



THE UNIVERSITY
of ADELAIDE

Removable Prosthodontics

Things to do

... and not to do

Prosthodontics

Implantology

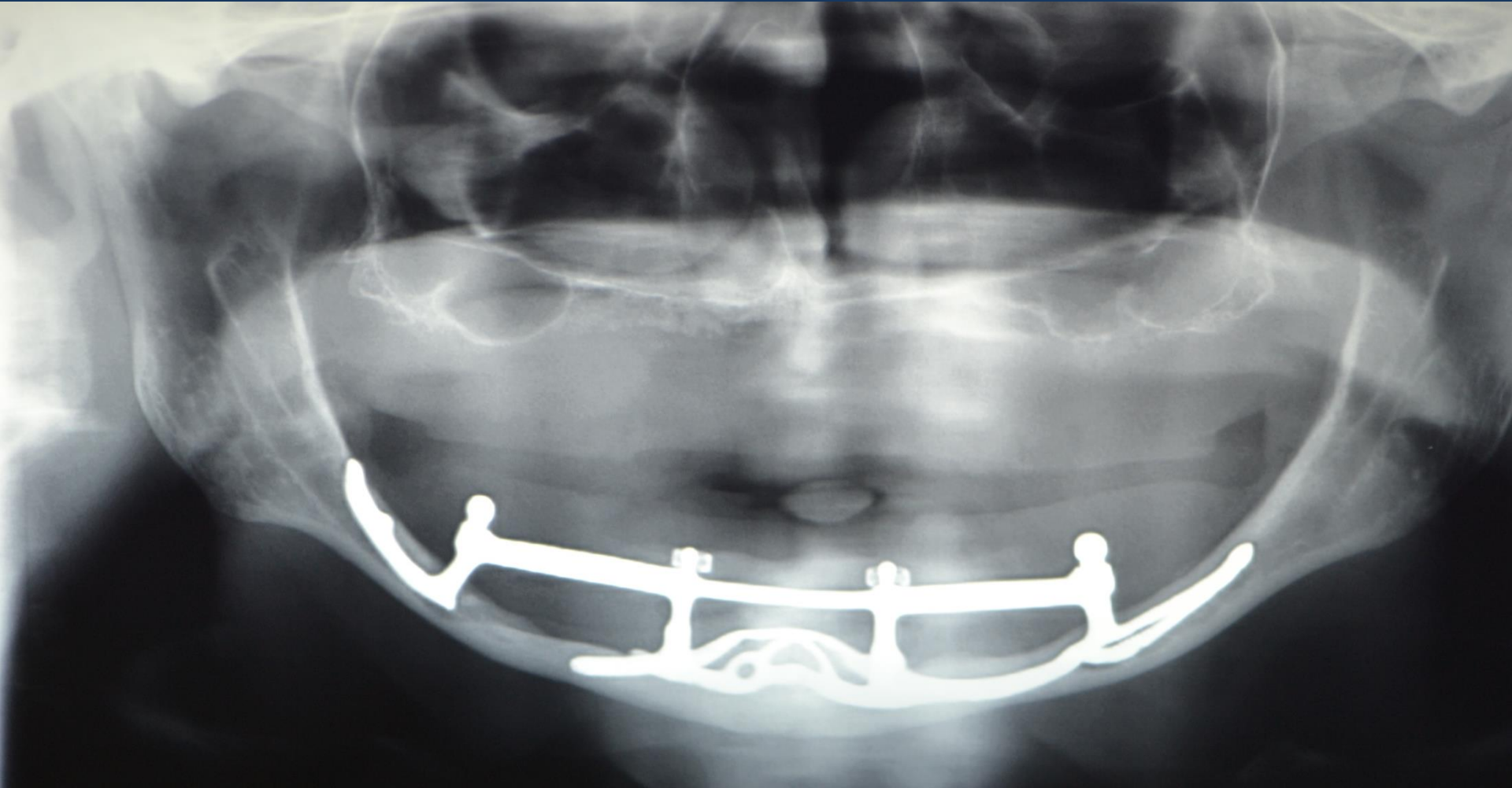
Maxillofacial prosthodontics

Orofacial pain

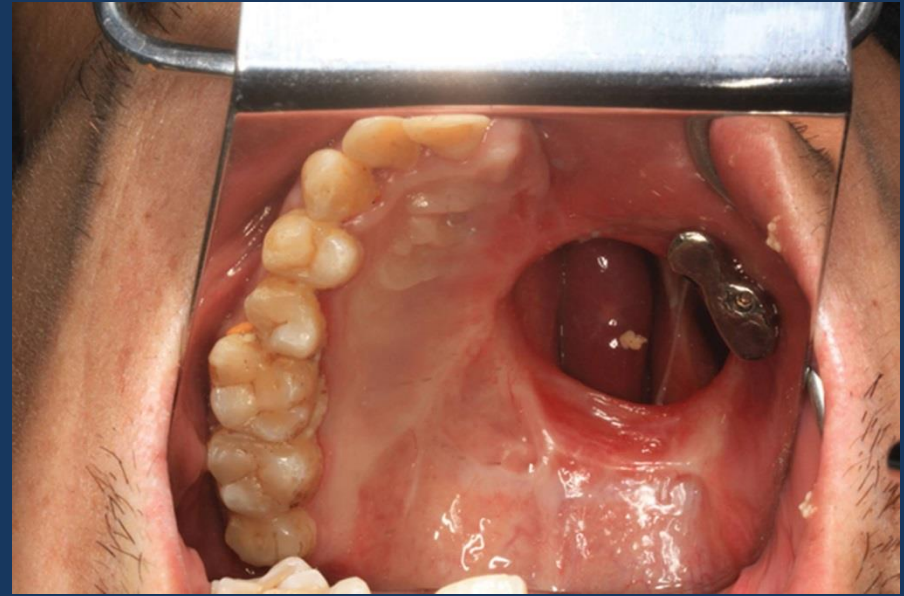
Fixed prosthodontics

Removable prosthodontics

Implantology

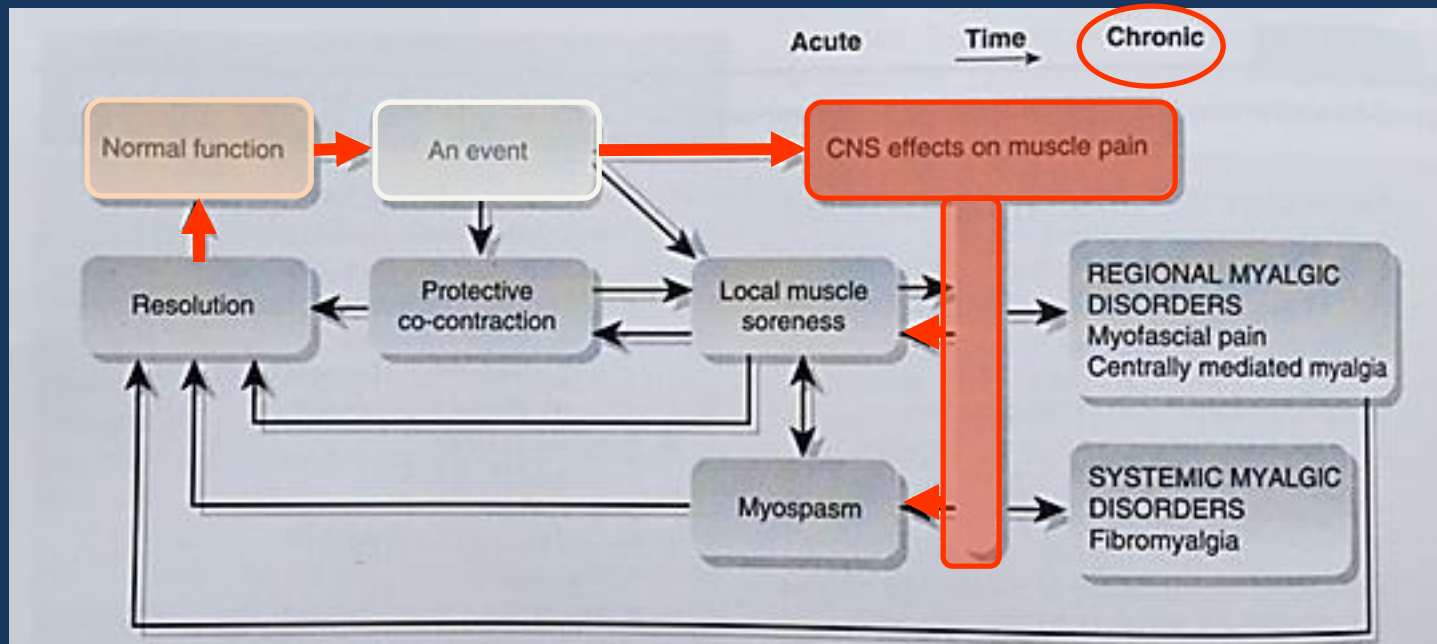


Maxillofacial prosthodontics



Orofacial Pain

Masticatory Muscle Disorders



Fixed Prosthodontics



Removable Prosthodontics



Principles of Prothodontics

Comfort

Function

Aesthetics

Tissue preservation

Avoiding complications

Determining case complexity

Treatment planning to avoid common problems

Impressions

Vertical dimension

Tooth arrangement

New materials and techniques

Difficult people

Determining case complexity

Technical

Psychosocial

Determining case complexity

Technical

Principles of Prosthodontics

Existing stable occlusion

Existing un-stable occlusion

No existing occlusion

Determining case complexity

Technical

American College of Prosthodontists

TOPICS OF INTEREST

Classification System for Complete Edentulism

Thomas J. McGarry, DDS,¹ Arthur Nimmo, DDS,² James F. Skiba, DDS,³
Robert H. Ahlstrom, DDS, MS,⁴ Christopher R. Smith, DDS,⁵
and Jack H. Koumjian, DDS, MSD⁶

The American College of Prosthodontists has developed a classification system for complete edentulism based on diagnostic findings. These guidelines may help practitioners determine appropriate treatments for their patients. Four categories are defined, ranging from Class I to Class IV, with Class I representing an uncomplicated clinical situation and a Class IV patient representing the most complex and higher-risk situation. Each class is differentiated by specific diagnostic criteria. This system is designed for use by dental professionals who are involved in the diagnosis of patients requiring treatment for complete edentulism. Potential benefits of the system include: 1) better patient care, 2) improved professional communication, 3) more appropriate insurance reimbursement, 4) a better screening tool to assist dental school admission clinics, and 5) standardized criteria for outcomes assessment.

J Prosthodont 1999;8:27-39. Copyright © 1999 by The American College of Prosthodontists.

INDEX WORDS: complete dentures, diagnosis, treatment planning, prosthodontics, dental education, graduate dental education, outcomes assessment, quality assurance, treatment outcomes

COMPLETELY EDENTULOUS PATIENTS exhibit a broad range of physical variations and health concerns. Classifying all edentulous patients as a single diagnostic group is insensitive to the multiple levels of physical variation and the differing treatment procedures required to restore function and comfort. A graduated classification of complete edentulism has been developed that describes varying levels of loss of denture-supporting structures.

This article defines complete edentulism as follows: the physical state of the jaw(s) following removal

of all erupted teeth and the condition of the supporting structures available for reconstructive or replacement therapies. The condition of edentulism, for the purpose of this article, is divided into four levels according to specific diagnostic criteria.

The absence of organized diagnostic criteria for complete edentulism has been a long-standing impediment to effective care for patients. Recognition of the diverse nature, scope, and degree of complete edentulism, although thoroughly described in the dental literature, has not been organized to efficiently guide dental educators, general dentists, prosthodontists, and third-party payers in providing the appropriate treatment for each patient. A system for facilitating patient identification is needed to improve patient treatment outcomes.

The American College of Prosthodontists (ACP) recognized its responsibility to the public and the profession to correct this dilemma. The Subcommittee on Prosthodontic Classification was formed in 1995 and charged with developing classification systems for prosthodontic patients. Timely implementation of this system will benefit patients, clinicians, and educators. The classification system for complete edentulism is presented in the following sections.

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1039-1137/99/0801-0027\$3.00/0

Classification System for the Completely Edentulous Patient

Class I

Ideal or minimally compromised

Class II

Moderately compromised

Class III

Substantially compromised

Class IV

Severely compromised

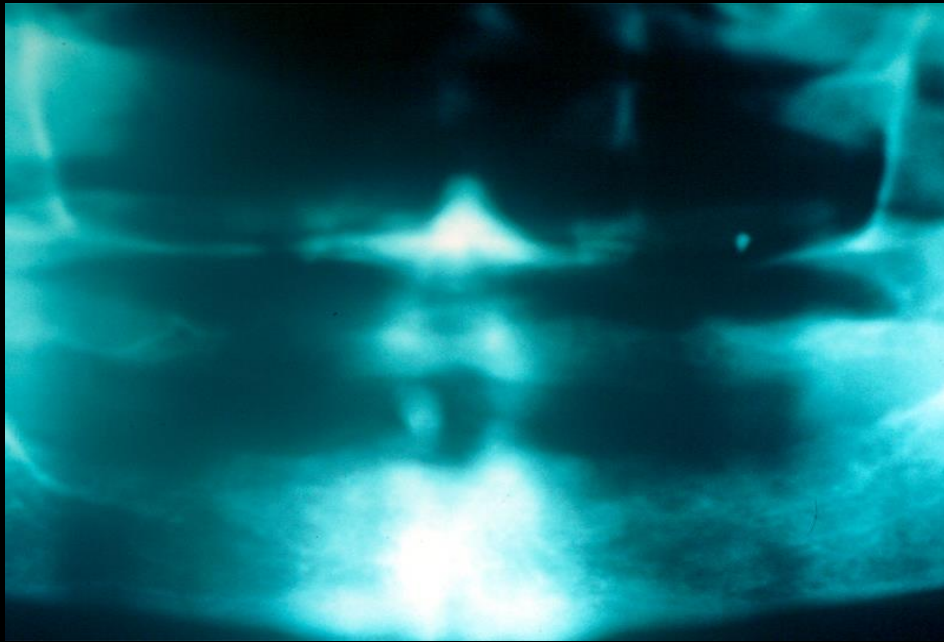
Diagnostic Criteria

1. Bone height--mandibular
2. Maxillomandibular relationship
3. Residual ridge morphology--maxilla
4. Muscle attachments

Bone Height

Mandibular

Type I



Residual bone height of 21mm or greater measured at the least vertical height of the mandible.

Type II



Residual bone height of 16-20 mm measured at the least vertical height of the mandible.

Type III



Residual alveolar bone height of 11-15 mm measured at the least vertical height of the mandible

Type IV



Residual vertical bone height of 10 mm or less measured at the least vertical height of the mandible

Bone Height-Mandibular				
	21 mm or greater			
	16-20 mm		★	
	11-15 mm			
	10 mm or less			
Residual Ridge Morphology-Maxilla				
	Type A-resists vertical & horizontal, hamular notch, no tori	★		
	Type B-no buccal vest., poor hamular notch, no tori			
	Type C-no ant vest, min support, mobile ant ridge			
	Type D-no ant/post vest, tori, redundant tissue			
Muscle Attachments-Mandibular				
	Type A-adequate attached mucosa			
	Type B-no b attach mucosa (22-27), +mentalis m		★	
	Type C-no ant b&l vest (22-27), +genio & mentalis m			
	Type D-att mucosa in post only			
	Type E-no att mucosa, cheek/lip moves tongue			
Maxillomandibular Relationships				
	Class I	★		
	Class II			
	Class III			
Conditions Requiring Preprosthetic Surgery				
	Minor soft tissue procedures			
	Minor hard tissue procedures			
	Implants - simple			
	Implants w ith bone graft - complex			
	Correction of dentofacial deformities			
	Hard tissue augmentation			
	Major soft tissue revisions			
Limited Interarch Space				
	18-20 mm			
	Surgical correction needed			
Tongue Anatomy				
	Large (occludes interdental space)			
	Hyperactive- w ith retracted position			
Modifiers				
	Oral manifestation of systemic disease			
	mild			
	moderate			
	severe			
	Psychosocial			
	moderate			
	major			
	TMD Symptoms			
	Hx of paresthesia or dysesthesia			
	Maxillofacial defects			
	Ataxia			
	Refractory Patient			★

Refractory patient

a patient who has chronic complaints following appropriate therapy

These patients continue to have difficulty in achieving their treatment expectations despite the thoroughness or frequency of the treatment provided.

Class IV



Determining case complexity

Technical

Psychosocial

Diagnosis and Treatment Planning

Demand and Need

Demand and Need

Patients	
Demands	

Demand and Need

Patients	
<i>Expectations</i> <i>Psychosocial context</i>	
Demands	

Demand and Need

Patients	Clinicians
<i>Expectations</i> <i>Psychosocial context</i>	
Demands	Needs

Demand and Need

Patients	Clinicians
<i>Expectations</i> <i>Psychosocial context</i>	<i>Diagnosis</i> <i>General health</i> <i>Available treatment</i>
Demands	Needs

Demand and Need

Patients	Clinicians
<i>Expectations</i> <i>Psychosocial context</i>	<i>Diagnosis</i> <i>General health</i> <i>Available treatment</i>
Demands	Needs

=

Demand and Need



Patients

Clinicians



Expectations

Psychosocial context

Diagnosis

General health

Available treatment

Demands



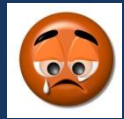
Needs

Demand and Need

Patients	Clinicians
<i>Expectations</i> <i>Psychosocial context</i>	<i>Diagnosis</i> <i>General health</i> <i>Available treatment</i>
Demands	Needs

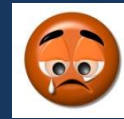
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Demand and Need



Patients

Clinicians



Expectations

Psychosocial context

Diagnosis

General health

Available treatment

Demands

≠

Needs

Case Study

Mrs J****

Combination Syndrome

Combination Syndrome

(Kelly, E Journal of Prosthetic Dentistry 27:140-50 1972)



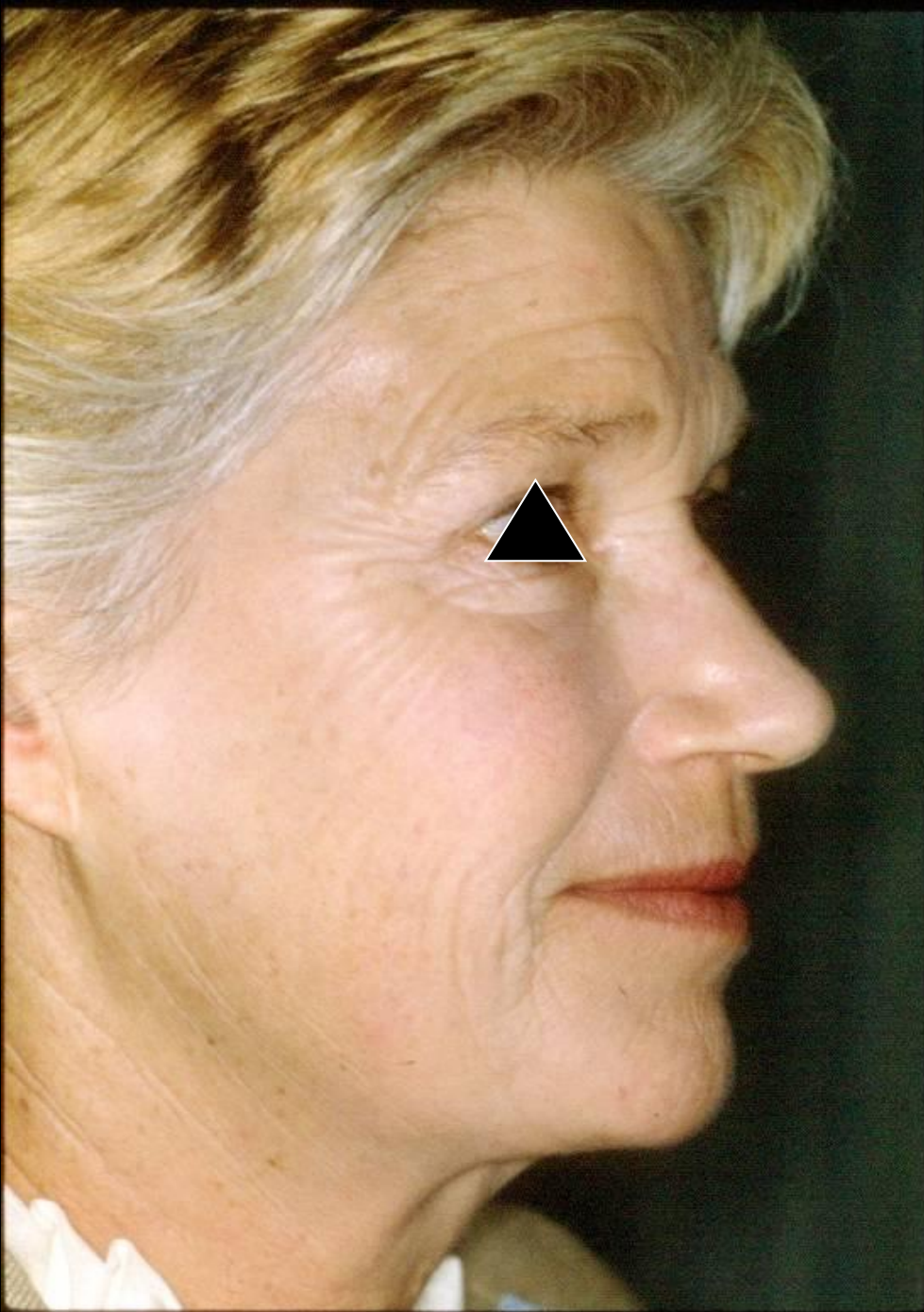
Combination Syndrome

(Kelly, E Journal of Prosthetic Dentistry 27:140-50 1972)

