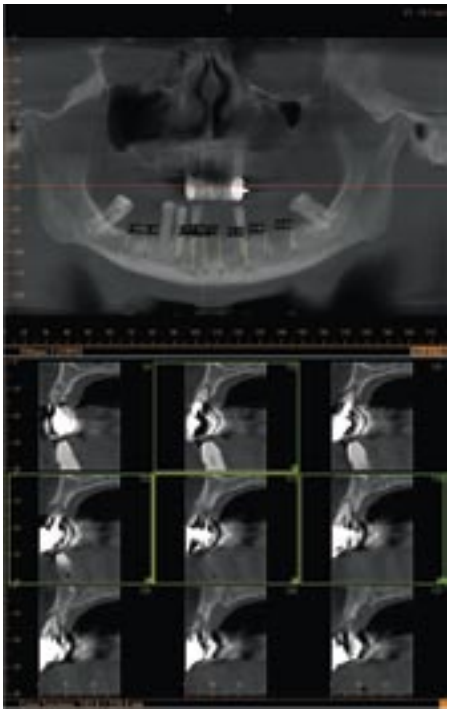
Is 80 *Too Old* for Dental Implants?

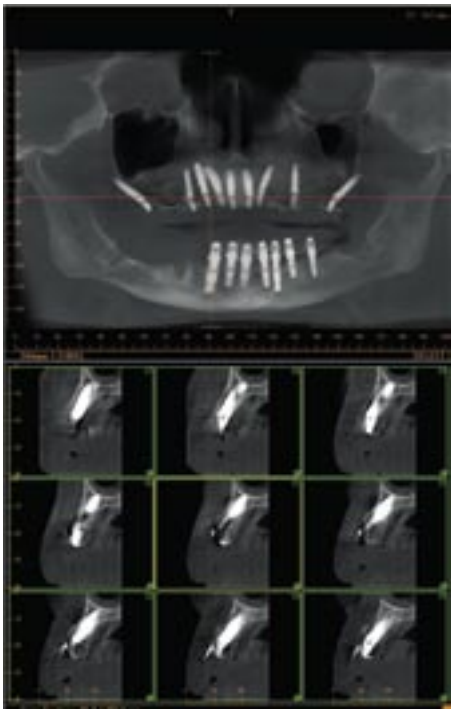
By Andrei Mark, D.D.S., Board Certified Oral & Maxillofacial Surgery

The answer is no, absolutely not! The age of the patient is not nearly as important as the overall health of the patient, as well as the jawbone density of the individual. These two elements are the most important criteria for determining whether or not a patient is a viable candidate for dental implants. I personally have treated patients as old as 94 years of age and had tremendous success with them.

I had a very challenging implant case involving a relative. The case was that of my 80-year-old mother-in-law. She first came into the office literally holding pieces of a 30-year-old max bridge in her hands and her local dentist proposing full dentures as the **only** solution to her problem.The psychological and emotional trauma from the mere thought of full dentures was devastating to this patient. Only a fixed prosthesis would serve to satisfy both her emotional and functional needs. Fortunately, my mother-in-law was in excellent physical condition which helped to make her an ideal candidate for the type of dental implant procedure she would require.



Pre-Op Scan



Post-Op Scan

Using the latest technology at my disposal, I took a CT scan with a state-of-the-art, i-CAT three-dimensional imaging system to see exactly what would be required for this case. This CT scan would clearly show if any resorption had taken place and help me to determine the exact positioning needed for optimal placement of the implant.

After performing the initial consultation, I then made an impression of the patient's mouth and fabricated an acrylic shell to be used both as a stent and a temporary restorative device.

The next step required that I extract all the roots for immediate placement of root form implants in the extraction sockets and place additional implants in non-extraction sites. I needed to achieve 40N insertion torque on all implants that were to be immediately loaded. I then placed and parallel angled straight abutments. Some minor preparation was needed to achieve parallelism. A full round-house maxillary acrylic temporary prosthetic was used to establish vertical and identify and adjust interference from temporary abutment posts. I then filled with acrylic and inserted the temporary bridge over the posts. After initial hardening was completed, I removed it several times, so as not to lock onto any unforeseen undercuts. I trimmed the excess tissue and adjusted the occlusion and cemented with Duralon, in order to ensure strong, long-lasting cement. (The first few cases in early implant stages were done with temporary cement and several implants were lost due to loosening of cement and rocking of implants). Post-op, the patient was medicated for infection and pain with amoxicillin, Vicodin, Naproxen and chlorhexidine gluconate.

Follow-up visits were required at one week, one month and three months to check the stability of the bridge. I advised the patient of her bite and told her that adjustment may be necessary. If any loosening or rocking of the bridge occurs, the patient is instructed to return to the office as soon as possible. In the days and weeks following surgery, the patient will need to learn how to chew again with fixed bridgework.

It brings me great satisfaction that I could quickly and effectively restore the functionality of the patient's teeth, while also helping to restore her self-confidence and self-esteem with a new smile. ■