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COMMENTARY

Maxillary Insufficiency Implant and Tooth-Retained Maxillary Overdenture: A Clinical Case Report

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Complex implant restorative cases must be evaluated with care prior to surgical scheduling. The patient must be exposed to all complications which may become apparent only after surgery has begun. It must also be remembered that a sedated patient is not able to make a decision relative to changes of their treatment plans at the time of surgery. It is therefore essential that the implant dentist thoroughly explain the treatment which is planned and alternatives to this treatment which may be essential, and only realized at the time of surgery. The explanation of the changes to the intitial treatment plan must also be spelled out in the form of a written informed consent. This helps protect both the patient and Implant Dentist and also prevents confusion as treatment progresses.

To achieve these requirements, an adequate diagnostic evaluation must be completed. This often includes both panoramic and cephalometric radiographic evaluation. The implant dentist must be able to recognize variations clinically in skeletal relationships, bone physiognomy that would interfere with treatment, anatomical anomalies that would alter the prosthetic considerations, and all other factors that would lead the implant dentist and the patient in a path of uncertainty and ultimate failure. These include, and are not limited to, such factors as implant site bone character, implant site bone trajectory, implant site attached gingiva, implant site muscle attachments, implant site inter-arch space, and implant site permucosal position. If a tooth is retained in the prosthesis, then one must also consider natural tooth abutment mobility, natural abutment crown to root ratio, natural abutment endodontic control, and natural abutment muscle attachment. Other considerations include the patient's general periodontal status, general home care, dental I.Q., dental muscle dynamics, tongue size, general TMJ status, occlusal plane, arch relationship, lip line, opposing occlusion, parafunctional tongue thrust, parafucntional bruxism, smoking or other tobacco use, and alcohol consumption. The subjective considerations which must be made are oral comfort potential, oral function potential, oral esthetic potential, and psychological status of the patient relative to overall expectations and positive versus negative considerations of the treatment proposed. The medical evaluation is also of obvious necessity and the Systematic Health Category is used to assess viability of implant dental surgical treatment. Medical evaluation, and clearance prior to implant surgery may also be required, and is based on the patient's health history. (These guidelines have been taken from the International Congress Of Oral Implantologists ''Patient Dental-Medical Implant Evaluation Form'', developed by the Misch Institute; Copyright ICOI).

The implant dentist must also be diversified and confident enough to use a variety of dental implant modalities to accomplish the ultimate goal of retoration of form, function, comfort, and esthetics. These various implant modalities require additional training which is either not being taught in recognized specialty programs or is not felt to be successful by those training these residents. It has been my personal experience that if a specialty director does not believe that either blade form implants or subperiosteal implants are successful, that the residents will have minimal to no exposure to these viable treatment protocols. This is unfortunate, since both the patient and the practitioner suffer from such omission.

University and Hospital programs at the larger institutions have a variety of complex computerized radiographic diagnostic equipment which help them accurately evaluate many of these factors. These are great tools during training programs and there is no doubt that these tools are appropriate. The patients in these environments don't realize, in many instances, that these diagnostic services are unique to the environment in which they are being treated. Knowing this should make an implant dentist even more aware that the radiographic and clinical evaluation of a potential dental implant restorative patient is utmost importance. The dental implantologist in private practice does not have the luxury of these tools nor will they be able to justify the cost of these tools in most, if not all, cases. Certainly, it is realized that there are exception so this when one considers the treatment of cancer and trauma patients. These are special circumstances which require special treatment protocols and expertise.

Statistically, most implants are placed and restored without these sophisticated dianostic tools. It is therefore essential that the implant dentist has a good understanding of diverse dental implant treatment protocols and will be able to make decisions which will best serve the patient primarily, and not compromise the doctor patient relationship relative to the outcome of treatment. Communication is therefore essential in the treatment of any condition in any medical discipline today. This communication is best achieved by the implant dentist who has the training and ability to complete both the surgical and prosthetic dental implant treatment plan. It has been this clinician's experience that patient communication, understanding, and acceptance are easier for the patient if they have trust and confidence in one practitioner. This of course also assumes that the practitioner has the benefit of appropriate training and experience to complete the proposed treatment.

Patient understanding of our proposed treatment is often not interpreted in the same way as we have tried to express it verbally. Therefore, any proposed treatment must also include a written informed consent which is thoroughly reviewed by both the doctor and the patient. This will certainly not prevent liability, but will aid in interpretation of liability if the practitioner is brought to task.

Patients must also understand that the treatment which is being completed, even if routine, may have certain associated inherent risks which may be uncontrollable by the practitioner. Unrealistic expectations by both the implant dentist and the patient can be damaging to both parties as well as to the public perception of Implant Dentistry.