

Residual Ridge Resorption (RRR)

Residual bone: component of maxillary or mandibular bone that remains after teeth are lost.

Residual ridge: the portion of the residual bone and its soft tissue covering that remains after the removal of teeth.

Residual ridge crest: the most prominent continuous surface of the residual ridge, not necessarily coincident with the center of the ridge.

Residual ridge resorption: is a term used for the diminishing quantity and quality of residual ridge after teeth are extracted. It is a chronic, progressive and irreversible process with the rate being fastest in the first 6 months after extraction. The size of the residual ridge is reduced most rapidly in the first six months, but the bone resorption activity of the residual ridge continues throughout life at a slower rate, resulting in removal of a large amount of jaw structure. This unique phenomenon has been described as residual ridge reduction.

Post tooth extraction, a cascade of inflammatory reactions is immediately activated, and the extraction socket is temporarily sealed by blood clotting. Epithelial tissues begin its proliferation and migration within the first week and the disrupted tissue integrity is quickly restored. Histologic evidence of active bone formation in the bottom of the socket is seen as early as 2 weeks after the extraction and the socket is progressively filled with newly formed bone in about 6 months. The most striking feature of the extraction wound healing is that even after the healing of wounds, the residual ridge alveolar bone undergoes a lifelong catabolic remodeling.

** Rate of RRR is different among persons and even at different times & sites in same person.*

** A basic concept of bone structure and its functional elements must be clear before bone resorption can be understood.*

The structural elements of bone are:

a. Osteocytes: These are cells responsible for metabolic activity of bone.

b. Intercellular substance or bone matrix consisting of fibrils or called Calcified cementing substance: The calcified cementing substance consists mainly of polymerized glycoprotein. Mineral salts namely calcium carbonate and phosphates are bound to these protein substances.

c. Osteoblasts: Osteoblasts, by their function of forming and calcifying the intercellular substance, are the active bone forming cells. The osteoblasts surround the bone in a continuous layer. In the course of bone formation, some osteoblasts get engulfed in the intercellular substance and become osteocytes.

d. Osteoclasts: Osteoclasts are the cellular components of bone that are responsible for bone resorption. Bone resorption always requires the simultaneous elimination of the organic and inorganic components of the intercellular substance.

Alveolar bone has two structural characteristics:

A hard compact outer layer is superimposed on a spongy somewhat resilient substructure. A healthy and thoroughly healed alveolar process has a layer of wear resistant compact bone of varying thickness. Beneath the compact bone is the spongy bone. The spaces between the trabeculae communicate throughout the spongy bone. Bone is constantly undergoing changes in response to replacement and functional demands.

Pathology of RRR:

1. Gross Pathology: A frequent lay expression for RRR is “My gums have shrunk”. Actually the basic change in RRR is a reduction in the size of the bony ridge under the mucoperiosteum. It is primarily a localized of bone structure. Sometimes it may leave the overlying mucoperiosteum excessive and redundant.

There exists a wide variety of shapes and sizes of residual ridges.

They are categorized into common residual ridge configuration in a system of six orders given by Atwood Order:

Order 1 : Pre-extraction

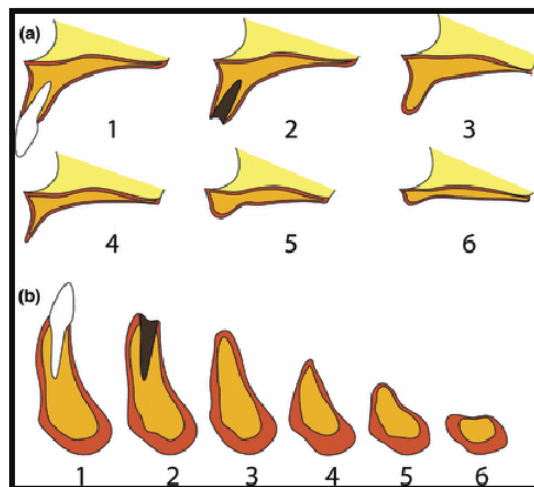
Order 2 : Post extraction

Order 3 : High, well rounded

Order 4 : Knife-edge

Order 5 : Low, well rounded

Order 6 : Depressed



RRR does not stop with residual ridge, but may go well below where apices of teeth were, sometimes leaving only a thin cortical plate on the inferior border of the mandible or virtually no maxillary alveolar process of the upper jaw. In clinical examination usually one can visually judge the residual ridge form. However, sometimes a knife-edge ridge may be masked by redundant or inflamed soft tissues.

