THE RATIONALE OF PARTIAL DENTURE CHOICE

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Choosing one of the possible procedures for restoring the partially edentulous dental arch involves borderline decisions. Often, a complexity of oral conditions may exist, regarding which decisions ultimately must be made. In addition, partial denture design is complicated by the many possible combinations of the remaining teeth, so the making of a choice in restorative procedure may become disconcerting.

Prosthodontists have been tolerant of a poorly organized approach to this problem. Sometimes, little logic is used in arriving at a selection of prosthetic treatment for the varied semiedentulous situations. The resulting uncertainty often has caused dentists to delegate responsibility in designing the removable partial denture.

With caries control methods not having gained nationwide application, many broken dental arches will continue to need partial denture service. Indirectly, modern periodontic treatment has also been responsible for a steadily increasing demand for partial denture service. Many periodontally involved teeth are returned to a condition of health for patients already partially edentulous. Formerly, most of these teeth would have been extracted. These patients will have been told, and rightly, that the missing teeth must be replaced at once to protect the results already achieved by occlusal equilibration and periodontal therapy.

Thus, a future load of increasing need for partial dentures is confronting dentistry. Much of this required service can be supplied only by the general practitioner. This prospect indicates an urgent need for clarification of at least those partially edentulous situations which are found repeatedly in clinical dentistry. The indications and contraindications for various restorative procedures should be better correlated with the principles of removable partial denture design so as to be successfully applied by a dentist with less than specialist training in prosthodontics.
Fig. 1A.—The partially edentulous situation which occurs with the greatest frequency is a mandibular class I condition.

FACTORS AFFECTING THE CHOICE OF PROSTHODONTIC TREATMENT

Classification in removable partial denture prosthesis should be specifically related to oral conditions. In the past, classification has been restricted only to the designation of vacant spaces in the dental arch. Actually, the size of edentulous spaces, even the location of remaining teeth, are secondary in diagnostic significance to the condition of the supportive structures. Other factors have much more important bearing on what should be done prosthetically than the number, or even the location, of the remaining teeth. Of these factors, only the most important will be discussed.

Bone Maintenance Potential.—The capability of the patient to replace bone elements as rapidly as they are used is at the top of the list of desirable conditions. A physical examination which accurately evaluates the systemic condition may be necessary. However, good roentgenograms of the complete alveolar process usually will give a dependable index as to the patient’s potential metabolic function as it affects bone maintenance.

Fig. 1, B and C.—The bone maintenance is exceptionally good, considering the long service of the abutments and that the patient is nearly 70 years of age. Note the extreme atrophy (particularly in A,) in the posterior edentulous ridges.
The ability of the patient to tolerate prosthetically induced stress loads is directly related to his past record of alveolar bone maintenance in areas of hyperfunction. Such dependable index regions of alveolar bone exist around teeth that have served as abutments, inclined teeth, teeth adjacent to edentulous spaces and which are in occlusion, and teeth in traumatic occlusion. The exception to this rule is in the patient who has undergone physical changes which would interfere with his metabolic function. Any restoration of masticatory function, to be more than temporary, must be attuned to the patient's evident ability to maintain alveolar bone.

Previous Cervical Bone Loss.—Even when a morbid metabolic function has been returned to a normal level, some permanent bone loss may have occurred. The extent of prosthetic load which may be safely allocated is then affected. The occlusal stresses are magnified since the extra-alveolar segment of the abutment tooth has been lengthened by cervical bone loss. This is not to say that such teeth cannot function as abutment teeth, but it does materially affect the type of mouth preparation and the choice of restoration.

Fig. 2.—A, The lower left bicuspids have carried a very heavy occlusal load for many years. The patient is a vigorous, healthy man, about 42, able to exert exceptionally heavy biting forces. Note the excellent bone maintenance. In spite of this, a carefully constructed class II partial denture base carrying the molars showed a loss of stability within a short time. This is a common example that even when there is normal alveolar bone there may be atrophy in the unused sector of the same dental arch. B, The boundary tooth in a class I situation may need extensive restoration, or often it may not be able to serve alone as an abutment for the needed extension restoration, but by union with an adjacent tooth adequate abutment service can be provided.

