

some teeth continued to exhibit mobility. Given the hopeless prognosis, these teeth were subsequently extracted and dental implants were placed. Following the osseointegration period, impressions, and models for implant-supported hybrid prostheses were obtained.

Outcomes: Due to continued mobility and other complaints noted at the 2-year follow-up a new prosthetic plan and rehabilitation were implemented. After the placement of implant-supported hybrid prostheses, at the 2-year follow-up, no complaints were detected in the patient, and the implants were functioning well. No functional, phonetic, or aesthetic problems were noted.

Conclusions: Initial periodontal treatment, followed by flap surgery and soft/hard tissue augmentations, can provide successful results for severe periodontal support loss cases. To maintain the health and structure of the masticatory system, restoring lost periodontal tissues and teeth with prosthodontic rehabilitation should be done carefully.

PC444 | Peri-Implant Soft Tissue Dehiscence Treatment – A Case Series

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Background: Implant therapy has become a common practice for replacing lost teeth, where patient satisfaction is crucial (Roccuzzo, Gaudio, et al. 2014). However, facial soft tissue dehiscence is a common concern following implant restorations (Cardaropoli, Lekholm, et al. 2006), with a 16.9% prevalence (Romandini, Pedrinaci, et al. 2021). Causes include anatomical factors, such as implant position and gingival type, along with pathological factors like recurrent inflammation (Fu, Su, et al. 2012).

Description of the procedure: All three cases described involve healthy patients with no associated systemic pathologies and non-smokers.

A 30-year-old patient, presented with mild peri-implant recession. The gingival margin of implant 12 was 1 mm above tooth 11. After adjustments to the prosthetics and placement of a temporary crown, the gingival margin moved coronally. Finally, a vestibular incision subperiosteal tunnel access (VISTA) with connective tissue graft (CTG) was applied, promoting an increase in peri-implant volume and resulting in complete coverage of the recession.

A 42-year-old, with the absence of keratinised mucosa and peri-implant recession exposing the implant 11. Modification of the abutment and crown was performed. Using a flap surgical technique with coronal advancement flap (CAF) and CTG, promoting coronal displacement of the gingival and volume gain.

A 50-year-old female patient, with a history of periodontal disease, presented with mucosal recession between two implants,

11 and 12, as well interproximal bone loss. A cantilever crown was selected, keeping implant 12 submerged.

Outcomes: The techniques used, including connective tissue grafts, CAF and VISTA, resulted in a coronal displacement of the gingival margin, an increase in keratinised tissue, and significant aesthetic improvement. Post-operative follow-up demonstrated stability of the results, with patients reporting greater satisfaction with aesthetics and oral health.

Conclusions: The periodontal surgical interventions CAF and VISTA on implants, combined with prosthetic adjustments in rehabilitation, improved aesthetics and peri-implant stability, resulting in high satisfaction for patients and clinicians.

PC445 | Soft Tissue Management of Gingival Recession With Implant Extraction, Sandwich Bone. Reconstruction Technique and Temporary Prosthesis Placement

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Background: Placing implants in the aesthetic zone is challenging and requires meticulous planning. Without careful preparation, complications such as improper implant positioning can lead to unsatisfactory functional and aesthetic outcomes, including gingival recession. This case involves severe gingival recession associated with a malpositioned implant in the central incisors, as well as a poorly designed crown. It requires a comprehensive treatment plan to restore both function and aesthetics effectively.

Description of the procedure: A 28-year-old female presented with gingival recession in the left central incisor (21) and poor aesthetics due to an improperly positioned implant. She reported previous implant placement and removal in this region twice. Clinical and radiographic evaluations indicated the need for implant removal and augmentation. The treatment plan involved extracting the malpositioned implant and placing a new implant with simultaneous bone grafting using the sandwich technique, along with a connective tissue graft for adequate bone and soft tissue support.

During healing, a temporary Maryland bridge maintained aesthetics. Three months post-surgery, a fixed temporary prosthesis was placed, supplemented by an additional connective tissue graft to enhance soft tissue volume and stability. After another 3 months, the final crown was placed, resulting in satisfactory aesthetic and functional outcomes.

Outcomes: The patient achieved complete resolution of gingival recession with significant improvement in soft tissue contours and stability around the new implant. The combination of bone grafting, connective tissue grafting, and precise prosthetic management successfully restored functional and aesthetic outcomes.

Conclusions: This case highlights the importance of precise implant placement in the aesthetic zone and demonstrates the effectiveness of using connective tissue and bone grafts to manage gingival recession associated with malpositioned implants. A well-coordinated treatment plan, including temporary restorations, is essential for achieving optimal results.