Implant News & Views

"Keeping you up-to-date on implant dentistry"

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Simple Surgical Techniques to Maximize Prosthetic Results

Timothy Kosinski, DDS, MAGD

Replacement of missing teeth with the use of dental implants is predictable and has become common place. Patients now present to our practices with information gathered from many sources including the internet. They are educated about the benefits of implant dentistry and some of the surgical procedures. However, some cases are more difficult for the practicing dentist than others. The reluctance to consider dental implant surgical and prosthetic procedures by the general dentist may be more a matter of not feeling confident or competent in the procedure in a particular area of the mouth.

Bone contour and vital anatomy need to be considered and evaluated carefully to insure a high quality functional and esthetic result. Risks need to be addressed with the patient prior to any surgical intervention. A technique will be discussed here which will help minimize surgical risk and help the dentist in understanding anatomy and proper placement.

There needs to be a safe and effective mechanism in the placement of dental implants in the proper position. The step by step process of radiographic documentation insures an accurate surgical placement.

Figures 1-2: Retracted facial and occlusal view of the tooth #14 area. It appears that there is adequate width of bone.

Design

There has been significant design improvements of dental implants over the past few years, each creating better initial stability, less crestal bone loss over time, and improved retention, function and esthetics of the final restoration. Preservation of soft tissue contours is achieved by preserving crestal bone levels. The type and size of abutment placed within the implant has changed recently with the advent of the concept of implant platform switching. This proposed method of abutment placement has apparently shown a propensity to reduce circumferential bone loss around the dental implants.[1,4] The horizontal microgap is changed to be on the inside of the external diameter of the implant neck, and this process may result in decreased bone loss.

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Tidbits Tidbits Tidbits

Free Dental Implants

Note: This text can be seen on the website of **Guerra Family Dental** [http://www.guerrafamilydental.com/Dental_Implants.html]. It's an interesting concept and some food for thought. We would like to hear your opinions. Email us at dentpub@optonline.net.

Why Free Dental Implants?

I stopped charging my patients for dental implants and here is why I did it. Most implants in the United States are put in by one dentist and restored by another. Each of those dentists will charge a fee. That is why the total cost of a dental implant is so high. I both place and restore the dental implant myself. I place dental implants as one of my tools in dental reconstruction for my restorative work to make crowns and bridges and dentures to replace missing or damaged teeth. I charge for the restorative work and my patients save a lot of money!

In recent years, many United States patients have gone abroad for their dental implant work. In most countries outside the United States, one dentist will both place and restore the dental implant (as I do) so they have the advantage of a lower fee schedule to start with. The problem with going abroad is the lack of support the patient will get if there are any problems developing later on. There are also problems with training and education in some of these countries which might lead to poorer outcomes than work done in the States. What patients need here are dentists like myself who are trained in all aspects of dental reconstruction, including dental implant placment, so that more of them can provide a total service for their patients while working to lower fees to a more reasonable level. I am open and straightforward with my Fees, there will be no surprises.

Dental Implant Fees (Single Tooth):

	Typical Fees	Dr. Guerra Fees*
·	$1800 Implant Placement	$0 Implant Placement
·	$800 Abutment	$600 Abutment
·	$1000 Crown	$800 Crown
·	$3600 Typical Fee	$1400 TOTAL FEE

* 50% Down Payment required at time of Implant placement. You are also required to become a patient of our office if you reside less that 15 miles away.

As of May, 2008, with regard to endosseous root form implants, there is no indication whatsoever that any given implant, surface treatment, prosthetic attachment, placement technique or brand of implant offers any perceptible advantage to the patient in terms of the clinical result. For the present, all of these root form implants are created equal in terms of their effectiveness for patient treatment. There is not a single implant company that claims higher suc-

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Creativity Solves Problems in Prosthetically Challenged Implant Cases

Jack Marrano

The world of implantology is vast and continually evolving; clinicians and technicians are constantly faced with new complicated situations; therefore, we must adapt to each new circumstance as it arises, and create a new solution. Implant therapy is being presented on a regular basis as an alternative form of treatment to patients. In fact, implants are replacing the three-unit bridge as the standard of care for a single missing tooth. As this trend continues, more and more complicated situations will arise. Using our skills as clinicians and technicians we must inject creativity into our problem solving. When we can take a compromised situation or a difficult to restore case and turn it into a success story, there is something to be said about the feeling of reward and achievement upon conquering that challenge.

Often patients place financial restrictions upon us that hinder our restorative options; over the years I have learned and developed a system and mind set for dealing with these realities. In order to do so we must get creative and take our skills and materials to the limit.

Case study

A young female college student was in a bicycling accident resulting in severe trauma of teeth #'s 8-9 [anatomical crowns sheared off subgingivally but left intact] with the subsequent loss of tooth # 10. The initial evaluation showed bone and soft tissue loss at site #10. It was determined that #10 would be replaced with an implant and #'s 7, 8, and 9 would be prepped for all ceramic restorations, addressing the super facial contours and slight rotation of # 7. The patient refused the recommendation of bone grafting. In the case, we will see how I address and solve some common problems seen in dental practices, and, together, we will discover a perfect solution to the imperfect case.

