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The Foundation of Knowledge

Case Report: Corticobasal® Implant Success in a Potential CPAP Pitfall - A 9-Year Patient Follow-Up

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Abstract

Background: Severe edentulism compromises systemic health and psychosocial well-being. Within two years, the patient developed COPD and sleep apnea with a questionable prognosis due to CPAP / BiPAP therapy. Corticobasal® implants enable immediate functional loading by anchoring in cortical bone.

Case presentation: A 67-year-old male with hypertension, diabetes, and depression underwent flapless placement of ten BECES® and KOS® Micro implants, followed by a fixed bridge within 72 hours in March 2017.

Results: At 9 years, Corticobasal® implants showed 100% survival, no peri-implant bone loss, and sustained mastication and speech.

Conclusion: Corticobasal® implantology offers predictable, long-term outcomes for medically complex patients, ensuring rapid function and improved quality of life. Therefore, Corticobasal® implants are modality of first choice even in such adverse conditions.

Clinical significance: Immediate functional loading with Corticobasal® implants provides a reliable restorative option, minimizing healing delays and enhancing psychosocial recovery in patients with systemic co-morbidities.

Keywords: Corticobasal® implants, immediate functional loading, edentulism, psychosocial rehabilitation, medically complex patients

Introduction

The rehabilitation of posterior maxillary edentulism continues to pose significant challenges in implant dentistry, primarily due to anatomical limitations, compromised bone quality, and the proximity of vital structures such as the maxillary sinus[1,2]. Conventional implant placement in this region often necessitates extensive grafting procedures to address sinus pneumatization and alveolar resorption. Although mostly effective, these interventions are associated with increased morbidity, prolonged treatment time, and elevated financial burden, making them less desirable for patients with systemic fragility[3]. In recent years, immediate implant placement strategies have emerged as a transformative alternative, offering predictable outcomes without the need for invasive augmentation procedures.

Pterygoid implants, by engaging dense cortical bone in the pterygoid region, bypass the limitations of sinus involvement and provide robust posterior support. Their ability to facilitate immediate loading protocols not only enhances functional rehabilitation but also significantly improves patient satisfaction by reducing treatment duration[4]. Similarly, Corticobasal® implantology has redefined the management of atrophic jaws. Unlike conventional endosteal implants that rely on cancellous bone, Corticobasal® implants achieve stability through cortical anchorage, ensuring immediate functional loading even in severely resorbed maxillae.

This approach is particularly advantageous in medically compromised individuals, where delayed healing, systemic fragility, or contraindications to grafting render traditional techniques unsuitable. By minimizing surgical morbidity and enabling rapid restoration of function and aesthetics, Corticobasal® implantology aligns with the growing emphasis on patient-centered, minimally invasive care.

Together, tubero-pterygoid and Corticobasal® implants represent a paradigm shift in maxillary rehabilitation. Their application underscores the importance of adapting implantology to the needs of complex medical profiles, demonstrating that immediate implant strategies can deliver safe, predictable, and efficient outcomes even in patients traditionally considered high-risk for conventional protocols[5].

Case Presentation

A 67-year-old male reported to our facility with the chief complaint of missing teeth in the upper right and lower left back regions of his jaw and wanted to get his missing teeth replaced. His medical background was complex, including hypertension, type 2 diabetes, and dyslipidemia. Laboratory findings showed persistent hyperglycemia, normal renal function, mildly elevated liver enzymes, and occasional trace proteinuria.

Oral clinical examination revealed **severe edentulism and alveolar bone resorption**, collapsed vertical dimension rendering him unsuitable for conventional endosteal implants that rely on cancellous bone. Radiographic evaluation via orthopantomogram (OPG) confirmed varying degrees of alveolar ridge resorption; however, it also identified sufficient

cortical bone density to facilitate cortical and basal fixation (osseofixation).

Given his systemic fragility, prolonged healing protocols and bone grafting procedures posed significant risks and difficulties in phonation, which had led to a significant decline in his overall quality of life.

