The multiplicity and sophistication of the offering in the field of prosthetic elements in implantology allow the practitioner to make a choice appropriate to the clinical particularities of each case. If the practitioner chooses a standard implant abutment, the dental technician will have to make adjustments, which implies considerable losses in precision and time. Moreover, with such abutments it is difficult to create an anatomical emergence profile because it cannot be modified and the base of the abutment cannot be changed. This observation is equally applicable to the angulation, which might even be selected by default.

A customised abutment created with CAD/CAM is the most accurate and simplest solution for an optimal result. The abutment is individually designed in order to ensure the homothety of the thickness of the materials and therefore the overall strength of the prosthesis. The dental technician has in this case maximum freedom in terms of design in order to create an abutment with the optimum emergence profile and angulation. In this manner, the abutment is specifically designed and fabricated for each patient.

Titanium has been established in dental implantology as the reference material owing to its biomechanical properties and its biocompatibility. Today, we are able to benefit from over 40 years of clinical and experimental experience in implantology. Customised abutments can be fabricated from titanium, zirconia or hybrid materials, such as a combination of titanium and zirconia. In certain clinical circumstances improves the aesthetics of the visible areas while respecting the requirements of biocompatibility and biomechanics.
mas, etc.) resulted in the patient being entirely opposed to another intervention of this kind on the opposite side of the mouth.

During an appointment in October 2011, I was able to persuade the patient to accept implant treatment. I suggested first removing the three-unit bridge on teeth 25–25 and then extracting the roots of teeth 25 and 25, as well as seating of a denture on the day of the extraction, followed by placement of three implants in regions 24 and 25. With the extraction of tooth 26, and seating of a four-unit bridge as the final prosthetic solution.

As the height of the available bone around tooth 26 was insufficient, I would not place an implant in that area but a tooth extension (a sinus lift would otherwise have been essential). The treatment plan was accepted by the patient two weeks later, and teeth 25 and 25 were extracted at the end of the month.

The patient was seen on 10 January 2012 for implant placement: two implants (NobelReplace RP, Nobel Biocare) with a diameter of 4.5mm and a length of 15mm for regions 25 and 24, and one implant (Nobel-

In May 2012, implant-level impressions were taken (opentray impression technique), and the patient’s occlusion was recorded using silicone and a bite tray. Owing to the constraints related to the angulation of the implants in regions 24 and 25, I opted for titanium abutments. The angle of the implant in region 25 allowed for the insertion of a titanium-zirconia abutment for good gingival grip and a better aesthetic result.

Ten days later, two titanium abutments (ANA. T; Laboratoire Dentaire Crown Ceram) and one titanium-zirconia abutment (ANA. TZ, Laboratoire Dentaire Crown Ceram) were screwed onto the implants at a torque of 55N, and sealed with compos-