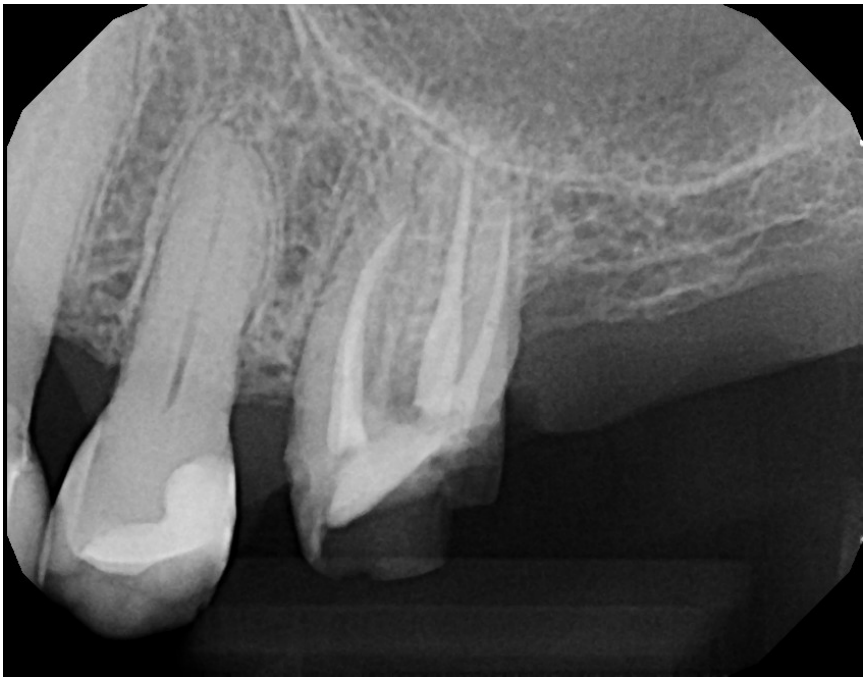
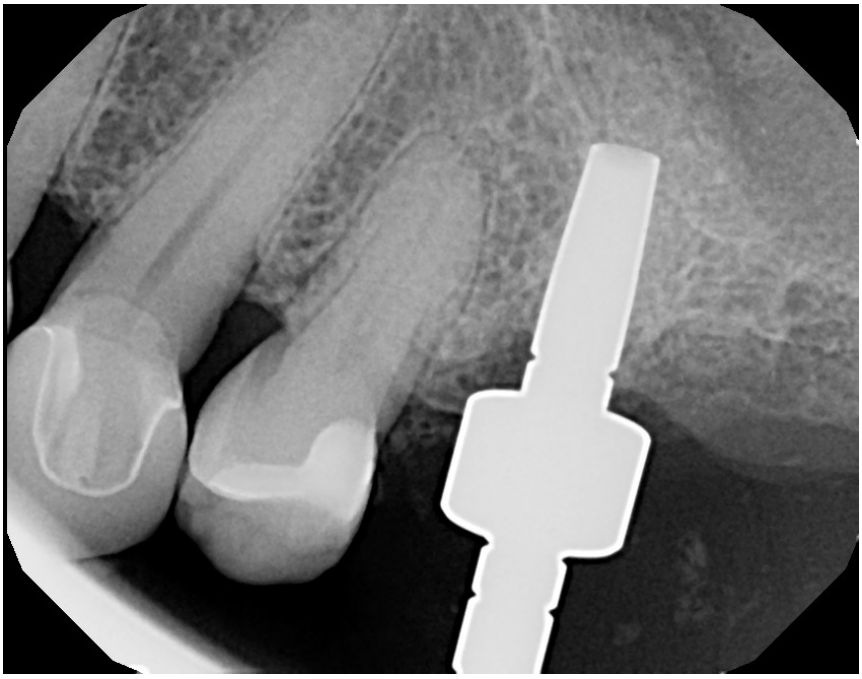
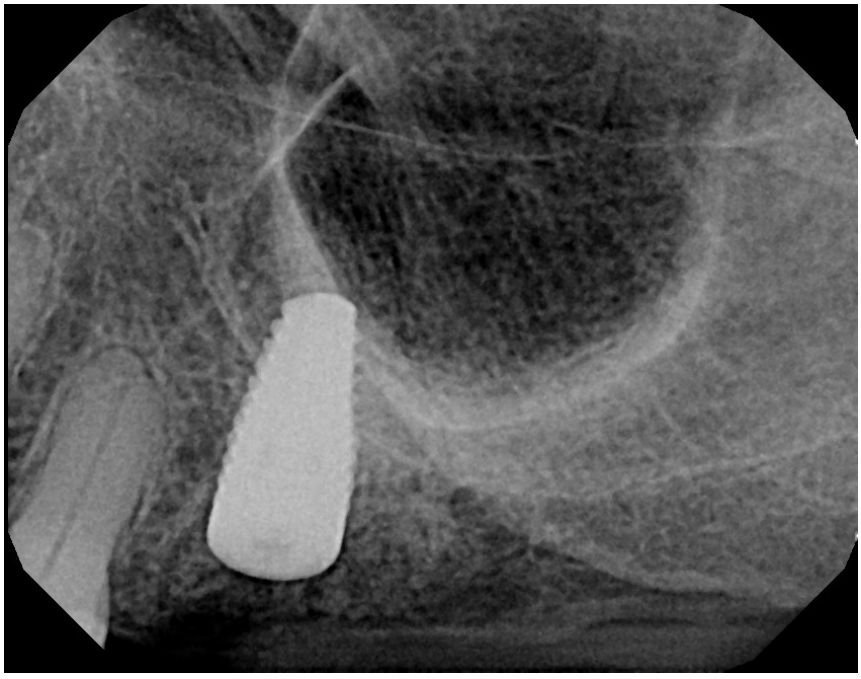
Placing an Immediate Molar Implant