The decision to proceed with Corticobasal® implants was guided not only by anatomical feasibility but also by the patient's urgent need for rapid functional and aesthetic rehabilitation.

The extraction of upper right impacted third molar was done immediately before implant placement in the region.

The implants were placed in the tuberopterygoid region utilizing the IF® Methods 10, 16b, 11, 9, 8a, and 7a in the maxillary arch and IF® Methods 3, 4, and 5a in the mandibular arch.

In this context, **Corticobasal® implantology** emerged as a pragmatic and reliable solution. Under very trying circumstances not only by anchoring implants in distant highly mineralized and dense cortical bone along with the unique polished surface, second to none metallurgy and technique-sensitive procedure of bypassing the limitations of atrophic alveolar architecture, ensuring immediate functional loading, and minimizing surgical morbidity.

Fig. 1a

Fig. 1b

Figs. 1a-1b: *Pre-operative intraoral view of patient.*

Fig. 1c: *Pre-operative orthopantomogram (OPG) of the patient showing partially edentulous areas and reduced bone volume in March 2017.*

Materials and Methodology

Implant Type	Dimensions (D x L)
BECES® ex	3.5 mm x 23 mm
BECES® ex	3.5 mm x 23 mm
BECES® ex	3.5 mm x 12 mm
BECES®	3.6 mm x 14 mm
BECES® ex	3.5 mm x 23 mm
BECES® ex	3.5 mm x 19 mm
BECES®	3.6 mm x 17 mm
BECES® ex	3.5 mm x 12 mm
BECES®	3.6 mm x 12 mm
KOS® Micro	3.7 mm x 12 mm

Table 1: *Corticobasal® implants with their respective dimensions utilized in the full mouth rehabilitation.*

A total of ten single-piece implants were utilized (Manufacturer: Simpladent® GmbH, CH-8737 Gommiswald, Switzerland), fabricated from high-strength Ti6Al4V Grade 5 titanium alloy. This material was selected for its superior biocompatibility and mechanical resistance, which is essential for the thin-shaft design of Corticobasal® implants. The implant selection included BECES® and BECES® ex designs, characterized by their smooth, polished surfaces designed to resist bacterial colonization, as well as KOS® Micro implants, which utilize lateral bone compression to enhance primary stability. Specific dimensions allow the clinician to bypass areas of alveolar resorption and utilize deeper, more stable cortical bone. Under local anesthesia, the implants were placed using a flapless or minimally invasive technique. The method of "osseofixation" provided immediate mechanical stability, independent of the cancellous bone volume. Once seated, the thin, malleable necks of the implants were adjusted for parallelism using specialized bending tools to facilitate an optimal prosthetic path of insertion.

Following the Strategic Implant® protocol, the implants were immediately loaded with a full-arch bridge. This provided the patient with a fixed functional solution within two days of the surgery. High-precision impressions were taken to fabricate a full-arch fixed reconstructive bridge. This prosthesis was permanently cemented, acting as a rigid functional splint to distribute masticatory forces across all ten implants. By immediately engaging the implants in functional loading, the protocol promoted bone

remodeling and prevented the micro-motion often associated with traditional delayed-loading techniques.

Post-operative care included a standard antibiotic regimen and strict oral hygiene instructions to maintain the health of the peri-implant tissues over the subsequent 9-year follow-up period.

Fig. 2a

Fig. 2b

Fig. 2c

Figs. 2a-2c: *Immediate post-operative rehabilitation intraoral view of the patient in March 2017.*

Fig. 3: *Eight months post-operative orthopantomogram (OPG) of the patient showing multiple Corticobasal® implants in both the maxillary and mandibular arch, and fixed prosthesis thereon.*

Outcomes and Follow-Up

After nine years, the treatment demonstrated a 100% survival rate with no signs of peri-implantitis. The patient experienced a dramatic recovery in mastication and speech, and notably survived all interim medical complications, including COVID-19. In addition, he suffered from COPD and sleep apnea in 2019, requiring BiPAP. Clinically and psychologically, the aesthetic restoration resolved his depressive symptoms, significantly boosting his confidence and quality of life through stable, long-term functional success.

