

maintenance appointment.

Occlusal overload can cause a variety of problems, including loosening of abutment screws, implant and prosthetic failure (Zarb and Schmitt, 1990).

Occlusal contact patterns should be assessed, as well as the mobility of the implant and opposing dentition.

Successful implants should not be clearly mobile. A failing implant is not mobile until all or most of the bone has been lost.

Abnormal occlusal loading will negatively affect the various parts of the implant-supported prosthesis.

Hence, premature contacts or interferences should be identified and corrected to prevent occlusal overload.

There should be light centric contact with no contacts in lateral excursions (Engleman, 1996).

Lundgren and Laurell believe that shim stock should be able to be held only with hard clenched teeth (1994).

Possible bruxism and parafunctional activities must be evaluated as excessive concentrated forces can result in rapid and significant peri-implant bone loss.

If a failed implant is connected to a multi-unit prosthesis, it may mask evidence of mobility.

#### **Maintenance protocols (Lang, Wilson and Corbet, 2000)**

These should be customised for the individual patient.

There is insufficient data on exact recall intervals, methods of plaque and calculus removal and appropriate antimicrobials for maintenance around implants.

Before implant placement, the patient's ability for home care and motivation must be assessed and the patient must understand their role in caring for the implant.

The patient's motivation and skill in undertaking oral hygiene measures may influence prosthetic design.

Importantly, if the patient is unable to achieve adequate oral hygiene, then this should be a possible contraindication to implant placement.

It is essential to monitor peri-implant tissues at regular intervals so that disease be noted early in treatment if possible.

The maintenance appointment should

**Implant dentistry is not always smooth sailing and we need to be aware of the possible pitfalls and issues**

include evaluation of:

- Presence of plaque and calculus and oral hygiene
- Clinical appearance of peri-implant tissue and deposit removal from implant/prostheses surface
- Occlusal status and stability of prostheses and implants
- Probing depths and presence of exudates or bleeding on probing
- Patient comfort and function
- Possible need for antimicrobials



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- Re-evaluation of present maintenance intervals that may be altered depending on the clinical situation
- Mobility.

Any movement would indicate possible lack of osseointegration of the fixture, possible failure of the cement bond between the superstructure and the retainer, or screw failure by fracture or loosening.

If an abutment is loose, then the microgap widens, which can result in the formation of a fistula.

By using the recommended torque settings, biologic considerations of the peri-implant areas, and adhering to certain biomechanical principles governing abutment and restoration shapes and sizes, we can avoid much heartache through careful planning so that we have content patients with favorable lifelong outcomes. **IDT**

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