

IMPLANT PLATFORM: A SPECIAL JUNCTION

When preparing teeth, we keep our prep margins near the gingival margin (or just below it in esthetic cases). We don't want open margins or cement too deep or near the bone as this can cause infection, bone loss, pockets, recession, exposure of our crown margins and esthetic problems.

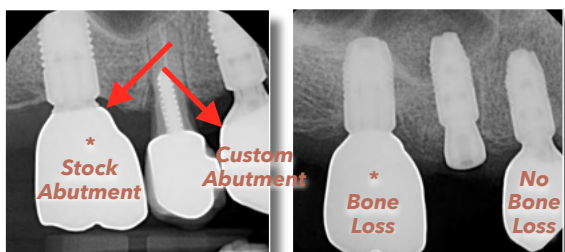
Implants seem different because they are not teeth, but open margins and cement at the implant platform can cause the same problems that happen to teeth to happen to implants as well. That is why we want custom abutments to mimic tooth preparations and move restorative margins coronally, away from the implant platform. Don't use stock abutments, even if cemented in the lab as the margin is too close to the bone, and will cause bone loss as well (see below).



Custom Abutment



Stock Abutment



The red arrows point to the location of the abutment crown interface. The imperfect stock abutment interface is near the bone, and the custom abutment interface is near the gingiva, similar to the tooth crown adjacent. After 5 years, there is bone loss around the implant with the stock abutment, but no bone loss around the implant with the custom abutment. Both crowns are screw retained.

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PHASED FULL MOUTH RECONSTRUCTION

Why is a periodontist writing about full mouth reconstruction...AGAIN?

In 2017 I published a newsletter about treating my dad's whole mouth. The goal then, and in every newsletter, was to share what I learned in the hope of helping dentists become aware of how to find information to provide types of care to challenge themselves and improve the lives of their patients through increased knowledge.

My dad's case was a phased treatment, but still completed within a couple of years, keeping in mind he lives in Dallas, Texas. The distance certainly adds a level of complexity.

This newsletter is about my dad's sister, who lives in Oregon. Although closer by, a 5 hour drive is also problematic. Her care was VERY phased and started with me in 2008 after she travelled to her home country of Romania to get her upper arch treated with full coverage restorations, and double abutted surveyed crowns in the mandible to support a removable partial denture. Her entire treatment, from preparation to seating of all restorations, was completed in 2 weeks in Romania, with open margins and bulky crowns throughout.

Full mouth reconstruction with me was never the plan. Iatrogenic restorations, distance, lack of consistent dental care and home care with recurrent caries, and a high risk for periodontal disease dictated the course...In the end, hygiene is much improved, and a prescription for long term Periostat will help maintain the work shown below.

This **ProbeTips** newsletter will show you how I treated my aunt. It involves challenges that you each may face, particularly with regard to managing implant restorations.

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PERIODONTOLOGY IMPLANTOLOGY ORAL MEDICINE

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She is driven to achieve esthetic and predictable outcomes, particularly for anterior implant cases, and is always looking to improve processes and results. You can email her directly below with questions, comments, or suggestions for future newsletters, or to sign up for the eNewsletter.



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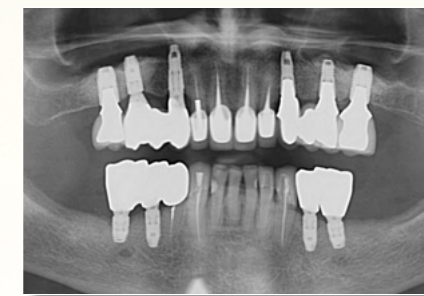
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PROBE TIPS

A QUARTERLY PERIODONTAL
NEWSLETTER

BY PAMELA NICOARA DDS MSD

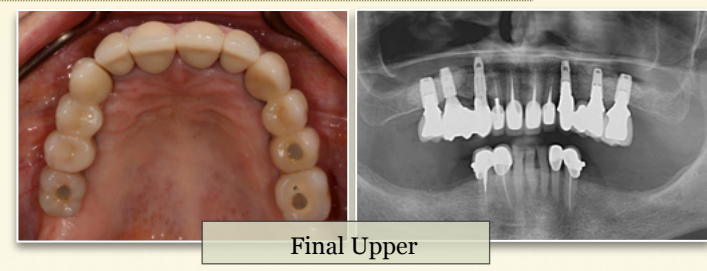
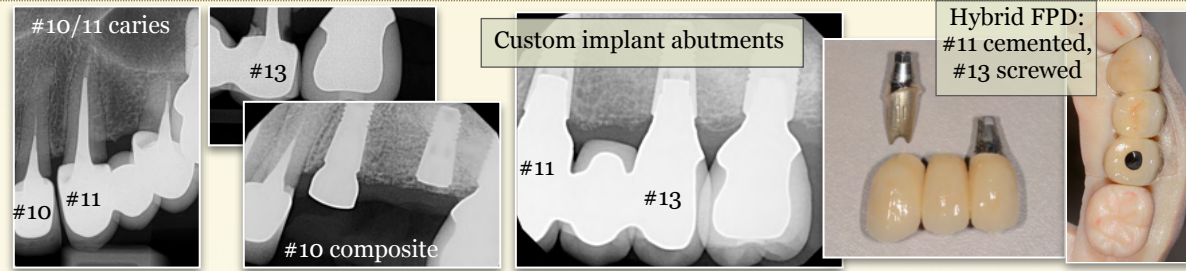
Phased Full Mouth Reconstruction Another One!?!



