of those malformations are longitudinal, complex and include multidisciplinary approach of different specialties.

**Clinical Procedure:** Patient was initially referred to the Department of Orthodontics, Dental Polyclinic Zagreb. She had a history of surgical treatment at the Department of Maxillofacial Surgery, Clinical Hospital Dubrava in Zagreb. Patient had a bilateral palatal and lip cleft which included the cleft of processes alveolaris and premaxilla in upper anterior region. The main complaint of the patient was personal dissatisfaction with the look of her smile and she wanted esthetic and functional correction of the teeth and occlusion. A therapy plan was created which included three phases; orthodontic, periodontology and prosthodontic phase. Orthodontic therapy lasted for 3 years and the result was beyond expectations. The therapy was conducted with fixed orthodontic appliance in both jaws, combined with intraoral appliance for maxilla expansion, quad helix (SMA). Periodontology therapy was done in two stages. The goal was the removal of excess hyperplastic mucosa and the management of keratinized tissue in the esthetic region. During the first stage, plastic surgery was done to the upper vestibular anterior region along with free gingival graft which was taken from palate region. During the second stage a tunnel technique was done with connective tissue graft in the upper anterior region to make a correction of the bilateral cleft line. After 6 months of healing, the patient was sent to the Department of Prosthodontics where upper frontal teeth were restored with all-ceramic crowns.

**Outcomes:** The clinical outcome of this multidisciplinary approach was a very successful esthetic and functional rehabilitation of the patient, who was very satisfied with the result and the confidence gained in communication with other people.

**PC116**

**Multidisciplinary treatment approach of cervical crown fracture**

G. Kavuncu1, K.N. Köse1, N. Karptitsaris2, O. Uysal2, T. Cetin2, L. Kuru2

1Istanbul/Turkey, 2Istanbul/Turkey

**Background:** Treatment of dental trauma requires detailed diagnostic examination and accurate treatment plan. It is important to consider biological, functional and aesthetic aspects. In this case report, crown lengthening procedure combined with endodontic, orthodontic and prosthodontic approaches is presented in treatment of a maxillary right incisor with cervical crown fracture.

**Clinical Procedure:** A 35-year-old female patient was referred to periodontology clinic with tooth fracture. Intraoral examination showed a complicated crown fracture with pulp involvement in maxillary right incisor. Periodontal examination revealed that fracture line was 1 mm below gingival margin buccally and at same level with gingiva lingually. There was no mobility. No alveolar fracture or root fracture was observed radiographically. A temporary root canal therapy using a calcium hydroxide dressing was kept for 14 days, until definitive root canal filling was performed by using gutta-percha points and AH Plus sealer (Dentsply). Then the tooth extruded with orthodontic treatment for 6 weeks actively, was maintained in retention for 8 weeks to avoid any relapse and to ensure remodelling of periodontal tissue. Finally 3 mm of clinical crown was evident. Crown lengthening procedure was planned to achieve a better gingival design. First incision was made 3 mm apical of gingival margin as symmetrical to left central incisor followed by sulcular and interdental incision. Full thickness flap was raised. Ostectomy and osteoplasty were performed by paying attention to biological width. Flap was closed primarily. Sutures were removed 1 week later. The tooth was successfully restored with all ceramic crown (Ivoclar, Vivadent, Schaan, Liechtenstein) 6 weeks after removal of sutures.

**Outcomes:** At 6 month follow-up, periodontal tissues around teeth were healthy. No relapse or complication was observed. Multidisciplinary approach involving endodontics, orthodontics, periodontics, and prosthodontics is a unique method in obtaining functionally and aesthetically successful rehabilitation of complicated crown fracture.

**PC117**

**Multidisciplinary treatment of a complicated crown-root fracture: a case report**

M.H. Akkaya, E. Yaprak, B. Zengin

Kocaeli/Turkey

**Background:** Traumatic tooth fractures in the permanent teeth are mostly seen in maxillary incisors. Fractures in anterior region causes some aesthetic, psychosocial, functional and therapeutic problems. The aim of this paper is to report the treatment of a maxillary anterior tooth with a severe fracture extending to the alveolar bone.

**Clinical Procedure:** A systemically healthy 17-year-old male patient was referred to Kocaeli University Faculty of Dentistry with complaint of tooth fracture due to a car accident. Clinical and radiographic examinations revealed the presence of a complicated crown-root fracture at the buccal aspect of the upper left incisor tooth. The surrounding gingiva was quite inflamatory and probing depth was 7 mm associated with the fracture. Following the phase I periodontal therapy and root canal treatment, a mucoperiosteal flap was elevated. All tissue remnants were removed. Missing dental tissues were restored with composite filling material, preserving the biological width during the surgery. The patient was scheduled for a follow-up period.

**Outcomes:** The patient was satisfied both aesthetically and functionally at the end of the treatment protocol. There was no clinical sign of periodontal and periradicular pathology during the 6 months follow-up. All periodontal parameter scores were within the accepted limits. This report presents successful treatment of a crown-root fracture case in an anterior tooth. Although the management of this kind of defects with multidisciplinary approach is complex and time-consuming, this approach seems more conservative and economic comparing with other treatment alternatives including implant therapy.

