So I’m learning again to do dentures, and given that I’ve bumped up my fees a lot, and taken Dr. John Nosti’s course on Dentaltown (need to review it again tonight), I’m actually enjoying them more. The fact that I’m working with Brian Carson is also making them more enjoyable.

However, last week I had an immediate maxillary denture that did not come even close to seating right. Bite was way off, vestibules were way-the-hell overextended—everything. Talked with Brian afterward and realized I needed to have done a lot of alveoloplasty, which I did not do, so it wasn’t seating properly. In addition, I probably didn’t mold the cheeks/lips adequately during the initial impression, which is why it was so overextended.

But all that said …

What Do You Differently for Immediate Dentures?

• What do you take the initial impressions with? Does it matter if they have a lot of remaining teeth, or just a few?
• Do you need to do proper border molding just like for a conventional CD?
• Should I take a face bow? Maybe a Kois Facial Analyzer?
• What if their occlusal plane is all jacked up because of missing or drifted or tipped or hypererupted teeth?
• What’s the best method to record their bite?
• How much alveoloplastying do you do, and how do you know? (Brian has already said he’ll send me a ridge reduction guide in the future, thank goodness.)
• Do you always flap, alveoloplasty and suture, or are there times you just yank the teeth and stick the immediate in?
• What’s your follow-up schedule?
• When do you do the first soft reline, and what material do you recommend? (Currently we just have COE-SOF T)
• How long do you let them keep the first reline in before redoing it?
• How long do you tell them to keep the denture in immediately after the extractions? My recollection is 24 hours before they take it out, so it provides pressure to keep swelling down?

OK, hopefully that’s not too many questions for one post. Looking forward to the answers!

I do quite a few immediates. My father was an oral surgeon and I did a ton with him. I also worked in a denture clinic for a couple of years and saw a lot of immediates.

First and most important is work with a great lab. It seems you found one.

I use alginate for both the initial and final impressions.

I use a custom tray I make for the final. I usually do not border mold but I do place some alginate up around the tuberosities with my fingers. I let the custom tray do the rest. For lowers I place alginate with my finger on the linguals in the molar regions and in the labial fold.

I never take a face bow and use putty for the bite if they have a lot of teeth. If not, I make a partial base plate and wax rim for the bite along with putty or blu mousse.

I do as little alveo as possible. Usually 1 out of 10.

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I try to be very careful with the extractions and most of the time can just place the denture. Maybe a suture or two if the papilla tears.

I see all my patients for the next several days. I have them wear the denture overnight until I see them the next day. Most of the time, I have them wear it again overnight until the second day. At that postoperative appointment I show them how to take it out and clean it, but emphasize the importance to wear it as much as possible for the first couple of weeks to get used to it.

The soft relines are case-by-case. I see how the patient is doing and go from there. Sometimes it’s within a week or 10 days, and some three months or longer. It just depends. I’ve done some that I never soft reline, they went straight into the permanent reline in 6–8 months.

I did two today, eight teeth each with no alveo and just a couple of sutures in the one. Will see them tomorrow.

Just my way. Hope this helps.

Chip, I’ve done a handful this year with good success. A few pearls I have found:

• Extract posterior teeth first (up to first premolars or canines), allow 4–6 weeks of healing and then do your impressions. Don’t let patients talk you into doing posterior and anterior extractions at same time of delivery if there is a significant number. (You will regret it at delivery.)
• Don’t soft-reline at delivery appointment if you can avoid it (gets messy, and usually not necessary when tissue swells in the next 24–48 hours). Typically I’ll have the patient just call as needed if the denture starts to loosen. Future relines when denture starts to loosen or patient complains about how nasty the lining is.
• Hard reline at 6 months (separate fee): I find placing a vent hole in palatal area helpful when doing the impression for a lab-processed hard reline (less voids/air pockets and aids in seating).
• Most important, lower their expectations and inform the patient that immediates are not as predictable as conventionals. Spend some time going over what they can expect (soreness, adjustment period for speech and eating, etc.) but also the benefits (improved smile, teeth for chewing, healthy oral cavity).
• Additionally, charge appropriately because they tend to be more of a headache and you want to have some buffer built into the fee if you need to redo it.

