Restoring missing mandibular incisors with implants

**Fig. 1:** Pre-op.—**Fig. 2:** Pre-op peri-apical X-ray.—**Fig. 3:** Resin-bonded provisional restoration.—**Fig. 4:** Lingual view.—**Fig. 5:** Twelve weeks post-extraction.

**Fig. 6:** Following implant placement.—**Fig. 7:** Peri-apical X-ray at implant insertion.—**Fig. 8:** Immediate provisionalisation.—**Fig. 9:** Modification of provisional restoration.—**Fig. 10:** Eight weeks post-implant placement.

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Mandibular incisors can be vulnerable to early loss due to their inherent weak periodontal support and high prevalence with respect to periodontal disease. What are the most common treatment options for missing mandibular incisors? Aside from removable prosthesis options, the restorative options for a fixed prosthesis include a conventional bridge, a resin-bonded bridge (Maryland Bridge) and implants. For a case in which one or two mandibular central incisors are missing, a three- or four-unit bridge has often been the treatment of choice. A resin-bonded bridge, in these cases, can be a reasonable alternative to a conventional bridge; whereas implant treatment, more often than not, is not suitable due to insufficient space. When more than two incisors are missing, the implant option may become the first choice for most clinicians these days.

Preparing mandibular incisors for bridge abutments is an extremely delicate procedure that often leads to root-canal treatment due to pulp damage that might occur during the procedure. Even without the risk of pulp damage, it is still quite a challenge to recreate natural contour and shade on such tiny dentition. Dental implants have, in many cases, become the treatment of choice for restoring missing teeth and have been documented to have a high degree of success. With implant therapy, the preparation of healthy teeth adjacent to the edentulous area can be avoided. An additional advantage to the implant restoration is the maintenance of the alveolar bone, which otherwise would undergo resorption with other restorative options, hence, often complicating aesthetics.

What's happening in the real world? Are we comfortable enough placing implants in the mandibular anterior region? In spite of understanding both the disadvantages of conventional fixed bridgework and the advantages of implant restorations, we often make the treatment choice for missing mandibular incisors in favour of the bridge. Why is that? What hinders us from providing an implant option for patients in such cases? Restoring mandibular incisors with implants can be one of the most difficult dental treatments to perform due to the limited amount of bone and inter-arch space. Placing implants in the mandibular anterior region can be challenging due to:

1. insufficient facio-lingual bone volume;
2. insufficient mesio-distal space between adjacent teeth;
3. insufficient height of remaining alveolar bone;
4. the presence of mental-labial depression, which limits the facio-lingual angulation of implants; and
5. the preservation or recreation of the interdental papilla being an extremely delicate procedure.

One of the prerequisites for the successful placement of an implant is the presence of adequate bone volume. Tarnow et al. stated that a submerged implant, following the delivery of the prosthesis, will create circumferential or horizontal bone resorption of 1.5 to 4 mm. Grunder et al. also stated that at least 2 mm of lateral alveolar bone must be present beyond the body of the implant to compensate for the effects of bone remodelling. If this amount of bone is not present, part or all of the facial or buccal bone plate will be lost after remodelling, with the subsequent risk of soft-tissue recession. This amount of bone around an implant rarely exists in the mandibular anterior region. Therefore, ridge augmentation procedures are often required to create adequate bone volume to maintain a 2 mm alveolar thickness following implant placement.

Another prerequisite for successful implant treatment is sufficient inter-arch space. The creation of a natural-looking implant restoration largely depends on the appropriate placement of the implant during surgery. In order to achieve this goal, careful planning and precise implant placement are essential. An implant requires a minimum distance of 1.5 mm between the implant and adjacent tooth to maintain interproximal bone and interdental papilla. Standard diameter implants of 4 mm or greater therefore require a mesio-distal space of at least 7 mm to place an implant. For an interdental papilla between two adjacent implants to be established, the interproximal distance should be more than 7 mm.

Thus, a minimum mesio-distal space of 1.4 mm is required to place two standard-diameter implants adjacent to each other. Implant manufacturers have introduced narrow-diameter implants (5.0 to 3.5 mm) in an attempt to solve these problems. However, these implants still require a minimum mesio-distal space of 6.0 to 6.5 mm to allow adequate implant-arch support and high prevalence with respect to periodontal disease.

