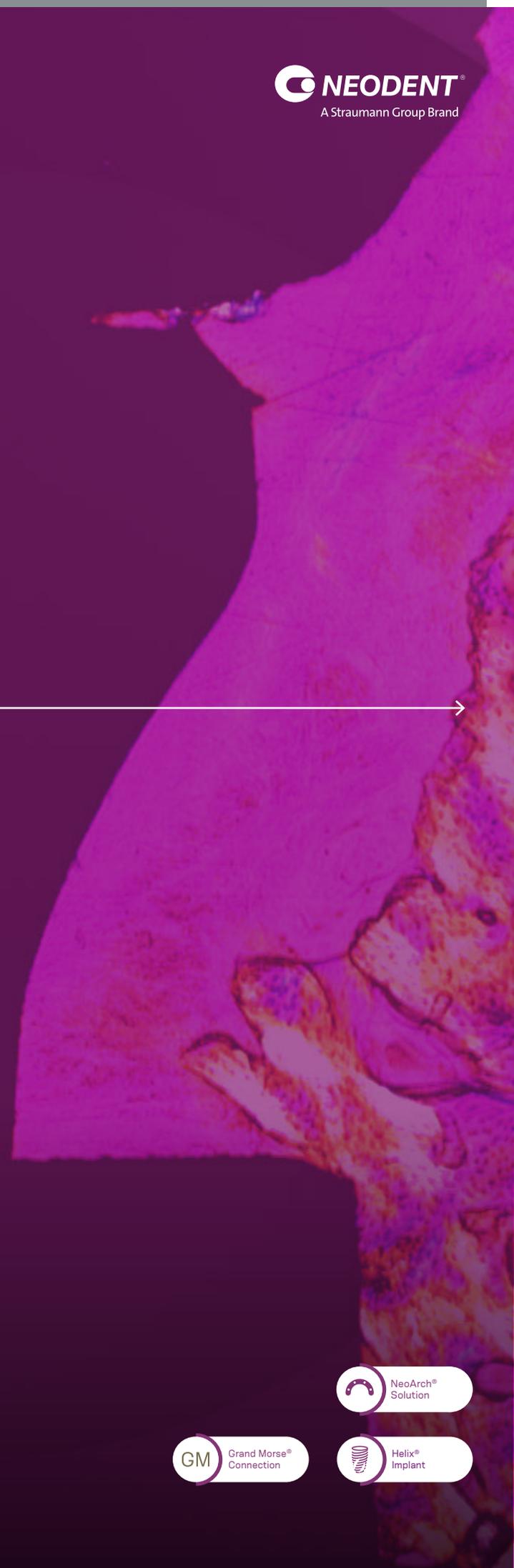


CLINICAL CASE

ATROPHIC MAXILLA REHABILITATION WITH
IMMEDIATE LOADING USING GM[™] ZYGOMA-S
IMPLANTS ASSOCIATED WITH HELIX GM[®]



CLINICAL CASE

Atrophic maxilla rehabilitation with immediate loading using GM™ Zygoma-S implants associated with Helix GM®.

DENTAL SURGEON IN CHARGE



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USA

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PATIENT MEDICAL HISTORY

Sixty-nine-year-old patient, controlled diabetic (ASA 2). Edentulous and atrophic maxilla. Mandible with natural teeth and fixed prosthesis over implants (36 and 46).



PLANNING

By performing an initial tomography (CBCT), it could be verified that the patient has an atrophic maxilla. After the evaluation, the following planning was carried out: anatomical tray impression, occlusal rim wax adjustment, artificial teeth selection and, after its approval, the confection of the multifunctional guide.

With the prototype of the patient's maxilla, it was defined that the zygomatic implants would be placed instead of doing bone reconstruction.

ATROPHIC MAXILLA REHABILITATION WITH IMMEDIATE LOADING USING GM™ ZYGOMA-S IMPLANTS ASSOCIATED WITH HELIX GM®.

DESCRIPTION OF THE PROCEDURE

The procedure was performed under intravenous sedation and local anesthesia in the following nerve branches: superior alveolar, incisor, and palatine. Starting with a supracrestal and oblique incision, followed by a detachment of the gingival flap, then obtaining adequate visualization of the zygomatic arch. The instrumentation was performed following the drilling protocol recommended by the manufacturer, proceeding with the installation of the GM™ Zygoma S 3.75 x 35mm implants in the posterior region of the maxilla, reaching final torque of 60N.cm.

In the premaxilla, three implants were installed, two implants Helix GM® 3.5 x 8mm in the canine regions and one in the midline Helix GM® 3.75 x 8mm.

