Principles of Esthetic Implant Restorations

Optimal implant outcomes depend first on implant positioning and soft tissue management, and then on the restorative process.

Implant positioning should always be correct in depth and angle. It should be **deep enough** to avoid premature thread exposure with normal soft tissue recession over time (typically 3mm apical to where the CEJ was or would be at the intended tooth site). Angulation, if possible, should **allow screw exit at the cingulum** of anterior teeth or center of the occlusal surface of posterior teeth. For some anterior teeth, particularly if the teeth are flared, an exit at the cingulum is impossible and angled screw channels are used to allow for a **screw retained restoration** to prevent sub-gingival cement extrusion, particularly in combination with a **custom abutment**.

Once implant position is correct, **bone and soft tissue grafting** are use to rebuild lost tissue, or maintain what was there. Most tissues never improve with time, and building back after the fact is very difficult, so building the best foundation possible to start with is paramount.

Finally after implant integration, special care is taken in my practice to fabricate a **temporary implant crown to shape tissues** to make the final impression process in your office as simple as possible particularly with regard to the lab who will have less to think about when they simply need to follow the existing contours.

Canine Implants

One of the more difficult implant positions to manage are the canines, particularly in the maxilla where esthetics are a priority. Any maxillary anterior implant can be a challenge, but the canines are more difficult because of the canine prominence which can be lost without attentive grafting procedures, particularly in someone with a thin biotype.

The goal of any implant should be not only to have a long lasting support for the crown above, but especially to help hide the fact that there is an implant supporting your supra-gingival restoration, particularly in patients with a high smile line. Not only for cosmetics, but also for hygienic reasons to help minimize the amount of food impaction that can lead to bacterial invasion and bone loss, soft tissue loss and eventual implant loss.

I hope you will enjoy this **ProbeTips** newsletter which will **review four different canine implant cases** ranging from the maxilla to the mandible, and from immediate placement to ridge augmentation with delayed implant placement.

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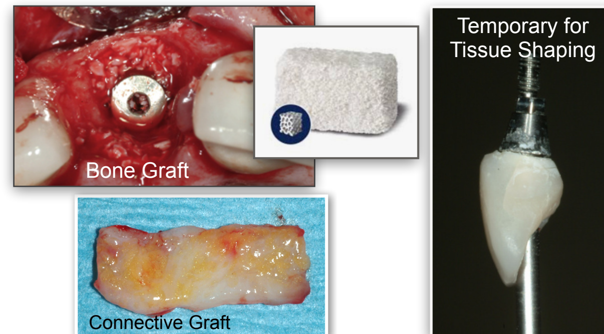
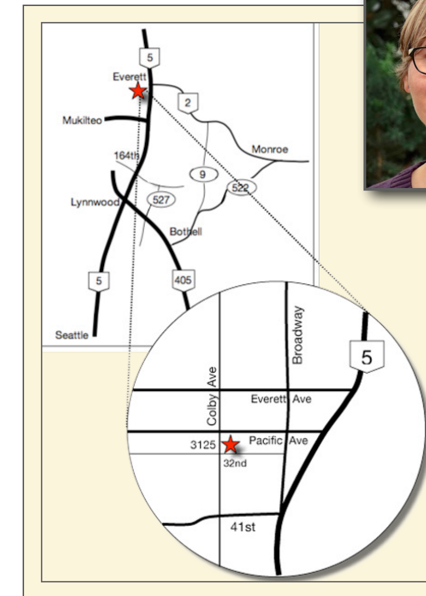


Pamela A Nicoara DDS MSD PLLC

PERIODONTOLOGY IMPLANTOLOGY ORAL MEDICINE

Pamela Nicoara is a Board Certified Periodontist practicing in Everett since 2007. She is a UW Perio graduate, and a transplant from Dallas, Texas.

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.