Chip, I factor in cost on doing two sets. I place the immediates, see the patient back about every two weeks (the resorption is incredible) to just monitor how healing is progressing, then we move to make another final set.

So another question for you guys (while I’m digesting and sorting all the other stuff thus far):

• How do you deal with patients who have major undercuts or large tori?
• If you’re saying you rarely do ridge reduction … are there certain kinds of cases where you do typically do them?
• VPS heavy/light in the custom tray for final impression.
• Wax rims in the posterior to get the bite correct and blue bite registration.
• Always request a surgical guide.
• Extract anteriors, alveoloplasty where necessary.
• Have patient keep the immediate in for 24 hours.
• 24-hour postop and adjust where necessary
• One-week follow-up

In your final impression, border-mold the heck out of the heavy body VPS. I usually run through the motions as soon as I seat the custom tray, then again at the one-minute mark and again at the two-minute mark. By then your VPS won’t flow and you’ve captured everything needed. I also go through the border molding process with the light body as well, but not as vigorously. I tend to cut back my custom trays a good 2 millimeters from the border in the initial impression so that the VPS border molding defines the border, not the custom tray.

Generally, I’ll reline once with a silicon-based soft liner every four weeks until it’s not needed and then do a hard reline (both chairside).

I haven’t started marketing a final denture yet, because I’ve had relatively good success with immediates, but it’s definitely an interesting idea. Any thoughts on how to market and charge for a final denture? ■

I use the System 2 and I have System 1. I like them but have started using them more and more as preliminaries for custom trays. I have a lot of problems getting good posterior lingual extension on the mandibular with the Accudent system. I can get close, but the roll is always too thin for me too feel comfortable about it staying stable during pour-up. So recently I changed my protocols a little.

Before starting, everything is about managing expectations. At every step, manage expectations. I use the leg amputation example all the time. Socks on a rooster is too obscure of an analogy for most people, IMO.

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1. I start by making an Accudent impression. If it comes out perfect I will use it as my final, but usually I feel I can get it better with a custom tray, so if I am doing a whole arch at once the alginate is more frequently used. If I have already removed the posterior I now almost always go to a custom tray.

2. I make a custom tray on my Ministar, and I use rope wax to allow some flexibility in getting the borders close, but just short intraorally.

3. Make final impression with a combination of heavy body on borders and medium body in the tray part. I load the tray while my assistant keeps the patient’s mouth dry. This combo has worked really well for me. Little to no overextension, and no two-step border molding. The key is to not overextend the rope wax—especially in the tuberosity regions—and to not overseat the tray.

4. Records, design and approval depends on the case scenario. I don’t use a face bow, but I have been thinking recently that it would a far more accurate way of communicating occlusal plane on an immediate case then a stick bite. It is not important for occlusion like in fixed. Averages work fine for a denture.

5. Delivery - I do some alveoplasty on most max cases. It has a significant impact on patient comfort and healing, but I agree it is better to be conservative even if you have to deal with more challenges.

6. Postop at 24 hours, one week.

7. Coe Soft at 10–14 days.

8. Coe Soft is replaced an average of two more times over the next 6–8 months as the
patient feels they need it.

9. When resorption is slowed drastically (it never stops, of course) we do a hard reline. Usually around Month 8.
I enjoy dentures, and the surgery that comes with them.

About managing expectations, I think everyone will agree that this is an important step. In regards to the leg amputation analogy, I heard someone use a prosthetic eye as an analogy. Someone who gets a prosthetic eye doesn’t expect to see out of it, but a lot of people expect to have dentures and function with them like it is their own teeth. Also, the dentures are not a replacement for your teeth, they are a replacement for no teeth!

During the height of the recession, our local newspaper made deals with local businesses. We signed contracts for 10 quarter-page ads per month for less than $5k per year. So we could afford to go up against Aspen Dental. Their ads were always in black and white. Our denture ads were in color. Then we started to use some of McCall’s color bleeds. Transition from black and white to color. … I probably overthought it, but it seemed to increase our immediate cases. Of course, it fits right into the QDP.

I wasn’t kidding when I said in the Dentaltown article on dentures that to get proficient at fixed full-mouth rehabs, one should be good at the removable ones. Dentures are the ultimate full-mouth rehabs. Sure, my initial records appointments most likely take longer than most doctors’ (face bow, CR bite, photos, etc.) but in the long run, getting a more predictable result means fewer adjustments and fewer postop visits. Immediate dentures are a bit of a different animal, but still can be very predictable.

