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IMMEDIATE FULL-MOUTH REHABILITATION OF SEVERELY
ATROPHIC MAXILLA AND MANDIBLE USING 22 BASAL
IMPLANTS WITHOUT SINUS LIFTING OR BONE GRAFTING:
A CASE REPORT

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IMMEDIATE FULL-MOUTH REHABILITATION OF SEVERELY ATROPHIC MAXILLA AND MANDIBLE USING 22 BASAL IMPLANTS WITHOUT SINUS LIFTING OR BONE GRAFTING: A CASE REPORT

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Abstract

Background: Full-mouth rehabilitation in elderly patients presents significant clinical challenges, particularly when conventional implantology is contraindicated due to severe bone resorption, systemic factors, accumulation of contra-indications, or patient intolerance for lengthy surgical procedures. Cortical and basal implant systems have emerged as a viable alternative, offering immediate loading, minimal surgical trauma, and the ability to engage dense cortical bone without the need for augmentation procedures.

Case Presentation: We report the case of a 76-year-old female patient who presented from a neighboring country with severe bone resorption affecting both the maxilla and mandible. The patient had previously consulted several clinicians seeking implant treatment; however, implant placement in the maxilla had been considered difficult or not feasible due to the severity of maxillary bone resorption. In the mandible, the patient retained only the anterior teeth, namely the four incisors and two canines, with marked posterior bone resorption bilaterally and a relatively higher anterior

mandibular bone level. Following medical evaluation and laboratory investigations, full-mouth immediate rehabilitation was performed using basal implants. Ten implants were placed in the mandible and twelve implants were placed in the maxilla. These amounts exceeded the instructions of the implant manufacturer for the minimum amount of implants per jaw. The treatment included surgical flap elevation in the mandibular anterior region, bone-leveling using a piezo reamer, metal framework try-in, bite registration, and final prosthetic delivery within a short treatment timeline.

Conclusion: Immediate full-mouth rehabilitation with cortical and basal implants represents a predictable, immediately effective and efficient, only minimally invasive oral implant treatment modality for elderly patients with compromised bone volume. The technique eliminates the need for sinus lifting and bone grafting, shortens total treatment time, reduces surgical morbidity, and provides immediate functional and esthetic results. Proper case selection, precise surgical execution, and thorough prosthetic planning are critical to long-term success.

Keywords: Cortical and basal implants; cortical anchorage; full-mouth rehabilitation; immediate functional loading; minimally invasive implantology; sinus-free implantology; bone atrophy; occlusal rehabilitation; elderly patient.

1. Introduction

Edentulism and severe dental compromise in the elderly population remain a significant global public health concern. The loss of natural teeth, combined with progressed alveolar bone resorption, creates substantial functional, esthetic, and psychological burdens. Conventional implant therapy, while often considered as successful, frequently encounters limitations in this patient cohort specifically, inadequate bone height and width, proximity to vital anatomical structures such as the maxillary sinuses and inferior alveolar nerve, systemic comorbidities, and reduced patient tolerance for prolonged and multi-stage treatment protocols. Conventional dental implants according to the method of “osseointegration” show a quite low percentage of cases that can be considered both successful and healthy⁸.

Traditional approaches to overcoming bone deficiency include sinus floor elevation (sinus lifting), guided bone regeneration (GBR), block bone grafts, and distraction osteogenesis. Although these techniques can provide adequate bone volume for standard implant placement, they significantly prolong treatment duration, increase surgical morbidity, carry massive additional risks, and substantially escalate treatment costs. For elderly patients, the biological and psychological burden of multiple surgical procedures over extended periods can be prohibitive.

The older term “basal osseointegration”, also referred to as cortical and basal implantology, offers a fundamentally different paradigm. These implants are specifically designed to anchor into or rest on (lateral basal implants) the dense cortical bone found in the basal (cortical) regions of the jaws, which is far less susceptible to resorption than the alveolar crest. These areas of the bone are considered as infection-free and hence, the success of the implants will never be affected by infections. By bypassing the resorbed crestal bone and engaging multiple cortical plates, basal implants achieve high

primary stability, enabling immediate functional loading within 72 hours of surgery. This concept eliminates the ancient requirement for “bone grafting” and “sinus augmentation” in the vast majority (or all) of the cases.

