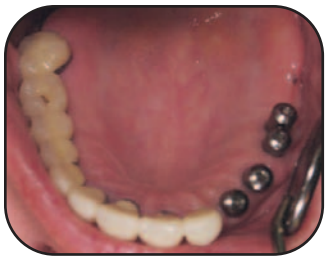
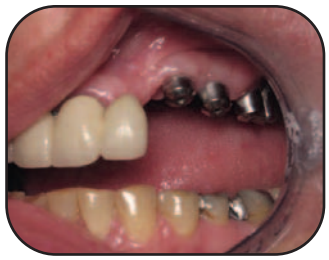
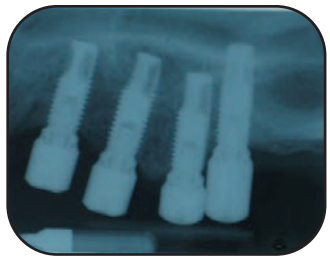
This Case is Trouble

drgwhite | Total Posts: 1,092 | Member Since: 2/15/2001 | Location: New Jersey | Posted: 9/13/2005 5:00:27 PM | Post 1 of 57

Sent this pt to the periodontist over a year ago. Generalized moderate to advanced perio disease. She has a roundhouse on the upper, long span. Upper left was in poor condition when I sent her; haven't heard much from her since. The periodontist sent me a progress note four months ago that he had to remove the UL bridge (#11 - 14) and he put in four implants. I was shocked he put implants in without letting me know. I called the pt at that point to come in; she made an appt and cancelled it. I finally see the pt today with a note from the periodontist telling me she's ready to be restored. Here's what it looks like.







How…am I supposed to restore this? Any ideas?

Howard M. Chasolen, DMD | Total Posts: 1,209 | Member Since: 11/15/2002 | Location: Sarasota, FL | Posted: 9/13/2005 5:12:48 PM | Post 2 and 3 of 57

Gary, I can't even begin to describe how I feel about this issue. Here is what I do:

1) Tell the pt you can't be sure how this will turn out, and even if you will work with the case.
2) Charge her $750 for an implant level impression to diagnose and let her know perio should have conferred with you first.
3) If you can restore, credit $750 towards treatment. If not, $750 bye, bye.
4) Use custom UCLA abutments and a lab that can mill.

Is this a periodontist you usually work with? This bullcrap and has to stop in the profession. The crest of the implant is more than half way up the adjacent tooth, which happens to be three miles anterior. Good luck!

Or have him take them out...non restorable. Too bad. People don't change until they get burned. Problem is you don't want the patient to suffer because your periodontist is a bonehead. The patient does not and should not have to know better.

Time for a talk with your periodontist. Seriously, what the ©&!! was he thinking?

In one of my implant posts this summer, I discussed the three types of implant surgeons.

The first does not even consider the proper quantity and quality of bone at all.

The second considers the quantity and quality of bone, but has no regard for where the tooth will be restored. "I placed 4.3x13s and they look great. Couldn't be my problem." Problem is, the anticipated tooth position was never considered, and even though you have nice size implants, you can't use them. That is your guy.

The third not only places adequate implants, but considers tooth position; bone grafts where necessary and considers soft tissue. Look for this guy (or lady).

pmgpenn | Total Posts: 146 | Member Since: 3/16/2005 | Location: Pennington, NJ | Posted: 9/13/2005 5:19:25 PM | Post 5 of 57

All hope may not be lost. I would place a cover screw on the third implant from the front and forget about it. Howard's advice for charging for a fixture level impression is good. I do think with custom abutments on the other three implants, a bridge can be fabricated that will serve the patient from a functional standpoint.

I completely agree with Howard that this does have to stop. I want to place about half of my own implants and hire a periodontist in my practice to place the others and do augmentation procedures, so we can be on the same [page] with all cases. There was really no reason to place those two implants that close together.

continued on page 14

continued from page 12

drgwhite | Total Posts: 1,092 | Member Since: 2/15/2001 | Location: New Jersey | Posted: 9/13/2005 5:22:04 PM | Post 8 of 57

Howard, thanks for the advice. Pt is a real nice lady, but went to someone "in the plan," that I wasn't really familiar with. I worked with him a couple of times, but never [on] a perio/restorative or implant case. The periodontist I usually work with would never pull this. In fact, I communicate more with her than any other specialist. I guess I'm just used to that level of teamwork.

modblman | Total Posts: 47 | Member Since: 6/9/2004 | Location: Chalfont, PA | Posted: 9/13/2005 6:20:29 PM | Post 15 of 57

I would tell the patient the constraints we have in getting good occlusion and esthetics, and do the best you can while issuing no guarantees….

