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Staged Bicortical Implant Rehabilitation in a Medically Compromised Patient.

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ABSTRACT

Background: Managing extensive maxillary tooth loss and periapical pathology in medically compromised individuals demands careful surgical planning to minimize hemorrhagic complications and preserve masticatory function. This report describes the staged oral rehabilitation of a 54-year-old male on active anticoagulant therapy and pharmacologic management for hypertension, presenting with right maxillary partial edentulism and symptomatic crown fractures with apical infections in the left quadrant.

Case Description: Treatment was sequenced in two distinct surgical phases to avoid complete masticatory disruption. Phase one involved implant placement in the right maxillary quadrant (sites 1.5 and 1.6) to re-establish a stable posterior occlusion. The second phase addressed the contralateral quadrant (sites 2.3–2.6), where multi-unit implants were placed utilizing strategic bicortical anchorage and corrective angulation. Immediate-to-early acrylic provisional prostheses were delivered and splinted for approximately 2.5 months to ensure splinted load distribution during osseointegration. Definitive rehabilitation was executed using monolithic zirconia ceramic bridges across both quadrants.

Conclusion: A staged surgical protocol combined with bicortical anchorage and immediate splinted temporization offers a safe, predictable treatment pathway for hypertensive and anticoagulated patients requiring bilateral posterior maxillary reconstruction. In this case monoblock implants are used, but bicortical anchorage is achieved during placement. However, it's important to note that these are compressive monoblock implants.

Keywords: Dental Implants; Bicortical Anchorage; Anticoagulant Therapy; Staged Rehabilitation; Zirconia Prosthesis; Maxillary Edentulism.

CLINICAL CASE PRESENTATION

A 54-year-old male patient, currently under pharmacological management for hypertension and receiving anticoagulant therapy, presented with an edentulous area in the first quadrant, along with fractured crowns associated with apical infectious processes in the second quadrant.

A staged treatment approach was established. Initially, rehabilitation of the first quadrant was performed in order to restore functional occlusion on the right side. Subsequently, a second surgical phase was planned for the treatment of the second quadrant.

Following implant placement in both regions, provisional

restorations were delivered, splinting the implants for a period of approximately two and a half months. Final rehabilitation was completed with zirconia prosthetic restorations.



Figure 1. Initial X-Ray

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Figure 2. Initial Photograph after completing the first quadrant

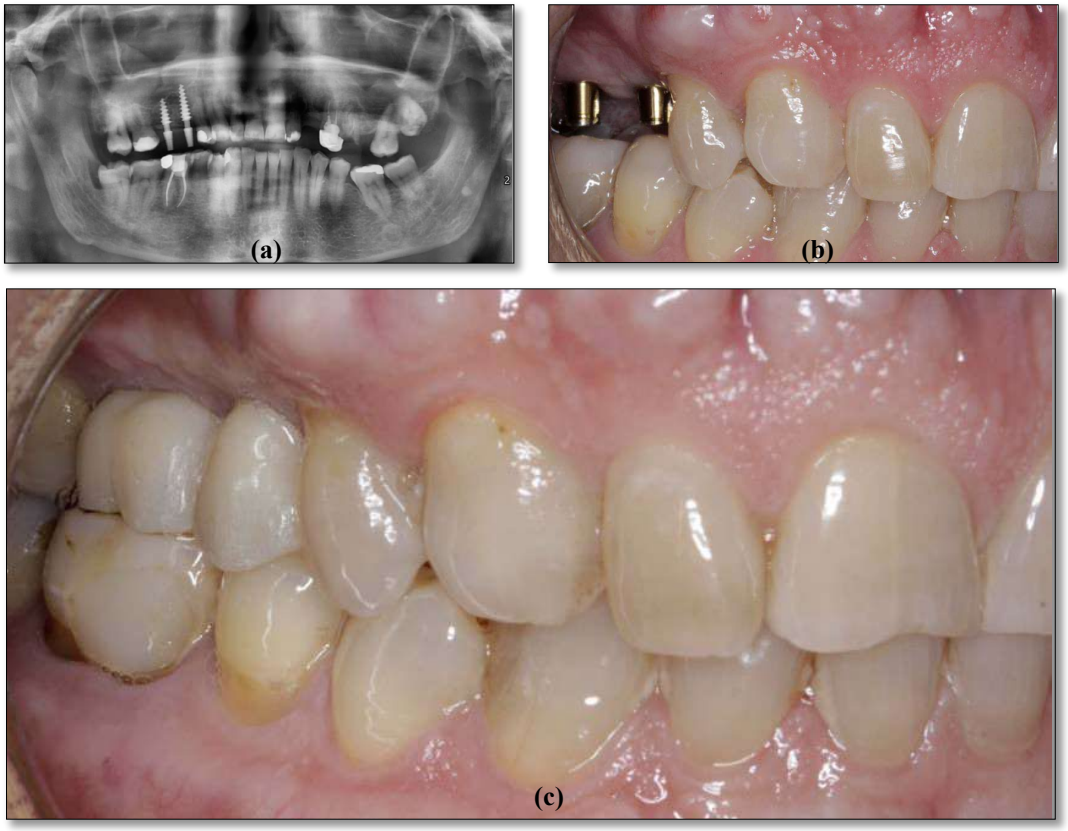


Figure 3. (a) RX Initial, Implants at 1.5 1.6., **(b)** Implants at 1.5 1.6, **(c)** Definitive ceramic restorations at 1.5 1.6.