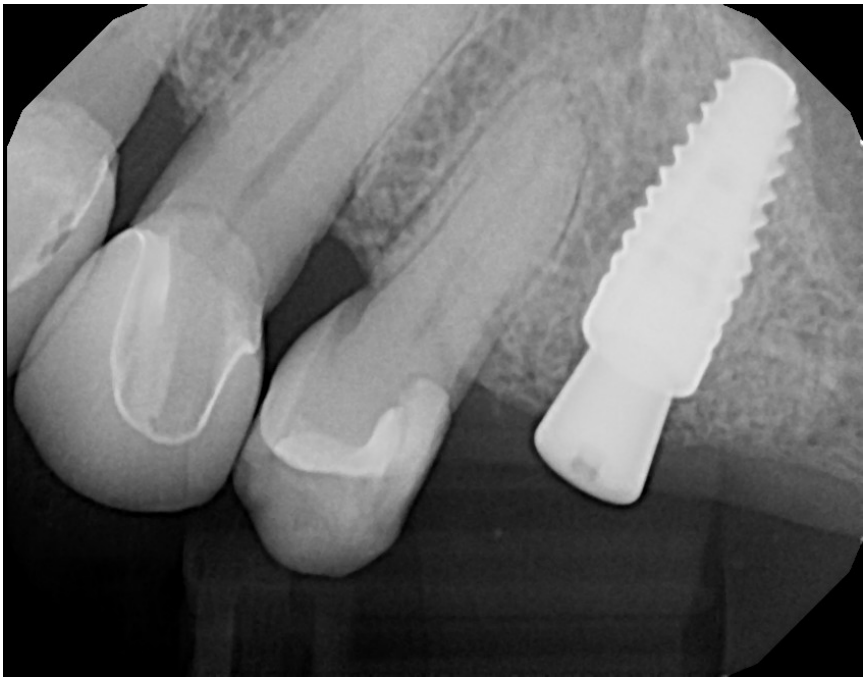
Darryl Burke August 10, 2018

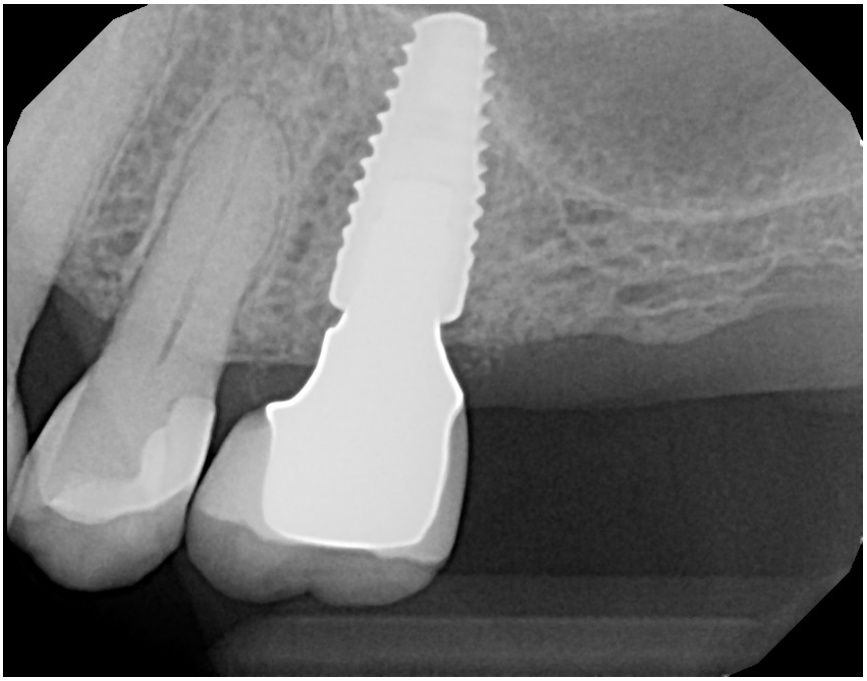
For the alumni out there, how many attempt to place immediate molar implants on a regular basis? I can honestly say I have only placed one immediate Maxillary Implant. I also posted that case in one of my previous blogs.







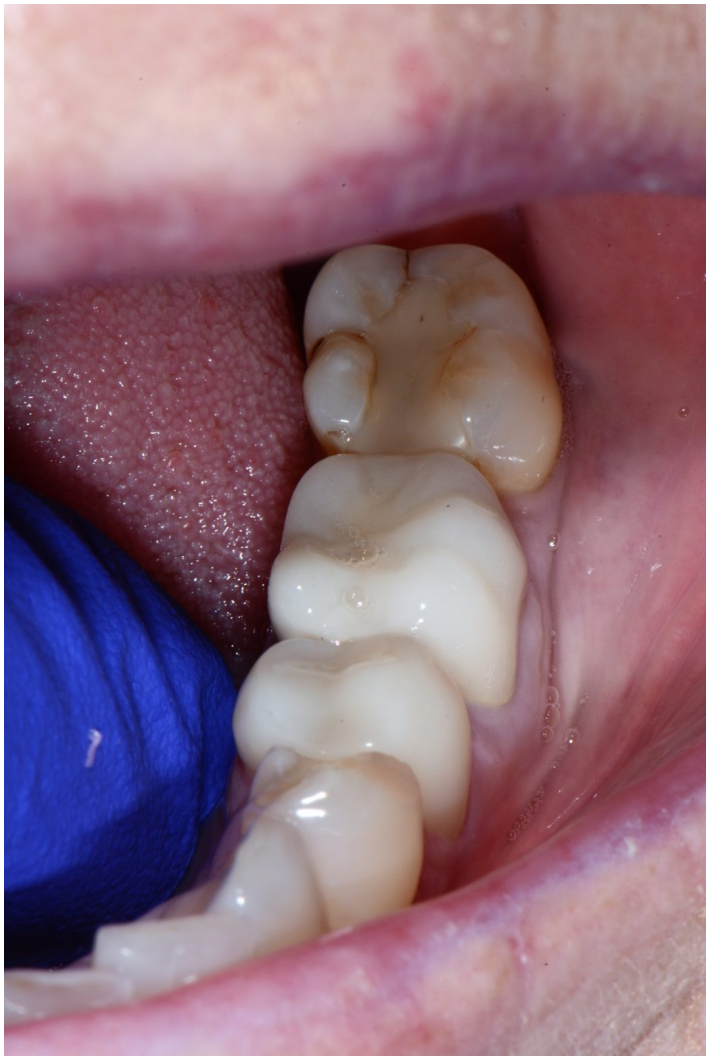


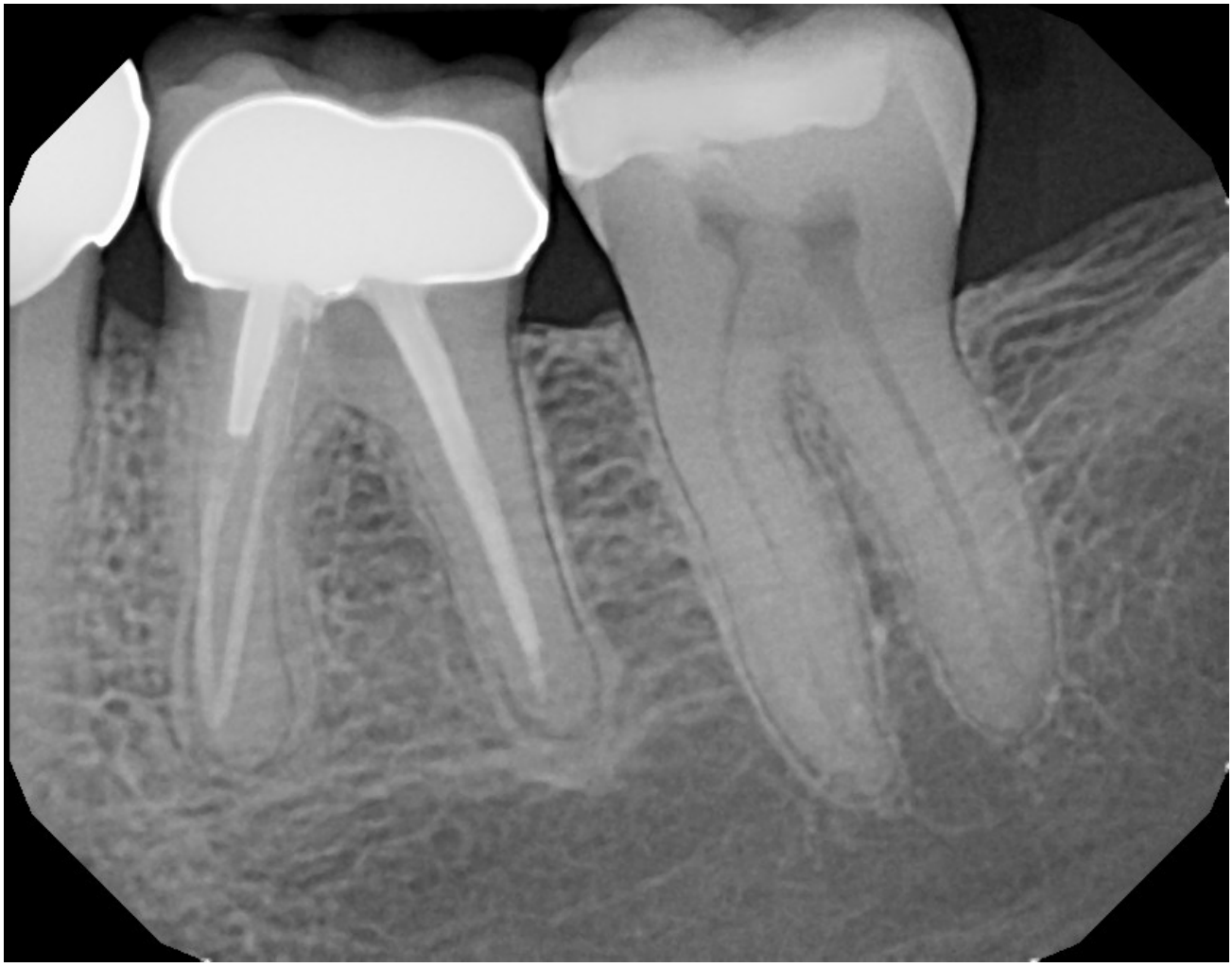


I had a great result, but a Maxillary Molar Implant is not something I normally do and when I did this surgery it was originally scheduled for just an extraction and graft. As Dr. Engel has said before he does not place upper immediate molar implants.

