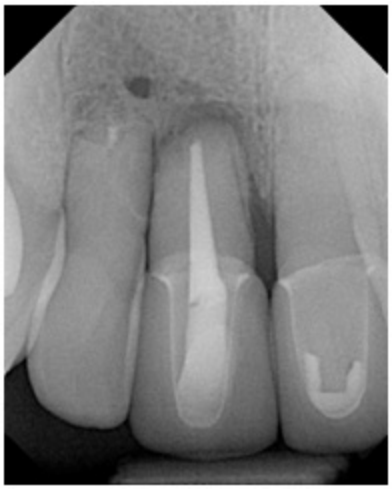
CASE PRESENTATION
(/spear-review/category/case-presentation/)

Benefits and Risks

By Gary DeWood (/spear-review/author/gary-dewood/) on March 9, 2012 | (/bookmarks/bookmark/10724)



This maxillary right central incisor is going away. The resorption evident on the root has left it little support, and it exhibits a 3+ mobility. The patient eats carefully but has no discomfort associated with the tooth at all. He travels extensively, and his primary concern is one in which he has tooth in hand somewhere far away and an important meeting or meetings to attend, so he's ready to do something. “Something” covers a wide range in cases like this, and I see my job as assisting the patient through a process of determining the most appropriate solution for him.

The Scenario

I often present a scenario to students in which the patient has bilaterally missing mandibular first molars. To make it more interesting, I note that the maxillary first molars have not erupted and the mandibular second molars have not tipped or shifted mesially. The teeth have been missing for more than 10 years. The patient is 55 years old and has decided that he wants to have a tooth in each space, so the “Do Nothing” choice that is always available has been removed from the table. What should I recommend to the patient? Most dental audiences immediately recommend an implant (https://www.speareducation.com/spear-review/category/implants). I am not so quick to do that.

The Identification of Choice

As I see it, there are three ways to treat the space: an implant and crown, a fixed bridge, or a removable partial denture. Which one is “BEST”?

That's a really loaded question, as it requires a value selection. When Cheryl and I started in practice, we had a wonderful patient who wore a lower RPD replacing bilaterally missing first molars that she had been wearing since she was 39 years old. When I met her she was 98 and that partial was doing very well both for

her and by her. I have seen fixed bridges serve patients for decades with no negative effect on function or health. I have seen implants that truly replaced the teeth as if they were still there.

Point is, they all work. The problem with recommending the implant too soon is one of “choice.” If I can help the patient become emotionally connected to one solution before considering others, it will make the financial discussion an “arrangement” discussion rather than a values discussion.

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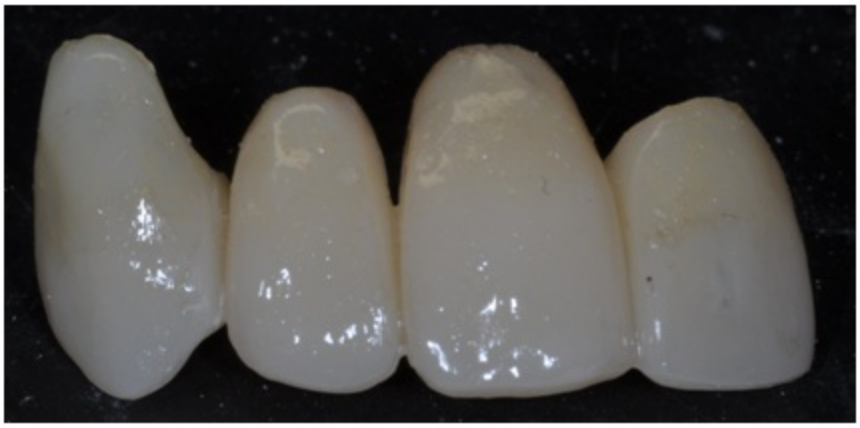
“As you consider the tooth in that space, is it one that comes out to be cleaned or one that stays in place like your natural teeth?”

“If it stays in place, is it a tooth that you clean under by threading floss, or one that is separated from the teeth on each side?”

If the patient has now expressed and claimed a desire to have a tooth that stays in and can be flossed, the choice has been made. Now, informing him about the alternatives is informational and comparative, BUT the patient already knows what he wants.

The Reality of Circumstances and Temperament



The figure above is the provisional with ovate pontics in the sites of lateral and central incisor. My patient liked the theory of an implant but not the reality of it. He decided that the time frame required and the need to consider bone augmentation prior to knowing whether or not the implant would be an acceptable esthetic (/spear-review/2013/08/evaluating-facial-esthetics-facial-profile) solution were not things he was willing to undertake to replace this tooth. In his case the decision was a four-unit fixed bridge. (The lateral incisor provided only liability in the selected plan due to the resorption it exhibited.) He came to this decision understanding everything I could help him know about his choices, and when that is something I help patients clearly understand, they always make the right choice.