Long-term clinical success in the management of compromised intertooth spaces utilizing small-diameter implants

By Paul S. Petrungaro, DDS, MS

Management of edentulous sites in the oral cavity with dental implants has been well documented in dental literature during the past 35 plus years. Patients seeking tooth replacement for partial or totally edentulous situations have been able to enjoy natural appearing and functioning prostheses that are fixed, stable and, in some cases, so natural it’s difficult to ascertain a dental implant restoration from a tooth restoration. Using dental implants to replace the natural tooth system in the esthetic zone has also seen an increase in restorative treatment plans and, with the advent and perfection of immediate restoration protocols initially reported in the literature, achieving natural soft tissue esthetics around dental implants can be predictable and successful. However, certain clinical situations can complicate or negate the procedure altogether.

One of these complications is insufficient intertooth spacing between natural teeth and, most commonly, with congenitally missing lateral incisors following orthodontic treatment. Often as a solution to this, the dentist chooses a removable partial denture or some type of resin-bound bridge, both of which may not be appealing to younger individuals. In extreme cases, the dentist may elect to proceed with a fixed bridge, which would cause excessive destruction to the natural teeth serving as abutments and, for a young individual, this could be devastating to these teeth during a 40-50 year period, if not sooner.

To properly form an ovate pontic type emergence profile in the soft tissue, which is required for a fixed bridge to have a natural clinical appearance, consideration must be given to the intertooth edentulous space. This is also very important when choosing dental implants for natural tooth replacement. Wallace, Michal and Salama, et al.9-12 stated that for a normal two-piece implant, the implant should be placed at least 3.5 mm from the adjacent teeth. As a result, using a 3.5 mm diameter implant, the maximum inter-tooth space to support interproximal bone and natural soft tissue papillary contours should be 6.5 mm, and with a 3.0 mm diameter implant, 6.0 mm for the edentulous space. Often, the intertooth space in these cases is smaller than 6.0 mm. Taking these parameters into account, small-diameter implants (3.0 mm is the smallest from most dental implant manufacturers) should not be used in cases with less than 6.0 mm of inter tooth space, to prevent potential tooth root damage, crestal bone loss and unnatural appearing gingival tissues and papillae.

Small-diameter, or mini, implants were developed more than 20 years ago and, initially, the recommended use was to support temporary removable prostheses during the healing phase for advanced bone-grafting procedures and/or conventional implant placements.8-9 Their use was later expanded into immediate conversion of full dentures into implant-supported dentures for partially edentulous cases and for anchorage of single tooth implant restorations in compromised intertooth spaces.8-10 Implants are available from 1.8 mm in diameter to 2.8 mm diameter and offer a fixed permanent tooth replacement option for patients who otherwise would not be able to have implants placed and restored. Their ease of use and atrocities place utilization a flawless approach, along with only one coring procedure, as well as simplistic abutment transfer and provisional construction make the use of these implants in the aforementioned sites a must for the dental implant practice.

The following case report will demonstrate the use of the Dentiatus ANEW (Dentatus USA, Ltd, New York, NY) implant for the management of the compromised, congenitally missing lateral space in a 17-year-old young woman with a 10-year clinical follow up.

Case report

A 17-year-old, non-smoking female presented for tooth replacement in the congenitally missing maxillary left lateral incisor site (Fig. 1). The patient had recently completed orthodontic therapy, and the orthodontist and general practitioner had agreed that this was the final obtainable result in regard to the remaining intertooth space between the maxillary left central incisor and maxillary left canine (Fig 2). The result of intertooth space was less than 3.0 mm, and conventional two-stage implants with abutment options were ruled out. The patient and her parents ruled out conventional tooth-replacement options and chose the minimally invasive procedure, a small-diameter implant, 1.8 mm in diameter, which would allow for natural papillary contours to be developed.

After administration of an appropriate local anesthetic, an ovate pontic contour was created utilizing a football-shaped diamond in the attached, keratinized tissue of the edentulous site (Fig. 3). This scalloped-type tissue contour helps in the creation of the natural-appearing papillary contours.