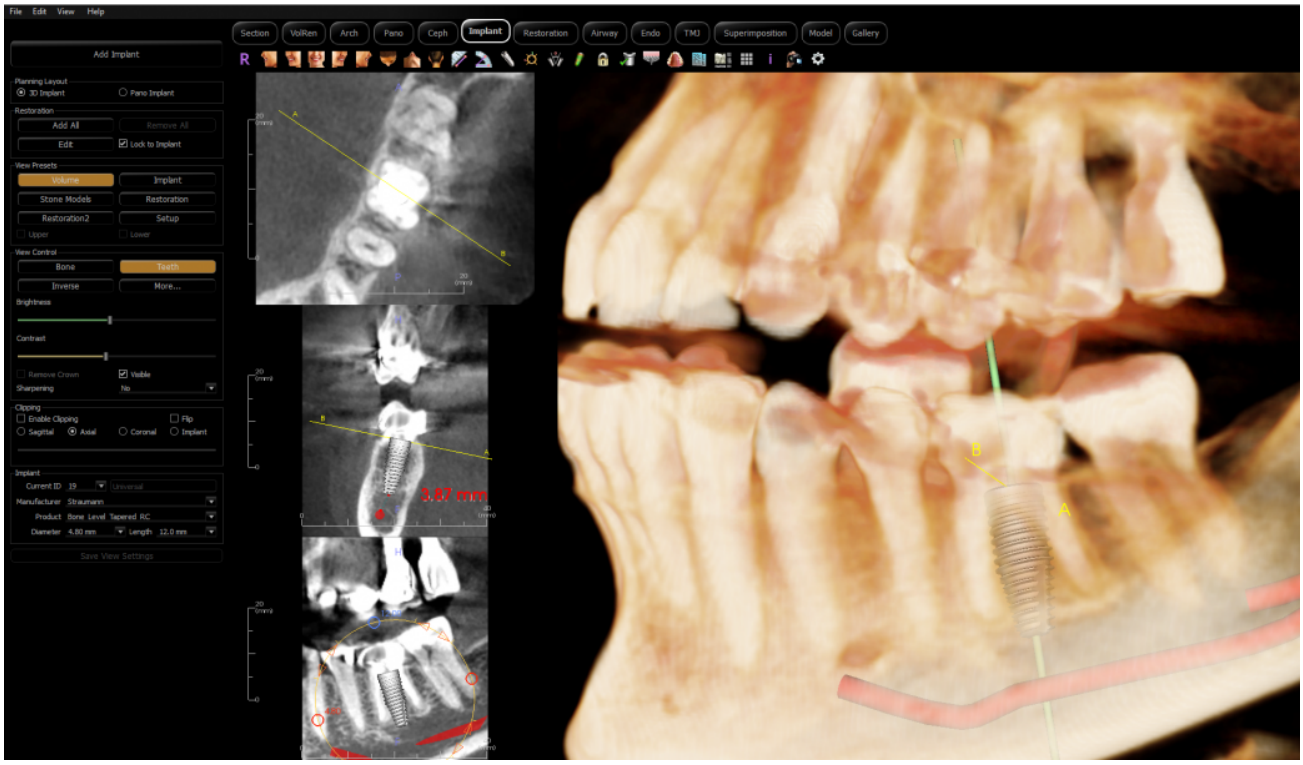
With that being said, how many place lower immediate molar implants? What are your thoughts and what are your limitations? For the most part I do not place lower molar immediates because when placing I want predictability. We have a bigger space to place that implant in the molar region. We need the width, but we also need the length, 2 mm of natural bone to gain stability. Unless all these specifications for me are there I wont place.

When placing a molar immediate how do go about it? Do you remove the tooth first, then start your osteotomy? You can but trying to drill that initial pilot through that inter-septal bone might be a little tricky. I saw a case posted from an alumni, it was a very nice job. He mentioned he used the needle nose drill that is used for the Straumann 2.9 implant. Here let me show you a different way that I actually learned from Dr. August de Oliveira from Southern California. Lets look at the case.

