Aesthetic management of a single dental implant

Dr Michael Sonick details a case involving both form and function in the aesthetic zone.

A medically and periodontally stable 57-year-old man was presented with coronally fractured tooth #9, which had a history of endodontic treatment (Fig 1). The tooth was deemed restoratively hopeless.

**Treatment Plan**
1. Extraction of tooth #9 and socket preservation
2. Three-month healing period
3. Placement of implant #9 and connective tissue graft
4. Three-month healing period
5. Implant #9 exposure, placement of healing abutment and connective tissue graft
6. Three-month healing period
7. Final implant #9 crown restoration

**Extraction and Socket Preservation of Tooth #9**
After oral sedation with 0.25mg triazolam and local anesthetic induction using two per cent lidocaine with 1:100,000 epinephrine and 0.5 per cent buccapvaine with 1:200,000 epinephrine, a sulcular incision was made circumferentially around tooth #9. The remaining root was extracted atraumatically using a piezoelectric periosteum device (Fig 2). Thorough degranulation of the extraction site with a pear-shaped carbide finishing bur and Prichard curette proceeded. No dehiscence or fenestration was detected. Freeze-dried bone allograft (FDBA) was used to obliterate the extraction socket. A bioabsorbable collagen plug (CollaPlug®, Zimmer Dental, Carlsbad, CA) was used to cover the graft.

**Implant Exposure with Connective Tissue Graft**
After oral sedation with 0.25mg triazolam and local anesthetic induction using two per cent lidocaine with 1:100,000 epinephrine and 0.5 per cent buccapvaine with 1:200,000 epinephrine, a flap was created using a trapezoidal papilla-sparing incision design that involved a palatally-oriented crestal incision over the #9 site with two vertical releasing incisions made on the buccal, both avoiding the mesial and distal papillae. A full-thickness flap was raised past the mucogingival junction. Degranulation of the site with a pear-shaped carbide finishing bur and Neumaster revealed adequate apico-coronal, buccolingual and mesio-distal dimensions for implant placement. After osteotomy preparation, a rough-surfaced, internal hex 4mm (platform) x 13mm (length) implant was placed into the filled site (NanoTine® Parallel Walled Certain® Implant, Biomet 5i, Palm Beach Gardens, FL) (Fig 5). Primary stability was achieved, and a cover screw was placed.

In order to form an aesthetic soft tissue profile by expanding mucosal dimensions, a connective tissue graft was harvested from the palate and placed on the buccal aspect of the ridge overlying the implant. The graft was stabilised using 5-0 chromic gut sutures (Fig 6). After periosteal release via lateral scalpels incisions, the flap was primarily closed with 4-0 ePTFE sutures in an interrupted and horizontal mattress fashion (Fig 7). The area was re-temporised with a resin-bonded fixed partial denture.

**Post-Operative Instructions**
After each surgical procedure, the patient was instructed to take ibuprofen 600mg every 4-6 hours, hydrocortisone 75mg/acetaminophen 750 mg every 4-6 hours as needed for pain, and doxycycline 100 mg every day for 10 days. The patient was instructed not to brush at or near the surgical site but instead to rinse with 0.12 per cent chlorhexidine or warm saline twice daily. The patient was also directed not to chew in the affected area for at least two weeks. Suture removal occurred at 10-14 days post-surgery.
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The choice between cement and screw-retained implant-supported prosthesis may be a matter of clinicians’ preference or dictated by particular clinical situations. This case report presents a clinical situation and the guidelines that led to the ultimate prosthetic treatment decision based on implant angulations, interocclusal relationship and arch position. The clinical considerations are presented to aid the clinicians in determining the most appropriate method of retention for a screw-retained implant-supported fixed partial denture (FPD).

A screw-retained implant-supported fixed partial denture (FPD) has certain physical advantages. However, according to several studies they require precise positioning of the implant for optimal location of the screw access hole. Also, obtaining passivity of frameworks that are screw-retained is difficult due to dimensional discrepancies inherent in the fabrication process.

