



**INTEGRATIVE APPROACH TO THE USE OF TWO-STAGE
DENTAL IMPLANTATION IN PATIENTS WITH COMPLETE
JAW ADENTIA**

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ABSTRACT	KEYWORDS
<p>The use of dental implants for orthopedic treatment of patients with primary and secondary periodontal diseases has become increasingly common in recent years [1-3]. The continuous further development of dental implant systems, professional development of specialists and the growth of the competence of dental laboratories ensured the success and confidence of this approach. However, its success undoubtedly depends on the proper planning and conduct of the surgical stage and the subsequent manufacture of the prosthesis. The integrity of this process and the constant interaction between the orthopedist, the surgeon and the dental technician are crucial [2]. Completely toothless maxillary and mandibular patients or partially toothless patients with an unfixated bite (without antagonistic tooth contact) are a particular problem for a specialist in dental implant rehabilitation. Difficulties in these clinical situations arise both at the stage of surgical implant placement and at the stage of prosthetics [1, 3, 5]. In order to improve the method of two-stage dental implantation in fully and partially toothless patients with an unformed bite, a comprehensive method was proposed using full or partial prostheses at all stages of implantation: from preparation for surgery to the creation of a permanent orthodontic structure.</p>	

Introduction

The aim of the study are: to improve and determine the methods of two-stage dental implantation in patients with complete adentia. To determine and implement a method of temporary prosthetics for the period of orthopedic treatment when using dental implants with a full or partial removable plate prosthesis.

Materials and Methods:

During the study period, 27 completely toothless patients were selected, who underwent two-stage treatment using dental implants. At all stages of orthopedic rehabilitation in this group of patients, a method using removable plate prostheses was used. At the first stage, removable prostheses were made or existing prostheses were modified. This ensured the fixation of the height of the bite and the

central occlusive position, as well as the restoration of aesthetics and function of the dental system for the entire period of orthopedic treatment. Thus, removable dentures were a temporary solution. Patients had the opportunity to make a clear choice in favor of removable prostheses, and their decision to choose implants was more definite. At the planning stage, all patients underwent cone-beam computed tomography. The use of removable prostheses allowed CT to be performed in the central occlusal position and to assess the interalveolar height and the ratio of alveolar protrusions on the upper and lower jaw. Using CLCT processing software, the implant size was selected based on the measurement of the bone bed and its most favorable position in the bone tissue. CLCT Removable plate prostheses were modified for the exact location of the implants in accordance with the results of research. A hole was drilled in the prosthesis near each artificial tooth and a metal or gutta-percha radiopaque pin was installed. During the implant placement procedure, it was possible to orient and transfer into the oral cavity the work performed in the CLCT study. The necessary points were transferred to a removable prosthesis, and after preparation, a hole was drilled in this area to start drilling and a surgical template was created. During surgical intervention after local anesthesia, an artificial tooth was placed in the mucous membrane and bone tissue was drilled from the mucous membrane to a depth of 1-2 mm. After cutting off the muco-periosteal flap from the alveolar process, a place was determined for further formation of the bone bed and subsequent installation of a dental implant of a pre-selected size. After the operation, the prosthesis was restored to fill the hole used during the operation, and the prosthesis was reused by the patient as a temporary prosthesis; after two to three months, the implant was surgically opened and a gum shaper was installed. The removable prosthesis used after the operation had to be deformed and the gum shaper installed after the second surgical procedure. Then, with the help of an orthodontic mass, the place of separation of the healing abutment was determined, which allowed it to be used in the future; two to three weeks later, after the healing of the gum, they began to manufacture a permanent prosthesis. The plastic removable prosthesis was deformed by creating a through hole in the place corresponding to the installed implants. This made it possible to use temporary prostheses as individual spoons for taking accurate functional impressions. The method of open transfer was used. It was important to choose the transfer material so that it was at a lower height than the chewing surface of the temporary prosthesis. This makes it possible to determine the occlusal height and central occlusal position using a montel or bite plate and transmit the data to the dental laboratory. This allows you to transfer the data of the temporary prosthesis and save the parameters of the patient's musculoskeletal system for the entire period of use. A permanent abutment was selected in the dental laboratory, and a temporary removable prosthesis was installed in the center. Then permanent restorations were made and installed.

Conclusion:

The manufacture of a removable temporary prosthesis gives the patient more information about the choice between a removable prosthesis and a non-removable prosthesis with implants. The use of temporary prostheses as a method of intermediate prosthetics makes it possible to restore the aesthetic and functional parameters of the alveolar system during orthopedic treatment using implants. The use of radiopaque markers allows the use of removable temporary prostheses when planning and conducting computed tomography. It is also possible to transfer data directly to the surgical field by converting a temporary prosthesis into a surgical template. The use of modified temporary prostheses allows them to be used as individual impression spoons, which makes it possible to transfer accurate

data on the occlusal height and central occlusal position to permanent restorations. This makes it possible to accurately reproduce in permanent teeth the parameters of the musculoskeletal system registered during the use of temporary teeth. Temporary teeth act as a prognostic material for the aesthetics of permanent teeth. Based on the above conclusions, it is possible to recommend the widespread use and introduction into dental practice of the use of removable temporary teeth during treatment on implants. Using this method, it is possible to solve many difficulties and clarify and pay attention to possible errors at all stages of implantological treatment in completely toothless and partially toothless patients in the case of an unfixated bite.

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