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Preprotective and Protective Protocol in Implantology

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Abstract- This presentation, based on various studies and our experiences, aims to highlight the paraprothetic and prosthetic protocol in oral implantlogy. The purpose of this paper is to perform prosthetic simulation prior to any surgical-implant procedure, as oral implant logy arises as a consequence and in response to prosthetics in cases of partial or total insufficiency. By comparing the clinical efficacy of the early and late protocol of dental implant placement according to the protocol. The objectives of this paper are to determine the position, diameter, and number of implants determined by the therapeutic angle that present cases with insufficiency and then indicate the need for prosthetic (suprastructural) work depending on the anatomical considerations of the jaw. Planned prosthetic work may have to vary depending on the appropriate jaw implant position. What needs to be emphasized is proper diagnosis and prosthetic treatment / planning as well as surgical stages.

Keywords: *protocol, prosthetic, prosthetic, implant, oral, surgical.*

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Preprotective and Protective Protocol in Implantology

Cases Praesantation

Erza Mulaj [α], Berat Lenjani [σ], Shqiponje Gashi [ρ] & Ilirian Lenjani [ω]

Abstract- **This presentation, based on various studies and our experiences, aims to highlight the paraprothetic and prosthetic protocol in oral implantlogy. The purpose of this paper is to perform prosthetic simulation prior to any surgical-implant procedure, as oral implant logy arises as a consequence and in response to prosthetics in cases of partial or total insufficiency. By comparing the clinical efficacy of the early and late protocol of dental implant placement according to the protocol. The objectives of this paper are to determine the position, diameter, and number of implants determined by the therapeutic angle that present cases with insufficiency and then indicate the need for prosthetic (suprastructural) work depending on the anatomical considerations of the jaw. Planned prosthetic work may have to vary depending on the appropriate jaw implant position. What needs to be emphasized is proper diagnosis and prosthetic treatment / planning as well as surgical stages.**

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I. Entry

Over the past decade, implant-prosthetic interventions have become an indispensable part of modern dentistry, helping dentists improve the quality of life of the infants who need dental interventions.

The implantological treatment replaces the missing teeth and should be a paraprosthetic surgery to meet prosthetic needs. Without prosthetic planning, there is no justification for dental implant intervention, and overall prosthetic success depends on the proper protocol and execution of the surgical phase. In many cases, implant therapy is clearly the preferred way to replace missing teeth. Both the surgical and the prosthetic stages require care in planning, diagnostics, evaluation and therapy. (Rizzo 1988)

Maintaining anatomical (natural) structures, functional and aesthetic elements and patient desires are the goals of implant therapy. Implantology treats partial and complete painlessness and as a substitute for other disciplines such as the jaw.

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Diagnosis and treatment planning. Implant therapy is contraindicated in patients with periodontal disease, the first purpose of care being the diagnosis, prevention and treatment of oral diseases. Replacing damaged or destroyed tissue from disease - by prosthetic definition - is the secondary purpose of dentistry (VanBlarcom 1994).

It should be assumed that before any treatment planning process involves implant therapy and is based on the above premise, disease control and prevention are the main planning objectives of treatment (Devan 1952).

The purpose of this illustrated review is to introduce new strategies and developments for the treatment and diagnosis of periimplant diseases. Periimplant disease is a matter of concern for modern dentistry. The number of implants exhibiting biological complications increases as implantable dentistry expands the thinking world. Diagnosing and treating those diseases is still controversial and difficult. We present new treatment for infection control and biological rationale for the additional use of directed bone regeneration, with an illustrative explanation of the treatments presented on two occasions.

The foundation of successful implantological therapy is the diagnosis, treatment planning of both the prosthetic and surgical stages of treatment. The need for proper planning, in other words, cannot be overemphasized. Planning, treatment, and communication with patients should include alternative methods of dental replacement. The principle of informed consent means that the patient is fully informed of all treatment options, including the advantages and disadvantages of each option such as treatment, function, aesthetics and ultimately psychological outcome.

Dental implant therapy is only an option for dental replacement and should be presented as such for all patients. Failure to inform patients of all treatment options is a frequent cause of litigation and malpractice.

II. Epidemiology

The epidemiology of peri-implantitis is heterogeneous due to the different bone loss thresholds and pocket depths used, creating a discrepancy in the

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prevalence figures. The prevalence of peri-implantable mucositis varied between 19 and 65%, while the prevalence of peri-implantitis ranged from 10 to 40%. The prevalence of peripheral implant over a median follow-up of 2 years was 34% at the patient level and 21% at the implant level. Corresponding incidence rates were 0.16 and 0.10 for patient - year and implant - year, respectively.