2. Microscopic Pathology: Microscopic studies have revealed osteoclastic activity on the external surface of the crest of residual ridges. The scalloped margins of Howships lacunae sometimes contain visible osteoclasts which cause bone resorption. There exists a wide variation in the configuration, density and porosity of the residual ridges, sometimes even with evidence of osteoporosis.

Studies have shown the presence of new bone and reversal lines inside the residual ridge and minute areas of bony repair on the periosteal side in some specimens. The mucoperiosteum shows varying degrees of keratinization, acanthosis, edema and architectural pattern of mucosal epithelium in the same mouth and between subjects. Similarly, varying degrees of inflammatory cells are found in areas that appear from clinically normal to frankly inflamed in edentulous patients or who were denture or non-denture wearers. Inflammatory cells include lymphocytes and plasma cells. There exists proximity of small blood vessels to area of bone resorption.

Pathogenesis of RRR:

Immediately following the extraction (order II), any sharp edges remaining are rounded off by external osteoclastic resorption, leaving a high well rounded residual ridge (order III). As resorption continues from the labial and lingual aspects, the crest of the ridge becomes increasingly narrow ultimately becoming knife-edged (order IV). As the process continues, the knife-edge becomes shorter and even eventually disappears, leaving a low well rounded or flat ridge (order V). Eventually, this too resorbs, leaving a depressed ridge (order VI). RRR is chronic, progressive, irreversible and cumulative.

According to American college of prosthodontists: Based on Bone Height (Mandible only)

Type I : Residual bone height of 21 mm or greater measured at the least vertical height of the mandible.

Type II : Residual bone height of 16 - 20 mm measured at least vertical height of the mandible.

Type III : Residual alveolar bone height of 11 - 15 mm measured at the least vertical height of the mandible.

Type IV : Residual vertical bone height of 10 mm or less measured at the least vertical height of the mandible.

Direction of bone resorption:

- ✓ Maxilla resorbs upward and inward to become progressively smaller because of the direction and inclination of the roots of the teeth and the alveolar process.
- ✓ The opposite is true of the mandible, which inclines outward and becomes progressively wider.
- ✓ This progressive change of the edentulous mandible and maxilla makes many patients appear prognathic.

* Thus, RRR is centripetal in maxilla and centrifugal in mandible.

Patterns of bone resorption

In the Mandible, large proportions of bone loss occurs in the

- ✓ Labial side of anterior residual ridge,
- ✓ Equally on the buccal and lingual side in premolar region and
- ✓ Lingually in the posterior or molar region.

In the Maxilla bone loss primarily occurs on the labial or buccal aspect.

Therefore, while teeth arrangement we should try to restore the natural position of the teeth before they were lost, Hence

- ♣ Teeth in the maxillary arch are arranged slightly labially and buccally .
- ♣ While in the mandible, teeth in the anterior region are arranged labially, on the center of the ridge in the premolar region and slightly lingually in the molar region.

Maxilla V/s Mandible

- It is a clinically acknowledged fact that the anterior mandible resorbs 4 times faster than the anterior maxilla.
- Woelfel et al have cited the projected maxillary denture area to be 4.2 sq in and 2.3 sq in for the mandible; which is in the ratio of 1.8:1.

- If a patient bites with a pressure of 50 lbs, this is calculated to be 12 lbs/sq in under the maxillary denture and 21 lbs/sq under the mandibular denture.
- The significant difference in the two forces may be a causative factor to cause a difference in the rates of resorption.
- Cancellous bone is ideally designed to absorb and dissipate the forces it is subjected to.
- The maxillary residual ridge is often broader, flatter, and more cancellous than the mandibular ridge.
- Trabeculae in maxilla are oriented parallel to the direction of compression deformation, allowing for maximal resistance to deformation.
- The stronger these trabeculae are, the greater is the resistance

Consequences of RRR:

- a. There is apparent loss of sulcus width and depth.
- b. Muscle attachments are displaced closer to the crest of the residual ridge. Due to loss of VDO lower face height is reduced and mandible is rotated anteriorly.
- c. Patient may develop habitual prognathic appearance.
- d. Inter-alveolar ridge relationship is altered.
- e. Morphological changes in residual ridge may appear such as sharp, spiny, uneven residual ridges.
- f. Resorption of the mandibular canal wall and exposure of the mandibular nerve.
- g. Location of the mental foramina close to the top of the mandibular residual ridge.

This provides serious problems to the clinician on how to provide adequate support, stability and retention of the denture.

