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

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

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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.

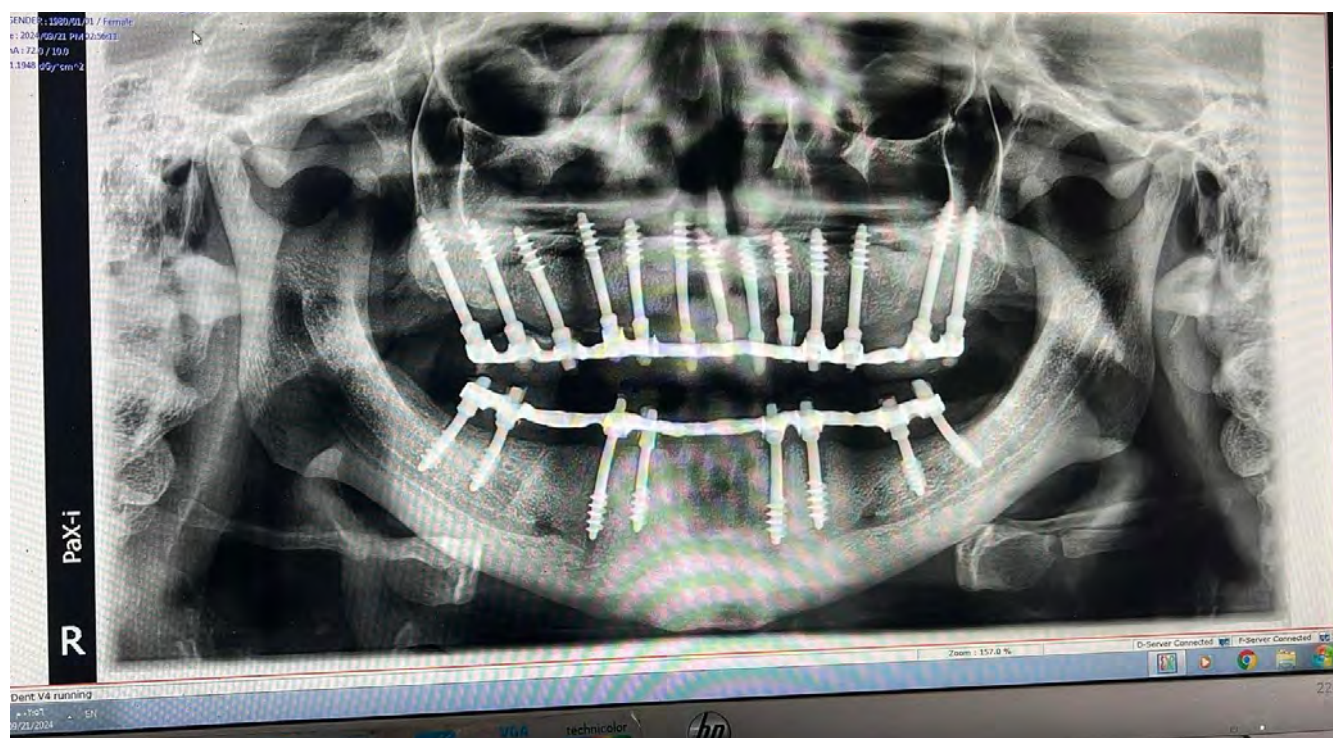


Fig. 5: One-year follow-up panoramic radiograph, showing a ring-bridge design of the prosthetic work pieces.



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.

