

Original Article

Analysis of Cases of Anterior Hyperfunction Syndrome: A Clinical Study

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ABSTRACT:

Background: Anterior hyperfunction syndrome is when an edentulous maxilla is opposed by natural mandibular anterior teeth. This leads to various complications in patients requiring denture. The present study was conducted to analyze the cases of anterior hyperfunction syndrome in study population. **Materials & Methods:** This study was conducted on 80 patients having edentulous maxilla wearing maxillary denture and partially edentulous mandible wearing mandibular removable partial denture. They were analyzed for various signs and symptoms seen in patients with anterior hyperfunction syndrome. **Results:** Maximum cases were recorded for lack of maxillary denture adaptation (male- 12, female- 8). The need for replacement for maxillary denture was seen in 5 males and 4 females. Growth of the tuberosities was seen in 4 males and 5 females. Lack of mandibular denture adaptation was seen in 7 males and 3 females. Need for replacement for mandibular denture was seen in 6 males and 2 females. Papillary hyperplasia was seen in 1 male and 1 female. Hypermobility of the anterior part of the maxilla was seen in females (7) and males (3). Extrusion of lower anterior teeth was seen in 3 males and 2 females. The difference was significant (0.01). **Conclusion:** The prevalence rate of combination syndrome was 30% with slight male predominance. Most common sign was lack of maxillary denture adaptation and the need for replacement for maxillary denture.

Key words: Anterior hyperfunction syndrome, Mandible, Maxilla.

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INTRODUCTION

Anterior hyperfunction syndrome occur when an edentulous maxilla is opposed by natural mandibular anterior teeth, including loss of bone from the anterior portion of the maxillary ridge, overgrowth of the tuberosities, papillary hyperplasia of the hard palatal mucosa, extrusion of mandibular anterior teeth, and loss of alveolar bone and ridge height beneath the posterior mandibular removable dental prosthesis bases. It is also known as combination syndrome.¹

If the bilateral distal extension mandible and completely edentulous maxilla are rehabilitated with removable partial dentures, there are chances that mandibular denture base sink gradually because of resorption of alveolar bone in the posterior aspect of mandible leading to posterior open bite. The lack of posterior occlusal contacts causes an eventual and progressive shift of masticatory function to anterior

segments. The absence of teeth can be managed by partial or complete denture if patient has few missing teeth or complete loss of teeth respectively. The prognosis depends upon various factors. The situation becomes difficult when maxillary complete denture opposes mandibular removable partial denture.²

Saunders et al³ added six more characteristics (1) loss of vertical dimension of occlusion, (2) occlusal plane discrepancy, (3) anterior spatial repositioning of the mandible, (4) poor adaptation of the prostheses, (5) epulis fissuratum and (6) periodontal changes.

Completely edentulous maxilla and partially edentulous mandible with only anterior teeth remaining include loss of occlusal vertical dimension, occlusal plane discrepancy, anterior spatial repositioning of the mandible, and poor adaptation of the prosthesis, epulis fissuratum and periodontal changes are few conditions. The present study

was conducted to analyze the cases of anterior hyperfunction syndrome.

MATERIALS & METHODS

This study was conducted in department of Prosthodontics. It included 80 patients of both genders. All patients were of Kennedy class I ie having edentulous maxilla wearing maxillary denture and partially edentulous mandible wearing mandibular removable partial denture. All were informed regarding the study and written consent was obtained. Ethical clearance was taken from institutional ethical committee.

General information such as name, age, gender etc. was recorded. The hypermobility of the anterior part of the maxilla (HAM), extrusion of the mandibular anterior teeth (EMAT), epulis fissuratum (EF), presence of loose hypermobile tissue overlying the alveolar ridge, lack of adaptation of prostheses (LA maxilla/ mandible), growth of the tuberosities (GT), papillary hyperplasia (PH), necessity for replacements of prostheses (NR maxilla/ mandible) were recorded. Results thus obtained were subjected to statistical analysis. P value less than 0.05 was considered significant.

