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FULL-MOUTH IMMEDIATE REHABILITATION WITH BASAL
(CORTICAL) IMPLANTS COMBINED WITH SURGICAL
CORRECTION OF BIMAXILLARY DENTAL PROTRUSION:
A CASE REPORT

DR. SALEM BARMAWI, DR. AMINA SALEH ABDULBAKI

IMMEDIATE FUNCTIONAL REHABILITATION OF TERMINAL
DENTITION USING BCS® CORTICOBASAL® IMPLANTS:
A TWO-YEAR FOLLOW-UP CASE REPORT

DR. MOHAMMAD ABUSHAREKH

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FULL-MOUTH IMMEDIATE REHABILITATION WITH BASAL (CORTICAL) IMPLANTS COMBINED WITH SURGICAL CORRECTION OF BIMAXILLARY DENTAL PROTRUSION: A CASE REPORT

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Abstract

Background: Bimaxillary dental protrusion combined with posterior tooth loss creates a complex esthetic, functional, and psychological burden for affected patients. Conventional correction typically requires prolonged orthodontic treatment, often combined with premolar extractions or orthognathic surgery, followed by a separate implant-prosthetic phase to replace missing posterior teeth. Basal (cortical) implant systems, which anchor into resorption-resistant cortical bone and permit immediate functional loading, offer an alternative that allows simultaneous correction of alveolar protrusion and full-arch rehabilitation within a single, compressed treatment timeline.

Case Presentation: We report the case of a 57-year-old female patient who presented with severe bimaxillary anterior dental protrusion accompanied by multiple missing posterior teeth in both the maxilla and the mandible. The pronounced dentoalveolar protrusion had resulted in advanced gingival recession, with several teeth displaced beyond the confines of the alveolar housing due to excessive labial inclination and protrusion. The extensive posterior tooth loss,

together with the advanced dentoalveolar changes, had led to a loss of the vertical dimension of occlusion (VDO), resulting in an incorrect maxillo-mandibular relationship and significant occlusal dysfunction. The patient reported severe psychological distress, including repeated bullying and mockery from family members and people around her because of her dental and facial appearance, and requested a rapid, comprehensive solution.

Following clinical and radiographic (OPG) assessment, a combined surgical-prosthetic protocol was carried out in a single treatment episode. All remaining compromised and malpositioned teeth were extracted, and approximately 7 mm of protrusive alveolar bone was resected from the maxilla to correct the dentoalveolar profile and expose a level cortical bed. Ten immediate Corticobasal® implants (Manufacturer: Dr. Ihde Dental AG, Dorfplatz 11, 8737 Gommiswald, Switzerland) were then placed in the maxilla. The identical protocol extraction, alveolar bone resection, and implant placement was subsequently carried out in the mandible, where eight additional basal implants were placed, for a total of

eighteen basal implants across both arches. Treatment continued with metal framework try-in, occlusal verification, and delivery of the final fixed prosthesis.

Conclusion: Combining surgical reduction of the protrusive alveolar segment with immediate basal implant placement allows simultaneous correction of bimaxillary protrusion and full-arch rehabilitation of missing posterior teeth in a markedly shortened treatment timeline compared to conventional orthodontic-surgical implant sequencing. In a patient whose primary complaint was esthetic and psychosocial, the rapid transformation of facial profile and dental appearance provided substantial functional and psychological benefit.

Keywords: Corticobasal® implants; cortical anchorage; bimaxillary dental protrusion; pre-implant bone reduction; immediate functional loading; full-mouth rehabilitation; dento-facial esthetics; psychosocial impact of malocclusion.

1. Introduction

Bimaxillary dental protrusion and anterior positioning of the maxillary and mandibular dentoalveolar segments beyond the ideal skeletal profile is a common cause

of lip incompetence, an unesthetic convex facial profile, and significant psychosocial burden. Patients with this condition frequently report being subjected to teasing, mockery, or bullying regarding their appearance, which can profoundly affect self-esteem, social confidence, and quality of life. When bimaxillary protrusion is compounded by loss of posterior teeth, patients face a combined esthetic and functional deficit that is considerably more difficult to manage.

The conventional approach to correcting dentoalveolar protrusion relies on comprehensive orthodontic treatment, frequently combined with premolar extractions or, in more severe skeletal cases, orthognathic surgery, followed sequentially by implant placement to restore missing posterior teeth once orthodontic movement is complete and healing has occurred. This staged approach can require several years to complete and imposes a substantial cumulative burden, which may be poorly tolerated by patients experiencing acute psychological distress related to their appearance. It should be mentioned here also that earlier treatments with fixed orthodontic appliances have found to be the reason for

generalized and early tooth loss as well as indication for complete implants rehabilitation due to that orthodontic treatment^{10,11,12}. Considering the severe side effects, an orthodontic treatment would have been no option for this patient.

Cortical and basal implants offer a fundamentally different treatment paradigm. Rather than repositioning teeth orthodontically, the protrusive alveolar bone segment itself can be surgically reduced at the time of tooth extraction, correcting the dentoalveolar profile directly, while immediately loadable basal implants are anchored into the underlying dense cortical bone, a region that is resistant to resorption and is not compromised by the protrusive or resorbed crestal bone above it. This combined surgical-prosthetic approach allows correction of both the esthetic deformity and the missing dentition within a single, markedly compressed treatment episode.

This case report documents the full-mouth rehabilitation of a 57-year-old female patient with severe bimaxillary dental protrusion, bilateral posterior tooth loss in both arches, and substantial psychological distress attributed to bullying from family members and those around her.

Treatment combined extraction of the remaining compromised dentition, surgical resection of approximately 7 mm of protrusive alveolar bone in each jaw, and immediate placement eighteen basal implants in total, followed by immediate provisional loading and delivery of the final fixed prostheses.

