Osseodensification facilitates ridge expansion with enhanced implant stability in the maxilla: part II case report with 2-year follow-up

Drs. Ann Marie Hofbauer and Salah Huwais offer another case study using a novel biomechanical site preparation technique

Bone behavior “strength” is directly related not only to its bulk of mineral density but also to its collagen integrity (Lang, et al., 2002). So, maintaining that bulk will determine the implant’s stability and its long-term success.

Osseodensification is a novel biomechanical site preparation technique. It produces low plastic deformation due to its non-extraction site preparation method, which preserves the bone to enhance the host.

It utilizes a multi-fluted Densifying Bur technology (Versah™, LLC) that creates and expands a pilot hole without excavating significant amounts of bone tissue through a unique, highly controllable, fast, and efficient procedure with minimal heat elevation. The taper design allows the surgeon to modulate pressure and irrigation, while providing a unique real-time haptic feedback that makes the Densifying Bur intuitive for every skilled implant surgeon.

When the densifying bur is rotated at 800-1500 RPM in the counterclockwise non-cutting direction (Densifying mode), downward surgical pressure coupled with steady external irrigation creates a gentle compression wave inside the osteotomy that works with the fluting to generate a densified layer through compaction and autografting the surrounding bone while plastically expanding the bony ridge at the same time (Meyer, Huwais, et al., 2014). The Densifying Burs can also be rotated in the clockwise cutting direction (Cutting Mode) to cleanly cut bone if needed. This dual use capability allows for clinical versatility — it may enable the implant surgeon to autograft the maxillary sinus and efficiently expands any ridge in either jaw with minimal heat elevation. The unique, highly controllable, fast, and efficient procedure with minimal heat elevation.

Our previous case report involved a ridge expansion with implant placement for single crown restoration. Consent was given by patient to utilize osseodensification site preparation for ridge expansion with immediate implant placement and ridge augmentation if needed.

Figure 1: Hard and soft tissue deficiency in area of tooth No. 6

Figure 2: Significant loss in alveolar ridge due to buccal plate resorption post extraction and socket graft
The upper right anterior area was anesthetized using infiltration with 1.8 ml 4% Septocaine® (Septodont) with 1:100,000 epinephrine. Interproximal papillae were conserved. U-shaped incisions with extended vertical releases were made (Figure 3) to allow for Modified Roll Soft Tissue Augmentation technique. A full thickness flap was reflected, and a 3.0-mm crestal alveolar ridge width was confirmed by direct measurement (Figure 4).

A 1.7-mm initial pilot osteotomy was created to a depth of 13 mm utilizing a high-speed surgical handpiece and a surgical motor (W&H). The pilot drill was rotating at 1200 RPM in a clockwise (CW) rotation. Using the pilot drill as a paralleling pin, an X-ray was taken to confirm the angulation between the adjacent teeth and the implant.

Once the correct position of the implant was confirmed, osseodensification was utilized using Densah™ Bur VT1828 (Versah™, LLC) running in a non-cutting counterclockwise (CCW) direction at 1200 RPM (Densifying Mode) with a bouncing motion to expand the osteotomy to 2.8 mm (Figure 5).

Sequential use of Densah™ Bur VT2838 running in a non-cutting counterclockwise (CCW) direction at 1200 RPM (Densifying Mode) with a bouncing motion was utilized to expand the osteotomy to a 3.8-mm diameter (Figure 6).

Osseodensification facilitated maxillary ridge expansion to form an osteotomy of 3.8-mm diameter without any buccal bone dehiscence (Figure 7), which allowed for total implant length placement in autogenous bone.

One 4.2/13 Legacy2™ (Implant Direct™) was placed with an insertion torque.
Implant stability was tested with an (Osstell®) ISQ implant stability meter. Buccal-lingual ISQ reading was 81. A healing abutment was placed, and the Modified Roll technique was used as soft tissue augmentation in the buccal of implant No. 6 site (Figure 11A).

Buccal-lingual ISQ readings were obtained weekly for 6 weeks. At 3 weeks post placement, ISQ reading for implant No. 6 was 67. Although many studies have suggested that implants with ISQ 67-68 have the stability needed for loading, our team chose to wait for further soft tissue maturation.
Figures 12A-12C: Six weeks’ healing revealed ISQ 79/83 reading

Figures 13A-13B: Final restoration of single crown restoration was delivered with adequate buccal ridge anatomy

Figures 14A-14B: One-year follow-up revealed maintained buccal anatomy

Figure 15: One-year radiographic follow-up revealed maintained crestal bone level

Figure 16: Two-year follow-up revealed maintained crestal bone level
At 6 weeks post placement, ISQ reading was increased substantially to 79/83. This increase in stability allowed us to start the restorative phase. The patient was referred back to his restorative dentist for final restoration at 6 weeks. Final restoration of a single crown was delivered with adequate buccal ridge anatomy (Figure 13).

Supportive and follow-up care
The patient returned at 1 year for clinical and radiographic follow-up. Examination revealed healthy hard and soft tissue with no sign of inflammation or infection. The patient maintained buccal bone anatomy, and adequate coronal bone level was evident. The 2-year radiograph taken by the patient’s restorative dentist demonstrated no change in alveolar bone height (Figure 16).

Discussion
In this case, osseodensification utilizing Densah™ Bur technology has facilitated ridge expansion in the maxilla with maintained alveolar ridge integrity, allowing for total implant length placement in autogenous bone with adequate primary stability. Despite compromised bone anatomy, osseodensification preserved bone bulk and promoted a shorter healing period. According to Trisi, et al., 2009, immediate implant loading can be recommended when insertion torque value (ITV) is at least 45Ncm, and ISQ is at least 68. Osseodensification technique can be recommended to enhance primary stability and possibly allow for earlier loading due to higher ITV and ISQ.

Conclusion
Osseodensification utilizing the Densah™ Bur technology produces stronger osteotomy for any implant. It preserves the bone to enhance the host. This allows for clinical versatility, which may facilitate enhanced implant stability and efficient expansion of any ridge in either jaw.

Scan the code to view a video of the procedure, or visit http://www.versah.com/osseodensification-with-ridge-deficiency/

REFERENCES