Implants work. They integrate. Because of this, implants are now part and parcel of the routine clinical practice of dentistry. The overall success rate for dental implants varies between 88% and more than 98%.1 This rate of success rivals almost every other aspect of dental treatment in predictability. Patients are happy that they can get a “third” set of teeth. However, many still want more. Today’s patients want their teeth not only to eat with, but also to augment and improve their appearances. The demand on dentists is to provide ideal function and ideal esthetics all at once. This frequently presents a unique challenge. Implants have a success rate that is upwards of 90%. However, implant procedures require adequate alveolar bone. Dentistry has fortunately evolved to the state where ideal rehabilitation of the smile is predictably attainable in many cases. While two decades ago, predictable implant placement was not thought possible, today dentists can make teeth look and feel natural with the newer generation of porcelain restorations.

Table 1—Sequences of Implant Placement

- Teeth are extracted, bone is allowed to heal, and adequate bone exists for implant placement.
- Teeth are extracted and implants are placed simultaneously (the immediate implant) with or without bone grafting, membrane placement, and soft tissue grafting.
- Teeth are extracted and allowed to heal. Inadequate bone is present for implant placement. The site is developed independently of implant placement (site development). Bone is allowed to heal and implants are then placed conventionally.
- Teeth are extracted and allowed to heal for 2 or more months. Inadequate bone is present for ideal implant placement. Implants are then placed in conjunction with bone regeneration.

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Figure 1—Tooth No. 8 had endodontic therapy and two failed apicectomies. Note the grayish discoloration cervical to the crown, as well as the recession.

Figure 2—Note the amount of alveolar bone loss present on the labial of tooth No. 8 once the flap is reflected. The vertical incisions were made at the line angle of tooth No. 8 to avoid any lost papilla.

Figure 3—Tooth No. 8 was extracted and 7 mm to 8 mm of the labial plate of alveolar bone had been lost. At this point, it was decided that the placement of a dental implant would be too unpredictable.

Figure 4—A combination of autogenous and freeze-dried bone was packed into the extraction socket. A Resolut membrane was placed over the bone graft. The membrane was stabilized with two BioTacks®.

Figure 5—A connective tissue graft harvested from the palate was placed superior to the graft. The connective tissue graft would obliterate the hole from the extraction site as well as plump up the ridge.

Figure 6—Six months after the extraction bone graft and connective tissue graft, the alveolar bone had regenerated and was ready for implant placement.

Figure 7—Osteotomes were used during the surgical placement of the dental implant. Note that the osteotomes come in different diameters, depending on the amount of alveolar bone present and the size of the implant that is to be placed.

Figure 8—An osteotome is shown preparing the implant site. The osteotome not only expands the bone, thereby increasing the buccal-palatal width, but also improves the quality of the bone by increasing its density.
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U.S. Patent: 4,987,941; others pending.
adequate bone and soft tissue are not present, these frequently can be regenerated.

This article explores the sequence and techniques of implant placement in patients with inadequate amounts of bone and compromises in their soft tissues. There are numerous variances in the sequence in which implants can be placed, based on the author's recommendations, and are summarized in Table 1.

The scope of all of the multiplicity of bone regeneration and implant placement is too great for one article. Therefore, this discussion remains limited to stage IV implant placement.

### IDEAL IMPLANT PLACEMENT

The placement of dental implants requires one to think three-dimensionally: mesial-distally, facial-palatally, and incisal-apically. Since the focus of this article is esthetics, we will focus on the maxillary anterior teeth.

**Mesial-distal inclination**—The average implant diameter is 4 mm. Ideally, dentists like 3 mm

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**Case Study continued**

Figure 9—Three months after the placement of the dental implant, the discolored, keratinized epithelium was removed in anticipation of placement of a free gingival graft.

Figure 10—A free gingival graft was harvested from the palate. The discolored grayish epithelium was used as a template to determine the proper size of the graft.

Figure 11—The newly harvested free gingival graft was sutured into place with 5-0 gut sutures.