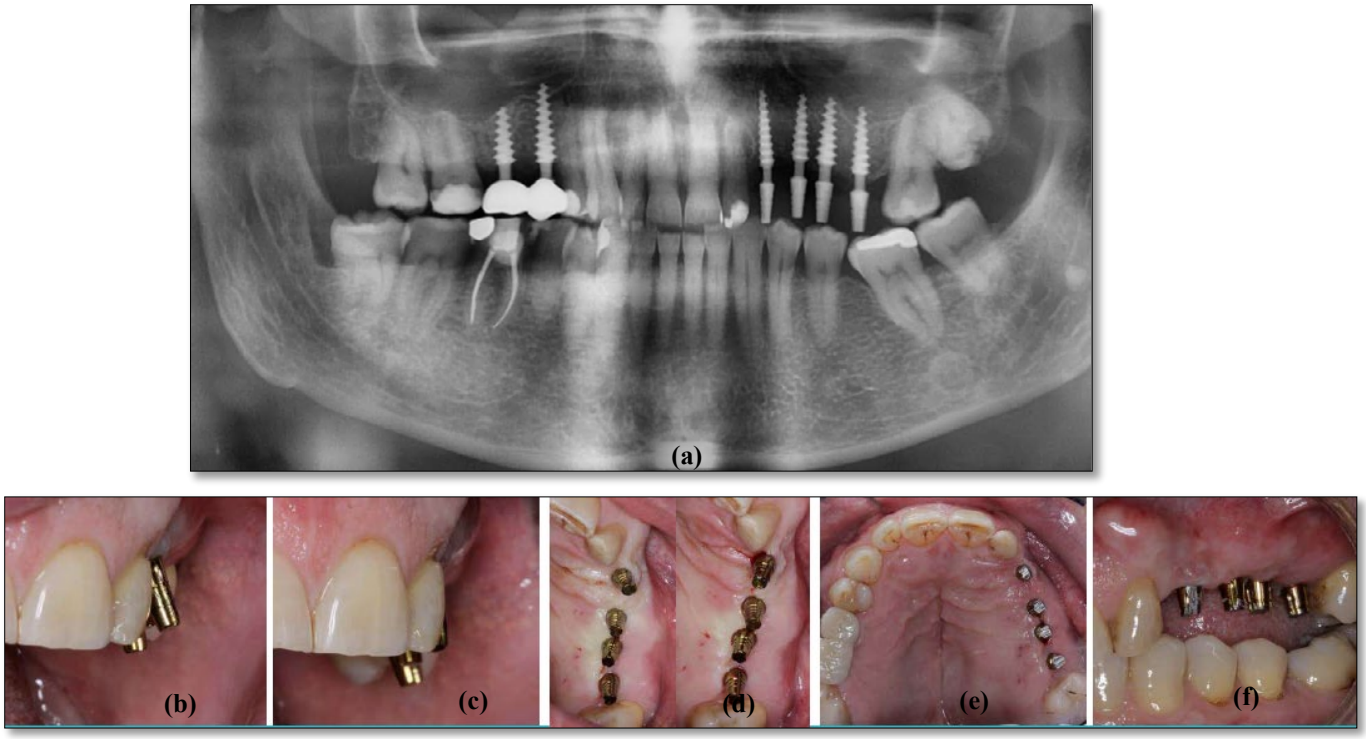


Figure 4. (a) RX Initial, Implants at 2.3 2.4 2.5 2.6, **(b)** to **(f)** Implant placement. Bicortical anchorage and angulation at implants 2.3 and 2.4

