

# IMPLANT OVERDENTURES: SURGERY

WEBINAR HANDBOOK



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## WELCOME!

This lecture covers the surgical preparations and execution in your implant overdenture practice. You will find practical, implementable, step-by-step strategies to learn how to avoid the failures, achieve the successes and *be better*.

Thank you for your time and participation today. I welcome and encourage you to continue the conversation with me at the contact information below.

Be happy, be healthy, and be better,

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Thank you.

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## What is an implant retained overdenture?

- Edentulous space has small “locator” emerging from gingiva
- The inside of the denture has a small “retention cap” that snaps into the locator
- This allows for the denture to “snap in” to a fixed, stable attachment
- It reduces/eliminates the need for vestibular extension or palatal coverage in order to attain retention
- It eliminates the need for clasps around natural teeth (in partials)

## Rules of Surgery

- Implants can diverge, but no more than 14 degrees
- Expect rocking if only using 2 implants in an arch
- Ideally, implants should be placed 10mm apart
- In nearly 100% of cases, 4 implants/arch is enough
- When bone width is a concern, or a patient isn’t willing to wait for full integration, consider an o-ball mini implant
- For partial dentures, do not place the implant too close to adjacent tooth, especially when the proximal surface creates an overhang



**How is this consistently accomplished? With a surgical guide.**

## HOW TO FABRICATE A SURGICAL GUIDE

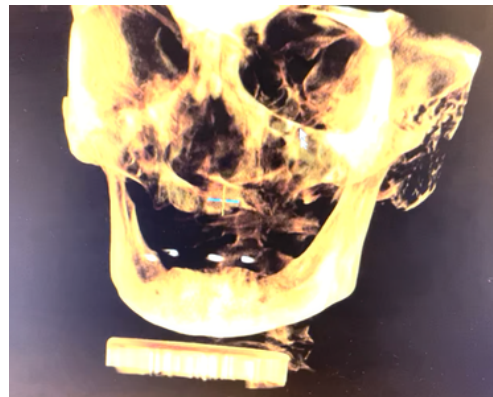
### For a patient who has teeth:

- Take a scan
- Take a CBCT
- Send both to your lab

### For a patient who doesn't have teeth:

Use their current denture or have the lab fabricate a denture model, then then:

- Add radiopaque stickers to the denture/model
- Scan the denture/model, making sure to include the stickers
- Take a CBCT of just the denture with the stickers
- Take a CBCT of the patient with the denture/model/stickers in their mouth



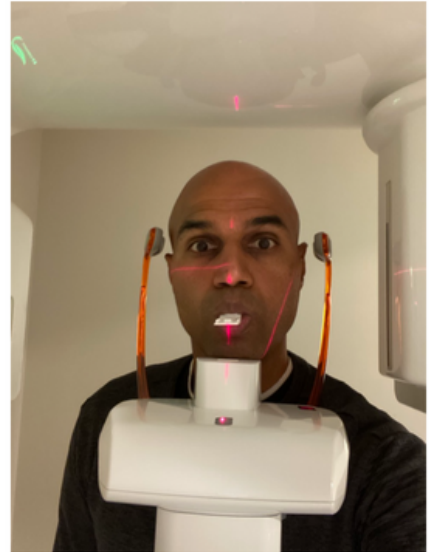
## If you don't have a CBCT

Do all of the above, but in each case, send the patient to an imaging center and order a head and neck CBCT saved as a DICOM file, which you can then send to your lab.

## If you don't have a scanner

You can actually order radiopaque impression trays.

- Take a PVS impression (I use Silginat by Kettenbach) with radiopaque impression tray
- Keep the impression in the mouth, and take a CBCT
- Then send the CBCT DICOM file to the lab, along with the impression.



However, if you don't have a scanner, consider getting one.