**For most clinicians these days.**
Case reports

Case I
A 67-year-old female patient presented with occasional throbbing pain in the mandibular anterior region. The patient's medical history was non-contributory. Clinical and radiographic evaluation revealed two separate peri-apical lesions, delayed placement of implants was planned. The teeth were carefully isolated with a periosteal andatraumatically extracted, preserving the thin facial bone. A wire-embodied provisional restoration was fabricated and bonded to the adjacent canines with flowable resin (Figs. 1 & 2). After ten weeks of healing, the provisional restoration was removed. The distance measured between the two mandibular canines was 15 mm (Fig. 5).

A crestal incision was made and a limited soft-tissue flap was reflected to expose the alveolar crest of bone. In this fashion, the patient experienced reduced post-operative swelling and discomfort. With a 1.6 mm twist drill and copious irrigation, ostotomies were performed at a speed of 1,500 rpm. The angulation of the twist drill was carefully monitored throughout the ostotomies. Following completion of the prepared implant sites, visual and tactile inspections of the internal bony walls was performed to ensure the absence of any fenestration or dehiscence at the cervical area. Two 2.5 mm-diameter implants (MDI) were then placed in the ideal 3-D position and torqued to 25 Ncm (Figs. 1 & 2). Immediately following implant placement, provisional restorations were fabricated at chairside using prefabricated temporary abutments.

The primary disadvantage of one-piece implants is related to the fact that these implants must be placed with a one-stage protocol. Therefore, the angulation of the abutment cannot be altered and only minimal modification of the abutment is possible. Without the prosthetic freedom of the abutment choices, the initial surgical positioning of one-piece implants becomes critical in obtaining an optimal result.

The advantages of one-piece implants include minimally invasive surgery, simple restorative procedures and no screw loosening. Furthermore, the amount of crestal bone resorption may be minimised, since there is no micro-gap or micro-movement between the implant and its abutment. This becomes even more critical for long-term aesthetic results in the anterior region. In order to demonstrate the successful use of one-piece implants, this article describes the restoration of mandibular incisors with one-piece MDIs.
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cement (Figs. 8 & 9). This could remove the risk of cement being forced into the gap between the implant fixture and soft tissue. The provisional restorations had no centric or eccentric occlusal contacts. The patient was instructed to avoid any function of the implant for eight weeks. After a healing phase of two months, a final impression was produced using friction-fit impression caps (Figs. 10 & 11). Definitive restorations were then fabricated on the working cast and adjusted to have slight occlusal contacts in centric occlusion and excursive movements (Figs. 12-14). The clinical re-evaluation demonstrated a minimal gingival change around the prosthesis, and a stable horizontal bone level was observed radiographically at the 15-month follow-up (Figs. 15 & 16).

Case II

A 56-year-old male patient presented with severe mobility and peri-apical lesions on teeth #23 and 14 (Fig. 17). A provisional restoration was fabricated and bonded to the adjacent natural teeth immediately following extraction (Fig. 18). The provisional restoration was left undisturbed for 11 weeks and the interdental papillae were preserved with ovate pontics (Figs. 19 & 20).

The interdental distance measured between teeth #22 and 25 was 8 mm, and two 2.5 mm-diameter implants were placed in position. The superior margin of the transmucosal portion was positioned sub-gingivally, and the height of the abutments was reduced to ensure adequate initial clearance (Fig. 21). Owing to the limited interdental space, the impression was produced using friction-fit impression caps (Figs. 19 & 20). An indexing jig was used to avoid any undue stress applied to implant fixtures during the impression procedure (Fig. 25). An altered cast was made, and a definitive prosthesis was fabricated. The clinical and radiographic evaluation at 11 months demonstrated a good aesthetic result with no significant peri-implant bone loss (Fig. 24).

Conclusion

Based on the clinical cases presented in this article, the utilisation of one-piece MDIs appears to be a good treatment option for replacing missing mandibular incisors. Considering the simplicity, ease of implant placement and immediate provisionalisation, this treatment offers a new option for patient care.

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