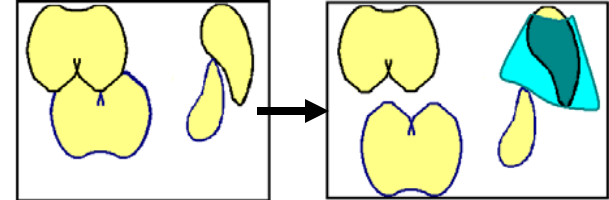
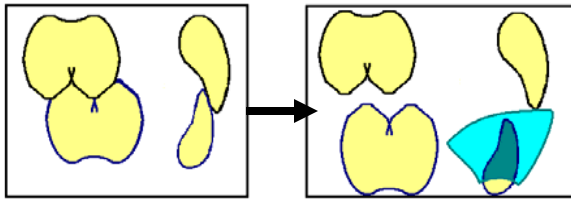


Therapeutic Protocol for Control of Nocturnal Parafunction -- Fabrication and Delivery Flow Sheet for an "NTI" type device

Determining an upper or lower device: *Check degree of incisal overlap in clenched centric occlusion*



With minimal to moderate incisal overlap, choose a **LOWER DEVICE**
 (Although an upper device may suffice, it may provide a clenching platform for the lower canine in extreme excursive parafunction, and is therefore avoided).

With moderate to excessive incisal overlap, choose an **UPPER DEVICE**
 (to minimize condylar rotation, a lower device would have to be considerably ramped, thereby adversely "pushing" upper centrals labially).

Confirm the DE can be parallel to maxillary plane while providing contact to upper central incisors.
 Ask patient to "bite on the device", with the intent of patient reflexively protruding to an incisive bite. Reline the device in this orientation.

Try in upper device with patient in "retruded" closure.
 While holding the device in place, ask patient to "bite on their back teeth" (although they won't be able to). The device will "tilt", resulting in the desired sloping (or ramp) of the DE (while lower device is never ramped)

Modify DE to minimize Vertical Dimension of Occluding while maintaining bi-lateral contact of opposing incisors
 Ask patient, "Which tooth hits harder?" If using an IG device, the curved surface allows device to be shifted sideways to help obtain bi-lateral contact. Otherwise, alter the DE accordingly.

The "Daytime Device", which has a minimal DE, is easiest to minimize

Have patient clench as hard as they can in extreme protrusion and retrusion,
 (following re-line with either acrylic or thermoplastic in the above orientation) and ask "How bad does that hurt?"
If incisors hurt: Modify the contact point on the ramp. (sure-fire method: sculpt out contact spot, add cold-cure acrylic, and have patient gently bite again. Adapted acrylic will provide ideal opposing contact) **If joint hurts:** Patient may be reflexively retruding in order to avoid irregular incisal contact. Modify DE as described at left, OR, there may still be excessive VDO

Protrusion: Upper centrals will be at the distal end of the DE. Confirm minimal freeway space between molars. Reduce DE as needed. (The DE may considerably sloped downward)

Retrusion: For patients with excessive overjets, the labial end of the DE may need to be extended (using cold-cure acrylic) so as to maintain perpendicular contact on the opposing incisor edges.

Protrusion: Confirm that DE does NOT slope "downward" beyond the upper incisors' edges, but re-directions to be parallel with maxillary plane. Extend as necessary to maintain incisor contact.

Retrusion: If incisors can get to the "heel" of the DE or further, distally extend the DE with cold-cure acrylic.

Check for extreme right and left excursions.
 Provide minimal posterior freeway space. Ensure no canine or posterior contacts. Reduce or modify DE as needed.
LOOK FOR occluding posterior cusp tips, and reduce them. There should never be posterior occluding while condyle(s) are translating.

If upper canine contact on lower DE in extreme excursive:
 Slope DE "down/apically" at its distal end and/or add to DE for central contact

Irregular incisal edges making for resisted excursions:
 Consider placing a "slide-bar" over incisors, using a Daytime device.

For occlusions with extreme overjet, or when lower incisor's protrusion from class III exceeds "normal" DE, then fabricate opposing devices and "split the difference" using the two DE's.