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THE DENTAL IMPLANT CLINIC

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Meet the Team

SURGICAL & RESTORATIVE:

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ENDODONTICS:

Leoni Papageorgopoulou
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(Endodontology)

Luis Ferrandez
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ORTHODONTICS:

Tony Ireland
PhD MSc BDS FDS D Orth
MOrth
RCS (Eng)
Specialist Orthodontist

PERIODONTAL:

Fernando Gonzalez Eriksson
BDS MClinDent
(Periodontology)

Karen Morrison
EDH

CONSULTANT RADIOLOGIST

Dr Suk Ng
PhD BDS Bsc FDSRCS (Eng)
DDRRCR

A Centre of Excellence

The Dental Implant Clinic is a Bath-Based custom built clinic. Within, a highly skilled multi disciplined dental team brought together by Jonathon Schofield, the practice principle, who has over 20 years experience in the field of dental Implantology.

The team work closely together to ensure that all patients receive a totally unique and holistic approach to treatment. Tooth preservation is at the heart of what we do.

The Dental Implant Clinic also houses an expert endodontic team, that is able to offer a full range of endodontic treatment, including emergency endodontic appointments.

Services

RESTORATIVE DENTISTRY
- Adhesive restorations
- Tooth surface loss treatment
- TMJ and Occlusion problem solving

HYGIENE SERVICES
- Direct access hygienist
- Treatment of chronic periodontal disease
- Motivation of patients who are reluctant to comply

ORTHODONTIC TREATMENT
- Fixed and removable appliances
- Consultant orthodontic reports
- Hypodontia cases
- Ortohodontic extrusion

SAVE ON IMPLANTS COURSES
- Fixed price implants as part of courses

CBCT SCANS
- Reported or unreported scans
- 2D or 3D images available
- Consultant radiologist report

SEDATION
- Sedation available for nervous patients for all treatment requirements

IMPLANTS:
- Single & Multi implant placement and/or restoration
- Overdentures

TREATMENT OF FAILING IMPLANTS
- Treatment of peri implantitis
- Replacement of prosthetic components
- Implant removal

BONE AUGMENTATION:
- Sinus Bone Grafting
- Guided Bone Regeneration
- Block Bone Grafting

EXTRACTIONS
- 'Atraumatic' extractions
- Surgical extractions
- Socket preservation

PERIODONTAL
- Surgical & non-surgical periodontal treatment
- Periodontal plastic surgery (for treatment of gingival recession)
- Connective tissue and free gingival grafts
- Crown lengthening

Periodontal Plastic Surgery

by Fernando Gonzalez Eriksson

It is common to see highly motivated patients, with a good standard of oral hygiene, suffering from gingival recession. Predisposing factors, such as a thin gingival biotype or previous orthodontic treatment, may allow for gingival inflammation. Overzealous brushing may also cause gingival recession. In some instances, the absence of keratinised gingiva may cause discomfort when brushing. This may lead to localised poor plaque control and persistent gingival inflammation, which may result in ongoing gingival recession. This is typically observed in the lower anterior region, where a localised gingival recession defect may also be aggravated by the presence of a pulling frenulum (Figure 1).


FIG. 1

Gingival recession can be often prevented or controlled by means of appropriate oral hygiene instruction and control of gingival inflammation. However, existing gingival recession defects often lead to aesthetic concerns. There are a number of periodontal plastic procedures aimed at correcting gingival recession defects and/or preventing further recession. The gold-standard procedure for root coverage is the **coronally advanced flap** with a connective tissue graft **(Figure 2 a, b, c)**. Where the bone levels are good and the interdental papillae intact, this procedure has been shown to offer predictable and long-lasting root coverage.


FIG. 2A


FIG. 2B


FIG. 2C

In other cases, where aesthetics are not important, a free gingival graft may allow us to achieve a strong band of keratinised gingiva that will eliminate discomfort when brushing and thus prevent further gingival inflammation and recession **(Figure 3)**. Similar principles apply around dental implants, where the presence of keratinised mucosa seems to be, if anything, more important that around teeth.