In any event, you're looking at custom angled abutments, and likely a bit of pink porcelain. Ask your lab technician to bake you up some shade tabs of pink porcelain for use in the office. Make lemonade.

drbean | Total Posts: 1,051 | Member Since: 3/1/2004 | Location: Greenville, TX | Posted: 9/13/2005 11:30:28 PM | Post 19 of 57

I sure would have liked to have seen the original tooth placement.

Howard, I know the patient is expecting fixed, but if this is just too botched-up at this point, and the patient isn't up for a revision surgery, could you present a sort-of hybrid prosthesis with contralateral clasps or attachments?

I hate asking porcelains to do too much (esp. the pink for some reason—location?), and then it is one of those names that pops up on the schedule repeatedly and your stomach hurts.

Any other alternatives besides burying the periodontist?

continued on page 16

continued from page 14

Howard M. Chasolen, DMD | Total Posts: 1,209 | Member Since: 11/15/2002 | Location: Sarasota, FL | Posted: 9/14/2005 4:49:30 AM | Post 20 of 57

Beaner, I am not sure what you mean by a hybrid with contralateral clasps. Removable? You could consider a fixed hybrid with angled abutments. Just have the case waxed to full contour in white wax with an implant level component within the wax-up so you can screw it in for the try in. This will tell you exactly what you need to know.

In reality, I have seen much worse and been able to restore it. What just gets me so fired up is the fact that the guy did the case without even talking to you, or planning it. If the teeth were periodontally involved, there was probably a compromised labial plate, forcing the angulation problem. A pre-op diagnostic set-up and template would have alerted the team about this problem, and possibly a bone graft was in order. If this was the mandible...much less of a problem.

So, everyone repeat after me:

1) "Implant dentistry is a prosthetic discipline with a surgical component."

2) "The maxilla is a different animal than the mandible."

Even using the Quint would have alerted you to aesthetic dilemmas. Did she wear a flipper? Big space for three months? A flipper with pink acrylic would have alerted you to how much bone was missing or the proper position for #11….

drbean | Total Posts: 1,051 | Member Since: 3/1/2004 | Location: Greenville, TX | Posted: 9/14/2005 5:10:57 AM | Post 21 of 57

Thanks Howard. I was wondering about fixed hybrid and wondering about removable. I didn't communicate that well. You answered me.

This patient waltzes in expecting a "bridge" like her other one I'm sure, and then you are left shaking your head.

And you are so right—I think it was the: "It looks like I can get an implant in here" approach, without any thought toward the end result. Yikes—Good luck!

drgwhite | Total Posts: 1,092 | Member Since: 2/15/2001 | Location: New Jersey | Posted: 9/14/2005 5:54:13 AM | Post 25 of 57

Thanks for the replies. I'll have more time to get more pics next visit. I like John's idea because I won't have to make these teeth a mile long. That canine especially is going to be trouble. I sensed though, from my initial conversation with her, that the periodontist made her believe that doing the implants would mean no removable. I took some impressions and am having the pt back to discuss this. I thought it would be a good idea to have the models and pics in front of us to help her understand the situation. I'm not one to put another doc down. In fact, many times in the past I've come up with creative ways to side-step iatrogenic issues. Might be hard to do here.

Uwe Mohr, MDT | Smart Ceramics Dental Art Studio | Total Posts: 138 | Member Since: 1/10/2005 | Location: Toronto, Canada | Posted: 9/14/2005 7:40:56 AM | Post 30 of 57

Gary, may I offer the lab perspective? If you really want to touch this one, fixture level impression, like Howard said.

Lab makes custom-milled abutments; it may just be possible to splint the two distal abutments. Actually, I think it's the only way to use all of them.

If you want to go fixed it's not going to look ideal (but we all knew that already).

I would suggest an operator-removable bridge, meaning, either mill all the abutments parallel, or make a milled bar over the lot, and then make a PBM bridge that is operator removable, either with locking screw, or if you want just removable so that the patient can clean, use Bredent's VKS on the bar. This will give you the option, that, if the bridge is not acceptable for whatever reason, you can turn it into a cast partial without having to touch the abutments….