Anchorage of prosthetic fixed partial dentures to implants can be achieved in two ways: some clinicians cementally have screw access openings, which can compromise aesthetics, weaken the porcelain around the openings and at cusp tips, and establish unstable occlusal contacts. Cementation of implant restorations eliminates unaesthetic screw access holes. Cemented restorations also have the potential to compensate for any minor dimensional discrepancies in the fit of restorations to abutments, which can contribute to lack of passivity. It has the potential to reduce stress to splinted implants, since

Screw-retained implant-supported fixed partial denture (FPD)

Michael Nawrocki and Dov M Almog provide implant information and a case report

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OSSEINTINTEGRATED IMPLANTOLOGY COURSE

Sunday 27th March – Friday 1st April 2011 Inclusive
Sunday 11th September - Friday 16th September 2011 Inclusive

This intensive format is ideal for delegates who wish to participate in a course over 6 consecutive days – £2200

Topics covered include:
- examination and treatment planning
- dealing with the patient within the practice
- anatomy, physiology
- biomaterials
- sterility
- surgical templates
- surgical techniques (to include bone augmentation and advanced surgical techniques)
- implant impression techniques
- jaw registration
- articulation
- periodontal consideration (to include maintenance protocol and guided tissue regeneration)
- Connecting teeth to implants
- Detailed literature review.

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- Dr Joe Omar on ‘Medical Emergencies’
- Dr Alan Cohen on ‘Medico – Legal Aspects’
- Mr Sean Goldner on ‘CT Scanning’
- Mr Keith Rowe on ‘Laboratory Techniques’

There will be hands-on session on the surgical, prosthetic and laboratory phases, and the delegates will attend a CT scan appointment with one of the patients on the course.

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the effects of minor misfit of the framework are not transferred directly to the implants, as is the case with prosthetic-retaining screws. In addition, the exposure of screw access holes in esthetic areas of the mouth can be avoided. On the other hand, any excess retained cement extruding from the prosthesis/abutment interface, especially when located sub-gingivally, can cause inflammation, infection, and periodontal complications.

As more and more dental practitioners are focusing on implant-supported fixed partial dentures (FPD) restoring dentists need to understand the restorative options they may have to deal with. Many dental practitioners and labs will persistently use a screw-retained implant-supported fixed partial denture system to offer an opportunity to minimise any controversy between the surgeons, restorative dentists and laboratories, creating greater understanding, appreciation and professional camaraderie.

Case Report

Patient presented for implant supported FPD after having teeth #8, 9, 10 extracted with socket preservation.

A CBCT study was performed with the iCAT CBCT machine (Imaging Sciences International, Hatfield, Pa) and revealed reasonable alveolar dimensions, both vertical and horizontal. However, by utilising ImplantMaster™ software (iDent Imaging, Inc., Foster City, CA, 94404-1294), it was discovered that the residual bone trajectory (BRT) and the planned prosthetic trajectory (PPT) were in conflict, that is, projecting a compromised restorative trajectory lingually in implant site #9 and buccally in implant site #11 (Fig. 1). Nevertheless, following a treatment planning conference, rather than considering bone grafting, a decision was made to proceed with these angulations and a 3-D reconstruction of a patient’s anatomy was attained and a virtual surgical guidance template was designed and computer manufactured with precise drilling holes’ distribution and trajectory for implants #9 and #11.

The palatal trajectory of the implant in tooth position #9, the patient’s deep bite which resulted in severely limited space for prosthetic components, dictated a screw-retained prosthetic FPD construction solution for the case.

The extremely buccal angulation of the implant replacing tooth #11 resulted in a buccally located screw access opening, which compromised aesthetics, and potentially weakened the porcelain around the screw opening in the proposed screw-retained three units FPD. The aesthetic dilemma could be solved by either gold plating of the metal portion of the screw chamber, which can reduce the need for opaque composite material, or by metal cut back to hide the non-aesthetic metal. We chose to overcome this aesthetic and structural obstacle by using a separate telescopic crown design to cover the metal sub-
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MIS makes it simple with SEVEN implant. The only implant in the world that comes with a specially designed and sterilized final drill, allowing a short and safe drilling procedure.
The patient, a 36-year-old female office worker, was initially referred for implant therapy (via one of my implant course delegates) for replacement of the missing upper right central incisor. The upper central incisor had been lost following accidental trauma when she was 17 years old; the resultant space had been initially restored with a removable denture, but more recently with an adhesive bridge.

At the time of the trauma, the patient had asked her dentist if she was able to have a dental implant, but was told that there was insufficient bone and that such treatment was impossible.

On examination the patient was fit and well, a regular attender, non-smoker with low alcohol consumption. Extra oral examination found nothing abnormal.

Intra orally, the patient had signs of widespread gingival recession, oral hygiene was excellent, with no deposits and BPE codes healthy in all sextants. The patient presented with a composite occlusal restoration (UL6, LL6) and an adhesive “Maryland” bridge restoring UR1 with retainer wings UR2 UL1. There was Class 1 occlusion with general overcrowding, no interferences and canine guidance.

Radiographic assessment of UR2, UL2, revealed absence of periapical pathology, non-convergence of roots in adjacent teeth with good bone height. The missing upper right central incisor had healthy adjacent teeth and a healthy, bony site. The edentulous area had reduced volume with respect to soft and hard tissue.