I am sure I differ a little bit from many, but this is what works well for me in a PPO environment:

1. Set expectations (always #1 most important with dentures).
2. Alginate impressions.
3. Temporary dentures.
4. Extract all teeth in an arch at once. No one wants to do multiple surgery visits, and it really cuts into your overhead. I almost always do this with sedation—better for all involved. I always do some alveoloplasty, but it is usually more rounding/smoothing than removing.
5. Soft tissue relines as needed for three months (usually one or two).
6. #2 most important: Use your temporary denture as
your impression tray for finals; a local lab can return in a day.
7. By doing #6, you can usually skip most steps of doing a complete denture (border mold, wax rim) unless something in temp was way off.
8. Deliver and adjust

If you ever have to adjust a denture more than two times, it needs either occlusion adjustment or a soft reline.

By doing the above, I usually spend a total of 1–1½ hours nonsurgical time for an arch, and still get the same great results. Temp dentures are the way to go, and it really helps set patient expectations with the first one: “Oh, this is just the temporary/trial.” Plus, it gets patients out of the problem of comparing the denture to their original teeth; they start comparing your final denture with the temporary one instead, which is much more realistic.

After skimming the thread, my thoughts include suggestions that have little to do with actual technique, more about the consent form

1. For about 10 years now in my small practice, I have included on my consent form that (blank) months after the delivery date, my fee includes a “honeymoon period” of free adjustments, relines and repairs (not replacements). I like the phrase “honeymoon” since it implies a lot of positive images instead of negative ones. Usually the “blank” is six months but if I smell a rat, I will reduce it to three. Sometimes I will even negotiate the denture fee, offering a value of $25 for each month of the honeymoon. Managing this honeymoon period is never a problem because I tell them I do denture adjustments during the middle of the day, if possible, when I’m not too busy. This is pitched at the consent phase since we are still negotiating (i.e., teaching and selling) and I get to control that aspect. Nobody ever squawks with the consent form in front of them.

2. The consent form also says there are no reimbursements for prosthetics, just that I will do my best to satisfy both the patient’s and my expectations. My worst experience, before using this policy, is worth mentioning. A patient family that I had been working with for about 10 years evolved into an elder-care situation wherein the daughter began to take care of her elderly dad. She pushed him to get his teeth fixed with many upper extractions (treatment plan: posteriors first) and a full upper with lots of buccal undercuts. Each heard only what they wanted to hear and not what I was saying during the initial phases. They didn’t want to pay for the needed alveoloplasty, because daughter was paying for her dad’s treatment. I was too accommodating; I was going through an elder-care deal also. I took a final impression too early and did not do the reductions. Delivered the denture and he couldn’t wear it; I reimbursed totally. Turns out he didn’t want it in the first place and didn’t want to hurt his daughter’s feelings. Lost the family; they never came back. I did not manage it well.

Lessons: do a denture only if the patient wants it and is paying for it, not someone else. Offspring paying for dentures are a big red flag for me. Large undercuts are a manageable problem and have to be planned for from the outset. Most tori removals are simple.

TBS, I made an upper one time for a nice guy who had a walnut size palatal tori because I (and he) didn’t want to remove it. The denture had a window in the middle of the palate. He came to see me after having one made at the dental school in town that didn’t have the window that he could wear.

This summer, I made a successful upper conventional denture for a nice lady who had a (likely) large palatal tori that had been removed before her previous denture. Half of her sore spot issues with my new denture have been on that palatal area; I think the periosteum in that
area never grew back and she has attached palatal gingiva on top of raw scored bone. I told her it is like her tibia, rather exposed.

Every case is different, but every case has a consent.

I’ve pretty much stopped doing immediates and now do interim immediates (economy anterior teeth only, posterior pink acrylic flat rims, the cost is out of pocket and covers the lab bill, materials, and some of my time ... the big savings are less time on the back end). Then, after six months of healing, I do edentulous impressions to start building the standard complete dentures at standard fee. We offer patients the option to send the interims to the lab for a reline and they can use these as a backup pair should they drop their final dentures and it needs repairs.