III. Case Report

Sick N.N. born in 1968 on the basis of general health history (orthopedic intervention in extremities, bone fracture). The patient does not take any medication for any disease, smoker (up to 11 cigarettes per day) with relatively good oral hygiene.

During oral examination, we observed post-canine tooth loss in all four dental arches and after dental examination, implantable prosthetic surgery was required, the second frame we also placed 2 implants at position 25 (3.75X10), 26 (3.75X11.5) and also bypassing at position 24. On both sides of the first superior premolar position, the bone is presented very thin in thickness.



Photo 1: The patient is presented with all the possibilities of interventions to solve the problem of insomnia in both jaws with fixed superficial interventions

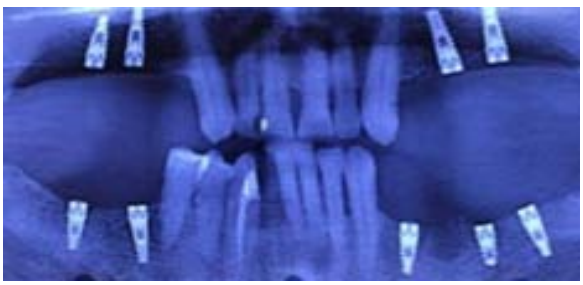


Photo 2: In the first frame we place 2 implants at position 15 (3.3X11.5) and 16 (3.3X11.5) bypassing at position 14 which we will treat prosthetically as a maxillary hanging bridge

To avoid bone regeneration we decided to bypass the area. In the third frame we placed three implants in position 34 (3.3X10.0), 36 (3.75X11.5), 37 (3.75X11.5) where in the next prosthesis the first position 35 will be treated as an intermediate elementn the fourth frame 2 implants were placed in positions 46 (3.3X11.5), 47 (3.3X11.5), prosthetic loading (superstructure) was done after three months starting with implant discovery and healing screw placement.

To avoid any possible movement of the transfer method (which gives the three-dimensional position of the fixation in the patient's mouth) we attach them by means of a curtain thread and place on that thread a pattern that has a very minimal and non-negligible structure.



Photo 3: Superconducting zirconia ceramic material of the upper jaw

The measures deal with polyester material which guarantees the present position at the right time and strength. After the polymerization of the polyether, the masses are sent to the laboratory and the healing screws are placed in the mouth, the pre-prepared lab specimens are placed in the wound and re-applied with the direct abutment provisional method.

After that the protocol is the same as the fixed prosthetics where the structural tests are done based on the work of the fixed prosthetics, biscuit tests, static as well as dynamic occlusion and glazing superiority is cemented.

The periodic examinations that the patient has at our clinic show a clinically good oral and radiologic condition that provides us with a successful implantable and prosthetic prognosis.



Photo 4: Completion of the circular ceramic zircon superstructure in both jaws

It means that in this case pre-prosthetic protocols in implantology have been respected programming of a prosthetic work before implants are placed and co-operation with the laboratory as an important element for a successful rehabilitation of both jaws in both functional and functional terms aesthetic. The position, diameter and number of implants are

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determined by the requirements of the prosthesis and the anatomical considerations of the jaws respectively the jaw bone.

The number, position, and size of dentures will therefore be based on anticipated needs or prosthetic planning, however, rehabilitative prosthetic requirements dictate implant choice and position, in many cases anatomic surgical jaw restraints will also affect the final choice, number and implant placement.

Prosthetic planning or even treatment is the major determining factor in implant, choice, and placement decisions. The functional and aesthetic element of treatment success depends on adequate diagnostics and treatment planning.

IV. Discussion

The use of dental implants to help treat partial and complete edentulism is well documented. However, most implant literature reports results associated with implant survival and success when adherence to fixed placement and loading protocols. Based on conventional research, the elaborated protocols highlight implant osteointegration - 3 months in the mandible and 4 to 6 months in the maxilla. Our work is in line with the papers and literature consulted and develops protocols for clinical procedures for early or immediate restoration or loading of dental implants. The review evaluates factors influencing accelerated loading and restoration decisions, including bone quality and quantity, implant design, implant separation, and prosthetic pattern. Conclusions and recommendations are made based on the consensus group experience in charge of considering these procedures and on the current literature published in these protocols.

V. Conclusion

With reference to the above objectives it is worth noting that the position, diameter and number of implants is determined by the therapeutic angle of the cases with insufficiency and then the need for prosthetic (suprastructural) work is indicated depending on the anatomical considerations of the jaw. The planned prosthetic workings may vary depending on the choice of the appropriate position of the implant in the jaw. Implant prosthetic intervention was used to select partial and total morbidity.

Disclosure

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