A team approach is very important to all implant treatment. The patient, her dentist Dr. Don Rellins and I had a pre-treatment planning discussion to review all aspects of the case. The goal was to establish boundaries by discussing everyone's expectations and potential complications. Input from the patient about their perceptions and desires can be very significant. Limitations and potential road blocks to success must be determined in order to design a road map to solving these problems. Once everything is taking into consideration and boundaries are established, agreements can be made on how to proceed and achieve the appropriate final outcome.

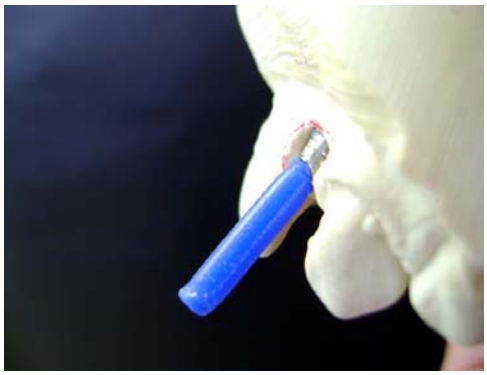


fig. 1- rope wax had been inserted into the hexed interface showing the extreme facial angulation.

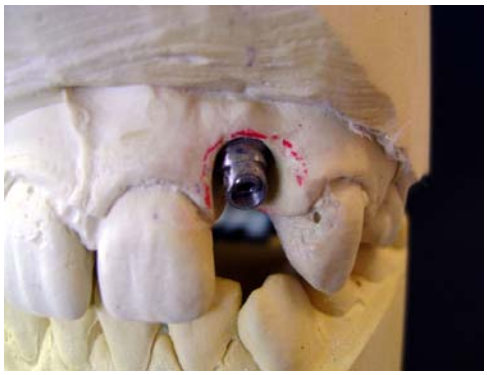
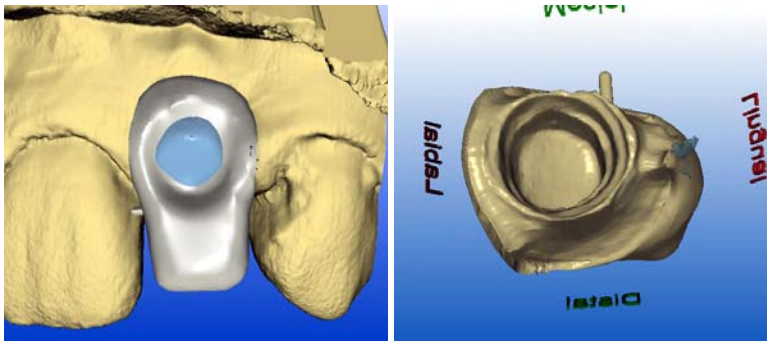


fig. 2

Dr. Rellins, performed endodontic therapy on teeth #'s 8-9, followed by simple post and core buildups. Using a technique he developed 25 years ago, Dr. Rellins used the patient's anatomical crowns as interim restorations. He prepped the core buildups; the fracture lines of the anatomical roots became the margin for the anatomical crowns. He utilized the severed teeth recovered from the accident, being careful not to damage them any further, and hollowed them out. Once he was able to seat the crowns into their former position in relation to their anatomical roots,he cemented them in.



figs. 3-4

Compromised

A 3.5 by 11mm Imtec Endure implant was placed in the site of #10. The position of the implant presented us with one of several challenges involved with the case. The implant was in a compromised

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Creativity Solves Problems in Prosthetically Challenged Implant Cases

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position. Although placement was ideal from a bone perspective it was prosthetically challenged. In prior discussions all ceramic restorations were requested, but an all ceramic zirconium abutment is not available for the Endure System. Now what do we do?

Creativity

When I received the case in the lab, I started my problem solving just as I would a mathematical equation. I know (x) is where we are now and (y) is what has to be achieved to get to (z) the final result. I began dissecting the case piece by piece to obtain a solution. I needed a ceramic abutment, which does not exist for this implant, an all ceramic crown designed for the nonexistent abutment and I had to address the buccal angulation issue and extreme crown height.

First, the implant position and tissue loss in the anterior maxilla posed our greatest problem, followed by the need to achieve an all ceramic solution with a system that does not offer a zirconium implant abutment. The impression was taken with the open tray method, and the model was fabricated. I obtained a hexed machined gold interface and screwed it into position.

As you can see, there is extreme facial angulation of the implant **[figs. 1-2].** To correct this and meet all our ceramic needs I decided to fabricate a custom "zirconium abutment". This abutment which is essentially a PFZ coping of sorts and became a telescopic solution to my ceramic abutment issue; by doing so I was able to block out the gold alloy of the hexed interface, correct the angulations and fake the position of the implant and also provide an all ceramic base for my ceramic restoration.