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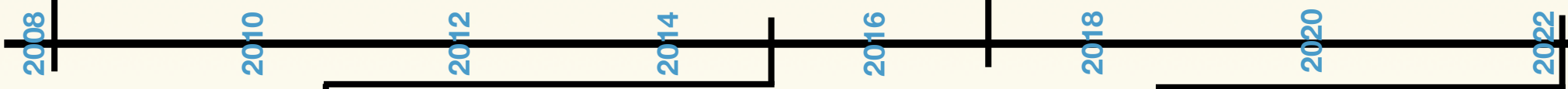
FEBRUARY 2023

Phased Full Mouth Reconstruction #2



1
2008
Upon returning from Romania with upper arch restorations, I extracted #3 due to caries and periodontal disease. It was not immediately replaced.

3
2019
Teeth #10, 11 and 13 were found to have caries, such that #11 and 13 could not be maintained. The caries on #10 was repaired with composite to maintain the existing full coverage restoration. To attempt to a **screw retained** solution, a *hybrid* fixed partial denture was fabricated to make #13 screw retained, and #11 cement retained overcome any lack of draw of the implants. The next step was to use implants to replace the lower partial denture, using short implants due to lack of space to the inferior alveolar nerve. COVID caused a pause until 2022. In the meantime, significant caries became a problem again...



2
2015
Not replacing #3 may have caused excessive force on weakened #4 and 6, which also had periodontal disease exacerbated by open crown margins. After #3 was replaced with an implant and **screw retained** crown, #4 and 6 were removed and replaced with implants and restored with a conventional cement retained FPD. That same year, #14 was extracted due to caries and periodontal disease, and replaced with an implant and **screw retained** crown.

4
2022
Assuming her dentist was managing caries, I did not notice decay on adjacent teeth until after placing the implants. To minimize surgery and maintain bone, I decoronated/submerged #28 replacing it with a cantilever, replaced full coverage crowns on #22, 23 and 27, and used composites to repair adjacent decay. **Splinted screw retained** implant crowns were chosen to mitigate bone loss around the short implants due to periodontal risk, as well as a *Periostat* Rx. To manage the lack of draw, implant #29 was cemented to the custom abutment in the mouth (screw-mentable), and implant #20 had the hex portion of the custom abutment removed by the lab to allow for cementation in the lab rather than in the mouth and allow room for 'play' for seating.

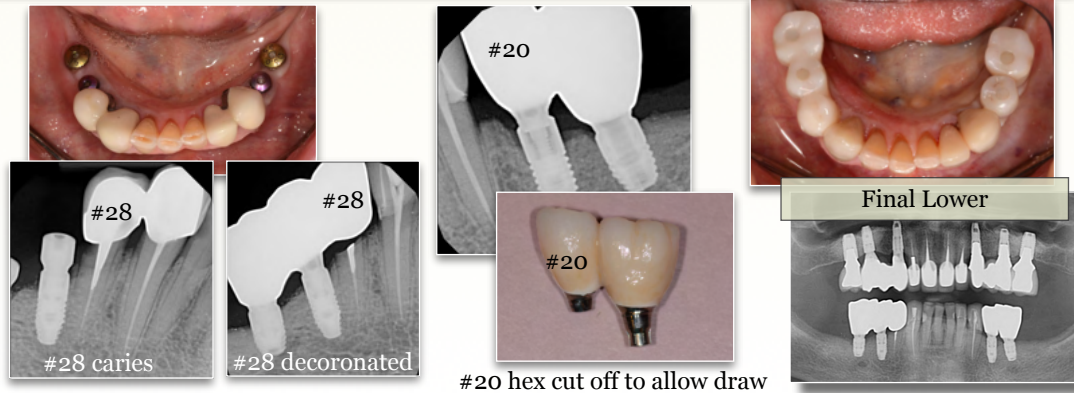
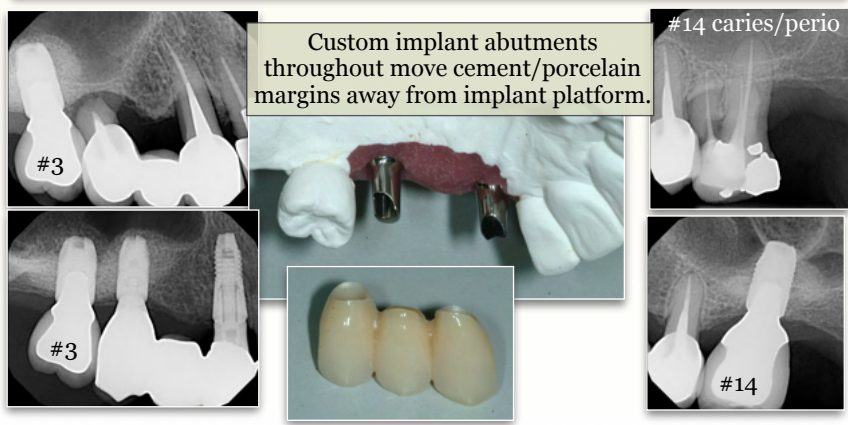
Screw Retained is the Aim!
Custom Abutment is a Must!

Hopefully it is clear that in the course of my aunt's care, as time passed I wanted to use screw retained implant restorations on custom abutments as much as possible. This is particularly important for patients like her with a higher risk for bone loss.

Custom abutments can be seen throughout the images, although more obvious in the maxillary restorations as there was more soft tissue present compared to mandibular restorations.

Screw-mentable restorations can work, but again, a custom abutment is needed to move the cement gap away from the implant platform at the bone level.

I will devote the next newsletter to detailing implant restoration including impression techniques, abutment options (angled abutments and angled screw channels), screw retained restoration tips and tricks, and more!



Cement retained FPD on implants #4/6, screw retained crowns on #3 and 14.