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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.

PC119

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

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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

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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 periosteum, 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

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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