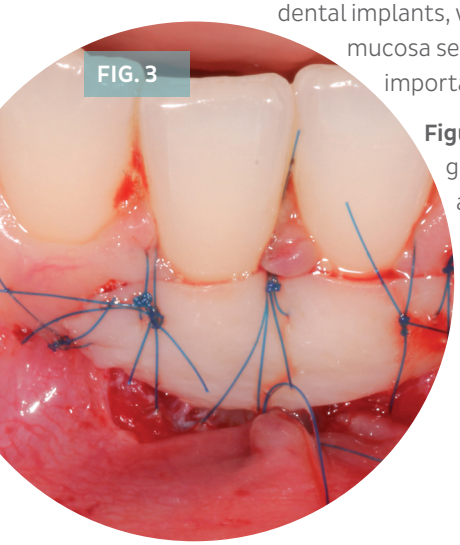


FIG. 3

Figure 4(a, b) shows a case of generalised gingival recession where our patient achieved a significant aesthetic improvement. Other benefits of root coverage procedures may include prevention of root caries and tooth sensitivity.


FIG. 4A


FIG. 4B

Retrieval of an Implant Aesthetic Failure

by Jonathon Schofield

This patient came to The Dental Implant Clinic because she was very unhappy with the appearance of her implant that was placed by another dentist.

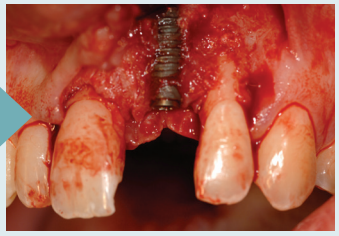
The implant had been placed six years previously when she was aged 21 in preparation for her graduation photographs.

She was bitterly disappointed with the finished result and refused to smile for her graduation photographs.

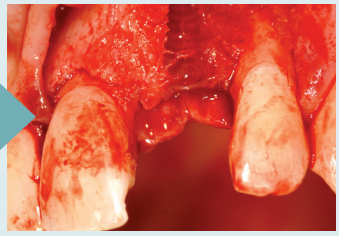
When I first met the patient I noticed that she had a very high smile line but was always trying to cover her smile with her hand.

The patient with her implant at UL1

When the patient's lips were pulled back it was clear that the implant had been placed too labially. The implant threads were visible underneath the gum.

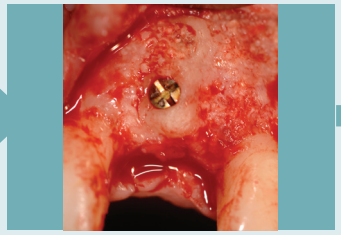


When a flap was raised, it was clear that none of the labial aspect of the implant was housed in bone.



The implant was removed

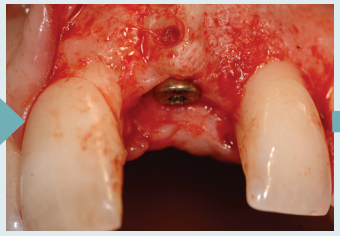
The site was left to heal for 6 weeks. During this time new keratinized mucosa formed over the boney defect.



A block graft was harvested from the chin and screwed into place to repair the bone defect.

Once healed, the block bone graft restored the hard tissue volume and gave a better contour to the overlying soft tissues.

An occlusal view showing the enhanced labial volume once the block graft had been placed.



The block graft was left to heal for six months. Next the implant was placed.

The implant was left under the mucosa for eight weeks whilst osseo-integration occurred. During this time the patient wore a temporary denture.

After eight weeks the implant was exposed.

The implant was restored with a temporary crown for three months. This was replaced, after three months, with a permanent crown.

The treatment took 18 months to complete.

Here are the before and after photographs to compare

Bisphosphonates Beware by Elliott Ballantyne

Bisphosphonates (BP) have been commonly used over the past 40 years to treat osteoporosis, Pagets' disease, hypercalcemia of malignancy, osteolytic lesions of multiple myeloma and bone metastases associated with breast, prostate, lung and other soft tissue tumours.

It is estimated that 30 million BP prescriptions are written in America with a staggering 190 million worldwide (Gutta and Louis, 2007; Madrid and Sanz, 2009). They are ideally suited for the treatment of bone disease because of their binding affinity to bone mineral at sites of active bone metabolism.

