

## Coronally Advanced Flap- A Mini Review

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### Abstract

Recession of the gingival tissue occurs due clinical attachment loss and the bone supporting the gingiva. Common etiology of gingival recession includes trauma (e.g. aggressive tooth brushing), inflammation, parafunctional activities (e.g. nail biting), abnormal habits (like tooth picking), iatrogenic (e.g. inadvertent scaling) among many others [1]. Resultant apical migration of the gingiva leads to exposure of root to oral environment which can result in thermal sensitivity, however majority of patients can be asymptomatic and only a few complain of esthetic aspects. Patients having a thin biotype of gingiva are prone to gingival recession when compared to those having a thick biotype.

The prime role of a periodontal therapy is to maintain periodontal health and to preserve and restore the tissues which may have been lost due to the periodontal disease. Since Gingival recession many times pose a great challenge due to functional and esthetics aspects associated with it, a thorough understanding of the pathology and its management is paramount.

**Keywords:** *Gingival Recession; Tooth Brushing; Biotype*

### Treatment protocol

The choice of the surgical protocol depends upon the type and size of defect, width of remaining attached gingiva, crestal bone height, Gingival phenotype among many other factors [2].

If the gingival recession is non-progressing and is not invoking any symptoms then first line of treatment will be tooth brushing instructions along with a strict maintenance program. However if the condition is progressing and/or symptomatic then the situation warrants surgical intervention [3].

### Coronally displaced flap

First described by Bernimoulin, *et al.* in 1975, this procedure involves coronal positioning of gingival tissue covering the defect providing excellent esthetic result [4]. Outcome of this procedure is more reliable in Miller class 1 and 2 recessions when compared to Class 3 and 4 [5]. Several factors like width of remaining attached gingiva, height of the papilla, cervical wear of the tooth and vestibule depth influence the success of the procedure.

### Technique

After placing an intrasulcular incision with preservation of the papillae using a scalpel with a No. 15C blade. Mesial and distal vertical relaxing incisions were given and a full thickness mucoperiosteal flap was raised. The flap was then positioned coronally and the flap was stabilised using suspension suture in the mesial and distal papillae, while simple sutures were used to close the releasing incisions.

Patient was prescribed analgesics and antibiotics (amoxicillin, 500 mg every 8 hours for 7 days) and for chemical plaque control 0.12% chlorhexidine rinse, every 12 hours for 14 days was prescribed and was instructed on oral hygiene and care of the surgical sites. The sutures were removed after 15 days.

The initial height of the recession is an important factor that should be taken into consideration as it certainly influence the success of the treatment. Less is the recession greater are the chances for a better root coverage [6]. The outcome observed in the present patient were consistent with the treatment outcomes in the previously done studies [7-10].

### Conclusion

We have tried to highlighted all the tech of CAF and it is expected that clinicians will have proper knowledge regarding treatment and diagnosis of class 1 and 2 miller recession defects.

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