The characteristic features that occur when an edentulous maxilla is opposed by natural mandibular anterior teeth, including:

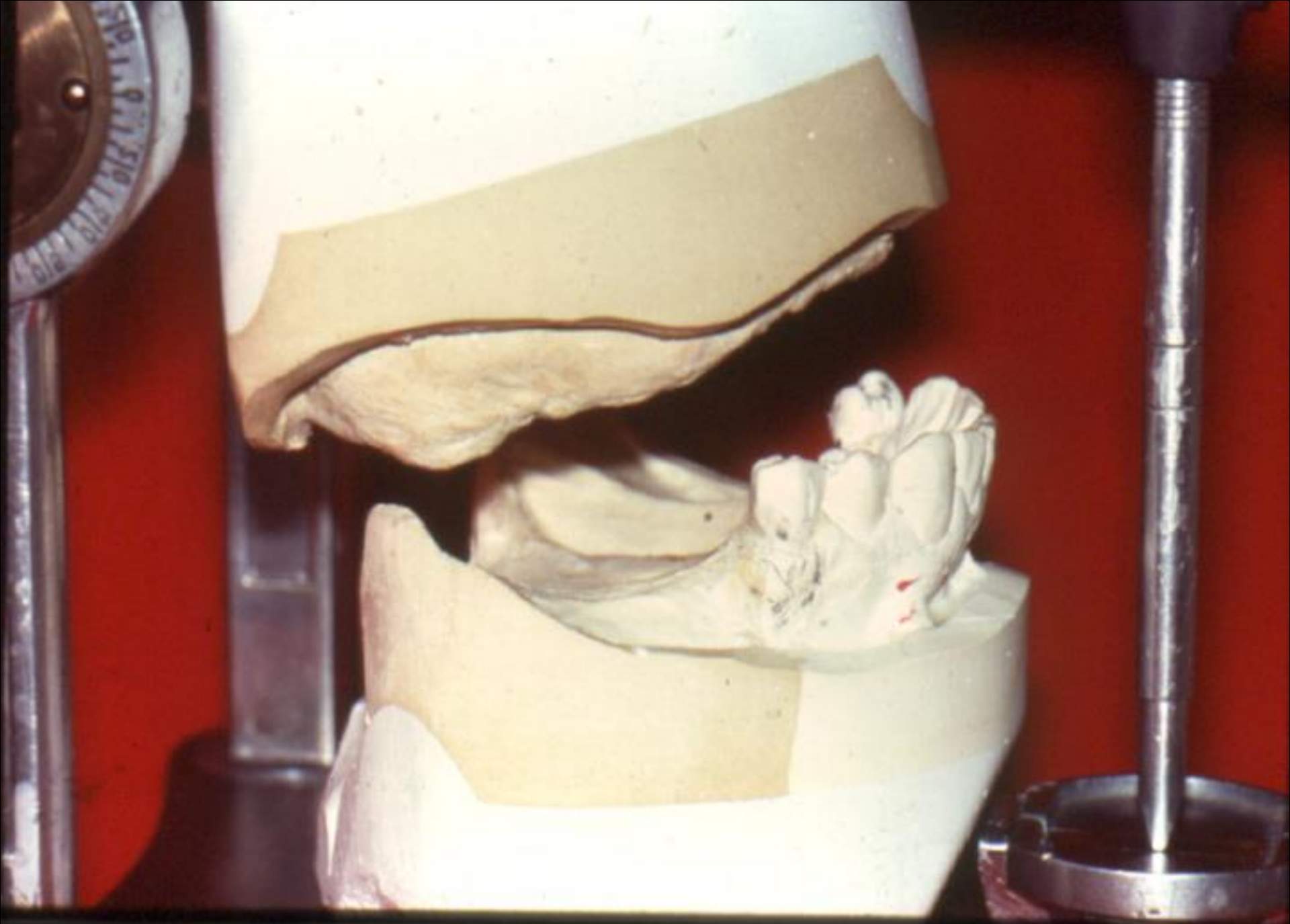
- loss of bone from the anterior portion of the maxillary ridge
- overgrowth of the tuberosities
- papillary hyperplasia of the hard palatal mucosa
- extrusion of the mandibular anterior teeth
- loss of alveolar bone and ridge height beneath the mandibular removable partial denture bases
- Hypertrophic tongue
- Gagging

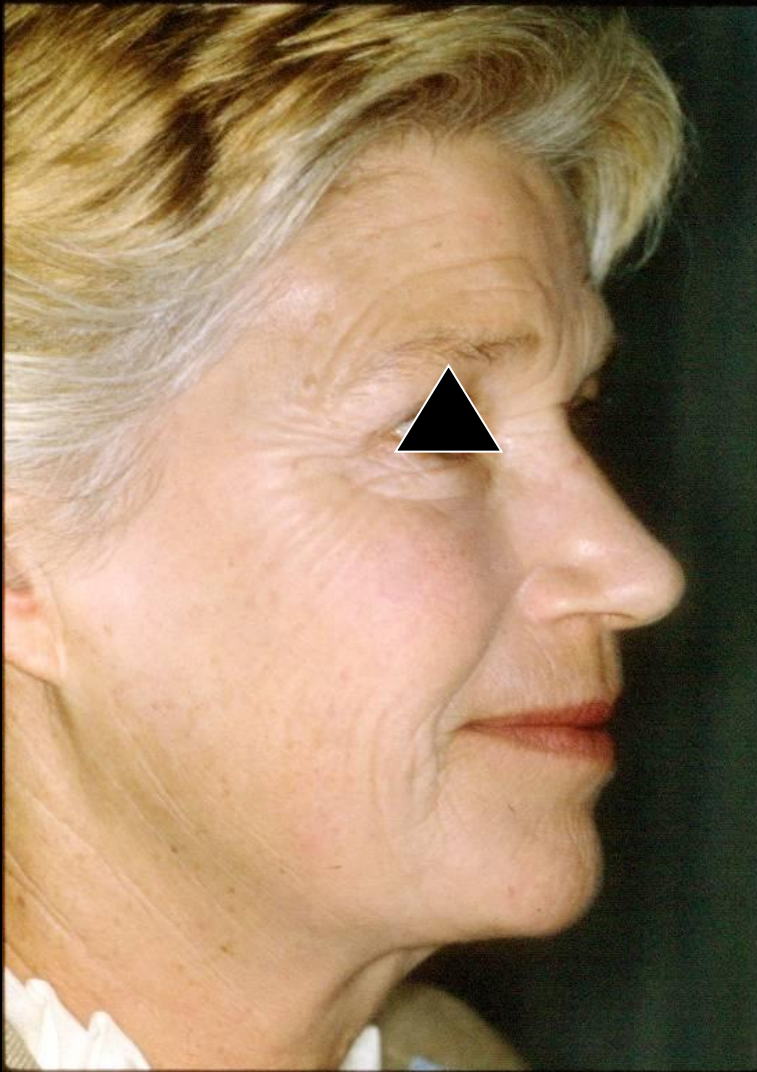












Demand and Need

Patients	Clinicians
<i>Expectations</i> <i>Psychosocial context</i>	<i>Diagnosis</i> <i>General health</i> <i>Available treatment</i>
Demands	Needs

≠

Dealing with difficult cases

Determining case complexity

Treatment planning to avoid common
problems

Common Technical Problems

Denture base

Upper underextended	20 %
Upper overextended	5%
Lower underextended	10%
Lower overextended	20%

Occlusion

Antero-posterior slide	10%
Lateral slide	20%
Working side interferences	25%
Balancing side interferences	5%

Vertical Dimension

No freeway space	40%
Overclosed	5%

Tooth position

10%

Common Technical Problems

Denture base

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Upper overextended	5%
Lower underextended	10%
Lower overextended	20%