Abutment Root Form, Length, and Stability.—The next most critical influence in recovery of the patient’s dental facilities is the anatomic condition of the prospective abutment teeth. The length of the root determines the intra-alveolar support which can counteract the extra-alveolar stress or the work portion of the lever arm.
Form of the abutment root is important, because if the root tapers sharply, any previous cervical loss of bone is doubly significant. The amount of the remaining alveolar wall which supports the abutment load is reduced rapidly when the root is steeply tapered. Such roots can be used for abutment support only when definite measures have been taken to supplement the abutment function. The splinting of two or more adjacent teeth is the most dependable solution in this situation.

Extent of Periodontal Involvement.—The degree of lateral mobility of an abutment tooth is of lesser clinical significance. Unless there also has been serious periodontal damage, the tooth will recover its previous firmness. However, this recovery depends upon the alleviation of the local predisposing conditions which produced the excess mobility in the first place.

Fig. 3.—These class I partial dentures have resin bases, but frequently the base is made of cast metal. The lower denture has a linguoplate type of major connector. This maxillary partial denture has a posterior palatal bar. This unit may be omitted in some cases.

Mobility of teeth is reason for careful investigation of the area because the degree of recovery of the cervical bone is dependent upon the vitality of the osteogenic tissues. The restorative program must be planned so that the traumatized teeth are effectively stabilized to achieve bone regeneration. Frequently, this requires the splinting of adjacent teeth.

Caries Susceptibility.—Extreme caries susceptibility is a factor in making the choice between complete and partial denture service. Once the decision to retain the remaining teeth has been made, caries susceptibility is related to the type of tooth restoration to be supplied. Even though the patient may have shown complete cooperation in the exercise of caries control measures, with a satisfactory reduction of the bacterial count, complete crown coverage is indicated as a further protection against recurrent or new carious lesions. This creates a problem in esthetics when anterior teeth are to be restored, and, therefore, is a factor to be considered constantly in oral rehabilitation.

Size and Form of the Residual Ridge.—The subbasal support is a controlling factor in the choice of a partial denture, as it also may have been a potent reason
for not rendering complete denture service in the first place. If the ridge form is extremely poor (low, flat, and with reduced surface for support), adequate stress control will be a serious problem. Not only will this influence the choice of the type of restoration, but also the mouth preparation and the design of the appliance will need modification to meet possible magnified stresses. Stress control will become an acute problem when the mandibular ridge must support a restoration after lengthy disuse of the posterior edentulous areas.

Location of the Remaining Teeth.—The location of the remaining teeth is more important in partial denture construction than the number of teeth that are left. Root form and length, number of roots, crown form, form and bulk of the surrounding alveolar process, and the location of the remaining teeth in the dental arch are factors which are rated well above mere numbers.

CLINICAL CLASSIFICATION OF PARTIALLY EDENTULOUS SITUATIONS

A removable partial denture classification means little or nothing unless it also has clinical application. To say that the same type and design of partial denture is indicated in each situation where the same teeth are missing is to presume that oral conditions never vary. To presuppose that the potential abutment teeth and their supporting structures are equally capable where the same teeth have been lost is equally unrealistic.

Thus, it is improper to delegate (without proper instructions) the important step of designing the removable prosthesis to a laboratory technician. He must depend entirely on the cast, which shows only that certain teeth are missing. This practice is vulnerable because it completely disregards the adequacy of the oral structures to provide support. Planning and designing the removable partial denture must be done by the only person who can evaluate the oral condition—the examining dentist. The province of the laboratory technician is to produce, but not to prescribe, the prosthesis.

In choosing a basis for a classification, we should seek one which is fundamental. Nothing is more essential than achieving support for the needed prosthesis. The longevity and comfort of the denture is most dependent upon this factor.

A classification system, to be applicable, must completely correlate with oral clinical conditions. The system also must be closely integrated with restoration design so that practical measures can be applied to keep induced stress loads within physiologic limits.

Six groups or classes are required to correlate the situations in semiedentulism and the conditions which are most commonly associated with each group. The proposed method is a classification of partially edentulous conditions based upon (1) the ability of the boundary teeth and their supporting structures to supply abutment facilities for the needed partial denture and (2) the location of the edentulous spaces in relation to the teeth which remain.1

CLASS I

Class I represents an edentulous situation in which all remaining teeth are anterior to the bilateral edentulous ridges (Fig. 1A). This is the most frequently
Fig. 4.—A, An exercise prosthesis is used to recondition the regions of alveolar disuse before placing a functional load on the depleted ridges. Note the maximum tissue coverage of the bases. 
B, each base has been covered with autopolymerizing resin. This restoration is worn for from 3 to 5 months without teeth. During this time the patient bites rapidly but lightly on a finger placed on the base near the abutment tooth of each side. This exercise is repeated frequently. Also, the patient alternately retains mouthfuls of hot and cold fluids to induce thermal stimulation. 
C, The restoration has been completed with the teeth placed in a balanced occlusal relationship. Note the narrowed occlusal surfaces.
occurring class, and its highest incidence is on the mandible. Often, the posterior teeth have been missing for many years.