Subsequently installed with a torque of 20 N.cm, a GM Exact Mini Conical Abutment 60° (1.5mm transmucosal height) in the zygomatic implants, GM Exact Mini Conical Abutment 17° (1.5mm transmucosal height) in the region of 13 and midline, GM Mini Conical Abutment (1.5mm transmucosal height) and in the region of 23. Then, the Wide Mini Conical Abutment Protection Cylinder was placed on top of the GM Mini Conical Abutment, finishing the procedure with a continuous suture on site

PROSTHETIC DESCRIPTION

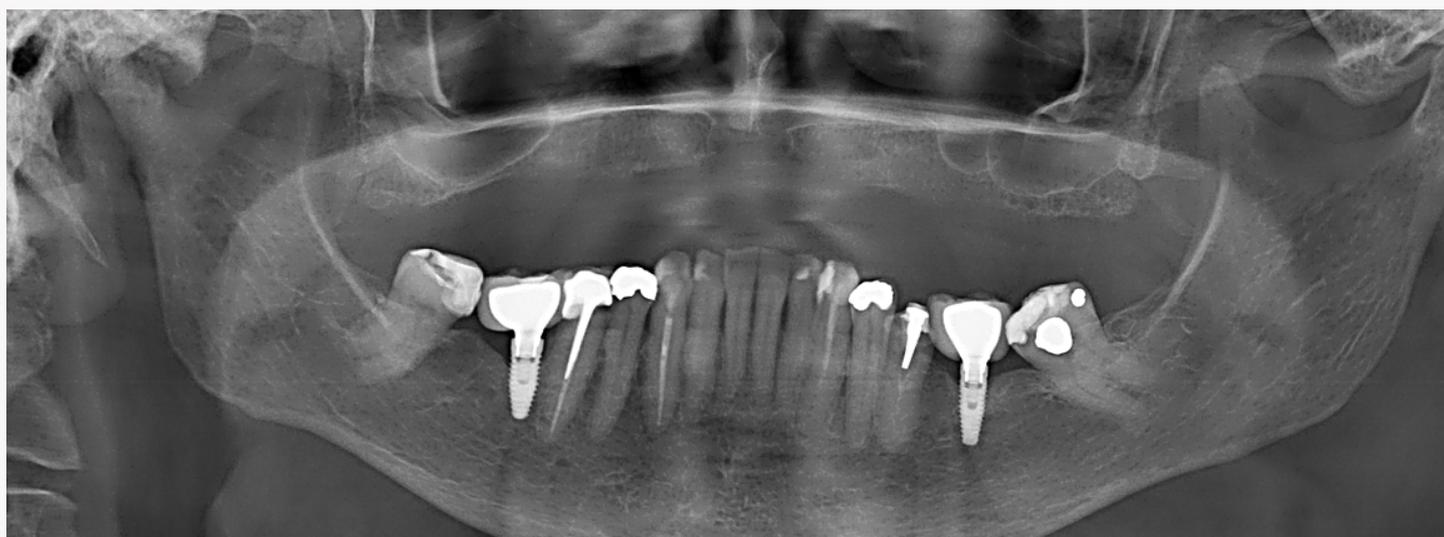
On the following day, for the impression, it was used the Slim Mini Conical Abutment Open Tray Impression Coping, they were attached to the multifunctional guide using acrylic resin. The occlusal registration (of centric relation) was performed after fixing the resin, followed by the insertion of the impression material (addition silicone).

With the laboratory plaster model obtained, the teeth were tested in wax, confirming the final positioning of the prosthesis. After approval, a titanium bar was milled, and the prosthesis was acrylized.

The prosthesis was installed the following week, and the occlusal adjustment was performed following the principles of bilateral balanced occlusion.

NEODENT® MATERIALS

- GM™ Zygoma S 3.75 x 35mm
- Helix GM® 3.5 x 8mm
- Helix GM® 3.75 x 8mm
- GM Exact Mini Conical Abutment 60° (1.5mm)
- GM Exact Mini Conical Abutment 17° (1.5mm)
- GM Mini Conical Abutment (1.5mm)
- Wide Mini Conical Abutment Protection Cylinder
- Slim Mini Conical Abutment Open Tray Impression Coping