Howard M. Chasolen, DMD | Total Posts: 1,209 | Member Since: 11/15/2002 | Location: Sarasota, FL | Posted: 9/14/2005 7:44:09 AM | Post 32 of 57

Uwe, I like what you are saying, but I sure don't like unilateral removable prostheses. And anyway, why should this patient suffer with that? Would any of you guys accept this outcome on your wife? Don't proceed unless the tooth and gingiva colored wax-up look great. They won't, and then you're screwed.

continued on page 18

continued from page 16

Uwe Mohr, MDT | Smart Ceramics Dental Art Studio | Total Posts: 138 | Member Since: 1/10/2005 | Location: Toronto, Canada | Posted: 9/14/2005 8:32:41 AM | Post 33 of 57

Howard, it wouldn't be unilateral; I would definitely anchor it with clasping on the other side. I agree with you on the wax-up, but I would also do a temp bridge with temp abutments. That will show more of the problems, like how are the actual insertion angles/screw angles, screw head exposures, and how bulky will the profile be at tissue level. It is at this point you will find if you have to bury any of the implants, I found out the hard way. My preference still goes to a bridge, but I would make it either fixed removable or operator removable.

Howard M. Chasolen, DMD | Total Posts: 1,209 | Member Since: 11/15/2002 | Location: Sarasota, FL | Posted: 9/14/2005 8:44:12 AM | Post 35 of 57

Uwe, I agree about the temporization. Maybe even customs for the provisional. Use a Turbyfill branching philosophy with this case. Charge for the provisional and if you can't be happy with each other, no refund, no further treatment.

drgwhite | Total Posts: 1,092 | Member Since: 2/15/2001 | Location: New Jersey | Posted: 9/14/2005 12:12:32 PM | Post 37 of 57

…I plan on calling the surgeon tomorrow, but I don't see what he could possibly say to me to make this better.

Howard, do I ask the lab for a wax-up after I've taken the fixture level impression? Usually, I have a wax-up before the implants are placed. I do have an alginate of her current condition with the healing caps in place.

Uwe Mohr, MDT | Smart Ceramics Dental Art Studio | Total Posts: 138 | Member Since: 1/10/2005 | Location: Toronto, Canada | Posted: 9/14/2005 12:56:17 PM | Post 40 of 57

Gary, I would strongly suggest having the wax-up done on the actual implant model, because emergent angles are going to be super critical, and what good is a wax-up that just looks good, but does not incorporate the problematic situation you are dealing with. You should also have it waxed-up with temp abutments at least, if not even on gold, plastic, or metal. You want to give yourself every possible [piece of] info you can get. It will show your lab clearly where the limitations of this case are. Lots of luck.

Howard M. Chasolen, DMD | Total Posts: 1,209 | Member Since: 11/15/2002 | Location: Sarasota, FL | Posted: 9/14/2005 12:58:49 PM | Post 41 of 57

Gary, you need a GI mask soft tissue master cast with implant level analogs. Then have a plastic or temporary component, anything inexpensive that mates the implant crest geometry and was a screw retained wax-up. Or, as Uwe suggested, which was great, just process a provisional with tooth colored and cervical pink acrylic and try it in the mouth for a while. Use the branching concept. This is really a great idea that can only make you a hero and you get paid too. So, you know what I mean with the branching concept?

jamesm1976 | Total Posts: 52 | Member Since: 2/8/2003 | Posted: 9/14/2005 2:22:06 PM | Post 44 of 57

PUNT this case:

A year ago a dentist in town had to settle a MAJOR malpractice suit in a very similar case. He sent a patient to an OS [oral surgeon] for evaluation for extractions and implant placement. A year later the patient shows up with implants ready to restore. Problem is that the OS @&$*! up the implant placement. The dentist didn't say anything, and restored the case as best as he could. Two years later the case failed. The dentist and OS were sued and had to settle out of court because they didn't follow proper protocol in restoring the case. Experts testified that the dentist should have coordinated the case from the start, and since he didn't, he shouldn't have touched the implants.

Just a quick story to make you feel good about your situation.

Find it online

This is just a sample of the Dentaltown.com message boards. To read the whole thread go online to: http://www.dentaltown.com/idealbb/view.asp?topicID=55619