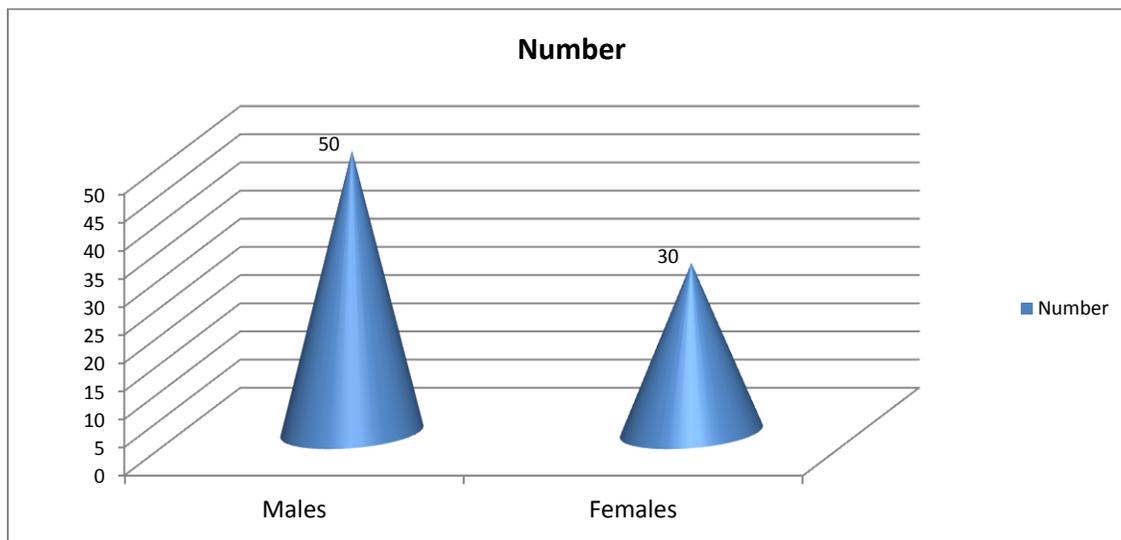
RESULTS

Table I Number of anterior hyperfunction syndrome patients

Total examined	Anterior hyperfunction syndrome	%
240	80	30%

Out of 240 patients examined, 80 (30%) patients were found positive for anterior hyperfunction syndrome.

Graph I Distribution of patients



Graph I shows that out of 80 patients, males were 50 and females were 30. The difference was non-significant (P- 0.1).

Table II Occurrence of signs in patients

Signs	Males	Females	P value
Extrusion of lower anterior teeth	3	2	0.01
Epulis Fissuratum	5	2	
Growth of Tuberoisity	4	5	
Hypermobility of Anterior Maxilla	7	3	
Papillary Hyperplasia	1	1	
NR maxillary denture	5	4	
NR mandibular denture	6	2	
lack of maxillary denture adaptation	12	8	
lack of mandibular denture adaptation	7	3	
Total	50	30	

Table II shows that maximum cases were recorded for lack of maxillary denture adaptation (male- 12, female- 8). The need for replacement for maxillary denture was seen 5 males and 4 females. Growth of the tuberoisities was seen in 4 males and 5 females. Lack of mandibular denture adaptation was seen in 7 males and 3 females. Need for replacement for mandibular denture was seen in 6 males and 2 females. Papillary hyperplasia was seen in 1 male and 1 female. Hypermobility of the anterior part of the maxilla was seen in females (7) and males (3). Extrusion of lower anterior teeth was seen in 3 males and 2 females. The difference was significant (0.01).

DISCUSSION

Early loss of bone from the posterior part of the mandible leads to increase in function in the anterior region as a result of posterior hypofunction. Hypertrophy of the anterior mandible with anterior hyperfunction develops. Forces originating from the lower anterior teeth are directed toward the anterior portion of the unsupported maxillary denture leading to loss of bone and ridge height anteriorly, the posterior residual ridge becomes larger with the development of enlarged tuberosity. The changes in tissue form and health seen in this syndrome can be attributed to several factors, one of which is the biomechanical factor. When mandibular anterior teeth are present, patients tend to favor these teeth functionally because of the ability to generate maximum force. Excessive anterior function and parafunctional in excursive movements constantly overload the anterior ridge to result in alveolar bone resorption and possible development of epulis fissuratum.⁴

We found that out of 240 examined patients, 80 had this syndrome. Another paramount aspect of this syndrome is a repercussion of ridge resorption is impairment in established posterior occlusal contact leading to the progressive collapse of vertical dimension of occlusion causing the mandible to move forward resulting in pseudomandibular prognathism.⁵

A study by Ashok et al⁶ found 89 patients completely edentulous maxilla. Thirty-two patients had a Kennedy Class I removable partial denture and 57 had Kennedy Class II. Three major alterations were observed in 28.5% of the studied population. Nevertheless, these changes were present only in 27% of patients with Kennedy Class I removable partial denture. Resham et al⁷ in his study have found 32% prevalence rate. However in our study, it was 30%. Males were more as compared to females. The bone resorption beneath the mandibular distal extension, wearing of artificial teeth, positional changes in anterior teeth instigate parafunctional activities, thereby augmenting the force per unit area on the maxillary alveolar bone.

Lack of maxillary denture adaptation, need for replacement for maxillary denture and lack of mandibular denture adaptation showed higher prevalence rate as compared to other indices. This is in agreement with Ahen et al.⁸ The growth of the tuberosities was often seen unilaterally, accentuating the lack of occlusal stability provided by acrylic teeth. One can theorize that disocclusion on the working side with natural teeth would generate a lever force on the non-working side with acrylic teeth, dislodging the complete prosthesis, giving space for down growth of the tuberosities and leading to the resorption of mandibular residual ridges. There is need to check for denture flanges to avoid these complications.⁹

Maximum support of the denture-bearing area, preservation of the mandibular posterior abutment, and balanced occlusion were all proposed to prevent bone loss and excess pressure on the anterior maxillary alveolar ridge. Similarly, Van et al¹⁰ suggested the avoidance of total tooth extraction, the preservation of a few teeth, and the use of overdentures. Both implants retained and implant supported prostheses have become increasing popular and have been proven successful in prosthetic rehabilitation of partially and completely edentulous maxilla and mandible.¹¹ The unstable occlusion in combination syndrome results in progressive posterior mandibular atrophy.

CONCLUSION

The prevalence rate of anterior hyperfunction syndrome was 30%. Males showed higher prevalence than females. Most common sign was lack of maxillary denture adaptation and the need for replacement for maxillary denture.

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