If the price is too high, there are many labs that actually give away scanners to their customers as long as you order a minimum amount of lab work per month. A very common lab that does this is Dandy lab out of New York

## OK, now you have a surgical guide

Use manufacturer's instructions to best utilize their surgical kit to place the implants



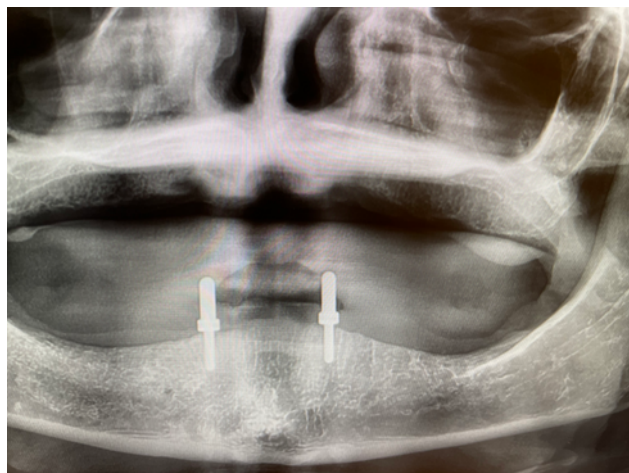
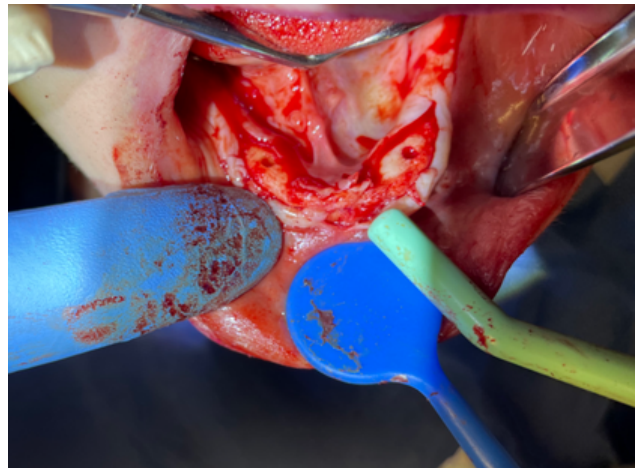


## Flapping vs Not Flapping

Most surgical guides are supported by a combination of teeth, soft tissue, and bone. Placing a flap, especially a large flap, can sometimes alter the fit of the guide, so here's what I do:

1. Without flapping, secure the surgical guide in place
2. Use the surgical guide to make a pilot drill through the tissue
3. Use the surgical guide for the first drill down to its appropriate length
4. Then, remove the guide
5. Place a large mucoperiosteal flap
6. Finish the surgery on exposed bone

*This way, you get the benefit of the surgical guide for angulation, position, and depth, but still with the benefit of being able to see exactly where you are drilling*



## **A brief note about utilizing CBCTs in your office**

A cone beam provides incredibly sophisticated and accurate imaging of both the hard and soft tissue. Our training in dental school for adequate analysis and interpretation of this type of imaging is insufficient.

If you have a CBCT, make it standard to always send the file to a board certified radiologist. Every single one. In only 6 months, my office has identified a pituitary tumor and two instances of carotid artery plaques. We would have certainly missed these if interpretation was left only to me and my team.