**PC118**

**Multiple coronal advanced flap: frontal approach. A case report at 7 years**

B. Morandi1, M. Di Stefano1, M. De Sanctis2

1Milan/Italy, 2Milano/Italy

**Background:** Abstract: Gingival recession are common diseases in adult population (Serino et al 2004).They are seldom localised at buccal surface in high hygienic standard population (Loe et al 1992). When time passes by, recessions get worsed and worsed (Agudio 2009) and are often associated with hyper-sensitivity (Rees & Addy 2002), non curious cervical lesions (Pini
Prato et al 2010) and root cavities (Bignozzi et al 2003). This paper was meant to describe a simple and highly predictable surgical technique for the treatment of frontal multiple recession defects (Zucchelli & De Sanctis 2007). Results are presented at 7 years.

Clinical Procedure: Introduction: A 35 years old man, Asa 1, Philosophical psychologic profile (House 1950) presented Miller Class I multiple recession on upper anterior teeth. Inter-proximal clinical attachment was conserved -RT 1- (Cairo et al. 2011). The entire technique is well documented step by step, from first incision to half-full-half thickness incisions. From surgical papilla creation to final suture.

Outcomes: Conclusion: The presented microsurgical technique (Zucchelli & De Sanctis 2007) without the need of any graft or vertical incisions demonstrated simplicity and predictability. Medium terms results (7 years) are discussed.

PC19

Multiples Miller Class III gingival recessions in the anterior mandible zone treated with coronally advanced flap and sub epithelial connective tissue grafts: two cases reports

M.M. Fernandez, M.L. Pasart

Buenos Aires/Argentina

Background: Society has changed over the many years of its existence and so has dentistry treatments. Nowadays in clinical practice it is more frequent to diagnose multiple gingival recessions not only due to periodontitis but also because of orthodontic treatments, mechanical factors and others. The aim of this case report is to describe in two different patients, a surgical approach for improving root coverage in Miller Class III gingival recessions in the anterior mandibular teeth.

Clinical Procedure: Two healthy women of 24 and 50 years old came to our clinic searching for treatment to improve their clinical conditions. Both were non-smokers and presented multiples gingival recession Miller Class III in the lower anterior teeth. They also complained about having hypersensitivity. After non surgical periodontal treatment, the two patients were treated with the coronally advanced flap technique associated with subepithelial connective tissue grafts and enamel matrix derivatives. At baseline and at 18 months after surgical treatment, the following parameters were recorded: plaque index (PI), probing depth (PD), clinical attachment level (CAL), recession depth (RD), biotype and the presence of keratinized tissue apically to the recession.

Outcomes: Successful root coverage and esthetic outcomes can be reached with this surgical technique, together with gingival thickening and establishing adequate function. The coronally advanced flap associated with connective tissue grafts results an efficient and predictable treatment to achieve root coverage and esthetic results in deep multiple gingival recessions Miller Class III, in the mandibular anterior zone.

PC120

New suspensory suture technique with anchor at the contact point for periodontal and implant plastic surgery: suspensory suture with pulley at the contact point

C. Godoy1, E.G. Javer2, R. Jorquera1, E. Lozano3, J. Basualto1

1Providencia/Chile, 2Santiago/Chile

Background: This suture technique helps to improve the adaptation and stabilization of the flap, maintaining its coronal displacement, designed for the tunneling technique and its modifications.

Clinical Procedure: An anchor will be made to the contact point in relation to the teeth involved in the surgery, from vestibular a loop is created with the suture towards the palatine below the contact point and then traction in pulley towards coronal and end knotting in the palatal incisal area, thus displacing the tissue, stabilizing it in its new position during the first days of healing, critical moment for any flap and graft procedure. First an anchoring point is created, it is located in relation to the involved teeth contact point, being able to be in composite or a pre existing splint. Beginning in vestibular, the needle is carried from incisal to apical taking the flap in relation to the papilla base, maintaining entry and exit in margins of keratinized gum without taking peristeme, leaving the short end facing incisal. Then the needle goes from tail under the contact point or splint towards palatal without passing through the connective tissue or papilla, it is returned in the same way to vestibular leaving a loop in palatal side, the needle then goes over the contact point passing to through the loop returning then to take the short end that we left in vestibular side, to finally pull coronal, ending the knot in the palatal incisal side.

Outcomes: This new suture design is simple and easy to apply achieving a lasting coronal displacement and stabilization, allowing adequate early healing of the tissues in the tunneling technique procedure.

PC121

Nine-year results of deep Miller Class I and Class II gingival recession defects treated with platelet-rich fibrin (PRF): a case report

E. Kayan1, B.C. Uzun2, C.Z. Koyuncuoğlu1, M. Tunali1, E. Firatli1

1Istanbul/Turkey, 2Manisa/Turkey

Background: Platelet-rich fibrin (PRF) belongs to a second generation of platelet concentrates, with simplified processing and without biochemical blood handling. Its chief advantages include ease of preparation and lack of biochemical handling blood, which makes this preparation strictly autologous. Despite the fact that PRF is widely used for the treatment of gingival recession defects, its long-term effects on the width of attached gingiva and gingival keratinization are still unclear. The purpose of this case report is evaluating the long-term clinical outcomes of deep Miller class I and class II gingival recession defects treated with PRF membrane.

Clinical Procedure: A 34-year-old female patient was referred to our clinic with deep gingival recessions in the mandibula localized at 43 and 44 teeth regions. Clinical diagnosis of the regions with vestibule Miller class I and class II gingival