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

Case report
A 15-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 treatment. The 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 provisional (Fig. 7). One year later, the provisional healing was completed and restoration fabrication at the left lateral incisor site. A 10-year postoperative clinical image 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 excellent 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 limits on how far they can go and require implants 3.0 mm wide or less, as was demonstrated in the text of this article. Avaliability of small-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
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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 40 plus years. Patients seeking tooth replacement for partial or totally edentulous situations have been able to enjoy natural appearing and functional prostheses that are fixed, stable, and, in many cases, so natural that 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 been seen as 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-bonded 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, Misch and Salama, et al. stated that for a normal two-piece implant, the implant should be placed at least 1.5 mm from the adjacent teeth. As a result, using a 3.5 mm diameter implant, the minimum intertooth 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 types of 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 intertooth 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 and/or conventional implant placement. They have been well documented in dentistry.

Implants are available from 3.18 mm 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 andatraumatic placement utilizing a flapless approach, 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 Dentatus ANEW (Dentatus USA, Ltd, New York, NY) implant for the management of the compromised, congenitally missing lateral space in a 7-year-old young woman with a 9-year clinical follow-up.

Case report
A 14-year-old, non-smoking female patient presented for treatment in the congenitally missing left lateral incisor site (Fig. 1). The patient had recently completed orthodontic therapy, and the orthodontist and general practitioner had agreed 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 resultant intertooth space was less than 5.0 mm, and conventional two-stage implants with abutment options were ruled out. The patient and her parents ruled out conventional tooth-replacement procedures 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 Dentatus ANEW Implant was then placed after a single coring of the site with a 1.4 mm needlepoin CDPs 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 interim provisional crown was then followed out and retrofit to the abutment coping with flowable composite. The margins of the provisional were corrected and provisionalized after the mount. The restoration was polished and seated with the set screw from the provisional.

The 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 provisional (Fig. 7). One year later, the provisional healing was completed and restoration fabrication at the left lateral incisor site. A 10-year postoperative clinical image is seen in Fig. 8 and a 10-year postoperative CT scan of the implant in Fig. 9.
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