2. Diagnosis: Clinical And Radiographic Assessment

2.1 Patient Profile

The patient was a 57-year-old female who presented with chief complaints of severe protrusion of the upper and lower anterior teeth, an unesthetic facial profile, difficulty chewing due to the loss of multiple posterior teeth in both jaws, and marked psychological distress. The patient reported that she had been repeatedly bullied and mocked by family members and by people around her because of her dental and facial appearance, and she expressed a strong wish for rapid, comprehensive correction. Her medical history was unremarkable, with no identified contraindications to extraction, alveolar surgery, or implant placement.

2.2 Extraoral and Intraoral Examination

Extraoral examination revealed marked bimaxillary dental protrusion with incompetent lip seal at rest and a convex facial profile.

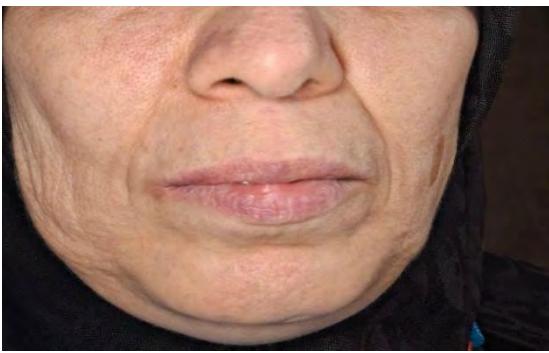


Fig. 1: Pre-operative extraoral frontal photograph showing lip incompetence and dental / facial appearance secondary to bimaxillary dental protrusion.



Fig. 2: Pre-operative extraoral lateral (profile) photograph showing a convex facial profile and protrusive lip line.

Intraoral examination confirmed severely proclined and irregularly spaced maxillary and mandibular anterior teeth, with generalized diastemas, occlusal disharmony, and bilateral loss of posterior teeth in both the maxilla and the mandible. Remaining teeth demonstrated variable mobility, and at least one grossly carious, non-restorable molar was identified.



Fig. 3: Pre-operative intraoral photograph – frontal occlusal view showing bimaxillary anterior protrusion, irregular spacing, and posterior edentulous segments.



Fig. 4: Pre-operative intraoral photograph – anterior view showing midline diastema and proclined maxillary and mandibular incisors.



Fig. 5: Pre-operative intraoral photograph – lateral view showing a grossly carious mandibular molar and posterior tooth loss.



Fig. 6: Pre-operative intraoral photograph – tongue-retracted view confirming posterior mandibular tooth loss and irregular remaining dentition.

The clinical findings confirmed a complex full-mouth rehabilitation case characterized by severe bimaxillary dentoalveolar protrusion, bilateral posterior tooth loss in both arches, compromised residual dentition, and a substantial esthetic and psychosocial burden.

2.3 Radiographic Assessment

Panoramic radiography (OPG) was performed. Radiographic findings included:

- Generalized horizontal bone loss in the posterior segments of both arches, with edentulous ridges bilaterally.

- A markedly procumbent anterior alveolar bone contour in both the maxilla and the mandible, consistent with the clinically observed dental protrusion.
- Periapical and periodontal changes associated with several of the remaining anterior teeth.
- Adequate cortical bone thickness in the basal (cortical) regions of both jaws including the pterygo-maxillary buttress region, the posterior mandibular cortex, and the symphyseal region confirming suitability for basal implant placement once the protrusive alveolar segment was reduced.

Diagnosis: Bimaxillary dentoalveolar protrusion with bilateral posterior edentulism, compromised anterior dentition, and associated esthetic and psychosocial impairment.



Fig. 7: Pre-operative panoramic radiograph showing partial edentulism with missing teeth in the upper and lower arches, existing restorations on the upper right premolar and upper left molar, and a tilted / malpositioned upper left molar requiring evaluation prior to treatment.

3. Treatment Plan

3.1 Treatment Rationale

Given the severity of the dentoalveolar protrusion, the bilateral loss of posterior teeth in both arches, and the patient's urgent request for a rapid esthetic and functional solution in view of her psychological distress, it was decided to avoid prolonged conventional orthodontic treatment and instead pursue a combined surgical reduction and immediate full-mouth basal implant rehabilitation. The key objectives were:

- Extraction of all remaining non-restorable and malpositioned teeth in both arches.

- Surgical resection of approximately 7 mm of the protrusive alveolar bone segment in each jaw to correct the dentoalveolar profile and expose a level cortical bed. Immediate provisional loading within 24 to 72 hours with a fixed prosthesis.
- Placement of multiple basal implants in both arches, utilizing dense cortical bone and bypassing the compromised, protrusive alveolar bone.
- Immediate provisional loading with a fixed metal framework.
- Final full-arch prosthetic rehabilitation restoring an ideal occlusal relationship and a corrected facial profile.

No orthodontic tooth movement, sinus lifting, or staged bone grafting was planned.

3.2 Surgical Protocol

After completion of the required medical evaluation and confirmation that the patient had no contraindications to surgical intervention, the procedure was performed under local anesthesia. The remaining maxillary teeth were extracted, and approximately 7 mm of the protrusive maxillary alveolar bone was

then resected using a surgical bur / piezo device to correct the procumbent alveolar contour and to expose a level, dense cortical bed suitable for implant anchorage.

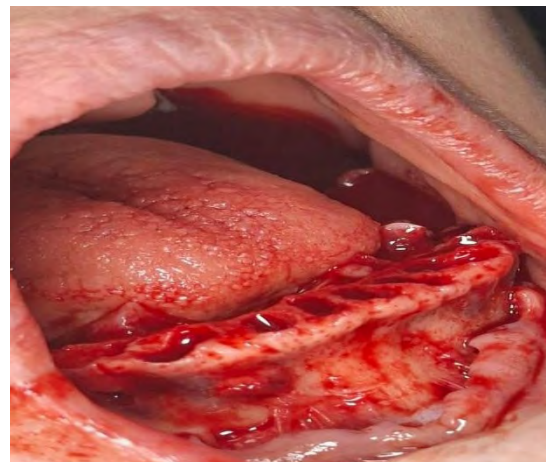


Fig. 8: Intra-operative photograph immediately following extraction and osteotomy, showing the resected alveolar ridge with active bleeding.

