



Practical Removable Prosthodontics  
in  
Ageing Patients

Finlay Sutton





complete denture construction protocol is based on the guides published by the British Society of Prosthodontics in 1996. These are as relevant today as when they were first published. The guides can be found at: <https://www.bsppd.org.uk/About/1996-Patient-Guidelines.aspx>. It is relevant to refer to these Guides in Prosthodontic Dentistry as well as these instructions. We attempt to give the patient "odontic privacy". A phrase created by Dr John Besford, whereby only the patient and treating prosthodontic team know that the patient has prosthetic teeth.

**Removable prosthodontics is not easy**  
Complete denture prosthodontics is not easy and takes effort and graft to get good at it. Like anything in life worth doing – it is hard, but it's definitely worth the effort.

**The most important factor in delivering successful dentures**  
Technical factors are extremely important but are not the most important factor in delivering successful dentures. Patient's education and understanding of their role is the single most important factor in the success of dentures.

Finlay Sutton and Rowan Gerstang 2018

the pairing and the treatment team as a co-production – the patient assuming responsibility for choosing between the treatment options offered and playing the leading role in making aesthetic decisions. Distinctions are drawn between the idealised white, "nobody-in-particular", attention-seeking denture at one extreme, and the highly personalised, discreet and naturalistic denture at the other. Reproducing nature in this way is time consuming and therefore expensive, but many denture sufferers see it as good value. Methods for creating the latter, which through its very normality switches off the social observer's attention, are explained in detail in papers two and three of this series. These papers are designed to help clinicians and technicians involved in providing removable prosthodontics improve the appearance of their dentures and increase their patients' aesthetic satisfaction. They are not scientific articles in the Popperian sense of advancing theories which are capable of being falsified. Instead, they are an amalgamation of 22 years of combined experience in providing removable dental prostheses. We have found this branch of dentistry immensely interesting and have been very fortunate to have had the satisfaction of seeing our patients' lives changed for the better.

**Introduction**  
"Of course, dentures are essentially social appliances." Prof Chif Chaitin

**The predicament of the denture patient**  
When approaching the subject of dental prostheses for patients for whom fixed restorations are not a practical or even a best fit option, the authors believe that it is important to consider the life circumstances of people who have lost many or all of their natural teeth. This is not only because of conventional reasons advocating holistic dentistry – "treat the whole patient, not just the mouth" – but also because the day-to-day experience of people who wear complete dentures (or nearly complete partial dentures) are radically different from those of

our denture patients. Although denture patients may be concerned about the appearance of their natural teeth, some being fed their teeth are too irregular, too dark, too worn down, have unwanted diastemas, etc., at least they still have their own teeth. In contrast, those obliged to wear dentures have often been subjected to more anxiety-producing, lab-reconstructing and potentially humiliating experiences than denture patients.

People deprived of all or most of their natural teeth, because of dentistry or the lack of it, often feel guilty. "They believed they have lost one of life's battles and it was their own fault" (which is often not the case). In addition to this symbolic loss and feeling of failure, denture wearers may live in constant fear of a variety of practical scenarios that their denture could be seen to move in their mouth while speaking or eating, or worse still get knocked out of it by a collision in a public place, that it may fracture, that it may get moulded while they are in hospital (especially when asked to remove it for an operation requiring a general anaesthetic), or that while on holiday swimming, etc.

There when the full consensus of their speech is degraded by it, or they think it looks artificial. Many denture wearers also suffer chronic discomfort, loss of biting and chewing power, leading to restricted choice of food and the need to turn down invitations to restaurants and especially to meals at other people's homes, when they cannot choose "safe food". These denture wearers can be called "denture sufferers" to distinguish them from the many who manage to cope. Many complete denture sufferers find inhibited with their sexual partners, their mouths becoming effectively a "no go area". Such common problems may be additional to any aesthetic shortcomings which they feel their artificial teeth and gums display.

The reasons for our mentioning these other problems here is that dentists who do not regularly treat partly or totally edentulous people may be unaware of the extent of the to which denture sufferers can sink or, correspondingly, the subtle laughs to which they can be treated again by being provided with teeth which are comfortable, stable, permit satisfactory speech and mastication,

BRITISH DENTAL JOURNAL | VOLUME 224 NO. 7 | JANUARY 12 2018  
Official Journal of the British Dental Association

# RESOURCES

record rim. Not only are the impressions important for producing dentures with maximum retention, stability and support, but their extensions and the thickness of their borders have a decisive influence on lip support and profile. This article shows how the contours of the definitive impressions and the wax rims are developed so as to prescribe the overall form of the replacement gums and teeth. Properly trimmed rims are in essence an early three-dimensional rehearsal, an opportunity for developing the patient's preferred lip support and natural positioning of the denture teeth at subsequent stages. They can also give an early indication of what speech will be like with the new dentures. Without the 3D clinical information, laboratory technicians have to guess where to put the teeth and have little option but to fall back on the stereotypes of their textbook training.

**Denture fabrication**  
"Of course, dentures are essentially social appliances." Prof Chif Chaitin

It is outside the scope of these articles to provide a step-by-step guide to state-of-the-art complete denture construction. However, producing complete dentures which look wonderful in position if they are unworkable owing to poor fit and function. To have a chance of working well in the physical sense, dentures must have sufficient stability for the patient not to be constantly reminded of their presence. And for that dentures must rely on their fitting surfaces, polished surfaces and occlusal surfaces being optimally shaped and positioned for each individual tooth.

The reasons for our mentioning these other problems here is that dentists who do not regularly treat partly or totally edentulous people may be unaware of the extent of the to which denture sufferers can sink or, correspondingly, the subtle laughs to which they can be treated again by being provided with teeth which are comfortable, stable, permit satisfactory speech and mastication,

BRITISH DENTAL JOURNAL | VOLUME 224 NO. 8 | FEBRUARY 9 2018  
Official Journal of the British Dental Association

the Clinician as the first technical officer is outlined. The use of immediate replay video technology in allowing a patient to see what the trial denture really looks like is described. It is vital that the patient is completely happy with its appearance in every detail before denture is finished. Dealing with post-fitting aesthetic problems is considered.

**The materials of denture teeth**  
"Of course, dentures are essentially social appliances." Prof Chif Chaitin

**Porcelain teeth vs teeth of various resins**  
Through some practitioners prefer to use porcelain teeth, the majority of dentures are made with resin teeth. The principal reasons for this are: 1) that resin teeth are standard in most dental schools and colleges; and 2) that porcelain teeth have to be mechanically related in denture base materials, and their retention features, give an anterior and better in posterior, must be maintained to allow retention. This latter requirement prevents substantial grinding of the neck and back of the teeth where space is limited by a large ridge or replace/overdenture attachments, or too little inter-ridge space. In these circumstances resin teeth are necessary because they bond chemically to the acrylic denture base material. Apart from that, porcelain disadvantages as a denture tooth material - its brittleness when teeth include, their relative brittleness if a denture is dropped onto a hard surface and their abrasiveness when unglazed porcelain (ground or worn) opposes natural teeth - are thought to merit care to outweigh the advantages of extreme stain resistance and significantly greater wear resistance which porcelain teeth have. They are usually more expensive, too, since various stages of their manufacturing have not yet been automated and have to be done by hand. Any post-purchase surface characteristics, such as staining, crack lines, etc. require the use of a porcelain brush. Few clinics have immediate access to such being kits, which makes the addition and removal of characteristics more difficult for the patient to control.

Initially, the poly-methyl methacrylate (PMMA) resin used to make denture teeth were relatively soft and subject to rapid attrition and abrasion. However, improvements in chemistry and manufacturing have been continuous and today's resin teeth are harder and more stain resistant than before. Composite resins are used in some studies to improve wear resistance especially of posterior teeth, though these materials are more prone to staining and being chipped. Also, because of their filler particles, composite resins are also less translucent, which has a negative influence when processed facial edge translucency is required in the outer enamel layer. Composites is therefore more useful in posterior teeth.

**Choosing denture teeth for complete dentures**  
**Anterior teeth**  
When a dental clinician considers front teeth and shows them in the laboratory wax bite, a small procedural, positive evidence is being thoughtfully displayed. These teeth would have become a great help in the selection of denture teeth for any future dentures. They are not useful for shade selection because teeth undergo marked colour changes as they dry out, but in every other respect - size, shape and surface detail - they cannot be improved on as records of the natural dentition. We therefore advocate that dental practitioners wash extracted teeth, pack them loosely in some suitable small container and offer them to the patient to keep for reference as new dentures are made in the years to come. No doubt some patients will find the idea distasteful and decline the offer, but many patients will see the good sense of not simply throwing away these valuable personal

BRITISH DENTAL JOURNAL | VOLUME 224 NO. 7 | APRIL 12 2018

# RESOURCES

Full access PDF to my published scientific papers which explain my philosophy and clinical techniques:

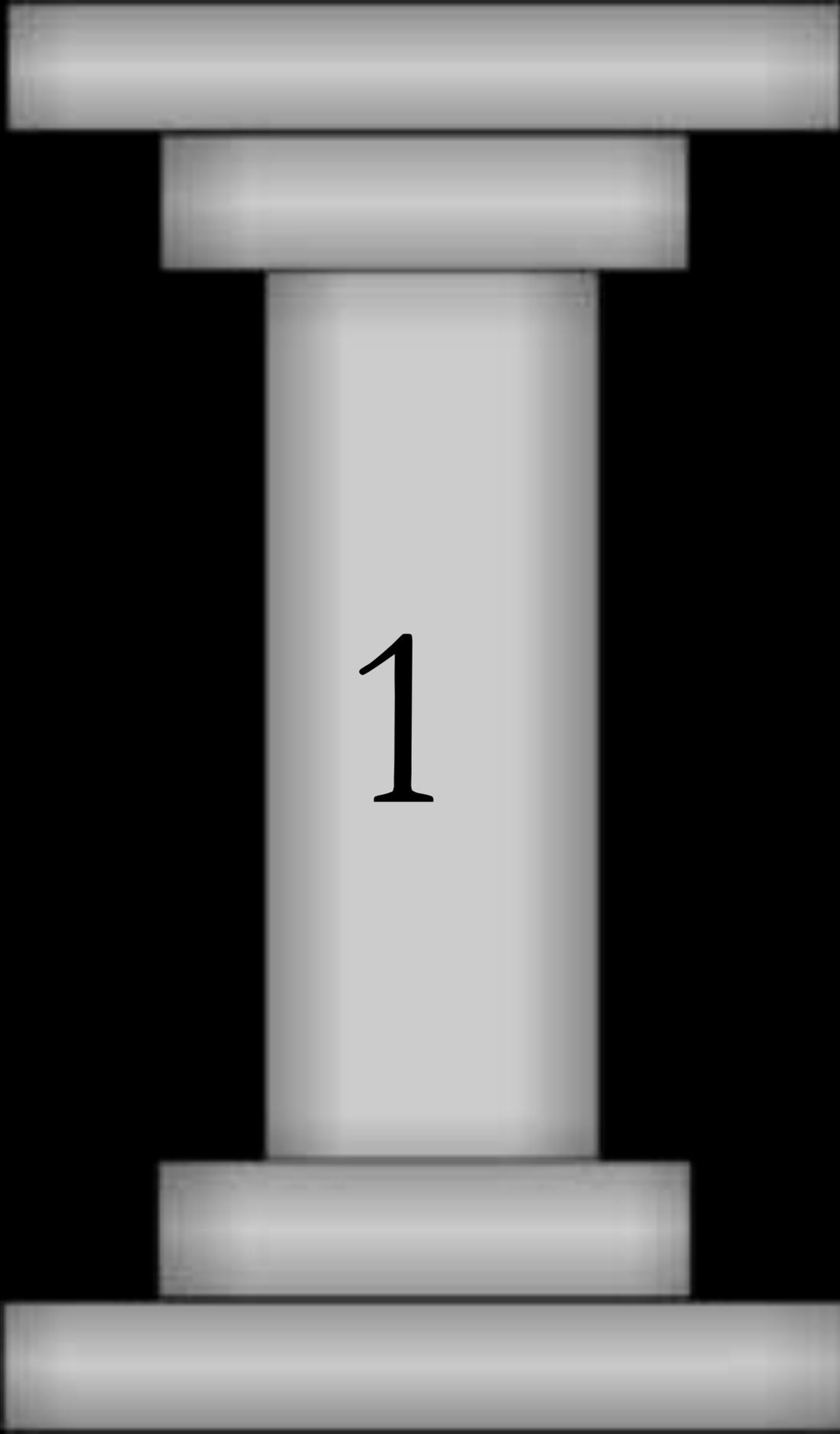
TC White Symposium 2020 - Practical Removable Prosthodontics in Ageing Patients Finlay Sutton 

References for TC White Symposium 2020 Practical Removable Prosthodontics in Ageing Patients Finlay Sutton 

References to go with my full membership presentation for the British Academy of Aesthetic Dentistry (BAAD) – Thursday 15th October 2020

PDF of Finlay's full membership presentation for the British Academy of Aesthetic Dentistry (BAAD)

Aesthetic possibilities in removable prosthodontics. Part 1: the aesthetic spectrum from perfect to personal John Besford and Finlay Sutton



