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TO: Dr. Keith Rossein

FROM: Gwen C. Klimas, Associate Director, ICOI

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Attached is a copy of your article from the ADIA&PM Newsletter Fall 2000 issue. I will mail you the original.

Sincerely,

Gwen C. Klimas

Did you know that if your doctor brings four or more team members to a meeting the doctor gets 25% off his tuition fee for the meeting?

ment zone around implants, the probe is in much closer contact to the bone. It is important to avoid introducing bacteria (seeding) into the sulcus around implants. Dipping the probe in chlorhexadine before usage in an implant sulcus site is advantageous. As with teeth, pockets greater than 4 mm are very difficult for a patient to maintain. It is often difficult to obtain accurate probing depths due to prosthesis design. Probing should be performed in the presence of bone loss (for monitoring purposes) or pathology. Probing can also give valuable information regarding tissue consistency, bleeding and/or exudate. Since x-rays can only judge mesial-distal bone levels, probing can aid in assessing facial-lingual bone levels.

Bleeding Index There are less blood vessels around implants in comparison to teeth. Bleeding alone is not the most reliable indicator since impingement on well adapted permucosal tissue and excessive probing pressure can false positive results. The presence of plaque and/or ulcerated sulcular epithelium are the indicators of a problem.

Evaluating and assessing the presence or lack of health is the first step to treating implant complications. Success comes from the interaction of many variables and a compliant patient. Surgical technique, good prosthetics, good oral hygiene and timely maintenance appointments enhance the success of dental implants. Documentation is imperative to monitor progress and identify potential problems.

Transitional Implants: The Key to Success

By Keith Rossein, DDS

Dental implants, as alternative treatment plans, have a high degree of success

due to proven protocols and excellent biocompatible materials. Most clinicians would agree that the success or failure of implant-supported restorations depends on the same basic factors—(1) proper surgical placement of the implants (2) an undisturbed healing period (3) adequate design of the prosthesis (4) establishment of correct guidance and occlusion (5) excellent home care and maintenance.

The use of transitional implants not only potentiates these factors but also will lead to higher patient acceptance of implant treatment plans. Until recently, only Dentatus USA (New York, NY) made a transitional implant system available. Within the last year, Bicon (Boston, MA), IMTEC (Ardmore, OK) and SteriOss (Yorba Linda, CA) all introduced their own transitional implants, demonstrating the importance of transitionalizing implant patients.

Think of transitional implants as a second set of implants, usually placed at the same time as the definitive implants, but that are immediately loaded with a provisional restoration. They offer many benefits to the implant team as well as the patient. For the purposes of this article, the discussion will be skewed toward the dental auxiliary.

Often, it is the auxiliary who first broaches the subject of implants with the patient. Anyone who has had to tell a patient that they will be without teeth for 2-3 weeks after surgery has experienced the look of chagrin and disappointment of the patient. With the advent of transitional implants, you can now confidently say to the patient that they will never be without teeth. That's the good news! The better news is that their provisional restoration will be a stabilized removable denture or a fixed, cemented temporary, which in most cases, is better than what they presently have. And the great news is that they can immediately return to their daily lifestyle. Ask yourself, "Which choice, with or with-

out teeth, would give you the greatest level of comfort in presenting implants as an alternative?"

Let's take a moment to look at all implant patients collectively. As a group, we are starting with the worst possible patients when it comes to oral hygiene. Why did they lose all of their teeth in the first place? For a majority the answer is either poor oral hygiene or lack of home care. It's mind boggling that, so often, clinicians wait until the final implant-supported restoration is inserted to begin oral hygiene instruction. This group of patients need to be at "full speed" in oral hygiene skills at the time of final placement.

Any experienced hygienist already knows that there is a learning curve in mastering proper oral hygiene techniques for a normal dentition and, that with implant patients, there are additional concerns. There are always various patient skill levels, and with implant patients, we are generally dealing with an older population that may have some physical limitations. In general, the motivational and communication skills of the hygienist will enable the patient to speed up the learning curve. However, one factor that is pertinent and necessary to the learning process is repetition.

Let's start with the premise that ideally, the provisional restoration should be made to resemble the final restoration as closely as possible. Doesn't it make sense that, within a few weeks after implant surgery, the patient could be brought back for an instructional session with the hygienist? And then you have the next 5-9 months to review and "tweak" their oral hygiene techniques and/or to make modifications in their home care regimen or products. By the time the final implant-supported restoration is placed, the patient will be executing proper oral hygiene from day one.

If the final prosthesis will be an overdenture on a Hader-type bar, it wouldn't

make sense to give the patient a fixed provisional. So transitional implants could be placed to retain a cemented splint, and the patient's old denture could be retrofitted with a soft relined over the splint. The patient would be taught the proper instrumentation to clean under the splint (which would be similar to the Hader-type bar) and the abutment portion of the implant. They would be instructed to remove and clean their prosthesis in the same manner that would be necessary for their new prosthesis.

The same would hold true if the final restoration was to be an implant-supported fixed bridge. The patient would be learning to clean around the same type of restoration, which would be similar in size, shape and position. Not only would the patient get the "feel" of what their teeth will be like, but the transition from the temporary stage to the final stage would be much easier. In some instances, the hygienist may observe that the patient will be incapable of adequate oral hygiene with a fixed restoration and may recommend that the dentist redesign the case for a removable. This is the time to find that out, not after placement of the final restoration.

Dental auxiliaries are an extremely valuable part of the implant team. Knowing that transitional implants can solve many of the patient's concerns and maximize the chance of overall success, should give you more ammunition, increasing your confidence and desire to recommend implants as an excellent treatment plan.

Dr. Keith Rossein is a consultant, author and lecturer who presents hands-on workshops on transitional implants, electrosurgery and an interactive lecture/participation seminar on stress management. Dr. Rossein has also authored four self-study courses. He is listed in the Seattle Study Clubs Speaker's Bureau and is a Speaker for the ADA Seminar Services. Dr. Rossein is the editor of Implant News & Views and can be reached at (516) 593-3806 or e-mail kdr@idt.net

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that if a doctor
brings eight
or more team
members to
a meeting the
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