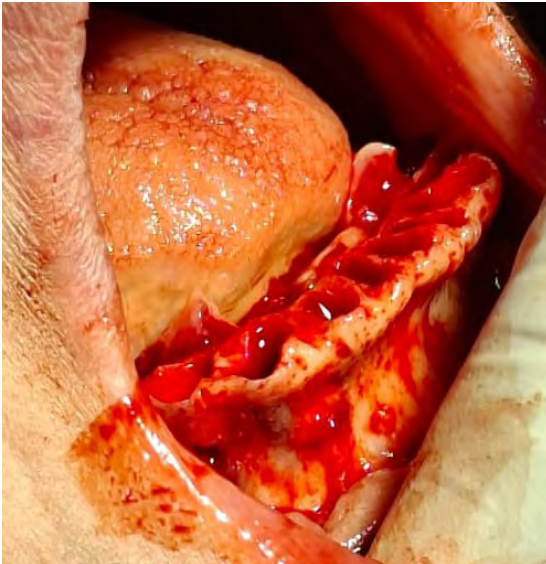


Fig. 9: Intra-operative photograph – close-up of the prepared alveolar ridge after bone resection, in preparation for basal implant placement.

Ten immediate basal implants were placed in the maxilla, engaging the dense cortical bone exposed by the alveolar resection. The identical surgical sequence extraction, resection of approximately 7 mm of protrusive alveolar bone, and implant placement was then carried out in the mandible, where six polished cortical and basal implants (BCS®, Manufacturer: Dr. Ihde Dental AG, Switzerland) were placed in addition to the two conical compression screws (TPG® uno, Manufacturer: Dr. Ihde Dental AG, Switzerland).

Eighteen cortical and basal implants in total were inserted across both arches. The extracted teeth and the resected segments of alveolar bone were retained for documentation.



Fig. 10: Photograph of the extracted teeth together with the resected segment of alveolar bone (approximately 7 mm), retrieved during ridge reduction.

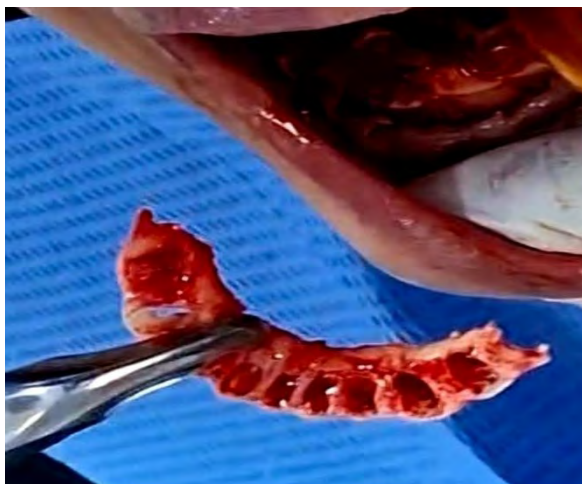


Fig. 11: Close-up intra-operative photograph of the resected alveolar bone segment held with surgical forceps, illustrating the extent of ridge reduction.



Fig. 12: Post-operative panoramic radiograph of the mandible showing a full-arch implant-supported fixed prosthesis (bridge) with multiple dental implants placed bilaterally in the posterior and anterior regions, while the upper arch shows natural anterior teeth with no implants.



Fig. 13: Intra-operative photograph showing the immediate basal implant abutments in place with sutures, prior to framework try-in.

3.3 Metal Framework Try-In and Occlusal Adjustment

A working impression was recorded to capture the implant positions, and a master model incorporating implant analogs was fabricated to guide construction of the immediate metal framework.



Fig. 14: Working impression showing implant transfer components and analogs, used for fabrication of the immediate metal framework.

The metal framework was then seated over the implant abutments in both arches, and the accuracy of fit, passive insertion, and inter-arch relationship were carefully evaluated. Bite registration was taken for both the maxillary and mandibular arches to guide the final prosthetic arrangement, correction of the dental protrusion, and occlusal adjustment.

A total of eighteen immediate basal implants were placed, ten in the maxilla and eight in the mandible. Implant type and length were selected according to the density and thickness of the available cortical bone at each site following alveolar resection. The distribution is summarized below.



Fig. 15: Post-operative panoramic radiograph showing bilateral full-arch implant-supported fixed prostheses in both the maxilla and mandible, with multiple dental implants placed throughout both arches supporting complete edentulous rehabilitation.

4. Results and Follow-Up

4.1 Immediate and Short-Term Outcomes

The surgical phase was completed uneventfully without intra-operative complications. Post-operative discomfort was managed with standard analgesics and antibiotics. All eighteen basal implants demonstrated satisfactory primary stability at the time of placement, allowing progression to immediate prosthetic rehabilitation. The provisional metal frameworks were fitted within a short interval and immediately restored a corrected anterior tooth position, improved lip support, and functional occlusion.

The patient reported immediate satisfaction with the visible correction of her facial profile and dental appearance, and expressed considerable relief regarding the psychological distress she had previously experienced. Post-operative healing showed progressive mucosal healing around all implant abutments, with no signs of infection or peri-implant complications.

4.2 Final Prosthetic Delivery

Following framework verification and bite registration, the final prosthetic teeth were fitted and clinically evaluated.