1

Technician



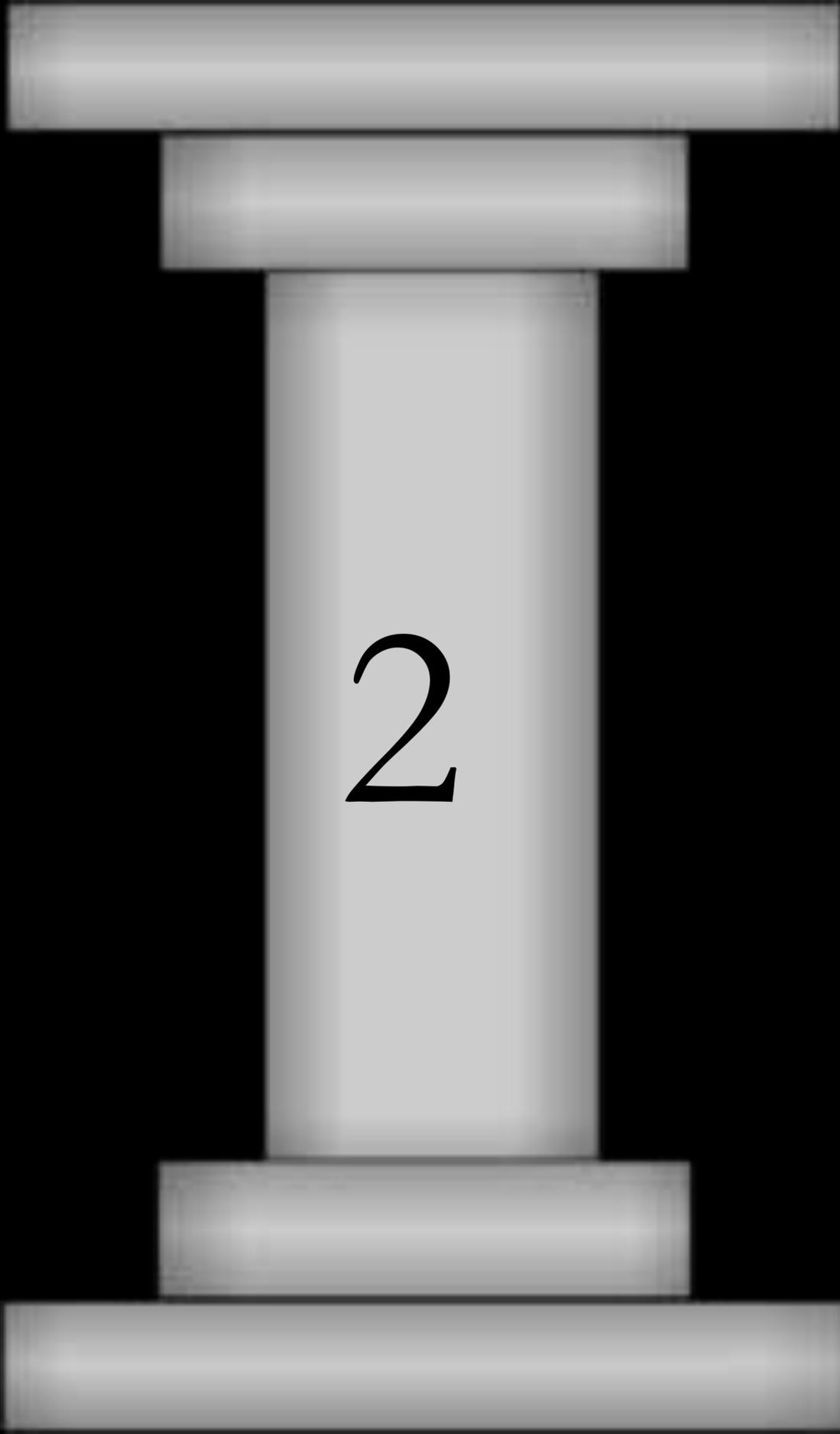
Rowan Garstang



Sam Hesketh

Removable prosthodontics

is difficult



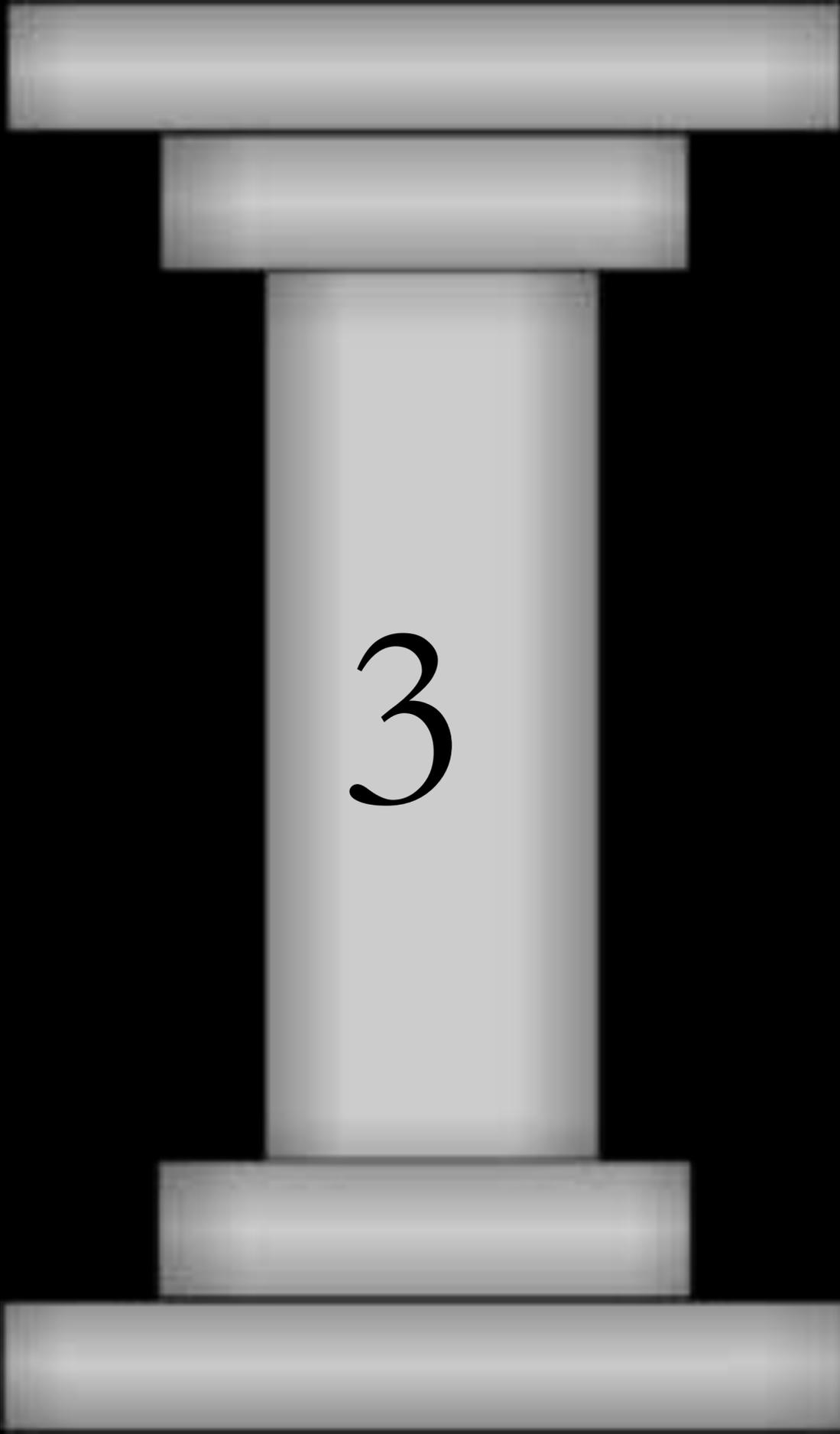
2

Mentor



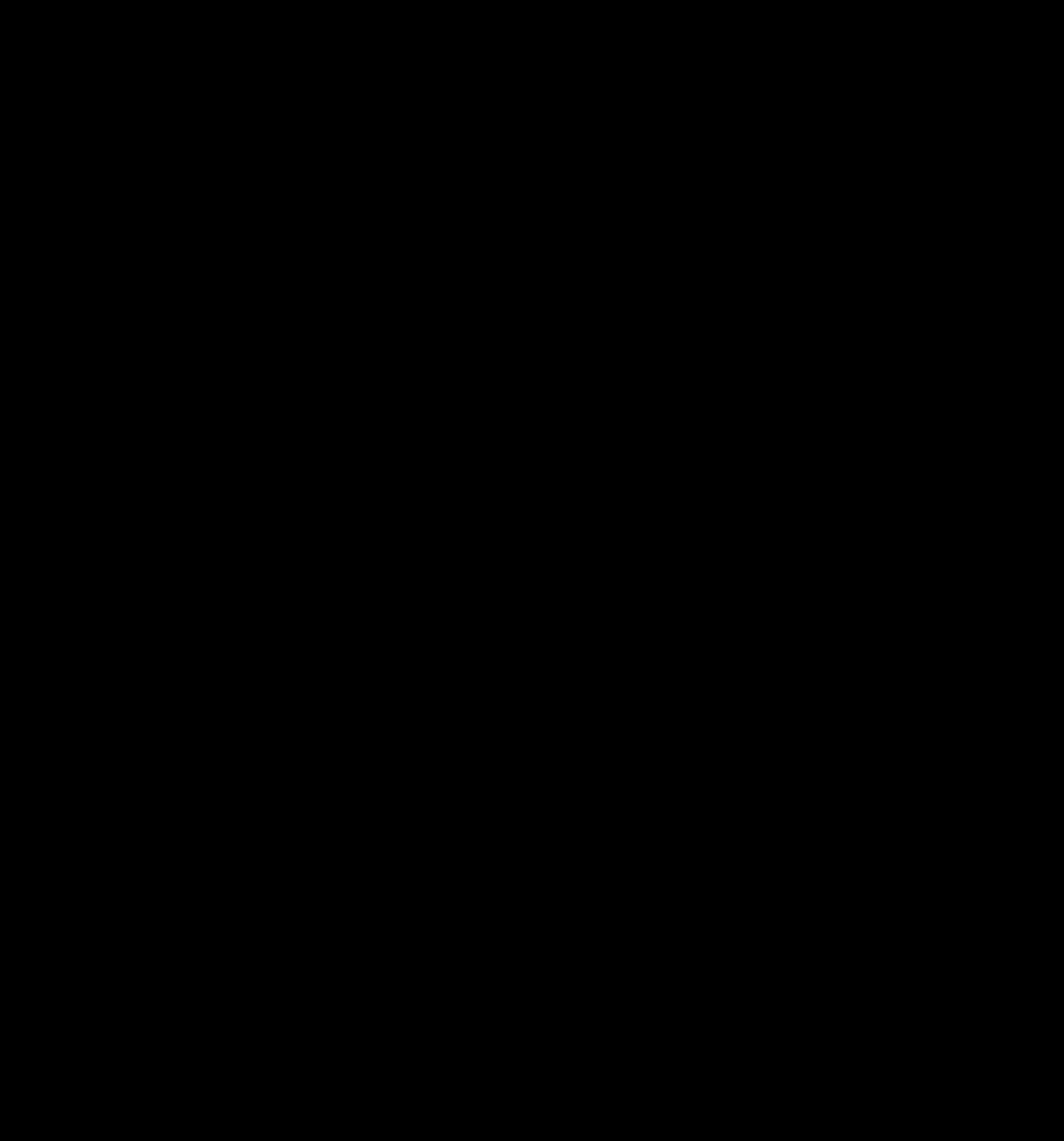
Dr John Besford

My mentor



3

Dentate  
photographs







Increased stability





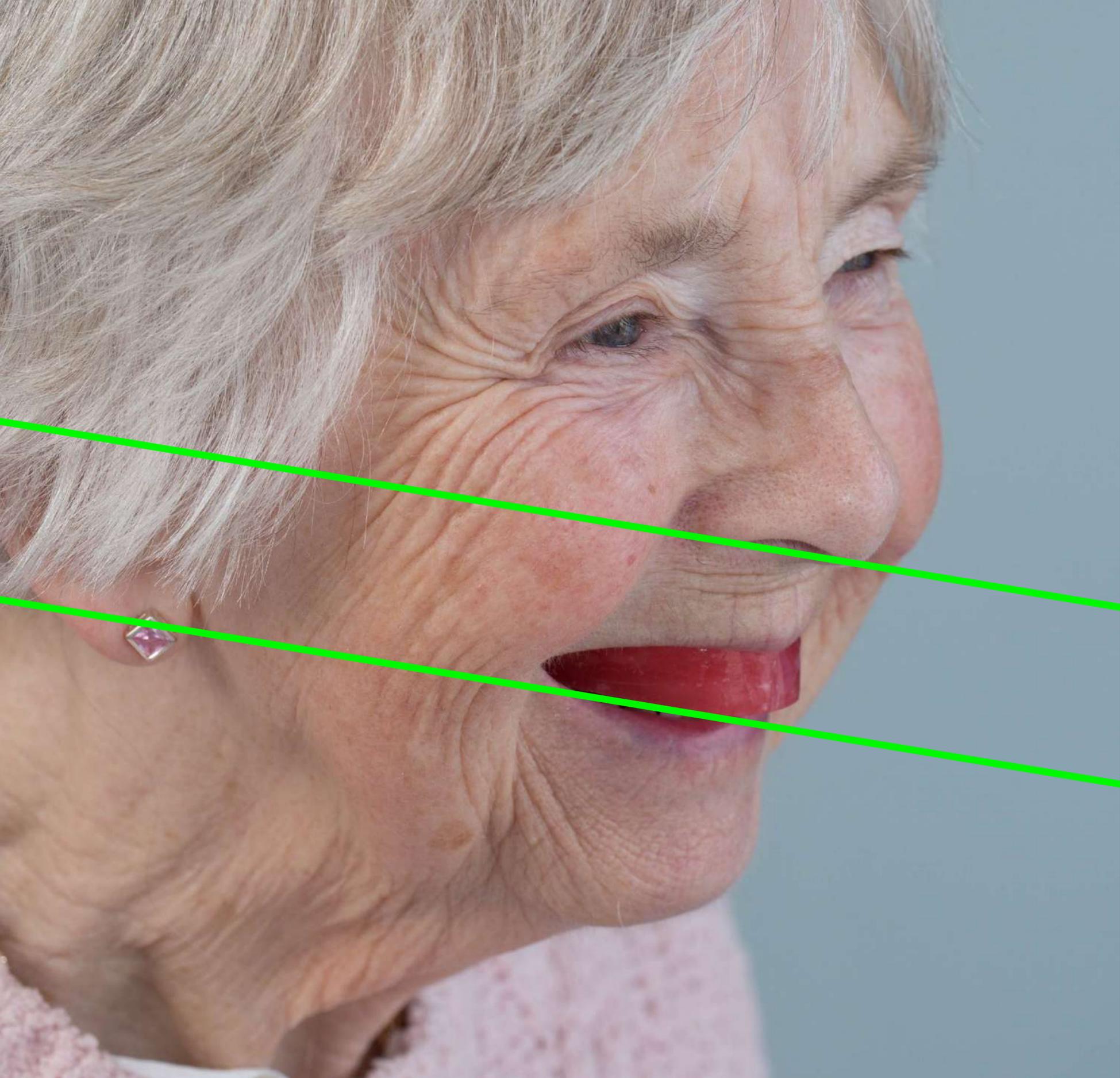


