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Joining Natural Teeth to Implants

Today's blog is very controversial. Many dentists will call it blasphemous to join natural teeth to dental implants. Dr. Danny Buser (immediate past president of the International Team for Implantology) reportedly said about this issue: Does the term "evidence based" mean anything to some of you? The age of the cowboy dentistry should be laid to rest. He was talking about joining natural teeth to implants. At a purely scientific level, it doesn't make sense to join an ankylosed implant to a tooth that is free to move around in its socket. Clinically, the situation is quite different.

Many clinicians (world wide) do splint natural teeth to implants using some common sense guidelines. Clinician opposition to bridging implants to natural teeth usually point to the likely potential for natural teeth to become intruded as a result of this union. Clinicians favouring this union will frequently employ telescopic copings on natural teeth and/or the use of internal attachments.

Two cases are presented today that illustrate the value of dental implants both in short and long span edentulous areas. Please feel free to share your experiences with me about this treatment modality.

CASE ONE:

Our patient is a 70 year old female with a class two division one malocclusion. She is now having difficulty with mastication due to the loss of a fixed bridge from #25 to #28. In addition, abutment #24 is deemed non restorable and must be extracted. Implants have been suggested in the #26,27 region but our patient is unwilling to undergo a sinus augmentation procedure to grow bone in the region.

Treatment Plan:

- ◆ Extraction #24, Implant #24
- ◆ Prep #23 cn, Prep #25,28 bridge
- ◆ Telescopic copings #25,28



#1 Impression post #2 analog in place #3 planning abutment #4 telescopic copings #5 metal framework #6 completed bridge

Natural teeth that are joined to dental implants receive an independent gold coping that is cemented with a resin bonded cement. The final bridge may be cemented with a weaker cement if the doctor wishes to maintain access to the implant screw (in case of future screw loosening).

About my Ceramist:

Masoud Niknejad of Picasso Dental Studios is a Master Ceramist. He maintains his own laboratory in Richmond Hill, Ontario.



FUTURE BLOGS:

- ◆ The use and abuse of mini implants.
- ◆ The controversy of flap-less implant surgery
- ◆ The problem with angulated dental implants.
- ◆ Cowboys vs "Followers"-Surgical Considerations
- ◆ Cowboys vs "Followers"-Prosthetic Considerations
- ◆ Occlusal Considerations in Restorative Dentistry
- ◆ The "hype" on fancy "gadgets" to check occlusion.
- ◆ And the list goes on.....

EDITOR'S NOTE:

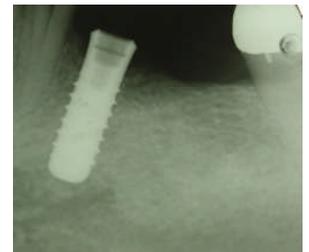
Blogs are a great way to share information. We all know that there are many ways to complete treatment in dentistry.

Please do not hesitate to contact me if you have any questions with regards to concepts described in my blogs. Further, I am always happy to assist you with patient care concerns from your own office.

CASE TWO:

Money again is a factor here. Our patient does not want to invest in two implants so we are going to offer the placement of one implant in the #35 site and join it to natural tooth #37.

Micro-motion, causing screw loosening of a dental implant is a frequent occurrence. In this treatment plan, we are using "solid" abutment for our implant. These abutments have thick abutment screws and do not easily loosen in the mouth...ergo, we cement crowns over these implant abutments.



Implant placement in the region of #35



Planning abutment to choose the height of the abutment chairside.



Impression coping for solid abutment.



Analogue insertion chairside confirms accurate fit of analogue to the impression coping.



Impression using poly vinyl siloxane material. Buccal groove on abutment #37 prevents rotation of telescopic coping.



Telescopic coping is cemented with a strong cement (resin bonded cement). The bridge may be cemented with a provisional cement for access to the implant screw if desired.