The conditions commonly associated with class I are: (1) six to ten anterior teeth remain (Fig. 1A), (2) the boundary tooth may not be capable of unaided abutment function (Figs. 1, B and C, and 2, B), (3) resorption of the residual ridge is seen in varying extent (Fig. 1, A and C), (4) the immediate stability of the edentulous sector depends largely upon the period of disuse (Fig. 1, A—right side of class I arch—and C), (5) the ultimate stability of the residual alveolar bone is proportional to the ability which the patient has shown in maintaining the bone structure (Fig. 2), (6) malposition and irregularity of the remaining teeth may have resulted from their migration, and (7) reduced interarch space often exists posteriorly.

The removable prosthesis for class I permits no choice; it must be an extension-base partial denture of bilateral design (Fig. 3). Often, because of extensive disuse atrophy (Fig. 2), the use of the appliance without occlusal function as an "exercise prosthesis" is indicated (Fig. 4). This is especially beneficial when an opposing complete denture must be used. The available subbasal support gives the maxillary denture a great advantage over the lower partial denture. Reconditioning the alveolar structure of the mandible first materially reduces this disadvantage.

The greatest variance in class I removable partial dentures is in mouth preparation. Splinting of adjacent teeth allows subnormal teeth to be retained when there is lowered physical tolerance, previous cervical bone loss (Figs. 1, B and C, and 2, B), or periodontal damage. In spite of such aid, the occlusal load often needs to be reduced when both tooth and ridge support are subnormal. Many class I dentures require reduced width of the teeth. While this decreases the masticatory load, it will not lessen the stresses generated in bruxism. Only one point of occlusal contact is needed to transmit the occlusal force when the teeth are clenched. However, the occlusal forces are materially lessened by following the proper procedure in attaining harmonious occlusion first of the remaining teeth and later of the artificial teeth.

Class I conditions have occupied most of the attention of dentists in partial denture prosthesis. This situation will gradually change as more posterior teeth are reconditioned endodontically and periodontally to increase the frequency of tooth-borne (class III) restorations.

Class II

Class II situations are those in which remaining teeth of either the right or left side are anterior to the unilateral edentulous ridge (Fig. 5). The associated conditions of class I also may occur in a class II group. However, almost invariably, another characteristic is found in class II. Since all teeth remain on one side of the arch, the patient experiences less noticeable impairment of mastication. This makes him less inclined to seek replacement of the missing teeth until much disarrangement of the remaining teeth has taken place.
Because of this common occurrence, certain characteristics occur in addition to those noted for class I situations: (1) more disuse atrophy of the residual ridge is likely, (2) extrusion of the opposing teeth often is more extreme, (3) the alveolar process may have accompanied the occlusal movement of the teeth (Fig. 6), (4) extensive restoration of the opposing teeth is frequently necessary because of their occlusal disarrangement, (5) extraction of teeth which show extreme movement in the occlusal direction may be necessary, and (6) temporomandibular joint disability is more frequent in long-standing class II situations than in class I.

Replacement of unilaterally missing posterior teeth has often been neglected. Some patients who develop a temporomandibular joint syndrome report that no recommendation for replacement was made when their teeth were extracted.

A unilateral loss of posterior teeth induces occlusal imbalance and deflective occlusal contacts. Occlusal equilibration is temporary unless the missing teeth are replaced and occlusal balance is also achieved in the region of the missing teeth.

Class II patients generally are more able to maintain the alveolar processes. This may be the reason that the teeth of one side have been retained. There is less need to splint adjacent teeth for multiple-abutment support than in class I situations. As with the class I restoration, there is little choice as to the type of removable partial denture. The extension base (Fig. 5) is mandatory because, unilaterally, no posterior abutment support remains.