Occlusal assessment confirmed a stable maxillo-mandibular relationship, a corrected anterior tooth position with resolution of the previous protrusion, and restoration of full posterior support in both arches. The patient was instructed to begin using the prosthesis for mastication and gradual functional adaptation, and definitive prosthetic cementation was subsequently completed.



Fig. 16: Final clinical photograph showing a close-up smile view of the upper anterior teeth, demonstrating a natural-looking, well-aligned fixed prosthesis with good gingival health and esthetic outcome.



Fig. 17: Final clinical intraoral photograph with cheek retractors showing a full-arch fixed prosthesis in both the upper and lower jaws, demonstrating good occlusion, symmetry, and healthy surrounding soft tissue.



Fig. 18: Final clinical photograph – lateral (profile) view of the patient smiling, showing natural lip support and a harmonious facial profile with the final anterior dental restoration in view.

4.3 Follow-Up

Follow-up examinations at one, three, and six months post definitive loading confirmed:

- Stable peri-implant soft tissue health with no signs of peri-implantitis.
 - Radiographically stable bone levels around all implant bodies.
 - No prosthetic complications (no fractures, no de-cementation, no screw loosening).
 - A markedly corrected dentofacial profile with resolution of the pre-treatment bimaxillary protrusion.
 - Patient-reported outcomes: high satisfaction with function, esthetics, and a substantial improvement in self-confidence and psychological wellbeing, with resolution of the distress previously associated with bullying.
- No sinus floor elevation procedure required.
 - No staged bone grafting or augmentation performed.
 - Immediate provisional loading of all eighteen implants.
 - Markedly shortened total treatment time compared with orthodontic-surgical implant sequencing.
 - Significant improvement in facial esthetics and psychological wellbeing.

4.4 Summary of Clinical Advantages

- Single-episode surgical correction of severe bimaxillary dental protrusion without conventional orthodontic treatment.
- Simultaneous rehabilitation of bilateral posterior edentulism in both arches.

5. Discussion

Bimaxillary dental protrusion combined with posterior tooth loss represents a particularly challenging clinical scenario, as it requires simultaneous correction of the dentoalveolar profile and reconstruction of missing posterior support. Conventional management and comprehensive orthodontic treatment, often combined with premolar extractions, followed sequentially by implant placement, can require an extended treatment period that may be poorly tolerated by patients experiencing significant psychosocial distress related to their appearance, as was reported in this case.

Surgical resection of the protrusive alveolar segment at the time of extraction allows direct correction of the dentoalveolar profile without relying on orthodontic tooth movement. When combined with immediately loadable basal implants anchored into the underlying dense cortical bone, this approach allows both the esthetic deformity and the missing dentition to be addressed within a single, markedly compressed treatment episode.

The decision to resect approximately 7 mm of alveolar bone in each jaw was based on the degree of protrusion observed clinically and radiographically, and was performed to expose a level, dense cortical bed capable of providing high primary implant stability. High primary stability achieved through cortical anchorage enabled immediate splinting of the implants with a fixed provisional restoration, consistent with the immediate loading protocols described for basal (cortical) implant systems.

From a patient-centered perspective, the psychosocial impact of visible dental protrusion, including the bullying reported by this patient from family members and those around her, should not be un-

derestimated. The ability to deliver a substantially corrected dentofacial appearance together with a fixed, functional dentition within a compressed treatment timeline offers considerable psychological benefit in addition to the functional and esthetic outcomes achieved.

The patient had developed a compensatory habitual smile pattern due to her previous severe dentoalveolar and skeletal protrusion. Before surgery, she habitually forced her upper lip to cover her prominent teeth and protrusive maxillo-mandibular profile. Despite successful orthognathic correction, this compensatory lip posture has persisted as a learned behavioral habit and remains evident during smiling.

6. Conclusion

This case report demonstrates that combining a full extraction in both jaws with vertical surgical resection of a protrusive alveolar segment with immediate Corticobasal® implant placement is a viable approach for the simultaneous correction of severe bimaxillary dental protrusion and rehabilitation of bilateral posterior edentulism in both arches.

The technique achieved a corrected dentofacial profile, restored full-arch function at an adequate vertical dimension, and provided substantial psychological benefit within a markedly shortened treatment timeline compared with conventional orthodontic-surgical implant sequencing. The six-month follow-up data confirm stable peri-implant tissues, prosthetic integrity, and high patient satisfaction.

Careful case diagnostics regarding the bi-alveolar protrusion, precise surgical execution of the alveolar reduction, and thorough prosthetic planning remain critical to the long-term success of this combined approach. Continued follow-up, typically after three months and then every twelve months (the so-called Belgrade protocol), will guarantee the predictability of the treatment modality shown here. Long-term observations give proof that this treatment and following the follow-up protocol strictly yields stable results with zero losses of BIPS® after year four. Corticobasal® implants undergo a dynamic interaction with the peri-implant bone and therefore, these implants will potentially stay in and functional forever⁸.

This new implant technology shows optimal long-term results, it avoids the hassles of peri-implantitis as well as bone augmentations and all kind of healing times. This technology is today the specialist standard, the patients' first method of choice, and it replaces the formerly used technology of "osseointegration"¹³.