Figure 12—After a few months of healing, an esthetic color blend was achieved and no grayness existed. Note that, despite the fact that no tooth was present in the area of No. 8, papillae appeared to already be regenerating. This was a result of the fact that bone was regenerated beneath the soft tissue.

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of space between an implant and the adjacent teeth. This helps prevent damage to the periodontal ligament and allows enough room for papilla regeneration. Adding together the implant size (4 mm) and an additional 3 mm on either side, this gives a minimum of 10 mm of space in a mesial-distal direction for placement of a single implant. One rarely encounters this much space. It is possible to achieve ideal esthetics—without harming the adjacent teeth—with 8 mm of space and a 4-mm implant. In the author's opinion, when a patient undergoes orthodontics, the orthodontist should be urged to create at least 8 mm of space from adjacent root cemento-enamel junctions (CEJs) to root apices when completing the case.

Facial-palatal direction—This direction is a little more controversial. With a screw-retained restoration, dentists would probably want the access hole in the cingulum area, so as not to show any metal. However, most restorations today use custom abutments with cement-retained restorations. It is therefore advisable to angle the long access of the center of the implant slightly palatal to the incisal labial line angle of the maxillary anterior teeth. This allows a nice emergence profile obtained.

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Figure 13—Second-stage surgery was performed. The initial incision was made palatally from line angle to line angle of the adjacent teeth. This allowed placement of the palatal tissue labially, thereby increasing the amount of soft tissue over the implant. A protective screw was placed in the implant so the bone could be profiled and a proper emergence profile obtained.

Figure 14—The temporary healing abutment was screwed into place and the area sutured in second-stage surgery. Please note the buccal root prominence over the labial surface of tooth No. 8.

Figure 15—The final prosthesis was now in place. Note the nice symmetry between teeth Nos. 8 and 9. (Restoration courtesy of Dr. Mark Samuels.)

Figure 16—A closer view of the completed implant restoration for tooth No. 8. Note the lack of gingival discoloration and the complete regeneration of the papilla between teeth Nos. 7 and 8 and 8 and 9.

Figure 17—Second-stage surgery was performed. The initial incision was made palatally from line angle to line angle of the adjacent teeth. This allowed placement of the palatal tissue labially, thereby increasing the amount of soft tissue over the implant. A protective screw was placed in the implant so the bone could be profiled and a proper emergence profile obtained.

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Incisal-apical direction—The author prefers to use a 4-mm-diameter implant in the esthetic zone, as this allows for sufficient running room to establish adequate restorations and also minimizes the amount of postcementation recession. For ideal esthetics, the implant should be placed approximately 3 mm to 4 mm apical to the anticipated CEJ. In this way, the implant can have adequate running room from its seating platform to the restoration. It has also been shown that 4-mm implants exhibit less recession than 5-mm implants at 6-month postoperative examinations.3

LESS-THAN-ADEQUATE BONE VOLUME

Frequently, enough bone exists to place a dental implant. However, the amount of bone may not be ideal to create an esthetic restoration. This creates a surgical dilemma. Three questions are then often posed, as follows:
1. Should bone first be regenerated and the implant placed after bone regeneration? This is the most conservative approach.
2. Should the implant be placed in conjunction with bone regeneration? This is perhaps the most technique-sensitive approach.
3. Should bone be placed and the implant placed after the bone has healed? This is a compromise between the two previous approaches.
3. Should the implant position be altered to fit the bony architecture? When asked by their restorative colleagues why the implant is not in an ideal position, surgeons frequently lament, “Well, that is where the bone was.” The following two cases demonstrate implant placement in less than adequate bone. Bone regeneration is performed before implant placement in Case 1. Case 2 shows simultaneous implant placement with bone regeneration.

**CASE 1**

The patient was referred for periodontal therapy of tooth No. 8 in preparation for a new crown (Figure 1). Dental evaluation of this healthy 40-year-old woman revealed that tooth No. 8 had received endodontic therapy and two apicoectomies. The crown-to-root ratio was less than 1:1 and the tooth was deemed hopeless. In addition, the keratinized attached gingival tissue was discolored from the previously performed apical surgery.