# 1. Lip Support



## 2. Incisal plane



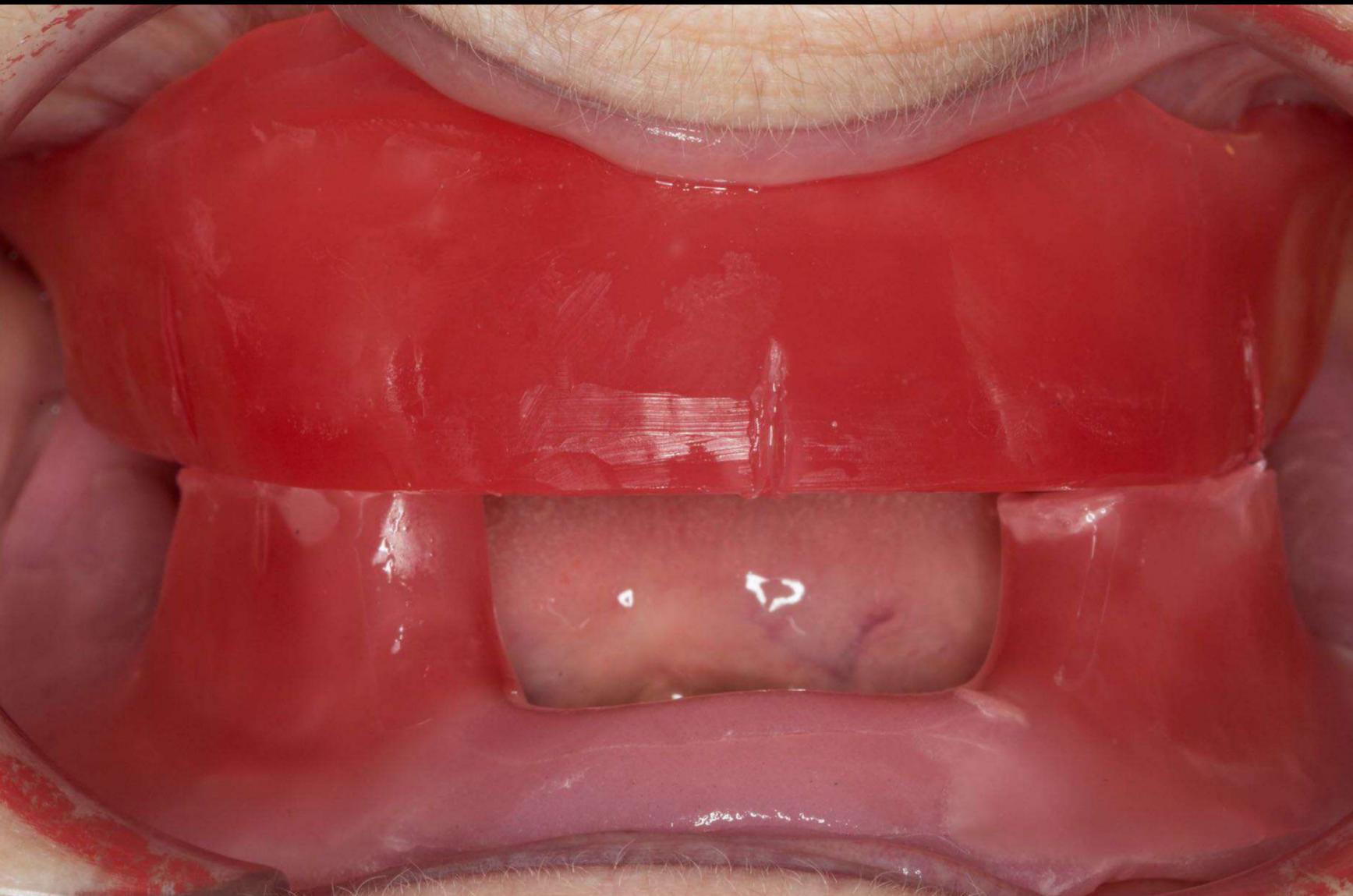


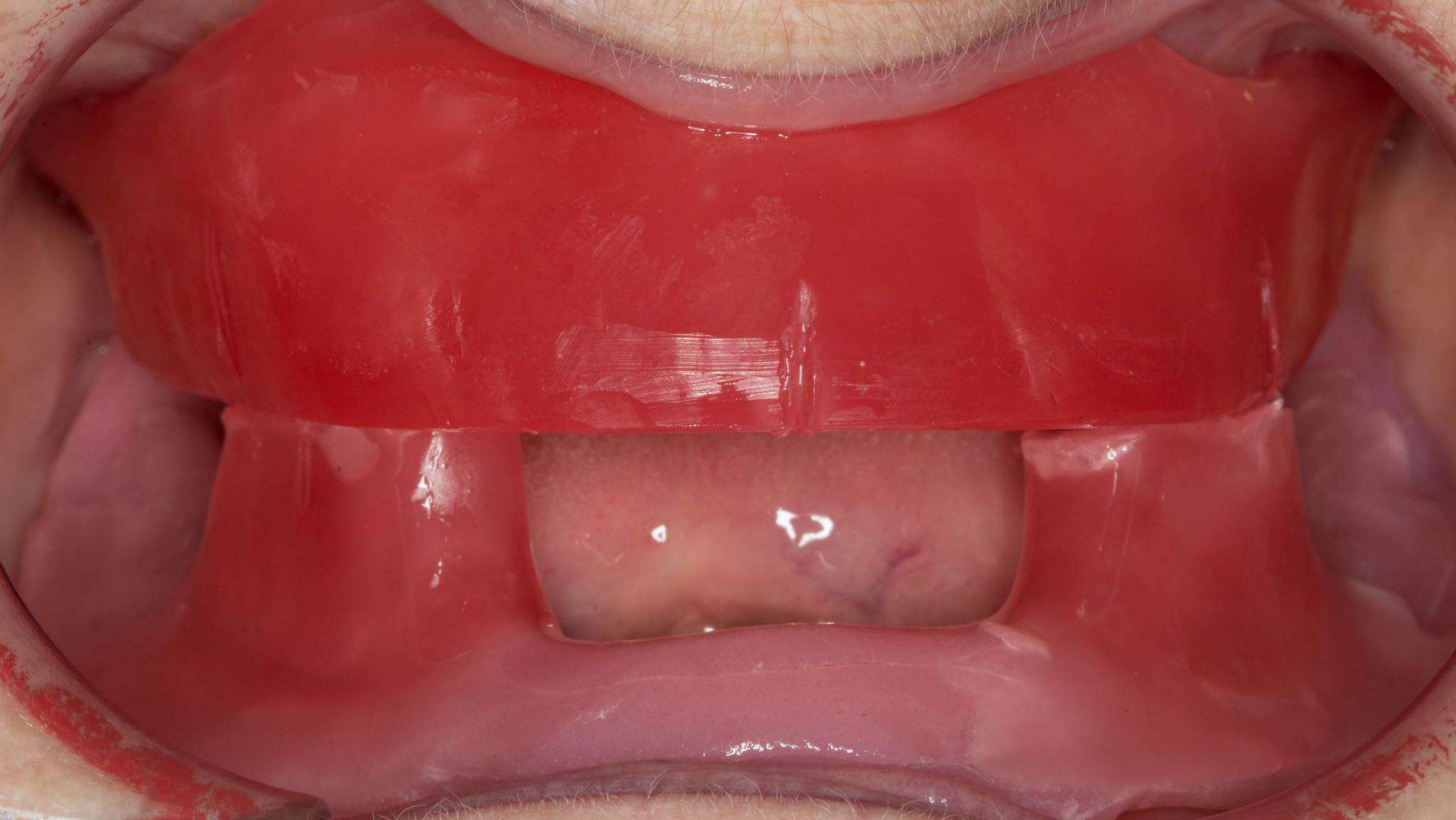
3. Occlusal plane



4 & 5 Buccal corridors and centre line

# 6. Occlusal Vertical Dimension





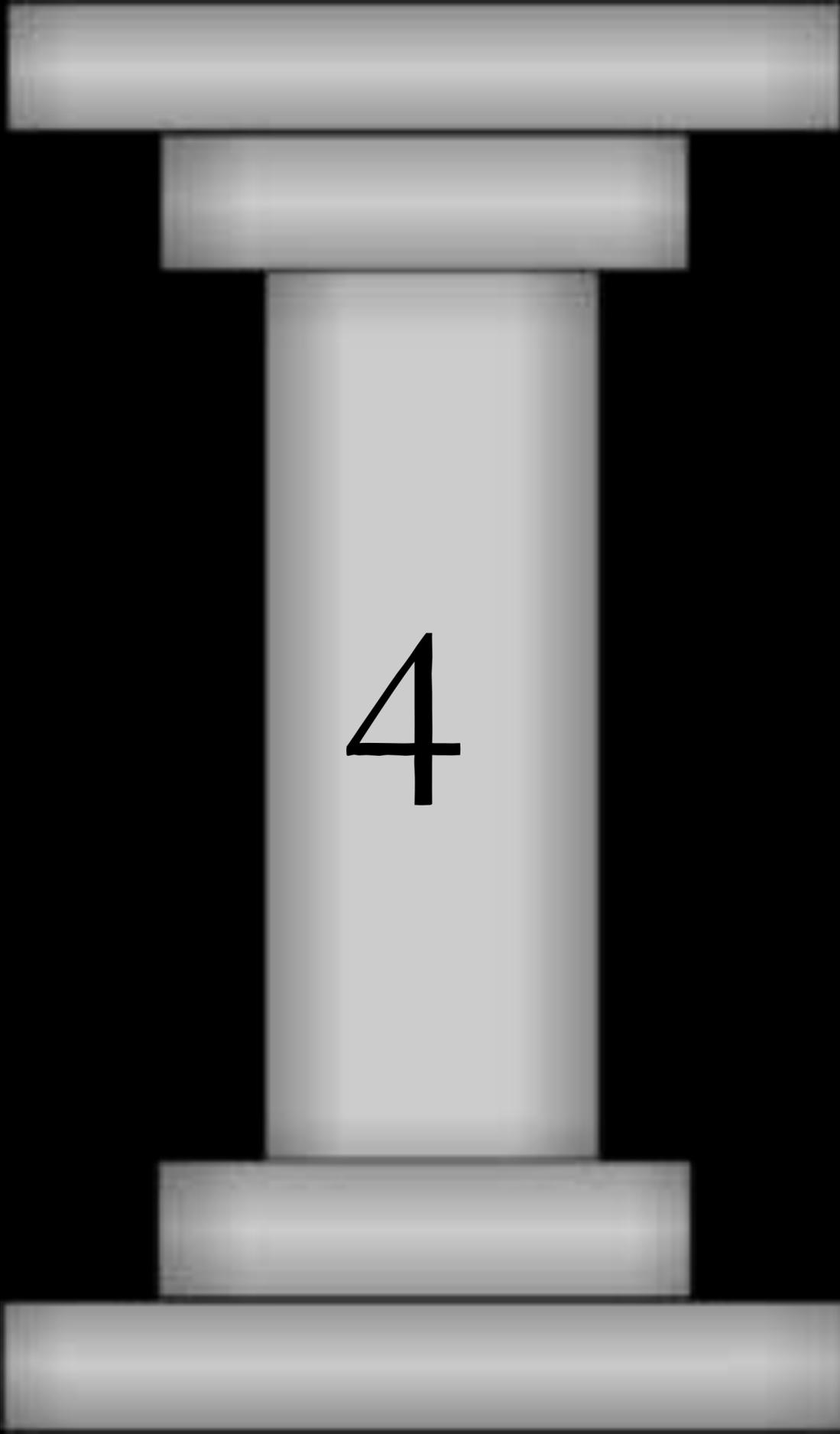












4

Impression  
making











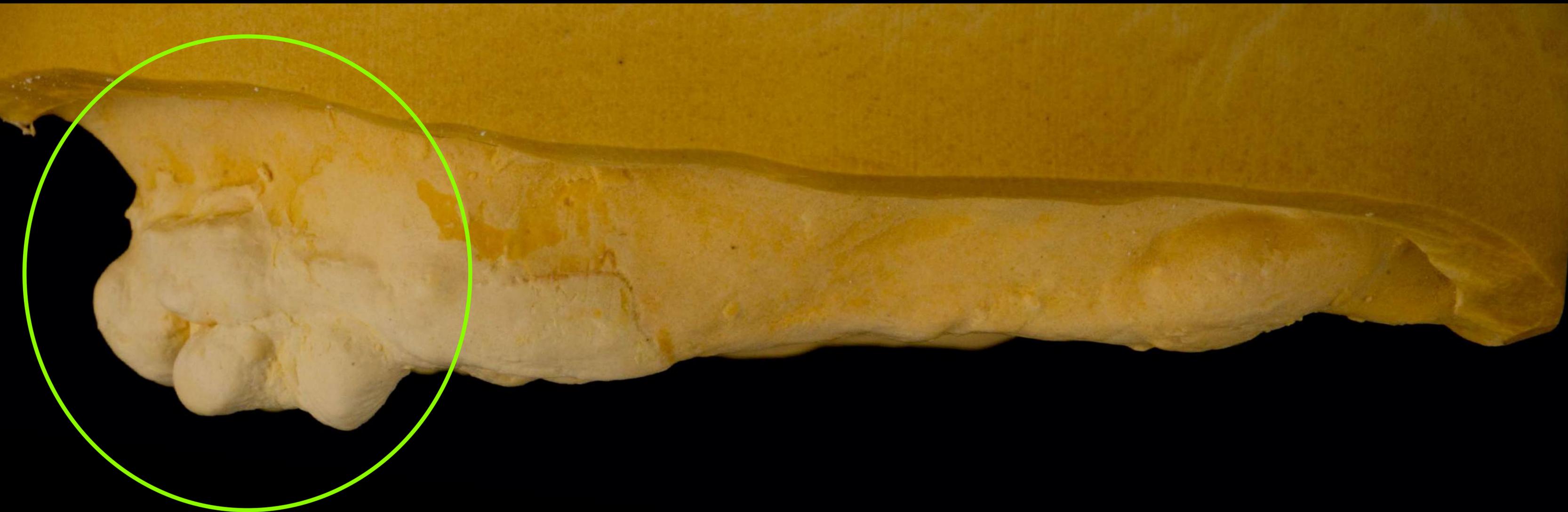


