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The Bundle Bone Problem:

Perhaps the biggest concern with “conservative” surgeons is the Immediate placement of dental implants into extraction sites. **Buser et al** states the following: “Bundle bone is a histologic term for the portion of the bone of the alveolar process that surrounds teeth and into which the collagen fibers of the periodontal ligament are embedded. Bundle bone is functionally dependent in that it resorbs following tooth extraction or loss.”

The controversy of Flapless Implant Surgery

Its getting cold out there but this subject should warm you up. It makes perfect sense that cutting the gingiva will only encourage more tissue recession and cause more pain. Dentists have been experimenting with flap design, avoidance of vertical release incisions and minimally invasive surgery for a long time.

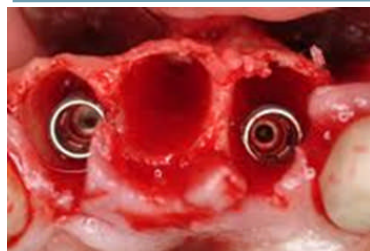
Quoting **B.H. Choi et al** “Flapless implant surgery has numerous advantages, including the preservation of circulation, soft tissue architecture, and hard tissue volume at the site, decreased surgical time, improved patient comfort,

and accelerated recuperation.

Anti “Flapless” surgeons frequently point to the obvious inability to directly visualize and deal with the presence of thin or absent labial plates of bone along with the presence of dehiscence and fenestrations. New techniques have been developed that deal with fenestrations in a thin labial plate. Small soft tissue windows (tunnels) are created over the defects to tunnel in grafting material over the defect **but without a barrier membrane!**

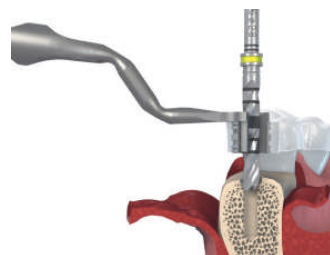


Tunnel technique for flapless surgery.



Computer Guided Surgery:

Flapless surgery is probably used most frequently when a guided surgical stent is utilized to place implants. Personally, I prefer the open flap design for best visualization of the surgical site. The photo below illustrates my viewpoint.

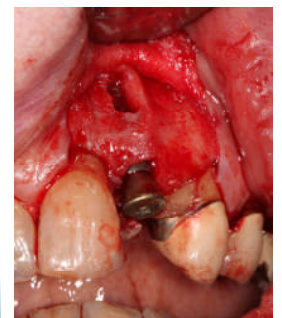


In this photo, we see a guided surgery stent in place but it is made to work with the soft tissues fully reflected.

Fortin et al assessed the postoperative discomfort and use of analgesics after flapless or conventional implant surgery. The patients in the flapless group experienced significantly less pain than the patients in the conventional group.

In an extensive literature review of Flapless Implant Surgery comparing 14 prospective cohort studies, **Brodala et al** showed that the long term survival rate of implants placed with the flapless technique was over 98%.

In today's blog, we look at different clinical scenarios that prosecute or defend the use of flapless implant surgery.



This is an immediate extraction with placement of a dental implant. Using a flapless technique, how can you adequately augment the fenestration and the socket vs using a fully flapped surgical site?

Whether flapped or flapless surgery is performed, the labial bundle bone will resorb! Looking at the above photo, it seems logical that flapped surgery will likely result in better ability to augment the socket around the implant and augment the labial wall if there is a fenestration or dehiscence. Direct visualization of the osseous crest of bone relative to the top of the implant will be easier with the fully flapped surgical site....Buser recommends delaying placement into healed sockets.

About my Ceramist:

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



FUTURE BLOGS:

- ◆ Cowboys vs “Followers”- Surgical Considerations
- ◆ Cowboys vs “Followers” - Prosthetic Considerations
- ◆ Occlusal Considerations in Restorative Dentistry
- ◆ The “hype” on fancy “gadgets” to check occlusion.
- ◆ Bikini Dentures vs functional stability in removable Prosthodontics
- ◆ Training Tissues in Implant Dentistry (Emergence Profile)
- ◆ The Perils of “Thin\Scalloped” Gingiva - a Restorative Perspective.

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.

Chasing Perfection: Veneers

I'd like to have a one-on-one with the guys who think that making veneers is less complicated than fabricating full coverage crowns. Take a look at this case. There are concerns with regard to gingival height, occlusion, sequencing of events, fabrication of provisionals that maintain the soft tissue changes and creating a final result that has good surface texture and colour characteristics that match the dentition. Maybe it's time to revisit the difference in professional fees for veneers vs crowns.



Notice the difference in the gingival height between #11 & 21. A gingival plasty will be required to correct this problem.



It all starts with a diagnostic wax-up. A template is brought to the mouth for the gingival plasty. Well made temporary veneers hold the tissues at the correct height for about 2 months before final impressions.



Modifications in shape of veneers required



Note the occlusal contact in the region of #22\32 & 23\33. To keep the veneers from undergoing shearing forces, we will have to change the occlusion in this area.



Not all veneer cases require changing the gingival architecture or require modifications to occlusal load. Ask your ceramist how challenging it can be to fabricate veneers using a layering technique on top of pressed ceramics...probably more intricate than making crowns!!!!