Advanced Restorative Techniques
And The Full Mouth Reconstruction
- The Periodontal Prosthesis. Part 8

By Prof. Paul Tipton, UK

Introduction
The periodontal prosthesis or as it is also commonly known the Lindhe / Nyman bridge is a technique developed by the two leading periodontists of the 1970’s, Jan Lindhe and Stu Nyman in Gothenburg. Their technique allows multiple pontic replacement in fixed bridgework often on severely mobile, compromised and reduced number of abutment teeth. The science is overwhelmingly in favour of this type of bridge in certain situations where conventional dentures and implants are not possible for whatever reasons.

The technique relies on good oral hygiene, a reduced but healthy periodontal condition, multiple cantilevers often with three pontics cantilevered off the last remaining abutment, supra gingival margins, acrylic or composite veneering material on a metal framework and with a balanced form of occlusion (with non-working side interferences deliberately placed).

In effect the bridgework acts as a “living denture” and the balanced occlusion stabilizes the mobile bridgework. This type of bridge has increased but not increasing mobility and excellent long term success rates. Bridge design can vary from end abutment bridges to cantilevered bridges and often with a 12 unit bridge supported only by two mobile canine abutments.

Clinical Studies
The clinical studies date back to articles published in the Journal of Periodontology in April 1979. The material consisted of 299 individuals (aged 23-72 years, mean age 48.7 years) who during the period 1969 to 1973 were referred to the Department of Periodontology, University of Gothenburg, for periodontal treatment. The limiting criterion for acceptance of patients for this study was that their dentition had lost 50% or more of the periodontal tissue support. In addition, they had to be (i) willing to accept periodontal treatment including tooth extractions, periodontal surgery and, if indicated, prosthetic treatment, (ii) capable of maintaining optimal plaque control and, (iii) willing to appear for regular appointments for additional maintenance care. Forty-eight of these patients (22 males and 26 females), namely those who still 8 years following initial treatment participated in the controlled oral hygiene program and appeared at the 8-year follow-up reexamination constituted the “non-bridge treatment group” (Group I). The remaining 251 patients displayed at the initial examination a similar degree of periodontal disease as the patients of Group I but, in addition, the breakdown of the periodontal tissues around certain teeth had reached a level where tooth extractions and subsequent prosthetic replacement were required. Out of these 251 individuals, every fifth (in consecutive order according to date of commencement of treatment), i.e. in all 50 patients, were selected to form the “bridge treatment group” (Group II). In these 50 patients, 74 fixed bridges were placed. According to the design of the bridgework “the
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bridge treatment group was divided into three subgroups:

Group IIa: 21 bridges of cross-arch extension with abutment teeth present at the distal termination of the bridges. In this bridgework, the number of pontics between two neighboring abutments ranged from one to eight.

Group IIb: 39 bridges of cross-arch extension with distal cantilever segments in one or both sides of the jaw. In this bridgework, the mean number of free-end pontics per cantilever segment was 2.3 (range 1-7).

Group IIc: 14 bridges of unilateral extension.

Success Rates

The overall success rate for this very extreme style of bridgework was over 92% success after the eight years of the study.

The analysis of the total material (332 bridges in 251 patients) regarding frequency of and reasons for technical failures which were encountered in the various bridgework after placement, gave the following result:

1. Loss of retention of retainer crowns from abutment teeth (11 bridges, 3.3%).
2. Fracture of bridgework (seven bridges, 2.1%).
3. Fracture of abutment teeth (one tooth in each of eight bridges, 2.4%).

Conclusions

The results showed that following a combined prosthetic / periodontal treatment, periodontal health can be maintained in patients enrolled in a controlled oral hygiene program. The type of maintenance care exercised in the present study was equally effective in patients for whom fixed bridgework was part of the initial treatment. Severe reduction of periodontal support around the abutment teeth and differences in design of the bridgework did not influence the periodontal status or longevity of the bridgework during the observation period. However, failures of technical nature occurred...
in 26 out of the 332 bridges. These failures appeared as (i) loss of retention of retainer crowns from abutment teeth in 11 bridges, (ii) fracture of bridgework in seven bridges, and (iii) fracture of abutment teeth in 8 bridges. All of these potential failures could be reduced by further adaptation of the bridge design and construction techniques.

Case Study

This lady was referred to me by her GDP from Birmingham with severe mobility of her remaining teeth, an inability to wear a partial denture, aversion to dental implants and a request to fix her teeth (Figs. 1-4). On examination it was noted that there was grade 1 - 2+ on all of the teeth with a reduced periodontal support. After an initial phase of periodontal treatment including visits with both hygienist and periodontist she was declared sound and healthy but with increased mobility of her teeth. Her response to periodontal therapy indicated a likely success for a periodontal prosthesis type of bridge-work. Initial diagnostic work included full mouth diagnostic waxing and prototypes (Figs. 5-8). This was followed by initial tooth preparations and fitting of the prototypes to try out the new aesthetics and function. At a subsequent stage further tooth preparations were completed and impressions taken using a polyvinyl siloxane material in a stock plastic tray (Figs. 9,10).

As was indicated in the last article it is exceedingly difficult to take accurate impressions of mobile teeth. Hence the impressions were silver plated and silver dies prepared of the preparations in both the upper and lower jaws, and duralay bonnets fabricated (Figs. 11-14). At a second visit further impressions were completed by first placing the duralay bonnets on the teeth and then splinting them together with further duralay and coat-hanger wire using the “bead on technique” and then taking an overall Impregum location impression in a custom made tray (Figs. 15-18). Following this the silver dies were placed back into the impressions and further stone models poured to produce the highly accurate master models (Figs. 19,20).

Occlusal records were taken by using a facebow, measuring the inter-condylar distance and a cadax record (Figs. 21-23) so as to programme the fully adjustable articulator (Figs. 24,25).

Metal substrutures were then cast and tried in the mouth and the fit and accuracy verified (Fig. 26). Composite restorative material was veneered onto the metal subframes to produce the final restorations (Fig. 27, 28). Using the fully adjustable articulator a balanced form of occlusion was achieved by placing non working side interferences. In Right Lateral excursion this was achieved by guiding contacts on UL4, LL4 on the balancing side (Fig. 29), and with contacts on UR12345 and LR12345 on the working side (Fig. 30). Whilst moving into a left lateral excursion the balancing side guiding contacts were achieved on UR5 and LR5 (Fig. 31) and on the working side between UL123 and LL123 (Fig. 32).

The restoration in the upper jaw was a 12 unit bridge on 6 mobile abutments with the three cantilever units on the upper left hand side, and one cantilever on the upper right hand side (Fig. 33). In the lower jaw the bridge consisted of a 12 unit bridge on 7 mobile lower teeth with one cantilever each side (Fig. 34). The final result can be seen in Figs. 35 and 36.

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