Implant No.	Jaw	Region / Tooth Position	Implant Type	Length (mm)
1	Maxilla	Floor of the nose	BCS®	20*3
2	Maxilla	Floor of the nose	BCS®	20*3
3	Maxilla	Floor of the nose	BCS®	20*3
4	Maxilla	Floor of the nose	BCS®	20*3
5	Maxilla	Floor of the nose	BCS®	20*3
6	Maxilla	Floor of the nose	BCS®	20*3
7	Maxilla	Floor of the nose	BCS®	14*4.5
8	Maxilla	Floor of the nose	BCS®	14*4.5
9	Maxilla	Sphenoid bone	BCS®	20*4.5
10	Maxilla	Sphenoid bone	BCS®	20*4.5
11	Mandible	Chin	BCS®	20*3
12	Mandible	Chin	BCS®	20*3
13	Mandible	Chin	TPG® uno	19*3.5
14	Mandible	Chin	TPG® uno	15*3.5
15	Mandible	Mylohyoid region	BCS®	17*3.5
16	Mandible	Mylohyoid region	BCS®	17*4.5
17	Mandible	Mylohyoid region	BCS®	14*3.5
18	Mandible	Mylohyoid region	BCS®	14*4.5

Table 1: Distribution and characteristics of the immediate basal implants placed in the maxilla and mandible.

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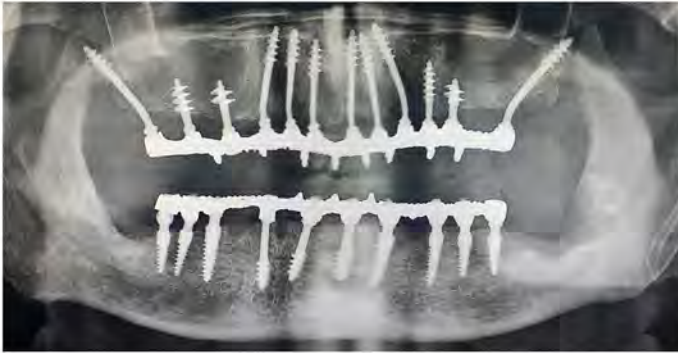
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ⁱ The journals of the International Implant Foundation IF® do not operate within the doubtful system of "Impact Factors". Our authors must calculate their own Experience Factor and provide evidence of this factor to the reviewers. The Experience Factor is obtained by multiplying the number of implants placed or prosthetically restored by the years of their observation. The other important metric is the number of years (NOY) spent working with implants prosthetically or surgically (C. Fodor, A. Ihde, S. Ihde, O. Šipić, Ł. Pałka, A. Lazarov: The "Experience Factor" – an alternative to "Peer Reviews" and "Impact Factors" in oral implantology and a method to assess the experience of court experts and authors in the medical field. CMF Impl Dir 2020; 14: 175–182). The EF and NOY of several authors may be added together or stated separately in one publication.

Abstract

Background: Rehabilitation of terminal dentition remains a major challenge in implant dentistry. Conventional implant protocols frequently require staged treatment approaches involving bone augmentation procedures and delayed loading. Corticobasal® implantology offers an alternative treatment philosophy based on strategic cortical anchorage and immediate functional loading.

Case Presentation: A 44-year-old medically fit, non-smoking female presented with terminal dentition characterized by extensive carious destruction, compromised remaining teeth, and impaired masticatory function. Clinical and radiographic examinations revealed poor restorative prognosis of the remaining dentition. The patient requested a fixed prosthetic rehabilitation with immediate restoration of function and esthetics.

Intervention: All remaining teeth were extracted during a single surgical session. Twenty-one BCS® Corticobasal® implants (Dr. Ihde Dental AG, Switzerland) were immediately inserted according to the principles of strategic implantology. Thirteen implants were placed in the maxilla and eight implants in the mandible.

A metal-acrylic cross-arch splinted prosthesis was delivered 72 hours after surgery and cemented using Fuji Plus glass ionomer cement. Following one year of successful function, the provisional restoration was removed to permit direct clinical evaluation of all implants prior to fabrication of the definitive prosthesis.

Outcome: Clinical examination after one year revealed no implant mobility, pain, suppuration, or other signs of biological complications. A definitive prosthetic rehabilitation was subsequently delivered. Clinical and radiographic follow-up at two years demonstrated maintenance of implant stability and prosthetic function without major complications.

Conclusion: This case demonstrates that immediate rehabilitation using BCS® Corticobasal® implants may provide a predictable graftless treatment modality for patients with terminal dentition. The favorable outcomes observed after two years support the concept of strategic cortical anchorage combined with immediate functional loading.

Keywords: Corticobasal® implant; BCS® implants; immediate loading; osseofixation; Strategic Dentistry®; terminal dentition.

Introduction

Terminal dentition frequently requires comprehensive rehabilitation to restore oral function and esthetics. Conventional implant treatment protocols often involve multiple surgical interventions, delayed loading periods, and bone augmentation procedures, resulting in increased morbidity, prolonged treatment duration, and higher treatment costs.

Corticobasal® implantology represents an alternative treatment approach based on engagement of highly mineralized cortical bone structures to obtain immediate implant stability. This treatment philosophy permits immediate functional loading and frequently eliminates the need for augmentation procedures^{2,3}.

The unique design characteristics of BCS® implants may further contribute to favorable biomechanical behavior. From an orthopedic perspective, this concept resembles the principle of bone sharing rather than bone bearing, whereby both the implant and surrounding skeletal structures participate in load transmission. Such an approach may potentially reduce the adverse effects associated with stress shielding and disuse-related bone remodeling^{4,5}.

This report describes the immediate full-mouth rehabilitation of a medically fit female patient presenting with terminal dentition using BCS® Corticobasal® implants with clinical and radiographic follow-up extending over two years.

Case Presentation

Indications and alternative treatments:

A 44-year-old female patient presented seeking a **fixed solution** to restore masticatory function and esthetics. As the patient lived in an area of constant civil war and wars as well as with constantly increasing inflation, a “conventional implant treatment” lasting 8 to 15 months or longer was of course not acceptable.

The patient was medically fit and reported no relevant systemic diseases. She was a non-smoker.

Clinical examination revealed terminal maxillary dentition characterized by multiple grossly decayed teeth exhibiting extensive coronal destruction and poor restorative prognosis (Figure 1). The patient complained of compromised chewing ability and dissatisfaction with the existing dentition.

