Treatment Planning for Restorative Implantology

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KEYWORDS

- Past medical history • Examination and occlusion • Dental imaging
- Fixed and removable prosthodontics • Dental implant success

KEY POINTS

- More than 30 million Americans are missing all of their teeth, according to the American Academy of Implant Dentistry.
- More than 5 million implants are inserted annually in the United States.
- Patients are demanding fixed prosthodontics as opposed to removable prosthodontics.
- In the completely edentulous patient and some partially edentulous patients, implants have become the treatment of choice. To meet these demands, the restorative dentist should have a good foundation in fixed and removable prosthodontics, to have continued success in restorative implantology.
- The goal is to deliver the best implant crown or prosthesis for the patient.
- If problems occur along with increased office visits, patients can become frustrated and discouraged.
- Treatment planning for restorative implantology should be looked at in 4 sections: (1) review of past medical history, (2) oral examination and occlusion, (3) dental imaging (ie, cone-beam computed tomography), and (4) fixed versus removable prosthodontics. These 4 concepts of treatment planning, along with proper surgical placements of the implant(s), result in successful cases.

More than 30 million people Americans are missing their teeth, according to the American Academy of Implant Dentistry. Misch[1] commented that "more than 5 million dental implants are inserted each year in the United States" and "more than $1 billion in implant products was sold in the United States in 2010." Implantology (surgical or restorative) is practiced by general dentists, prosthodontists, oral surgeons, periodontists, and endodontists. The restorative dentist should have a good foundation in fixed and removable prosthodontics to have continued success in restorative implantology.

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Wood and Vermilyea[2] stated "it is imperative that the dentist restoring the implants, after consultation with appropriate specialists, be responsible for the treatment planning."

The restorative dentist should discuss the case with the surgeon (by telephone, in person, or via written form). There should not be any confusion regarding the implant system being used and the parts needed. Before consents are signed, the restorative dentist should make sure that they have the tools needed to restore the case. The surgeon and clinician should maximize the exchange of information regarding the surgery. The restorative dentist should inquire about (1) if there were any surgical complications, (2) insertion torque, (3) if there was a need for bone grafting or sinus lift, (4) the size/diameter of the platform and length of the implant, (5) the implant manufacturer, (6) the estimated time of placement of the healing cap, and (7) the clearance from the surgeon to begin the restorative treatment. When there is teamwork between the surgeon, restorative dentist, and the laboratory technician, the result can be a masterful replica of a normal oral cavity. The untrained eye simply does not know the difference.

All responsibilities fall in the lap of the surgeon and restorative dentist. All discussions should be finalized with the patient so that they understand the risks, benefits, and options/alternatives from a surgical and restorative standpoint. Lewis and Klineberg[3] stated that "patients should be informed of the spectrum of potential complications and maintenance issues that can occur with implant-borne prostheses, and informed of the biological consequences and associated future costs." Klein[4] went further in saying "Patient expectations of treatment time, provisional prosthesis requirements, and esthetic demands should be discussed." Dentistry's covenant of trust[5] begins by stating "The dental profession holds a special position of trust with society… the profession makes a commitment to society that its members will adhere to high ethical standards of conduct." The patient's health, well-being, comfort, and peace of mind should always be at the forefront of any dental services rendered.

Patients should know in advance approximately how many office visits are involved and should be given a cost for the restoration(s), including parts. A frustrated patient does not refer others and could seek legal action if they are stuck with a bill and the final outcome was not delivered as promised. The restorative dentist should be careful about what they say or promise to a patient; it is best not to promise anything. In this chapter, treatment planning for restorative implantology there will be four sections: (1) review past medical history, (2) oral examination and occlusion, (3) dental imaging (ie, cone-beam computed tomography [CBCT]), and (4) fixed versus removable prosthodontics. These 4 concepts of treatment planning, along with proper surgical placements of the implant(s), result in a successful implant cases (**Fig. 1**). The fifth concept, dental implant surgery will be discussed in the other chapters of this book.

There are many philosophies that differ and create debates among the groups of specialists mentioned earlier. Quality dentistry should be documented daily and incorporated into the practice of implant dentistry to provide successful cases and patient satisfaction. In this article, current literature is reviewed, along with evidence-based systematic reviews (to eliminate bias views), including advice from those in the dental profession with years of experience, which helps the restorative dentist manage and treat their cases successfully.

REVIEW OF PAST MEDICAL HISTORY

It is prudent for the clinician to review each patient's medical history, which often sets the stage for the treatment to be delivered. The dentist who chooses not to treat those

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