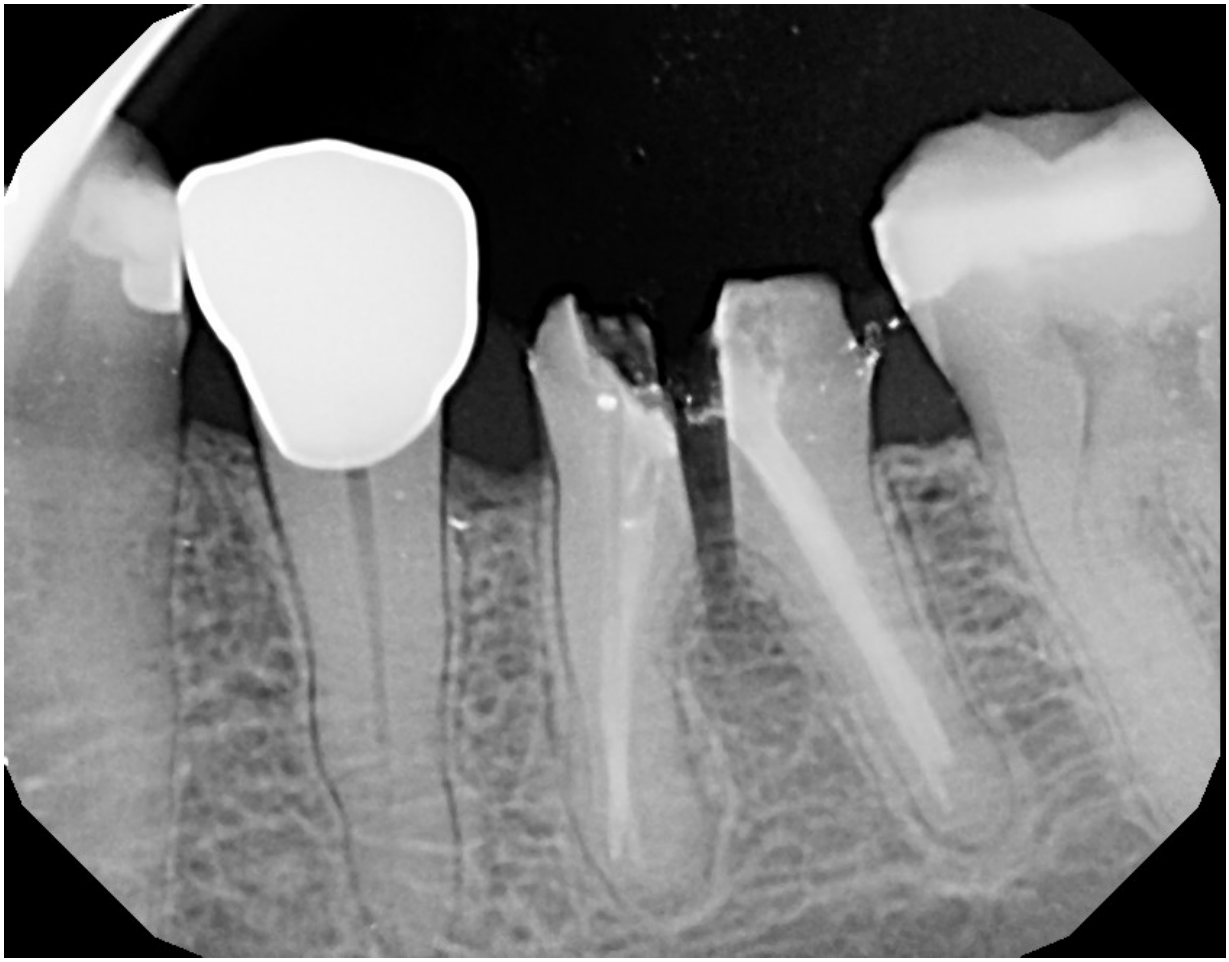




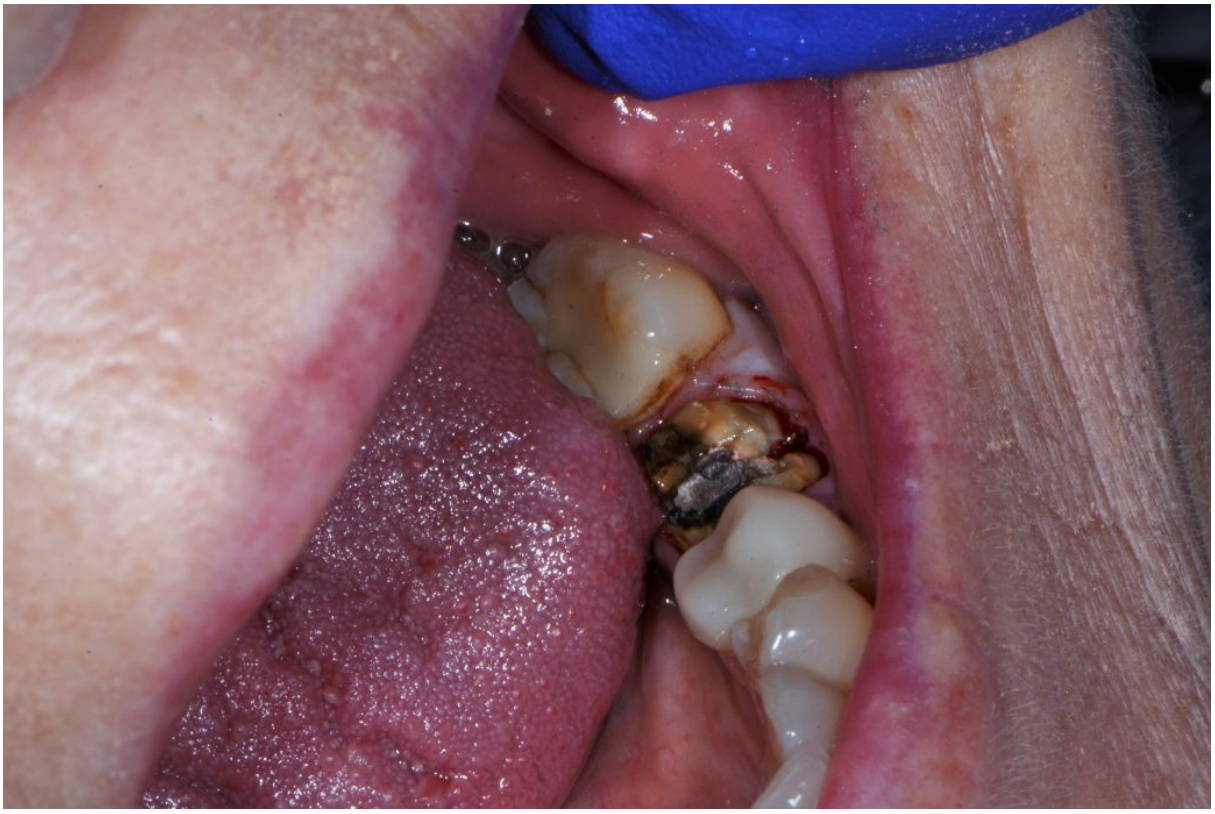
My patient had a RCT post and crown done years ago but now the tooth was hurting her. Originally I told her that she needed a retreatment, but I probed the ML area and I got a 10 mm pocket. After determining the tooth was fractured I took a cone beam to see if an immediate would be possible since her roots were divergent. Also,I needed to check on where the IAN was.