This case report documents the comprehensive full-mouth rehabilitation of a 76-year-old female patient with severely compromised dentition, altered vertical dimension, and generalized advanced bone loss in both arches. The treatment was carried out using immediately loadable cortical and basal implants in a single surgical visit, followed by immediate provisional loading and final prosthetic delivery. Sinus lift, bone augmentation and flap elevation procedures were fully avoided.

Another significant difference between traditional osseointegrated and the new osseofixed implants (as used here) is that the new implantology (often called implantology 2.0) provides not a symptomatic, short-lasting approach that is full of flaws and side effects as the technology of osseointegration is. The results of this modern treatment have proved to be long-lasting and effective with outstanding esthetic results⁸ in the largest

ever-published original long-term study with more than 17.000 Strategic Implant® involved and observed up to twelve years.

2. Diagnosis: Clinical And Radiographic Assessment

2.1 Patient Profile

The patient was a 76-year-old female who presented with chief complaints of pain, poor chewing function, esthetic dissatisfaction, and difficulty eating. Her medical history revealed controlled hypertension managed with antihypertensive medication; no contra-indications to implant surgery were identified. She was a non-smoker with no history of previous bisphosphonate use or radiation therapy.

2.2 Extraoral and Intraoral Examination

Intraoral examination revealed severe bone resorption affecting both arches. The maxillary arch demonstrated advanced generalized alveolar bone atrophy, which explained the previous clinical difficulty in planning conventional implant placement without augmentation procedures. In the mandibular arch, the patient retained only the anterior teeth, consisting of the four incisors and

the one canine. This remaining anterior dentition was associated with marked posterior mandibular bone resorption on both the right and left sides. The anterior mandibular bone level remained relatively higher than the posterior molar regions, creating an uneven bone profile and an altered prosthetic foundation.

The clinical findings confirmed a complex full-mouth rehabilitation case characterized by severe maxillary atrophy, bilateral posterior mandibular resorption, compromised residual dentition, altered occlusal plane, and reduced functional efficiency.



Fig. 1: Pre-operative intraoral photograph – mandibular arch showing failing bridge, carious destruction of abutment tooth, and edentulous posterior segments.

2.3 Radiographic Assessment

Panoramic radiography (OPG) was performed. Radiographic findings included:

- Generalized horizontal bone loss affecting all quadrants, with crestal bone levels ranging from 30 to 60% root length loss.
- Periapical radiolucencies associated with multiple teeth indicative of chronic apical periodontitis.
- Pneumatized maxillary sinuses with limited crestal bone height in the posterior maxilla (residual bone height < 4 mm bilaterally in the maxillary sinus region).
- Adequate cortical bone thickness in the basal (cortical) regions of both jaws – specifically the pterygoid plates, zygomatic process, posterior mandibular cortex, and symphyseal region – confirming suitability for basal implant placement.
- Reduced inter-arch space due to collapsed VDO, requiring prosthetic restoration of vertical dimension.

Diagnosis: Full-mouth dental failure with advanced periodontal disease, failing restorations, periapical pathologies, compromised posterior bone volume, and loss of vertical dimension of occlusion.

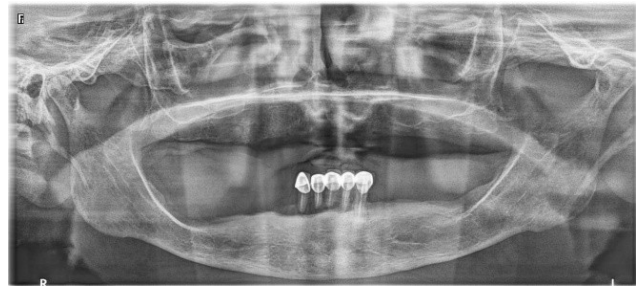


Fig. 2: Pre-operative OPG – mandibular arch showing failing bridge, carious destruction of abutment tooth, and edentulous posterior segments.

3. Treatment Plan

3.1 Treatment Rationale

Given the patient's age, the extent of dental compromise, the severely resorbed posterior maxilla precluding conventional implants, and the patient's wish to avoid prolonged treatment, it was decided to pursue full-mouth immediate basal implant rehabilitation. The key objectives were:

1. Extraction of all remaining non-restorable teeth in a single surgical session.
2. Placement of multiple basal implants in both arches utilizing dense cortical bone, bypassing the resorbed alveolar crest.
3. Immediate provisional loading within 24 to 72 hours with a fixed prosthesis.
4. Restoration of ideal vertical dimension of occlusion and anterior guidance.
5. Final metal-ceramic full-arch prosthetic rehabilitation.