The goal of therapy was to remove the tooth, rebuild the alveolar ridge, reobtain normal cosmetic keratinized tissue, and have well-integrated implant-supported crown. The sequence of therapy was as follows:

**Atraumatic Tooth Extraction**

A full-thickness mucoperiosteal labial flap was elevated and the tooth was extracted atraumatically, preserving what remained of the alveolar bone (Figure 2). Two vertical incisions were made at the line angle of tooth No. 8, so the adjacent papilla would be preserved.

**Hard and Soft Tissue Regeneration**

The remaining alveolar bone was deemed inadequate for the predictable placement of a dental implant (Figure 3). Seven millimeters of the labial plate were not present. It was decided that a bone graft would be placed. Autogenous bone was harvested from the area of the anterior nasal spine and mixed with 50% demineralized freeze-dried bone graft and placed into the alveolar defect. In addition, a Gore-Tex® Resolut membrane (distributed by Nobel Biocare) was trimmed and placed superior to the graft and stabilized with two BioTacks® (3I Implant Innovations Inc.) (Figure 4). A connective tissue graft was harvested from the palate and placed superior to the Resolut membrane (Figure 5). It was secured with 5-0 gut sutures (ETHICON, INC.). The purpose of the graft was twofold. First, it created a sterile environment in which the graft could heal un molested by oral bacterial infection. Second, the soft tissue added to the volume of the potential implant recipient site. It is the author’s experience that overbuilding the soft tissue in the esthetic zone by 25% is advisable to achieve ideal esthetics.

**Implant Placement**

Six months were allowed to pass before the implant was placed. The implant site was anesthetized and reentered (Figure 6). While bone regeneration is obvious, it was deemed...
still inadequate for ideal implant placement. The Resolut membrane dissolves in approximately 8 weeks. This would probably not be sufficient time to achieve adequate bone regeneration. To preserve the remaining alveolar bone, Summers Osteotome Kit (3i Implant Innovations, Inc.) was used to prepare the implant site (Figures 7 and 8). Osteotomes provide three important benefits. They preserve bone, for no bone is drilled away; the bone is expanded to allow the placement of a large implant as a result of the osteotome’s tapered design; and the osteotome can improve the quality of bone by increasing its density. Bone density is probably the most important factor in assuring an implant’s success. After the preparation of the osteotomy site, the implant was placed and allowed to heal subgingivally.

**A multiplicity of implant techniques are available to the clinician today to get an acceptable result.**

**Cosmetic Soft Tissue Correction**

One of the patient’s chief concerns was the apical discoloration of the soft tissue secondary to the apicoectomy. It was decided to correct the discoloration before second-stage implant surgery. Three months of healing were allowed before the free gingival graft was performed. The amalgam-discolored epithelium was removed surgically and a bleeding connective tissue bed remained (Figure 9). A free gingival graft was harvested from the palate, and removed tissue was used as a guide to size the free gingival graft (Figure 10). The free graft was then sutured into place with 5-0 gut sutures (Figure 11). Three months later, a good soft tissue color match was evident (Figure 12).

**Second-Stage Surgery**

At the 3-month postgingival grafting and 7-month postimplant placement appointments, excellent tissue maturation was seen (Figure 12). Note the presence of papilla adjacent the edentulous space at tooth No. 8, despite the absence of a tooth. This will occur when adequate bone is present beneath the soft tissue. Soft tissue usually follows the underlying bone. Second-stage surgery allows another opportunity to enhance the cosmetic result. The initial incision is made from the palatal line angles of the adjacent teeth (Figure 13). A full-thickness flap is then reflected labially. This augments the already present soft tissue to an even greater extent.

After trephination of the excess bone that grew over the implant, an EP Temporary Healing Abutment (3i Implant Innovations, Inc.) was placed (Figure 14). Note the soft tissue protuberance over the labial of the edentulous site at No. 8, which mimics the natural root prominence (Figure 14). The entire complex of palatal soft tissue was moved labially during this procedure.

