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CASE REPORT

Preserving esthetics, occlusion and occlusal vertical dimension in a patient with fixed prostheses seeking dental implant treatment

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Abstract The preservation of esthetics and occlusal vertical dimension is critical in patients with existing full-arch tooth-retained fixed prostheses. This clinical report describes the provision of a maxillary complete immediate denture for use over implants in a patient with a maxillary full-arch fixed dental prosthesis over nonviable teeth. The existing fixed dental prosthesis was used in the fabrication of the maxillary complete immediate denture to preserve esthetics. The technique involved the recording and preservation of the occlusal vertical dimension and occlusion with the existing prosthesis. The technique is simple, quick, cost effective and less challenging clinically and technically.

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1. Introduction

The demand for dental treatment from patients with missing teeth is increasing worldwide. Various types of treatment, including the use of conventional complete and partial dentures and tooth- and implant-supported fixed and removable prostheses, may be indicated for partially or completely eden-

tulous patients. The purpose of dental treatment is to respond to unique patients' needs. Thus, treatment should be highly individualized according to the patient and the disease (Allen et al., 2011; Jivraj and Chee, 2006; Nadig et al., 2011; Shahghaghian et al., 2014; Zitzmann et al., 2010).

The treatment of patients seeking dental implants and presenting with failed fixed dental prostheses is challenging. Many concerns arise in such cases, including preservation of the esthetics and occlusal vertical dimension of the existing prosthesis, preservation of the horizontal relationship of the dentition, atraumatic removal of the existing prosthesis (alone, or with the abutment teeth in cases of poor prognosis), surgical placement of dental implants, and temporization of the dentition with a provisional fixed or removable prosthesis. Each of these factors is important for the clinical and technical success of treatment (Chaimattayompol et al., 2002; Palmer et al., 2000). With the advent of dental implant-supported prostheses and the increased life expectancy of the elderly population, the

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restoration of mastication, phonetic function, and esthetics in elderly patients is a challenging task, even for the experienced clinician. However, the use of implants and restorations has reached a reasonably predictable level of success (Kammeyer et al., 2002). This case report illustrates a method by which a failed fixed prosthesis was converted into an implant-retained complete denture in a middle-aged patient.

2. Case report

A 43-year-old man reported to the Department of Prosthodontics, College of Dentistry, King Saud University, Riyadh, Kingdom of Saudi Arabia, with the chief complaint of tooth mobility. On general physical examination, the patient seemed to be in good general health. He had maxillary (14-unit) and mandibular (12-unit) full-arch splinted fixed prostheses (Fig. 1). Detailed clinical and radiographic examinations revealed generalized advanced periodontitis at the 11 maxillary abutment teeth (Fig. 2). The patient had used the maxillary prosthesis for 9 years, and was satisfied with its esthetics despite chipped porcelain at tooth #23 (Fig. 1). The occlusal vertical dimension and horizontal jaw relationship were found to be satisfactory, but the patient's oral hygiene status was not satisfactory. No other intraoral pathology was observed, and salivary flow was adequate.

A diagnosis of maxillary fixed dental prosthesis failure was made. The treatment options available initially were removal of the prosthesis and extraction of all maxillary teeth, followed by provision of a new conventional immediate complete denture and then a permanent conventional complete denture; or provision of an immediate complete denture over implants, followed by provision of a screw-retained implant-supported fixed prosthesis.

The patient was eager to receive implant treatment, but refused immediate provision of a new denture; he wanted to preserve the esthetics of the existing maxillary fixed prosthesis. The prosthodontist and implant surgeon discussed the case again in detail, and formulated a new treatment plan based on the patient's demand and consideration of his local and general health condition. This plan included the removal of the existing maxillary fixed prosthesis, extraction of all maxillary teeth, placement of six maxillary implants, and utilization of the existing fixed prosthesis in the fabrication of an immedi-



Figure 1 Intraoral views of the upper fixed prosthesis.

ate maxillary complete denture to be fitted over the implants. This approach preserved the maxillary esthetics and involved the provision of an implant-supported fixed prosthesis after complete healing and osseointegration of the dental implants.

The risks and benefits of all options were explained to the patient, and he accepted the new treatment option. A final comprehensive treatment plan was drafted. The goal was to preserve esthetics and the vertical and horizontal jaw relationships of the existing fixed dental prosthesis with the provision of an implant-supported fixed prosthesis. The initial diagnostic phase included the improvement of oral hygiene and review of the patient's history and medical condition.

After the elimination of active disease and potential causes of future disease, the surgical and prosthetic rehabilitation phase was initiated. The vertical and horizontal dimensions of occlusion were analyzed thoroughly. Before removal of the maxillary fixed prosthesis, a silicone bite registration index (Imprint™ Bite Registration Material; 3M ESPE, Minnesota, USA) and facebow record were made to document the jaw relationships (Fig. 3). Using Niswonger's method (Millet et al., 2010), marks were placed on the tip of the nose and chin to record the vertical dimension of occlusion. After informing the patient about possible complications and obtaining his consent, the maxillary prosthesis was removed under local anesthesia (Xylestesin™-A, 3M ESPE, Seefeld, Germany) using a crown remover and forceps. The prosthesis was removed without damage, and teeth #15, 21, and 27 were extracted along with it (Fig. 4). These teeth were then removed from the prosthesis, and the prosthesis was cleaned and disinfected in the laboratory and stored for future use (Fig. 5). All remaining maxillary teeth were extracted (Fig. 5), and the patient was then transported to the implant surgeon's clinic, where six implants were placed (Fig. 6).

The patient returned to our clinic for the fabrication of the immediate maxillary complete denture. The fixed prosthesis was seated in the patient's mouth with the help of the previously made silicone putty index (Fig. 7). The patient was asked to close the jaws lightly, and the vertical dimension of occlusion was verified with reference to the marks placed before prosthesis removal. Using polyvinyl siloxane bite registration material (Imprint™; 3M ESPE), the relationship between the intaglio surface of the old prosthesis and the maxilla was recorded with the same vertical dimension of occlusion (Fig. 8). An alginate (Jeltrate®; Dentsply, Surrey, UK) maxillary impression was then made carefully (Fig. 9). In the laboratory, maxillary and mandibular cast were poured with type II gypsum stone (Shera; Werkstoff Technologie GmbH, Lemförde, Germany). The upper cast was then mounted on an articulator with the lower cast, utilizing the previously obtained maxillary and mandibular records, along with the maxillary prosthesis. A wax-up of the immediate maxillary complete denture, incorporating the old prosthesis, was made. Investment of the denture in flasks, de-waxing, packing of the mold with heat-cured acrylic resin (Dentsply), and curing of the denture using a short cycle (Athar et al., 2009) were then performed in the laboratory. After finishing and polishing, the denture was ready for insertion (Fig. 10).

In the clinic, the denture was then tried in the patient's mouth (Fig. 11). Pressure-indicating paste (Mizzy Inc., New Jersey, USA) was used to identify and address any areas of pressure caused by the intaglio surface of the denture. The occlusion was verified and the immediate denture was deliv-

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