Panoramic radiographic evaluation confirmed the compromised condition of the

remaining dentition and supported the diagnosis of terminal dentition requiring comprehensive rehabilitation (Figure 2). After discussing available treatment alternatives, the patient elected to undergo immediate rehabilitation using Corticobasal® implants.

Treatment Objectives

1. Elimination of teeth in general
2. Immediate restoration of masticatory function with the help of implants and fixed (cemented) bridges
3. Provision of a fixed prosthetic rehabilitation
4. Avoidance of bone augmentation procedures
5. Rapid restoration of esthetics and quality of life

Surgical Procedure

Under local anesthesia, all remaining teeth with hopeless prognosis were extracted atraumatically during a single surgical appointment. Extraction sockets were thoroughly debrided.

Immediately following extraction, a total of 21 BCS® / Corticobasal® implants (Manufacturer: Dr. Ihde Dental AG,

Switzerland) were inserted according to the principles of Strategic Dentistry®. All implants had a diameter of 3.5 mm. For each site, the correct surgical IF® Method (IFM) was applied⁷.

Maxillary Implant Distribution

Thirteen BCS® implants were placed in the maxilla. All implants measured 3.5 × 23 mm and were strategically distributed to maximize cortical engagement and optimize biomechanical load transmission.

Mandibular Implant Distribution

Eight BCS® implants were placed in the mandible as follows:

Lower right posterior region (IFM 5a)

- Two BCS® implants measuring 3.5 × 17 mm with lingual cortical engagement

Anterior mandible (IFM 2)

- One BCS® implant measuring 3.5 × 23 mm
- One BCS® implant measuring 3.5 × 20 mm
- Two BCS® implants measuring 3.5 × 23 mm

Lower left posterior region (IFM 5a)

- Two BCS® implants measuring 3.5 × 17 mm with lingual cortical engagement

High primary stability was achieved in all implants through strategic cortical anchorage, allowing immediate functional loading.

Immediate post-operative radiographic evaluation confirmed satisfactory implant positioning and favorable implant distribution throughout both arches (Figures 3 and 4).

Prosthetic Rehabilitation

Following implant placement, impressions were obtained for fabrication of a cross-arch splinted metal-acrylic fixed prosthesis.

The provisional prosthesis was delivered 72 hours after surgery and cemented using Fuji Plus glass ionomer luting cement (GC Corporation, Japan). Occlusal adjustments were performed to establish favorable functional relationships and minimize unfavorable loading conditions.

The metal-acrylic prosthesis successfully restored esthetics, phonetics, and masticatory function and remained in service for one year.

After one year of successful function, the provisional restoration was sectioned and removed to facilitate direct clinical evaluation of each implant individually. The assessment revealed:

- Absence of implant mobility
- No pain or discomfort
- No suppuration or signs of infection
- Healthy peri-implant soft tissues

Following confirmation of favorable implant conditions, a definitive fixed prosthetic rehabilitation was fabricated and delivered (Figure 7).

Follow-Up and Outcomes

The patient attended regular follow-up visits for clinical and radiographic evaluation.

One year after treatment, direct clinical examination of all implants demonstrated favorable biological conditions without evidence of implant failure.

At the two-year follow-up examination:

- No implant mobility was detected.
- No biological complications requiring intervention were observed, no peri-implantitis was found.
- No prosthetic failure occurred.

- The definitive prosthesis remained stable and functional.
- The patient reported substantial improvement in comfort and chewing ability.
- The patient expressed high satisfaction with the esthetic outcome.
- No clinical or radiographic evidence of any implant failure according to the 1st Consensus Document of the International Implant Foundation IF®⁶.

Radiographic evaluation demonstrated maintenance of implant stability and preservation of the prosthetic reconstruction without evidence of progressive pathological bone loss (Figure 8).

Discussion

The present case demonstrates the successful rehabilitation of terminal dentition using Corticobasal® implantology combined with immediate functional loading.

Unlike conventional implant protocols that frequently depend upon adequate alveolar bone volume and may necessitate augmentation procedures, Corticobasal® implants rely upon strategic

cortical anchorage to achieve high primary stability and permit immediate restoration of function^{2,3}.

An important feature of the present case was the use of a metal-acrylic cross-arch splinted prosthesis during the first year following implant placement. This approach permitted immediate functional loading while allowing subsequent direct clinical evaluation of each implant prior to fabrication of the definitive prosthesis. The absence of mobility, pain, suppuration, or other clinical signs of implant failure during this reassessment provided additional support for the predictability of this treatment approach.

Furthermore, the isoelastic characteristics associated with BCS® implants may facilitate a more physiological transfer of functional forces to the surrounding skeletal structures. From an orthopedic perspective, this concept resembles the principle of bone sharing rather than bone bearing, in which the implant and supporting bone collectively participate in load transmission. Such a biomechanical philosophy may potentially reduce the adverse effects associated with stress shielding and disuse-related bone remodeling^{4,5}.

The favorable clinical and radiographic findings observed over the two-year follow-up period support the potential benefits of strategic cortical anchorage combined with immediate functional loading.

Nevertheless, further prospective investigations involving larger patient populations and longer observation periods are required to strengthen the evidence supporting this treatment modality.

