

Treatment of Fistula Tract after Immediate Implant Placement and Immediate Provisionalization: A Case Report:

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ABSTRACT

Immediate implant placement and immediate provisionalization (IIP) is becoming a more common treatment due to patient's demands for having the implant and the crown in the same day of the tooth extraction. However, it's not always possible to perform this treatment due to tooth infection, lack of buccal bone or poor implant stability. There are different timings for implant placement after tooth extraction. It's possible to do immediate placement if all the requirements are present after the tooth extraction. If not, early implant placement (4-6 weeks post extraction) or delayed implant placement (4-6 months) requiring soft and hard tissues healing should be performed. A 63-years-old female patient was referred to the Implant Department of NYU for extraction and implant placement of maxillary first premolar diagnosed with pulpal necrosis with asymptomatic apical periodontitis. An initial CBCT scan was taken and the implant treatment plan selected was for IIP with a flapless approach. On the day of the surgery, the tooth #12 was extracted, and lesion was curetted. Immediate implant placement with immediate provisional was then performed. Four months later, the patient presented with sensitivity in the implant area and clinically there was a fistula tract with pus apical to the implant. A full-thickness flap was reflected to remove the lesion and guided bone regeneration was performed. After three months, patient came back without signs or symptoms of any infection. The purpose of this case report is to demonstrate a complication of a fistula tract after immediate implant placement and its treatment.

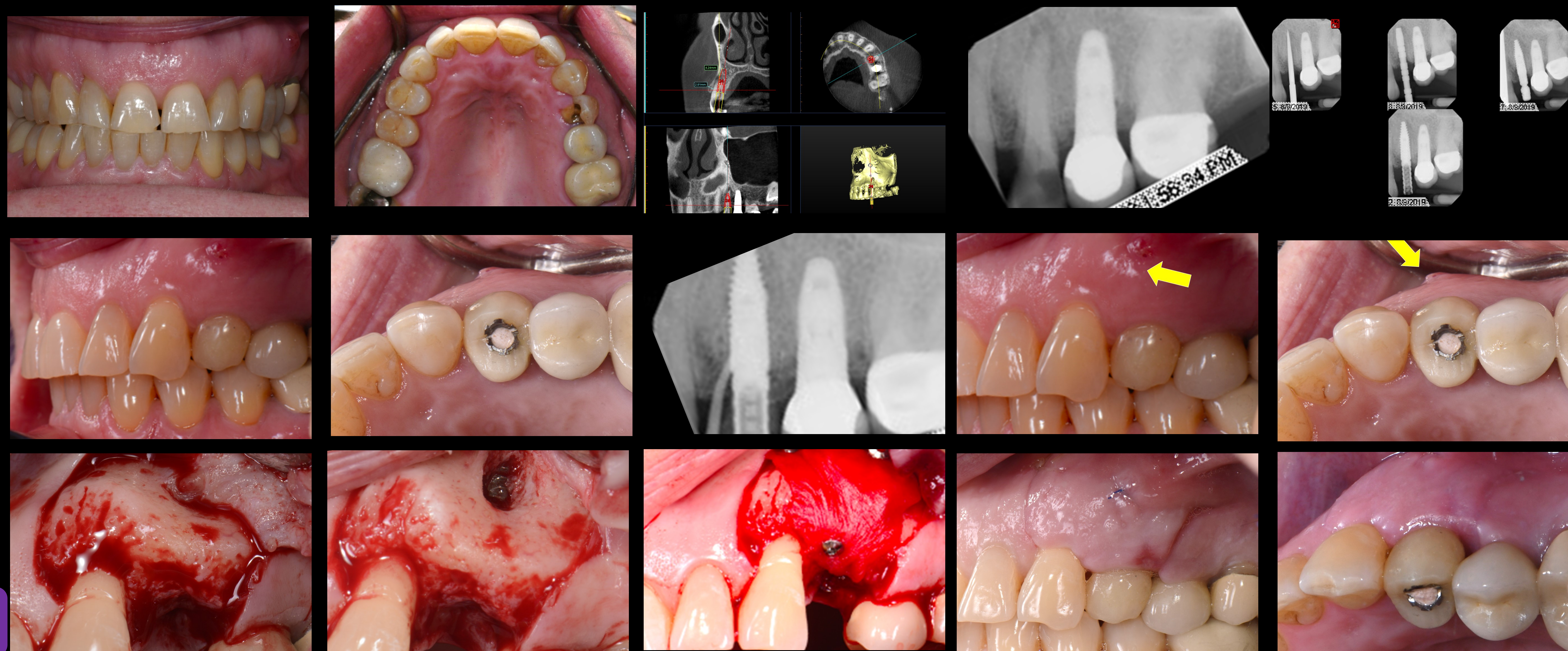
DISCUSSION & CONCLUSION

A 63 year old female patient came to Implant Dentistry department of NYU for an implant placement on upper left first premolar diagnosed with pulpal necrosis with asymptomatic apical periodontitis. An initial CBCT was taken and the implant placement was planned for IIP with flapless approach. On the surgical day, fresh extracted socket were evaluated and deep curettage was done to assure granulation tissue was remove prior to immediate implant placement with immediate provisionalization. At a 4 months post op, the patient came back with sensitivity and clinically found a fistula tract with pus content. No presence of mobility, bleeding on probing, nor deep pockets were found with high stability of the implant more than 35 Ncm. Periapical radiography with gutta percha tracing lead to the apical of the implant site. As a result, full thickness flap at the implant site was raised and found granulation tissue at the buccal aspect. Complete curettage was achieve leaving a buccal dehiscence apically the implant. The implant was not compromised Bone material was used to fill in the space and close with resorbable membrane to correct the bony defect. The implant was not compromised

Result: At a 3 month post op, the patient did not complain of any sensitivity, and no signs of periapical radiolucency. The implant was 100% successful without any clinically signs and symptoms. However, more cases and clinical data with long term follow is needed.

Conclusion: This surgical procedure can be a possible option to allowed the healing of the site without compromising the implant and further complications.

CASE PRESENTATION



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