Implant treatment in the anterior mandible has favourable long-term success rates when compared with other areas of the mouth (Gokcen-Rohlig et al. 2009). Placement of dental implants in the interforaminal area is considered as a safe and predictable procedure. However, perforation of the lingual cortical plate can result in a profound and potentially life threatening sub-lingual bleed (Bucal 2008). The blood supply to this area is provided by the submental, sublingual and mylohyoid arteries which if perforated, may set-off a massive internal haemorrhage in the floor of the mouth. Although rare, this can ultimately cause protrusion of the tongue resulting in airway obstruction and necessitate surgical intervention. It has been recommended by Tepper et al (2001) that CT imaging of this area is warranted to visualise 3D bone anatomy prior to surgery, thereby reducing the possibility of surgical instrumentation of this sensitive area.

In this case report I shall show how CBCT coupled with chairside diagnostic imaging has helped plan, simplify and execute implant
placement in the anterior mandible.

_Patient history_

A 44-year-old female who has been undergoing long term periodontal treatment presented with mobile and painful lower incisors. She exhibited very good oral hygiene but with a periapical area and mobility associated with the UR4 and grade 2 mobility of her lower incisors. The patient described difficulty and embarrassment when eating due to the movement of her lower teeth and wanted a fixed solution.

_Clinical examination_

The patient had a lightly restored dentition with a thin gingival biotype. As previously mentioned, her oral hygiene was good and she was a non-smoker (gave up 11 years previously). She exhibited bi-lateral canine guidance with no evidence of any parafunction. Her BPE scores were 312/231.

_Treatment options:_

Due to the patients’ history of periodontal disease and associated mobility, she was aware that some form of replacement was necessary. The patient did not want a removable restoration and preferred a fixed solution. In this area of the mouth either fixed bridgework or an implant retained prosthesis were possible. After discussing the options, and highlighting the increased risk of peri-implantitis of implants in patients with previous periodontal disease, [Esposito 2006] the patient opted for a fixed implant retained solution. The treatment was to be planned in such a way that if she lost her posterior molars in the future, a full arch fixed prosthesis could be made after subsequent implant placement.

_Treatment plan:_

1. Continuation of periodontal treatment and oral hygiene advice
2. CBCT Sirona Galileos scan to assess bone height, bone profile and associated anatomy.
3. Extraction of all four lower incisors and the UR4
4. Placement of two Straumann SLA active implants
5. Restoration with a Screw retained 4 unit PFM bridge

_CBCT_

It was decided to take a full volume CBCT to further assess the upper teeth and the UR4 for future implant replacement. The CBCT showed excessive bone loss around the anterior incisors with a small area of periapical radiolucency around the LL1. A cross-sectional view showed thick well developed cortical plates
with very little lingual concavity. Due to the good bone height, and minimal pathology, immediate implant placement was planned.

Due to the patient’s bone loss the lower incisors had drifted, giving a less than desirable tooth position. One of the patient’s main complaints was the gaps which had appeared between the lower incisors and the uneven appearance of the incisal edges.

To aid implant placement in the correct angulation, a Cerec Blu-Cam image was taken and manipulated so that the lower tooth positions were in harmony with the rest of the dentition. This proposal was then overlaid onto the CBCT scan and was used to facilitate implant planning. The aim was to provide the patient with a screw retained bridge with access holes though the lingual aspects of the lower incisors, whilst maintaining a sound margin of safety from the lingual cortical plate.

Due to the patient’s previous periodontal history, it was decided to use Straumann Standard plus implant in this case. The design of this implant incorporates a 1.8mm polished collar above the active surface of the implant. This results in the implant-to-abutment junction being located 1.8mm superiorly to the bone crest.

**Surgical procedure**

The patient was given 400mg Ibuprofen and a Chlorhexidine mouth rinse before the surgery began. The procedure was carried out under intra-venous sedation using Midazolam.

The lower incisors were removed using periotomes and forceps. The sockets were curetted and thoroughly irrigated. A crestal incision with distal relieving incisions was made. Due to the CBCT and surgical stent only a small lingual reflection was necessary.

Implant placement was carried out using standard ITI protocols. Two Straumann SLA-Active standard plus implants of 4.1 x 10mm were placed. The implants exhibited excellent primary stability with an insertion torque of greater than 35Ncm. The patients’ bone quality was estimated to be type D1-2 (Lekholm & Zarb 1985). Due to the high primary stability...
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and good bone quality it was decided to adopt a single stage surgical protocol, thereby placing healing abutments over the implants. The site was closed using 5.0 PGA sutures and a tooth supported denture replacing the lower incisors was fitted. Careful examination of the denture was carried out to ensure there was no contact, or transfer of occlusal load onto the implants from the denture. The patient was seen seven days after surgery for suture removal and review.

The patient healed without incident and due to the favourable lingual undercuts of the lower teeth was able to comfortably wear the denture during the healing process. Due to financial reasons the planned implant placement for the UR4 site was deferred until a later date.

After eight weeks of healing, fixture level open tray impressions were taken in Impregum (3M ESPE), and 4-unit screw retained bridge was fabricated. The tooth set of the denture was duplicated on the final bridge as the patient was happy with the tooth size and shape. Due to the previous bone loss, pink porcelain was added to the bridge to improve the emergence and reduce the crown lengths of the lower incisors.

The bridge was seated and torqued to 35Ncm and composite placed in the access holes, a baseline long cone periapical radiograph was taken to serve as a baseline for bone level measurements. The occlusion was checked, with the patient exhibiting canine guidance in excursive movements. The patient was shown how to clean under the bridge using super floss and tepe brushes and placed on a long term maintenance programme.

**Prognosis**

The bridge has a good long-term prognosis as this patient is highly motivated, and exhibits excellent oral hygiene. She is aware of the increased risk of complications, and the possibility of losing more teeth in the long run, but after having worn a denture for three months, she is determined to avoid becoming a long-term denture wearer. The patient will see me at six-monthly intervals and sees a hygienist every three months for maintenance.

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**Author info**

Dr Nilesh R Parmar BDS (Lond) Msc (ProsthDent) Msc (ImpDent) Was voted Best Young Dentist in East Of England in 2009 and runner up in 2010. He is one of the few dentists to hold a University Of London degree from all three London Dental Schools and is due to start his 3rd Msc in Orthodontics at Warwick University this year. Nilesh is an Astra Tech Clinical Coach and has his own practice in Southend on Sea, Essex. He also works as a visiting implantologist at Sparkly Smiles in Blackheath and the London Bridge Dental Practice. www.dmileshparmar.com.