1. Initial panoramic radiographic of the patient.

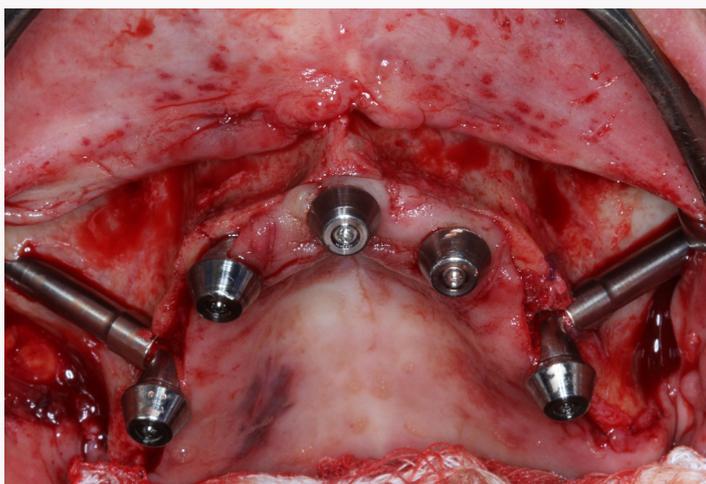
ATROPHIC MAXILLA REHABILITATION WITH IMMEDIATE LOADING USING GM™ ZYGOMA-S IMPLANTS ASSOCIATED WITH HELIX GM®.



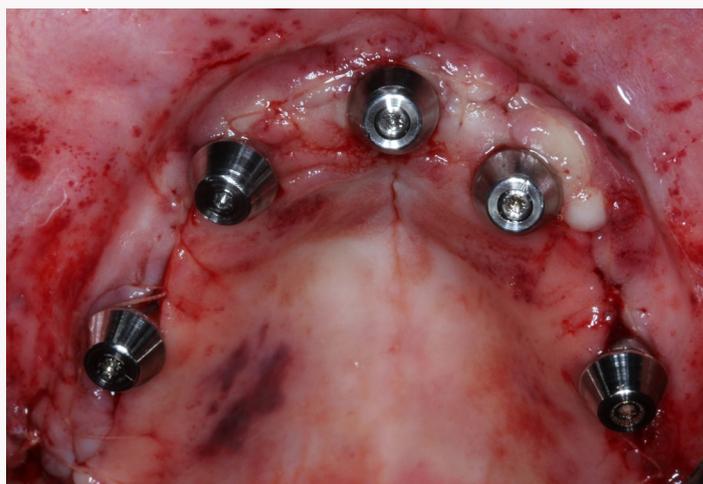
2. Initial clinical aspect of the removable prosthesis in the maxilla, vestibular view.



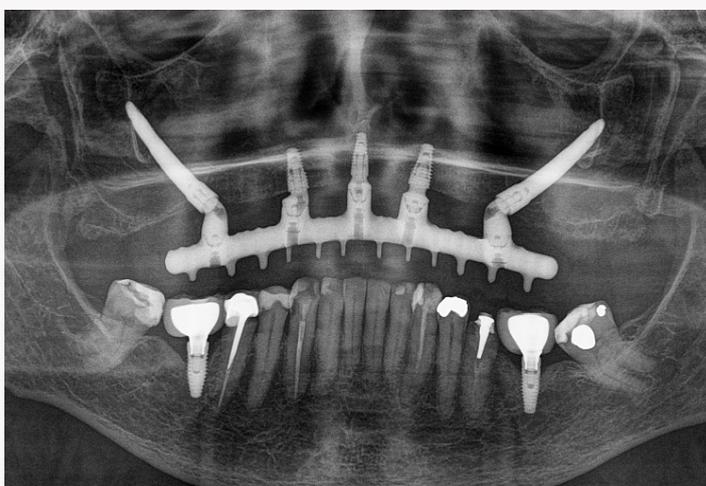
3. Maxillary initial clinical aspect, occlusal view.



4. Clinical aspect after installing two GM Zygoma S and 3 Helix GM. Occlusal view.



5. Post-surgical clinical aspect with positioned Wide Mini Conical Abutment Protection Cylinder, occlusal view.



6. Final radiographic aspect, post-surgical.



7. Post-surgical clinical aspect with prosthesis installed, vestibular view, seven days follow-up.

Experienced clinicians performed the procedures presented. The clinicians are fully responsible for the reliability of the information and for the procedures and results reported. Any review, dissemination, distribution, copying or other use of this information by persons or entities, without previous written permission, is prohibited. The presented material can be subject of reviews without previous notice. No liability is accepted for any errors or omissions in the contents.

It is the clinician's exclusive responsibility to evaluate the patient's health conditions and viability of the procedure. The reproduction of this clinical case does not imply the success of similar procedures, as it will depend on the clinician's technique and ability, on patient's conditions on the previous and post procedure.

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