Occlusal Stability and Occlusal Therapy

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I'm sure you've taken a lot of lectures on occlusal scheme. In other words, mutually protected occlusions, canine guidance, anterior group function, bilateral balanced occlusions, etc In the case of prosthetic treatment, I think that good results can be obtained if one of the above methods is selected and applied appropriately in consideration of the doctor's preference and the patient's occlusal status. The first thing to consider before applying this occlusal scheme is the centric relation. While scholars in the past have overemphasized the importance of centric relation, it seems that the importance of centric relation is relatively less emphasized in recent years as the tendency to treat with habitual or maximum intercuspation rather than centric relation has increased. In most cases, the reason why the problem does not occur even if the patient is treated at the maximum intercuspal position is that the patient's adaptability is enough to or higher than that to withstand CO-MI discrepancy and TMJ derangement. On the other hand, in the case of patients with poor adaptability, occlusal instability causes muscle pain (Occluso-muscle disorder) and intracapsular disorder.

Most of the occlusal problem patients who visit the dentist are less adaptable, and in this case, the occlusal stability must be obtained in the centric relation. If the occlusal problem patient has degenerative joint disease in TMJ, it will be more difficult to obtain the occlusal stability. I would like to talk about the importance of the occlusal stability as a case solved by obtaining occlusal stability through the making and adjustment of splint in the prosthesis and the occlusal adjustment in the oral cavity.

Profile

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