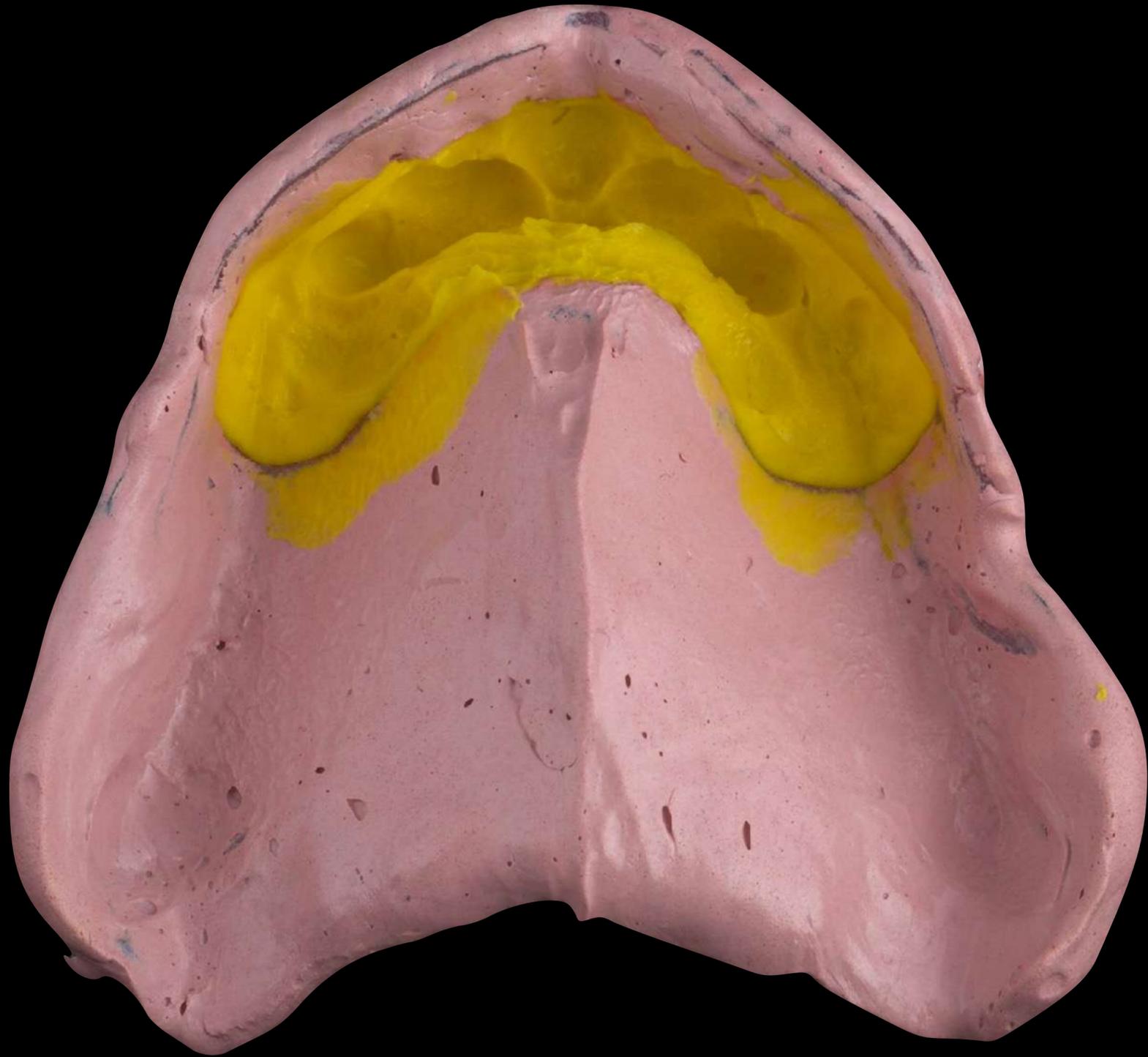














Fast x 8





Shape



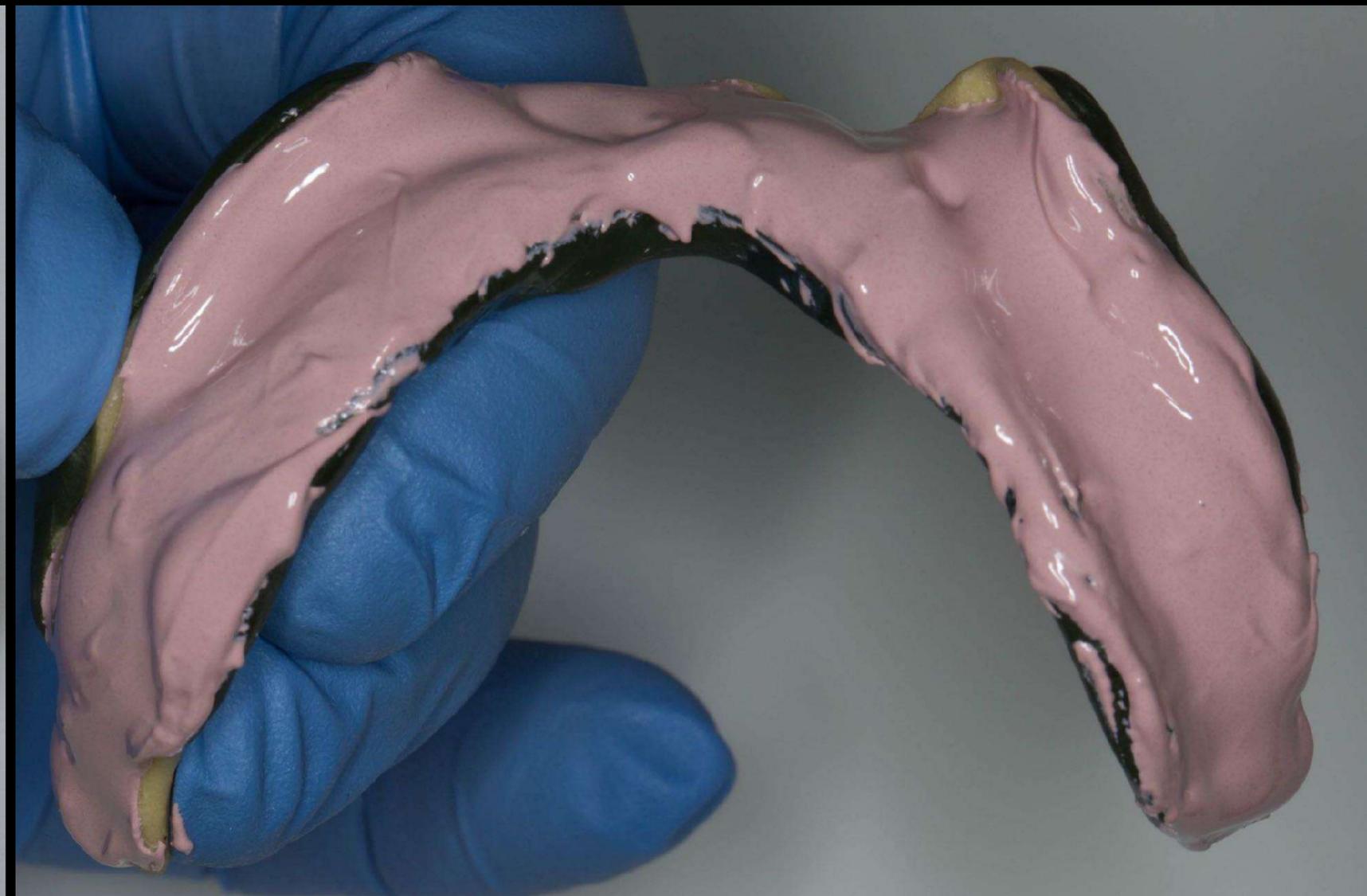














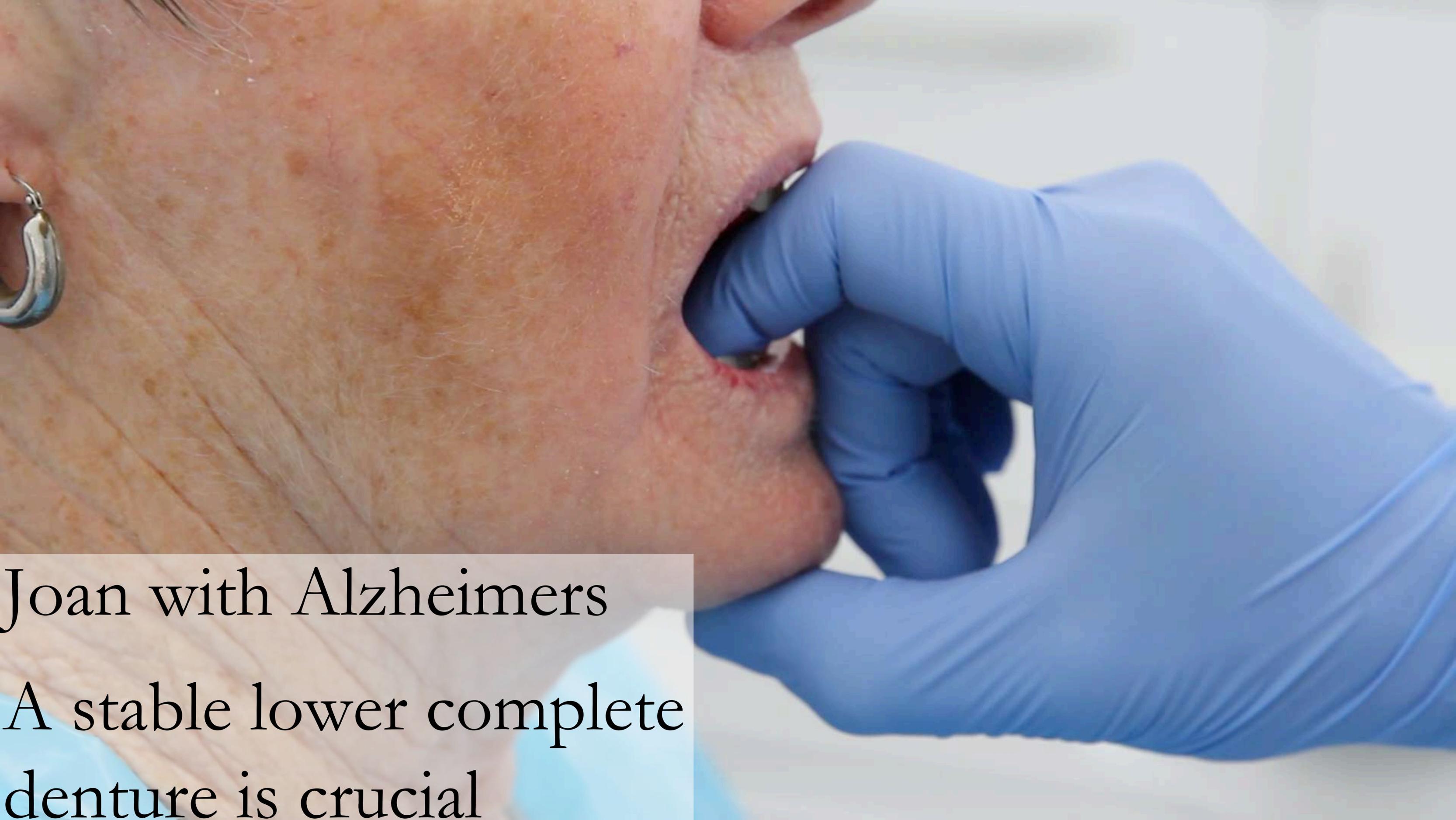






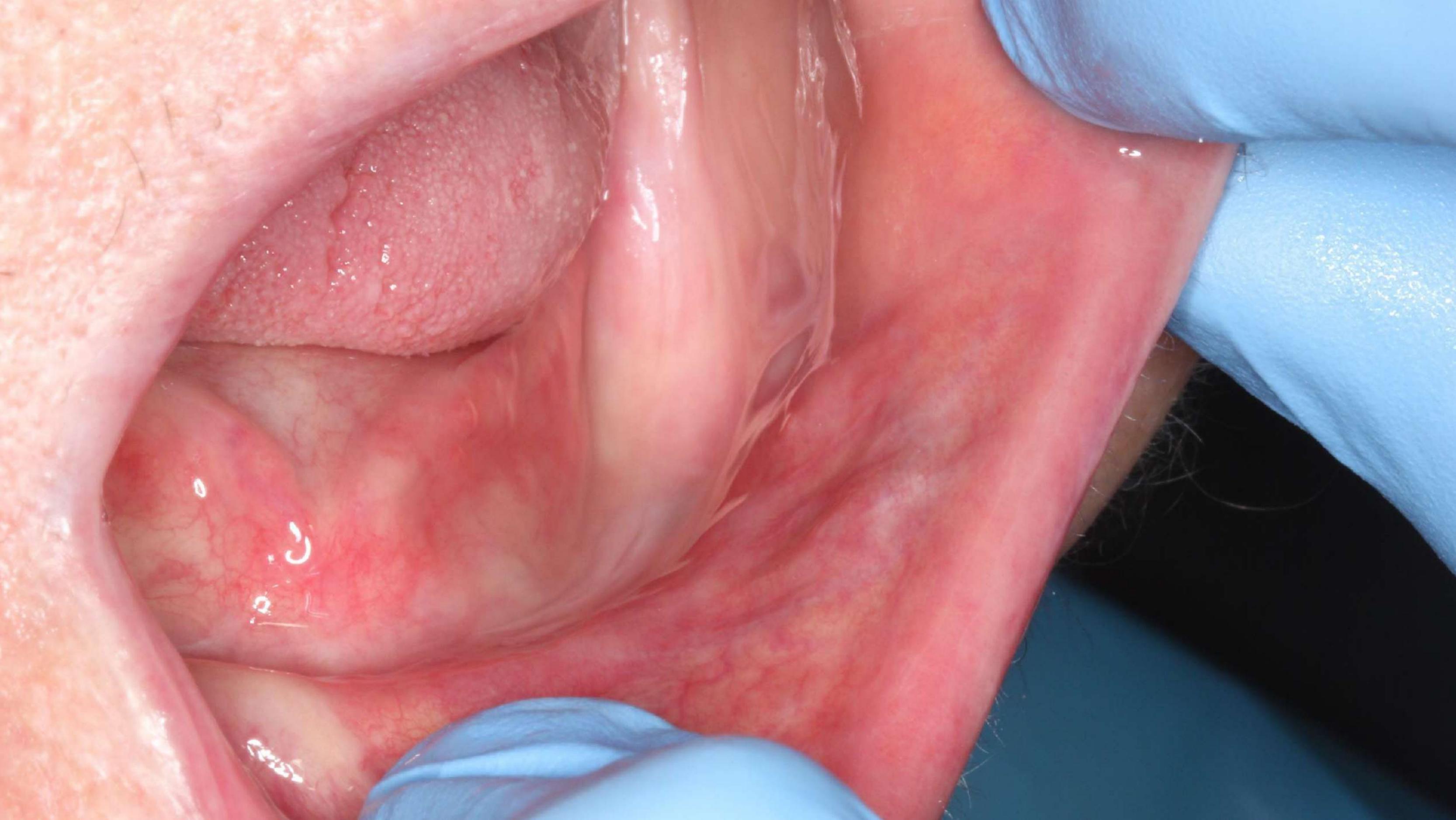






Joan with *Alzheimers*

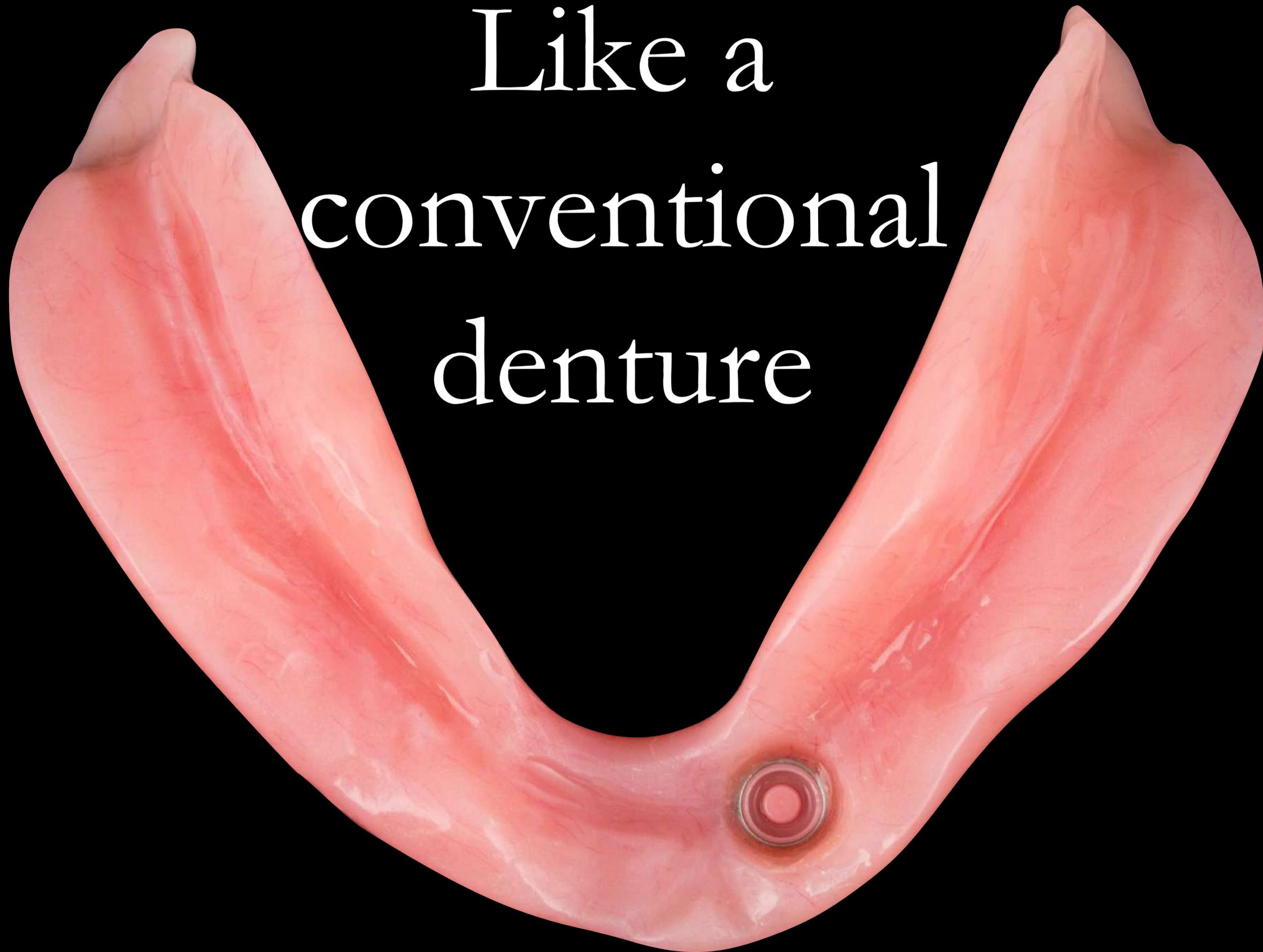
A stable lower complete denture is crucial