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Tooth position

10%



Jaw relation records



Jaw relation records

Common Technical Problems

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Vertical Dimension

No freeway space	40%
Overclosed	5%

Tooth position

10%



Tooth arrangement



Dealing with difficult denture cases

Determining case complexity

Treatment planning to avoid common problems

Impressions

Impression Techniques

Extensions

Accuracy

Detail

Tissue displacement

Impression Techniques

Extensions





Impression Techniques

Extensions

Accuracy

Impression Techniques

Extensions

Accuracy

Detail

Impression Techniques

Detail



Impression Techniques

Extensions

Accuracy

Detail

Tissue displacement

Combination Syndrome

Management Strategies

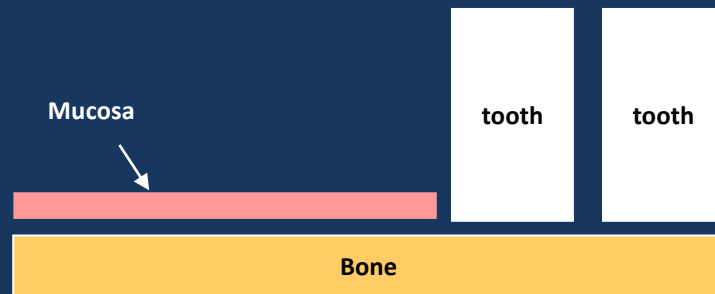
Impression Technique

Impression Technique

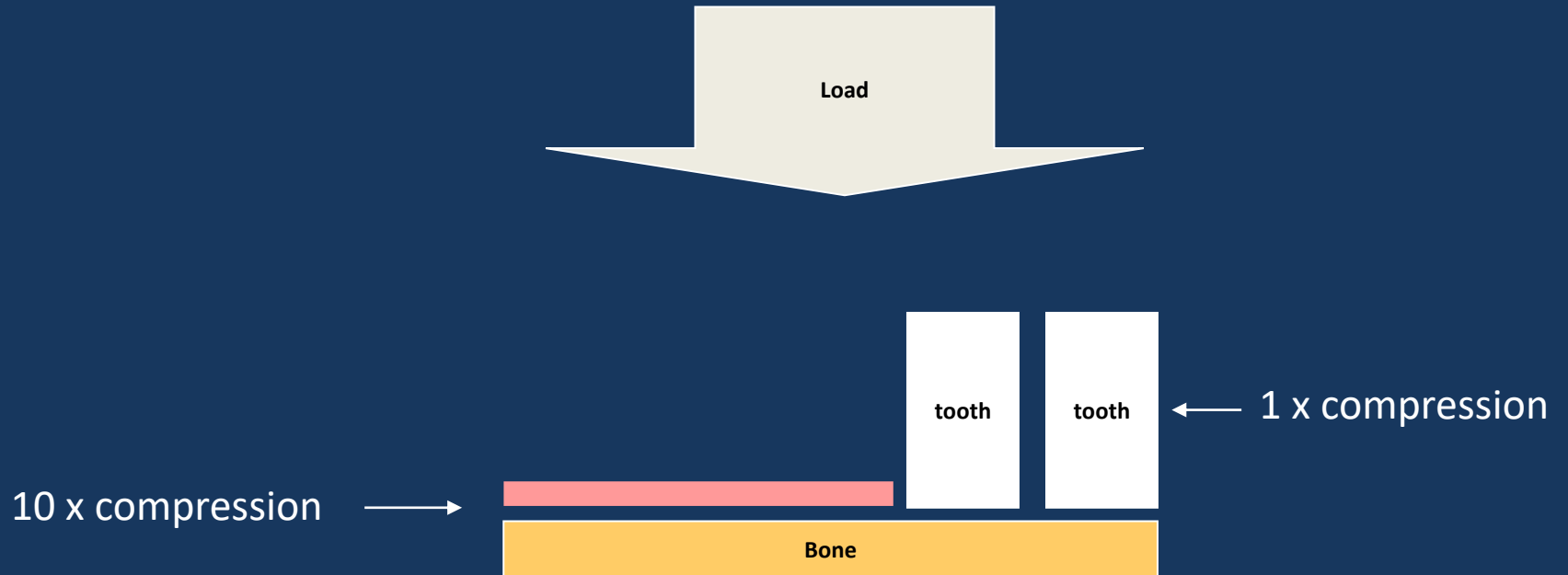


Jaw Relations Technique

Anatomy

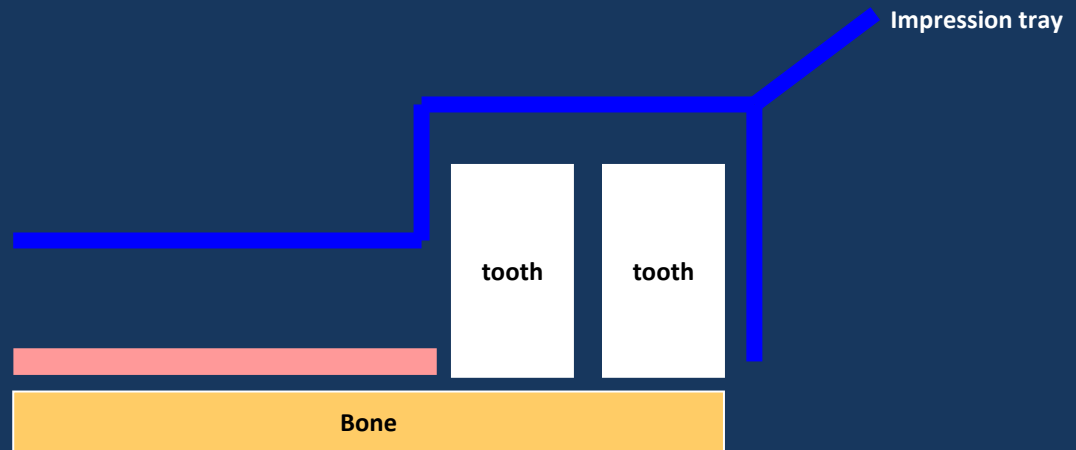


Under Normal Loads

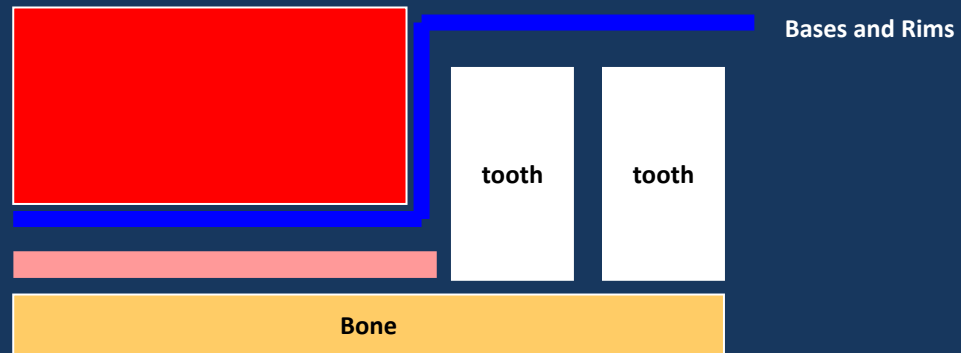


Impression

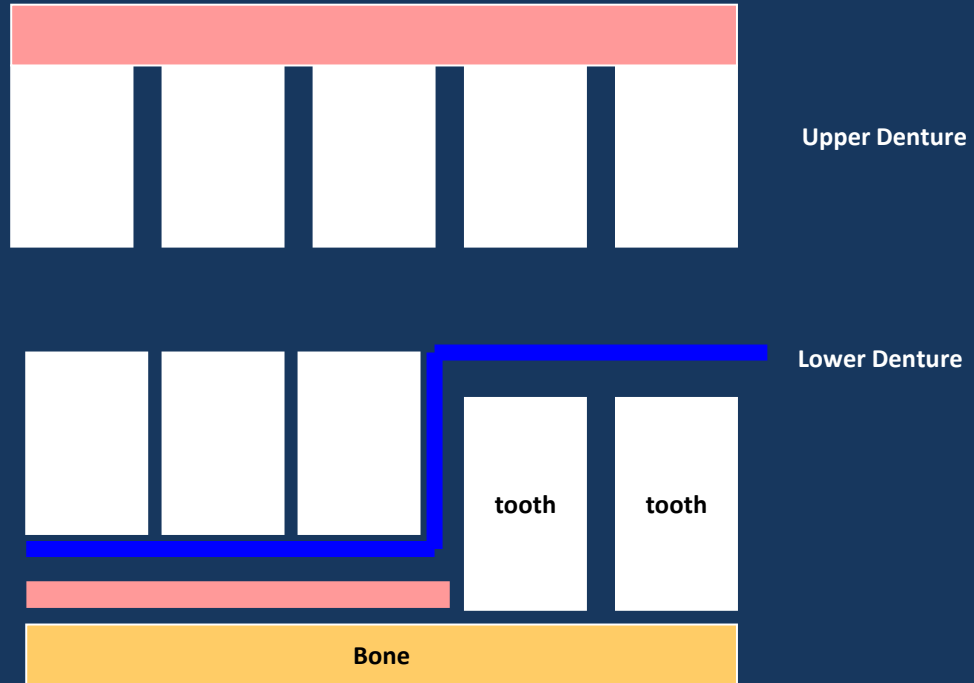
High viscosity material



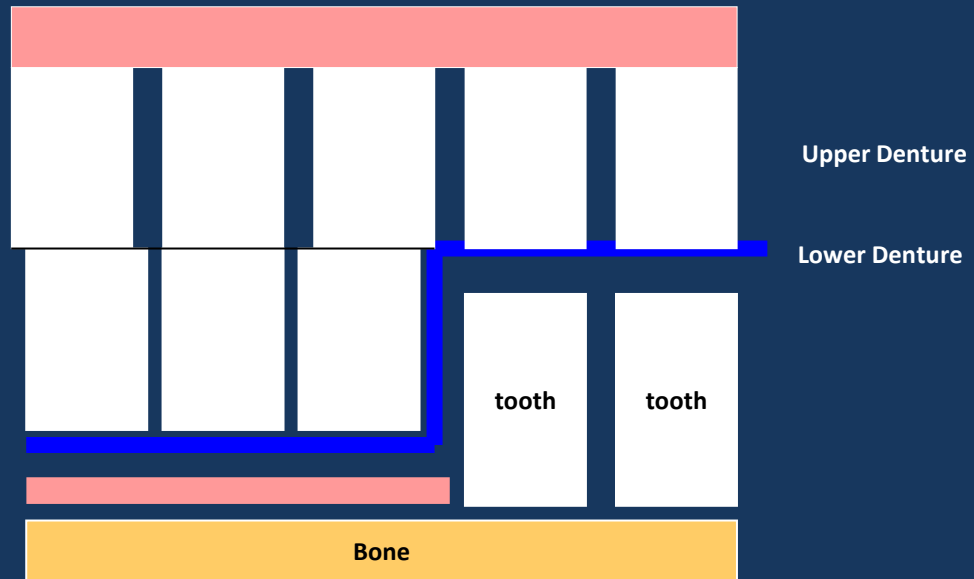
Jaw Relation Records



Function

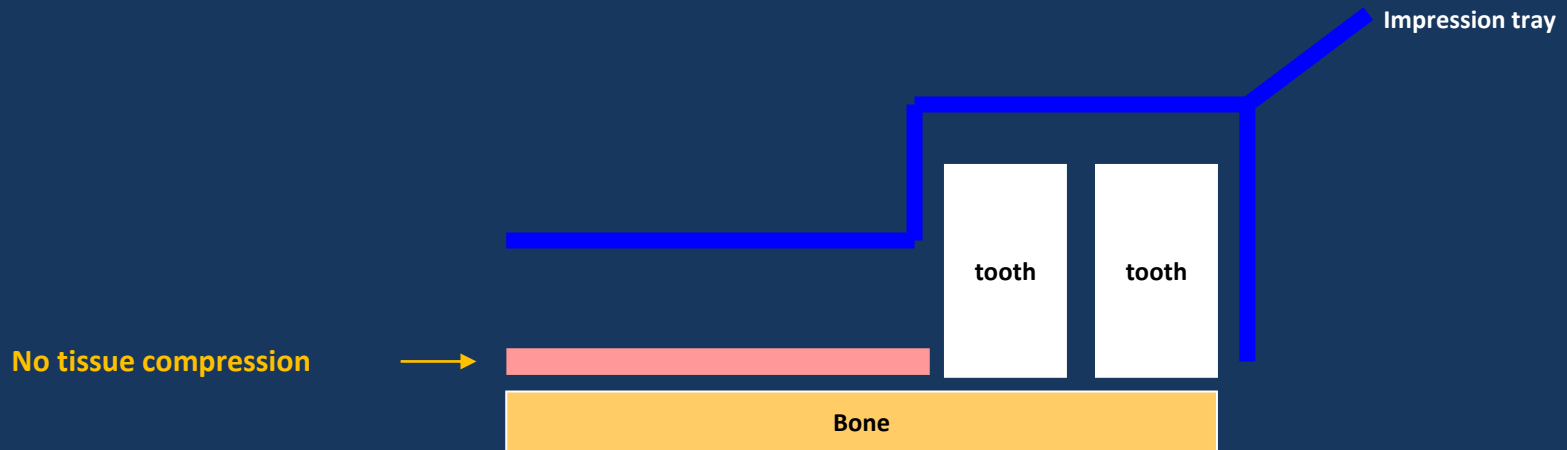


Function

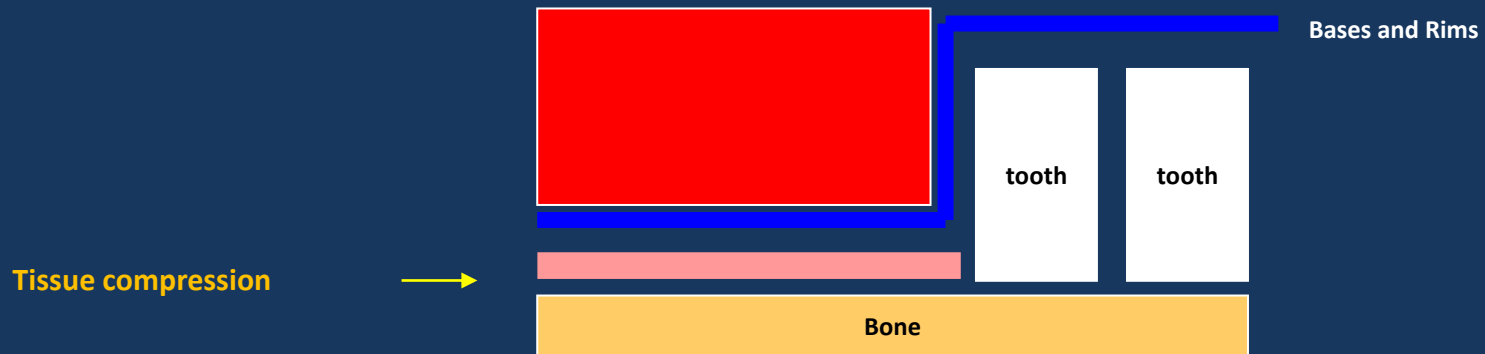


Impression

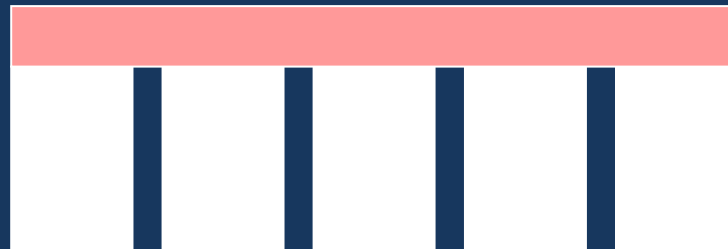
Low Viscosity



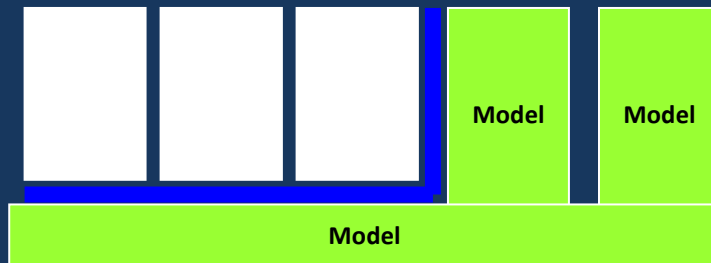
Jaw Relation Records



Jaw Relation Records

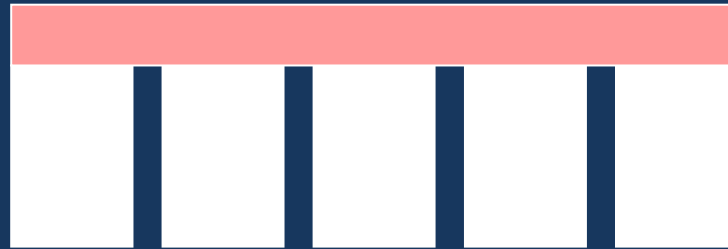


Upper Denture

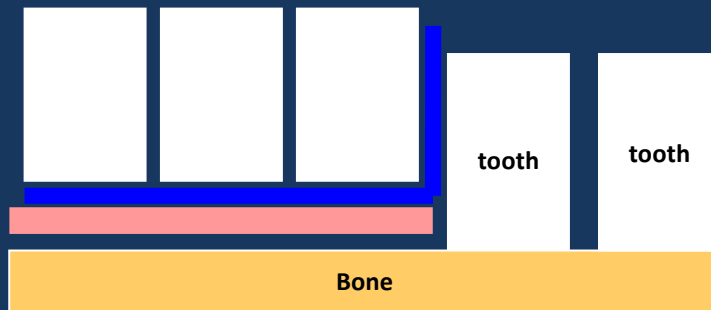


Lower Denture

Function



Upper Denture



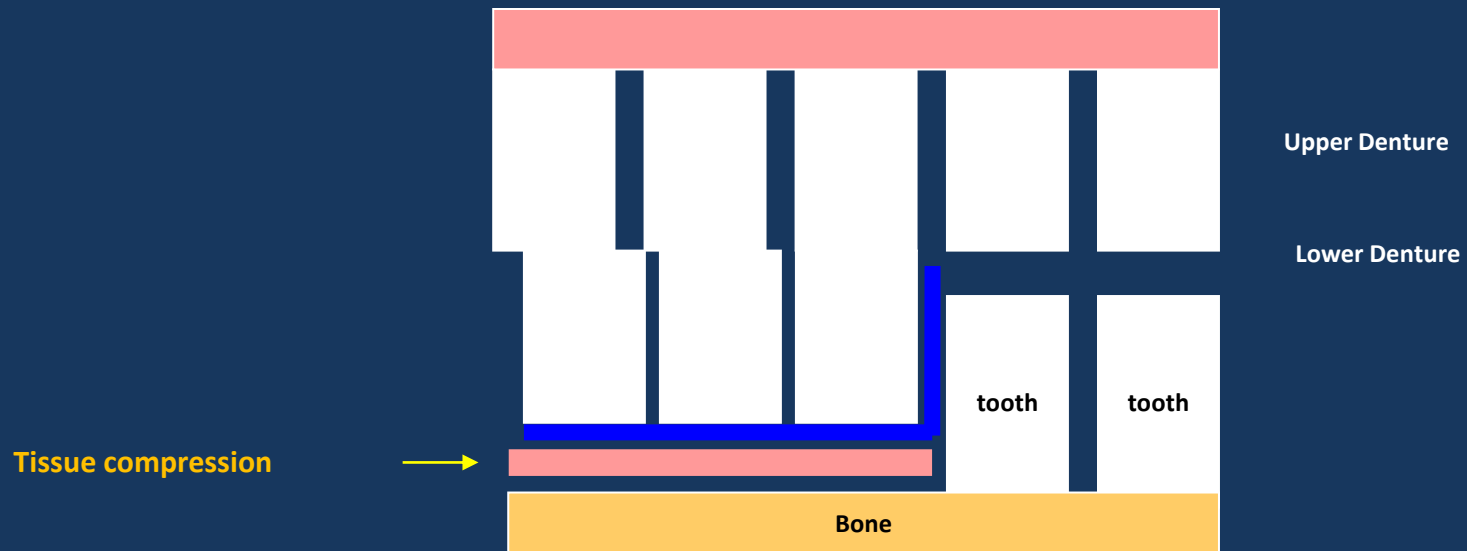
Lower Denture

No tissue compression



Bone

Function



Dealing with difficult denture cases

Determining case complexity

Treatment planning to avoid common problems

Impressions

Vertical dimension

Occlusal Vertical Dimension



Occlusal Vertical Dimension

Common situations:

Small increase in OVD required

(less than 5mm and less than 50% of freeway space)

Occlusal Vertical Dimension

Common situations:

Small increase in OVD required

(less than 5mm and less than 50% of freeway space)

Larger increase in OVD required

(increase < freeway space)

Occlusal Vertical Dimension

Common situations:

Small increase in OVD required

(less than 5mm and less than 50% of freeway space)

Larger increase in OVD required

(increase < freeway space)

Larger increase in OVD required

(increase > freeway space)

Small increase in OVD required

(less than 5mm and less than 50% of freeway space)

Freeway space

Increase OVD

4

2

8

4

10

5

12

5

16

5

Small increase in OVD required

(less than 5mm and less than 50% of freeway space)

Proceed with caution
and confidence!

Beware of the class II division 2 cases

Case Study

Mr T*****

Small increase in OVD required

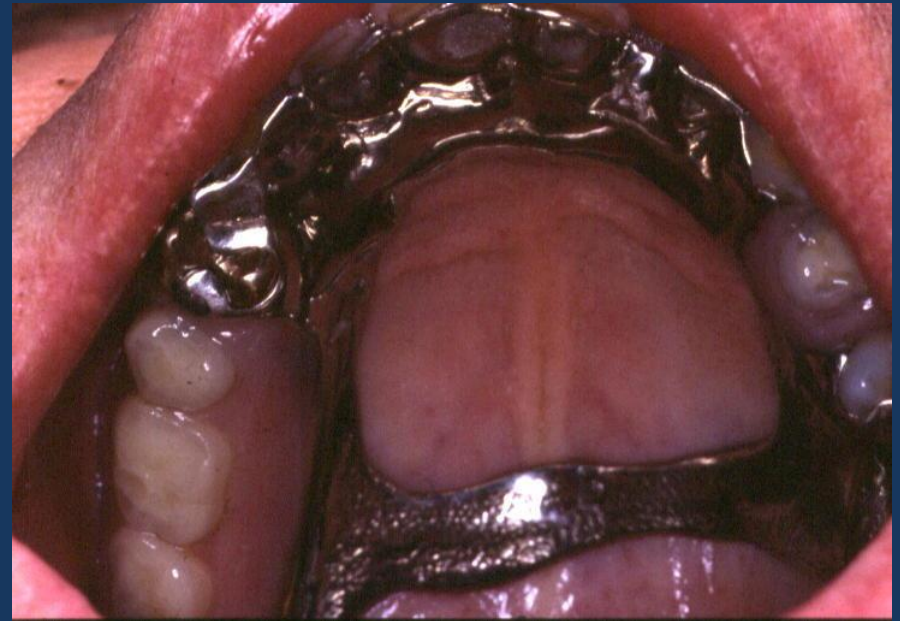
- Male age 56
- Lost maxillary right and mandibular left posterior teeth
- MPD and bruxing
- 10 mm freeway space
- Limited denture space
- Unstable occlusion with lateral slide on 14



Case Study

Mr T***** Small increase in OVD required

- Establish stable occlusion at existing vertical dimension with 14 inlay
- Construct partial denture to increase OVD by 5 mm
- Nightguard to control nocturnal habit



Does this type of treatment work?

Age 56

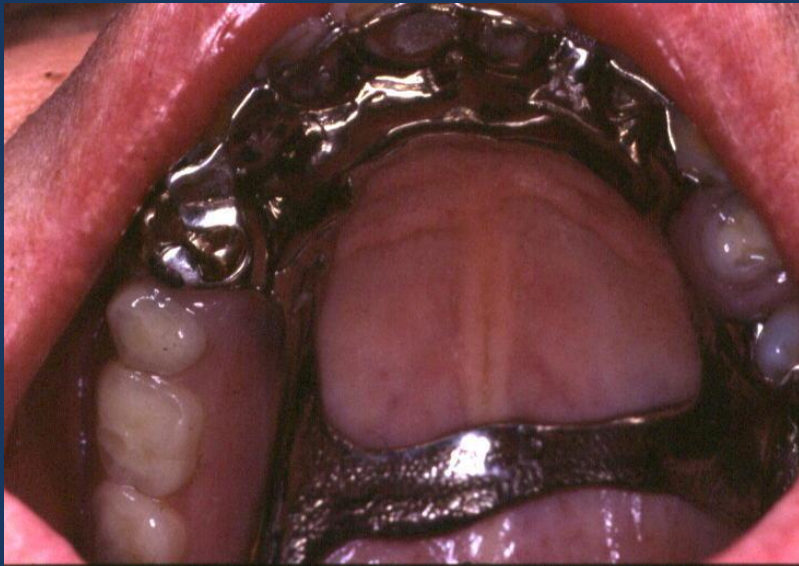


Age 66



Does this type of treatment work?

Age 56



Age 66



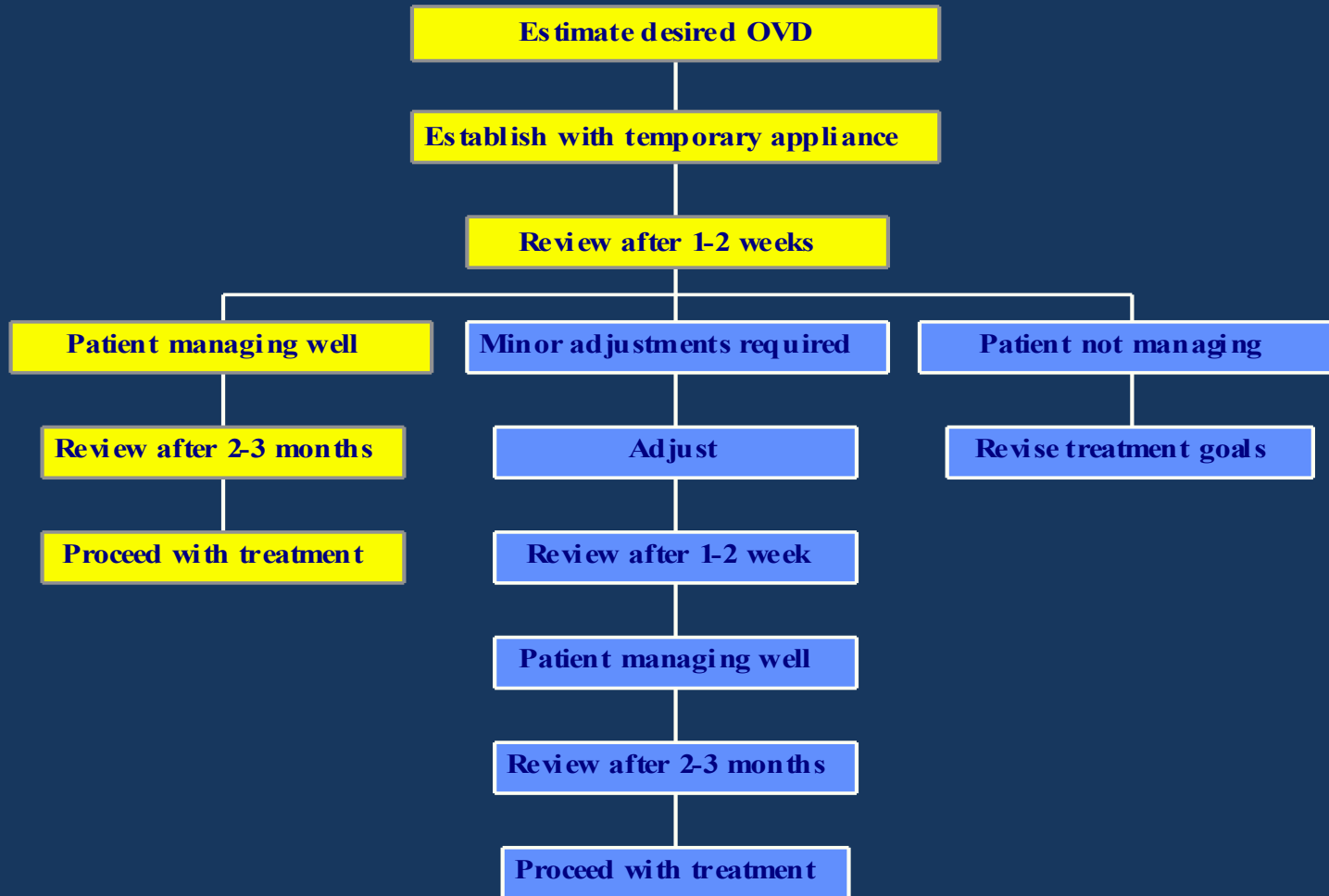
Larger increase in OVD required

(increase < freeway space)

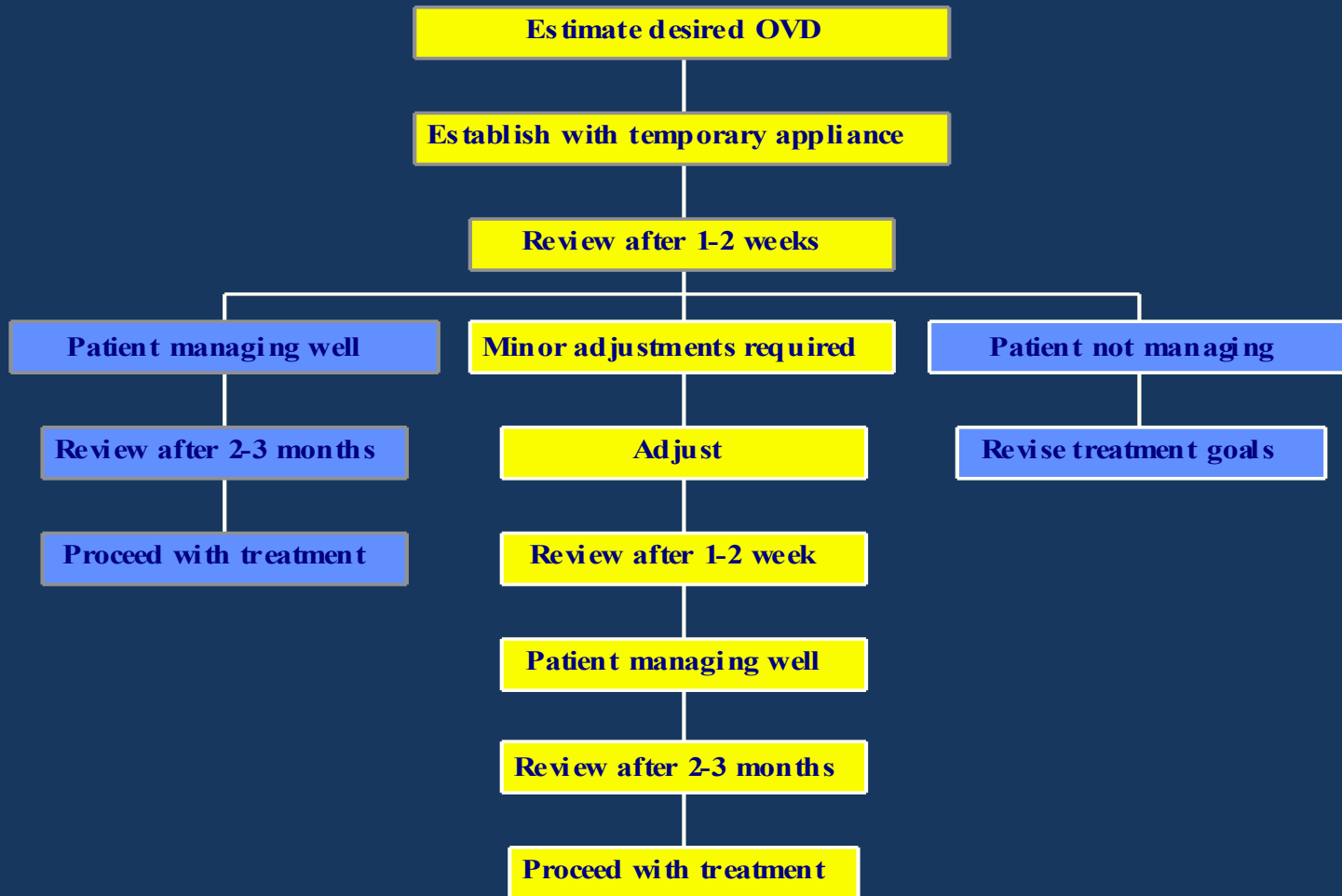
Increase OVD to desired extent with temporary
appliance

