Class III with Multiple Gingival Recession: Vestibular Incision Subperiosteal Tunnel Access (VISTA) and Platelet-Derived Growth Factor BB

Abstract

Gingival recession can result in pain, hypersensitivity, root caries and esthetic concerns. There are many therapeutic options are available for treatment of gingival recession defects. This case report presents a novel treatment strategy of an acquired class III malocclusion in an adult male that was associated with upper anterior multiple gingival recessions. Access to the surgical site is obtained by means of an approach referred to as vestibular incision subperiosteal tunnel access (VISTA). VISTA is introduced by recombinant human platelet-derived growth factor BB saturated onto a matrix of beta-tricalcium phosphate with connective tissue grafts and a resorbable collagen membrane for root dehiscences. Such novel method lead to better wound healing by promoting primary wound coverage, better blood supply, easier clot stability and space maintenance with less scar formation. Connective tissue procedures and guided tissue regeneration-based root coverage are developed in an attempt to overcome clinical limitations while providing comparable result. In this case report, VISTA is a reliable method for use in root coverage procedures with long-term follow-up. (Int I Ortho Implantol 2014;35:22-36)

Key word:

VISTA, gingival recession, root coverage, connective tissue graft, gingival surgery.

History and Etiology

A young man aged 24 years 7 months was referred to us by his family dentist for a second opinion. His main complaints were upper left lateral incisor lockin and mentalis strain (*Figs. 1-3*). The patient hoped to resolve his complications. No contributing medical, dental, or family history was reported. The etiology of the malocclusion was unknown, but the nature of the skeletal malocclusion suggested that it was genetic. The patient was treated to an optimal result as documented in Figs. 4-6. The cephalometric and panoramic radiographs document the pre-treatment condition and the post-treatment results (*Figs. 7 and 8*). The cephalometric tracings before and after treatment are shown to be superimposed in Fig. 9. The details for diagnosis and treatment will be discussed below.

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Fig. 1: Pre-treatment facial photographs



Fig. 4: Post-treatment facial photographs



Fig. 2: Pre-treatment intraoral photographs



Fig. 5: Post-treatmentintraoral photographs



Fig. 3: Pre-treatment study models



Fig. 6: Post-treatment study models



Fig. 7:

Pre-treatment pano and ceph radiographs. Note the upper and lower both sides 3^{rd} molar.





Post-treatment pano and ceph radiographs The upper and lower both sides 3rd molars were extracted and lower both sides 2nd molars were pulled back into an ideal occlusal relationship.



Fig. 9: Superimposed tracings.

The upper anterior teeth were slightly flare-out and lower anterior teeth were slightly retroclined with no affect on the patient's vertical dimension but mild alteration of facial profile after the treatment.

CEPHALOMETRIC					
SKELETAL ANALYSIS					
	PRE-Tx	POST-Tx	DIFF.		
SNA°	82°	82°	0°		
SNB°	83°	83°	0°		
ANB°	-1°	-1°	0°		
SN-MP°	37°	38°	1°		
FMA°	34°	35°	1°		
DENTAL ANALYSIS					
U1 TO NA mm	9 mm	11 mm	2 mm		
U1 TO SN°	116°	118°	2°		
L1 TO NB mm	8 mm	7 mm	1 mm		
L1 TO MP°	90°	86°	4°		
FACIAL ANALYSIS					
E-LINE UL	-3 mm	-2 mm	1 mm		
E-LINE LL	0 mm	-1 mm	1 mm		

Table 1: Cephalometric summary

Diagnosis

Skeletal:

- Skeletal Class III (SNA 82°, SNB 83°, ANB -1°)
- Mandibular plane angle (SN-MP 37°, FMA 34°)
- Bimaxillary protrusion with lip strain

Dental:

- Right side cusp Class III molar relationship
- Right side class III canine relationship
- Anterior teeth edge to edge
- About 2 mm space deficiency in upper arch and 2 mm in the lower arch.
- The maxillary dental midline was 2 mm shift to right side.
- The upper left lateral incisor was lock in.

ABO Discrepancy Index (DI) was 18 as shown in the subsequent worksheet.