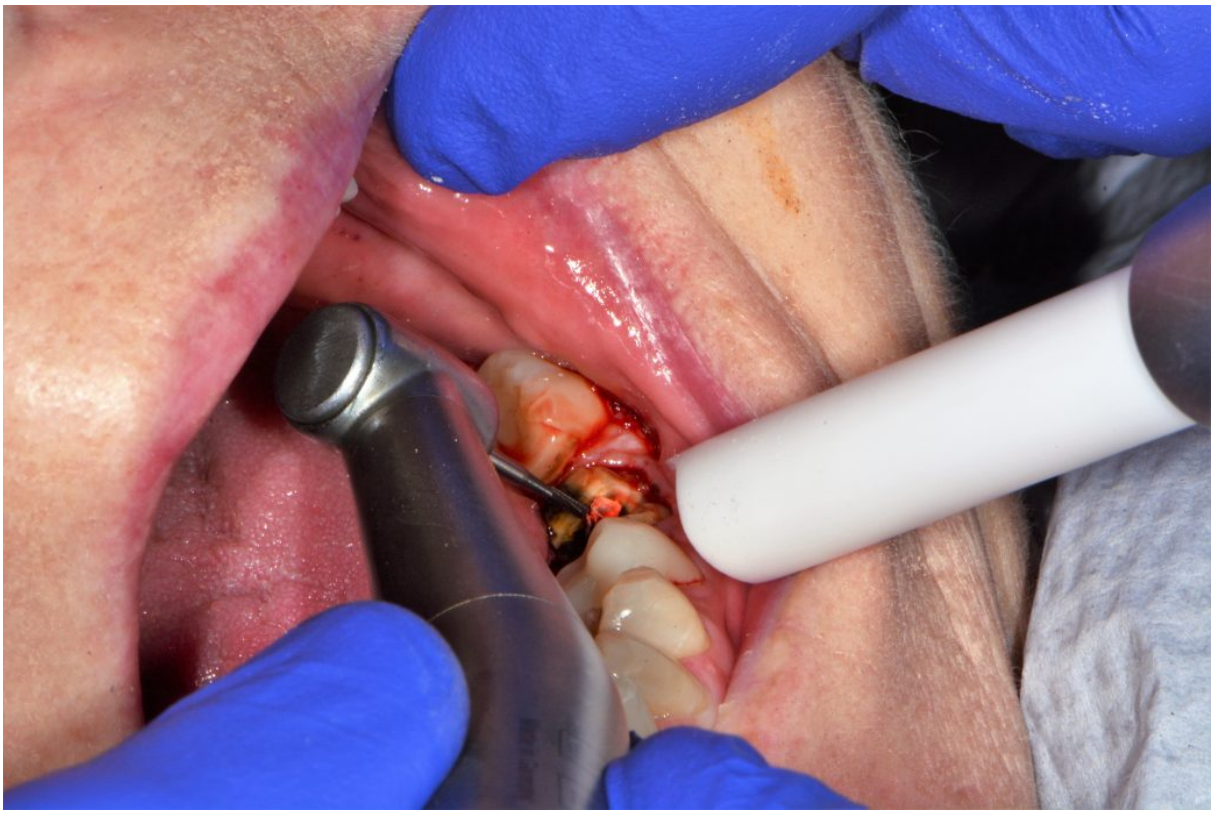


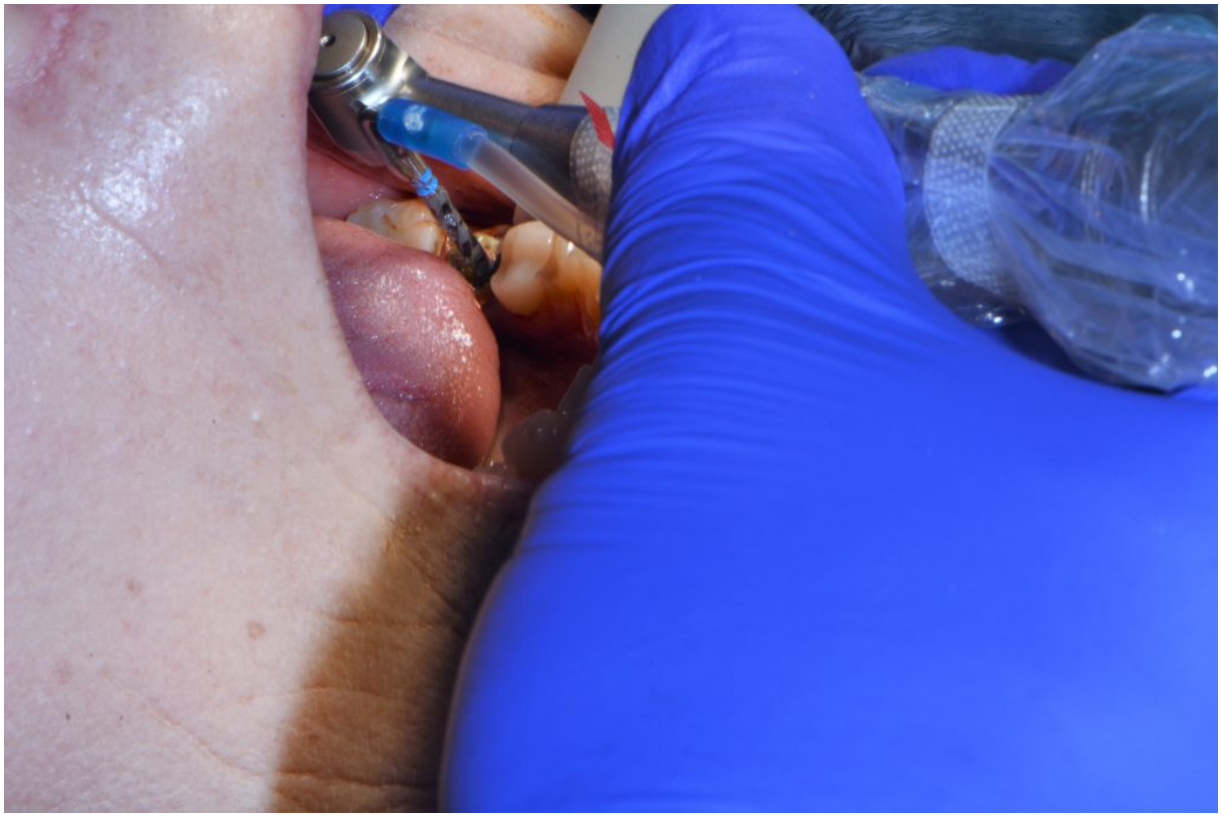
After studying the cone beam I determined an immediate is possible as long as I was able to keep my 4 walls. You can still place if you lose the buccal plate, but the graft needs to heal correctly for the implant to succeed. Remember predictability. So I removed the crown and sectioned the tooth. When sectioning it a good idea to make sure you are sectioning the tooth properly. Stop take an Xray.

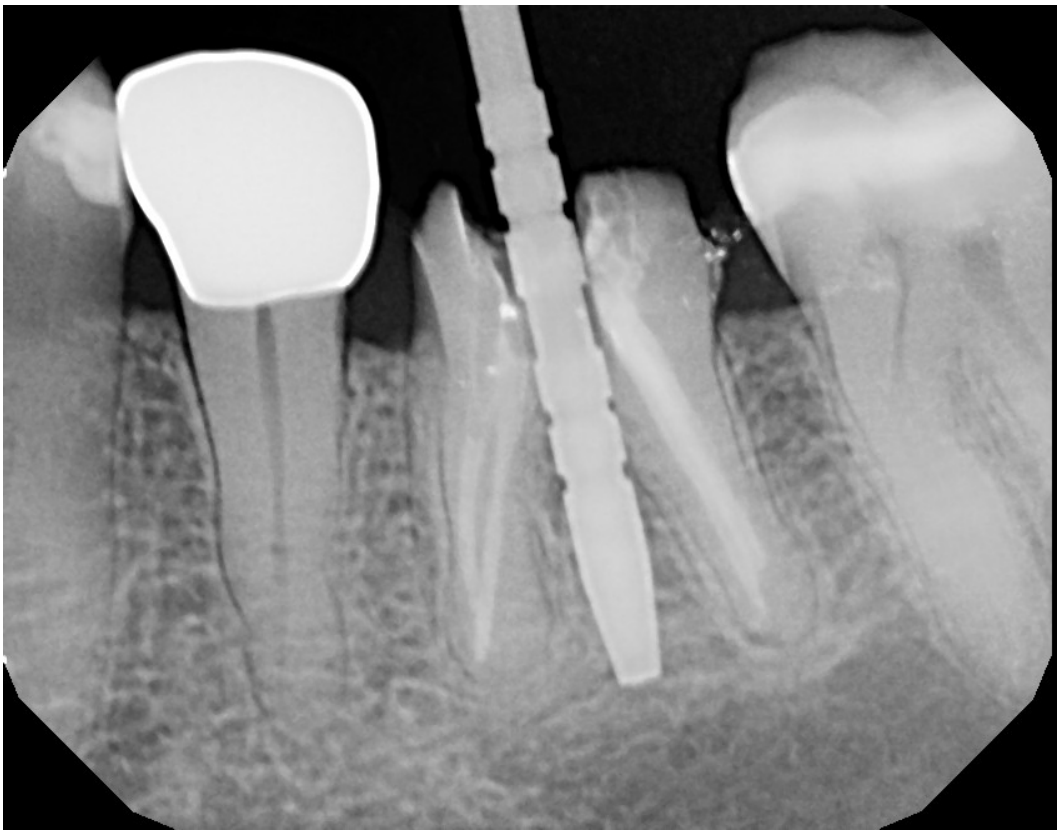


From here I took a surgical 557 to widen a circular hole so I could fit my pilot drill into. I proceeded to drill my pilot, I stopped to again to make sure that my angulation and position were correct.