Review for at least 3 months
to ensure patient acceptance

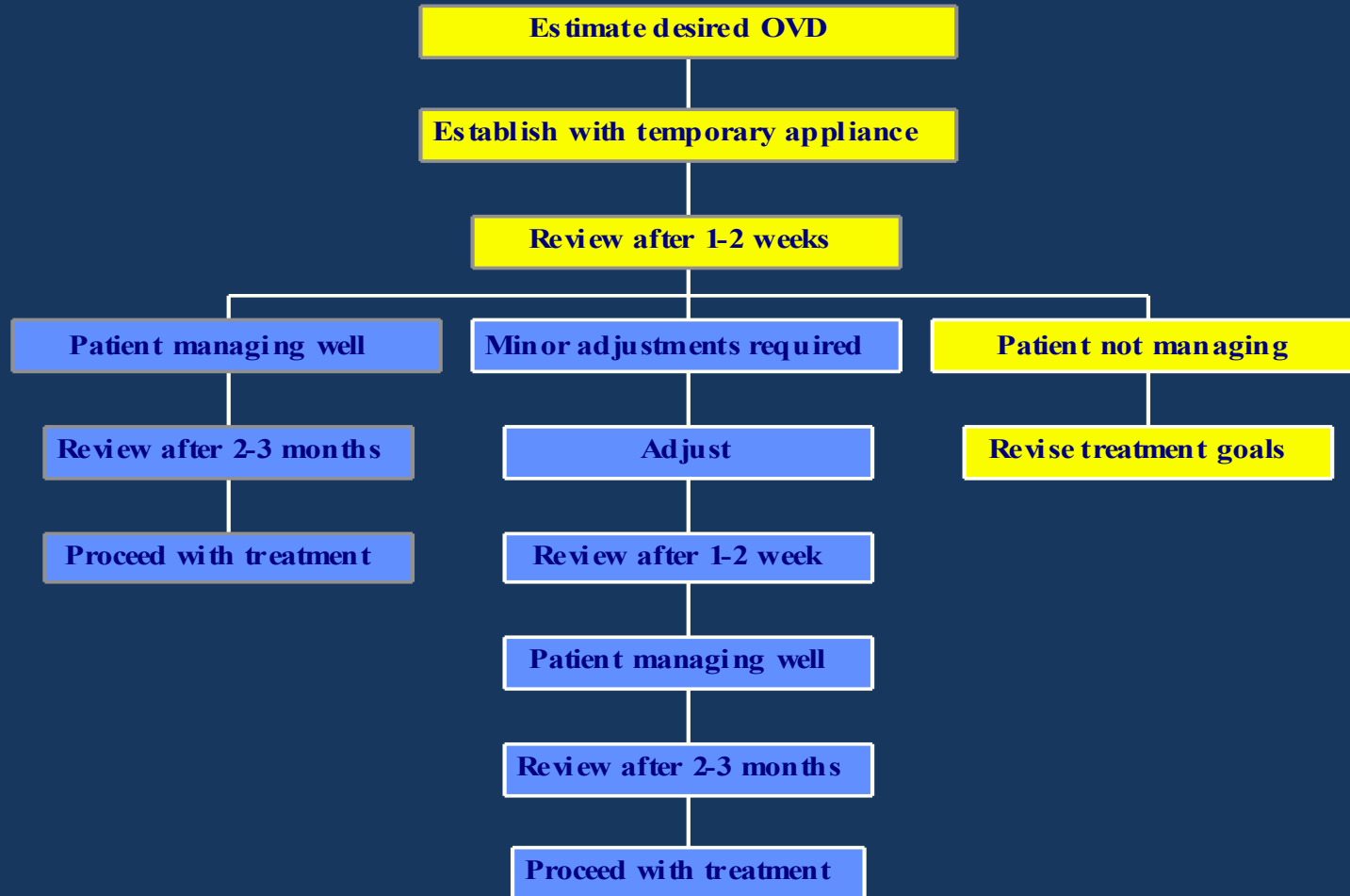
Changing vertical dimension (increase < freeway space)



Changing vertical dimension (increase < freeway space)



Changing vertical dimension (increase < freeway space)



Case Study

Mrs M*****

Larger increase in OVD < freeway space

- 64 year old female
- Lost maxillary posterior teeth
- Insufficient denture space
- 6mm freeway space
- 5mm increase in OVD required for treatment



Case Study

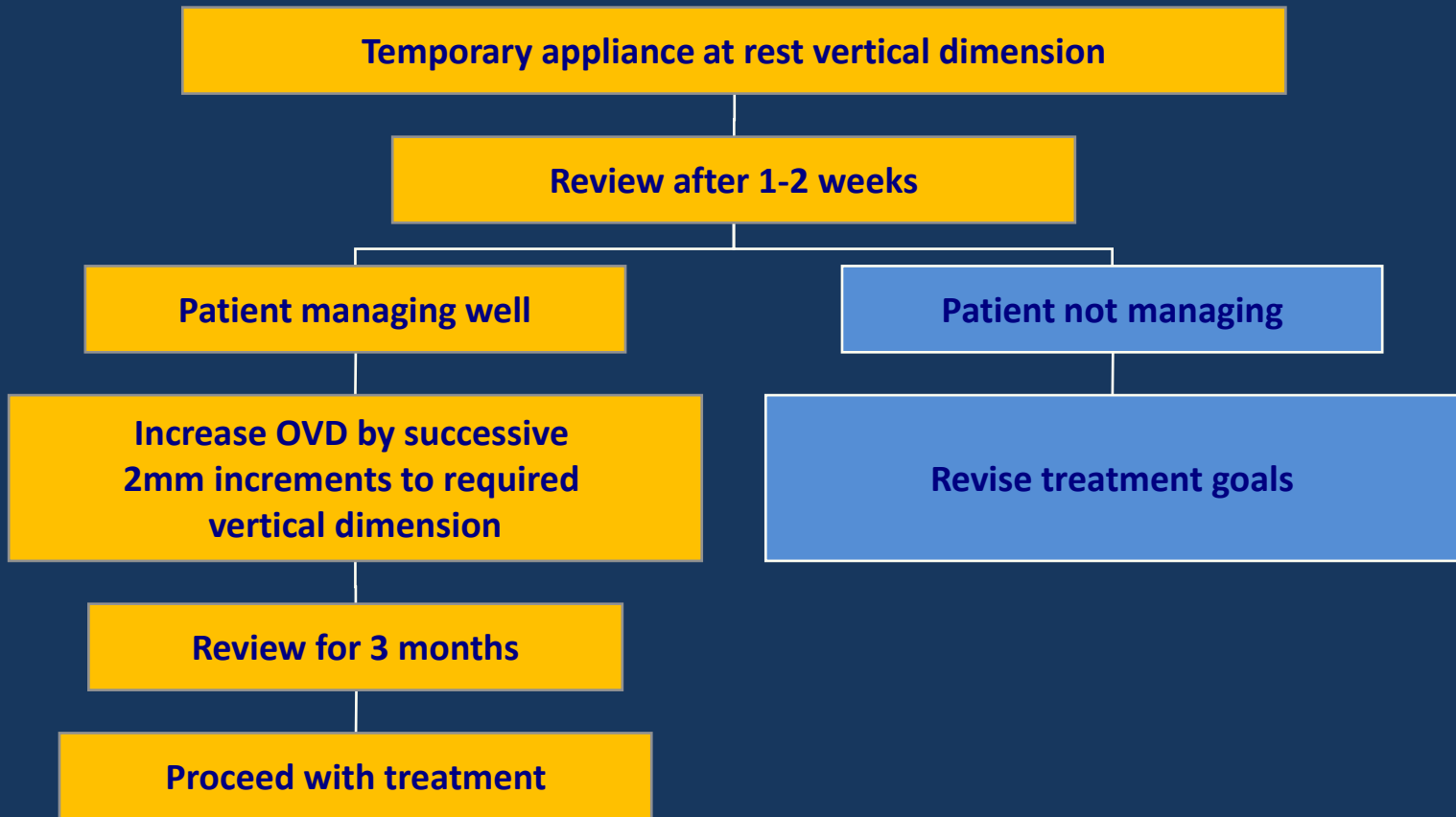
Mrs M*****

Larger increase in OVD < freeway space

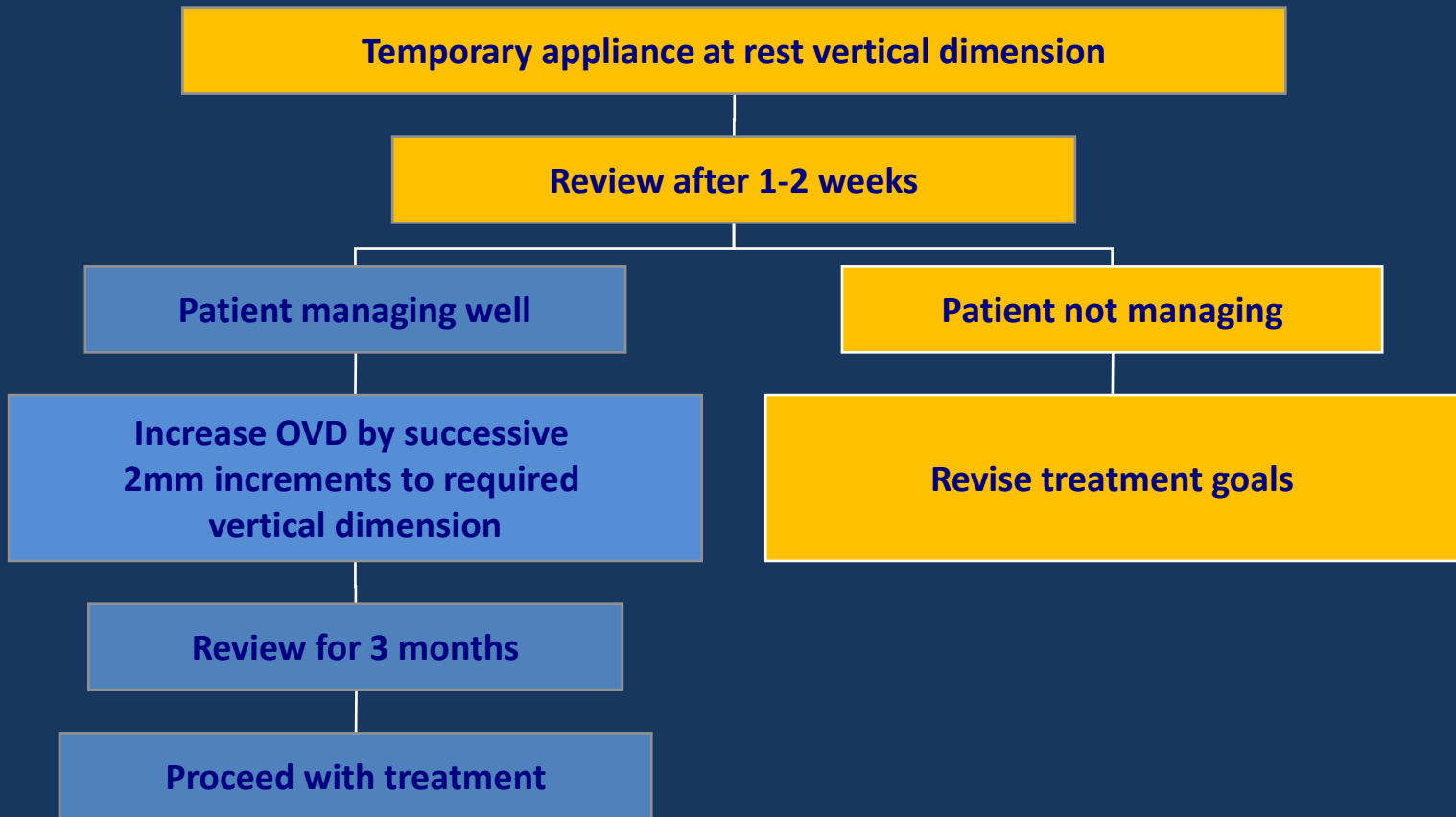
- Establish new OVD with temporary PU
- Review after 1-2 weeks
- Review for 3 months to assess patient acceptance of OVD
- Proceed with final treatment



Changing vertical dimension (increase > freeway space)



Changing vertical dimension (increase > freeway space)



Case Study

Mr B*****

64 year old male

Brachycephalic

GORD for 20 years

Moderate alcohol consumption

Freeway space = 12mm







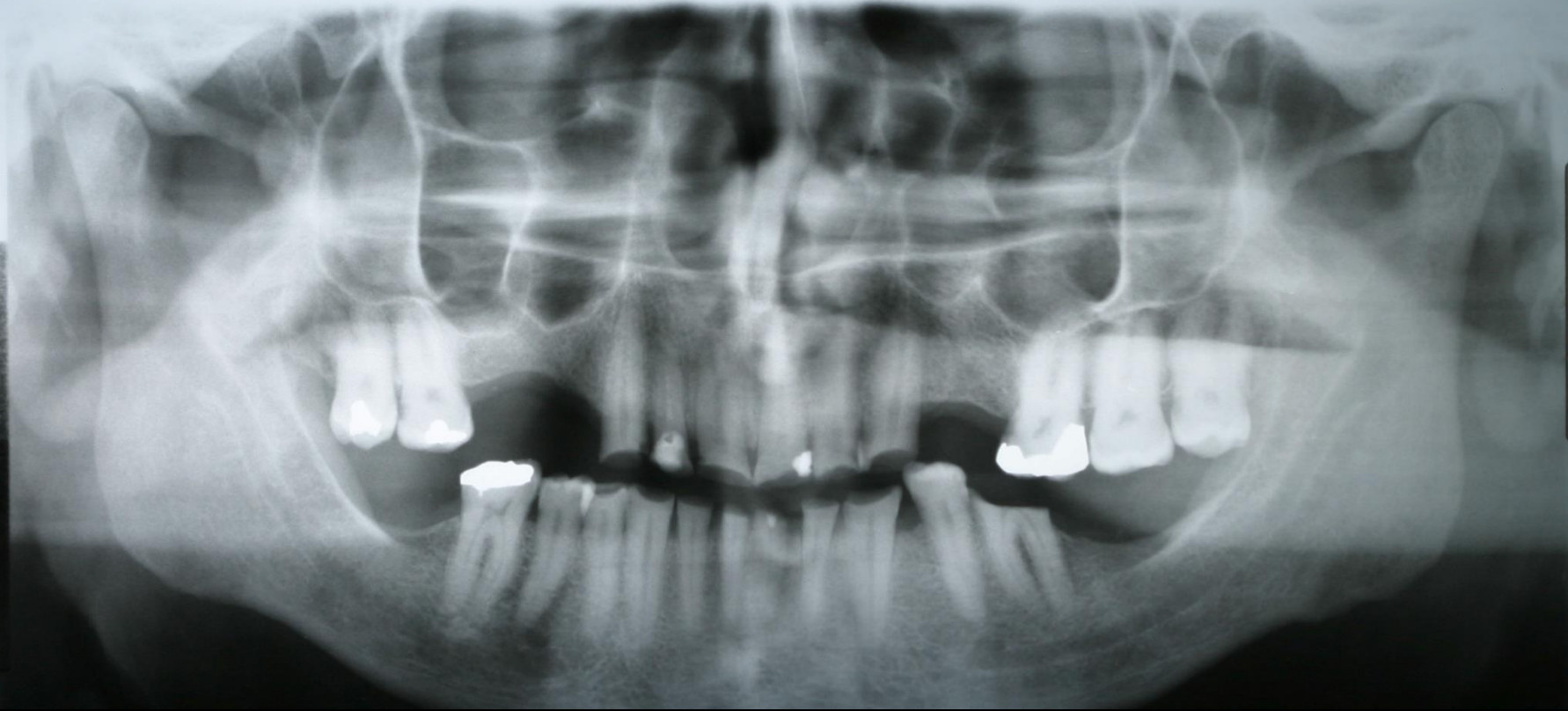


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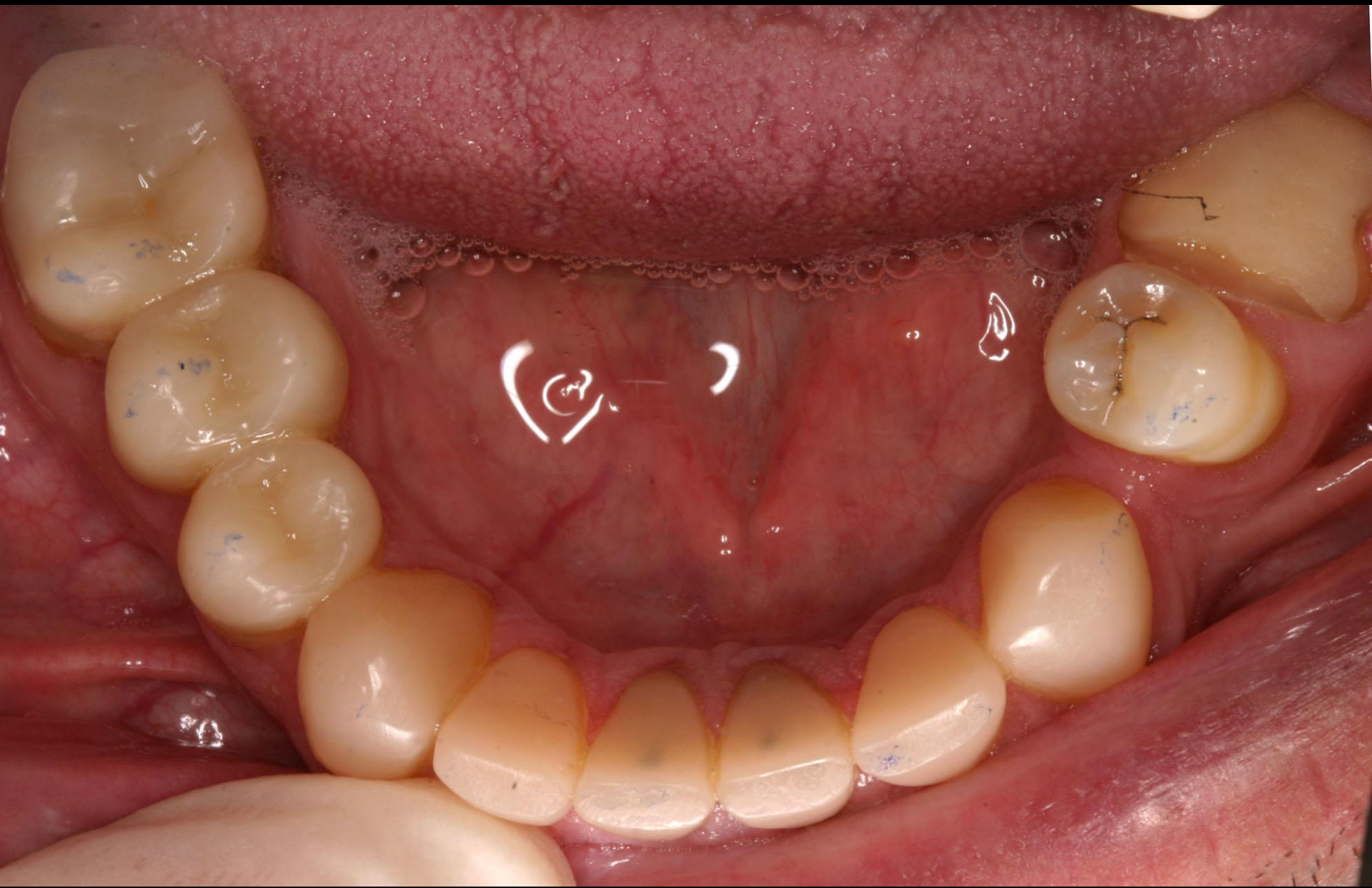
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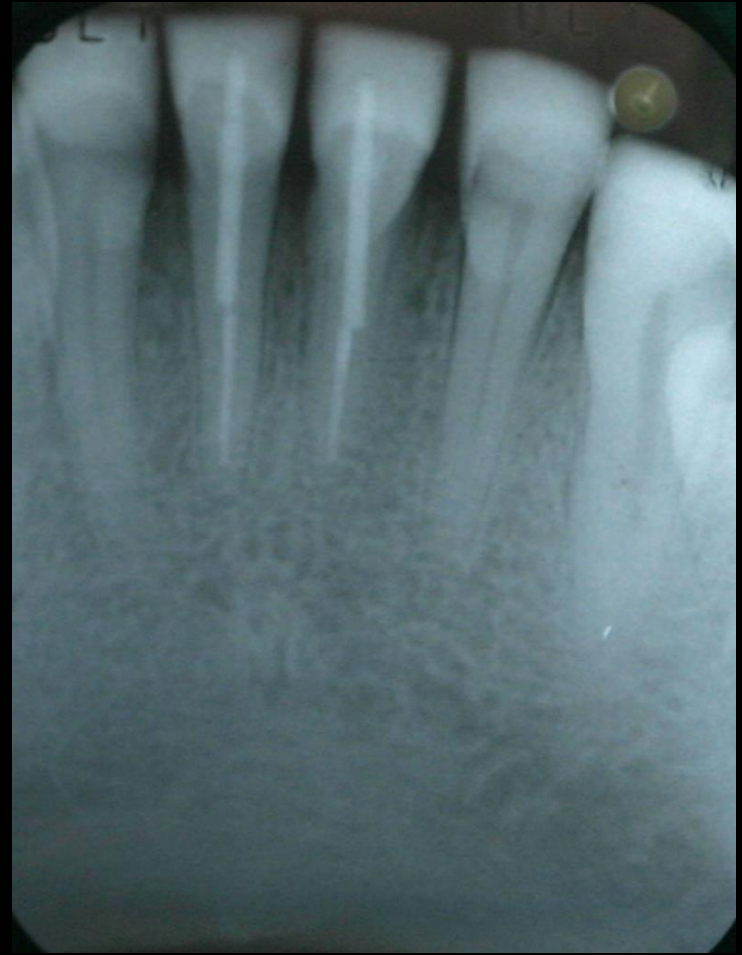
11 FEB 2004

