Complete maxillary implant prosthetic rehabilitation utilising a CAD/CAM fixed prosthesis

**Clinical report**

A 62-year-old female with failing implant prosthesis at the maxillary right canine area, included removal of the implant and the maxilla was ready for prosthetic rehabilitation after a few weeks of soft-tissue healing.

The development of the planned definitive maxillary restoration was carried out using a CAD/CAM process. The maxillary platform implant was placed (NobelReplace, Tapered Groovy). The new implant was submerged and primary wound closure achieved. Her existing prosthesis was re-inserted during the healing period to serve as a provisional prosthesis. Once osseointegration was achieved a few months later, the new implant was exposed and the maxilla was ready for prosthetic rehabilitation after a few weeks of soft-tissue healing.

**Conventional porcelain-fused-to-metal restorations**

The overall treatment plan included removal of the implant at the maxillary right canine area, replacement of a new implant at the maxillary right canine region and fabrication of a full-arch, zirconium oxide-based ceramic restoration in the maxilla.

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**Clinical report**

A 62-year-old female with a failing implant-supported maxillary prosthesis was evaluated at the tissue surface. The prosthesis to enhance oral hygiene maintenance. However, application of this prosthetic design in the maxillary arch is occasionally aesthetically inadequate and speech may be compromised.

**Porcelain-fused-to-metal restorations**

Conventional porcelain-fused-to-metal restorations require the placement of labial restoration margins below the free gingival margin in order to mask the hue and value transition between the sub-gingival implant sub-structures and the supra-gingival crown restorations. From a periodontal point of view, sub-gingival placement of restoration margins is related to adverse periodontal tissue response.**8** A result, restoration margins are best placed coronally from the free gingival margin.**3**

Porcelain-fused-to-metal restorations are commonly used in the posterior teeth because of their well-documented long-term clinical track record.**5,6** CAD/CAM ceramic-based materials are prescribed nowadays, owing to their demonstrated promising physical properties**2** and clinical longevity.**6**

This article describes the clinical application of high-strength zirconium oxide restorations in the prosthetic management of an edentulous maxilla with a failing implant prosthesis.

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definitive cast with the custom full-ceramic abutments were scanned (Zeno Scan, WIELAND Dental+Technik), and the prosthesis framework was designed using a software program (D700, 3Shape). The framework was milled in zirconium-base material (Zeno Zr Bridge, WIELAND Dental+Technik) with a milling machine (Zeno 4030 M1, WIELAND Dental+Technik). The prosthesis framework was sintered according to the manufacturer’s recommendations. Subsequently, over-laying low-fusing, tooth-coloured porcelain material (IPS e.max, Ivoclar Vivadent) was manually applied onto the exterior to create proper anatomic form (Fig. 3). Low-fusing, gingival-coloured porcelain material (IPS e.max) was applied to create proper lip support (Fig. 4).

During the delivery clinical session, the old prosthesis was removed and the new custom abutments were torqued to 32 Ncm (Fig. 5). The new prosthesis was tried-in to verify colour, occlusion, lip support, teeth form, and comfort. Upon confirmation of the patient’s acceptance, the implant abutments were sealed in gutta-percha (Fig. 6) and the prosthesis was cemented in resin-modified glass-ionomer luting agent (RelyX Unicem, 3M ESPE).

The patient was evaluated two weeks post-operatively. Anterior guided occlusal schemes were verified intra-orally before and after prosthesis cementation (Fig. 7). The patient reported no discomfort and she had been functioning well with the new restorations. No abnormal clinical signs were noted.

Discussion

Osseo-integration is a well-documented and predictable clinical treatment option. On the other hand, management of implant failure is also a clinical reality. In this clinical report, the failure of one implant at a crucial location indicated the need for re-fabrication of the whole implant prosthesis. As the patient desired a high level of aesthetics, full-ceramic restorations were selected. By prescribing tooth-coloured ceramic abutments and full-ceramic restorations, prosthesis margins were made at the gingival level and gingival retraction procedures were eliminated during impression and prosthesis insertion.

Full-arch prosthodontic rehabilitation using fixed prostheses usually requires longer-term provisional restoration in order to facilitate a predictable treatment outcome. In this patient, the existing maxillary prosthesis served as a long-term provisional restoration for verifying her adaptability and multiple professional clinical adjustments of provisional restorations were not required. This treatment sequence increased the margin of safety in the execution of the definitive full-ceramic restoration. Intra-oral verification of the new treatment occlusal scheme and detailed in situ clinical adjustment of the restorations on the day of prosthesis insertion still formed the essential foundation for proper treatment execution. In any major prosthodontic treatment, the patient should be informed of the potential financial and time implications should the need for re-fabrication of the restorations arise.

Conclusion

The functional management of an edentulous maxilla using a full-ceramic implant-supported maxillary prosthesis has been reported. New CAD/CAM-based restorative materials were used in treating this case. The use of high-strength full-ceramic restorations enhances overall aesthetic predictability and long-term functional outcome.