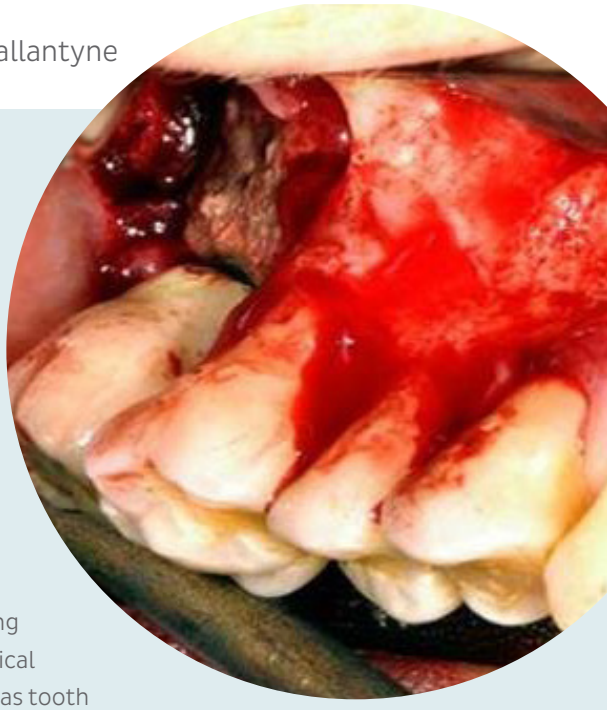
While there are shortcomings associated with many of the reported studies, there does appear to be a certain risk associated with both implant placement and the maintanence of osseointegrated implants in patients receiving oral bisphosphonates.

With an increasing proportion of the population being prescribed oral bisphosphonates, in particular, it is inevitable that some of these patients may require or request implant therapy. Therefore, the effects that these drugs may have on implant survival and success is very important. The first case of BRONJ in oral and maxillofacial surgery was only reported in 2003 and involved the failure of osseointegrated dental implants (Marx et al., 2005, Landsberg et al., 2008, 2011). Although studies describing the effects of nitrogen-containing bisphosphonates on alveolar bone are numerous, the effects of this class of drug on the oral soft tissue and oral wound healing are less well studied.

CLINICAL FEATURES – THINGS TO LOOK OUT FOR!

BRONJ may be an incidental finding, but it usually has a symptomatic clinical presentation, including pain, neuropathy, erythema, swelling, suppuration, tooth/implant mobility, halitosis, sinus tract formation, sequestration and possible pathologic fracture of the jaws (Zadik et al., 2012).

Elliott has a special interest in bone physiology and the actions of bisphosphonates. He was recently selected to do a presentation on the topic entitled "Bisphosphonates: Possible modes of action and implications for dental implant treatment. A review of the literature", at the 24th Annual Meeting of the European Association of Osseointegration in Rome in September.



Clinically, the disease presents as exposed alveolar bone that occurs spontaneously or becomes evident following an invasive surgical procedure such as tooth removal, periodontal surgery, apicectomy or dental implant placement.

Osteonecrosis of the jaws always originates in the alveolar bone and may extend to the basal bone or ramus in the mandible (Marx, 2007).

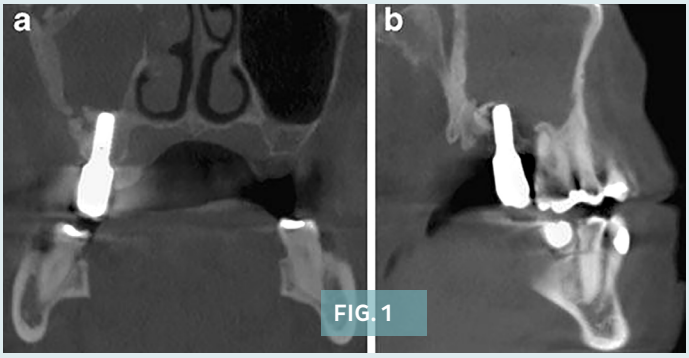


FIG. 1

Early subclinical radiographic signs such as sclerosis of the lamina dura, loss of the lamina dura, and/or widening of the periodontal ligament space, particularly in association with molar teeth have been observed (Marx, 2007). (figure 1)

Coronal view of a female patient with previous implant placement, sinus lift and oral bisphosphonate therapy. Notice sequestration and sclerotic changes of the lateral wall of the maxillary sinus.