Design

I used the Cerec Cad Cam System to design and mill the abutment. The hexed machined gold interface was adjusted facially to aid in correcting the angulations and scanned into the computer. The abutment was designed to fit over the top of the actual hex interface. The design also took into consideration the bone and tissue loss **[figs. 3-4].** I designed it with the idea of using pink porcelain not only to hide the

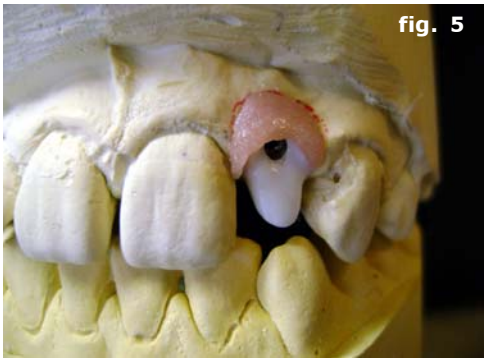
fig. 5

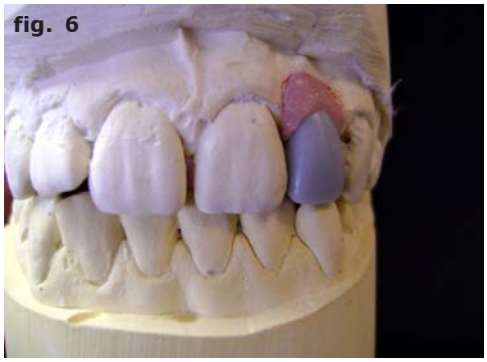
fig. 6


fig. 7


fig. 8


fig. 9


fig. 10


fig. 11

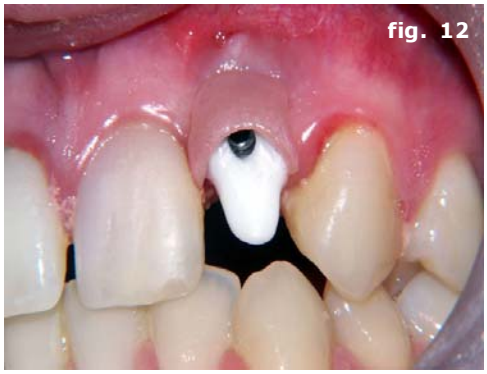
fig. 12

placement of the implant but to keep crown height at a normallevel and mimic the gingival contour of #7. The design of the abutment was carefully thought out; we did not want to mimic the super facial and slightly rotated characteristic of #7, since those would be corrected when a ceramic crown for that tooth was fabricated.

Once I was satisfied with my design it was milled from zirconium and sintered [oven baked]. After sintering I checked the fit of the coping to the hex interface and surrounding tissue. Because I was going with a telescopic solution I applied the Ivoclar Emax pink porcelain directly to the abutment **[fig 5].** I use pink porcelain quite often when dealing with compromised implant situations; over the years I have developed a system for its application and can achieve highly esthetic results. Technicians often ignore the importance of the esthetics of tissue, concentrating solely on the restoration and just filling the gap with tissue shaded porcelain.

I believe that fabrication of tissue shaded porcelain is just as important as the restoration itself and must be treated as such. In this case I used a universal shade for the tissue construction due to the extremely small amount I would be applying. On a much larger case, I would create extreme detail in the tissue as I do in the restorations. After the pink porcelain was applied, I began waxing the restoration to be fabricated in Empress Esthetic. When waxing a restoration to full contour, I look at the surrounding dentition taking into consideration the characterization that is immediately noticeable to the eye and mimicking that in my design.

I also took into consideration that we will be restoring teeth #'s 7, 8 and 9 at a later date so I to took the opportunity to idealize # 10. This is very important, the restoration must blend in with the surrounding dentition; by picking up the major details we can achieve this **[fig 6].** Once the restoration was waxed, it was invested, burnt out and pressed with an Empress Esthetics. I divested the ring and ground off the sprue. The restoration was checked for fit, contacts and occlusion **[fig. 7]**. The final contours should be harmonious with the rest of the anterior maxilla. At this juncture, I sprayed the model and restoration with Quick Check **[fig. 8].** This technique of covering everything with a white coating eliminates any distraction to the eyes so it is easier to evaluate the contours, contact and how the restoration blends into its environment. The incisal edge of the restoration was then cut back and incisal porcelains were applied; the restoration was stained and glazed to match the corresponding lateral.

At this point, I added surface texture to the tissue applied to my abutment - then stained and glazed that. Once the case was glazed, I verified everything one more time on the model to see that all the challenges of this case were met **[figs. 9-11].**

The restoration now has three main components, (1) the gold hexed interface, (2) the "custom Zirconium Abutment" with applied tissue shaded porcelain and (3) the all ceramic crown itself. All come together with precision.

Delivery

The custom zirconium abutment is cemented directly to the gold hexed interface; this can be done chair side, but is easier to do prior to the case leaving the laboratory. The "all ceramic abutment" is then tried in orally **[fig. 12],** with tissue adjustments made if need be. This is followed by a try in of the Empress restoration. After a successful try, the abutment can be torqued down into place and the final restoration can be cemented **[figs. 13-14].**


fig. 13


fig. 14

Conclusion

To find a solution in a real-world compromised case with financial restrictions, we have to be creative to achievable a functional and esthetic goal. It is also important to realize the capabilities of the technician, clinician, patient and restorative materials to obtain an understanding of what can or cannot be done. This case was a success, because we stayed within our established boundaries, and all of the patient's expectations were met.