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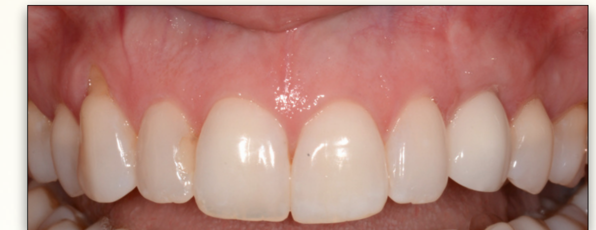
Probe Tips

A Quarterly Periodontal Newsletter

by Pamela Nicoara DDS MSD

Canine Implants



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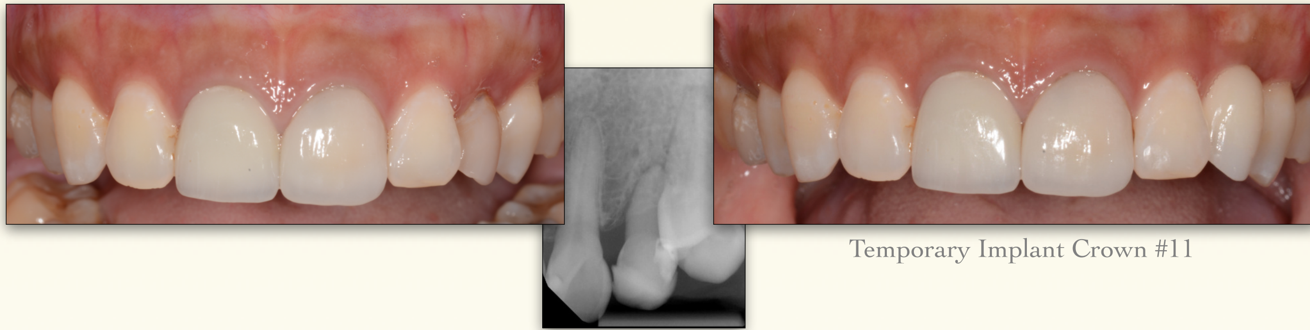
Canine Implants

Case 1: Immediate Maxillary Implant #11

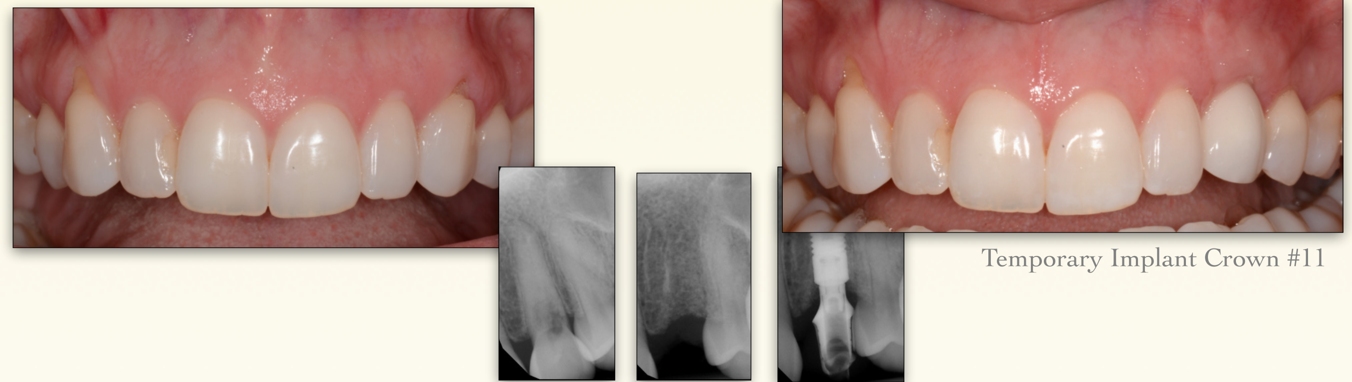
Most anterior implants in my practice are performed as immediate implant placement at the time of extraction. The extraction socket serves as a scaffold for bone grafting as the implant shape is generally more narrow than the socket, so bone grafting is placed in the socket space. Soft tissue grafting is also aided by attempting to use existing contours as a framework against which to augment. This minimizes surgical procedures which minimizes scarring or post surgical retraction. The case below is a maxillary anterior canine #11 replacing a failing primary tooth in a thin biotype…one of the hardest types of tissue to gain bulk and maintain bulk.



