

42. TREATMENT STRATEGY IN CASE OF POST-EXPLANT ALVEOLAR RIDGE DEFECT IN THE REHABILITATION OF PATIENTS WITH PERI-IMPLANTITIS.

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Introduction. Peri-implantitis is a complication in implant-prosthetic rehabilitation that causes morphological, functional, aesthetic and psychological disorders, inducing the formation of a "vicious circle" of successive diseases. Thus, early rehabilitation and the establishment of proper conduct is a key objective. Depending on the severity, the implant may be preserved or explanted. The effectiveness of these two surgical attitudes is currently the subject of heated discussion. Often, as in our case, explantation is performed resulting in a massive bone defect, which highlights a deficit of soft and hard tissue with an extensive area of diffuse inflammation in the vicinity of the vascular-nervous bundle. These problems present real challenges in subsequent rehabilitation.

Case presentation. The ST patient, f / 50 years old, addressed to the SRL "Omni Dent" clinic with complaints of mobility and pain in the lower right arch. At the clinical and paraclinical examination, was established the diagnosis of "Peri-implantitis in the region of the blade-type implant inserted in the right mandible at level d. 44-47". The implant was removed with the absolute indication for explantation which is the presence of grade III mobility in association with chronic inflammation and an extensive bone defect. After careful curettage and physiological solution irrigation, the defect was augmented with KP-3LM synthetic addition material. After 4 months, the replantation with conventional implants was performed. Analysis criteria: extension of the bone defect, appearance of soft tissues and three-dimensional characteristics of the alveolar ridge pre- and postoperatively; the quality of the regenerated implant site and the possibilities to redo implant-prosthetic rehabilitation.

Discussion. Clinically hyperemia, edema, purulent discharge, probing depth ≥ 5 mm, mobility and radiological peri-implant transparency on the entire implant surface were present. Both explantation and post-operative tissue regeneration run without complications (wound dehiscence, peri-osseous hematoma, exposure of the addition material, superinfection of the enlarged area). A generous bone amount was obtained in both widths and density (D2). Implant insertion was performed with torque ≥ 35 Nm. Peri-implant infection did not develop, post-operative anesthesia was maintained in the right chin region and disappeared after 3 months.

Conclusion. In extensive peri-implant defects the optimal solution may be explantation, which allows to arrest the bone resorption process as well as local and systemic spread of bacterial infection. Large cavities can be regenerated with synthetic addition materials to obtain favorable conditions for further treatment.