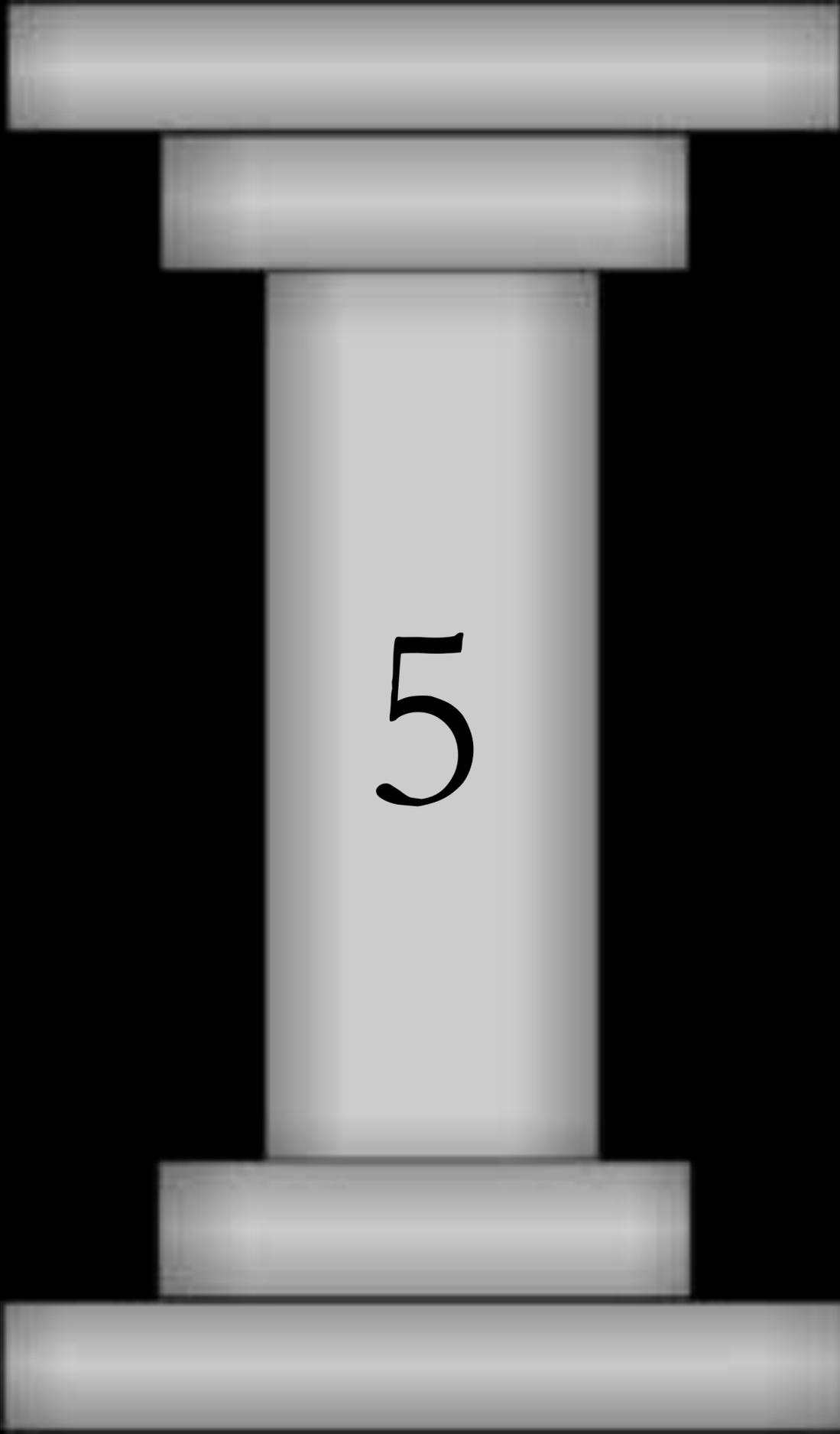


Like a  
conventional  
denture



Like a conventional denture





5

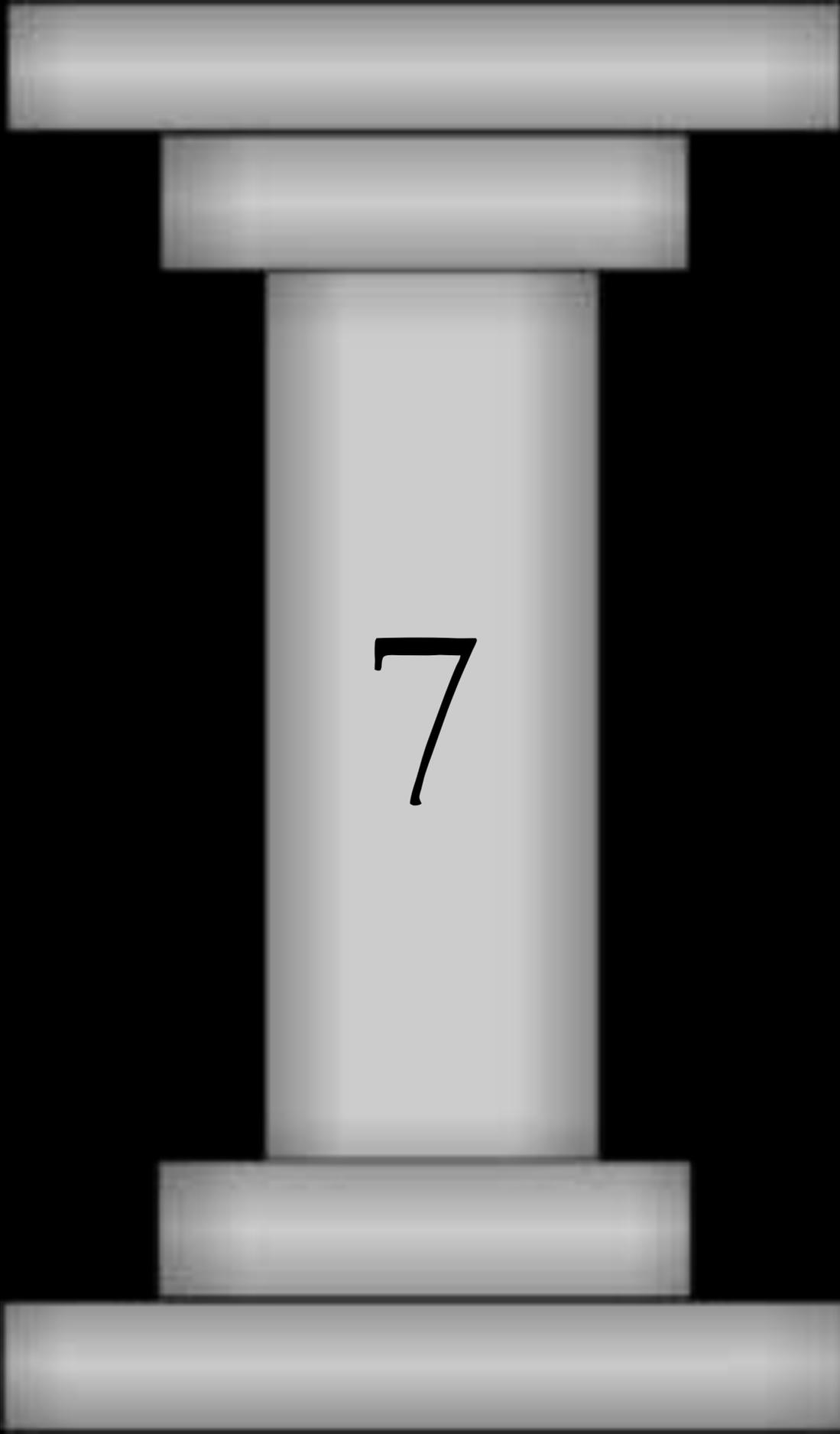
Try-in videos





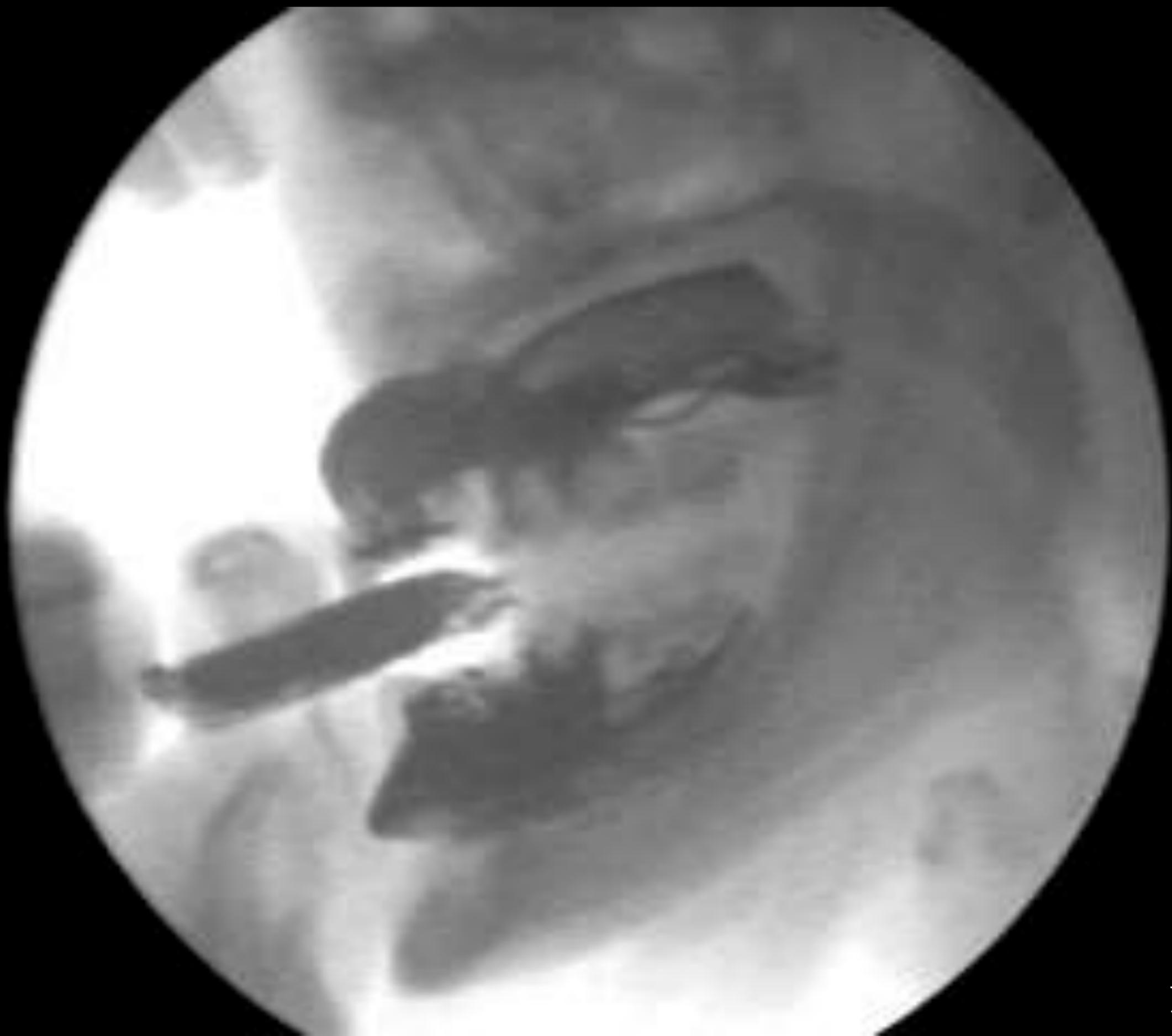






7

Patient  
communication



**Prof Roger Watson**



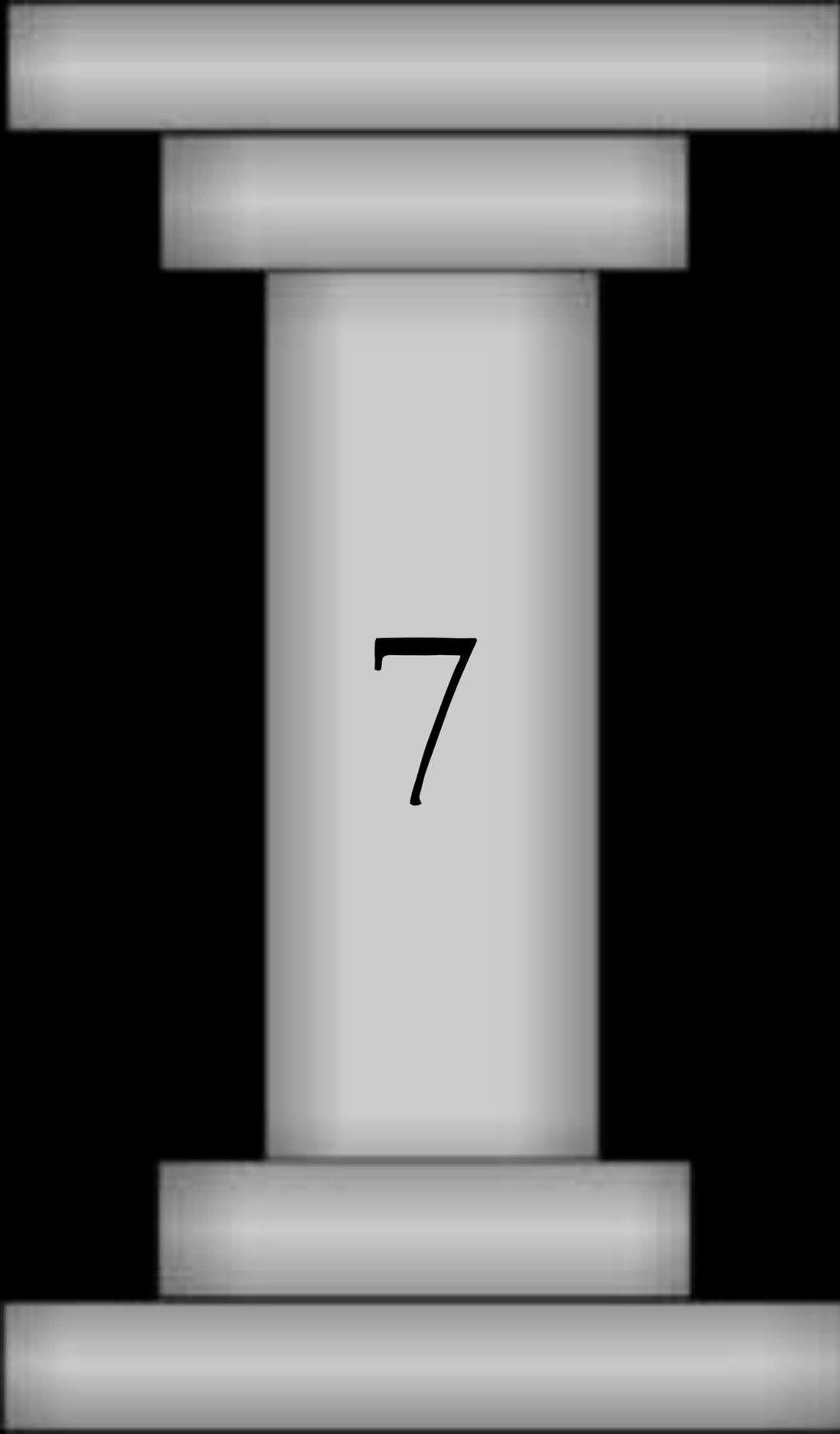
Consultation discussion