Note: The author would like to thank **Don Rellins DDS, MAGD** [Broadway, VA] for the case and outstanding clinical photos.

Jack Marrano is the Ceramist and Implant Specialist at Evolution Dental Laboratory [Buffalo, NY]. Upon honorable discharge from the Marine Corps Search and Rescue Unit in 2002, Jack decided to follow his passion for dentistry and become a lab technician. Jack was hired by Dentaform, the high end California dental laboratory where he was mentored by Brian Hatcher. He can be reached at 716-839-8008 or jackmarrano@gmail.com.

Simple Surgical Techniques to Maximize Prosthetic Results

continued from p. 1

As design improvements are made in implant dentistry, the predictability and improved long term prognosis of the systems make implants a more popular restorative technique for dentists. Surface coatings and treatments, design characteristics for size and shape of the implants and prosthetic parts all make the technique a clinical success[3].

Stabilization

Primary stability of a dental implant after surgical placement is also an important aspect in creating a functional, osseointegrated fixture. There are several techniques that can be used to create initial stability including making the osteotomy site slightly smaller than the final implant to be placed and using a self tapping implant design. The type of thread used in the body of the implant can affect initial stability; also, a combination of large threads for initial placement and smaller threads at the neck of the implant allow for condensing of crestal bone. A roughened surface allows for better anchorage in bone tissue compared to implants with smoother surfaces. Finally apically tapered implants condense bone laterally and ones with crestally widened necks allow for condensing of crestal bone as the implant is seated.[2,5,6]

Bone Loss

The greatest bone stresses around dental implants have been reported to be concentrated at the cortical bone at the crest of the edentulous ridge. Bone loss therefore begins at the implant neck. The implant neck should be smooth and polished and the crestal portion should

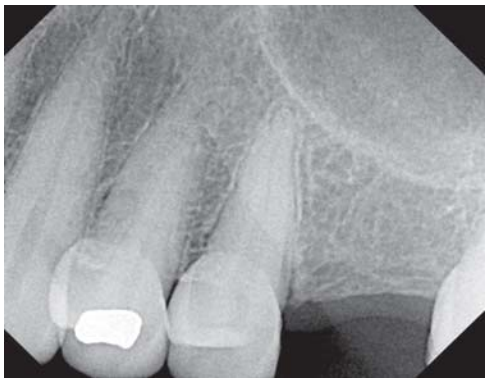

Figure 3-4: Panoramic and digital periapical radiograph of edentulous space.

Figure 5: The Sybron Implant System is simple and precise. The first drill used to initially determine angulation is the Lindemann Guide. This is a very sharp drill with a point. It also allows for lateral positioning as it cuts on its side.

Figure 7: A sharp tissue punch blade removes soft tissue at the surgical site and eliminates the need for a full thickness flap. Sutures will not be required following implant placement.

Figure 9: A 2.2 mm diameter Twist drill is used to establish depth. The black lines are clearly delineated 7mm, 9mm, 11mm, 13mm and 15mm.

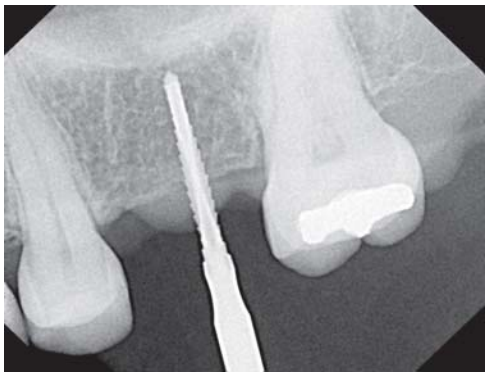

Figure 6: A digital radiograph is taken to determine proper angulation of the primary drill.

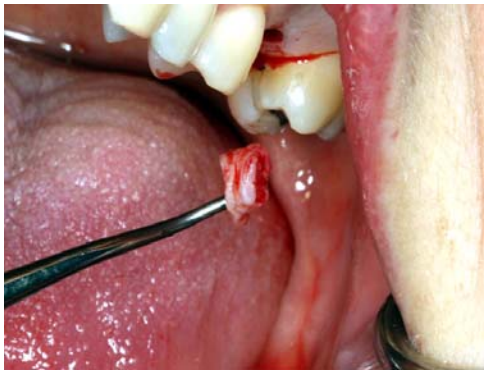

Figure 8: The soft tissue is simply removed with a curette. The tissue plug determines the depth of the soft tissue at the site.

not be designed as a load bearing area. Initially following placement of a dental implant there is bone remodeling and formation of a biological seal around the neck of the implant. A junctional epithelium is formed above the crest of bone. Crestal bone is not maintained above this junctional epithelium. It may be that when implant abutments are placed at the crest of the alveolar bone, the cortical bone will adjust to the biological width and resorb.

