

Papilla Fill Over Time

"Black triangles" cause many aesthetically minded dentists to cringe. Check out this case and be confident the next time you have a single an implant to restore.

Ken Barrack, DDS
 "Ken Barrack"
 Posted: 12/30/2008
 Posts: 1 & 3 of 17



Tooth #8 was extracted and replaced with single tooth implant, zirconia abutment, and PFZ crown with treatment completed in January 2006. I thought it was interesting to follow the patient at periodic re-care visits and watch the papilla fill in over time. It gives me something to go by when there is ideal conditions to show other patients what can happen to the "black triangle" over time. Maybe you will find it useful for the same purpose.



Figure 1: Tooth #8 will be extracted because of the parulis from the lesion of endodontic origin not healing

Figure 2: PA #8

Figure 3: Tooth #8 was extracted; an Essix retainer was used during the healing phases and implant healing phase. A screw retained provisional was used at stage II implant surgery to sculpt the tissue and form the implant site

Figure 4: Day one with the screw retained provisional placed. The expectation is that the tissue will fill in if I contoured the provisional properly.

Figure 5: Provisional – overbulked on the interproximals to "push" the tissue against the adjacent teeth contacts. The cervical area is flat or undercontoured because I do not want to change the cervical height with the adjacent teeth.



Figure 6: Four weeks with provisional only, because that was the next available time he could get in. I don't when along that month's time the papilla formed. Papillae fill and site is ready for impressing. The key is to trust the bone to contact parameters and adjust the provisional accordingly.

Figure 7: Zirconia abutment day one of restoration.

Figure 8: PFZ crown day one of restoration December 2005.

I show this case to patients who are contemplating single tooth replacement in the aesthetic zone with an implant. It gives me some guidance as to what I can expect for predictable tissue contours over time when the papillae are fairly short and the biotype is thick. It is also a good comparison when those factors are not the case with a partic-

continued on



January 2006.



February 2008.



February 2008.

ular patient. I can then explain the difference in their gingival situation and compare them to this one. I thought it was interesting to observe the tissue fill over the years. It gives me hope when I tell the patient that it might take some time for the "black triangle" to fill in.

[Posted: 1/2/2009]

How do others handle this situation when they know that there will be a black triangle for a bit of time before it fills in and the patient is asking about it?

For the exacting/demanding patient this can be tricky. ■

David S. Weber, CDT
 "David S. Weber, CDT"
 Posted: 1/3/2009
 Post: 5 of 17



Nice result!

When making the surgical guide, two of the items on my checklist are the path of insertion that is dictated by the interproximal contact walls, and M-distal spacing. Often the papilla height can be insured by "polishing" overly convex contacts, if it doesn't adversely affect the M-distal spatial relationship. The goal is for as minimal of an enamelplasty as possible, while keeping the

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contacts parallel with one another. That way the technician can keep those contacts as apical as possible, to maintain that magical 4.5mm space between the hard tissue height and those interproximal contacts created by your temporary and final restoration.

As you mentioned, making sure the facial contours are favorable (slightly undercontoured) is key. Often, when the fixture is set slightly lingual to equal prominence, we'll see more facial soft tissue at the site than the other central. In those cases we're able to slightly undercontour the abutment, and create a definitive CEJ [cemento-enamel junction] on the facial of the crown, thereby guiding the tissue height for an ideal gingival architecture outcome.

Thanks Ken. ■

Paul Goodman, DMD

"pmgpenn"

Posted: 1/3/2009

Post: 6 of 17

Great case and great job. I posted one I just started in the implant cases section. I manage the expectations from day one so the patient is fully aware that a black triangle/long tooth will likely be the result with implant dentistry in the front of the mouth. How much time, energy and money the patient wants to put into fixing it is up to them?

Was there any reason you did a cement retained final and screw retained provisional?

Thanks. ■ Paul

Ken Barrack, DDS

"Ken Barrack"

Posted: 1/4/2009

Post: 7 of 17



Thank you. I do the provisional crowns as screw retained because:

1. I don't want it to dislodge during the healing phase. The analogy would be an ovate pontic site healing under an FPD [fixed partial denture] provisional. I want constant pressure on the edentulous space. If the cemented provisional implant crown dislodges and I lose the pressure then

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the adjacent tissue can collapse and I can lose the papillae. I visualize the implant site as an "ovate pontic on a stick." The screw retained has much less chance of dislodging than the cement retained.

2. The one piece screw retained provisional is easier to modify. Using flowable composite, I can "add" or using composite polishing I can "take away" from the surfaces that need altering to gain the contours of the soft tissue. If I have two pieces (the abutment and the cemented crown), I have to alter too many things for my comfort.

3. No cement to worry about during the healing/sculpting time. Leftover cement can wreck the whole thing.

In summary, it is easier and more predictable with less worry because the cement is eliminated from the healing phase.

I used the ceramic abutment and PFZ crown as a cemented restoration because I did not want any grey metal showing.

There is no abutment that I know of for this 3i implant that the manufacturer (or after market Atlantis) has approved for a screw retained abutment/crown one piece where the porcelain is applied directly to the abutment (If you or anyone knows of one please let me know). Nobel used to have ceradep't abutments that were developed for the porcelain to be applied directly to them as a screw retained all-ceramic restoration. Other than that, I know technicians that figure if porcelain can be applied to zirconia, why not go for it. It is not recommended by the manufacturer that I know of. ■

"pjlee"

Posted: 1/4/2009

Post: 9 of 17

Dr. Barrack, great work, I know those papillae can ruin everything.

Couple of questions:

1. How long did you use the Essix retainer before you changed to screw-temp?
2. I've never used the screw-temp, how did you fabricate it? Does it come pre-made?

Thanks. ■ Paul

Ken Barrack, DDS

"Ken Barrack"

Posted: 1/4/2009

Post: 12 of 17



The Essix was used for used for seven months; from extraction through implant placement and uncovering. His treatment went from March to December from extraction to restoration. He did not like the Essix, but he liked it better than the one tooth treatment partial with palatal coverage.

I fabricate the provisional almost always chairside. It is quick, easy and I can see the results instantly. I have a clear matrix made; create a hole in the incisal area where the screw will be accessed, and another hole where I syringe Bis-acryl provisional material into the void and over the pre-fabricated temporary abutment that will hold the Bis-acryl. I then remove the clear shell, unscrew the provisional, shape and polish it, then screw it back in. If I want more or less material I just add or subtract until I think it will fly.

I have also indexed the implant at placement surgery and had the laboratory fabricate a provisional that is ready for insertion at uncovering. Whatever gets you to where you want to go. ■

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