Case Report

Neoss ProActive® Straight implants for the complete oral rehabilitation of a cancer patient.

Dr. AJ Ray-Chaudhuri, United Kingdom

Patient: 85-year old man, non-smoker, recurrent oral cancers.

Clinical situation: Successful long-term complete denture wearer until removal of an oral squamous carcinoma requiring new dentures.

Treatment plan: A complete obturator for the maxilla and complete denture for the mandible, both retained by four Neoss ProActive® Straight implants.

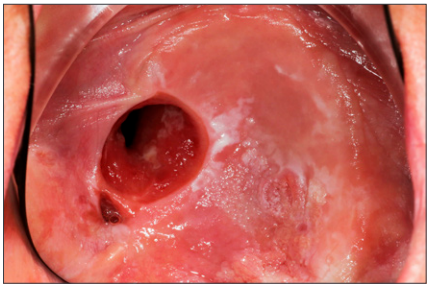


Figure 1

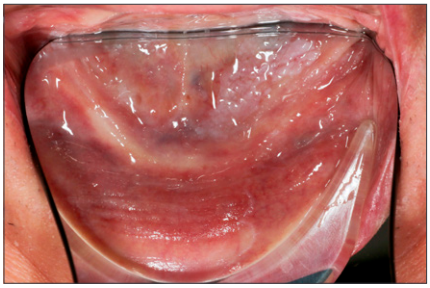


Figure 2

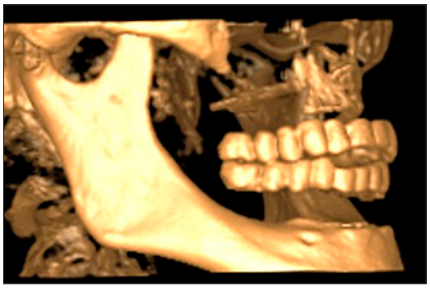


Figure 3

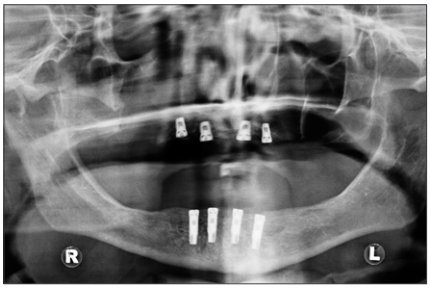


Figure 4

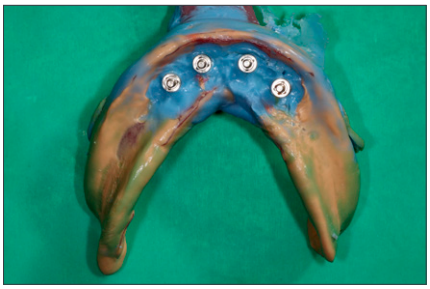
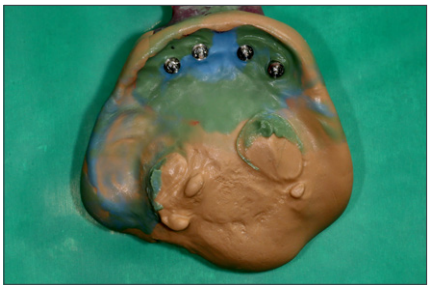


Figure 5



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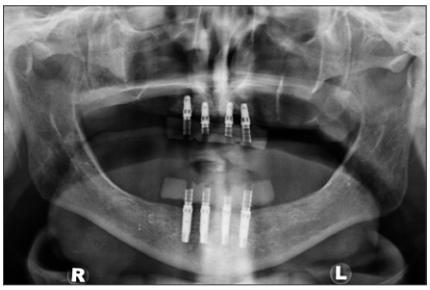

Figure 7

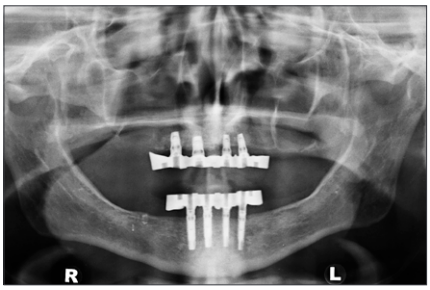

Figure 8

An 85-year old man, non-smoker with ischaemic heart disease was presented after surgical excision of a squamous cancer of the palate. The patient also had oral field change and suffered multiple recurrent oral cancers requiring surgical excisions during implant treatment. This resulted in multiple oro-antral communications requiring a maxillary obturator and an implant supported denture for the mandible. The patient required no chemotherapy or radiotherapy. (Figure 1 and 2).

Cone-beam CT scan illustrating limited height and width of bone in the anterior maxilla. (Figure 3).

Panoramic radiograph showing four Neoss ProActive® Straight implants placed in the maxilla and mandible, on separate surgical appointments, with simultaneous xenograft augmentation. (Figure 4).

Following six months of submerged healing, 4 mm PEEK healing abutments were connected to all implants to allow for soft tissue healing.

Upper and lower open tray fixture head impressions were taken with 13 mm copings using silicone and custom made trays. (Figure 5 and 6).

The casts were confirmed using acrylic jigs attached to Neoss Provisional Ti Abutment Multi. The accuracy of the cast was verified clinically and radiographically. (Figure 7).

Upper and lower screw-retained wax registrations and wax provisional dentures were created on the same provisional abutments to verify the vertical dimension, occlusion and tooth position. Upper and lower CAD/CAM titanium bars with attachments were designed and placed on the implants. (Figure 8 and 9).

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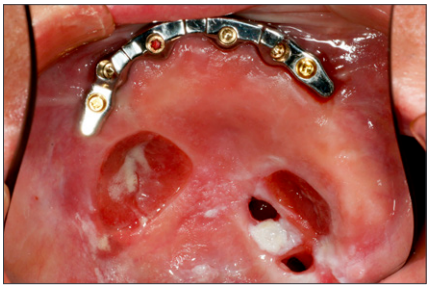

Figure 9

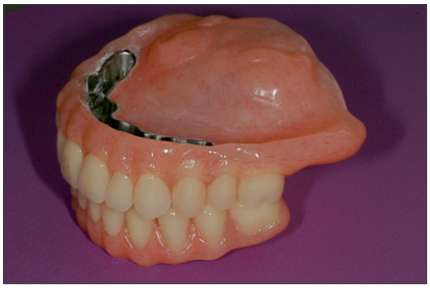

Figure 10

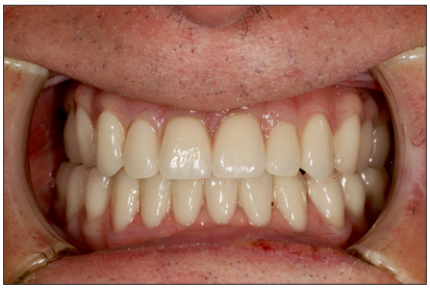

Figure 11

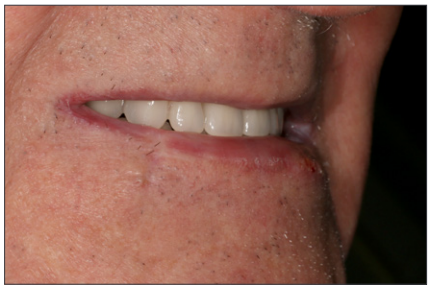

Figure 12

The patient was provided with upper and lower removable prostheses 18 months from implant placement (due to cancer recurrence), dedicated oral hygiene advice and reviewed for 3 years. (Figure 10).

The oral rehabilitation significantly improved the patient's ability to eat, drink and speak as well as his facial and dental cosmetics. (Figure 11 and 12).

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