Platform Switching

Platform switching uses an abutment that is smaller in diameter than the external neck of the implant. The theoretic objective is to prevent the normal bone loss down to the first thread of the implant that often occurs, thus improving soft tissue esthetics [7].

Case 1 [figs. 1-25]

The patient is a 47-year-old female missing her maxillary left first molar. Discussions about how to restore this edentulous space included the option of a conventional fixed bridge. Her maxillary second molar has a relatively small amalgam restoration, but the second bicuspid is healthy. Preparing two strong teeth to replace the missing tooth may have been considered conventional therapy in the past but dental implants are now more conservative and predictable. Our issue to be considered prior to dental implant diagnosis is having enough bone present to accept an implant with the maxillary sinus position determined by a panoramic or periapical radiograph.

This clinical case will demonstrate the use of the Sybron dental implant system (Sybron Dental Specialties Orange, CA). Sybron Implant Solutions is a division of Sybron Dental Specialties and part of the family of world renowned companies such as Kerr, SybronEndo, KaVo, Gendex, Pelton & crane and Imaging Sciences International (i-CAT).

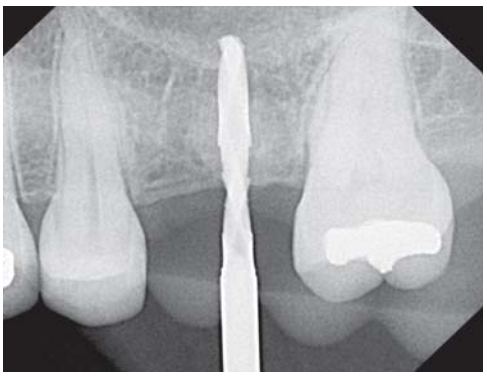

Figure 10: Radiograph illustrating the angulation that the implant will be placed in the center of the edentulous ridge. The small diameter twist drill radiograph shows that we are at the floor of the maxillary sinus, with adequate bone for implant placement. Penetration into the sinus would require augmentation with a tenting procedure, but this is not the case here.

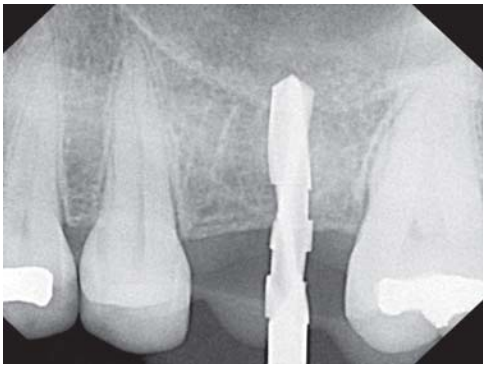

Figure 12: Radiograph of the 3.3mm Twist drill in site. Note the notches of the drill itself. The first break is at 7mm, the second at 9mm. This is intended to be our final depth, just at the floor of the sinus.

Figure 11: A 3.3mm Twist drill (actual diameter is only 2.8mm) is positioned so that an osteotomy 9mm into bone is made. Note that the soft tissue was approximately 3mm in height, so in determining a visual of how deep to place the implant in this flapless procedure, the 9mm that we want the implant to go into bone is added to the 3mm of tissue height. Therefore the line markings on the twist drill is visualized to 12 mm. Thus the visual is in between the second large black line, which is about 12mm.

Figure 13: A 4.1mm Twist drill (actual diameter is 3.5mm) is positioned. We drilled at 1200 RPM.

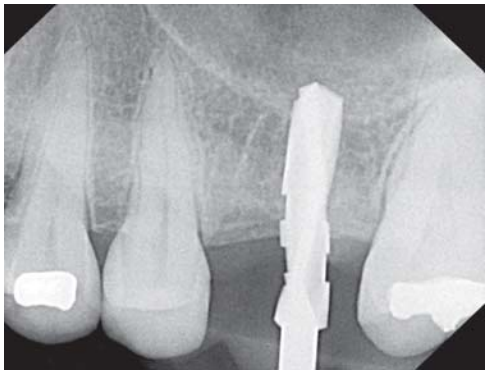

Figure 14: Radiograph of the 4.1mm Twist drill in ideal position at 9mm of depth.

Objectives

To restore the maxillary left first molar our primary objectives were to establish a correct occlusal plane relationship, fill the edentulous space and improve esthetics. Our choice of implant in this case was the SybronPro XRT dental implant. The SybronPro XRT implant design incorporates innovative micro threads, a mount free delivery system and self tapping threads. An internal octa (used in this case) or hex pattern allows for great stablility of the conventional or platform switching

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Simple Surgical Techniques to Maximize Prosthetic Results

continued from p. 7

abutments. Here, a 4.8mm crestal width with a 4.1mm body and 9mm tall implant was used in the tooth # 14 area. The determining factor in shape and size of the implant was based on the height and width of bone below the sinus area. If less bone had been available then a sinus lift or tenting may have been necessary.

