too wide
- Inadequate interocclusal distance

Most Common

Problem

- Sore Throat (pt is not sick)
- It hurts when I open wide...
- My upper denture pops out when I open to bite a sandwich...
- My upper denture pops out when I bite into a sandwich...
- Something is wrong, but I can’t figure out what...
- Clicking when speaking
- Dentures are “loose”

Visual Solution

- Overextended DL Flange (in Mylohyoid space)
- DL Flange too wide – maxillary
- DL Flange too wide – maxillary
- Poor post dam
- Occlusion
- Excessive VDO
- Aphasia – usually incisal or canine guidance
ADJUSTING RIMS FOR VDO

1. ADJUST A - D
2. ADJUST B - C
3. ADJUST D
4. RIMS FLUSH

5. ADJUST B & D FOR VDR & FWS
6. ADJUST B & D FOR VDO
7. ADJUST B & D FOR SIBILANTS
8. RIMS FLUSH AT VDO
MOUNTING RIMS @ VDO

9. FACE BOW
10. MOUNT U
11. CR AT ↑ VDO
12. MOUNT L AT ↑ VDO

13. REMOVE ALUWAX
14. RAISE PIN →
   A CONTACTS B.
   RECORD PIN POSITION
15. REPLACE C & D
16. RIMS FLUSH
    AT VDO
# IMPRESSION PROTOCOL FOR RUBBER BASE vs. PVS

<table>
<thead>
<tr>
<th>Prosthesis</th>
<th>Polysulfide Rubber (Rubber Base)</th>
<th>Polyvinyl Siloxane – PVS (Aquasil) *</th>
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<tbody>
<tr>
<td>Complete Dentures</td>
<td>Custom Tray – No wax relief</td>
<td>Custom Tray – 1 layer wax relief for tissue</td>
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<tr>
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<td>Compound Border molding</td>
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<tr>
<td></td>
<td>Rubber Base Adhesive</td>
<td>Aquasil brand adhesive</td>
</tr>
<tr>
<td></td>
<td>Light Body Rubber Base</td>
<td>LV or XLV syringe into tray</td>
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<tr>
<td>Altered Cast Impressions</td>
<td></td>
<td></td>
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<tr>
<td>Partial Dentures Tooth Borne</td>
<td>Custom Tray – with tooth stops</td>
<td>Stock Tray</td>
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<td>1 layer wax relief for teeth</td>
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<td>No wax relief for tissue</td>
<td>Monophase in tray + LV in syringe</td>
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<td>Compound Border molding</td>
<td>Or</td>
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<td></td>
<td>Rubber Base Adhesive</td>
<td>LV in tray + LV in syringe</td>
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<td></td>
<td>Light Body Rubber Base-syringe and tray</td>
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<tr>
<td>Immediate/Interim Dentures **</td>
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<tr>
<th>Partial Dentures Distal Extension</th>
<th>Custom Tray – with tooth stops</th>
<th>Custom Tray – 2-3 layer wax relief for teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate/Interim Dentures **</td>
<td>1 layer wax relief for teeth</td>
<td>1 layer wax relief for tissue</td>
</tr>
<tr>
<td></td>
<td>Compound Border molding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rubber Base Adhesive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Light Body Rubber Base-syringe and tray</td>
<td></td>
</tr>
</tbody>
</table>

*Nitrile gloves must be used with PVS*

*Although Polysulfide Rubber is our material of choice for REMOVABLE PROSTHESES, When using PVS – Aquasil, please use ONLY the following material combinations:*

- **Aquasil MONOPHASE – (purple color)** This is medium body tray material. Use with restraint due to thicker consistency.
  - Aquasil LV- (teal color) This is light body tray or syringe material.
  - Aquasil XLV (yellow color) This extra light body syringe material

**PVS is CONTRAINDIATED in dentitions with:**
- Large gingival embrasures
- Cemented fixed bridges with high pontics
- Mobile teeth **