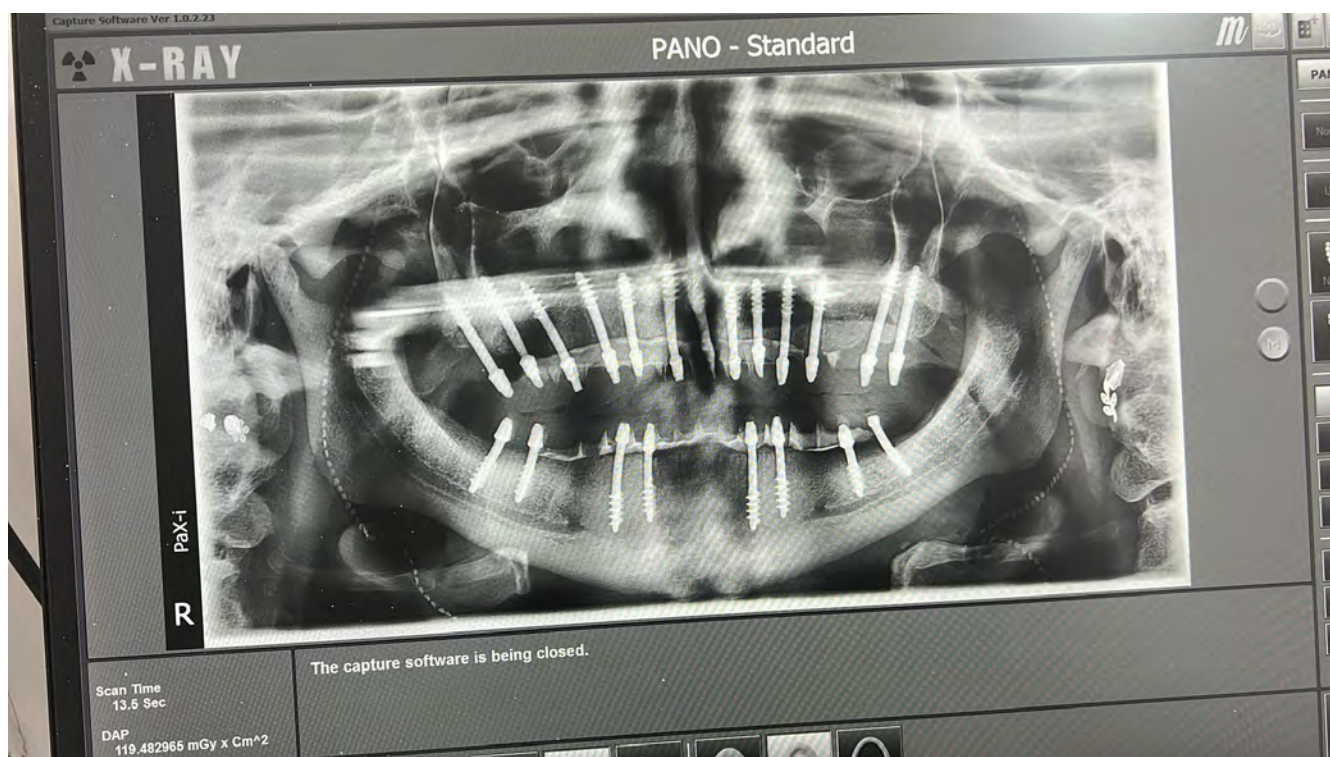


Fig. 7: Two-year follow-up panoramic radiograph, showing cemented PMMA bridges in both jaws.



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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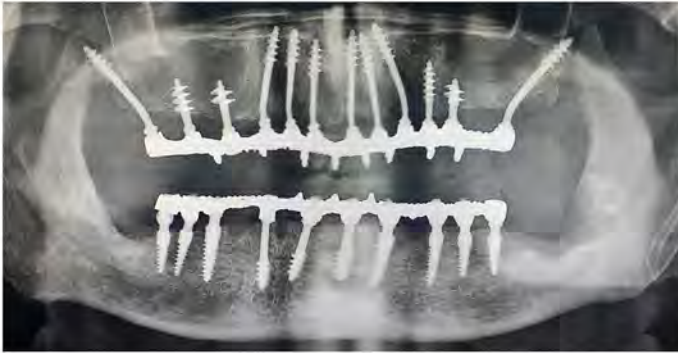
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| 1 Saves costs by 30-40% |  | 9 Aesthetic solutions for all patients |  |
| 2 Reduces treatment time by 98% |  | 10 Uninterrupted intra-bony perfusion |  |
| 3 Efficient workflow saves chair-time |  | 11 Easy long-term maintenance |  |
| 4 Immediate functional loading |  | 12 No peri-implantitis |  |
| 5 Low complication rate |  | 13 No patient selection |  |
| 6 Simple straight forward treatment |  | 14 Put more implants |  |
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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
1st Class IF[®] Teacher



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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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