No sinus lifting, bone grafting, or flap procedures were planned.

3.2 Surgical Protocol

After completion of the required medical investigations and confirmation that

the patient had no contraindications to surgical intervention, the procedure was performed under local anesthesia. A surgical flap was raised in the mandibular arch, particularly in the anterior region, to allow direct access to the irregular bony crest. A piezo reamer device was then used to adjust and level the anterior mandibular bone in order to correct the discrepancy between the higher anterior bone level and the resorbed posterior mandibular regions. This step was essential to prepare a more favorable prosthetic foundation and to facilitate an appropriate distribution of occlusal forces. Following bone leveling and surgical site preparation, ten basal implants were placed in the mandibular arch. In the maxillary arch, twelve basal implants were placed, taking advantage of available cortical anchorage areas and avoiding the need for sinus lifting or bone grafting. 22 implants in total were therefore inserted in both arches. The surgical procedures were completed within a short and well-organized clinical session, with attention to implant distribution, primary stability, and prosthetic parallelism.

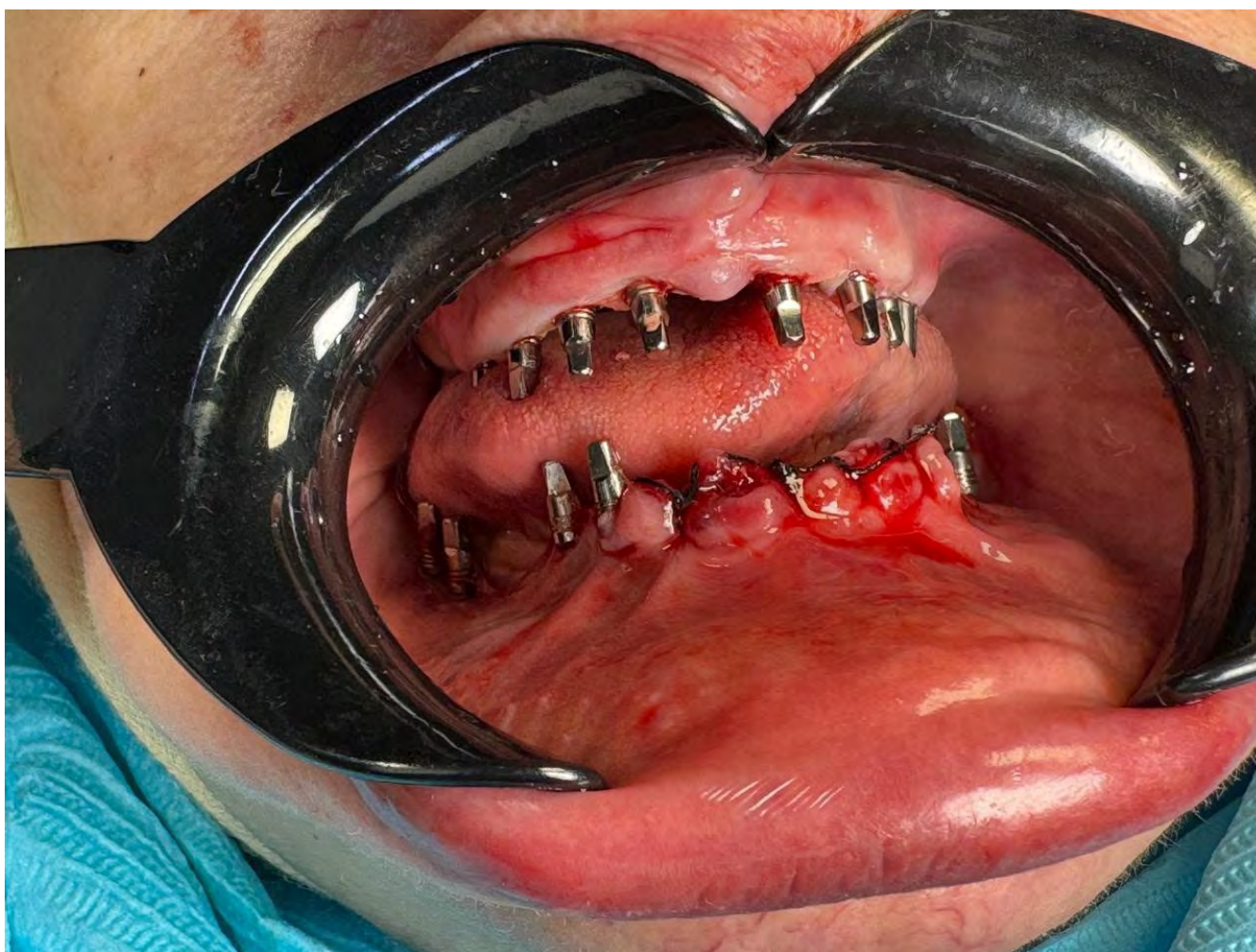


Fig. 3: Intra-operative photograph immediately following extraction and basal implant placement – frontal view showing multiple implant abutments in both maxillary and mandibular arches with post-surgical bleeding. Sutures visible in the mandibular anterior region.

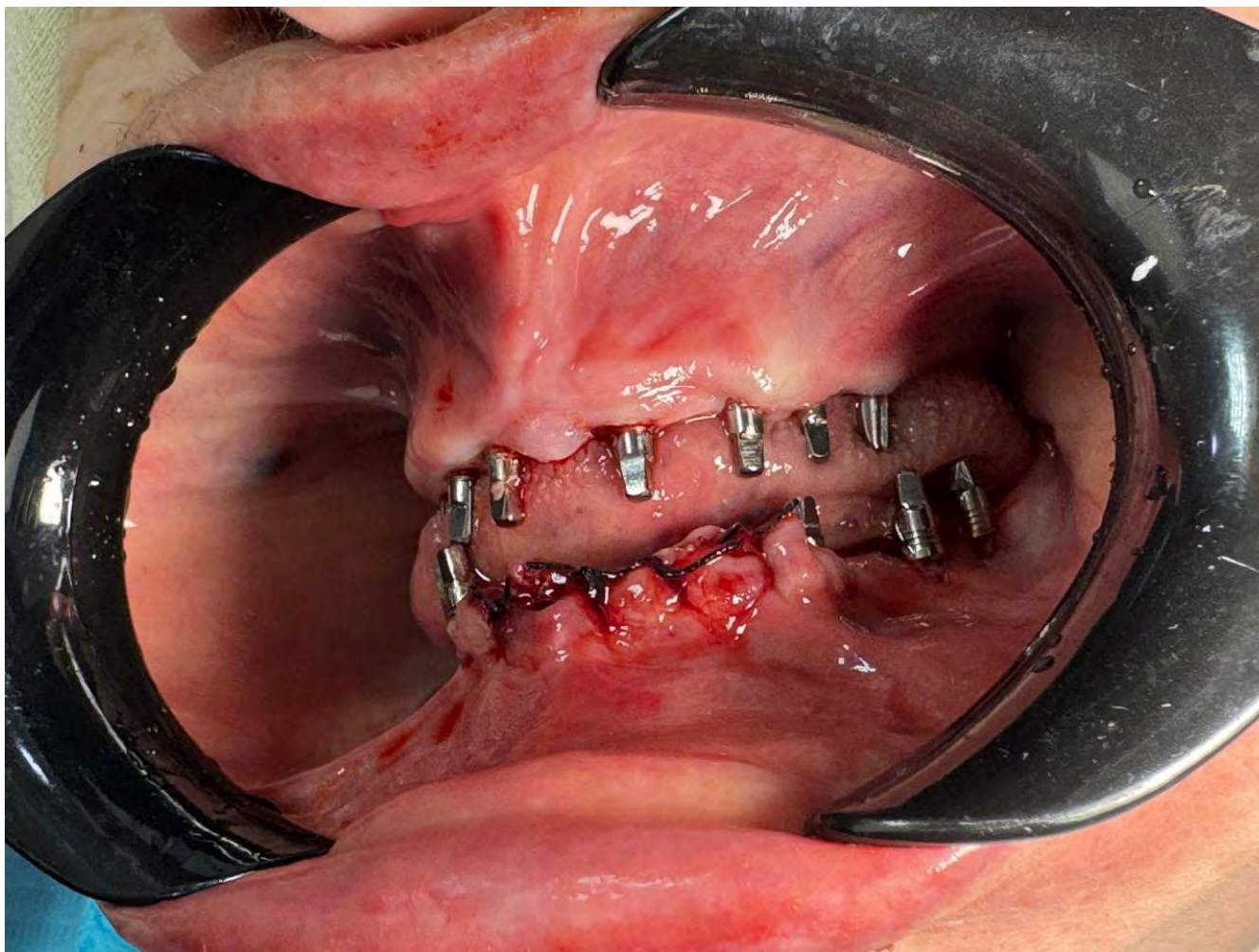


Fig. 4: Intra-operative photograph – lateral view showing symmetric distribution of basal implant abutments in both arches with suturing completed. Note the absence of grafting material.