Our patient had decided to remove all teeth at a stage where 11 teeth in the upper jaw and 7.5 teeth in the lower jaw were still present. Ihde et al⁸ reported in a prospective cohort study from Switzerland that the average patient that comes for consultation there will decide for total tooth removal at a time-point when around 8 teeth per jaw are left. This case fits to the result of Ihde et al⁸, because in the lower jaw, 7.5 teeth were still present and 7 of them were functional. The fact that more (but useless) teeth without antagonist were present in the upper jaw shows one more time that patients will at this stage of decay rather get all teeth removed than keep teeth in and request another round of restauration of teeth that will make the upper jaw ad-

equate for an immediately loaded implant restauration in the lower jaw. Ihde et al⁹ reported in a 12-year prospective cohort study (done without any patient selection) after treating 1640 full jaws and placing more than 17.000 controlled implants, using a well-established immediate functional loading protocol, a rate of 94% successful and healthy reconstructions, without observing any peri-implantitis. A comparative study that served as control found after the same time only 22% to 30% of the cases to be successful and healthy. Most of the reconstructions were hit by chronic peri-implant mucositis or peri-implantitis and did not fulfill the criteria of being “healthy”.

All patients in the studies published by Ihde et al^{8,9} were aware that the natural dentition is the main cause of their oral problems: more than 99% of all problems in the oral cavity are connected to natural teeth. The demand of dental chambers and some universities to “maintain natural teeth whatever the costs” seems therefore driven by financial interests and contradicts the wishes of patients.

Conclusion

Immediate full-mouth rehabilitation using BCS® / Corticobasal® implants allows successful restoring of function and esthetics in a medically fit, non-smoking female presenting with terminal dentition.

The favorable clinical and radiographic outcomes observed after two years suggest that Corticobasal® implantology may be used as a viable graftless alternative for comprehensive rehabilitation when immediate loading is desired.

Direct clinical reassessment of all implants following one year of function further supported the long-term stability and predictability of this treatment protocol.

Figures



Fig. 1: Pre-operative intraoral photograph demonstrating terminal dentition.



Fig. 2: Pre-operative panoramic radiograph.



Fig. 3: Intra-operative clinical photograph demonstrating immediate placement of BCS® implants.



Fig. 4: Immediate post-operative panoramic radiograph.

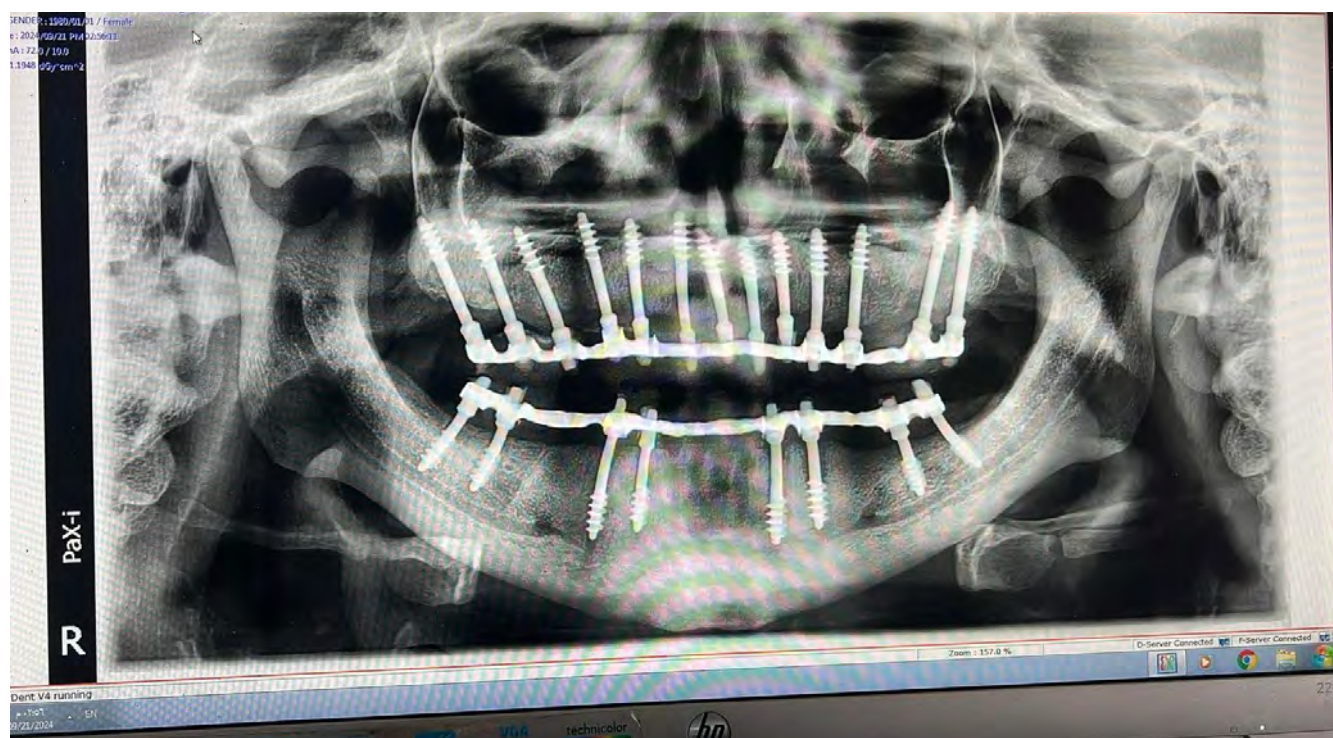


Fig. 5: One-year follow-up panoramic radiograph, showing a ring-bridge design of the prosthetic work pieces.



Fig. 6: Definitive prosthetic rehabilitation: Fixed PMMA bridges in both jaws. The frontal contacts visible here were removed during the control appointment in order to avoid the usage of an anterior pattern of chewing.