Following a formal discussion of her treatment options and advantages / disadvantages of each, a treatment plan was formalised in a detailed written patient report and verbal and written consent to treatment was obtained.

**Treatment Plan**

1. **Two stage implant surgery** was planned: Under LA, full flap elevation, implant placement (16mm NP NobelReplace tapered groovy) with hard and possibly soft tissue augmentation either simultaneously or at second stage surgery.

2. **Second stage surgery; uncovering of implant +/- soft tissue augmentation and attachment of under contoured modified healing abutment.**

3. **Fixture head impression for lab construction of ideal design screw retained composite prototype crown.**

4. **Fit prototype implant crown with negatively contoured sub-gingival emergence profile**

5. **Pick up impression using modified impression coping**

6. **Fit definitive under contoured zirconium abutment and all ceramic procera crown**

7. **Maintenance of implant restoration and remaining dentition by GDP. Including continued hygienist support.**

The treatment was carried out over a period of seven months.

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**Single tooth anterior implant, the ultimate aesthetic challenge**

Dr Richard Brookshaw discusses an interesting case presentation, placing a single tooth anterior implant in a young female patient.

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Reflection

The patient had an optimal result at the end of treatment, which she was extremely delighted with. Her management throughout was planned and executed with the utmost detail to attempt to deliver the most comfortable experience possible considering the nature of the treatment involved. She was offered a denture, which she had endured for the past 20 years and refused; a conventional bridge, which would have been destructive to the adjacent virgin teeth; or an adhesive bridge which she preferred to her denture but did not instil her with confidence. The patient was determined to undergo implant therapy if possible, and she had sought advice as to the feasibility 10 years ago but was dissuaded. She was willing to undergo any necessary treatment to augment the site ready for optimal implant therapy and was consented for the potential treatment sequence which may even involve block bone grafting and repeated soft tissue procedures.

As it was, she responded extremely well to treatment and her treatment was more simplified than expected. The utilisation of a laboratory made prototype restoration was a good policy which greatly improved the final result, although the patient’s finances were limited and it was carried out free of charge. The under contoured adjustment of the standard healing abutment at the minimally invasive second stage procedure encouraged more soft tissue growth, which also helped the final result. The patient was very amenable to the philosophy employed and never complained about the extra visits involved. Her focus was trying to gain the best possible final outcome. Translation of all of the information worked so hard to achieve in the prototype was also communicated to the laboratory in as accurate a way as possible, which helped ensure the final result.

The use of a narrow platform implant (3.5mm diameter) helped to keep the hard and soft tissue dimensions to a maximum and therefore perhaps allow greater long-term aesthetic success, which is why these implants are often utilised in the aesthetic zone.

Lengthy discussion was also had regarding root coverage procedures on the other recessions, which the patient is now considering following the good result achieved with the adjacent UR 2.

Fig 8: Advancement and closure of flap with 4/0 vicryl suture. simple interrupted sutures after periosteal release. Root coverage ur2 evident.

Fig 9: Healed site prior to second stage surgery.
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*References available upon request
A medically and periodontally stable 50-year-old woman presented with failing #8 and #9 teeth that exhibit asymmetry, lack of interdental papilla and a history of failing root-canal therapy and apicoectomy (Fig 1).

### Treatment Plan
1. Extraction of teeth #8 and #9, immediate implantation of #8 and #9 and immediate non-functional provisionalisation of #8 and #9
2. Three-month healing period
3. Gingivectomy to create mucosal symmetry
4. Six-month healing period, during which contour adjustments to interim restoration will be made to manipulate papillary regeneration
5. Placement of final single PFM crowns on implants #8 and #9

### Treatment Plan Rationale
Implant rehabilitation for sites #8 and #9 boosts long-term prosthetic success, which diminishes future costs and permits more future restorability options. The patient is an ideal candidate for immediate implant placement and provisionalisation due to her thick biotype, which resists recession, as well as the inherent coronal positioning of the gingival drape around #8 and #9 compared to the adjacent teeth, which allows any minor recession post-treatment to remain within aesthetically-pleasing bounds.