Facial:

- Straight profile (Fig. 1)
- Protrusive lower lip

Specific Objectives of Treatment

Maxilla (all three planes):

- A P: Maintain
- Vertical:Maintain
- Transverse: Maintain

Mandible (all three planes):

- A P: Maintain
- Vertical: Maintain
- Transverse: Maintain

Maxillary Dentition

- A P: Slight flaring of incisors
- Vertical: Maintain
- Inter-molar/Inter-canine Width: Expansion to relieve crowding and upper lateral incisor lock in

Mandibular Dentition

- A P: Anterior teeth retraction and posterior teeth tipback
- Vertical: Maintain
- Inter-molar/Inter-canine Width: Expansion

Facial Esthetics:

- Protrude upper lip
- Retract lower lip

Treatment Plan

Non-extraction treatment with a passive self-ligating bracket system (*Damon Q*) was indicated. Class III

elastics were used to correct the A-P discrepancy by flattening the plane of occlusion, and to enhance the camouflage effect. Treatment with Class III elastics was initiated early in treatment (*at the .014 NiTi stage*), and final alignment of the dentition was achieved shortly before the end of active treatment.

Appliances and Treatment Progress

We selected .022" slot Damon Q low torque brackets (U1=+2, U2=-5, and U3=-9). For the lower incisors, brackets were bonded by 022" slot Damon Q standard torque brackets.

The initial archwires were .014" NiTi, and the Class III elastics were upgraded gradually by 2 oz. In the fourth month of treatment, the wires were replaced with rectangular .014X.025" NiTi and we continued using Class III elastics (2 oz) to correct the A-P discrepancy. One month after the .014X.025" NiTi replacement, we performed vestibular incision subperiosteal tunnel access (*VISTA*) surgery from the upper right canine to the left canine for gingival

recession (*Miller Class I*)(*Fig. 10*). The sequence of operation was as follows: The recipient teeth were initially prepared through scaling and root planing (*Figs. 11 and 12*).

The VISTA approach began with a midline frenum incision made through the periosteum to elevate a subperiosteal tunnel (Fig. 13). The tunnel was created to extend through the gingival sulcus of the central incisors and beyond the mucogingival junction, to allow for tension-free coronal repositioning of gingival margins. We used 2 methods of surgery. On the right side we performed guided tissue regeneration (GTR), and on the left side we performed the connective tissue grafts (CTG) were pulled through the tunnel. On the right side, a resorbable collagen membrane (Lyoplant) was then trimmed to fit the dimension of the surgical area (Fig. 14). The width of the membrane was adjusted to extend 3 to 5 mm (or more) beyond the bony dehiscences overlying the root surfaces. Prior to its insertion, the membrane was saturated with 0.3 mg/ml rhPDGF-BB (GEM21S, Osteohealth) for at least



Fig. 10: Moderate-wide recession defect on the right area left maxillary central incisor and canine (Miller Class I).



Fig. 11: Scaling and root planing over upper left side.



Fig. 12: Scaling and root planing over upper right side.



Fig. 14: a resorbable collagen membrane in the right subperiosteal area

10 min. A suture was passed through the gingival margin and PDGF-saturated collagen membrane to advance the gingiva coronally. Coronally anchored suturing uses a modified horizontal mattress suture with the knot tied to the braces; thereafter, beta-tricalcium phosphate (β -TCP) hydrated with thPDGJ-BB was placed between the collagen membrane and the maxillary facial osseous cortex using a microsurgical elevator (*Fig. 15*). We carefully ensured that all bony dehiscences overlying each tooth root were covered. On the left side, connective



Fig. 13: The midline frenum incision and elevation through the subperiosteum tunnel



Fig. 15: GEM -21S is placed between the collagen membrane and the bone.

tissue grafts were obtained from both palatal side (*Fig. 16*). The grafts were placed within the subperiosteal tunnel and fixed to the braces using modified horizontal mattress sutures. Finally, the midline incision was approximated and sutured (*Fig. 17*).¹ After one month, clinical follow up showed uneventful healing (*Figs. 18 and 19*).

In the ninth month of the patient's treatment, we used .017X.025" TMA wires and Class III elastics (4.5 *oz*). After 17 months of treatment, the .019x.025" wires were applied. After 23 months of active treatment, the treatment was complete and all appliances were removed.



Fig. 16:

connective tissue grafts were embedded between membrane and subperiosteal area from the donate side on the both palatal area.



Fig. 17: Suture knot on the braces due to help coronal position.