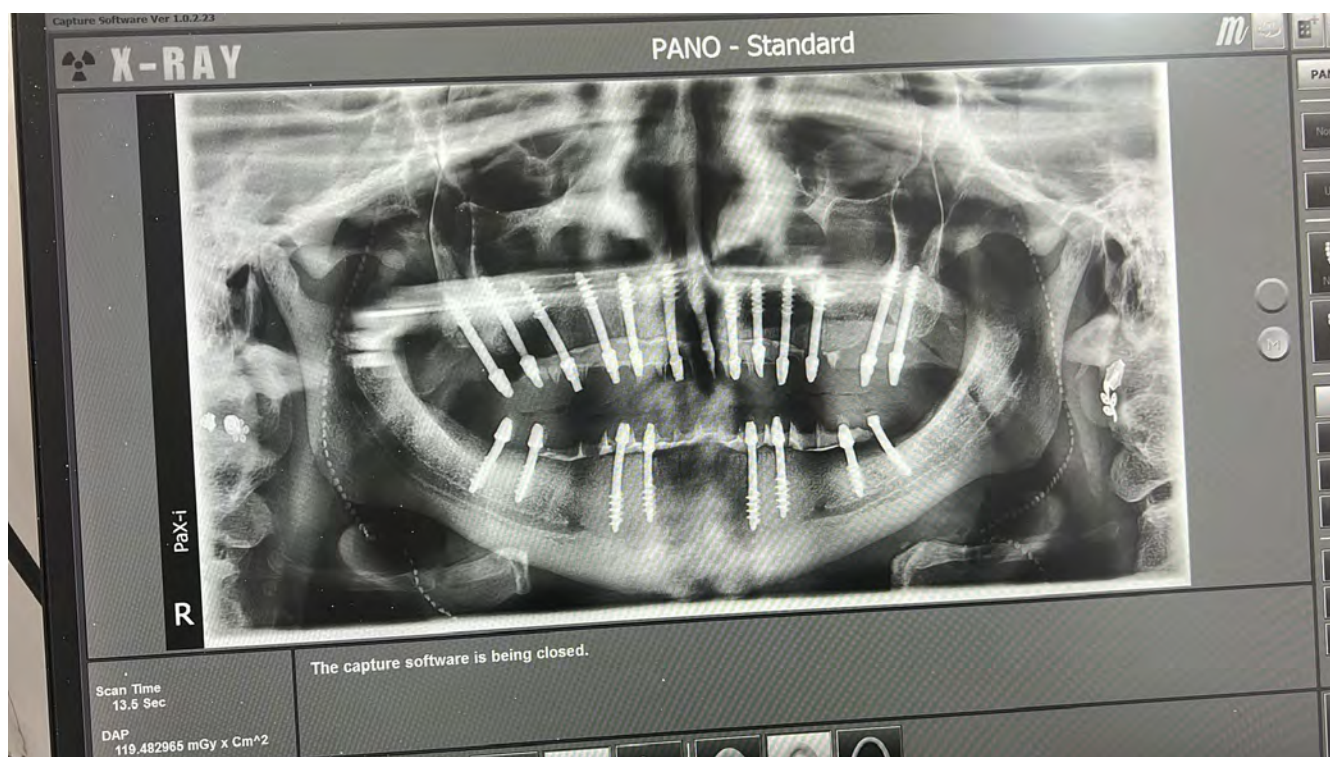


Fig. 7: Two-year follow-up panoramic radiograph, showing cemented PMMA bridges in both jaws.



Fig. 8: Direct clinical evaluation after sectioning and removal of the initial prosthesis, demonstrating healthy peri-implant soft tissues and favorable clinical conditions of the BCS® implants prior to delivery of the definitive prosthetic rehabilitation.

Declaration of Patient Consent

Written informed consent was obtained from the patient for publication of clinical photographs and radiographic records. The patient understood that all reasonable efforts would be made to preserve anonymity.

Conflict of Interest

The author declares no conflicts of interest related to this publication.

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16 Advantages of Osseofixation

Patients will hold you as their treatment provider, because you offer these advantages to them:

- | | | | |
|---|---|--|---|
| 1 Saves costs by 30-40% |  | 9 Aesthetic solutions for all patients |  |
| 2 Reduces treatment time by 98% |  | 10 Uninterrupted intra-bony perfusion |  |
| 3 Efficient workflow saves chair-time |  | 11 Easy long-term maintenance |  |
| 4 Immediate functional loading |  | 12 No peri-implantitis |  |
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| 6 Simple straight forward treatment |  | 14 Put more implants |  |
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 - Immediate implant placement
 - How to solve cases at all stages of atrophy
-

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 - Become a certified implantologist in just one week.
-

Conventional Implantology



1 Inspection Diagnostic procedures Treatment plan

2_a **Surgery 1**
Tooth removal

2_b **Surgery 2**
Bone augmentation/sinus-lifting
(necessary in up to 80% of the cases)

2_c **Surgery 3**
Implant placement
(adequate bone healing provided)

2_d **Surgery 4**
Placement of gingiva former

2_e Impression taking

3 Trying of the bridge frame
(5-10 days after impression taking)

4 Delivery of bridge (**4-24 months**
after implant placement)

Total

Treatment duration: 4 - 24 Months
Number of appointments: 7 - 12

Strategic Implant®



Inspection
Diagnostic procedures
Treatment plan

1

Removal of teeth, Implant
placement, Impression
& Bite taking

2

**Step 1 and 2 may be done in
the same (first) appointment.*

Trying of a sample bridge and aes-
thetic & functional corrections
(if required) **0 - 1 days** after
implant placement

3

Delivery of bridge (**1 - 3 days**
after implant placement)

4

Control of occlusion and
mastication

5

Total

Treatment duration: 2 - 4 Days
Number of appointments: 4 - 5

AIOW TEACHERS



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Surgical & Prosthetic Specialist and
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DR. MIGUEL

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DR. HABIB RITHA

I am very lucky to have learned this course. Thank you Dr Ihde for your generosity and your modesty. Thank you all to the team!

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Corticobasal® implants and its technology.**

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A world map in white silhouette on a dark blue background. A red circle with the letters 'SRB' in white is positioned over the Balkan region, specifically highlighting Serbia.

SRB

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