3.3 Metal Framework Try-In and Occlusal Adjustment

On the day following implant placement, the metal framework try-in was performed. The surgical flap that had been sutured during the first surgical session was reopened to allow insertion and clinical verification of the metal framework. The framework was seated over the implant abutments, and the accuracy of fit, passive insertion, and inter-arch relationship were carefully evaluated. Bite registration was then taken for both the maxillary and mandibular arches to guide the final prosthetic arrangement and occlusal adjustment.

Following framework verification and bite registration, the flap was left open until the third day, which was scheduled for delivery of the final prosthesis. This clinical sequence allowed rapid prosthetic progression while maintaining control over the surgical and prosthetic interface.

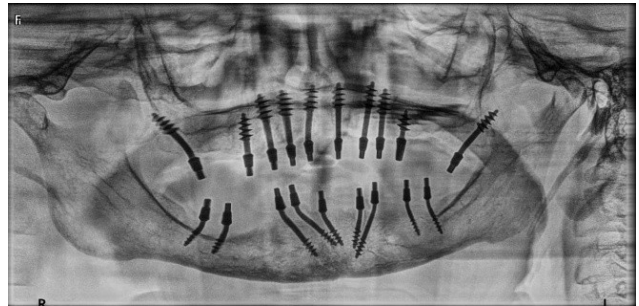


Fig. 5: Post-operative OPG – showing immediate basal dental implant rehabilitation of the maxilla and mandible, with multiple strategically placed basal implants providing full-arch support and immediate loading capability.



Fig. 6: Immediate post-operative view showing full-arch metal bridges placed on basal implant abutments in both arches – frontal view with lips retracted. Gingival healing in progress.



Fig. 7: Close-up view of the immediate full-arch metal prostheses in occlusion, demonstrating full coverage of both arches and restoration of vertical dimension.

4. Results and Follow-Up

4.1 Immediate and Short-Term Outcomes

The surgical phase was completed uneventfully without intra-operative complications. Post-operative discomfort was managed with standard analgesics and antibiotics. All 22 basal implants demonstrated satisfactory primary stability at the time of placement, allowing progression to immediate prosthetic rehabilitation according to the planned treatment protocol (implant stability quotient ISQ > 65 in all sites). The provisional metal bridges were delivered within 24 hours and immediately restored masticatory function and esthetics.

The patient reported immediate satisfaction with the restoration of her facial height, lip support, and ability to eat. Post-operative healing at the one-week review showed progressive mucosal healing around all implant abutments, with no signs of infection or peri-implant complications.

4.2 Final Prosthetic Delivery

On the third day, the final prosthetic teeth were fitted and clinically evaluated. Occlusal assessment confirmed a stable maxillo-mandibular relationship,

appropriate prosthetic seating, and restoration of oral function. The patient was instructed to begin using the prosthesis for mastication and gradual functional adaptation. Three days after the final delivery of the mandibular prosthesis, definitive cementation was performed. At this stage, prosthetic stability, occlusal accuracy, and functional suitability were verified before completion of treatment.

