ing soft tissue structure was
decisive in most cases.

Case report
A 56-year-old female pa-
tient was referred with a his-
tory of a persisting deciduous
upper canine and suffering
from periodontitis and apical
root resorption. Subsequently
to radiological evaluation,
probing revealed only a mini-
cmal circumferential pocket
depth of 5 mm and no exudation
of pus. Vitality of the tooth on
testing was negative and the
tooth was slightly movable. An
abnormal lateral position with
a slight movability had also
been recognised.

A decision was made for an
immediate implant protocol
assuming bone structure to be
unaffected. Under local anaes-
thetics the tooth was extracted
atraumatically, buccal and
palatal plate were intact with
sufficient bone thickness
(Fig. 2). Subsequently, the ex-
traction socket with a little
amount of apical inflammatory
tissue had been curedt fol-
lowed by irrigation using 5 per
cent hydroperoxide. Next, a
Camlog Screw-line (Promode
plus surface) implant (CAM-
LOG Biotechnologies AG,
Basel, Switzerland) was placed
using a 10° palatal angulation
during insertion, thus provid-
ing enough primary stability.
Implant diameter was 5 mm,
length was 16 mm throughout
(Figs. 3, 7).

However, the implant-
socket gap was closed using
bone material that was col-
lected with an Astra Tech
Bone Trap bone collector. A
provisional crown (plastic-
coated, highly polished, com-
posite) with screw retention
was fabricated and integrated
on the same day (Figs. 5, 6).
During the fabrication period a
healing abutment was attached
for three to four hours to main-
tain stable mucosal condition
and prevent mucosal collapse
(Fig. 4). When integrated, con-
tacts of the crown were care-
tfully removed during maximal
intercuspidation, protrusion
and lateral shift. A strict weekly
recall of the patient followed,
instructions were given to en-
sure perfect oral hygiene and a


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A stringent protocol was set up to avoid bite contacts and chewing with contact to the provisional crown.

X-rays were taken directly after surgery and prior to definitive restoration (Fig. 7) and stability of the implant-crown system was checked clinically throughout the healing time. Three months later the provisional crown was removed. At this time the surrounding soft tissue structures appeared to be within normal limits and unaffected (Fig. 8). Impressions were taken to fabricate a definitive crown (Fig. 9). By the time of definitive management, the mucoepithelial junction was at the same level as the area around the natural contralateral tooth. Papilla contour and surrounding tissue structure were preserved as predicted beforehand (Figs. 10–12). During follow-up (six months and 12 months) no signs of inflammatory lesion, loss of stability or soft tissue attachment were noted and the papilla remained stable.

Discussion

Various options are available for functional and aesthetic restoration of anterior teeth. Their choice is dictated by factors like severity of infection of the teeth to be extracted, the pocket depth and related bone defects. Immediate single-stage implant placement proved to be the least traumatic option, which best preserved both the soft tissue and post extraction socket.

A different use of surgical and prosthetic techniques is indispensable to account for conditions in the individual case. Given an adequate amount of hard tissue, soft tissue contours can be expected to return to normal as presented in this case report.

It was demonstrated that implants inserted immediately into fresh extraction sockets will heal predictably with clinically significant quantities of bone and preserving the surrounding soft tissue structures. Detective alveolar bone structures, especially a defective vestibular wall, that become visible during extraction, require additional measures that will have to be discussed soon.
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