Etiology of RRR

In equilibrium the two antagonistic actions (of osteoblasts and osteoclasts) are in balance. Ingrowth, although resorption is constantly taking place in the remodeling of bones as they grow, increased osteoblastic activity more than makes up for the bone destruction. Whereas in osteoporosis, osteoblasts are hypoactive, and, in the resorption related to hyperparathyroidism, increased osteoblastic activity is unable to keep up with the increased osteoclastic activity.

* Ridge resorption varies directly with some systemic or localized bone resorptive factors and inversely with some bone formation factors.

Systemic factors influence the balance between the normal bone formation and bone resorption. These factors create a natural resistance to unfavorable local factors. They are:

1. Estrogen.
2. Thyroxin.
3. Growth hormone.
4. Androgens.
5. Calcium.
6. Phosphorus.
7. Vitamin D.
8. Protein.
9. Fluoride.

Some local biochemical factors in relation to periodontal disease which affects the ridge resorption:

1. Endotoxins from dental plaque on unclear dentures.
2. Osteoclast activating factor (OAF).
3. Prostaglandins.
4. Human gingival bone resorption stimulating factors.
5. Heparin acts as a cofactor in bone resorption which is produced from mast cells.

RRR is a multi-factorial, biomechanical disease that results from a combination of anatomic, metabolic and mechanical determinants (functional and prosthetic).

1- Anatomic Factors: these factors includes amount of bone and quality of bone.

Amount of bone: When we clinically examine a completely edentulous foundation, we tend to gauge the residual ridge on the basis of it being high/low, broad/narrow, rounded/spiny,

covered by thick/thin mucoperiosteum. The rate of vertical bone loss in broad, high ridge may actually be slower than that of a narrow ridge because there is more bone to be resorbed per unit of time and because the rate of resorption also depends on the density of the bone.

Quality of bone: On theoretic grounds, the denser the bone, the slower the rate of resorption because there is more bone to be resorbed per unit of time.

2. Metabolic factors: it includes both nutritional disturbances and hormonal causative factors.

a. Hormonal Factors

1. Pituitary Glands and Hypophysis: is the master gland of the endocrine system. The control of the hypophysis over the endocrine system is complex and problems of dysfunction require the analysis of an endocrinologist. Such findings are of importance to the dentist because they involve the general health of the patient, which is reflected in the oral cavity.

2. Thyroid Glands: They are responsible for the regulation of the rate of metabolism. Hyperthyroidism increases the metabolic rate leading to negative nitrogen balance. Such a balance is equivalent to protein deficiency, which can be a direct cause of osteoporosis. Thyroxin also has a direct influence on the kidneys, causing an increased excretion of calcium and phosphorus. This depletion of calcium and phosphorus results in decreased bone apposition and increased osteoclastic activity.

3. Parathyroid Glands: Parathormone maintains blood calcium by mobilizing it from the bones through osteoclastic activity.

4. Islets of Langerhans: The failure of these glands to produce sufficient insulin for proper utilization of glucose causes diabetes mellitus. The syndrome of poor healing, low tissue tolerance and rapid resorption of bone is associated with the diabetic patient. In the absence of insulin, a relative nitrogen starvation occurs from increased gluconeogenesis with the amino acids being diverted from protein synthesis. A diabetic controlled by either insulin or diet is not affected by this mechanism. Since perfect control is rarely possible, a word of caution and explanation to diabetic patients is necessary so that they can appreciate their prosthetic difficulties.

5. Suprarenal Glands: The adrenal cortex produces steroid hormones called corticoids. Cortisone and related steroids are antianabolic. It may induce the formation of glucose from carbohydrates and may increase the calcium loss by direct effect on calcium excretion. The prolonged use and administration of such steroids are considered very dangerous to bone tissue. However, one of the beneficial effects of corticoids is to control the defense mechanism of inflammation.

6. Gonads: In general, the sex hormone (androgens and estrogens) promotes a protein anabolic action on all tissues including bone. A moderate amount of osteoporosis accompanies senescence because of the increased catabolic action reflected by atrophic and degenerative changes throughout the body. The ageing person produces decreased amount of androgens and estrogens, which results in faulty protein metabolism for tissue repair. The bone matrix suffers and normal bone loss cannot be compensated.

b. Dietary Factors

Food is classified as proteins, carbohydrates, fats, vitamins and inorganic elements.

1. Protein: is necessary to build and maintain tissue and to supply energy. The synthesis of osteoid tissue in protein starved people is compromised and calcification is decreased since the protein matrix is embarrassed.