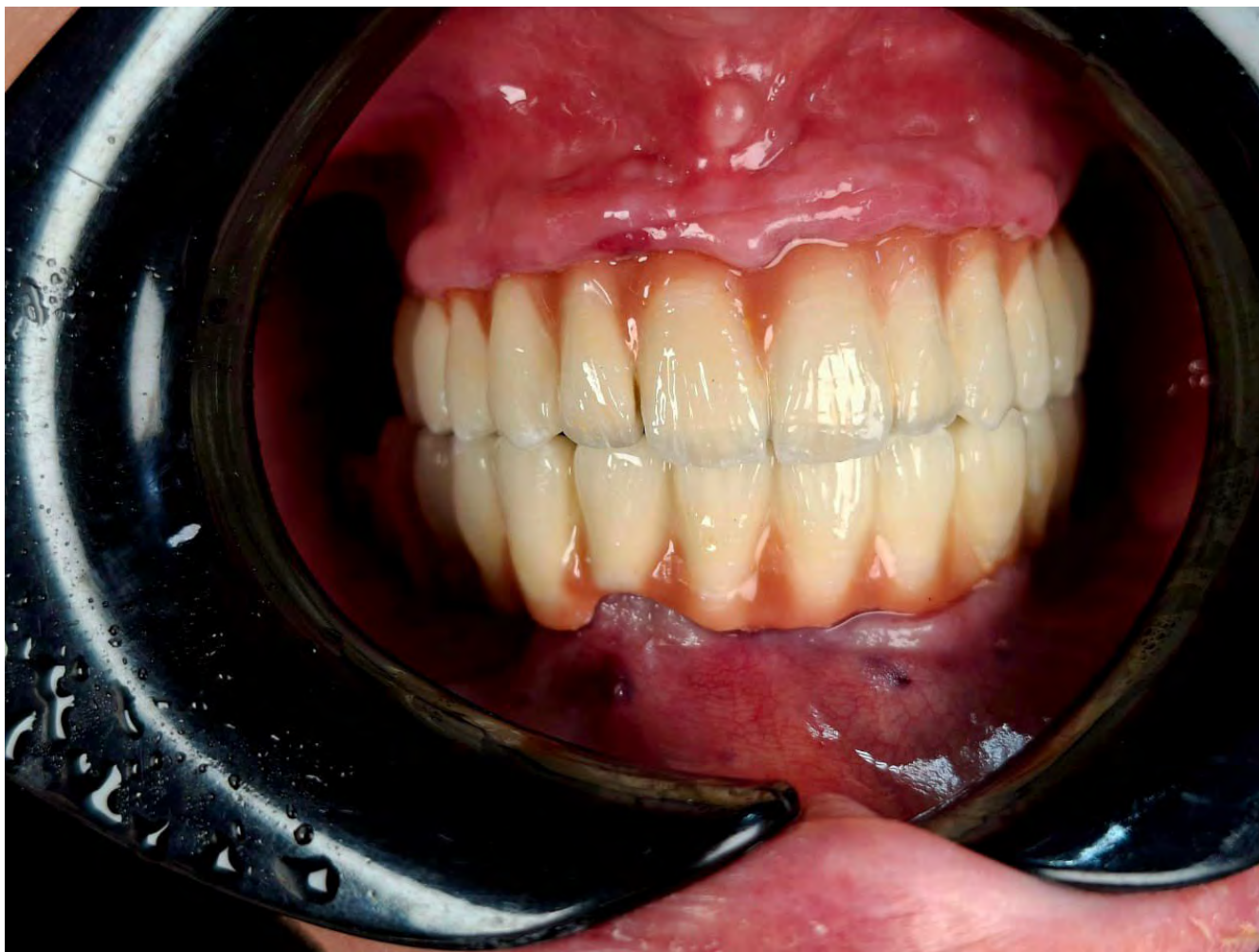


Fig. 8: Extraoral post-operative photograph showing the patient's final esthetic result – well-restored lower facial height, and excellent emergence profile of the final ceramic prostheses.

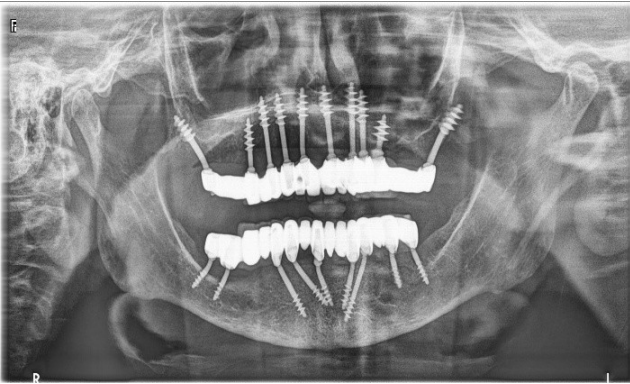


Fig. 9: Panoramic radiograph showing full-mouth implant-supported fixed prostheses porcelain fused to metal in both the maxilla and mandible with multiple osseointegrated dental implants.



Fig. 10: Final intraoral photograph showing full-arch ceramic fixed prostheses in occlusion – frontal view demonstrating ideal occlusal relationship, proper overjet and overbite, and harmonious ceramic esthetics with adequate lip support in both maxillary and mandibular arches.

4.3 Follow-Up

Follow-up examinations at one, three, and six months post-definitive loading confirmed:

- Stable peri-implant soft tissue health with no signs of peri-implantitis.
- Radiographically stable crestal bone levels around all implant bodies.
- No prosthetic complications (no fractures, no de-cementation, no screw loosening).
- Patient-reported outcomes: high satisfaction with function, esthetics, phonetics, and overall quality of life.