Fig. 4: *Orthopantomogram (OPG) showing multiple Corticobasal® implants' placement in maxillary and mandibular arch, follow-up from 2018.*

Fig. 5: *Orthopantomogram (OPG) showing multiple Corticobasal® implants' placement in maxillary and mandibular arch, follow-up from 2023.*

Fig. 6: *Orthopantomogram (OPG) showing multiple Corticobasal® implants' placement in maxillary and mandibular arch, follow-up from 2024.*

Fig. 7: *Orthopantomogram (OPG) showing multiple Corticobasal® implants' placement in maxillary and mandibular arch, follow-up from 2026.*

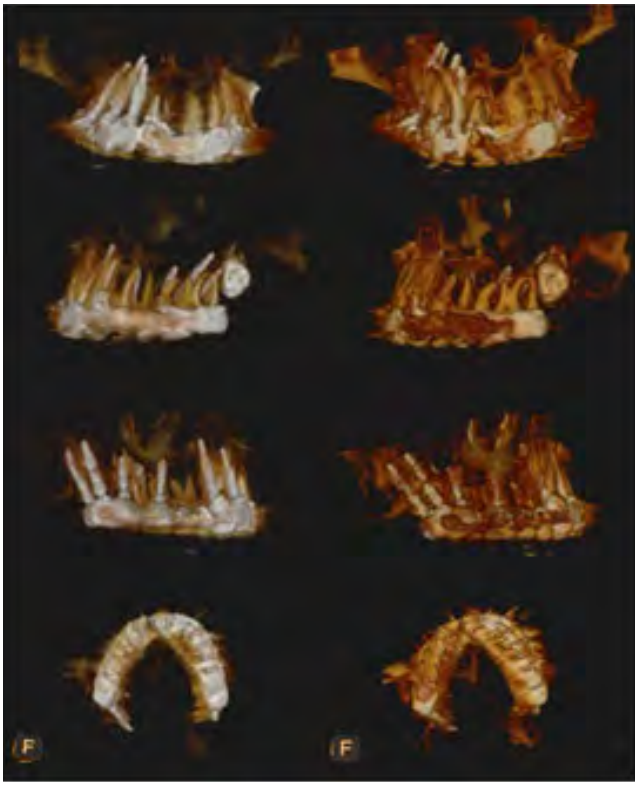

Fig. 8a

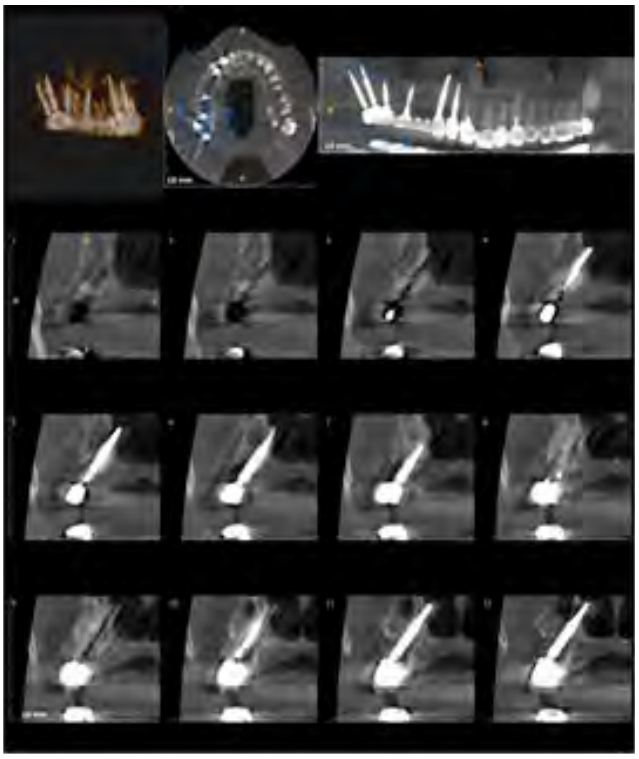

Fig. 8b

Figs. 8a-8b: *CBCT showing multiple Corticobasal® implants placement, 9-year follow-up, April 2026.*