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Case Study

Mr C*****

73 year old male

Edentulous in Maxilla for 15 years

GORD for 10 years but well controlled for 5
years

Freeway space = 5mm













Occlusal Vertical Dimension



Dealing with difficult denture cases

Malocclusions

Class II division 1

Class III

Class II Division 2 Malocclusion



Class III Malocclusion



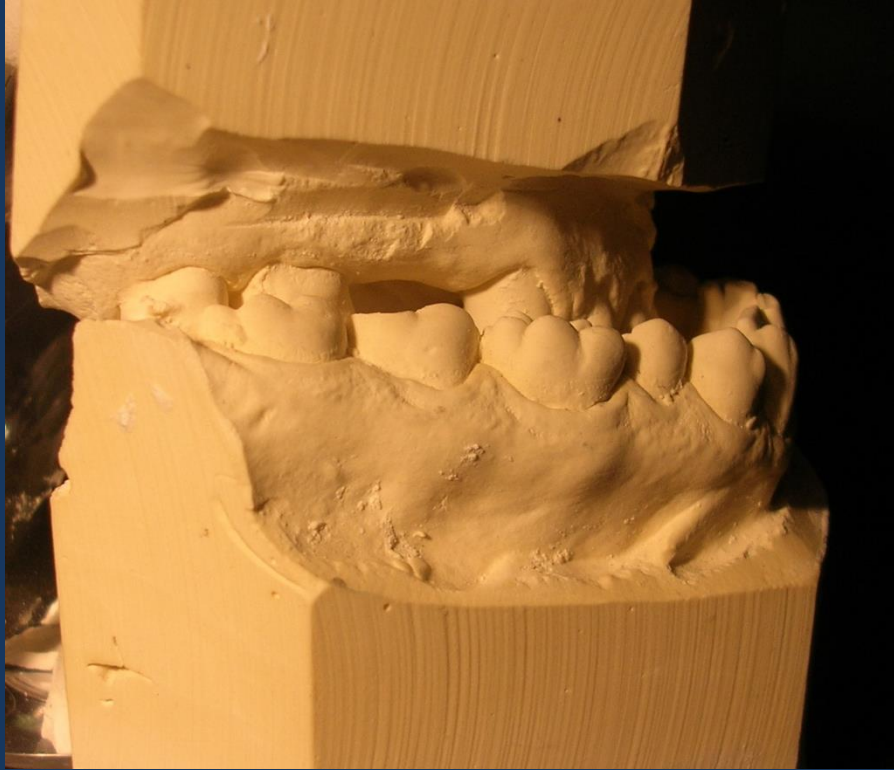
Class III Malocclusion

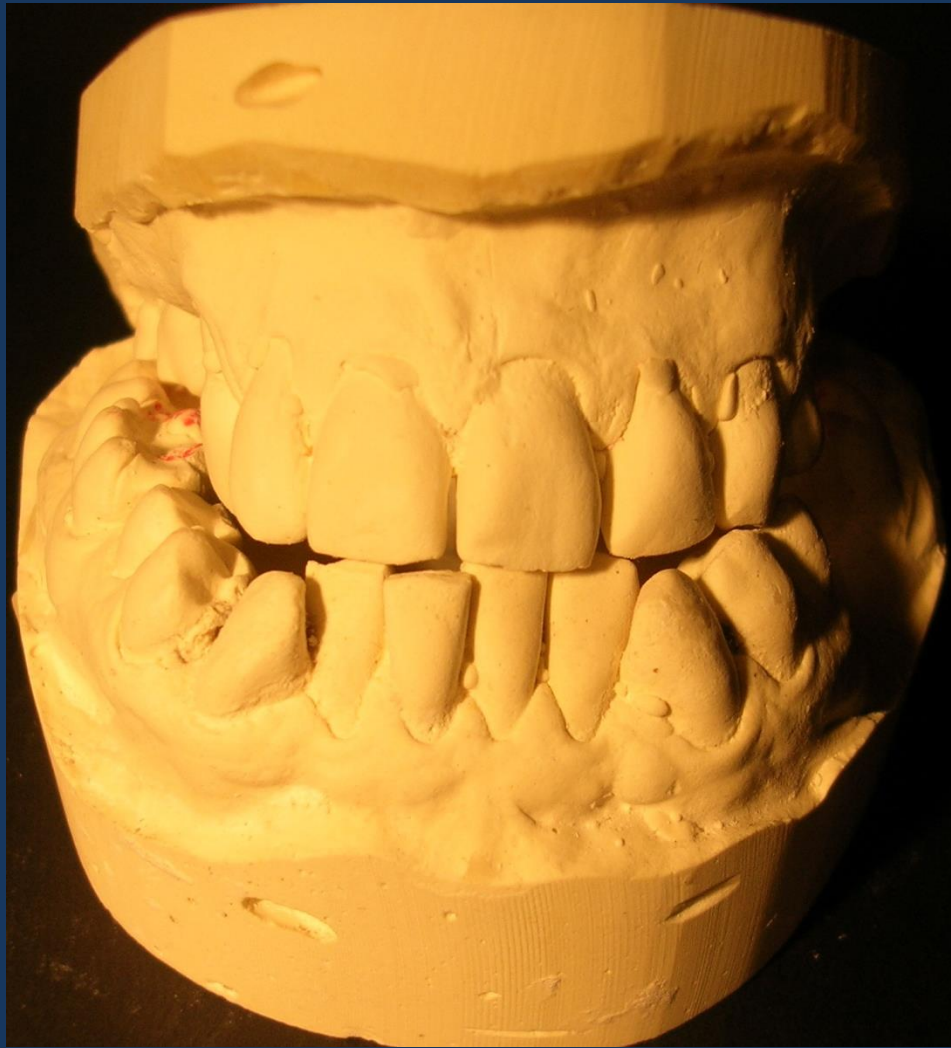
Skeletal

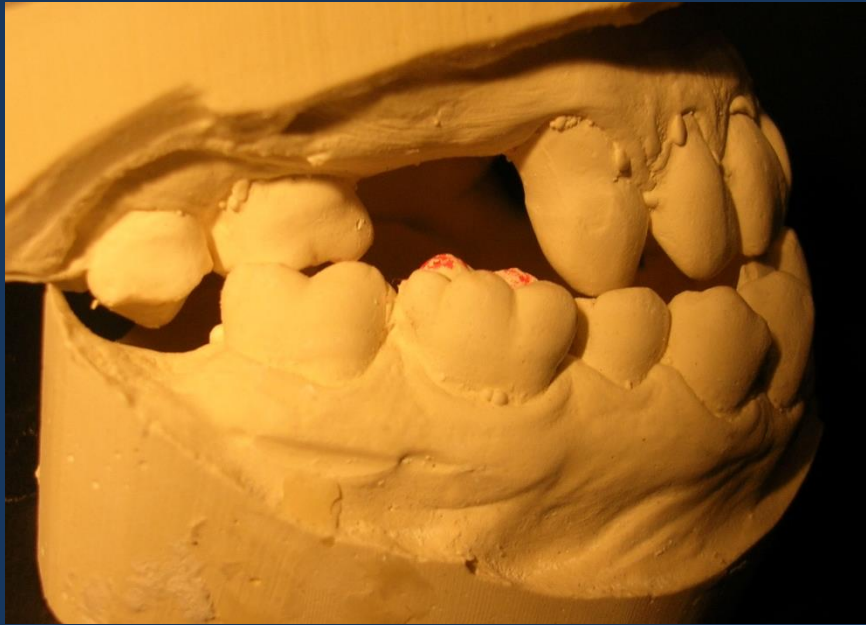
Pseudo-Class III

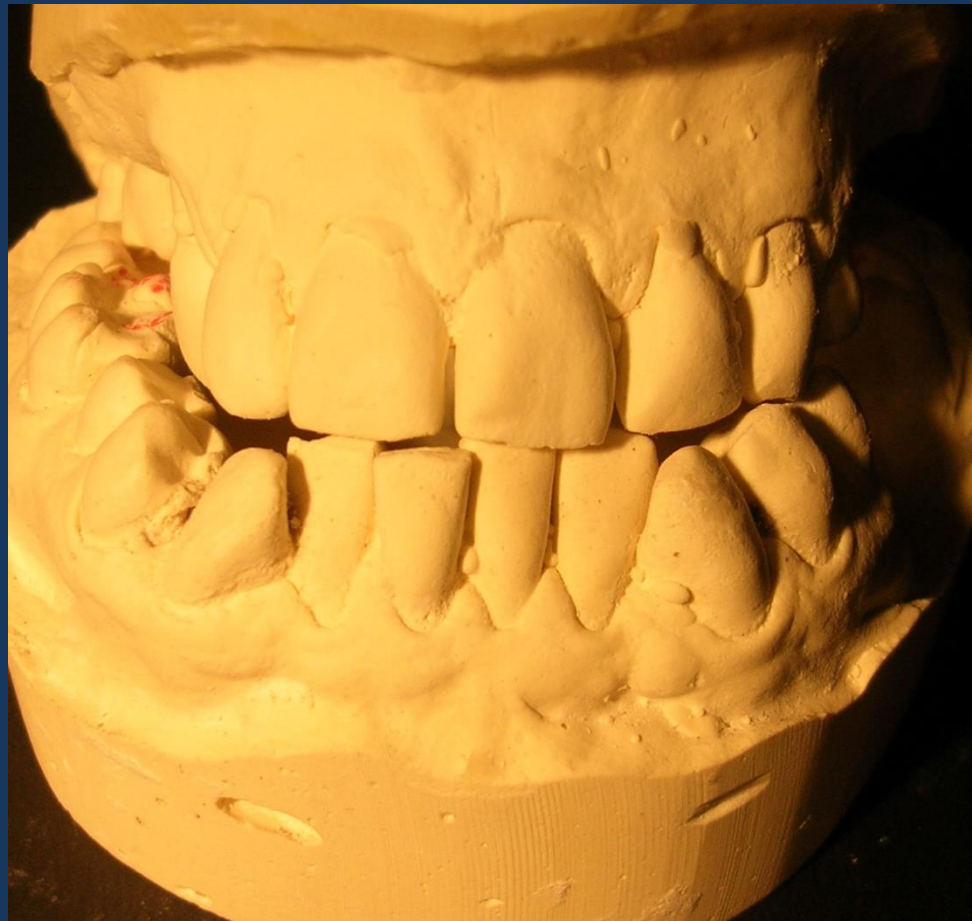










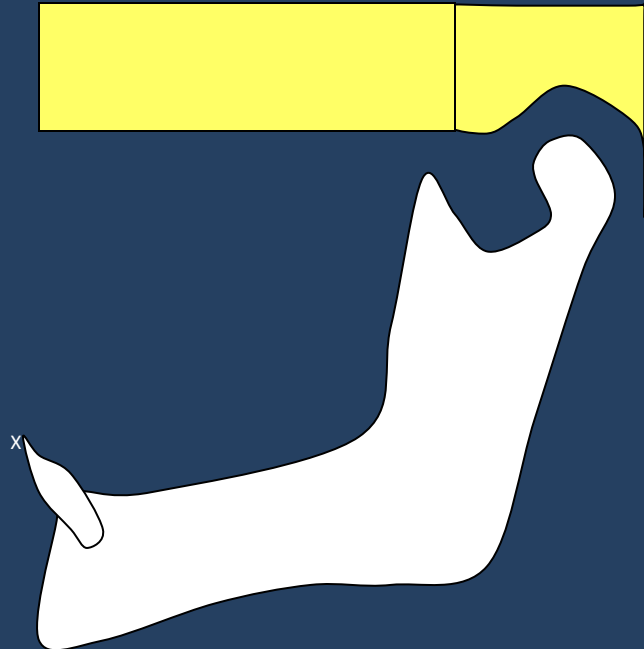


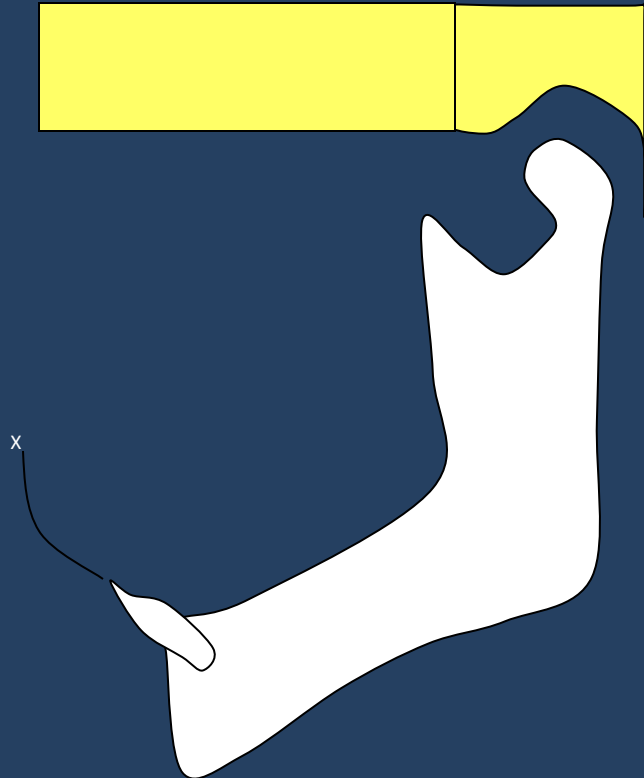
Class III Malocclusion

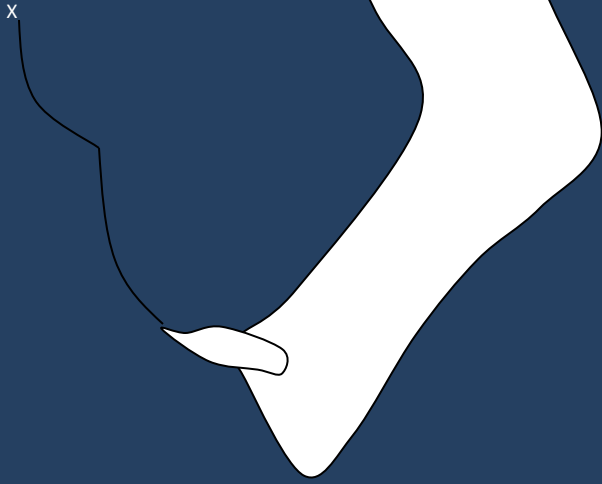
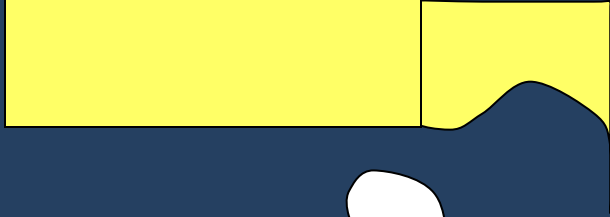
Skeletal

