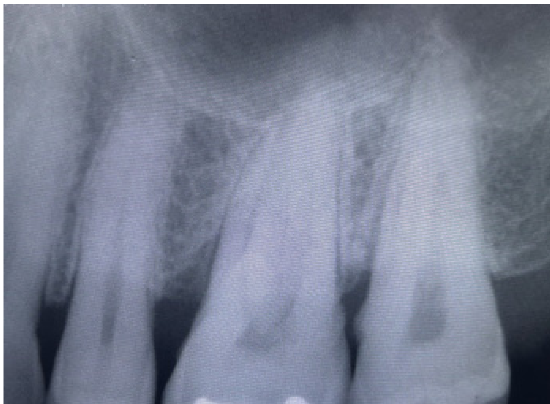
PARKER PERIO PRESENTS

The goal of our e-newsletter is simple:
Take cases that seem ***impossible*** and show you how Parker Periodontics makes them ***possible***.

We will keep you up to date on the latest cases completed here at Parker Periodontics and provide you with educational, real-life examples that relate to your daily practice.

IS AN IMPLANT POSSIBLE?

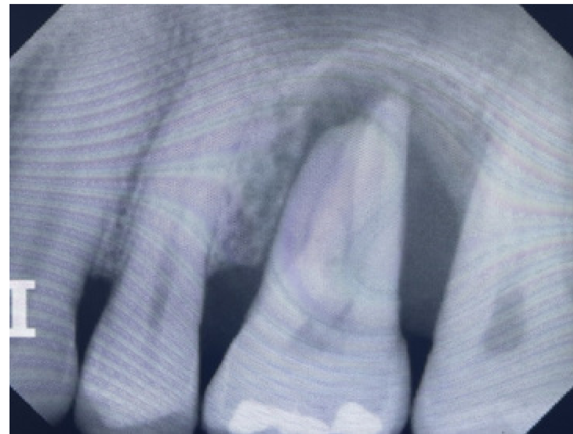


THE BACK STORY

David initially presented to our office with localized moderate chronic periodontitis that primarily affected the maxillary molars. Interproximal calculus was evident both clinically and radiographically between #14 and #15. A vertical bony defect was observed on the mesial aspect of #14 at that time. The areas were successfully treated with scaling and root planing and David returned to his dentist for periodontal maintenance. Five years later, David was referred back to our office to discuss the feasibility of implant replacement for teeth #14 and #15.

THE OBSTACLE

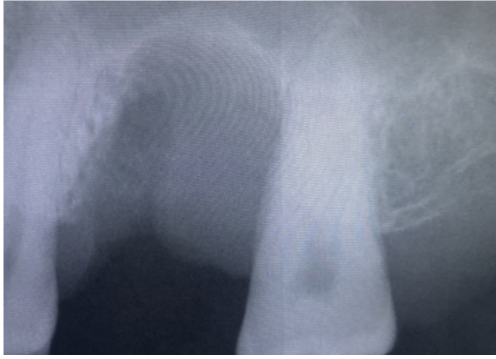
While not in pain, David presented with significant gingiva edema buccally and palatally at the tooth #14 position. Radiographs revealed blunt root apices and complete alveolar bone destruction interproximally #14-15. Upon seeing the bony destruction, we began to temper David's expectations that implant replacement would be feasible.

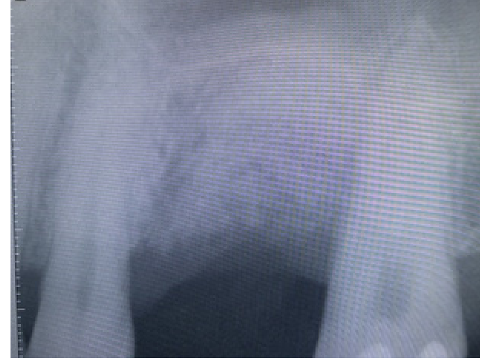


THE TREATMENT APPROACH DILEMMA

David felt strongly that an implant at #14 was his best long-term replacement option. He did not want to lose both #14 and #15. We purposed performing guided bone regeneration at #14 in order to improve the bony foundation investing tooth #15. The thinking was along the lines of "if we can stabilize #15 then a fixed partial denture may be possible." If insufficient regeneration was achieved, David understood that he would likely need to sacrifice tooth #15 in order to predictably regenerate sufficient bone volume for implant(s) in the upper left quadrant.

THE INITIAL TREATMENT

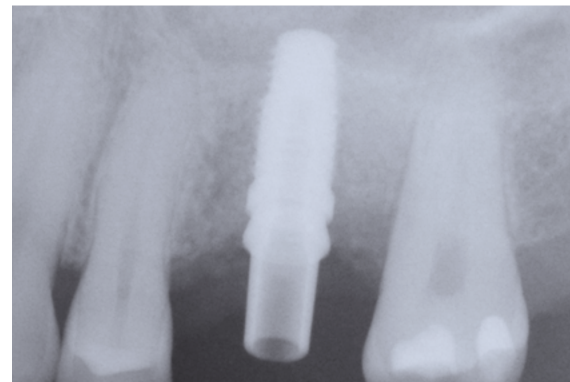


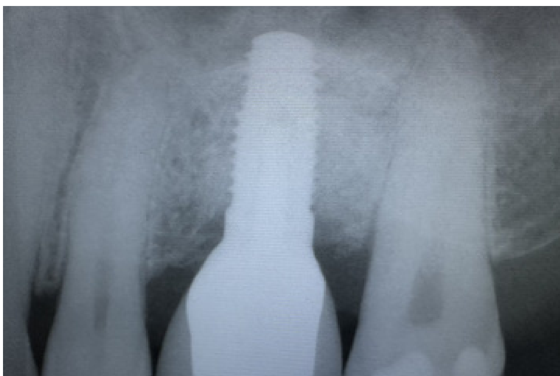


Tooth #14 was extracted. Significant palatal and distal bone loss was observed. The cystic lining of the periapical granuloma was removed. Guided bone regeneration was performed utilizing human allograft and platelet derived growth factor. A double layered collagen membrane was adapted and primary closure was achieved with EPTFE sutures. A vertical releasing incision and a periosteal release made passive primary closure possible. After 24 weeks of supervised healing, CBCT Scan was taken and we were pleasantly surprised by what we saw.

SECONDARY TREATMENT

Implant placement with concomitant crestal sinus augmentation was performed. Excellent initial implant stability was observed.





THE OUTCOME

The implant was allowed to osseointegrate and then restored without complication. David has successfully maintained a healthy #14 for more than nine years. Teeth #13 and #15 remain healthy.

LIKE IT? LOVE IT?
WANT TO KNOW MORE ABOUT IT?
HAVE A CASE YOU'D LIKE US TO DISCUSS?

FEEL FREE TO CONTACT US AT WWW.PARKERPERIO.COM TO REVIEW MORE CASES LIKE THIS ONE, OR SET UP AN OFFICE LUNCH & LEARN AT WWW.PARKERPERIO.COM/LUNCH-LEARN/ TO EDUCATE YOUR WHOLE TEAM!

PARKER
PERIODONTICS & IMPLANT DENTISTRY