4.4 Summary of Clinical Advantages

The following key advantages were documented in this case:

- Single surgical session for extraction and implant placement.
- No sinus floor elevation procedure required.
- No bone grafting or augmentation performed.
- No flap elevation in the conventional sense.

- Immediate provisional loading within 24 hours.
- Total treatment time from surgery to final restoration: approximately 72 hours.
- Minimal post-operative morbidity.
- Ideal occlusion and VDO restoration achieved.
- Excellent esthetic and functional outcome.

5. Discussion

The rehabilitation of the severely compromised edentulous or near-edentulous patient with extensive bone loss remains one of the most complex challenges in modern implantology. Conventional strategies for managing posterior maxillary atrophy, primarily sinus floor elevation, have been used through decades and represented the former the gold standard in conventional implantology. However, these procedures carry inherent risks, including sinus membrane perforation, sinusitis, graft resorption, and prolonged healing periods before implant loading. Large studies⁸ have shown in the last years that the “gold standard” has changed and that a much better

implant strategy is available and used now around the world.

Cortical and basal implantology was developed as a direct response to the former limitations. By engaging cortical and basal bone that is largely resorption-resistant and maintains its volume throughout life, the new implant technology circumvents the compromised alveolar crest entirely. This anatomical advantage is particularly significant in elderly patients, in whom crestal bone resorption is typically very profound.

The immediate loading protocol is used as a standard in the new concept. High primary stability achieved through multicortical anchorage enables immediate splinting of implants with a fixed provisional restoration. Studies have shown long ago that immediate functional loading promotes cortical bone adaptation around the implant through physiological piezoelectric stimulation, contributing to long-term osseointegration. This process follows the rules of bone modeling, rather than bone remodeling.

The decision to restore the vertical dimension of occlusion simultaneously with implant placement is justified by the comprehensive prosthetic planning

undertaken preoperatively. Using OPG data and mounted study models, the desired VDO was established prior to surgery and programmed directly into the provisional prosthesis. The patient adapted rapidly to the restored VDO without temporomandibular symptoms, a finding consistent with published literature on VDO restoration in edentulous patients. From a patient-centered perspective, the single-visit surgical approach with immediate loading is transformative particularly for elderly patients who may have difficulty tolerating multiple surgical appointments, prolonged treatment, or extended periods of edentulism. The psychological and functional benefit of leaving the clinic with fixed teeth on the day of surgery cannot be understated.

6. Conclusion

This case report demonstrates that full-mouth immediate rehabilitation using cortical and basal implants is a viable, safe, and highly effective treatment modality for elderly patients with severely compromised dentition and advanced bone resorption. The technique successfully addressed the full spectrum of clinical challenges including absent posterior

maxillary bone, altered occlusal plane, missing vertical dimension, and bilateral arch compromise in a single surgical session without sinus lifting, bone grafting, or conventional flap procedures.

The patient achieved ideal occlusion, restored facial esthetics, and full masticatory function within a condensed treatment timeline, with minimal surgical morbidity. The six-month follow-up data confirm stable peri-implant tissues, prosthetic integrity, and high patient satisfaction.

Basal implantology represents a paradigm shift in the management of the atrophic jaw, offering clinicians a powerful tool to deliver comprehensive fixed implant-supported rehabilitations to patients who would otherwise face either complex augmentation surgery or removable dentures. Continued long-term follow-up and prospective multicenter studies are warranted to further define the predictability and longevity of this treatment approach.

Implant No.	Jaw	Region / Tooth Position	Implant Type	Length (mm)
1	Maxilla	Floor of the nose	BCS®	20*4.5
2	Maxilla	Floor of the nose	BCS®	20*4.5
3	Maxilla	Floor of the nose	BCS®	20*4.5
4	Maxilla	Floor of the nose	BCS®	20*4.5
5	Maxilla	Floor of the nose	BCS®	20*4.5
6	Maxilla	Floor of the nose	BCS®	20*4.5
7	Maxilla	Floor of the nose	BCS®	14*4.5
8	Maxilla	Floor of the nose	BCS®	14*4.5
9	Maxilla	Sphenoid bone	BCS®	20*4.5
10	Maxilla	Sphenoid bone	BCS®	20*4.5
11	Mandible	Chin	BCS®	14*2.7
12	Mandible	Chin	BCS®	17*2.7
13	Mandible	Chin	BCS®	20*2.7
14	Mandible	Chin	BCS®	20*2.7
15	Mandible	Chin	BCS®	20*2.7
16	Mandible	Mylohyoid region	BCS®	14*2.7
17	Mandible	Mylohyoid region	BCS®	14*2.7
18	Mandible	Mylohyoid region	BCS®	14*2.7
19	Mandible	Mylohyoid region	BCS®	14*2.7