Fig. 18: Frontal view showed uneventful healing after one month post-operation.



Fig. 19: Palatal view showed uneventful healing after one month post-operation.

Results Achieved

Maxilla (all three planes):

- A P: Maintained
- Vertical: Maintained
- Transverse: Maintained

Mandible (all three planes):

- A P: Maintained
- Vertical: Clockwise rotation
- Transverse: Maintained

Maxillary Dentition

- A P: incisors slightly flaring
- Vertical: Extrusion of the posterior teeth
- Inter-molar/Inter-canine Width: *Crowding corrected* with arch expansion

Mandibular Dentition

- A P: incisor retracted and molars were tipped distally
- Vertical: Incisors extruded
- Inter-molar/Inter-canine Width: Crowding released corrected

Facial Esthetics

- Upper lip slightly more protruded
- Lower lip was retruded slightly

Retention

The upper fixed retainer 2-2 and the lower fixed retainer 3-3 were bonded on every tooth. An upper clear overlay retainer was delivered. The patient was instructed to wear the retainer fulltime for the first 6 months, and thereafter, only at night. The patient

was instructed in home care and maintenance of the retainer.

Final Evaluation of Treatment

The patient's CRE score was 27 points. The major discrepancies were as follows: Alignment/Rotations (*4 points*); marginal ridges (*4 points*); buccolingual inclination (*2 points*); overjet (*4 points*), with loss of some contact (*7 points*); left occlusal relationship (*4 points*); and unparallel root (*2 points*). The root coverage from upper right and left canine was 100% (*Fig.* 20).

Discussion

True gingival recession is a static condition in which the marginal gingiva is positioned apically relative to the cementoenamel junction. Recession may be localized to a single tooth but in other cases it more broadly involves multiple-tooth segments or the dental arches.² The etiology is multifactorial; possible causes include a response to bacterial plaque, the position of the teeth in the arch, toothbrush trauma, traumatic occlusion, high insertion of the oral frenula, narrow gingival areas, and anatomic defects such as dehiscences and fenestrations.³ Patient age and smoking habits may be secondary factors related to gingival recession.⁴ These various factors can exert significant individual influences but may also can act in association.

Planned dental movement does not inevitably constitute an etiological factor if teeth are not

dislocated out of their alveolar process limits. However, if a tooth is shifted without adequate biomechanical control, a bone dehiscence may develop and gingival recession would then be a consequence of the dental movement.⁵ Buccallingual dental shifting may also lead to bone dehiscence and subsequent gingival recession.⁶

A relatively high incidence of gingival recession occurs during orthodontic treatment of the mandibular central incisors because the labial bone covering the roots of these teeth is thin.⁷

However, Allais and Melsen⁸ contended that orthodontic treatment involving the mandibular incisors (*labial movement*) is unassociated with an increased incidence of recession. Thus, the effects of orthodontic proclination of the mandibular incisors on the periodontium remain controversial. Outward dental movement from the alveolar bone caused by excessive inclination of the incisors predisposes teeth to the loss of the labial gingival insertion, which can lead to gingival recession.^{9–12} Yet, several authors have stated that no evidence supports this association between orthodontic treatment (*movement*) and gingival recession.^{7,8,13} Dorfman¹⁴ reported that among 1,162 patients receiving complete orthodontic treatment, 2% showed insufficient amounts of keratinized gingiva in the mandibular central incisors.

The use of gingival grafts as a preventive measure in orthodontic patients at risk of gingival recession is also controversial.¹⁶ Several studies have addressed



Fig. 20:

Top: moderate-wide recession defect (Miller Class I). Bottom: 23 months post-treatment following VISTA. Both sides are satisfied with the results. Aesthetic criteria of success are fulfilled. this issue, but differences in their methodology and the heterogeneity in patient ages have rendered extensive analysis challenging. One study reported that younger patients tend to be lost more frequently to follow-up than older patients.¹⁵ Other factors that limit meta-analyses include variations in the amount of movement obtained and the orthodontic treatments performed, absence of a reference point in determining final inferior incisor inclination, differences in the orthodontic posttreatment evaluation period, and differences in the methods employed to analyze the periodontal variables.^{11,12}