Fig. 9a

Fig. 9b

Figs. 9a-9b: *Frontal view of patient.*

Discussion

"Osteosynthesis is contraindicated in patients presented with a severely compromised medical condition and / or with a high surgical risk failure[5]."

Rehabilitation in medically compromised patients demands approaches that balance safety with predictability. Conventional endosteal implants often require bone grafting and extended healing, which pose significant risks for individuals with COPD, diabetes, and hypertension. The use of BiPAP or CPAP therapy can inadvertently trigger a cascade of oral health complications, beginning with hyperventilation-induced xerostomia. The constant flow of pressurized air, particularly when exacerbated by mouth leaks, causes excessive drying of the oral mucosa and a depletion of protective saliva. This chronic dryness often leads to significant soft tissue and gum recession, as the lack of lubrication increases friction and inflammatory stress on the gingival margins. In this case, the patient's clinical course remained stable until 2019, when he developed pulmonary insufficiency accompanied by sleep apnea, necessitating BiPAP support and corticosteroid therapy despite his underlying diabetes

mellitus. His recovery was further complicated by a history of antidepressant use to manage low self-esteem and clinical depression, as well as an episode of COVID-19 infection. Despite these challenges, including periods of hyperventilation requiring BiPAP intervention, the overall treatment outcome was highly favorable. Notably, such complications could have posed significant pitfalls with documented studies showing failure of crestal / conventional implants. However, the use of Corticobasal® immediate implants ensured successful rehabilitation without compromise[6].

For patients with dental implants, this recession is particularly hazardous, as it results in the rough exposure of implant surfaces and abutments. These exposed areas become primary sites for rapid biofilm accumulation and plaque colonization, directly manifesting as peri-implantitis. If left unmanaged, this inflammatory process causes bone loss around the hardware, ultimately leading to implant failure. Additionally, use of a CPAP / BiPAP mask adds significant pressure to an immediately loaded prosthesis and indirectly adds to the loads, which generally results in conventional implant failure. This "pitfall end result" highlights a critical conflict between respiratory therapy and restorative dental health[6,7].

Corticobasal® implantology, by engaging dense cortical bone, avoids these limitations and allows immediate functional loading. In this case, rapid restoration of chewing, speech, and facial height was achieved within 72 hours, minimizing morbidity during the phase of treatment. Beyond functional recovery, the patient experienced marked psychosocial improvement, highlighting the broader impact of Corticobasal® implants in restoring confidence and quality of life in complex medical scenarios.

Approach	Conventional Implants	Corticobasal® Implants
Surgical Time	Multistage, often spread over three to six months	Single sitting / minimally invasive
Bone Requirement	Adequate cancellous bone (this is often missing)	Cortical bone anchorage (reliable and always available)
Mode of Integration Into the Bone	Osseointegration (old method)	Osseofixation (advanced, new method)
Bone Graft	Often require bone augmentation	No bone grafting ever required
Sinus Lift	Often require sinus lift	No sinus lift ever required
Healing Protocol	Delayed loading (three to six months)	Immediate functional loading (48-72 hours)
Suitability in Medically Compromised Patients	Limited (risk of poor healing, systemic fragility), not suitable for patients with periodontal issues and other chronic intraoral infections; uncountable medical contra-indications	Strongly recommended (minimally invasive, rapid rehab), suitable for diabetics, smokers, and for periodontally compromised patients
Surgical Complexity	Multiple complex instruments and steps	Fewer instruments used, flapless, simple, defined standards of treatment available
Strength and Stability	Moderate stability, especially in compromised bone	Excellent primary stability with cortical anchorage
Prosthetic Workflow	Often digital planning required with advanced laboratory support	Conventional impressions and simple techniques used
Key Advantages	None	Immediate functional loading directs correct integration of the implants into the bone during the crucial remodeling phase