Over  
promise

Under  
deliver

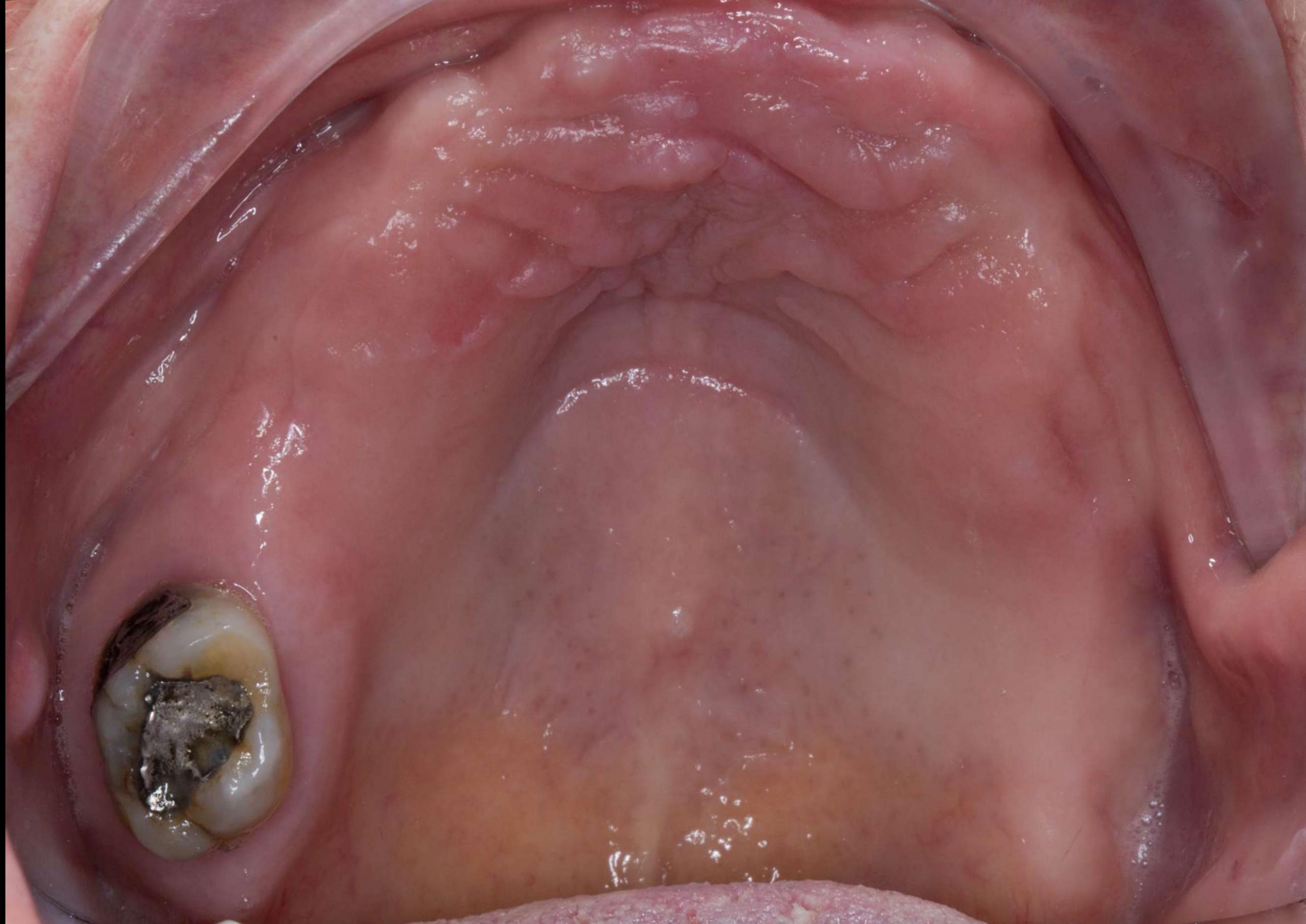
Under  
promise

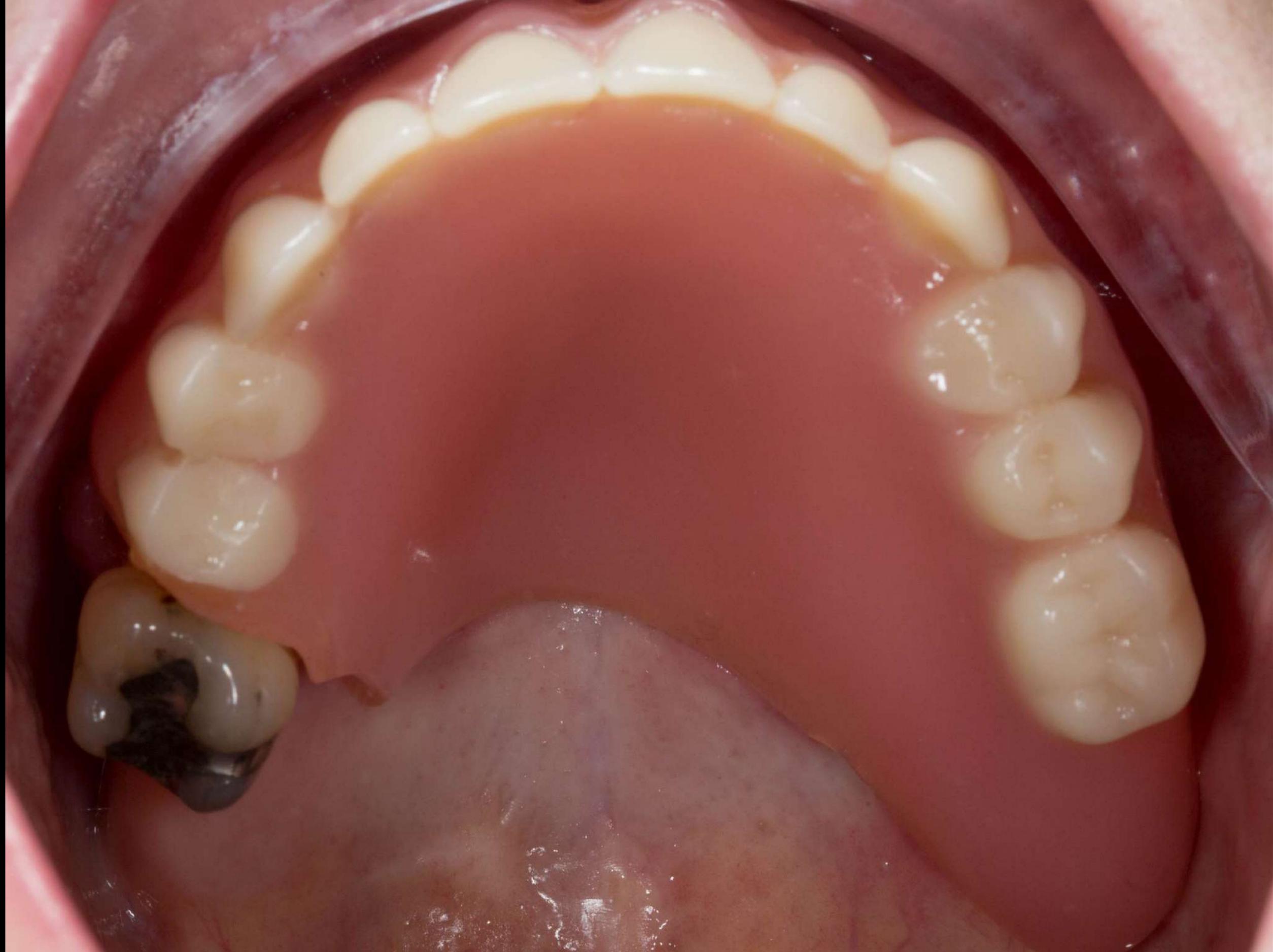
Over  
deliver

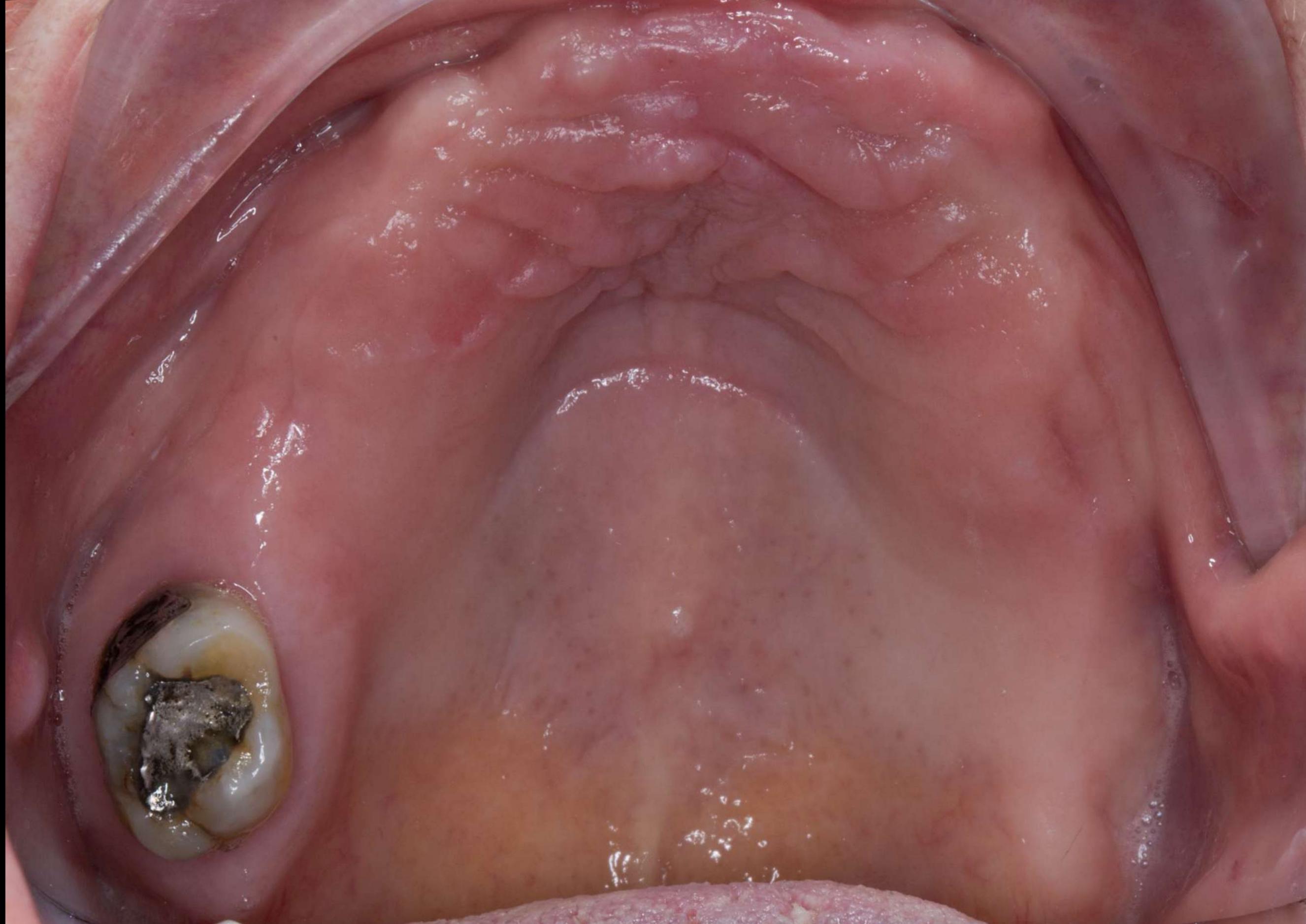


7

# Partial dentures





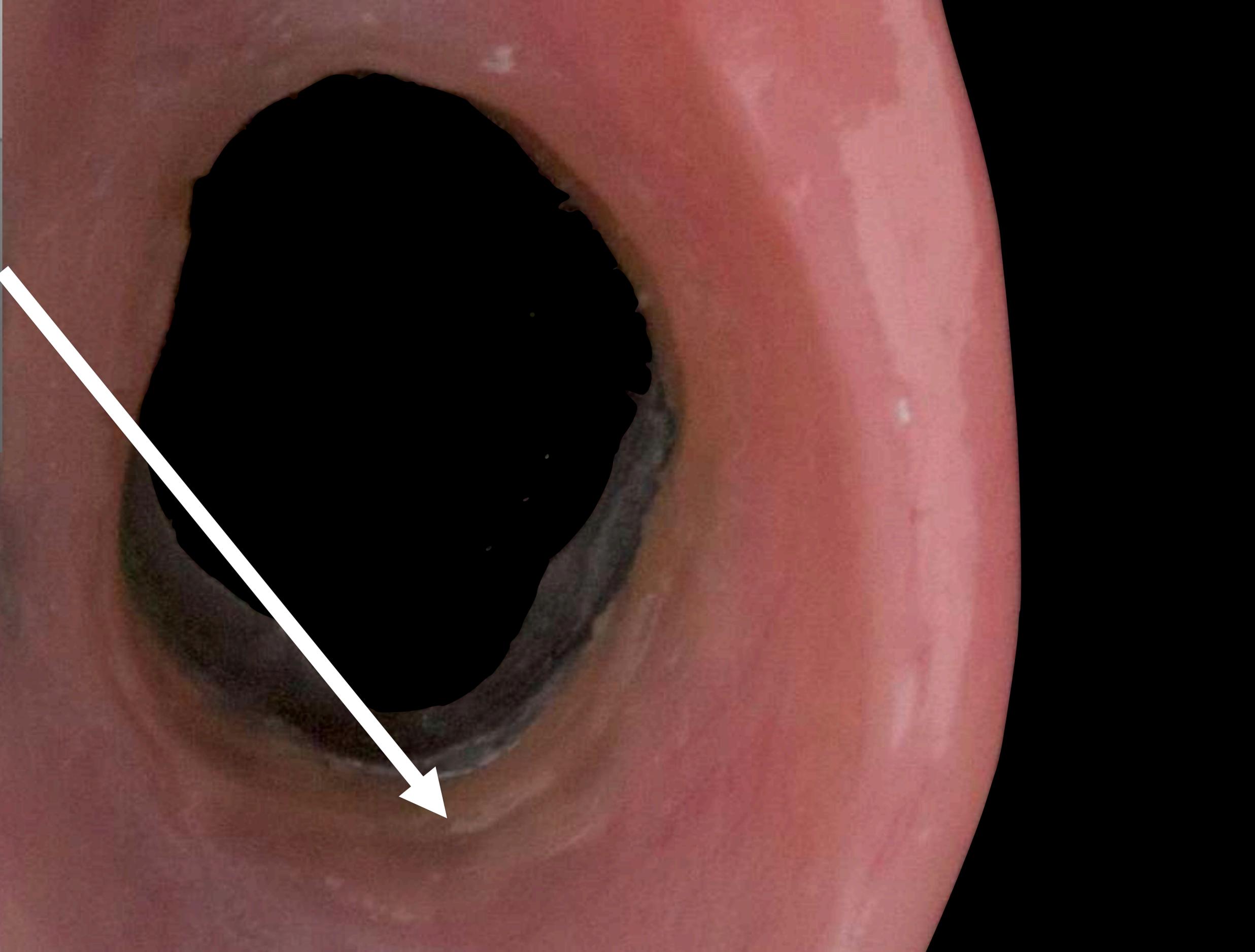


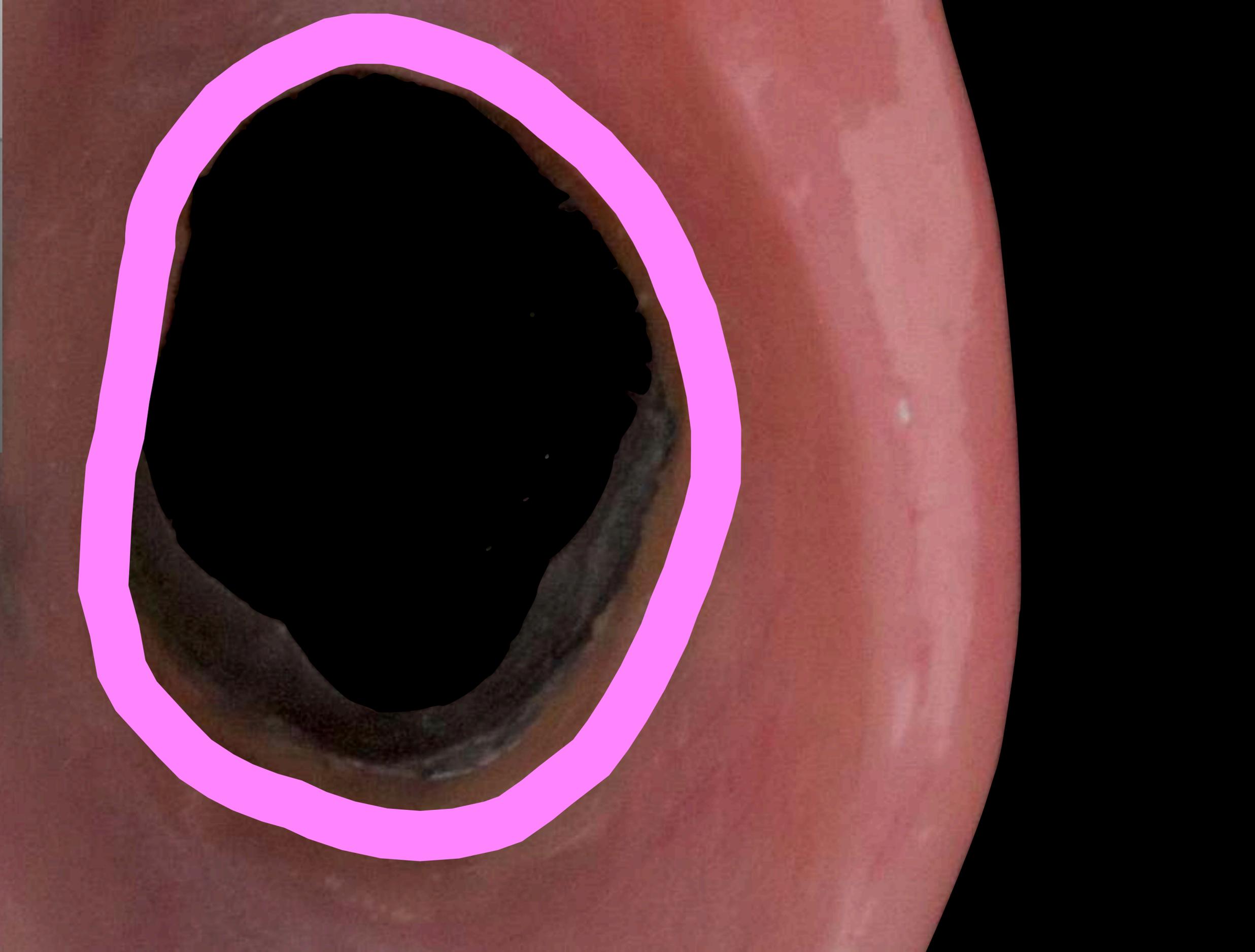
# Window denture

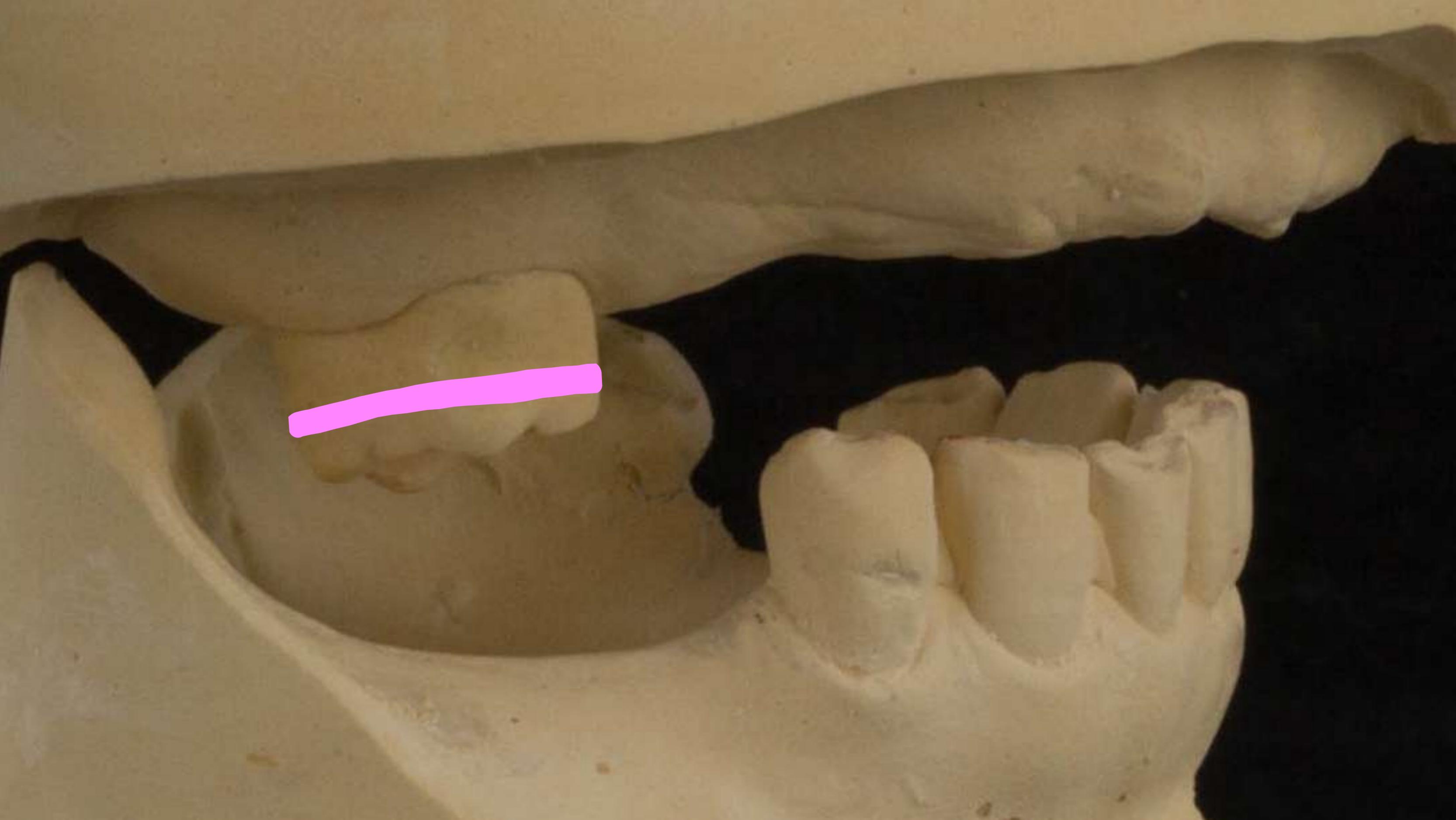