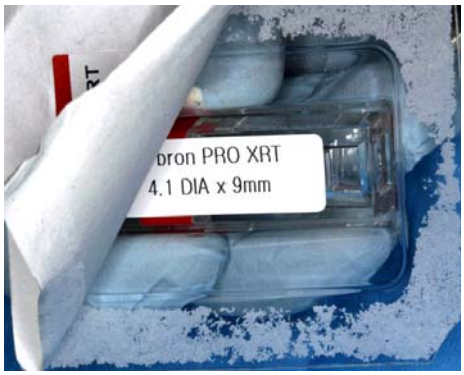

Figure 15-16: External and internal packaging of the Sybron Implant System XRT Octo implant.

Figure 17: An implant driver is placed into the internal octagon of the implant, the motor turned down to 25Ncm and the implant driven into the osteotomy site and stops when 25Ncm of torque is achieved.

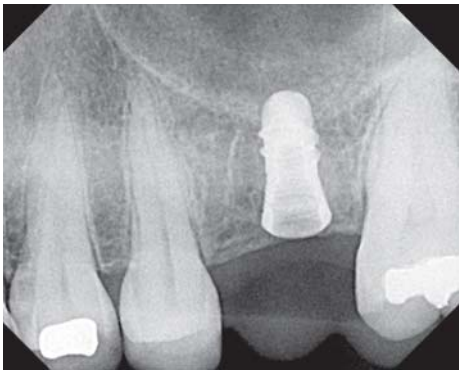

Figure 18: A radiograph of the implant in position. The tightness of the implant in bone is checked using a torque rachet. These record torque of 15, 25 and 35Ncm. 25Ncm of torque was achieved on this implant in the maxillary right first molar area. Once this level of torque is achieved either a cover screw or a taller healing abutment can be safely placed into the implant to allow for tissue and bone healing.

Figure 19: Occlusal view of the cover screw in position. Note there is no bleeding and sutures are not required. Once the implant integrates removal of the cover screw will allow direct access into the internal design of the implant.

Figure 20: A direct impression is made by using a two piece impression post with an octagon base which engages the internal design of the Sybron implant and a screw which threads it into position.

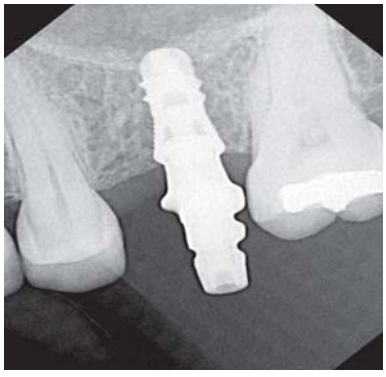

Figure 21: This x-ray is taken to insure that the impression coping engages the implant completely.

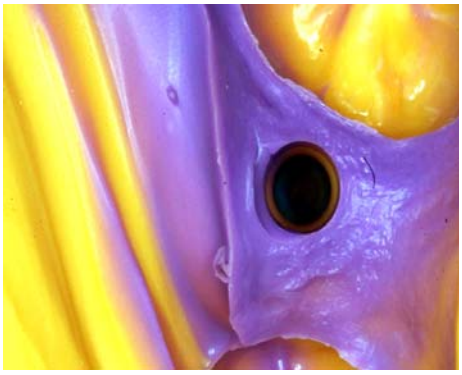

Figure 22: A polysiloxane impression is made with light and heavy body material. Note the clean contours of the impression. The impression coping must be retained properly in the direct impression to insure a proper abutment and crown fabrication.

Figure 23: Following fabrication of a master cast using the impression coping placed into a laboratory analogue, an abutment is prepared and crown fabricated. The prepared abutment is torque into position intraorally at 25Ncm.

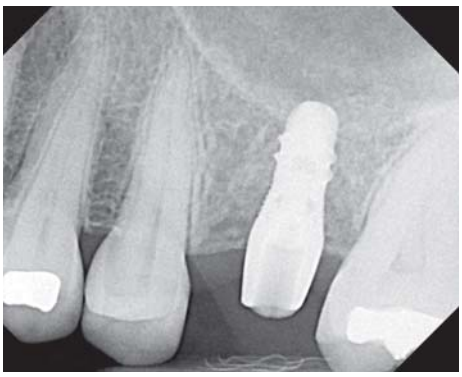

Figure 24: A radiograph is taken to insure a complete seat of the abutment into the implant.

Figure 25: A zirconia crown is cemented into place and a final radiograph taken.

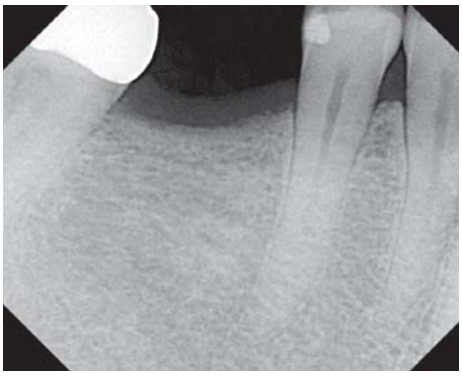

Figure 26: Digital radiograph of edentulous mandibular first molar.