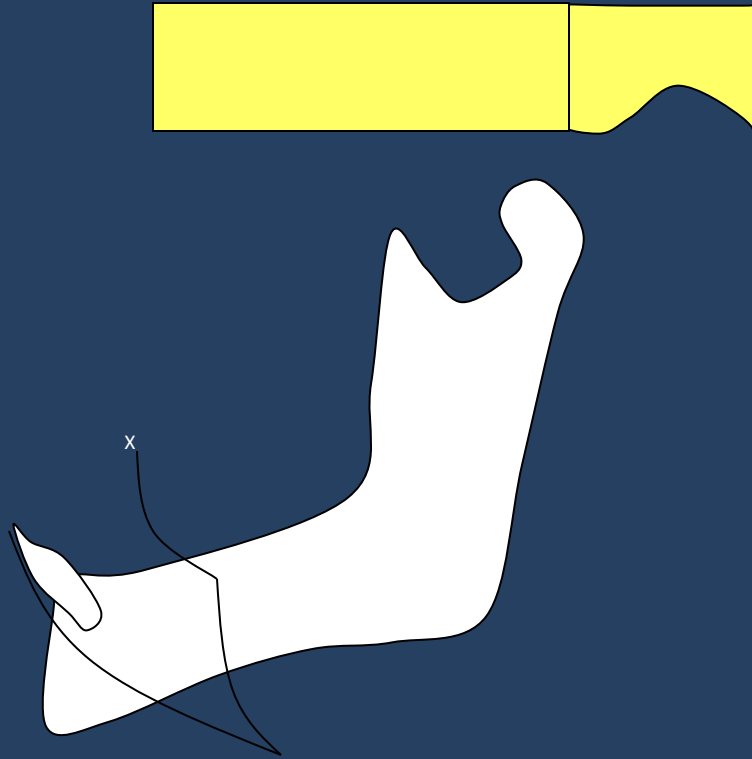
Pseudo-Class III

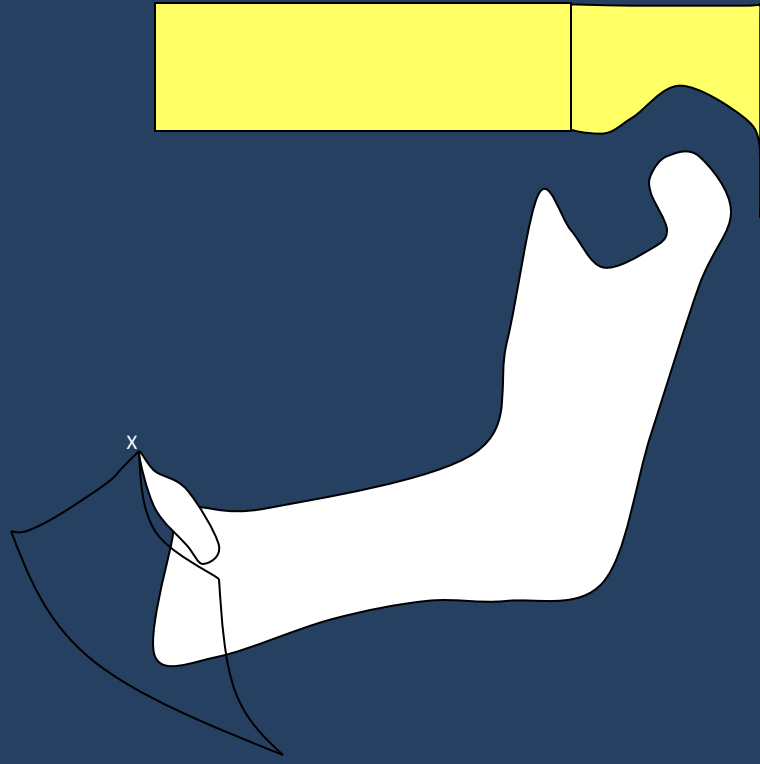


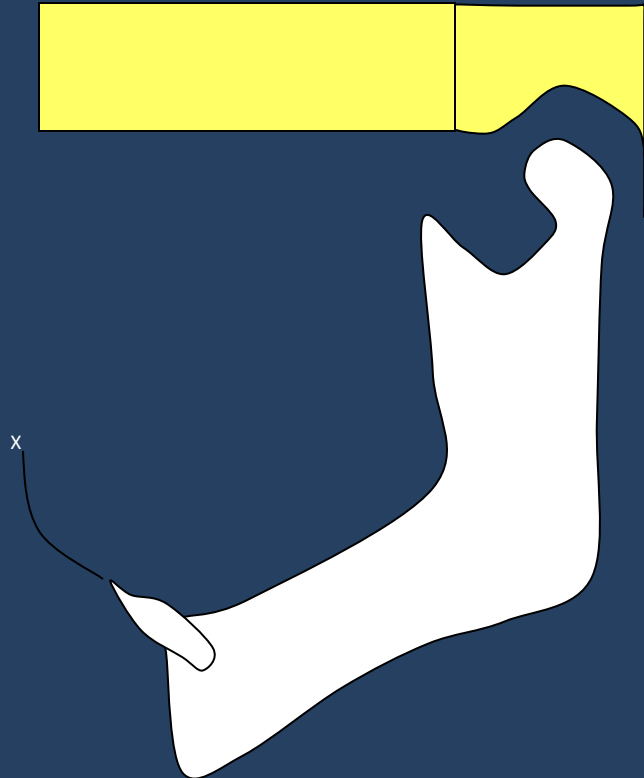


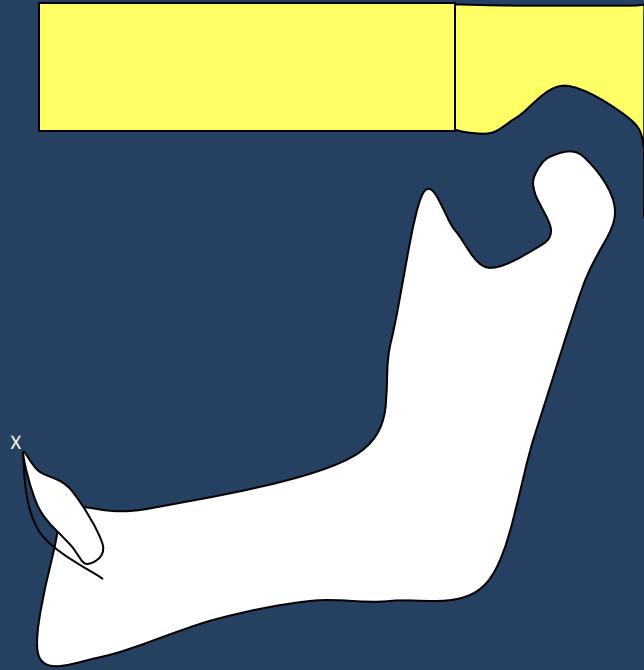


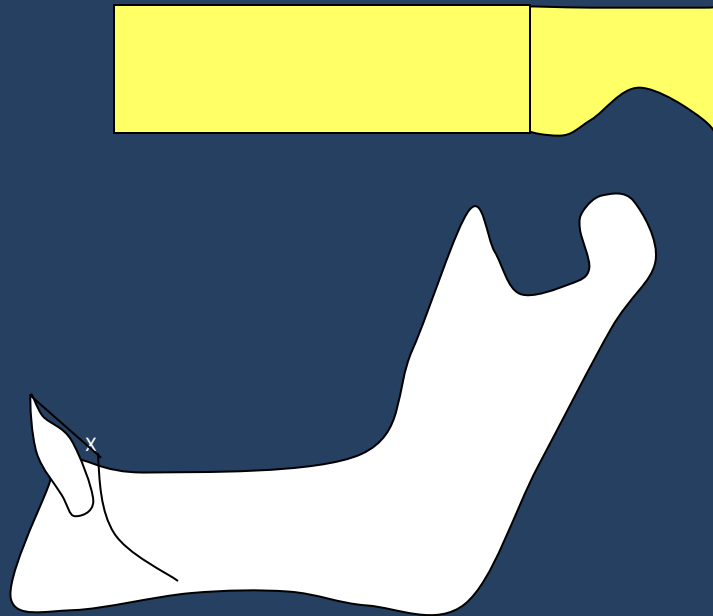












Dealing with difficult denture cases

Determining case complexity

Treatment planning to avoid common problems

Impressions

Vertical dimension

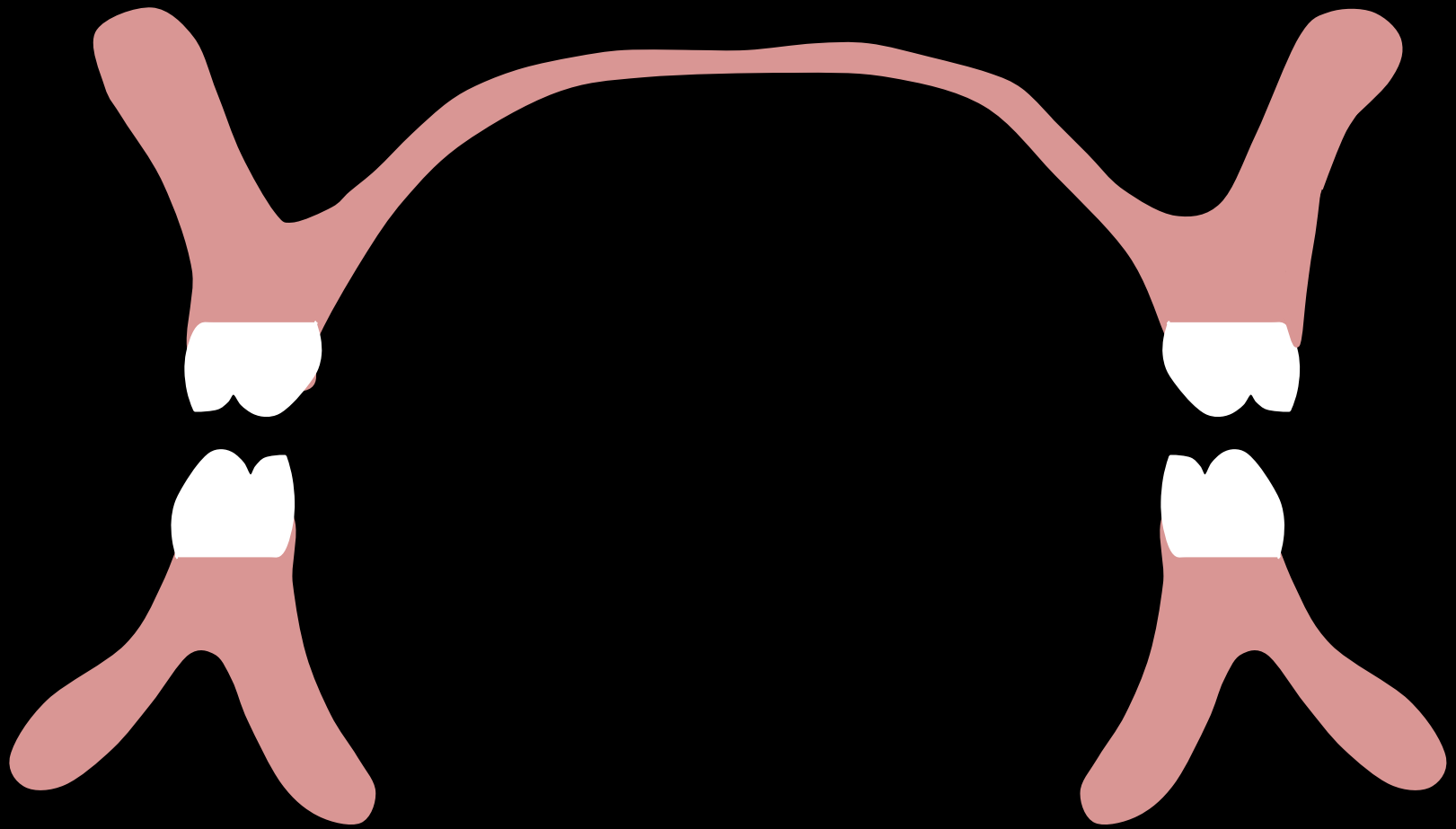
Tooth arrangement

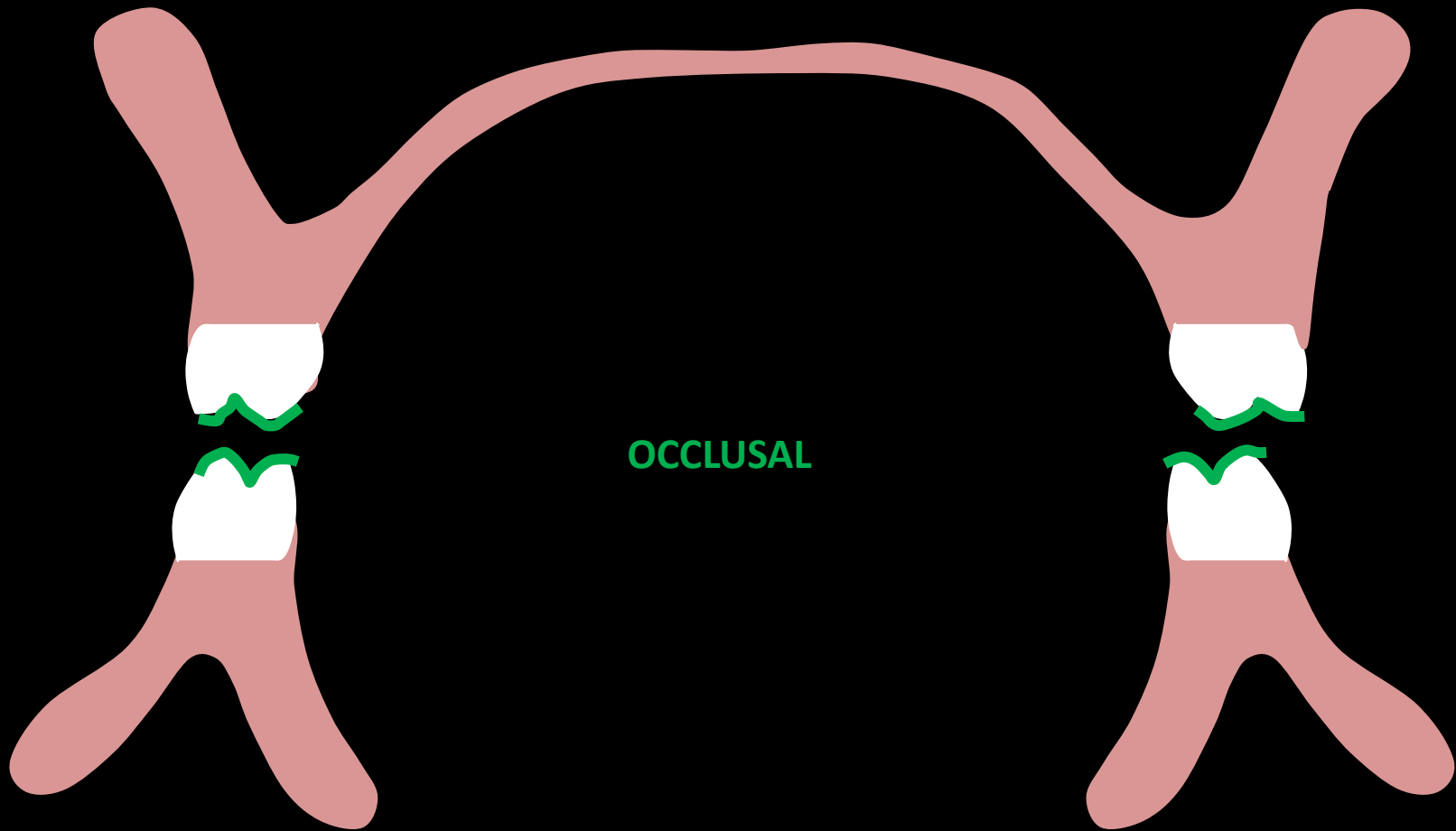
Sir Wilfred Fish



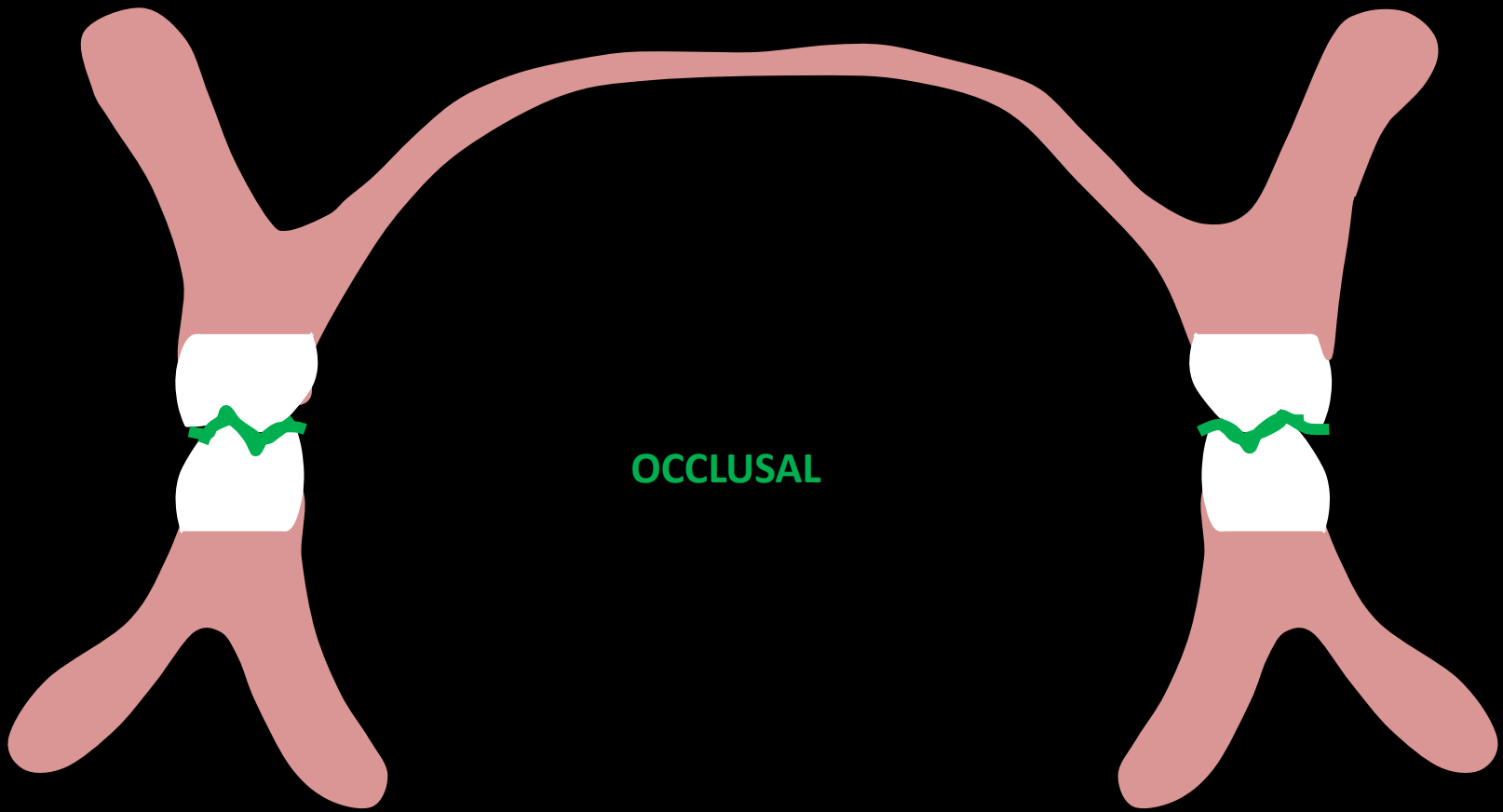
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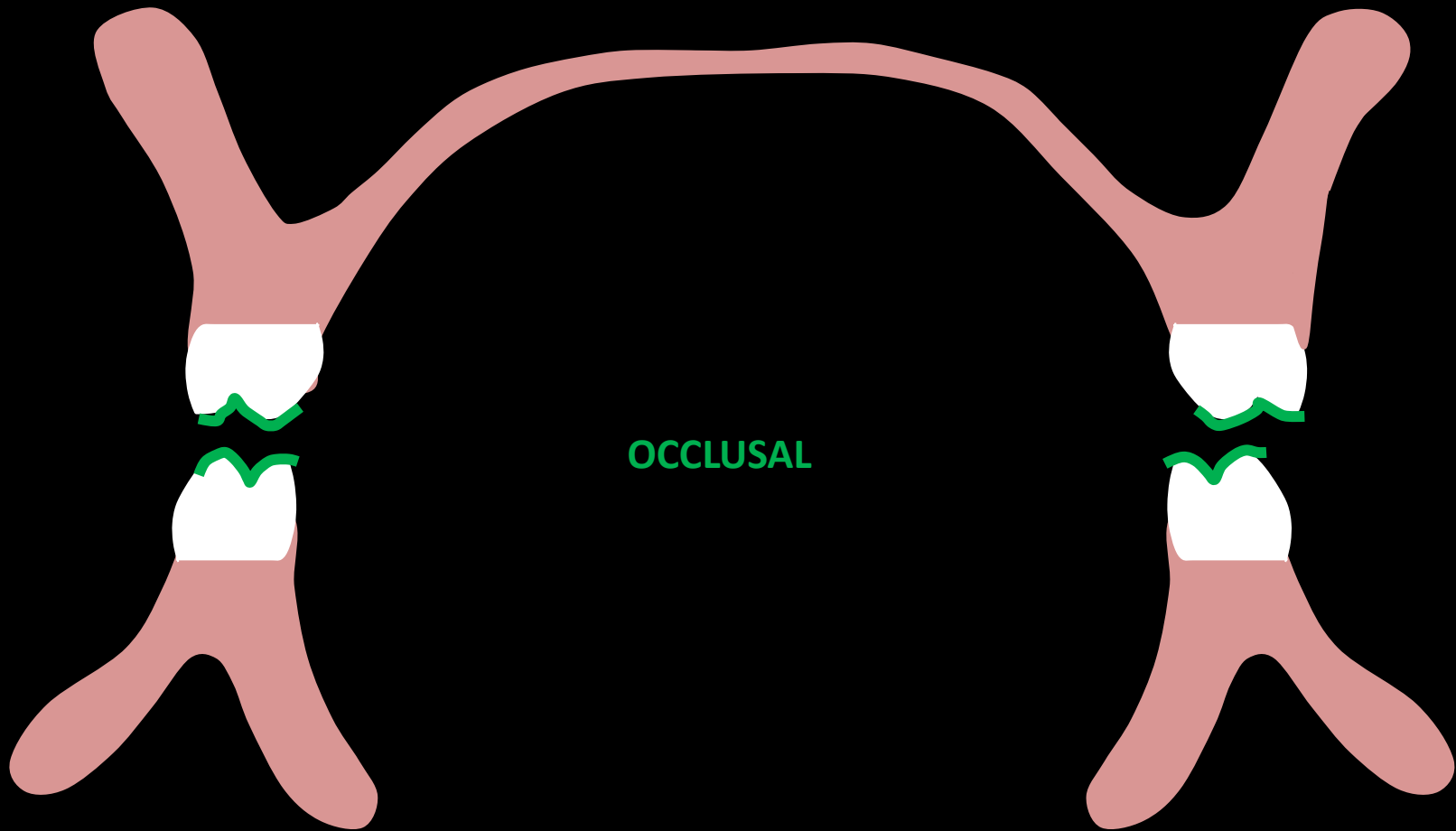