In certain situations it is necessary to perform orthodontic treatment prior to mucogingival treatment. These situations include the following: (1) the recession area is associated with shearing movements; (2) gingival recession is located adjacent to one of the mandibular incisors, and the orthodontic treatment plan affects a mandibular incisor extraction because of the Bolton discrepancy (*in this case, the affected tooth should be extracted*); and (3) cases of teeth in labioversion with gingival recession, where the teeth must be moved lingually prior to evaluating the need for mucogingival correction.¹⁷

Comparative clinical study of a guided tissue graft (*GTR*) versus a connective tissue graft (*CTG*) showed no significant difference in the results obtained using each method. For changes in keratinized tissue, the results showed a statistically significant gain in the width of keratinized tissue for CTG, compared with GTR.¹⁸

The minimally invasive VISTA approach presented in this case report, combined with a broad woundhealing growth factor, affords unique advantages for the successful treatment of multiple recession defects. The VISTA approach overcomes several of the shortcomings of the intrasulcular tunneling techniques used for periodontal root coverage. The VISTA technique provides broader access to the vestibule; a single vestibular incision can provide access to the entire region. In addition, VISTA allows visual access to the underlying alveolar bone and root dehiscences. The remoteness of the incision reduces the possibility of traumatizing the gingiva of the teeth being treated. Critical to the success of VISTA is a careful subperiosteal dissection that reduces the tension of the gingival margin during coronal advancement, and simultaneously maintains the anatomical integrity of the interdental papillae by avoiding papillary reflection.

In this particular case, considerations of optimizing both the blood supply and the patients' esthetics required a vertically placed vestibular incision. In the maxillary esthetic zone, superior alveolar arteries (*branches of the internal maxillary artery*) run in a superior-inferior orientation. Therefore, a vertically oriented initial incision is less likely to disrupt the blood supply than a horizontally positioned incision. Placement of the initial incision and a tunnel entrance within the maxillary frenum result in little to no visible scarring. This approach maximizes the esthetic outcome in this critical restorative area. An important technical difference between the VISTA and other tunneling approaches versus more classical techniques of gingival augmentation is

Fig. 21.:

Left: Pre-treatment intraoral photographs with moderate-wide recession defect. Right: 44 months post-treatment long term following VISTA with aesthetic criteria of success

the degree of coronal advancement of the gingival margin advocated for the procedure. The gingival margin, with its attached collagen membrane, is advanced to the most coronal level of the adjacent interproximal papillae rather than to the cementoenamel junction. The sutures are secured to the facial aspect of each tooth, effectively preventing apical relapse of the gingival margin during the initial stages of healing, and compensating for apical migration during the healing period. Apical migration of the gingival margin over relatively long follow-up periods appears either minimal or nonexistent with the VISTA tunnel procedure (*Fig. 21*).¹

Conclusion

We treated gingival recession successfully in our patient by using the VISTA procedure prior to orthodontic movement of the tooth. The VISTA method offers several advantages, including minimally invasive treatment, effective prevention of apical relapse of the gingival margin during the initial stages of healing, and improved esthetic outcomes.

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Discrepancy Index Worksheet

TOTAL D.I. SCORE	1	8			
<u>OVERJET</u>					
0 mm. (edge-to-edge)	=				
1 - 3 mm.	=	0 pts.			
3.1 – 5 mm.	=	2 pts.			
5.1 – 7 mm.	=	3 pts.			
7.1 – 9 mm.	=	4 pts.			
> 9 mm.	=	5 pts.			
Negative OJ (x-bite) 1 pt. per mm. per tooth =					
Total	=	1			
OVERBITE					
0 - 3 mm.	=	0 pts.			
3.1 – 5 mm.	=	2 pts.			
5.1 – 7 mm.	=	3 pts.			
Impinging (100%)	=	5 pts.			
Total	=	0			

ANTERIOR OPEN BITE

0 mm. (edge-to-edge), 1 pt. per tooth then 1 pt. per additional full mm. per tooth

Total

LATERAL OPEN BITE

2 pts. per mm. per tooth

Total

CROWDING (only one arch)

1 – 3 mm.	=	1 pt.
3.1 – 5 mm.	=	2 pts.
5.1 – 7 mm.	=	4 pts.
> 7 mm.	=	7 pts.
		-

=

=

Total

1	-

OCCLUSION

Class I to end on	=	0 pts.
End on Class II or III	=	2 pts. per sidepts.
Full Class II or III	=	4 pts. per side <u>pts.</u>
Beyond Class II or III	=	1 pt. per mm. <u>pts.</u> additional
Total	=	4