**The Final Restoration**

Four weeks of soft tissue maturation was allowed before the implant was temporized. In some cases it may take another 2 to 3 months before satisfactory soft tissue esthetics is achieved around the implant. The final result mimicked the natural dentition (Figures 15 and 16). Ideal parameters of esthetics were achieved, including complete papilla regeneration; ideal color match of the attached gingiva; adequate bone volume; ideal implant position; proper emergence profile; and ideal color match.

**Case 2**

Case 2 presented a slightly different challenge. This 32-year-old woman presented with internal and external root resorption of tooth No. 9 (Figures 17 and 18). In addition, she had already experienced vertical bone loss of the interradicular bone between Nos. 9 and 10 (Figure 18). The problem was similar to that of Case 1. However, the author had added complication of redevelopment of a soon-to-be-lost papilla.

**Bone density is probably the most important factor in assuring an implant’s success.**

(3i Implant Innovations, Inc.) autogenous bone was harvested from the anterior nasal spine. Using a trephine drill (Salvin Dental Specialties, Inc.), autogenous bone was harvested from the anterior nasal spine and placed into sterile saline. An osteotomy site was then prepared for the implant for tooth No. 9. A bone trap (Osseous Coagulum Trap, Quality Aspirators) was attached to the end of the high-volume evacuator to aid in the collection of additional autogenous bone (Figure 22). Cortical...
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and cancellous bone was easily collected from the resterilizable bone traps (Figure 22). A large molt curette (Molt #4, Ace Surgical Supply Co., Inc.) was used to collect the bone. In addition, a ronguer (Beyer Ronguer, Salvin Dental Specialties, Inc.) was used to harvest additional bone from adjacent alveolar bone (Figure 23).

**Implant Placement With Simultaneous Bone Regeneration**

The implant (Osseotite®, 3i Implant Innovations, Inc.) was inserted (Figure 24). Note that the coronal six threads of the implant were exposed and bone would have to be regenerated. An e-PTFE membrane (Gore-Tex® oval 6, distributed by Nobel Biocare) was placed apical to the defect. Two titanium tacks (IMZ Titanium Tacks, Nobel Biocare) were used to stabilize the Gore-Tex® membrane (Figure 25). The membrane was reflected and autogenous bone was placed between the implant and membrane (Figure 25). The membrane was trimmed so that at least 1.5 mm of space existed between the membrane and the adjacent teeth (Figure 26). This would minimize the potential for postoperative infection by diminishing the egress of bacteria.

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Stanford, Connecticut, 1999). Note the close adaptation of the membrane to the bone graft and adjacent bone. A tacking Gore-Tex® CV-5 suture was placed palatally to stabilize the graft (Figure 26). Six months were allowed to pass before the implant was exposed at second-stage surgery. Note the complete bony regeneration around the implant (Figure 27). All seven threads were then covered with newly regenerated bone.

**Temporization and Papilla Regeneration**

At the time of implant exposure, a temporary healing abutment was placed. The author recommends that the restorative dentist wait 4 weeks before placing a permanent abutment and temporary crown. The initial temporary crown is shown in Figure 28. Note the recession on tooth No. 10, a result of the previous loss of alveolar bone caused by the external root resorption and infection. Over the next 2 months, acrylic was slowly added to the distal contact point on tooth No. 9 and bonding agent was slowly added to tooth No. 9, a result of the previous loss of alveolar bone caused by the external root resorption and infection.

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Final Restoration
The final restoration can be seen in Figures 30 through 32. Compare the initial presentation of the infected tooth in Figure 17 to the final restoration seen in Figures 31 and 32. Harmony, symmetry, and good esthetics are evident. It is evident that the papillae have regenerated; there is bone beneath them.

CONCLUSION
These two cases show only one approach that can be taken to achieve an ideal esthetic result. A multiplicity of implant techniques are available to the clinician today to get an acceptable result. This is what makes the practice of implant esthetic regenerative dentistry so exciting.

REFERENCES
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