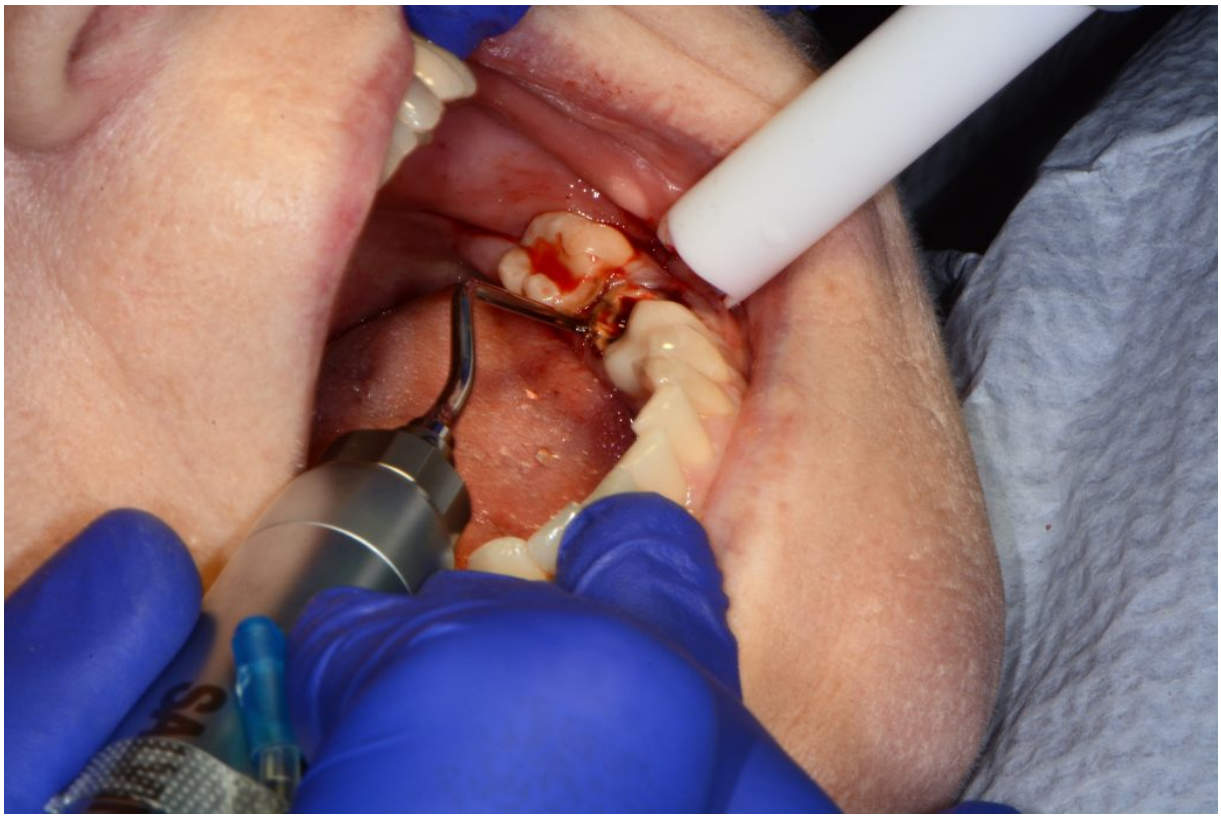


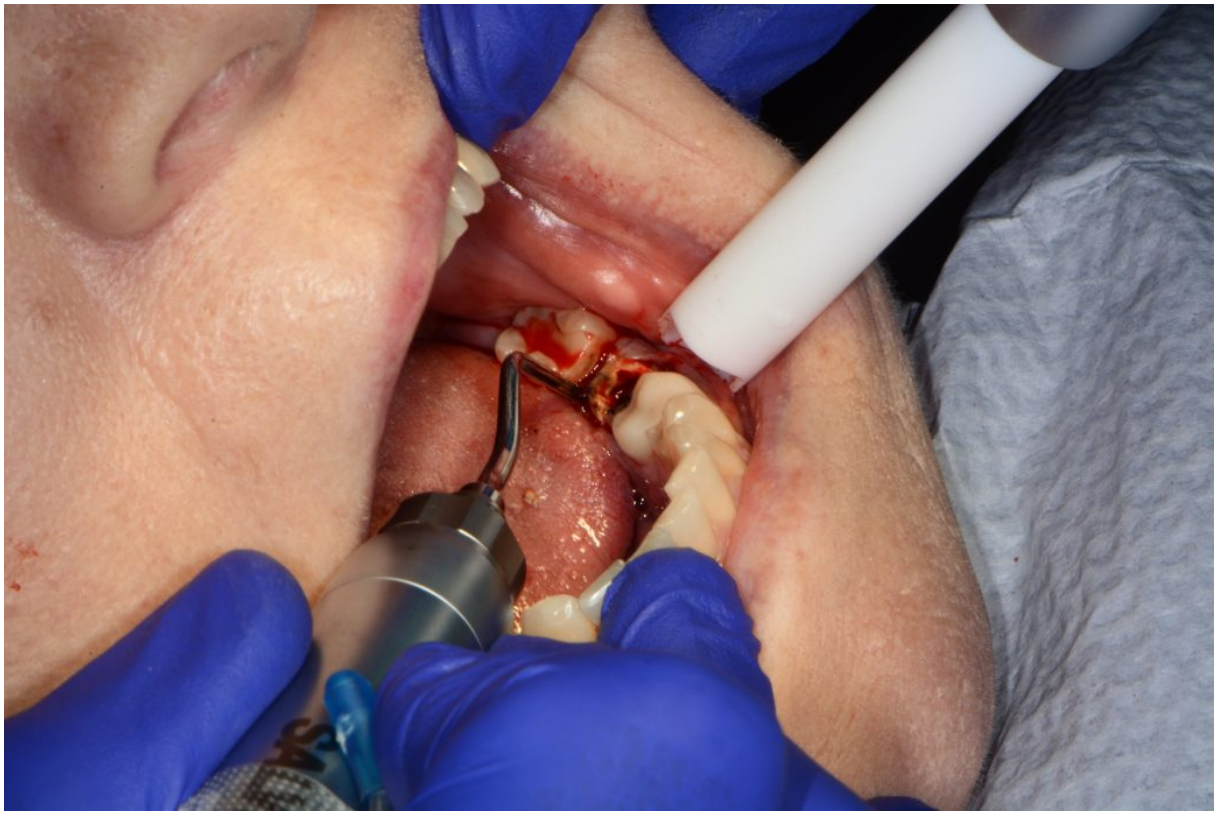




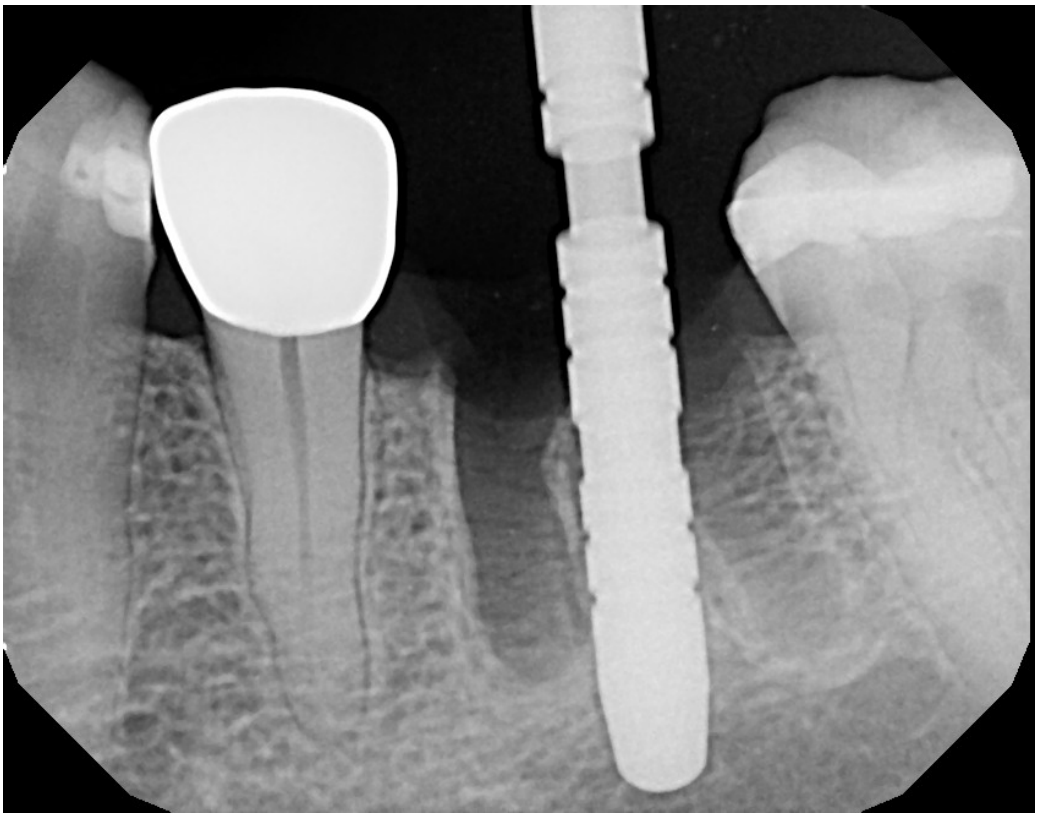


After that I continued on prepping my osteotomy using the tooth as my surgical guide. Once I prepped up to the final drill for the 4.1 mm Straumann I used my Salvin Autotome to gently remove the remaining roots and preserve my 4 walls.