Protein may not be available because of inadequate intake, improper assimilation or excessive loss as in nephrosis or because it is utilized as calorie requirements because of hyperthyroidism/ uncontrolled diabetes.

Inadequate incorporation of protein in diet (3 ounces/ day) will cause slow growth of bone. Bone apposition cannot keep up with normal osteoclastic activity and a negative bone factor exists.

2. Vitamins: The action of vitamins in many respects is said to be same as that of hormones. The relationship of vitamins and hormones can be explained on the basis that the endocrine glands produce intrinsic hormones and the vitamins are extrinsic hormones.

Vitamin A: A deficiency of vitamin A may result in poor development and calcification of bone. Prolonged deficiency of vitamin A causes renal damage by hornification of tubules, which then lose the capacity to reabsorb phosphorus. The imbalance of the calcium: phosphorus ratio leads to osteoporosis.

Vitamin B complex: The total effect of vitamin B complex is of a regulatory nature. Hypovitaminosis B results in loss of appetite, dietary insufficiency, increase in nervous irritability resulting in lowered resistance to stress and emotional tension. The total well-being of the individual is impaired.

Vitamin C: Lack of vitamin causes decalcification of the bone and has been held responsible for diffuse alveolar atrophy. The apposition of new bone slows down dramatically because osteoblastic activity is impaired. The collagen content of bones is also reduced in vitamin deficiency. The periosteum thickness and the cells appear immature and resemble fibroblasts. This condition may make the periosteum easily prone to injury by the denture base. Osteophytes appear as a result of avitaminosis C. The rapid loss of bone and the increased inflammation of the mucoperiosteum cause the development of these bony outgrowths.

Vitamin D: It is necessary for the calcium phosphorus balance to remain within tolerable limits. Vitamin D would be unnecessary if the exact required ratio of calcium and phosphorus were available in the diet. When bone loses its ability to calcify the matrix, administration of vitamin D will cause calcification and denser bone. Moderate overdosage causes excessively mineralized bone, but gross overdosage causes bone resorption. Many drugs act as vitamin antagonists. These drugs act largely on vitamin C and B complex and their excessive use may cause a marked vitamin deficiency.

* Some of the common vitamin inhibitors are nicotine, alcohol, barbiturates, morphine, some of the sulfa drugs and some of the antibiotics such as streptomycin and penicillin.

3. Carbohydrates (Starch and Sugars): They provide the chief source of energy. They are related only indirectly to bone resorption through association with diabetes and by substitution for more favorable foods.

4. Fats and Organic Substances: They are those, which yield heat and energy and only secondarily build/repair tissue.

5. Inorganic Elements:

Calcium salts (calcium carbonate and calcium phosphate)

Form the rigid supporting structure of bones. Phosphorus in the form of calcium and magnesium phosphate, gives hardness to bone. Abnormalities of the calcium phosphorus elements of the blood stream may be associated with alveolar resorption or rarefaction.

The body requires 0.7 gm of calcium/day, which can be obtained from 1 quart of milk. Other sources of calcium are dairy products, spinach, oranges, celery, chard, carrots and lettuce. The phosphorus need is about 1.5 to 3 gm daily dependent upon the form. Dry beans, milk, cheese, leafy vegetables, celery and carrots may fulfill these requirements.

Edentulous patients should follow a prescribed dietary regimen. This diet should be low in carbohydrates and high in protein intake. The diet should include at least a quart of milk or substitute dairy products, vegetables, fruits and a multiple vitamin supplement. The normal equilibrium may be upset and pathologic bone loss may occur if either bone resorption is increased or bone formation is decreased, or if both occur.

- Since bone metabolism is dependent on cell metabolism, anything that influences cell metabolism of osteoblasts and osteoclasts is important.

- The thyroid hormone affects the rate of metabolism of cells in general and hence the activity of both, the osteoblasts and osteoclasts.
- Parathyroid hormone influences the excretion of phosphorous in the kidney and also directly influences osteoclasts.
- The degree of absorption of Ca, P and proteins determines the amount of building blocks available for the growth and maintenance of bone.
- Vit C aids in bone matrix formation.
- Vit D acts through its influence on the rate of absorption of calcium in the intestines and on the citric acid content of bone.
- Various members of Vit B complex are necessary for bone cell metabolism.
- In general terms, anabolism exceeds catabolism during growth and convalescence, levels off during most of adult life and is exceeded by catabolism during disease and old age. Bone has its own specific metabolism and undergoes equivalent changes. At no time during life is bone static, but rather it is constantly rebuilding, resorbing and remodeling subject to functional and metabolic stresses.