### Extraction of Teeth #8 and #9, Immediate Placement of Implants #8 and #9, and Immediate Non-Functional Provisionalisation of Implants #8 and #9

After oral sedation with 0.25mg triazolam and local anaesthetic induction using two percent lidocaine with 1:100,000 epinephrine and 0.5 per cent bupivacaine with 1:200,000 epinephrine, sulcular incisions were made circumferentially around teeth #8 and #9. To create room for extractions instructions, the crowns on teeth #8 and #9 were reduced (Fig 2a). Teeth #8 and #9 were extracted atraumatically using a piezosurgical insert and serrated universal maxillary forceps (Figs 2b-2c). Degranulation of the sockets was performed using a carbide finishing bur and Neumeyer bur. A surgical guide was used to prepare the implant osteotomies, and proper positioning was attained (Fig 3). After finalisation of the osteotomy sites, rough-surfaced, internal hex 4 mm (diameter) x 13 mm (length) implants were placed into the #8 and #9 sites (NanoTite® Tapered Certain® Implant, BIOMET 3i, Palm Beach Gardens, Fla.) (Fig 4). Healing abutments were placed on the implants to prevent soft tissue and bony collapse during the period that extroral fabrication of the temporary prostheses occurred (Fig 5a). The orientation of the implants was ideal...

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**Aesthetic management of adjacent maxillary central incisors**

Extraction, immediate placement and immediate provisionalisation - a case presented by Dr Michael Sonick

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**Case courtesy of Cary A. Stajdohar DDS (Surgical); Jeffrey A. Babushkin, DDS (Restorative)
than 4mm and an implant-tooth of bone between the fixtures, an of the implants revealed a peak achieved. Radiographic review (Fig 5a). Primary stability was sockets at the cingulum positions and the fixtures exited from the Beach, Va. material (LifeNet Health, Virginia plant surfaces, freeze-dried bone bridge the circumferential gap be-

and the fixtures exited from the sockets at the cingulum positions (Fig 5a). Primary stability was achieved. Radiographic review of the implants revealed a peak of bone between the fixtures, an inter-implant distance of greater than 4mm and an implant-tooth distance of 2mm (Fig 5b). To bridge the circumferential gap be-
tween the socket walls and the implant surfaces, freeze-dried bone allograft (FDBA) was used as graft material (LifeNet Health, Virginia Beach, Va.).

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Dental implantology is a team speciality and the 2011 Congress programme continues to uphold and endorse this ethos. The team programme includes sessions for dental nurses, dental hygienists/therapists and practice managers, with the dental technicians being included in the plenary programme where two world class technicians will be speaking.

**Thursday 14 April**

**PLENARY PROGRAMME FOR CLINICIANS AND TECHNICIANS**

| Professor Tomas Alfredsson, Sweden | Professor Maurice Amiel, Brazil | Dr Stephen L Wheeler, UK |
| Professor Clark M Stanford, USA | Professor Michael Magnus, USA | Professor Tomas Albrektsson, Sweden |

**DENTAL IMPLANT TEAM PROGRAMME**

**Morning**

Combined Team Programme for Hygienists, Nurses, Practice Managers and Therapists

The team approach to implant dentistry: a blueprint for success

Mr Ardi D Daniels, USA

**DENTAL IMPLANT TEAM PROGRAMME**

**Afternoon**

Hygienists’ & Therapists’ Programme

The role of the dental hygienist in implant treatment

Ms Anita H Daniels, USA

Practice Managers’ Programme

Ringing the changes: turn every patient enquiry into an appointment

Mr Ashley Latter, UK

**Friday 15 April**

**PLENARY PROGRAMME OPEN TO THE WHOLE TEAM**

| Professor Joseph Kan, USA | Professor Tom Jemt, Germany | Dr Simon Wright, UK |
| Dr Stephen L Wheeler, USA | Professor Tom Jemt, Germany | Dr Simon Wright, UK |
| Professor Tomas Alfredsson, Sweden | Miss Helen McVicker, UK | Miss Helen Batty, UK |

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**About the author**

Dr Michael Sonick is a full-time practicing periodontist and implant surgeon in Fairfield, CT. A renowned educator, author, and clinical researcher, he is a Guest Lecturer for the International Dental Program at New York University School of Dentistry, a former Clinical Assistant Professor in the Department of Surgery at Yale University School of Medicine and University of Connecticut School of Dental Medicine, and a frequent lecturer on periodontics, dental implants and practice management for educational programs around the world. Locally, he is the founder and director of the Fairfield County Dental Club, an advanced continuing education organization that provides courses on the latest developments in dentistry to clinicians and their staff. Dr Sonick is also founder and director of Sonick Seminars, LLC, a multidisciplinary teaching institute located in his clinical office and teaching center. Courses are given on all surgical aspects of periodontics and implant dentistry. Unique to this program is the three part continuum: dentists to observe live surgery, participate during the Hands-On portion and attend lectures. Interested participants can contact Carole at 203 254-2006 or visit the website at www.sonickdmd.com.