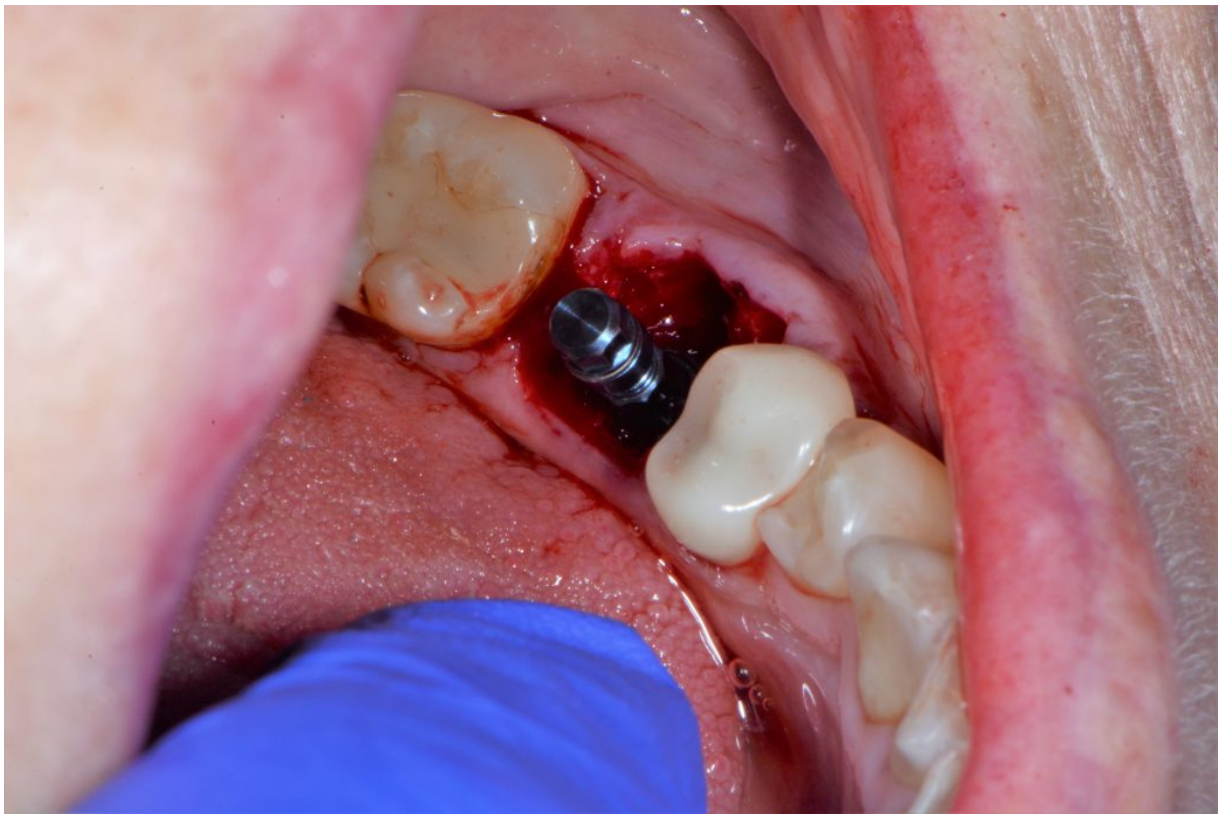


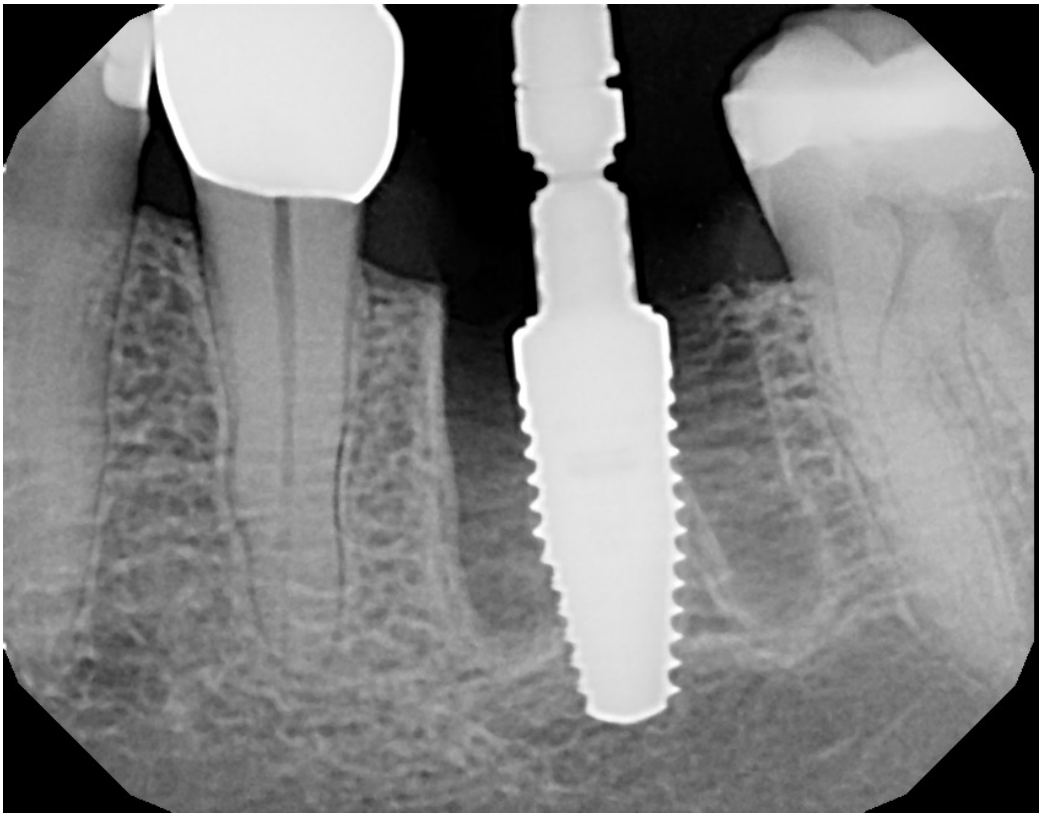
After the remaining root was removed I remeasured and the height of the bone bucco lingually so that my depth was 13 mm. 1 mm sub crestal to allow for remodeling.