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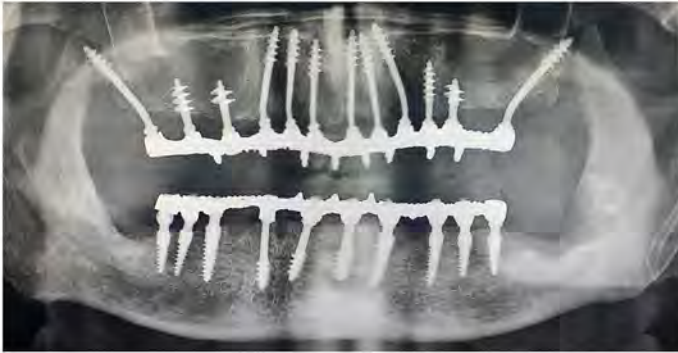
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16 Advantages of Osseofixation

Patients will hold you as their treatment provider, because you offer these advantages to them:

- | | | | |
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| 1 Saves costs by 30-40% |  | 9 Aesthetic solutions for all patients |  |
| 2 Reduces treatment time by 98% |  | 10 Uninterrupted intra-bony perfusion |  |
| 3 Efficient workflow saves chair-time |  | 11 Easy long-term maintenance |  |
| 4 Immediate functional loading |  | 12 No peri-implantitis |  |
| 5 Low complication rate |  | 13 No patient selection |  |
| 6 Simple straight forward treatment |  | 14 Put more implants |  |
| 7 Immediate implant placement |  | 15 Start treatment immediately |  |
| 8 Preserves bone elasticity |  | 16 Cost-effective implants |  |

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Conventional Implantology



1 Inspection Diagnostic procedures Treatment plan

2_a **Surgery 1**
Tooth removal

2_b **Surgery 2**
Bone augmentation/sinus-lifting
(necessary in up to 80% of the cases)

2_c **Surgery 3**
Implant placement
(adequate bone healing provided)

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

2_e 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

Strategic Implant®



Inspection
Diagnostic procedures
Treatment plan

1

Removal of teeth, Implant
placement, Impression
& Bite taking

2

**Step 1 and 2 may be done in
the same (first) appointment.*

Trying of a sample bridge and aes-
thetic & functional corrections
(if required) **0 - 1 days** after
implant placement

3

Delivery of bridge (**1 - 3 days**
after implant placement)

4

Control of occlusion and
mastication

5

Total

Treatment duration: 2 - 4 Days
Number of appointments: 4 - 5

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Learn from 7 world-renowned professors

in implantology, each bringing extensive experience and expertise to your training. Our faculty includes leading experts in dental implants.

WORLD-
RENOVED
PROFESSORS



DT Sanela Lazinica

Dentist technician and specialized IF® teacher for the work on the Strategic Implant®



Prof. Dr. Aleksandar Lazarov

Surgical and prothetical specialist: 1st Class IF® Teacher, Member of the IF® Board



Prof. Dr. Yan Vares

Craniomaxillofacial surgeon, Head of Department, Oral Implantology, 1st Class IF® Teacher



Dr. Fodor Romulus Calin

Surgical and prosthetic specialist, 1st Class IF® Teacher



SUCCESS STORIES

And Impressions from the course



DR. IONUTS UNGUREAN

I got to know that this way of implantology is pretty good, I got so excited about it, that I quit my job at a hospital. And I took over a clinic which works only with these implants. Since then I don't do anything else!



DR. MIGUEL

It changed my world, because with the Strategic Implant® everything is permitted, anything is possible, you improve oral health of the patient in only 24 hours, and the really important part for me you don't have peri-implantitis. Prof. Ihde forever!



DR. HABIB RITHA

I am very lucky to have learned this course. Thank you Dr Ihde for your generosity and your modesty. Thank you all to the team!

**There is no realistic alternative to modern
Corticobasal® implants and its technology.**

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and long lasting results!

A world map with a blue background. The country of Serbia is highlighted with a red circle and the letters 'SRB' in white.

SRB

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