ABSTRACT:
Introduction. Molar incisor hypomineralization (MIH) was defined as “hypomineralisation of systemic origin of permanent first molars, frequently associated with affected incisors”. MIH includes the presence of demarcated opacity, post eruptive enamel breakdown, atypical restoration. The approach to management suggested: risk identification, early diagnosis, remineralization for prevention of caries and post eruption breakdown, restorations. The clinicians very seldom notice that children with MIH usually have both-hypomineralisation and malocclusions, and they do not discuss combine treatment plan.

Aim. To present our interdisciplinary approach to a patient with MIH, combined with malocclusion.

Material and methods. We are presenting 9 year old child with contusion and fractura coronae dentis noncomplicata, distal occlusion, overjet, overbite and retrusion. Two consecutive stages were defined:

First stage:
- Professional oral hygiene and local remineralisation therapy
- Vital pulp therapy of tooth 21
- Space gaining for restoration of the lost height of the molars by the means of posterior bite-plane removable appliance
- Restoration of the molars with metal inlays
- Lingual tipping of the lower incisors

Second stage:
- Class II correction
- Growth control

Results.
First phase:
- The tooth 21 was restored with aesthetic composite material;
- Occlusion was raised with occlusal restorations (inlays) and orthodontic appliance.

Second phase:
Medialisation of mandible and holding maxillary growth with functional appliance and occipital EOA until class one occlusal relations.

Conclusion. Children with MIH should be examined and treated complex in collaboration with orthodontist and if necessary by other specialists too.

Key words: Molar incisor hypomineralization (MIH).

REFERENCES:
12. Laisi S, Ess A, Sahlgren C, Arvio P, Lukinmaa PL. Alaluusua S. Amoxicillin may cause molar incisor...
Molar incisor hypomineralization (MIH), which refers to the clinical picture of hypomineralization of systemic origin affecting one or more first permanent molars (FPMs). Laisi and co-workers found that the exposure of a child via placenta/mother’s milk to PCDD/Fs (At prevailing levels) is not associated with MIH [52]. Furthermore, a Turkish study showed a similar prevalence of MIH in children living in an urban area polluted by dioxins and in those living in an area with low pollution [53]. Fluorides. Fluoride is thought to affect enamel crystal formation mainly during the maturation stage inducing defects described as diffuse opacities [54]. The clinical expression of first permanent molars with Molar-Incisor Hypomineralization (MIH) represents a continuum of severity from hardly visible opacities to severe destruction of the enamel. In addition, affected teeth have a tendency to accumulate more severe defects over time, due to post-eruptive breakdown of hypomineralized enamel [1–4]. Which treatment would you provide for this newly erupted first molar with moderate hypomineralizations and no disintegration of the surface enamel? The patient is six years old, has good oral hygiene, normal occlusion and is cooperative. Fig. Molar incisor hypomineralization can be a result of a systemic upset during the first years of a child’s life when the crowns of permanent first molars and incisors are in the process of mineralization. The transitional ameloblast is considered as the most vulnerable stage to systemic disturbances. Risk factors associated with development of mih. Lygidakis NA et al4 conducted a study on 151 children with MIH. It was reported that 78% had experienced medical problems: prenatally (19%); perinatally (44%) and neonatally (22%). 7. Kabaktchicheva R, Bogdanov R. Clinical treatment approach of a child with molar incisor hypomineralization (mih) combined with malocclusion. J IMAB 2012;18(2):174-180. 8. Fayle SA.