### **Additional Impression**

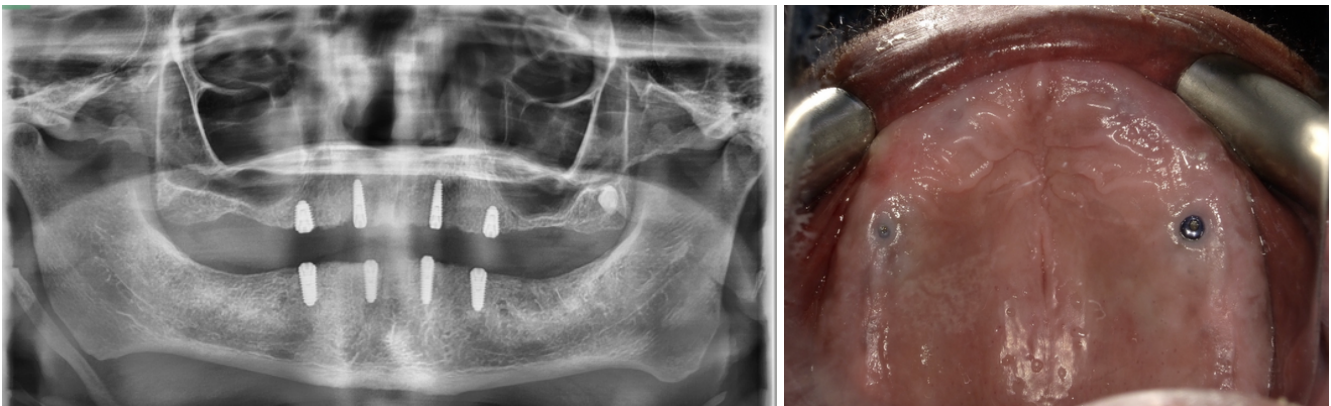
2.0 x 2.0 x 2.8 cm expansile mass expanding the pituitary fossa with extension into the sphenoidal sinus. Correlate clinically and additional follow-up with imaging is recommended,

### **Recommendations**

**Critical:** Findings above that require follow-up action or referral. Call report module activated with communication feedback loop requested.

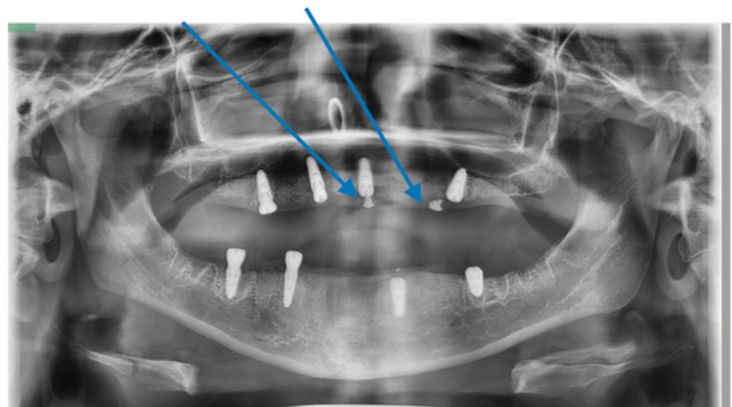
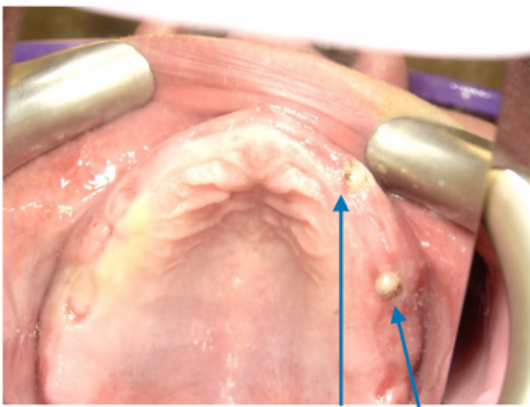
### **After implant placement and osseointegration has been achieved**

How do you find the implants under the tissue?  
Where do you cut?



## Do a full flap. *Patients love it!*

- Retain the surgical guide
- Use a healing cap instead of a cover screw at time of surgery
- **Guess where the implants are, ooze some flowable composite, then take a pan**
  - **This one is my favorite techniques**
- Add impression copings and take impression at time of surgery
- Take intraoral photos at time of surgery, and include in pt chart
- All, or a combo, of the above



## And once you have found the implants, test for stability using a documentable device



Now it is time to add your locators and begin denture fabrication. Please see my handout entitled “implant over dentures” on my website: [bebetterseminars.com](http://bebetterseminars.com).