

Treatment of Gingival Recessions

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Editorial

Gingival recession is an oral exposure of the root surface due to an apical displacement of the gingival margin below the cemento-enamel junction [1,2]. It is a process which involves both gingival margin and the underlying bone. Thus, bone dehiscence should be present for gingival recession to occur. These deficiencies in alveolar bone may be anatomical, pathological, traumatic or iatrogenic [3]. From an epidemiologic point of view, the prevalence, the extent, and the severity of gingival recession increased with age and it is significantly more frequent in males than females [4-6]. The current evidence suggests that the etiology of gingival recession could be multifactorial and numerous factors should be taken into account in diagnosis phase. These etiological factors include anatomical conditions, bacterial plaque, periodontal diseases, tooth brushing, iatrogenic factors... [7]. Treatment of gingival recessions is indicated mainly to cover the recession defect, as well as to improve clinical attachment level and, whether needed, create or improve the keratinized tissue amount [2,7]. The main goal of the treatment of gingival recessions consists in the complete root coverage, with minimal probing depth after healing and good aesthetic appearance related to the adjacent soft tissues [7]. The increasing demand in esthetics and the need to solve related problems of gingival recessions have yielded to the development of numerous surgical procedures that allow the coverage of denuded roots [1,7]. Gingival recessions can be treated with different surgical procedures, and root coverage can be obtained irrespective of the surgical approach adopted [7]. The prognostic anticipation of clinical outcomes after surgical procedures is a complex process including numerous factors. The prognosis for a successful treatment is one of the main criteria for deciding whether or not and how to perform root coverage surgery [3]. The prognostic factors can be categorized into three groups: defect related factors (Recession classification and size, adjacent papilla dimension, keratinized tissue...), patient related factors (Plaque control, Tooth brushing, Tobacco smoking) and operator related factors [3,8]. Hence, critical consideration and analysis of all these factors are crucial for the clinician to choose the most adequate surgical approach and to assess the predictability of root coverage. The surgical techniques used in root coverage may be categorized in pedicle flaps (Coronally Advanced Flap (CAF), Laterally Positioned Flap (LPF)), autogenous grafts (Free Gingival Graft (FGG), Connective Tissue Graft (CTG)) and regenerative procedures (Emdogain...) [1,7]. In addition, different alternatives for CTGs have been recently proposed in order to reduce morbidity due to graft harvesting (Acellular Dermal Matrix (ADM), Collagen Matrix (CM)) [7,9]. Even though no single technique could be considered better than all the others, the bilaminar technique (CAF+CTG) appears to be the most predictable approach in terms of recession reduction, complete root coverage and keratinized tissue gain and it could be considered the gold standard in root coverage for localized Miller Class I and II gingival recessions [10-17]. Regarding cases of multiple gingival recessions, additional factors may render the root coverage more difficult to achieve. These factors may include the increased avascular area, the root prominence, the reduced vascular bed, the limited blood supply... [7]. In such a case, the bilaminar technique or the modified coronally advanced tunnel technique could be considered as the predictable procedures to achieve complete root coverage [18-20].

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