The alternative voice

Personal opinions on implant related topics

‘Is the McGill consensus always the best option?’, by Niklas Karl Oskar Angelus

One of the most interesting messages I took home from the EAO’s 2012 scientific meeting in Copenhagen was that there is no longer 100% agreement on the McGill consensus. This view has been confirmed by one of the most striking cases from my own practice, described below.

If a patient has teeth in the lower jaw prior to treatment, and these all have to be removed during treatment, they are unlikely to be satisfied with a denture that attaches on two implants, as the McGill consensus suggests. Instead, an implant-supported bridge is likely to be the preferred option. However, the patient’s viewpoint will probably be different if they had an edentulous lower jaw and a poor prosthesis prior to treatment. In that case, a prosthesis supported by two implants is likely to be acceptable.

By deciding which of these two categories a patient falls into, we can speculate whether treatment according to the McGill consensus is likely to be appropriate or not.

The following case involved a 66-year-old female patient who was a smoker. She was healthy apart from atrial fibrillation, and took anticoagulation. She had a history of periodontitis and told the practice that some of her teeth had fallen out spontaneously.

The patient was informed about the treatment options that were available to her. These were:

- A total prosthesis in the upper and lower jaw
- A total prosthesis in the upper jaw and an implant-retained overdenture in the lower jaw
- A total prosthesis in the upper jaw and an implant-retained bridge in the lower jaw

Having discussed the options carefully, she selected the second one. All her teeth were extracted and she was provided with a total prosthesis in the upper jaw and a temporary total prosthesis in the lower jaw. After a healing time of eight weeks, two implants (Nobel Replace 4.3x13) were installed in regions 32 and 42. Following healing time of three months, the temporary prosthesis in the lower jaw was replaced by an overdenture secured by two ball attachments. We chose not to use locator abutments because the patient described herself as having limited manual dexterity, and a ball attachment-based overdenture is considered to be easier to manage than a locator-based one.

After initially being very satisfied with the overdenture, the patient started to complain about loss of retention. The problem was treated chairside by adjusting the ball attachment device. The patient was satisfied for some weeks, but then came back to the office complaining that in her opinion the ball attachments and the prosthesis no longer fitted together properly. Having discussed the problem with the dental technician, we decided to reline the prosthesis. During this process, I started thinking about a lecture at the EAO’s 2011 conference in Athens, during which Professor S Eitner presented a thesis that in some cases his only explanation for an implant-related prostodontic problem is that the implants have started wandering within the jaw. Although I feared this may have happened to this patient, I couldn’t find any signs that the implants had wandered.

The relined prosthesis solved the problem for some time, but the patient continued to be unsatisfied. Other factors contributed to the problems she was experiencing, including poor oral hygiene which resulted in calculus sticking to the ball attachments. Every time she came in for follow-up we pointed out this problem to her. However, over and above the poor maintenance, she still had an underlying dissatisfaction with her ball attachment-based overdenture. The literature says that overdentures secured by two implants may require some extra time chairside, but my experience with this patient made me ask how much extra time should realistically be allowed for.

Discussion

Based on the patient’s history of smoking and severe periodontitis, I concluded that the treatment provided (a prosthesis supported by two implants) was a better option than an implant-supported bridge, as the former was easier to clean.

However, one argument against the chosen treatment was the age of the patient, which may have made it difficult for her to successfully adapt to removable prostheses. It has been documented that patients often find it difficult to use removable prostheses when they receive them late on in life.

A factor that may have led to the patient being dissatisfied was a failure to understand that an implant-retained overdenture isn’t a fixed prosthesis. Even though we always explain this to patients, they sometimes have difficulty understanding it because the implants themselves are fixed. This underlines the importance of providing clear information and discussing treatment options in detail.

In hindsight, a better option may have been to suggest an implant-retained bridge in the lower jaw. If one or two of the implants used to secure the bridge should subsequently fail, the remaining ones could be used for an implant-based overdenture at a later stage. This would provide the patient with the preferred option of a fixed prosthetic rehabilitation, the feeling of having her ‘own teeth’, and perhaps increased quality of life. Should the first option cease to be viable later on, the second option would be easy to implement.
**Figure 1. Status before treatment.**

**Figure 2. Implants installed.**

**Figure 3. Coping abutments in situ.**

**Figure 4. The overdenture, designed according to the McGill consensus.**

**References**


4. Author: Niklas Karl Oskar Angelus, Dr med dent (University of Ulm, Germany 1997), Spesialkompetanse implantatprotesetikk (Haukeland Universitetssykehus Bergen, Norway 2010), private practice in Namsos, Norway