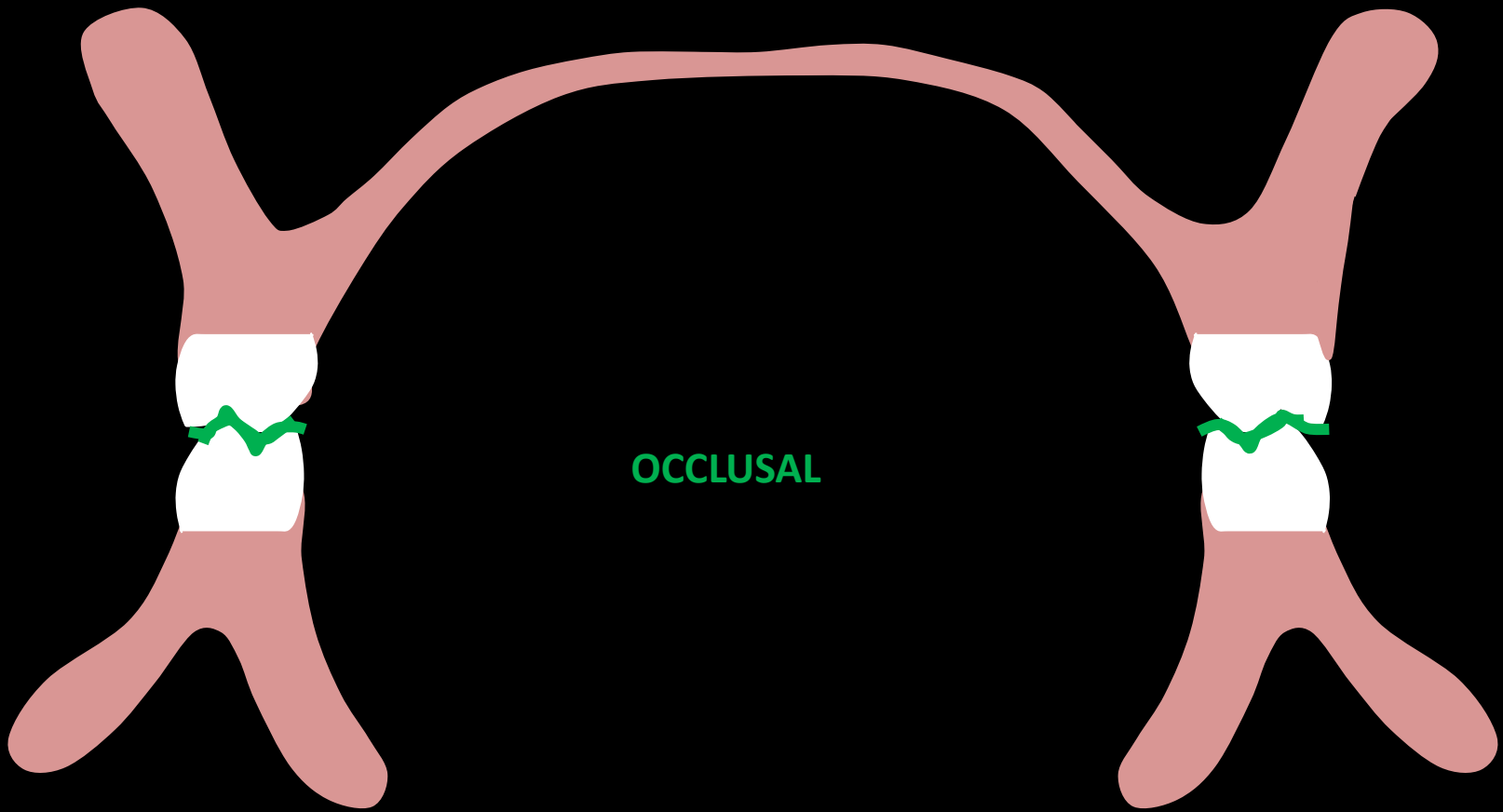
OCCLUSAL



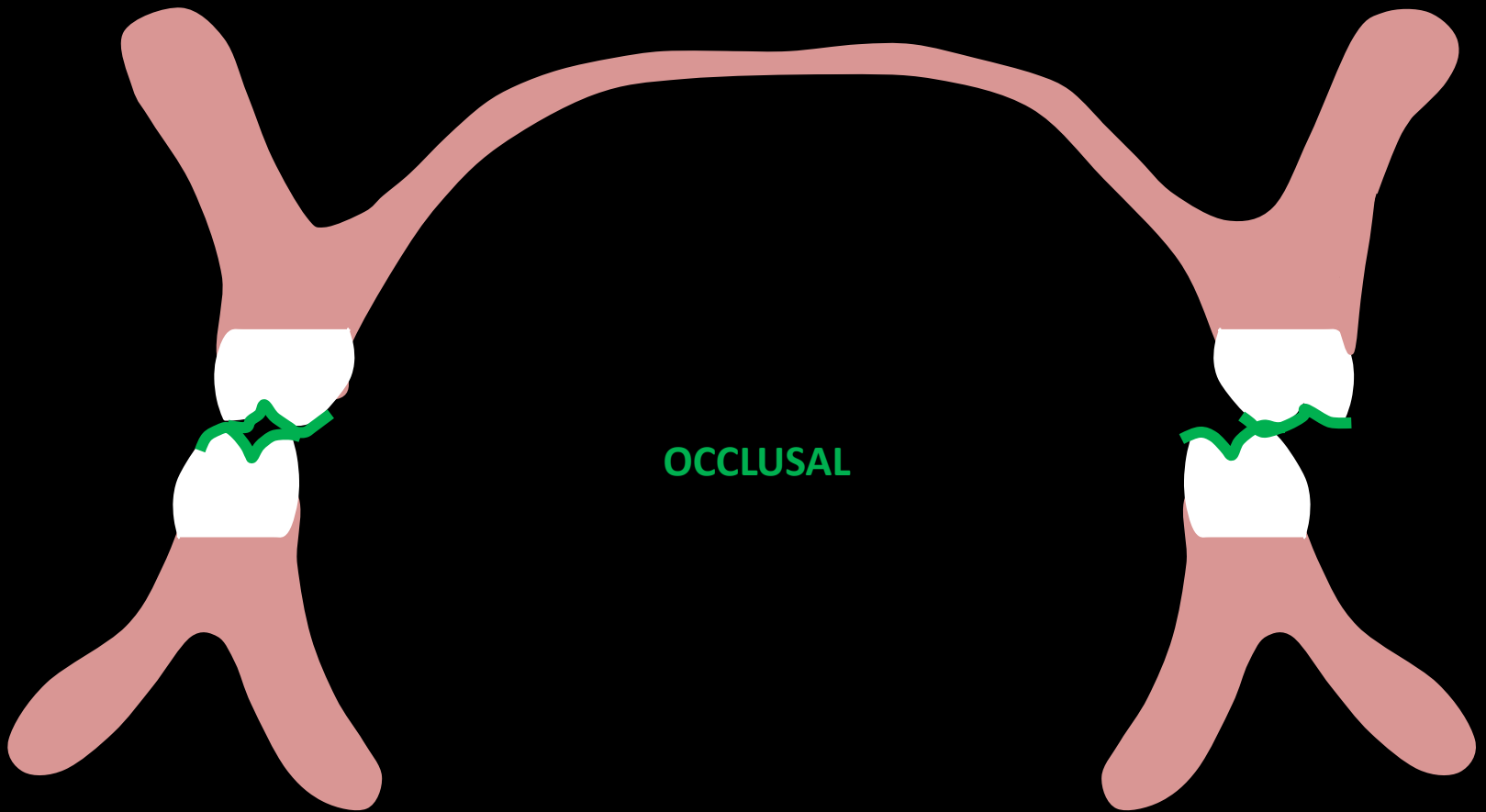
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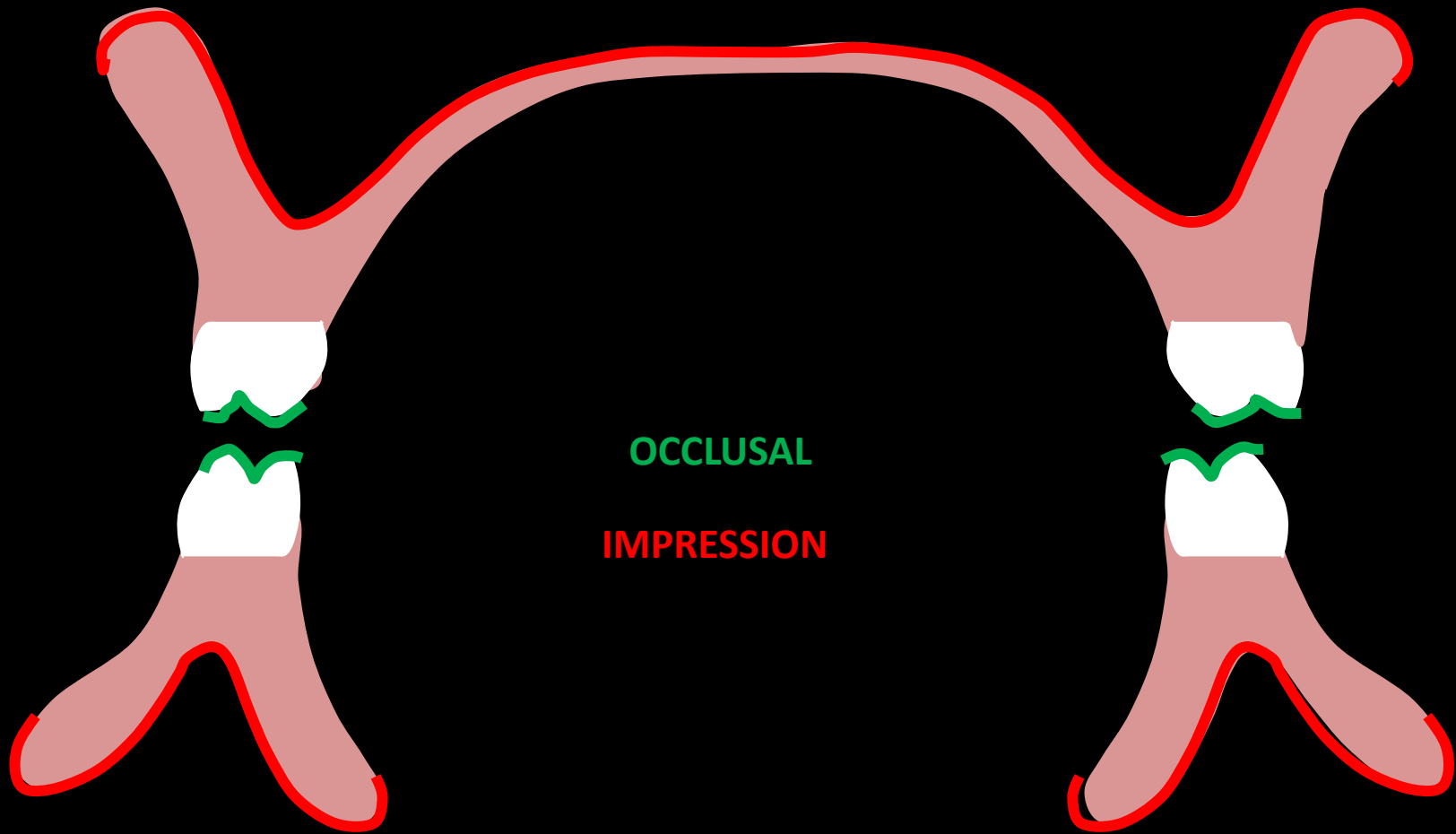
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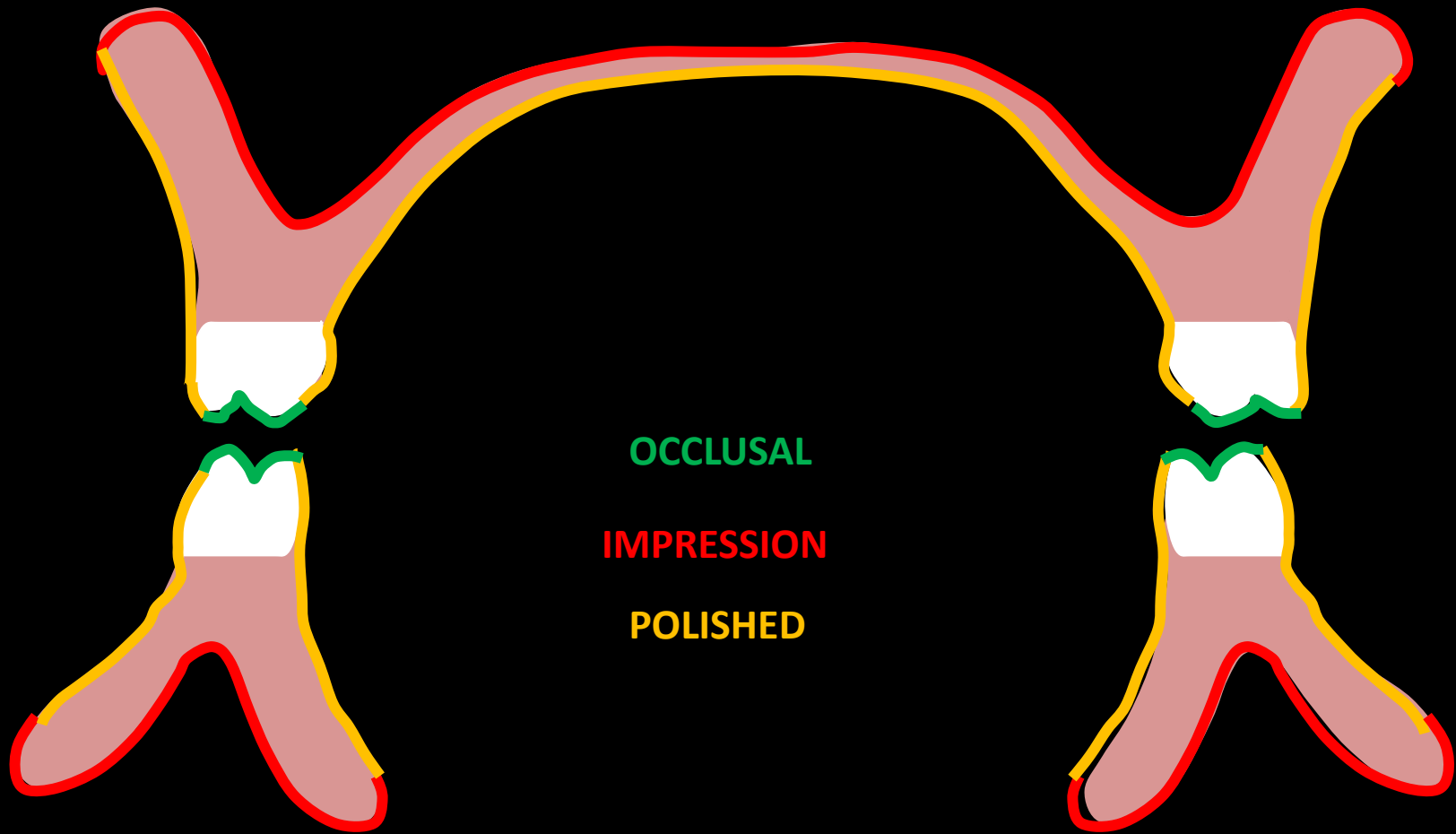
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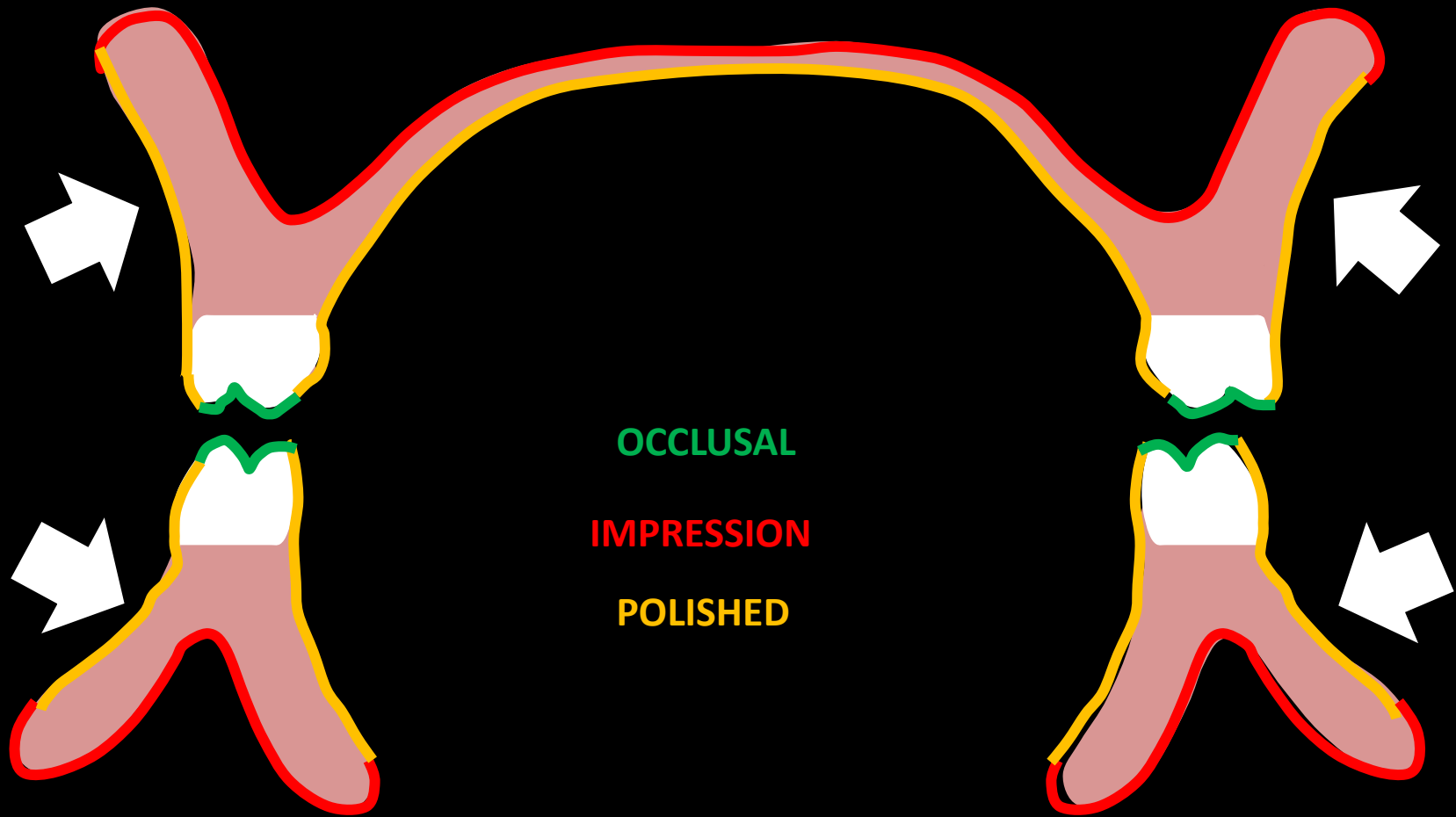
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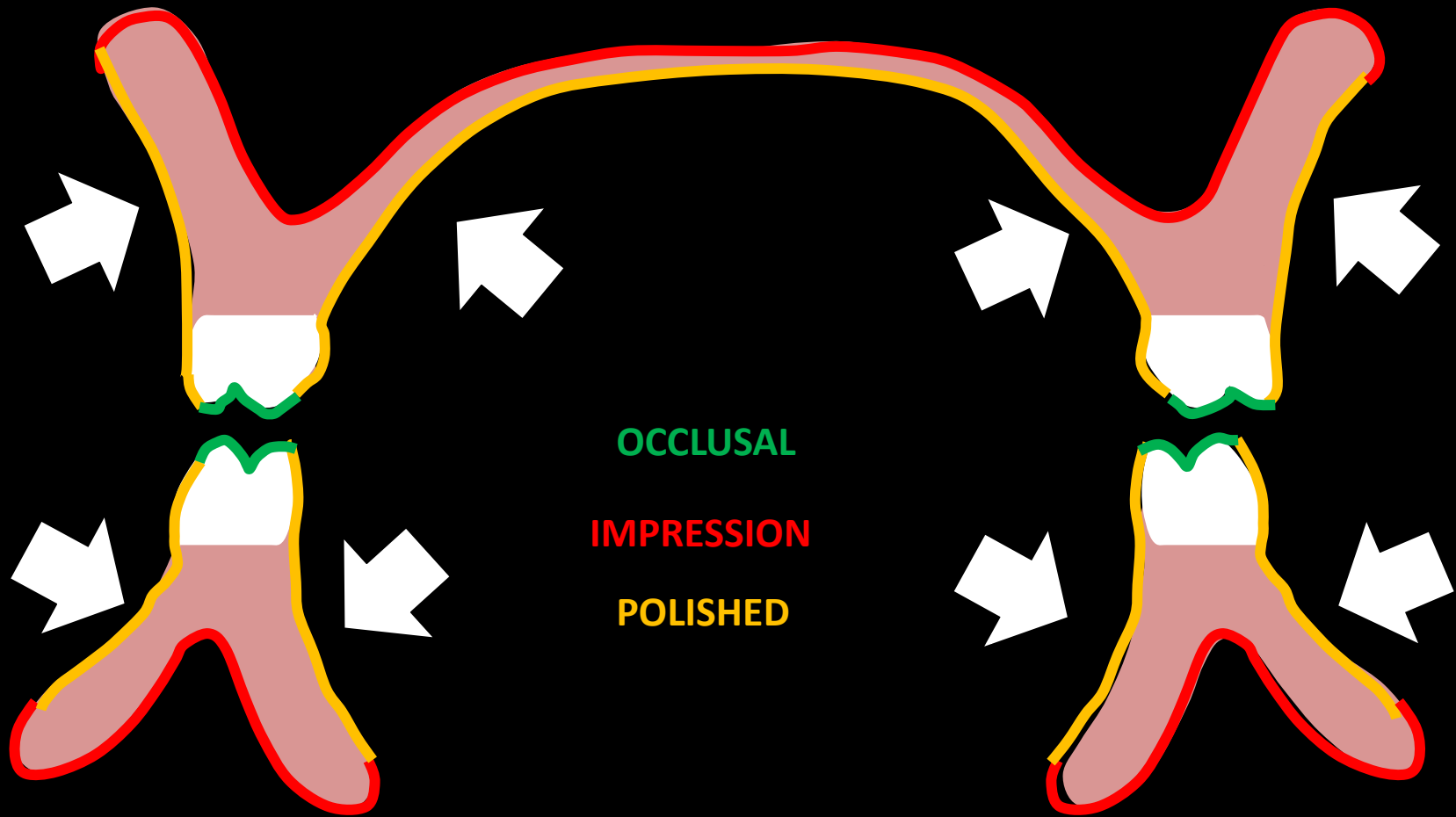
OCCLUSAL
IMPRESSION