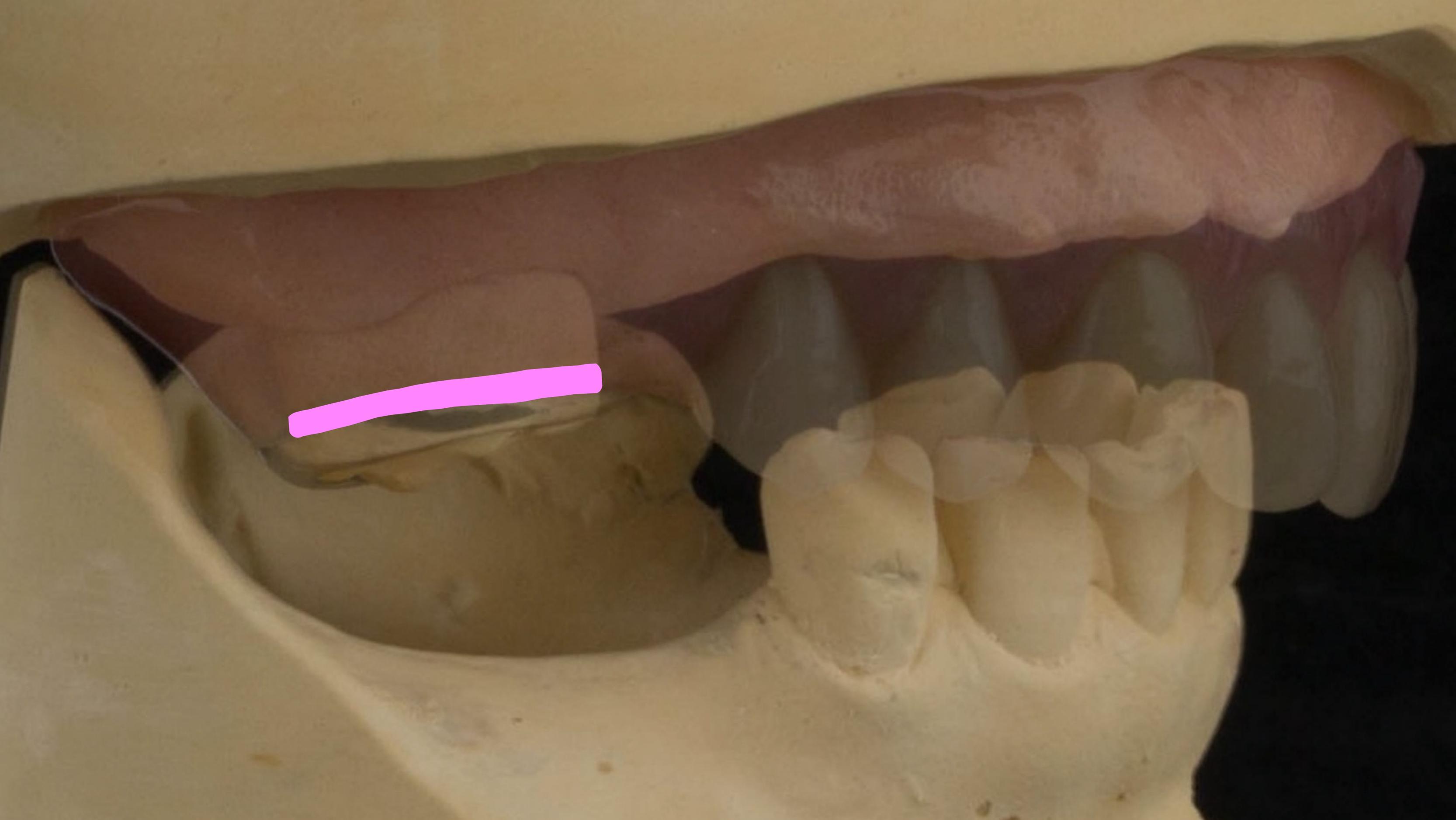
Window  
denture









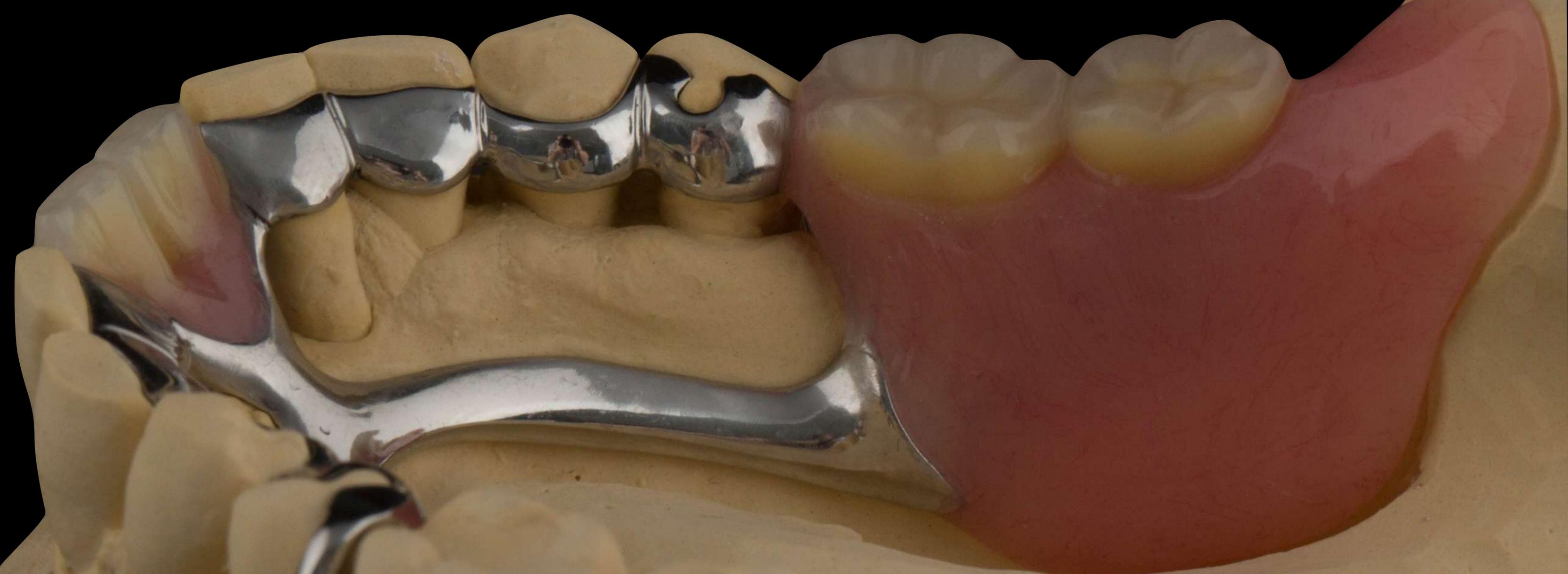




If support tooth fails - addition to convert to complete denture





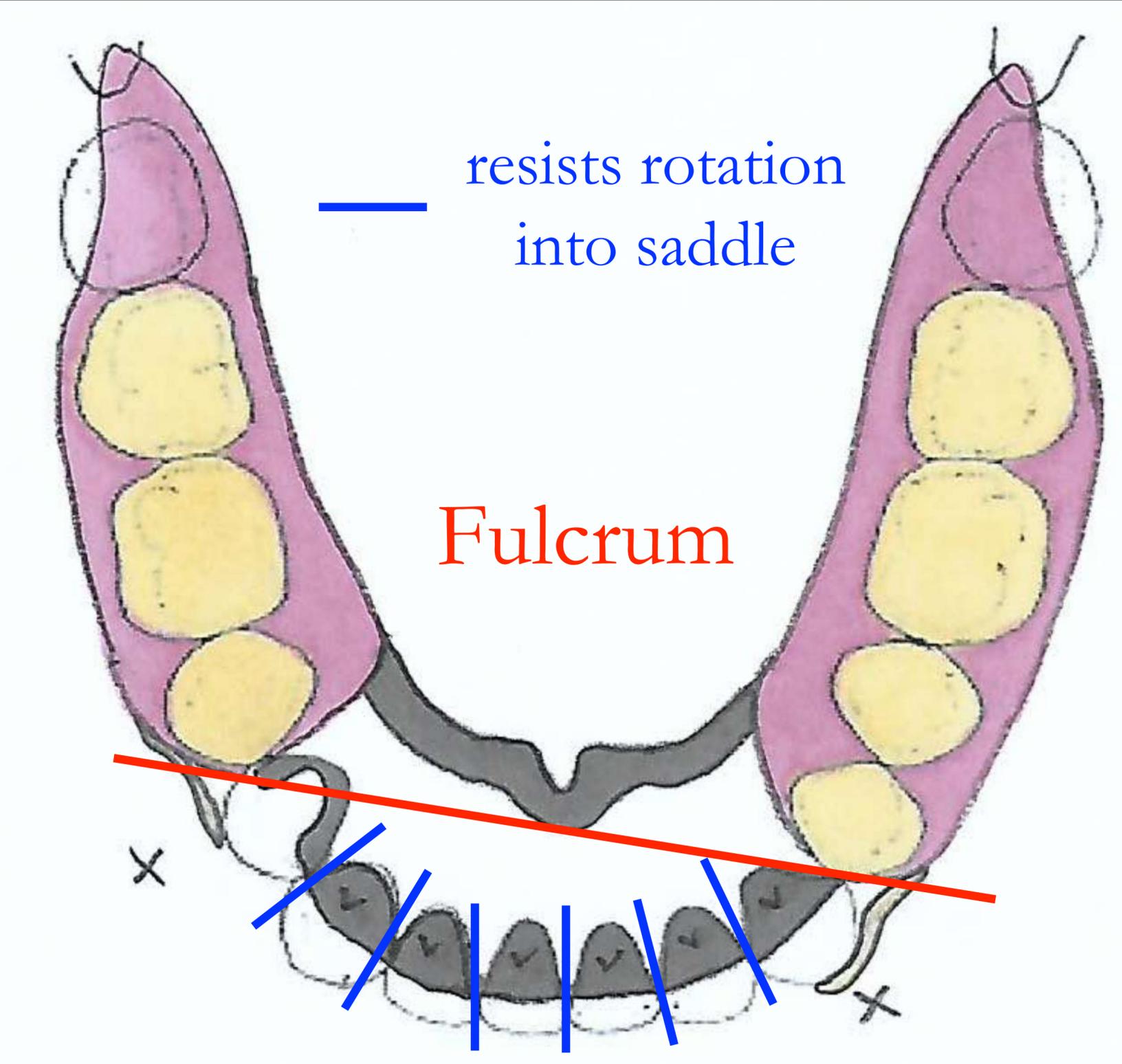
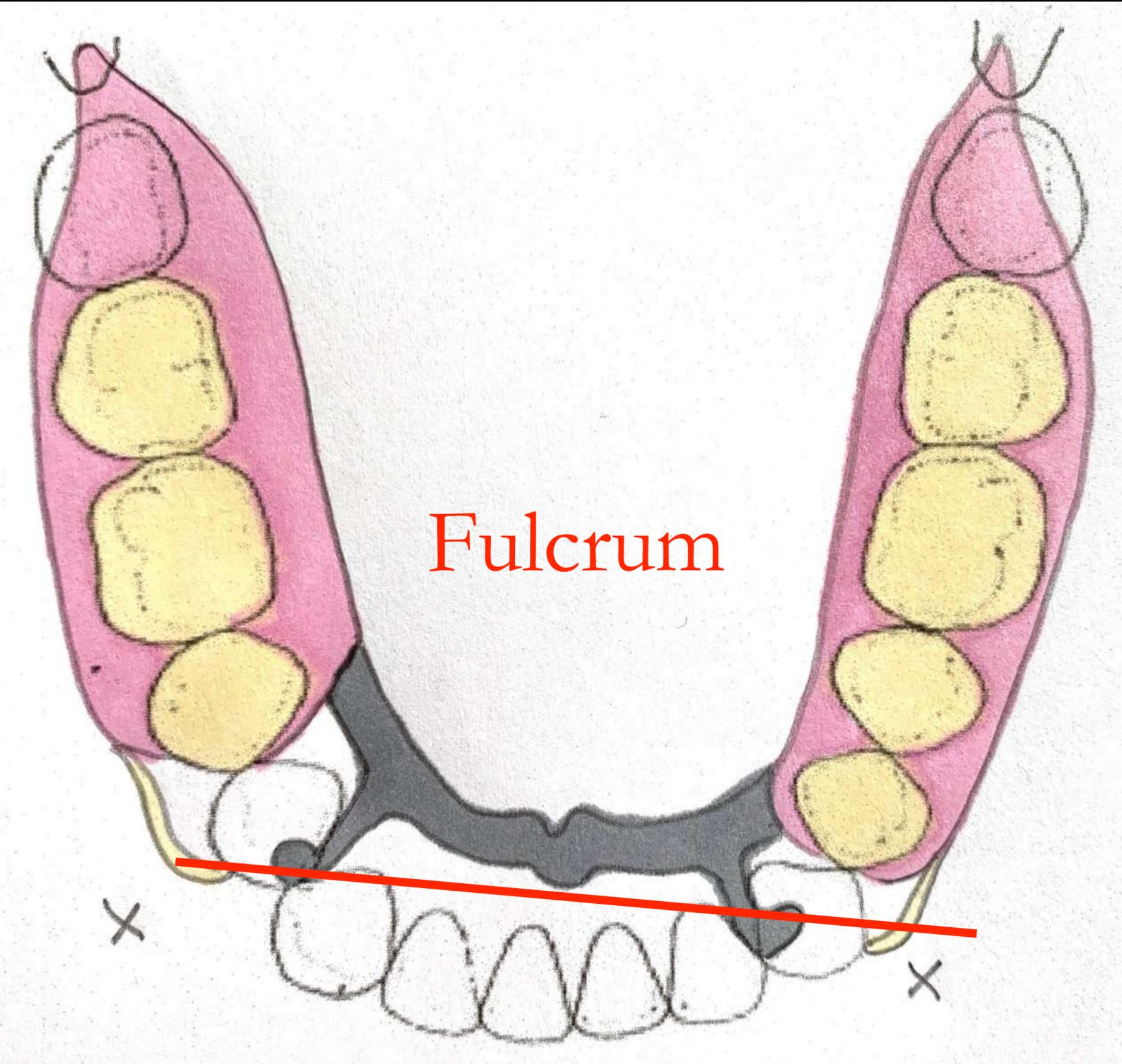


RPD design: a need to focus on Hygienic Principles.