The small-diameter implant chosen, a 1.8 mm x 14 mm Dentiatus ANEW Implant was then placed after a single coring of the site with a 1.4 mm needlepoint CEPi to Full depth, within the sculpted tissue emergence profile previously created (Fig. 4). Conversion to an esthetic provisional restoration was completed by placing an abutment coping with a delrin retention screw (Dentatus USA, New York, NY). An air shell provisional crown was then placed out and retrofitted to the abutment coping with flowable composite. The margins of the provisional were corrected and provisional冠 was cemented to the restorative. The restoration was polished and seated with the screw from the palatal immediate postoperative clinical view is seen in Fig. 5. The immediate postoperative periapical view is seen in Fig. 6.

The patient then went through the three-month healing and observation phase prior to construction of a lab-processed interim pontic crown (Fig. 7). One year later, the patient underwent fabrication of the left incisal site. A 10-year postoperative clinical view is seen in Fig. 8 and a 10-year postoperative CT scan of the implant in Fig. 9.

Please note the beautiful soft-tissue esthetic result obtained and excellence maintenance of the crestal and lateral contours.

Conclusion

The management of compromised intertooth spaces presents a challenge for the contemporary dental implant team. These spaces have limitations on how much bone can be added and require implants 3.0 mm wide or less, as was demonstrated in the text of this article. Availability of smaller-diameter implants allows patients who normally would have to proceed with a fixed bridge, or resin-bonded bridge, the luxury of dental implants with no preparation and/ or reduction to the adjacent natural dentition.

Proper placement procedures and restorative techniques can lead to very esthetic results, allowing for natural tissue contours and emergence profile formation, reminiscent of the natural tooth.

Acknowledgement

Originally published in Inside Dentistry, © 2014 to AEGIS Publications, LLC. All rights reserved. Reprinted with permission from the publisher.

References

6) Kan TY, SungYi Wang, K. Immediate placement and provisionulation of maxillary anterior single implants. A surgical and prosthetic rationale. Pract Periodontics Aesthet
Fig. 5. Immediate postoperative clinical view

Fig. 6. Immediate postoperative radiograph

Fig. 7. Lab-processed, long-term provisional restoration

Fig. 8. 10-year postoperative clinical view

Fig. 9. 10-year postoperative CT serial view


Paul S. Petrungaro, DDS, MS, FICD, FACD, DICOI. He is internationally recognized for his educational and clinical contributions to modern dentistry. He graduated from Loyola University Dental School in 1986, where he completed an independent study toward the DICOI certification at the Welsh National Dental School in Wales, U.K. He completed his residency in periodontics and has a specialty certificate in addition to masters of degree science in periodontics from Northwestern University Dental School. He is the former coordinator of implantology, Graduate Department of Periodontics, Northwestern University Dental School. Petrungaro has been in the private practice of periodontics and implantology since 1988 and holds a license in both Illinois and Minnesota.

mCME Self Instruction Program
CAPPmea together with Dental Tribune provides the opportunity with its mCME - Self Instruction Program a quick and simple way to meet your continuing education needs. mCME offers you the flexibility to work at your own pace through the material from any location at any time. The content is international, drawn from the upper echelon of dental medicine, but also presents a regional outlook in terms of perspective and subject matter.

Membership
Yearly membership subscription for mCME: 1,100 AED
One Time article newspaper subscription: 250 AED per issue. After the payment, you will receive your membership number and allowing you to start the program.

Completion of mCME
- mCME participants are required to read the continuing medical education (CME) articles published in each issue.
- Each article offers 2 CME Credit and are followed by a quiz Questionnaire online, which is available on www.cappmea.com/mCME/questionnaires.html
- Each quiz has to be returned to events@cappmea.com or faxed to +971 4 3686883 in three months from the publication date.
- A minimum passing score of 80% must be achieved in order to claim credit.
- No more than two answered questions can be submitted at the same time.
- Validity of the article – 3 months
- Validity of the subscription – 1 year
- Collection of Credit hours: You will receive the summary report with Certificate maximum one month after the expiry date of your membership. For single subscription certificates and summary reports will be sent one month after the publication of the article.

The answers and critiques published herein have been checked carefully and represent authoritative opinions about the questions concerned. Articles are available on www.cappmea.com after the publication.

For more information please contact events@cappmea.com or +971 4 3686744

For interaction with the authors find the contact details at the end of each article.