LINGUAL POSTERIOR X-BITE

1 pt. per tooth	Total	=		0
BUCCAL POSTERI	OR X-B	BITE		
2 pts. per tooth	Total	=		2
CEPHALOMETRICS (See Instructions)				
ANB $\geq 6^{\circ}$ or $\leq -2^{\circ}$			=	4 pts.
Each degree $< -2^{\circ}$ _		_x 1 pt.	=_	
Each degree $> 6^{\circ}$		_x 1 pt.	=_	
SN-MP $\geq 38^{\circ}$ Each degree > 38°		x 2 pts	=	2 pts.
$\leq 26^{\circ}$ Each degree $< 26^{\circ}$		_x 1 pt.	=	1 pt.
1 to MP \ge 99° Each degree $>$ 99°		_x 1 pt.	= =_	1 pt.
	Tota	al	=	0
OTHER (See Instruc	ctions)			

Supernumerary teeth x 1 pt. = Ankylosis of perm. teeth x 2 pts. =Anomalous morphology x 2 pts. =Impaction (except 3rd molars) x 2 pts. =Midline discrepancy (\geq 3mm) @ 2 pts. =_ Missing teeth (except 3rd molars) x 1 pts. = Missing teeth, congenital $_x 2 \text{ pts.} = ___$ Spacing (4 or more, per arch) x 2 pts. = Spacing (Mx cent. diastema \geq 2mm) @ 2 pts. = Tooth transposition x 2 pts. =Skeletal asymmetry (nonsurgical tx) (a) 3 pts. = Addl. treatment complexities x 2 pts. =

Identify: skeletal class III

IMPLANT SITE

Lip line : Low (0 pt), Medium (1 pt), High (2 pts)	=
Gingival biotype : Low-scalloped, thick (0 pt), Medium-scalloped, m	edium-thick (1 pt)
High-scalloped, thin (2 pts)	=
Shape of tooth crowns: Rectangular (0 pt), Triangular (2 pts)	=
Bone level at adjacent teeth : \leq 5 mm to contact point (0 pt),	5.5 to 6.5 mm to
contact point (1 pt), \geqq 7mm to contact point (2 pts) Bone anatomy of alveolar crest : H&V sufficient (0 pt), Defic	= ient H, allow
simultaneous augment (1 pt), Deficient H, require prior grafting (2 pts), Defic	ient V or Both
H&V (3 pts)	=
Soft tissue anatomy : Intact (0 pt), Defective (2 pts)	=
Infection at implant site : None (0 pt), Chronic (1 pt), Acute(2 pts)	=

Total

2

=

=

0

Total

INSTRUCTIONS: Place score beside each deficient tooth and enter total score for each parameter in the white box. Mark extracted teeth with "X". Second molars should be in occlusion.

IBOI Pink & White Esthetic Score

Total Score: =

3

1. Pink Esthetic Score

2. White Esthetic Score (for Micro-esthetics)

		-		
1. M & D Papillae		0	1	2
2. Distal Papilla		0	1	2
3. Curvature of Gingival Marg	gin	0	1	2
4. Level of Gingival Margin		0	1	2
5. Root Convexity (Torque)		0	1	2
6. Scar Formation		0	1	2
1. M & D Papillae		0	1	2
2. Keratinized Gingiva		0	1	2
3. Curvature of Gingival Marg	gin	0	1	2
4. Level of Gingival Margin		0(1	2
5. Root Convexity (Torque)		0	1	2
6. Scar Formation		0	1	2

Total =

1

2 Total = 1. Tooth Form 0 1 2 2. Mesial & Distal Outline 1 2 0 3. Crown Margin 2 0 1 4. Translucency (Incisal thrid) 0 1 2 5. Hue & Value (Middle third) 1 2 0 6. Tooth Proportion 1 2 0 1. Midline (0)1 2 2. Incisor Curve 0(1)2 0(1)2 3. Axial Inclination (5°, 8°, 10°) 4. Contact Area (50%, 40%, 30%) (0) 1 2 5. Tooth Proportion (1:0.8) (0)2 1 (0) 1 2 6. Tooth to Tooth Proportion