Long-term clinical success in the management of compromised intertooth spaces utilizing small-diameter implants

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Management of edentulous sites in the oral cavity with dental implants has been well documented in dental literature during the last 45 plus years. Patients seeking tooth replacement for partial or totally edentulous situations have been able to enjoy natural appearing and functioning prostheses that are fixed, stable and, in some cases, so natural it is difficult to ascertain a dental implant restoration for a tooth restoration.

Using dental implants to replace the natural tooth system in the esthetic zone has also seen an increase in restorative treatment plans and, with the advent and perfection of immediate restoration protocols initially reported in the literature, achieving natural soft-tissue esthetics around dental implants can be predictable and successful. However, certain clinical situations can complicate or negate the procedure all together.

One of these complications is insufficient intertooth spacing between natural teeth and, most commonly, congenitally missing lateral incisors following orthodontic treatment. Often as a solution to this, the dentists choose a removable partial denture or some type of resin-bonded bridge, both of which may not be appealing to younger individuals. In extreme cases, the dentist may elect to proceed with a fixed bridge, which would cause excessive destruction to the natural teeth serving as abutments and, for a young individual, this could be devastating to these teeth during a 40-50 year period, if not sooner. To properly form an ovate pontic type emergence profile in the soft tissue, which is required for a fixed bridge to have a natural clinical appearance, consideration must be given to the intertooth edentulous space. This is also very important when choosing dental implants for natural tooth replacement. Wallace, Misch and Salama et al. stated that an implant site requires, for a normal two-piece implant, the implant should be placed at least 5.5 mm from the adjacent teeth. As a result, using a 3.5 mm diameter implant, the minimum intertooth space to support interproximal bone and natural soft-tissue papillary contours should be 6.5 mm, and with a 4.0 mm diameter implant, 6.0 mm for the edentulous space. Often, the intertooth space in these types of cases is smaller than 6.0 mm.

Taking these parameters into account, small-diameter (1.6 mm) implants (3.5 mm is the smallest from most dental implant manufacturers) should not be used in cases with less than 6.0 mm of intertooth space, to prevent potential tooth root damage; crestal bone loss and unnatural appearing gingival tissues and papillae.

Small-diameter implants were developed more than 20 years ago and, initially, the recommended use was to support temporary removable prostheses during the healing phase for advanced bone-grafting procedures and/or conventional implant placements. Their use was later expanded into immediate conversion of full dentures into implant-supported dentures, support for partially edentulous cases and for anchorage of single tooth implant restorations in compromised intertooth spaces. Implants are available from 1.8 mm diameter to 2.8 mm diameter and offer a fixed permanent tooth replacement option for patients that otherwise would not be able to have implants placed and restored. Their ease of use and atraumatic placement utilizing a flapless approach, with only one coring procedure, as well as simplistic abutment transfer and provisional construction, make the use of these implants in the aforementioned sites a must for the dental implant practitioner.

The following case report will demonstrate the use of the Dentatus ANEW (Dentatus USA, Ltd, New York, NY) implant for the management of the compromised, congenitally missing lateral space in a 17-year-old teenage girl and a 10-year clinical follow up.

Case report A 17 year-old, non-smoking female presented for tooth replacement in the congenitally missing maxillary left lateral incisor site (Fig. 1). The patient had recently completed orthodontic therapy and the orthodontist and general practitioner had agreed this was the final obtainable result in regard to the remaining intertooth space between the maxillary left central incisor and maxillary left canine (Fig. 2). The resultant intertooth space was less than 5 mm, and conventional two-stage implants with abutment options were ruled out. The patient and her parents ruled out conventional tooth replacement options and chose the minimally invasive procedure. A small-diameter implant, 1.8 mm in diameter, which would allow for natural papillary contours to be developed. After administration of an appropriate local anesthetic, an ovale pontic contour was created utilizing a football-shaped diamond in the attached, keratinized tissue of the edentulous site (Fig. 3). This scalloped type tissue contour helps in the creation of the natural appearing papillary contours.

The small-diameter implant chosen, a 1.8 mm x 14 mm Dentatus ANEW Implant was then placed after a sin-
Fig. 5. Immediate postoperative clinical view

Fig. 6. Immediate postoperative radiograph

Fig. 7. Lab-processed, long-term provisional restoration

Fig. 8. 10-year postoperative clinical view

Fig. 9. 10-year postoperative CT serial view

gle coring of the site with a 1.4 mm spade drill to full depth, within the sculpted tissue emergence profile previously created (Fig. 4). Conversion to anesthetic provisional restoration was completed by placing an abutment coping with a silicon retention screw (Dentatus USA, New York, N.Y.).

An ion shell provisional crown was then hollowed out and retrofitted to the abutment coping with flowable composite. The margins of the provisional were corrected and provisional contoured out of the mouth. The restoration was polished and seated with the set screw from the palatal. The immediate postoperative clinical view is seen in Fig. 5. The immediate postoperative periapical view is seen in Fig. 6.

The patient then went through the three-month healing and observation phase prior to construction of a lab-processed provisional restoration (Fig. 7). One year later, the patient underwent final restoration fabrication at the left lateral incisor site. A 10-year postoperative clinical image can be seen in Fig. 8 and a 10-year postoperative CT scan of the implant in Fig. 9. Please note the beautiful soft-tissue esthetic result obtained and excellent maintenance of the crestal and lateral contours.

**Conclusion**

The management of compromised intertooth spaces presents a challenge for the contemporary dental implant team. These spaces have limits on how they are handled and require implants 3.0 mm wide or less, as was demonstrated in the text of this article. Availability of smaller-diameter implants allows patients that normally would have to proceed with a fixed bridge, or resin-bonded bridge, the luxury of dental implants with no preparation and/or reduction to the adjacent natural dentition.

Proper placement procedures and restorative techniques can lead to very esthetic results, allowing for natural tissue contours and emergence profile formation, reminiscent of the natural tooth.

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**References**


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