Table 2: *Comparative overview of conventional and Corticobasal® implants[5,8].*

Strategic Advantages for Medically Compromised Patients – Clinical Management for OSA / BiPAP Patients

Corticobasal® implants offer a strategic advantage for this compromised demographic through a minimally invasive, flapless approach that utilizes dense cortical bone and eliminates the need for extensive bone grafting. The associated immediate functional loading protocol, placing teeth (i.e. the splinting bridge) within 48-72 hours, facilitates rapid functional recovery while minimizing disruption to the patient's systemic health. The polished surface of these implants provides a more predictable outcome compared to conventional implants in high-risk patients. The reduced surgical trauma and accelerated healing make this approach superior for patients requiring continuous positive airway pressure[5,6,7].

Managing patients with Obstructive Sleep Apnea (OSA) or those using BiPAP requires a thoughtful, collaborative approach to ensure their safety and comfort. It all starts with a solid medical partnership; a quick consultation with the patient's pulmonologist is essential to confirm they are stable enough for the procedure. During the surgery, the patient is kept in a semi-erect or upright position. Lying flat for too long can make breathing difficult for those who rely on CPAP or BiPAP machines[7,9]. It is also important to carefully review their medications, especially long-term steroids, since these can interfere with the body's ability to heal and make it harder to fight off infections. Since these patients often have other health issues, strict infection control is necessary to prevent periodontal inflammation from complicating their overall health. The aim is to load (and thereby spit) within 72 hours; this quick turnaround is key for stability and helps prevent bone loss while ensuring osseofixation.

Corticobasal® Implants for Diabetic Patients

For patients managing diabetes, Corticobasal® implants offer a much more reliable path to a new smile, especially since diabetes can often lead to weaker bone density and slower healing. These implants are specifically designed to anchor into the deep, dense cortical bone, providing the kind of solid stability that traditional methods might strug-

gle to achieve. One of the biggest wins for diabetic patients is the "immediate functional loading" factor – getting fixed teeth within just 48-72 hours. This bypasses the long, drawn-out waiting periods that can sometimes be risky for those with blood sugar concerns. Additionally, the smooth surface of these basal implants is a game-changer for infection control; it helps prevent the buildup of biofilm and protects against peri-implantitis, which is a common hurdle in diabetic care. While we always aim for stable glycemic levels (ideally an HbA1c below 7) to ensure the best possible healing, research shows that patient satisfaction remains remarkably high, with very few complications reported in that critical first year[10].

Safe Implants for Cardiopulmonary Health

For patients prone to tachycardia, use of specific local anesthetics with low or no adrenaline is recommended to keep the heart rate steady during the visit. Safety is always the priority, so if oxygen saturation is fluctuating or heart rhythms are unstable, wait until the condition is better managed. Generally, if there has been a significant event like a heart attack, it is recommended to wait at least six months to ensure the heart is strong enough for the procedure.

Conclusion

Corticobasal® implants (BECES® / KOS®) offer a reliable alternative for complex full-mouth rehabilitations. This 9-year follow-up confirms that immediate loading is not only possible but sustainable, providing long-term satisfaction for patients with systemic health challenges.

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14 | Put more implants

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2b **Surgery 2**
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(necessary in up to 80% of the cases)

2c **Surgery 3**
Implantplacement
(adequate bone healing provided)

2d **Surgery 4**
Placement of gingiva former

2e Impression taking

3 Trying of the bridge frame
(5-10 days after impression taking)

4 Delivery of bridge (***4-24 months*** after implant placement)

Total

Treatment duration: 4 - 24 Months
Number of appointments: 7 - 12

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1 *

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2

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3

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4

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