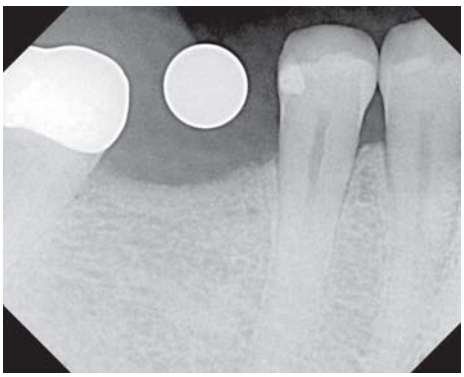

Figure 27: A 5mm ball bearing is used to determine the precise height of bone from crest to the mandibular canal.

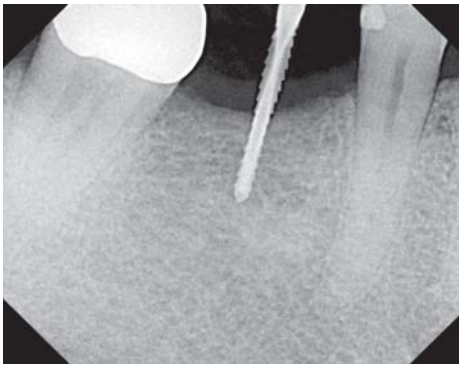

Figure 28: A Lindemann Guide drill penetrates the soft tissue and bone several millimeters. An x-ray determines angulation for the implant.

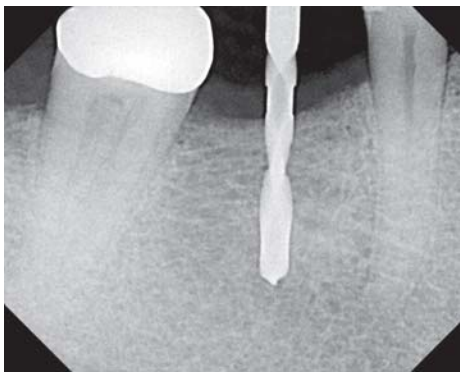

Figure 29: A 2.2mm diameter Twist drill is used to establish depth. The intention is to determine final depth no deeper than the apices of the adjacent root structures. The notches on the 2.2 mm Twist drill are marked 7mm, 9mm, 11mm, 13mm and 15mm. This digital radiograph indicates that we are 11mm at the crest of the ridge at the depth of the adjacent root apices.

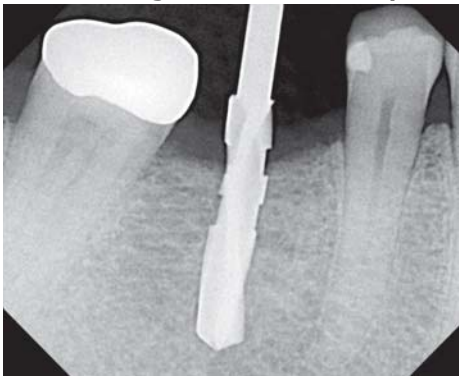

Figure 31: Radiograph of a 4.1mm Twist drill (actual diameter is 3.5mm) to 11mm depth.

continued to p. 10

Case 2 [figs. 26-44]

This case will demonstrate a simple surgical technique in placement of a single dental implant in the mandibular right first molar area and the use of platform switching restorative techniques.

Here, a 4.1mm wide by 11 mm tall implant was used in the tooth # 30 area. The determining factor in shape and size of the implant was based on the height and width of bone above the mandibular canal. The final restoration is a full gold crown due to the past history of the patient breaking porcelain on posterior crowns. My choice of dental implant was based on the necessity to reduce or eliminate functional load at the crest of bone and reduce bone loss. The theory of platform switching seems to support my choice and provide for a long term positive prognosis on this chronic bruxer. Of course the patient was provided a new occlusal guard for night use.

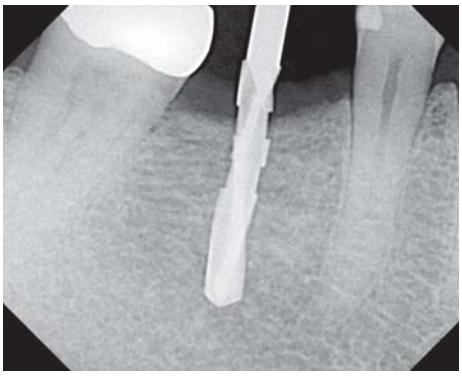

Figure 30: A 3.3mmTwist drill (actual diameter is only 2.8mm) is used to depth.

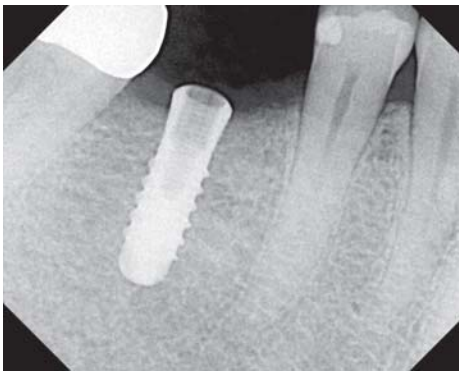

Figure 32: A 4.1mm X 11mm Sybron XRT-PRO implant placed into the bone.

