

MTG March 10

Recently Keith returned for a review appointment. I had last seen him a few years previously when he had been provided with a complete fixed maxillary implant retained bridge. The construction was a standard CAD/CAM milled titanium framework, wrap around acrylic veneer with denture teeth, supported on 7 implants. Keith had only appeared because the upper right 5 and 6 had shattered. In fact this had not really prompted him to attend, we had actually written to him again, suggesting a review appointment, and the combination must have reached critical mass for him to contact us. It's surprisingly difficult to get some of these characters to attend. I had not seen Keith since his initial review and hygiene visit shortly after fitting his definitive bridge, more than three years previously. When I did finally see him he was full of enthusiasm for his bridge: 'Yeah, they've been fantastic, amazing. You know it's just like me old teeth'. I could see whilst he spoke the missing contours of the UR5 UR6.

Now it must have been intervention from a higher place, as I was heading to Liechtenstein shortly afterwards for the launch of a new denture tooth. Hardly the most glamorous reason for a celebration, but this was billed as something different. I knew that my technician was presenting at this meeting, and inevitably with these launches we had only just received the teeth to provide the presentation material for the launch symposium. I felt a slightly strange sense of satisfaction relating to the impeccable timing of Keith having smashed his teeth. The technician was quite chuffed, a timely opportunity to replace a set of teeth and the new ones were to be tougher, nano-technologically enhanced with ceramic fillers, and had been designed to fit over titanium beams with less grinding. I duly removed Keith's bridge, and the nurse disinfected it ready for transportation to the lab. I was not prepared for the sight of the inflamed, erythematous and purulent mucosa beneath that bridge. 'How have you been cleaning under the bridge?' I enquired. 'Well, I haven't really' admitted Keith 'I've just used me normal brush and that. You know, just like me real teeth'. I was stunned, quietly taken aback muttering a 'just like your last teeth'. I recalled with horror, the memory of the periodontal disaster a few years previously. I immediately took a DPT. My sense of euphoria at the impeccable timing evaporated in an instant as the radiographic image of seven implants protruding by various amounts from the depleted alveolar bone appeared on the screen. What to say? Well, I just took a deep breath and explained how the bone had reduced over time and that this was a bad thing and that it was not feasible to build the bone back up and I didn't know how long they would survive, but it would need superhuman maintenance from now on. 'Is it bad then?' came the response from an unfazed Keith. 'Yes, it's bad'. I reviewed my notes from four years previously. I had tested Keith for the interleukin polymorphisms, he was negative. Well who knows, but it was probably the best test at the time. I had explained to Keith that whilst there may be no scientifically detectable genetic predilection he was therefore at least very susceptible to the obvious plaque induced bone loss and therefore any restoration would be provided with the caveat of maintaining meticulous oral hygiene.

Would a removable solution have been any better? Certainly easier to clean, but a loser if the patient doesn't remove it. So how did it get to this? How had this patient not reappeared? Peri-implantitis is

mercifully rare in our clinic, but here was a worthy contender for 2010 peri-implant case of the year. Treatment has started, I shall update in time. In the meantime the ADI have joined forces with the BSSPD for the meeting in Stirling titled 'Managing Failing Implants, how should we maintain them?' How's that for timing.