Fig. 5.—Teeth are missing posteriorly only on one side of the arch in the class II situation. The metal base is used in the maxillary arch more frequently than for lower partial dentures. Rebasing a maxillary base is not often necessary, because resorptive change is seldom encountered in a maxillary arch. For this reason, the use of an exercise prosthesis is not required for maxillary removable partial dentures. The problem of disuse atrophy is almost completely limited to the mandibular arch.

Occasionally, when posterior teeth have been lost, some portion of the occlusal function is replaced with a fixed prosthesis. This is done by splinting two or three adjacent teeth to support a fixed cantilever, distal extension. The method is used more often in class II but has been used bilaterally also. There is danger in this
practice. Destructive leverage is developed by such restorations. The restoration may seem to be satisfactory; however, should there be a physical decline for any reason, irreparable damage may be caused before any symptoms are noticeable clinically.

In addition, the residual ridge beneath the cantilever occlusal surface receives no stimulation and disuse atrophy occurs. Should this continue, the loss of ridge height may be considerable and the disuse renders the bone unstable. Further resorption will occur beneath a complete-denture base if one is needed later. Occlusal imbalance follows. The use of fixed cantilever restorations for class I and class II situations is to be condemned.

CLASS III

Class III situations are those in which an edentulous space (Figs. 7A and 7B) is bounded by teeth both anteriorly and posteriorly. A distinguishing characteristic is that one or more boundary teeth are unable to assume the total abutment support of the prosthesis. These weak abutments require the aid of other remotely located teeth, allowing the principle of cross-arch splinting to be utilized to resist lateral tilting forces (Figs. 7C and 7D).

An occlusal stress load has two principal components of force, one directed vertically, the other inclined laterally. The boundary teeth are not capable of assuming the lateral stress in class III situations because (1) the edentulous span is long, (2) the abutment root form or length is unfavorable, (3) the cervical bone is depleted around the abutment teeth, and (4) the occlusal load is excessive.
A unilateral fixed or removable partial denture would probably fail because of inadequate protection against forces which produce lateral tilting. Zones of impingement of the periodontium would follow which might easily exceed the tolerance level of the patient.

A class III condition may involve the need for support from more than one tooth at each abutment site. When a combination of impairments is noted, the need for splinting of abutment teeth is apparent. However, the use of a bilateral design is necessary even when adjacent teeth are splinted together.

Fig. 7A.

Figs. 7A and 7B.—Roentgenograms show the typical class III situation. The teeth which bound the edentulous spaces are unable to assume the complete stress loads (both lateral and vertical) which abutment service would exert upon them.
Effective endodontic and periodontic therapy will save many molar abutment teeth, and therefore, more tooth-borne class III partial dentures will be needed, with a reduction of those in class I or II. These molar teeth, although weak or even mobile, can support the vertical load so long as the trajectory of the force is axial in its application.\(^2\)\(^,\)\(^6\) The infrequent failures of fixed partial dentures that can be traced to overload are due to lateral, not vertical, stress loads. The removable tooth-borne prosthesis which is carried to the opposite side of the dental arch has a leverage advantage against lateral tilting forces which is very effective (Figs. 7C and 7D). The use of it makes a class III bilateral design so beneficial that mobile teeth may be expected to become firm and remain so when their environment is otherwise made favorable.

Two other advantages of the tooth-borne prosthesis over the extension-base, tissue-borne type are important. An occlusal load transmitted via a tooth reaches
the supporting bone through the principal fibers of the periodontal membrane as
they are stretched from a relaxed to an extended state. By contrast, occlusal loads
from an extension-base partial denture are transferred through its base to the
mucosa and, by compaction of this pad of tissues, on through to the subjacent bone.
This process is often accompanied by trauma from overload and possible prolonged
interference with circulation (as in bruxism).

A class III prosthesis employs a safer, more physiologic method of transferring
stress incident to occlusal pressures. In addition to this protective measure,
another important safety mechanism operates involuntarily to protect the tooth-borne restoration against overload. The periodontal membrane has rich proprioceptive
(sensory) innervation which is thought to be absent from the mucosal structures.
By this control, an involuntary reduction of occlusal forces is effected before
there is actual realization of pain or discomfort. Hence, the periodontal membrane
is protected, but the ridge covering is not. Perhaps this is one explanation of the
excellent record of long service that tooth-borne fixed partial dentures have given.