Osteoporosis and residual ridge modeling:

The clinical and patho physiologic views of osteoporosis has been refined recently to the concept of Type I and II osteoporosis.

Type I osteoporosis is defined as the specific consequence of menopausal estrogen deprivation, and characteristically presents the bone mass loss, notably in the trabecular bone.

Type II osteoporosis reflects a composite of age related changed in intestinal, renal and hormonal function. Both cortical and trabecular bone are affected in Type II osteoporosis.

3. Mechanical:

a. Functional Factors:

Functional factors include the frequency, intensity, duration and direction of forces applied to bone which are translated into cellular activity, resulting in either bone formation or bone resorption, depending upon on the patients' individual resistance to these forces.

Wolff's law postulates that all changes in the function of bone are attended by definite alterations in its internal structure. Forces within physiologic limits of bone are beneficial in their massaging effect. On the other hand, increased or sustained pressure, through its disturbance to the circulatory system, produces bone resorption. The amount and frequency of stress and its distribution and direction are important factors in treatment planning. Although the total amount of the necessary masticatory stress cannot be diminished, increasing tissue coverage and decreasing the length and width of the occlusal table may lessen the load/unit area.

The frequency of stress application modifies the reaction of alveolar bone to external forces. Constant pressure on bone causes resorption, while intermittent forces favor bone formation. Since recurrent forces over short intervals of time have essentially the same resorbing effect as constant pressure, a rest period between meals is beneficial. For this reason, the patient should be warned that gum chewing has a destructive effect on the bone.

Bruxism is an expression of nervous tension, which manifests itself as gnashing, grinding or clenching of the teeth while the patient is asleep or awake. Since most denture patients do grind their teeth in sleep, the dentures should not be worn during this period. Thus the supporting structures are afforded the rest period essential to the maintenance of the alveolar bone. While grinding of the teeth when the patient is awake may be a habit of tension, it may also be caused due to lack of interocclusal distance.

The principal concern should be in the pattern and position of the posterior teeth. There are two mandibular movements associated with mastication: a closing/cutting movement and a lateral or grinding movement. A sharp cusp will penetrate a bolus of food with less force than a flat occlusal form. However, a law of physics explains that forces applied to an inclined plane produce a resultant force or vector perpendicular or right angles to the plane. Applying this principle to occlusal form, the resultant force of the steep incline of high cusps would produce a lateral force, which might cause alveolar resorption.

Stress distribution favorable to healthy alveolar bone maintenance is dependent principally upon bilateral balanced occlusion. Balanced occlusion is that arrangement of the teeth, which will permit the necessary mandibular movements without tending to dislodge the denture or traumatize the supporting structure

b. Prosthetic Factors: The prosthetic factors are extremely difficult to evaluate because of tremendous number of variables, including anatomic, metabolic and functional factors. The

traditional design of dentures includes many features whose goal is to reduce the amount of force to the ridge and to thereby reduce RRR.

These prosthetic factors include:

- ◆ Broad-area coverage (to reduce the force per unit area).
- ◆ Decreased number of dental units.
- ◆ Decreased bucco-lingual width of teeth, and improved tooth form (to decrease the amount of force required to penetrate a bolus of food).
- ◆ Avoidance of inclined planes (to minimize dislodgement of dentures and shear forces);
- ◆ Centralization of occlusal contacts (to increase stability of dentures and to maximize compressive forces).
- ◆ Provision of adequate tongue room (to increase stability of denture in speech and mastication).
- ◆ Adequate inter-occlusal distance during rest jaw relation (to decrease the frequency and duration of tooth contacts).

4. Pathological factors:

Periodontitis: previously involved bone may be prone to increased resorption under prosthesis.

Diabetes mellitus: poorly controlled diabetes, whether insulin dependent or non-insulin dependent can be associated with a greater prevalence of severe periodontitis.

Acromegaly: lengthening of the mandibular ramus, continuous alveolar bone apposition & increased vertical dimension of occlusion are considerable features affecting the design of prosthesis.

Osteoporosis: it primarily occurs among elderly. It may occur due to decreased estrogen levels, lack of calcium intake & or failure in calcium absorption & transportation.

Fibrous dysplasia: it is a combination of bone resorption, fibrosis of marrow structure & disarrangement of bony architecture. It can be of variable types.