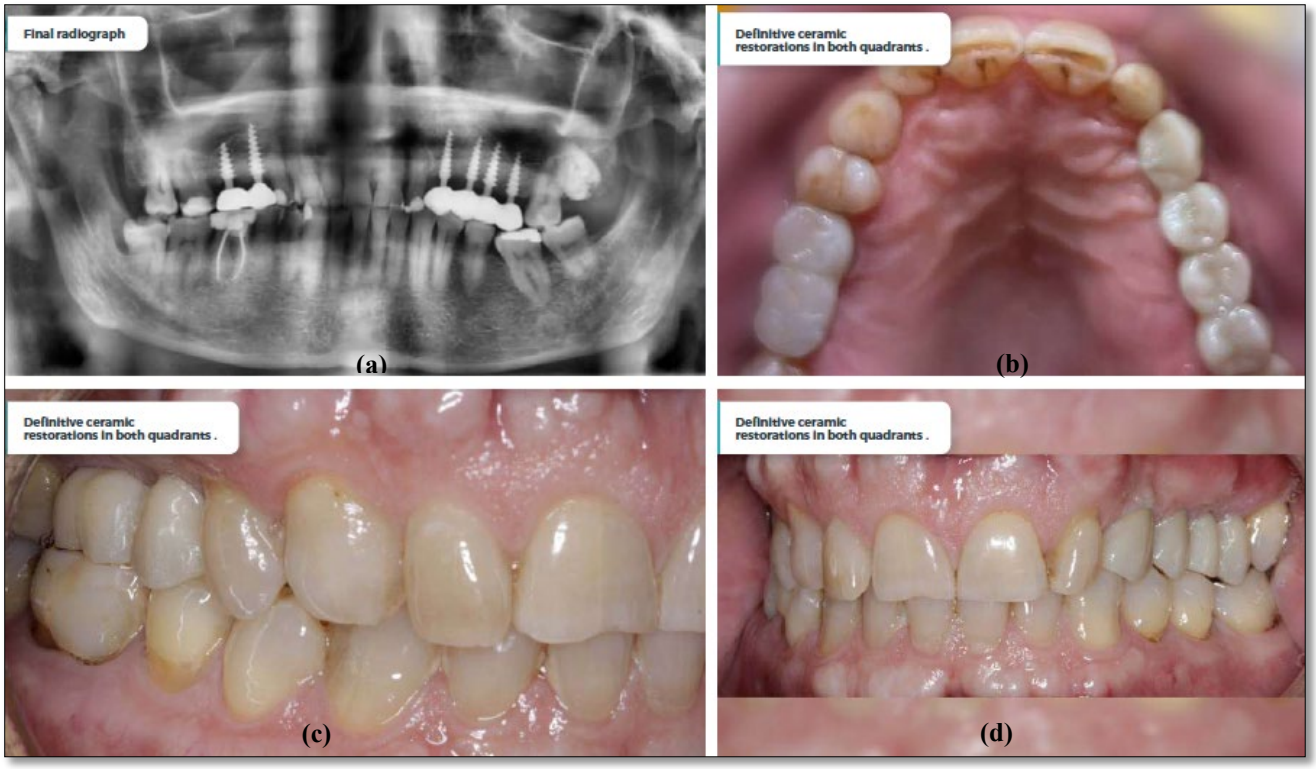
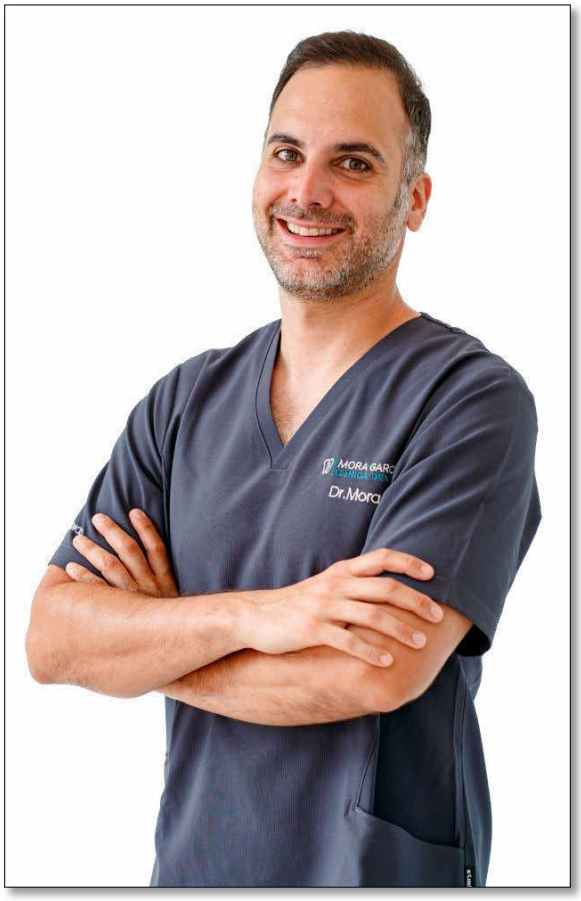


Figure 5. **(a)** Final radiograph, **(b)** Definitive ceramic restorations in both quadrants, **(c)** Definitive ceramic restorations in both quadrants, **(d)** Definitive ceramic restorations in both quadrants.

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