Simple Surgical Techniques to Maximize Prosthetic Results

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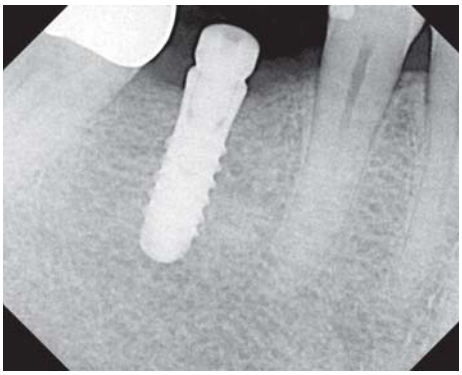


Figure 33: A 2mm tall platform switching healing abutment is torqued to place. Note the healing abutment fits inside the body of the implant creating a notch at the crest of bone.

Figure 36: Occlusal view of internal hex design of the Sybron dental implant prior to final impression.

Figures 39-40: A polysiloxane impression is made with light and heavy body materials. Note the clean contours of the impression.

Figures 34-35: Facial and occlusal view of the healing abutment in place following healing.

Figure 37: Two piece impression coping used for a direct impression of the implant.

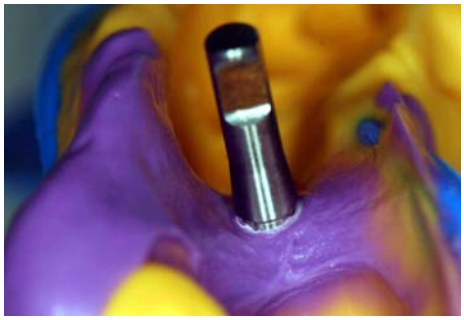


Figure 41: The impression coping is placed into a lab analogue and inserted into the final impression. Stability is checked.

Figure 43-44: Final full gold crown is cemented to place. A FGC was used due to the severe bruxing of this patient and a history of breaking porcelain in the posterior.

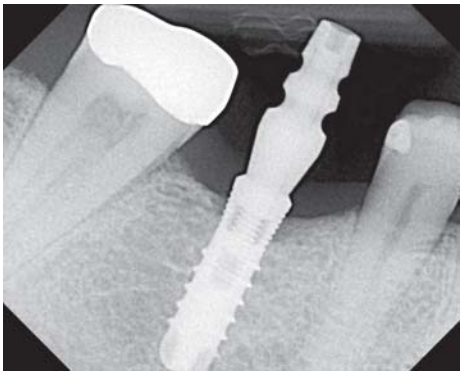
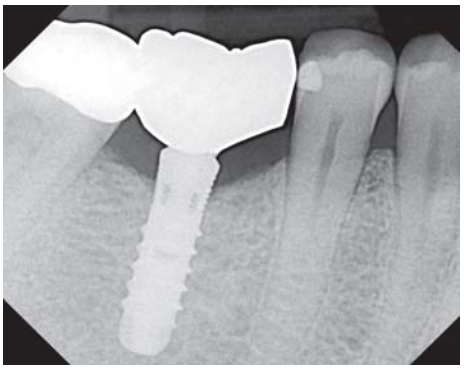


Figure 38: A radiograph is made in insure a compete seat of the platform switching impression coping. Again note that the coping fits inside the neck of the implant.

Figure 42: Facial view of the titanium abutment prepared and torqued into position at 25Ncm.



Conclusion

The use of dental implants to support, retain and stabilize single crowns greatly improved the quality of life in patients who may have been deemed bridge candidates. These implants provide an outstanding option for restoring single teeth. These cases highlight the technique to restore a missing maxillary/mandibular first molar utilizing a minimally invasive surgical procedure leading to an esthetic, functional prosthetic result.

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Tidbits

continued from p. 2

cess than any other company.
In the future we may have an implant or a surface or a technique that really proves superior in terms of patient treatment. When that happens, I will be the first to jump on the band wagon...

For your information we utilize a tapered implant with an internal connection. The market has shifted dramatically from external connection to internal connection due to the benefits of an internal connection. The implants we use in our practice are manufactured in the USA under strict quality control guidelines and are produced by Implant Direct http://www.implantdirect.com/us/default.asp The United States Department of Veteran Affairs issued a Commendation to Dr. Niznick of Implant Direct for designing and funding the largest dental implant study worldwide. In this study Implant Direct Implants were used. http://www.implantdirect.com/us/research.asp

What Implant Is That?

Dr. Lorne Lavine suggests we check out this very useful site. www.whatimplantisthat.com . If you have a radiograph of an implant that you are trying to identify, here is a great library. The site also asks its viewers and manufacturers to add to the library and fill in some of the blanks. This will be very useful when new patient shows up in your office. There is a "filter" that allows you to put in certain characteristics so that you don't have to scroll through almost 200 images.

This website was developed by **Nate Farley, DDS** and **Kent Howell, DMD** from Columbus OH. Thanks

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