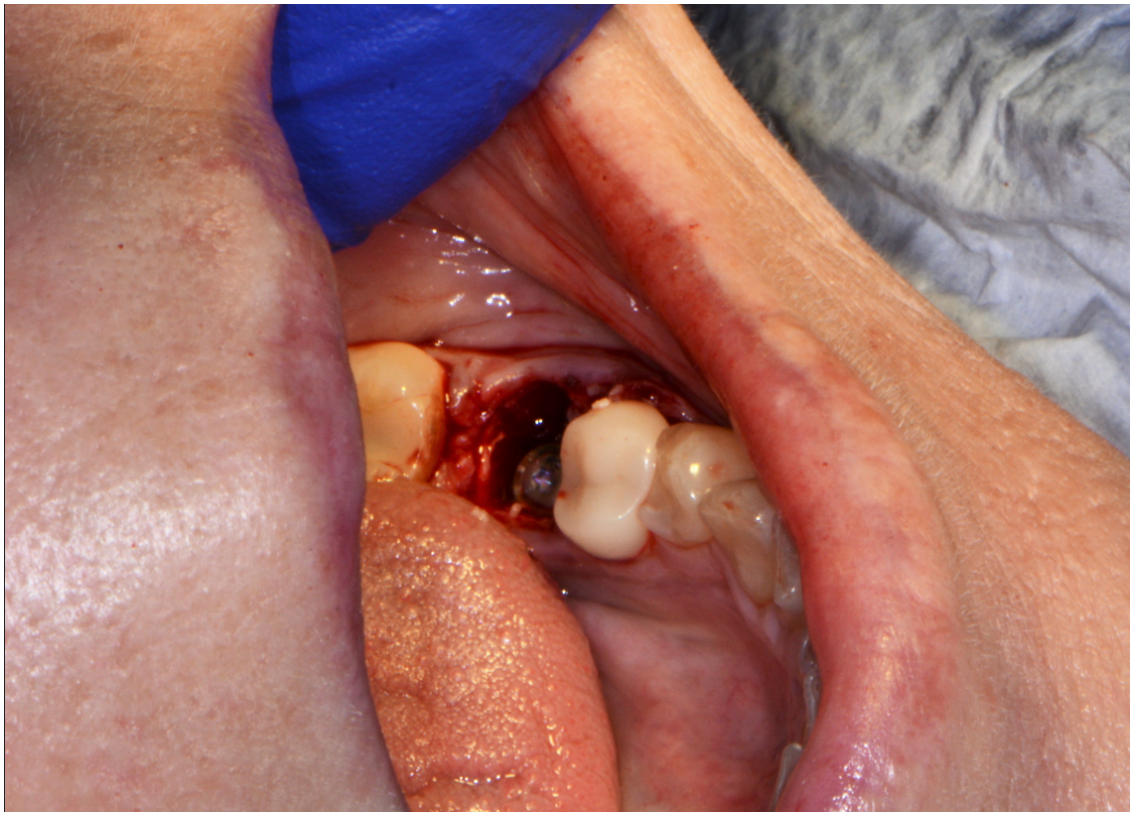


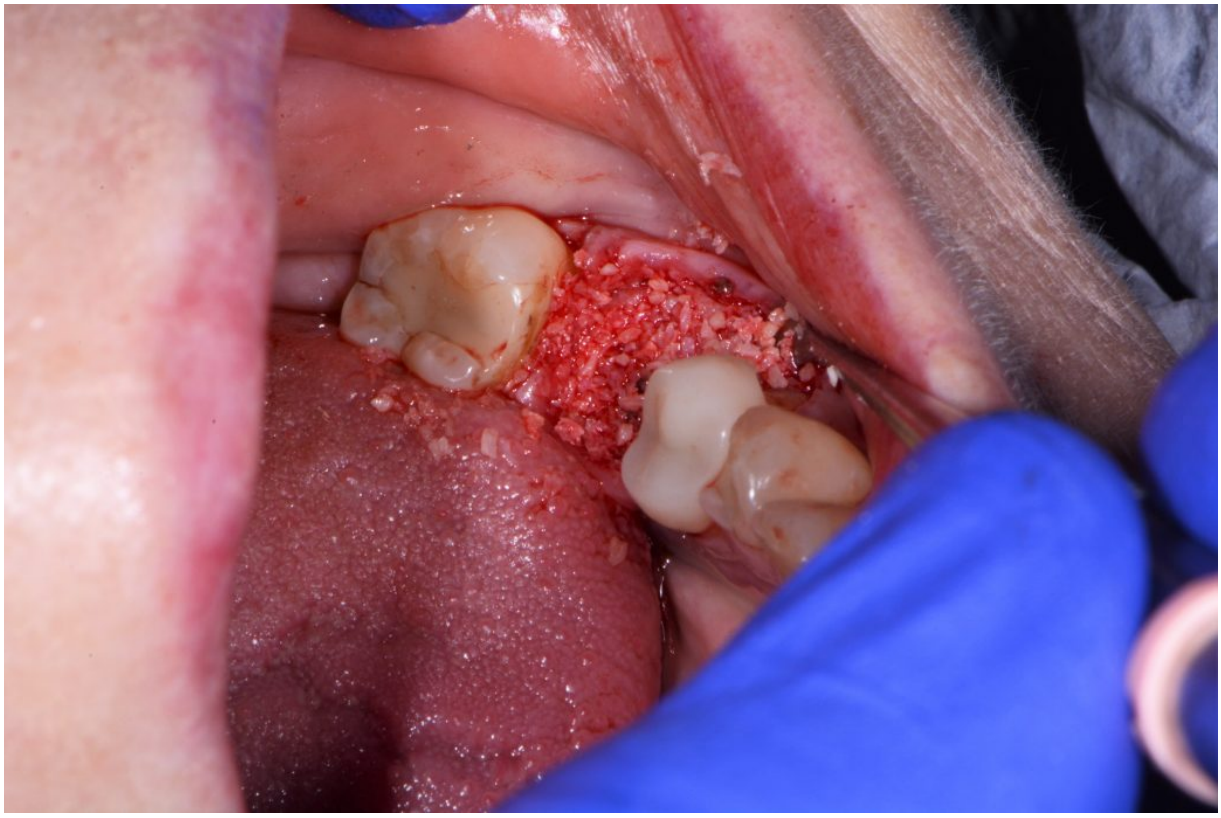
A Straumann 4.8 x 12 mm Implant was placed. 35ncm

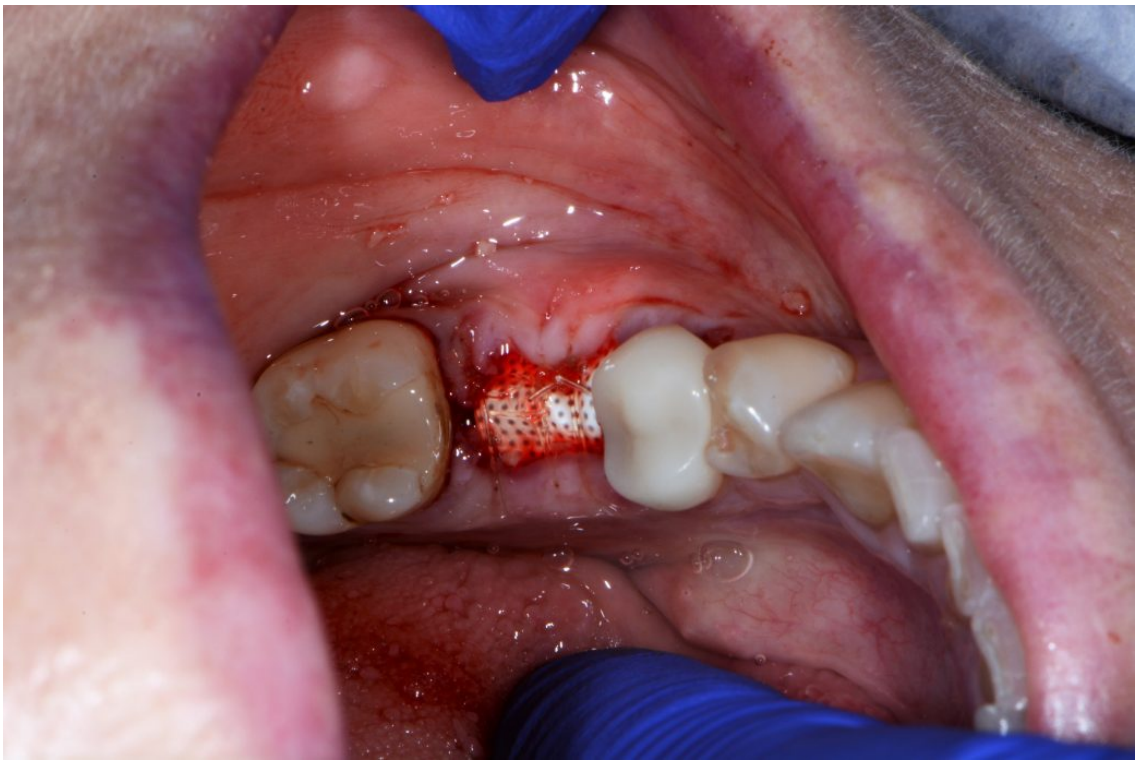
was achieved but I still placed a cover cap, grafted the remaining socket and placed a non resorbable membrane. I would rather let the gum heal then risk banging of the healing cap which might break my fibrin clot and cause a failure.

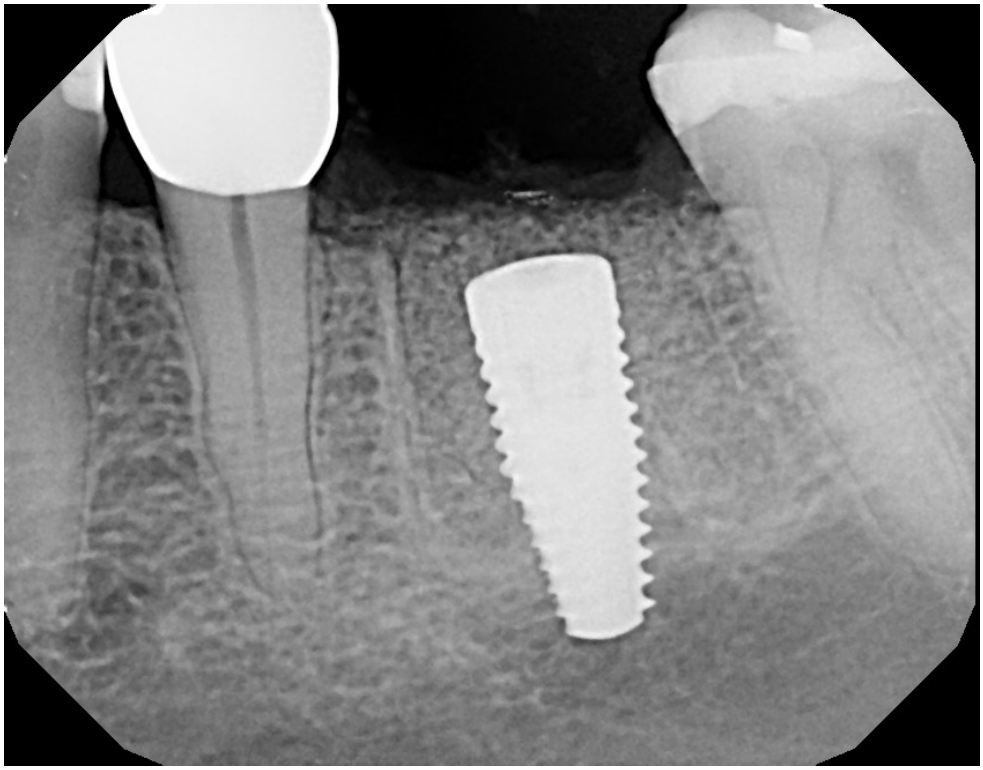












Remember when placing molar immediate implants you want predictability. As Dr. Engel says if you can place bone and titanium great, when in doubt, extract, graft, and come back and place another day.