The anterior maxillary implant and a high smile line: Often a great challenge

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This case report is based upon a speech held at the 36. International Annual Congress of DGZI in Munich on 13th of October, 2006. Placing an implant in the anterior sector of the maxilla with clear indication poses a great challenge in most situations, especially when the patient shows a high smile line and the treatment has been delayed. Today, however, osseointegration is no longer the only criterion when assessing the outcome of an implant treatment: The aesthetic result has become just as important. In the following, a passionate mountaineer explains two completely different initial situations after the loss of the upper left lateral incisor, and its replacement.

_Teufelsberg Mountain, 120 m, Berlin, uncomplicated

Especially when critically evaluated, there are not many clear indications for an immediate load implant in the anterior sector of the maxilla. Furthermore, one must differentiate between immediate treatment and immediate load. A possible bone loss and the surrounding soft tissues should be analyzed presurgically.

Our 37-year-old Prophylaxis Assistant had previously had an apicoectomy of the upper left lateral incisor. This apicoectomy was implemented up to the level of the cast crown. Afterwards, the tooth was clinically without symptom. However, after about 15 years it became increasingly mobile and finally reached a mobility of level 3, while being free of irritation periapically. This was most likely caused by the extreme ectomy (Fig. 1).

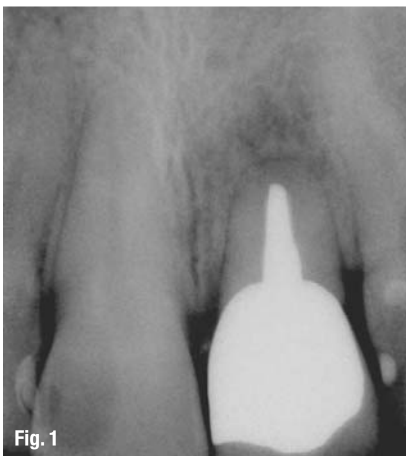
Fig. 1

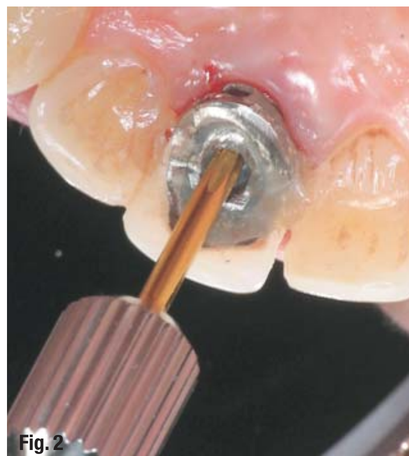
Fig. 2

Despite the low apical brightening we extracted the upper left lateral incisor, protecting the patient with antibiotics (Penicillin 1.5 Mega), and immediately inserted a NOBEL PERFECT implant 5.0 x 13 mm. The previous crown was separated from the extracted tooth and set upon a temporary titanium abutment to be used for about 6 weeks (Fig. 2). In order to guarantee an immediate treatment, but not an immediate load, the crown was not only screwed upon the implant, but the loads were distributed onto the neighboring teeth with help of DUALZEMENT. Furthermore, we deliberately let the temporary crown end above the gingiva line for the first 6 weeks in order to avoid irritations of the gingiva during the highly sensitive healing phase (Fig. 3).

After six weeks, the radiograph showed a healing process without complication (Fig. 4). This was also affirmed by the pinkish shade of the gingiva encountered when removing the temporary abutment (Fig. 5). Seven weeks after the permanent abutment was affixed, the final photograph (Fig. 6) shows an excellent result.

However, the treatment was relatively uncom-