Fig. 8.—The four incisors are supported by the ideal cuspid abutments. Note that the arc
between the abutments is not severe. When the arch form is such that the arc becomes un-
favorable, the abutment load may be made excessive because of the resulting leverage. In this
situation, the adjacent bicuspids may be included in the abutment support by a splint union
to form a multiple abutment. When the anterior class IV situation extends posteriorly beyond
the cuspid, a removable prosthesis is usually indicated. (Courtesy of Prof. F. B. Vedder, Uni-
versity of Michigan, School of Dentistry.)

CLASS IV

Class IV situations are those in which the edentulous space lies anterior
to the remaining teeth which bound it both to the right and left of the median
line. This class is frequently exemplified by a loss of two or more of the incisors.
The loss of one or both cuspids in addition to the incisors is less often encountered.
Occasions when the anterior edentulous condition extends to include posterior
teeth are infrequent.

When the space ends with teeth which can serve dependably as abutments
(the cuspids are good examples), the prosthesis most often is of the fixed type (Fig.
8). This is somewhat less likely when the lateral incisors are the terminal teeth.
Occasionally, when the arch form is such that it does not project anteriorly in an
A class IV situation not only includes loss of the lower incisors but much of the alveolar process of the anterior ridge. The use of a fixed restoration (such as in Fig. 8) presents the difficulty of esthetically placing the pontic units. As a result of such bone loss, from accident or disease, a removable prosthesis usually is necessary so that a bulk of resin may be added to support the lip for a pleasing facial contour. If the patient also has a prognathic relationship, there is another advantage in using a removable prosthesis. With the cuspid abutments weakened by the labial loss of bone, they might become overloaded by the anteriorly directed prognathic stress load. By extending the design posteriorly (B) the support of all remaining teeth is enlisted to counteract these forces.

A fixed prosthesis may even be preferred when the terminal teeth are first bicuspids. In such extreme use of the fixed partial denture, multiple-abutment support is necessary.

There are instances where the class IV situation calls for a removable prosthesis even when the restoration could be supported satisfactorily by the boundary teeth: (1) when excessive loss of alveolar bone (as in an accident or disease) requires a bulk of resin to support the facial structures (Fig. 9), (2) when support and retention must be gained from more and/or better abutment teeth, and (3) when wider distribution of the work load over a greater number of teeth is necessary.

The use of a fixed prosthesis when the missing anterior teeth extend beyond the cuspsids involves two primary difficulties. First, there is the danger that sufficient rigidity of the fixed denture may not be attained. If there is the least flexibility, the porcelain tooth substitutes will be fractured. Second, the use of metal backings is necessary to obtain maximum strength, which may interfere with attainment of an esthetic result. A removable partial denture is superior in both respects, strength and appearance.

The most important advantage of a removable prosthesis in this situation, however, would be obtained by extending the framework to include the molars. A powerful counterleverage to resist the tendency of the replaced anterior teeth to be tilted anteriorly and upward during incision is developed by including the second molars as abutments (Fig. 10). The incisal edge appearance is superior because the porcelain or resin can be used with no metal backing.

The extension of the anterior edentulous space makes the problem of stress control progressively more complicated. Either a fixed or a removable restoration can be used, depending on which most effectively controls the induced stress loads.
Fig. 10.—A removable prosthesis is used to replace the incisors and one cuspid. The remaining cuspid and adjacent bicuspid are united to form a multiple abutment, as are the two bicuspidsp of the opposite side. To accomplish this splinting, the restorations of choice are three-quarter (or complete) crowns. By survey of the wax patterns for these crowns, their forms may be so contoured as to provide lingual clasp retention. This eliminates any display of metal on the buccal surface by a clasp type of direct retainer. Another advantage is that the restoration may be extended posteriorly to enlist the aid of all remaining teeth in counteracting the forward and upward stresses which result from inclining or clenching the teeth. Anchorage in the second molar regions not only provides adequate indirect retention but also develops a favorable counter leverage to resist anterosuperior force load on this long class IV denture. If there is loss of bone anteriorly, resin can be added on the labial surface so that the lip will be properly supported. Since no metal needs to be placed on the lingual surface of the anterior teeth, the removable appliance has the esthetic advantage of a better appearance of the incisal edges of the teeth.

Fig. 11.—Class V is an infrequent situation. The lateral incisor usually presents a hopeless situation as far as provision of an abutment facility. A more satisfactory and esthetic result usually can be obtained by the use of an extension prosthesis which ends at the lateral incisor but does not utilize it for abutment service.