Temporary Implant Crown #11

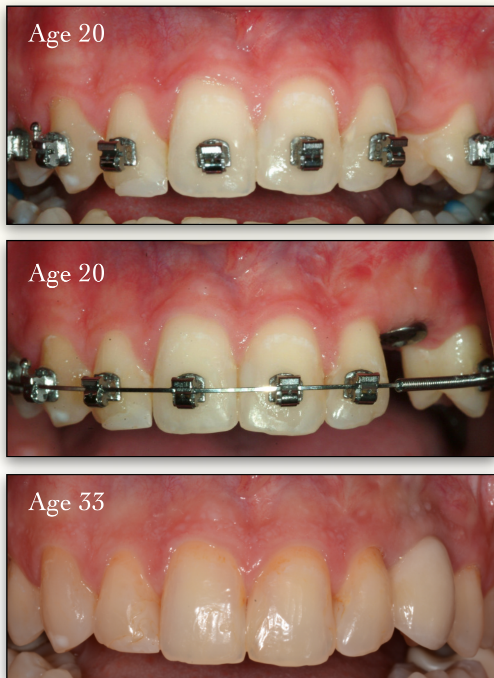
Case 2: Delayed Maxillary Implant #11

Many canines have very long roots and immediate implant placement is not possible because there is not enough bone apically in which to maintain correct implant position before reaching the nasal cavity or maxillary sinus. In these cases, as shown below, the tooth #11 with resorption is removed and the socket grafted with bone and augmented with soft tissue. After 6 months of healing, the implant is placed and soft tissues are manipulated to maintain as much bulk as possible, particularly at the time of temporary crown seating.

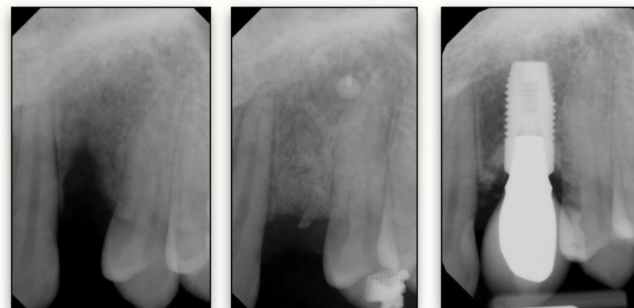


Temporary Implant Crown #11

Case 3: Ridge Augmentation #11

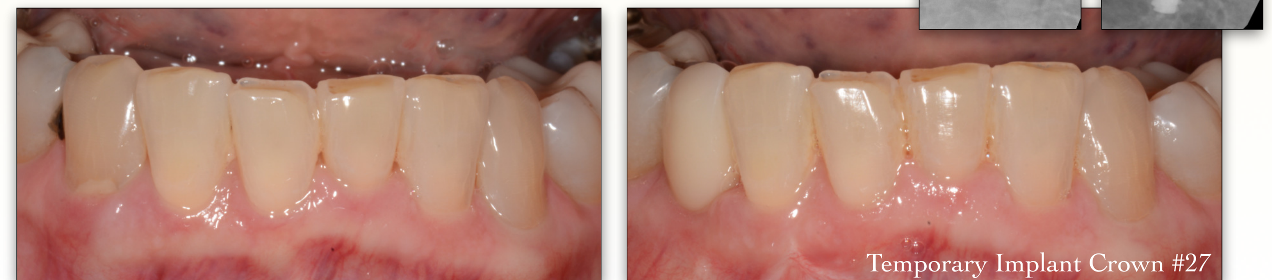


In some instances, the bone is so deficient, that ridge augmentation is required ahead of time to create the proper foundation for a long lasting restoration. In the case here, ridge augmentation included a non-resorbable membrane. After 6-9 months, the implant was placed and restored. This particular patient has had his implant for 13 years, placed at age 20. Note the relative intrusion and the shortened incisal edge, which can be improved with a new restoration.



Case 4: Immediate Mandibular Implant #27

We don't think of mandibular canines as being cosmetic, but the same care should go into 'non-esthetic' implants as it does into those that are more obvious, primarily for hygienic purposes. The less food impaction, the better the long term prognosis. Consider for yourself what you would want in your own mouth… something that functions similar to your natural tooth, or something that requires constant attention. Here, tooth #27 had root resorption and was replaced with an implant at the time of extraction, then temporized before final restoration.



Temporary Implant Crown #27