Paget's disease: (bone maintenance disorder) simultaneous increase of pronounced resorptive process & accelerated bone deposition. This alternate activity results in a typical mosaic pattern of the affected bone, known as "cotton wool appearance".

Treatment and Prevention of RRR:

The best way to manage the problem of residual ridge resorption is by using every means to prevent it.

a. **Prevention of loss of natural teeth.** Clinicians must try to retain residual roots whenever feasible.

b. **Proper design of dentures and maintenance.**

- ❖ Optimal tissue health prior to making impression.
- ❖ Impression procedures
 - ◆ Minimal pressure impression technique.
 - ◆ Selective pressure impression technique: places stress on those areas that best resist functional forces
 - ◆ Adequate relief of non stress bearing areas eg. Crest of mandibular ridge.
 - ◆ Broad area of coverage helps in reducing the force /unit area(Snow Shoe Effect) increased denture bearing area can greatly reduce the load per unit area on the underlying mucosa and improve denture comfort, always assuming that the OVD is not excessive.
- ✓ Avoidance of inclined planes to minimize dislodgment of dentures and shear forces.
- ✓ Centralization of occlusal contacts to increase stability and maximize compressive forces.
- ✓ Provision of adequate tongue room to improve stability of denture in speech and mastication.
- ✓ Adequate interocclusal distance during jaw rest to decrease the frequency and duration of tooth contact. Correcting the occlusal vertical dimension: Clinical studies have shown increased (excessive) OVD to be a common fault in many dentures. Guidelines suggest 2-5 mm of freeway space, but this may need to be increased in order patients or for those patients with atrophic mucosa overlying the residual ridges.
- ✓ Occlusal table should be narrow

The concept and arrangement of teeth in neutral zone helps the teeth to occupy a space determined by the functional balance of the oro- facial and tongue musculature. Eliminating disruptive occlusal contacts, which lead to denture instability

In general, occlusal tables tend to be too large. This leads to problems of support and stability, which put too much pressure on the atrophic mucosa during function.

- ◆ Overdentures help minimize ridge resorption and contribute to enhance retention stability, support of prosthesis along with preservation of proprioception.
- ◆ The introduction of dental implants has revolutionized clinical practice. Use of implants for providing implant supported or implant assisted prosthesis also helps avert continuing residual ridge resorption.

Reducing the forces required to drive the denture teeth through the bolus of food:

This may be achieved by either increasing the denture bearing area or reducing the size and altering the morphology of the occlusal table.

1- Increasing the denture bearing area: The smaller the size of the fitting surface of the denture, the greater are the loads applied to the underlying mucosa. In such cases, the denture bearing area may be increased using green stick impression compound before relining or by using a chair-side relining material prior to the denture being relined conventionally.

2- Reducing the size and altering the morphology of the occlusal table.

c. Nutrition

- ⊗ It has been seen that one of the cofactor in RRR is low calcium and vitamin D metabolism.
- ⊗ Diet counseling for prosthetic patients is necessary to correct imbalances in nutrient intake.
- ⊗ Denture patients with excessive RRR report lower calcium intake and poorer calcium phosphorus ratio, along with less vitamin D.

d. Preprosthetic surgery:

- Excessive RRR leads to loss of sulcus width and depth with displacement of muscle attachment more to the crest of residual ridge.
- Osseous reconstruction surgeries, removal of high frenal attachments, augmentation procedures, vestibuloplasties etc may be required to correct these conditions.

e. Immediate dentures: Some authors claim that extraction followed by immediate dentures reduces the ridge resorption.

f. Overdentures: Tooth supported over dentures help in improved stress distribution there by maintaining the integrity of residual ridge.

A study was conducted with overdentures supported by canines and it was seen that, the bone loss was 0.6mm whereas 5mm in conventional complete dentures.

g. Osseointegration and implant: Precautions during extraction to reduce RRR When a tooth is removed the labial plate should be preserved.

- The labial periosteal covering should remain intact as its inner layer is responsible for remodeling of bone.
- If a bone has to be removed it must be the palatal plate.

IMPORTANT NOTES:

1. Reduction of residual ridges (RRR) needs to be recognized for what it is: a major unsolved oral disease which causes physical, psychologic, and economic problems for millions of people all over the world.
2. RRR is a chronic, progressive, irreversible, and disabling disease. At the present time, the relative importance of various cofactors is not known.
3. Much is known about the pathology and the pathophysiology of this oral disease, but we need to know much more about its pathogenesis, epidemiology, and etiology.
4. The ultimate goal of research of RRR is to find better methods of prevention or control of the disease. Because prevention is the key.