CLASS V

The class V edentulous situation is one with a space bounded by remaining teeth at its posterior and anterior terminals (Fig. 11). However, there is an essential difference between classes V and III. While the boundary teeth in
class III can assume a portion of the abutment function (the vertical component of the work load), the anterior tooth which is a boundary in a class V condition cannot provide any abutment support. The distinguishing characteristics of this group are a long edentulous space and a very weak anterior terminal tooth.

A classic example of the class V condition is a space extending from a weak lateral incisor to the second molar (Fig. 11). For one or more of the following reasons, no satisfactory anterior abutment support is available: (1) the edentulous space is too long and the occlusal load would be excessive, (2) the form and length of the boundary tooth root is unfavorable, (3) there has been a loss of cervical bone around the anterior boundary teeth, and (4) splinting of adjacent anterior boundary teeth is not possible or it would not provide adequate abutment facility.

The prosthetic solution to the class V situation is a removable prosthesis of bilateral design with a free-end base which extends anteriorly (Fig. 12). Fortunately, class V problems are almost always in the maxillary dental arch, probably because of the vulnerable position of the upper cuspid to a blow on the face. With ample subbasal support to provide stability in a maxillary class V situation, an excellent result is usually obtainable. Since favorable indirect retention is available from the second molar of the opposite side, the class V partial denture also can be retained against the displacing force of gravity (Fig. 12).

Whenever there is a possibility of splinting the weak lateral incisor to the central incisor, this should be done. The removable prosthesis is then a bilateral class III type. When this cannot be done, however, the class V design must be utilized.
Fig. 13, A and B.—The class VI edentulous situation is one in which the boundary teeth are able to assume the total abutment function. Such favorable conditions are seen in the roentgenograms. A, Usually the restoration should be a fixed prosthesis. Properly designed, the clasp-retained removable restoration may be used in the limited instances in which it is indicated. B, The roentgenogram of a class VI situation taken nearly 15 years after the placement of the removable prosthesis seen in Fig. 13C.

CLASS VI

Still another edentulous situation has boundaries of teeth remaining anteriorly and posteriorly. Thus, three of the six groups have the same anatomic landmarks. However, class VI conditions are always such that the complete occlusal load can be tooth borne and, therefore, a fixed or removable unilateral prosthesis is possible (Fig. 13, A and C).

Because the abutments must bear both vertical and lateral components of the occlusal load, there are definite limitations under which the unilateral tooth-borne prosthesis can succeed. These conditions include: (1) the edentulous space should be short (Fig. 13), and/or the occlusal work load limited, (2) the abutment root length and form must be favorable (Fig. 13, A and B), and (3) there should be minimal cervical bone loss with ample evidence of the ability to pro-

Fig. 13C.—The removable prosthesis. This patient was past 50 years of age when the denture was first placed.
vide adequate bone maintenance. The abutment tooth should exhibit minimal mobility, and the crown form of the boundary teeth must present adequate retention for either the fixed or removable prosthesis.

In such instances, the fixed prosthesis is the restoration of choice.4 No prosthodontic procedure has a better clinical record than does the unilateral fixed partial denture if used within the indicated limits. However, no prosthesis has had a less favorable record than the unilateral removable partial denture (Fig. 13C). The reason is not that the work loads are transferred in a less desirable physiologic manner, but rather, the clasp retainers are not properly located so that the rotation of the denture can be prevented. While this defect can be avoided easily, it is advisable to curtail the use of the removable denture in class VI situations. When properly designed and executed (Fig. 13C), a removable unilateral partial denture can be used with complete confidence that it will be comfortable, efficient, and of long duration of service.

SUMMARY

Because the Kennedy classification of removable partial dentures has many excellent features and is established,7 it is urged that this classification be retained and simply modified. The addition of two groups provides six classes with which to designate different structural and anatomic situations that require dissimilar designs.

Within the proposed classification, there exists a logical correlation with the principles of design and construction of removable partial dentures. Unless the same principles are applicable in the design of such restorations when the same oral conditions are present, something less than principles is being applied. There can be but one logical conclusion. There has been an inaccurate grouping, and this grouping needs to be changed.

The suggested classification eliminates the defects in a practical manner. However, the advantages of an established method of classification of partially edentulous conditions are not lost.

REFERENCES


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