Öwall B et al Int J Pros 2002

RPI system

v Scandinavian RPD system







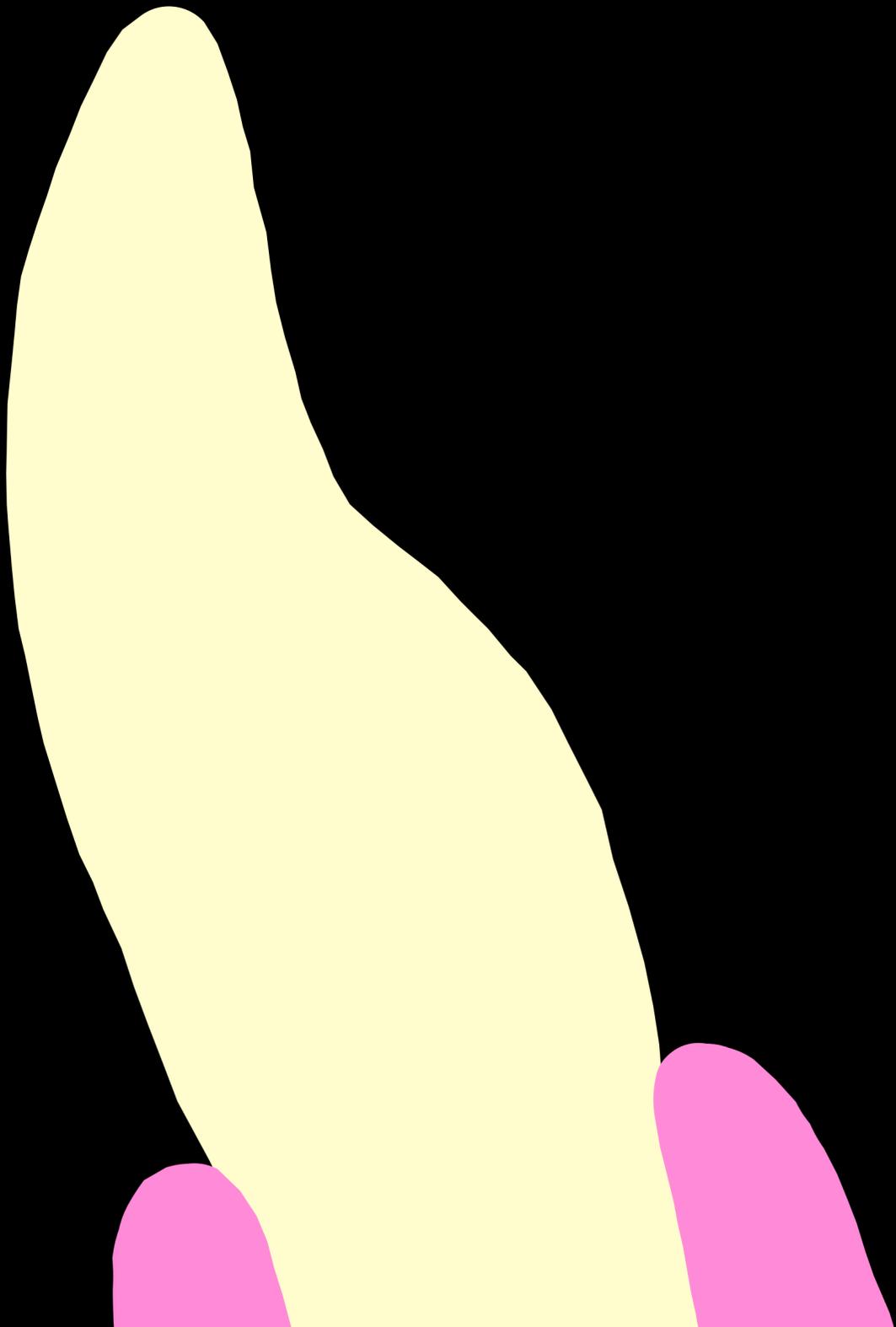


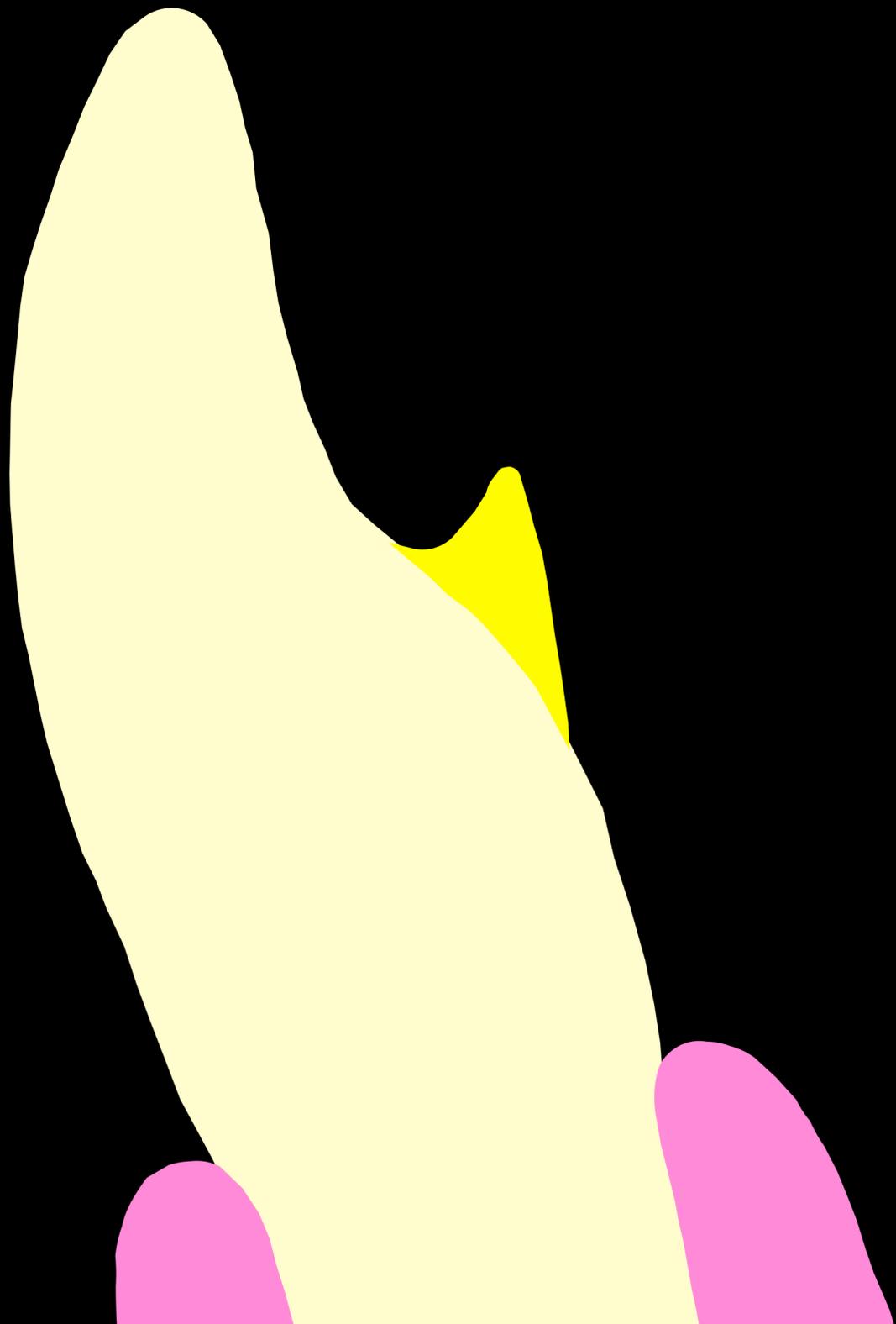
# Composite rest seats

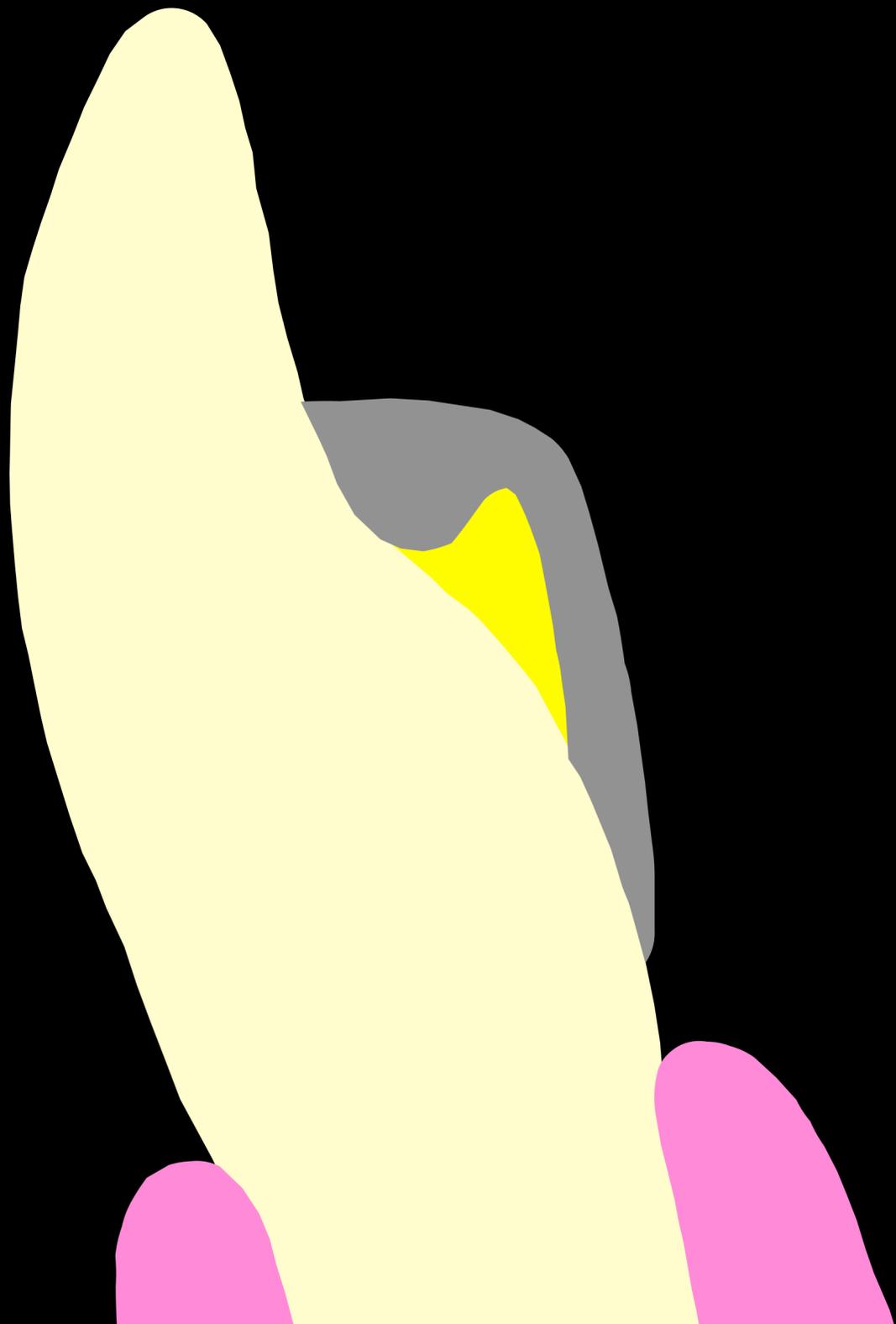


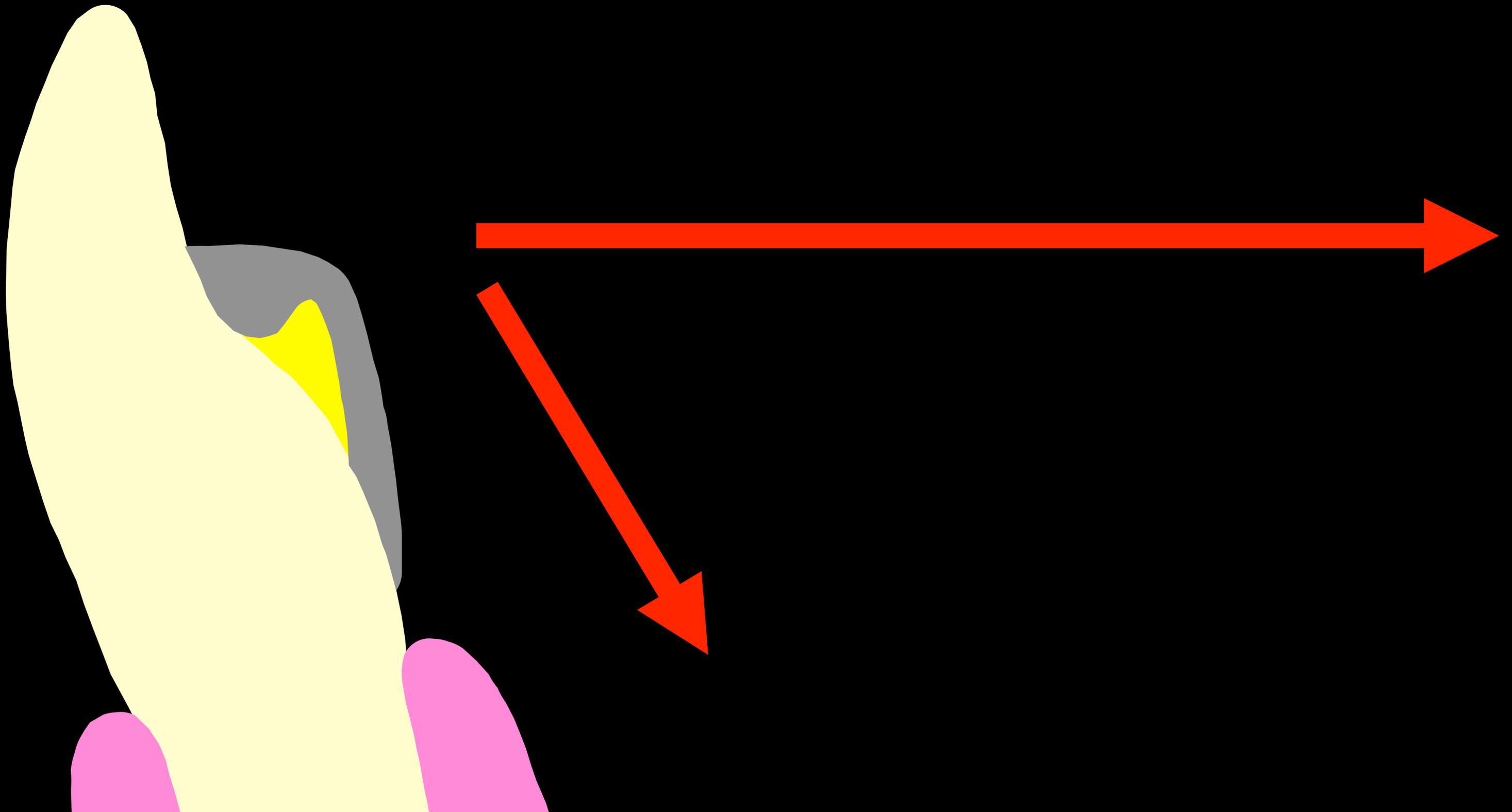
James S Brudvik

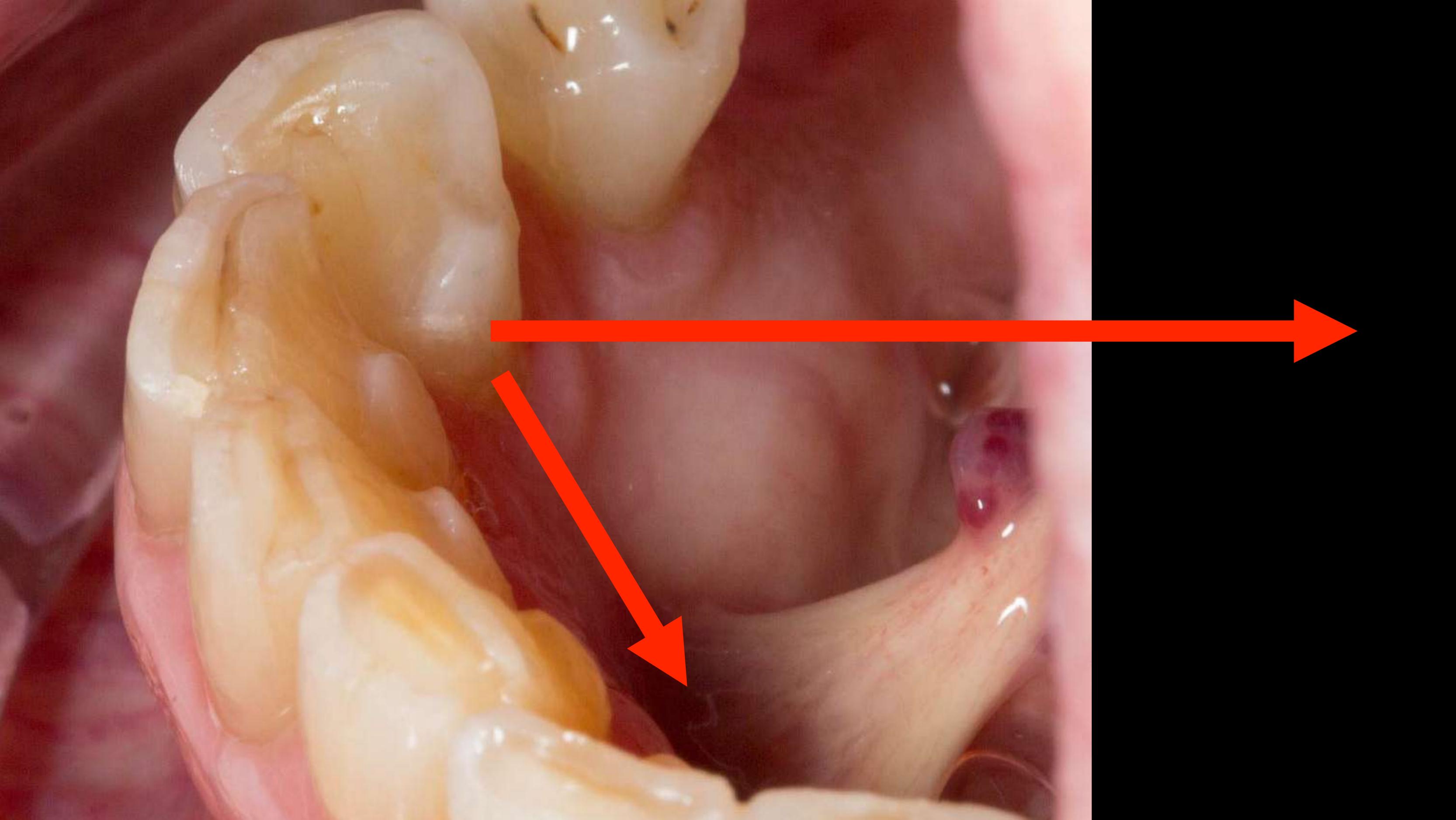
















Thank you!

