Important things that we need to get right with Static Jaw Registration

QMUL MClinDent Seminar B
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Face Bow – do we need to use one and why?
Case Example – Soft tissue management and facial support
Attempted Suicide – serious facial and maxillo / facial injuries – large asymmetry of left cheek and loss of many teeth
• Tooth position
• Face and Lip support
• Flangeless denture try in
• Agreeing aesthetics and then attempting to deliver – bone graft to create enough facial and upper lip support without denture
• Manage / Accept occlusal issues flowing from bilateral # condyles (AOB etc)
Assess how much support she lacks
Flangeless denture does not provide adequate facial / lip support but patient does not want to wear a removable appliance

• What are the options?
Surgical repair and augmentation of left facial asymmetry and anterior maxillary graft to ‘plump’ face and lip out
Must know where the anterior teeth are going in order to plan appropriate soft tissue cover.
Precise surgical implant stent – at this stage no keratinised tissue over implants and no labial vestibule
Secure the anteriorly repositioned palatal flap using healing abutments (small vertical incisions through soft-tissue) and two short bone screws
Denture / cover plate relined with Coe Pack in theatre and screwed into the palate with a long palatal bone screws – secondary intention healing

4 weeks healing
Is there a need for keratinized mucosa around implants to maintain health and tissue stability?

Jan L. Wennström, Jan Derks

Corresponding author: Jan L. Wennström
Department of Periodontology
Institute of Odontology
The Sahlgrenska Academy at University of Gothenburg
Box 450
SE-405 30 Gothenburg

Key words: attached mucosa, dental implants, keratinized mucosa, peri-implant disease, peri-implant soft tissue, soft-tissue recession

Abstract

Aim: The objective of the present review was to analyze the literature with regard to the need for keratinized mucosa around implants to maintain health and tissue stability.

Methods: Human and animal studies were identified through electronic and hand searches. Predetermined outcome measures were (i) implant loss, (ii) peri-implant health, (iii) oral hygiene, (iv) soft-tissue recession, (v) change in marginal bone level, and (vi) patient-centered outcomes.
After removal of palatal screws you can reline the denture with Coe Soft – it should be well retained by the healing abutments.
Verification jig and acrylic-based slide ‘on and off’ wax rim

Then it’s back to screw-retained fixed OI Prosthodontic stages
BOP around implants is best avoided for best long-term outcome.
The blue Tepe Brush - test
Quadrant Restoration
(Removing one or two of the stool legs with implants)

• This is what I used to do with bigger implant cases
• Use the implants to lock your jaw registration medium into position and then you can return the lost legs of the stool
Quadrant Restoration
(Removing one or two of the stool legs with implants)
Verification jig and acrylic-based slide ‘on and off’ wax rim
Jaw registration
how would you do it?

Filling spaces the old way
Ten-year evaluation of removable partial dentures: Survival rates based on retreatment, not wearing and replacement

A. H. B. M. Vermeulen, DDS, PhD, a H. M. A. M. Keltjens, DDS, PhD, a M. A. van’t Hof, PhD, a and A. F. Kayser, DDS, PhD, a
Trikon, Institute for Dental Clinical Research, School of Dentistry, University of Nijmegen, Nijmegen, The Netherlands

From a group of 1480 patients, 1036 were treated with metal frame removable partial dentures (RPDs) at least 5 years before this analysis. Of those, 748 patients who wore 886 RPDs were followed up between 5 and 10 years; 288 patients dropped out. The 748 patients in the study groups were wearing 703 conventionally designed metal frame RPDs and 183 RPDs with attachments. When dropout patients and patients who remained in the study were compared, no differences were shown in the variables analyzed, which indicated that the dropouts did not bias the results. Survival rates of the RPDs were calculated by different failure criteria. Taking abutment retreatment as failure criterion, 40% of the conventional RPDs survived 5 years and more than 20% survived 10 years. In RPDs with attachments crowning abutments seemed to retard abutment retreatment. Fracture of the metal frame was found in 10% to 20% of the RPDs after 5 years and in 27% to 44% after 10 years. Extension base RPDs needed more adjustments of the denture base than did tooth-supported base RPDs. Taking replacement or not wearing the RPD as failure criteria, the survival rate was 75% after 5 years and 50% after 10 years (half-life time). The treatment approach in this study was characterized by a simple design of the RPD and regular surveillance of the patient in a recall system. (J Prosthet Dent 1996;76:267-72.)
How would you take a jaw registration here? LLQ

Patient-Centred Outcomes
Patient-Centred-Outcomes – do not just related to cosmetics -
I hope that this was helpful

The End

Thanks for your attention and I hope you all enjoy the rest of the conference