OCCLUSAL
IMPRESSION
POLISHED



OCCLUSAL
IMPRESSION
POLISHED



OCCLUSAL
IMPRESSION
POLISHED



Common Denture Problems

Inadequate freeway space

Working side interferences

Upper underextended

Lower overextended

Lateral Slide

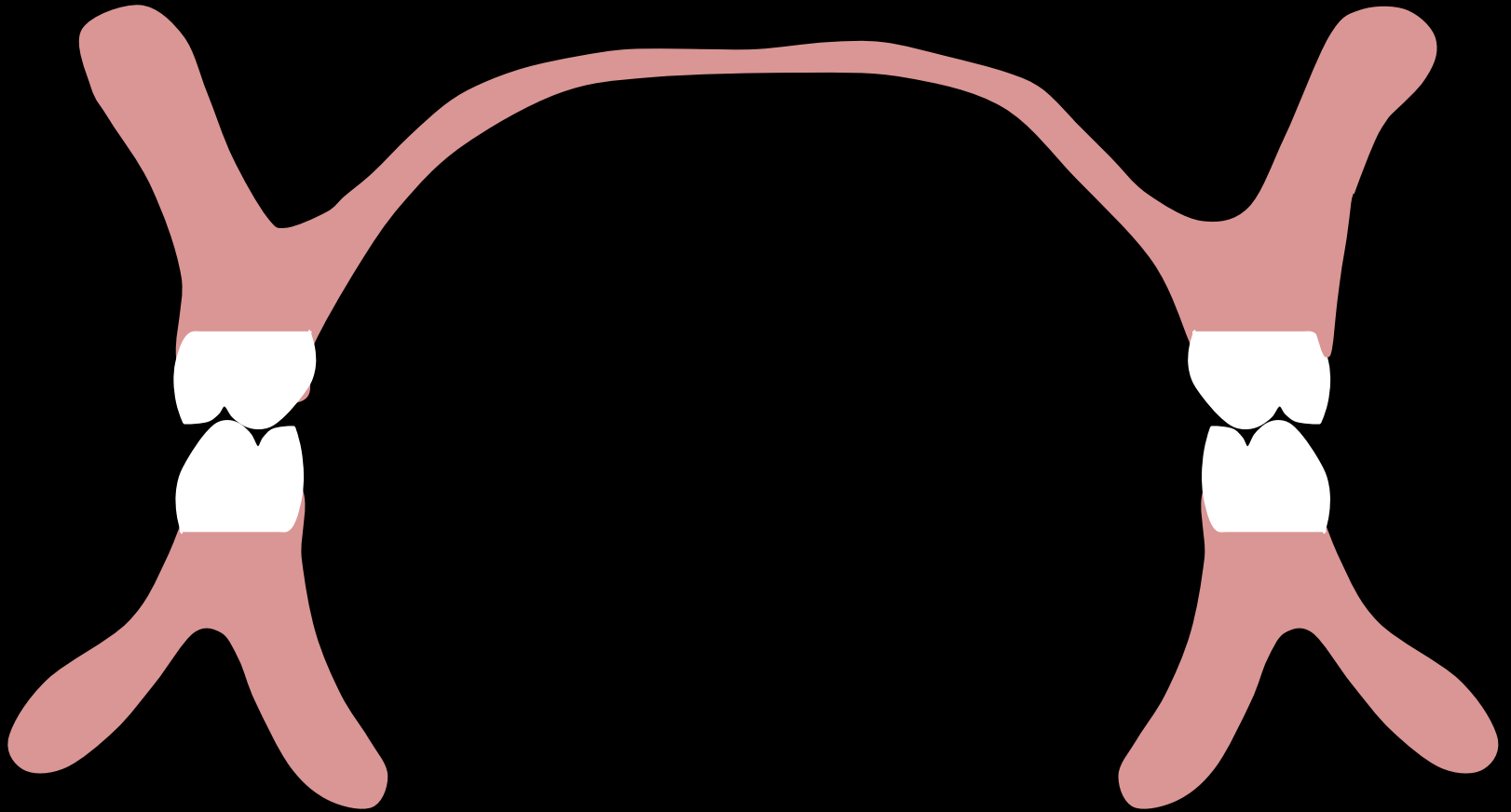
Antero-posterior slide

Lower underextended

Tooth position

Balancing-side interferences

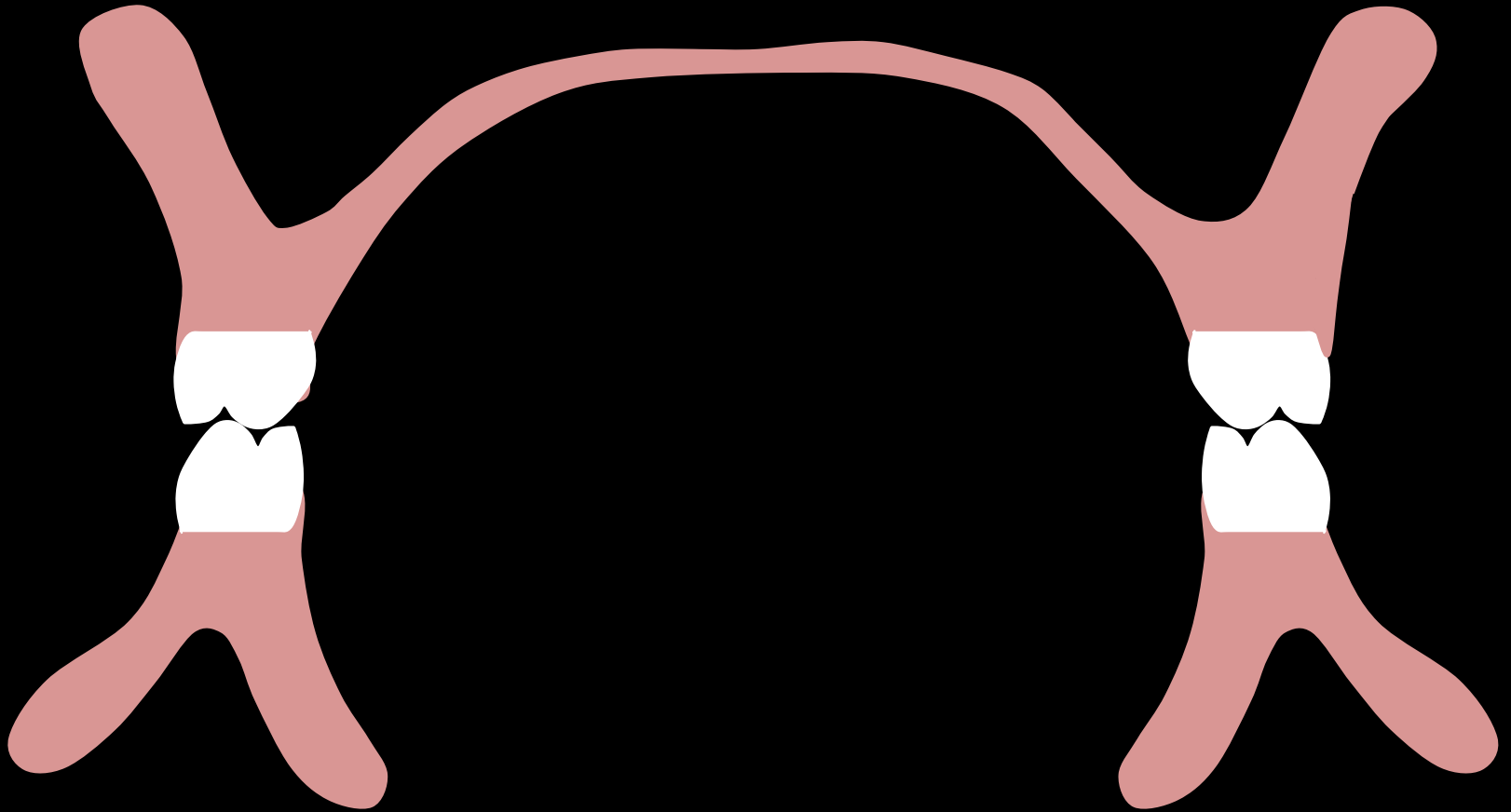
Maximum Intercuspation



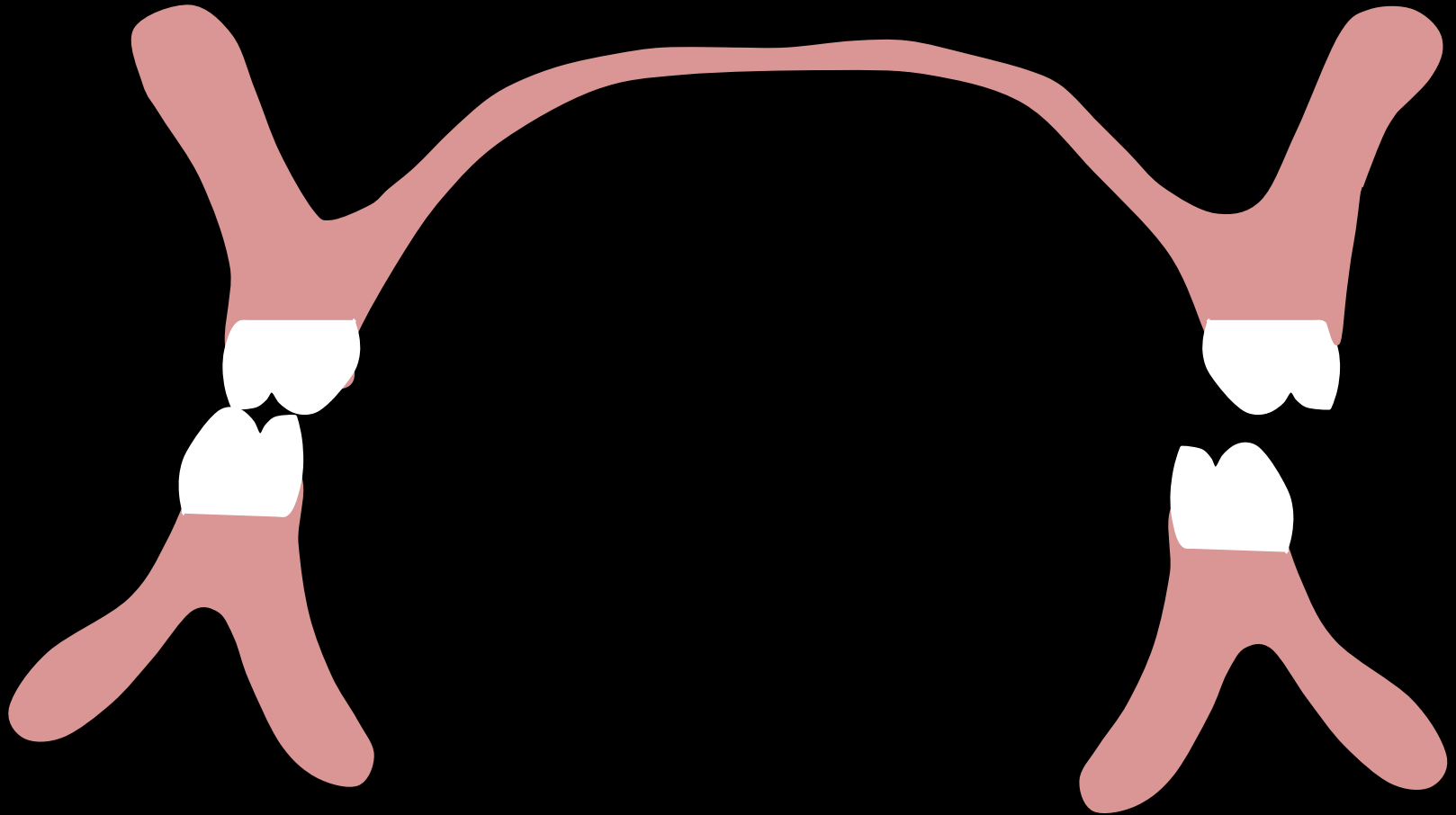
Balanced Occlusion



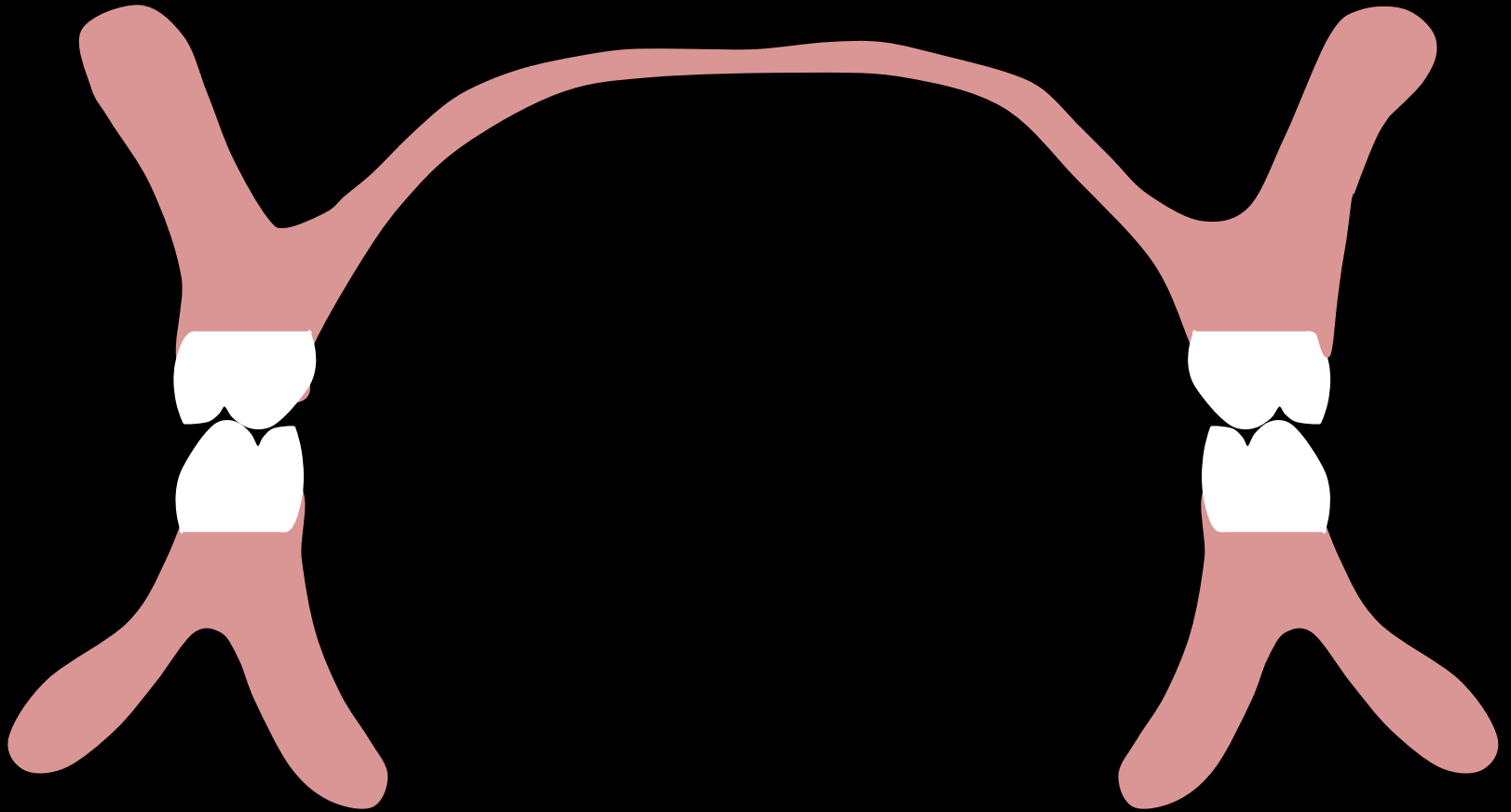
Maximum Intercuspation



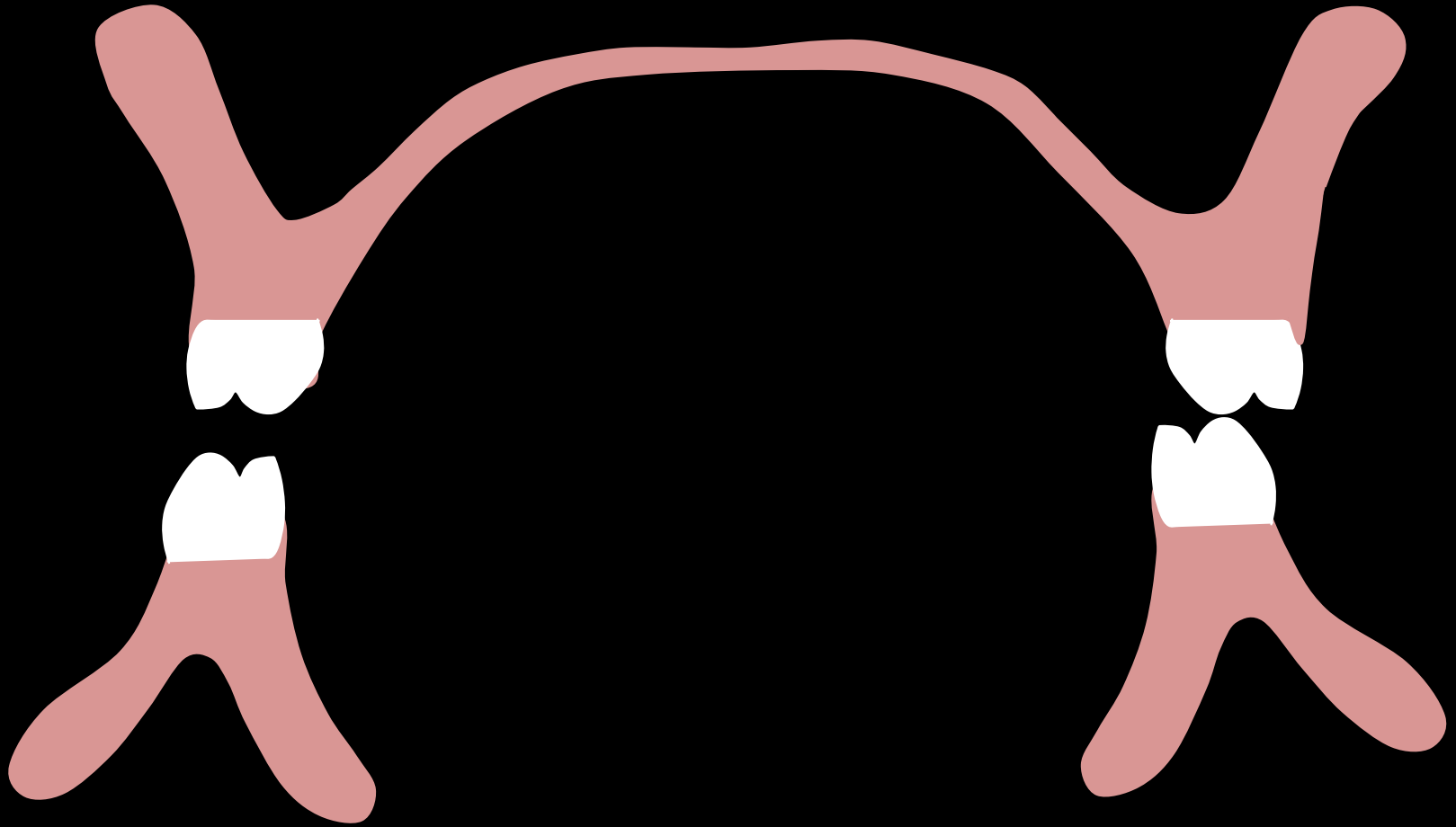
Unilateral Balance



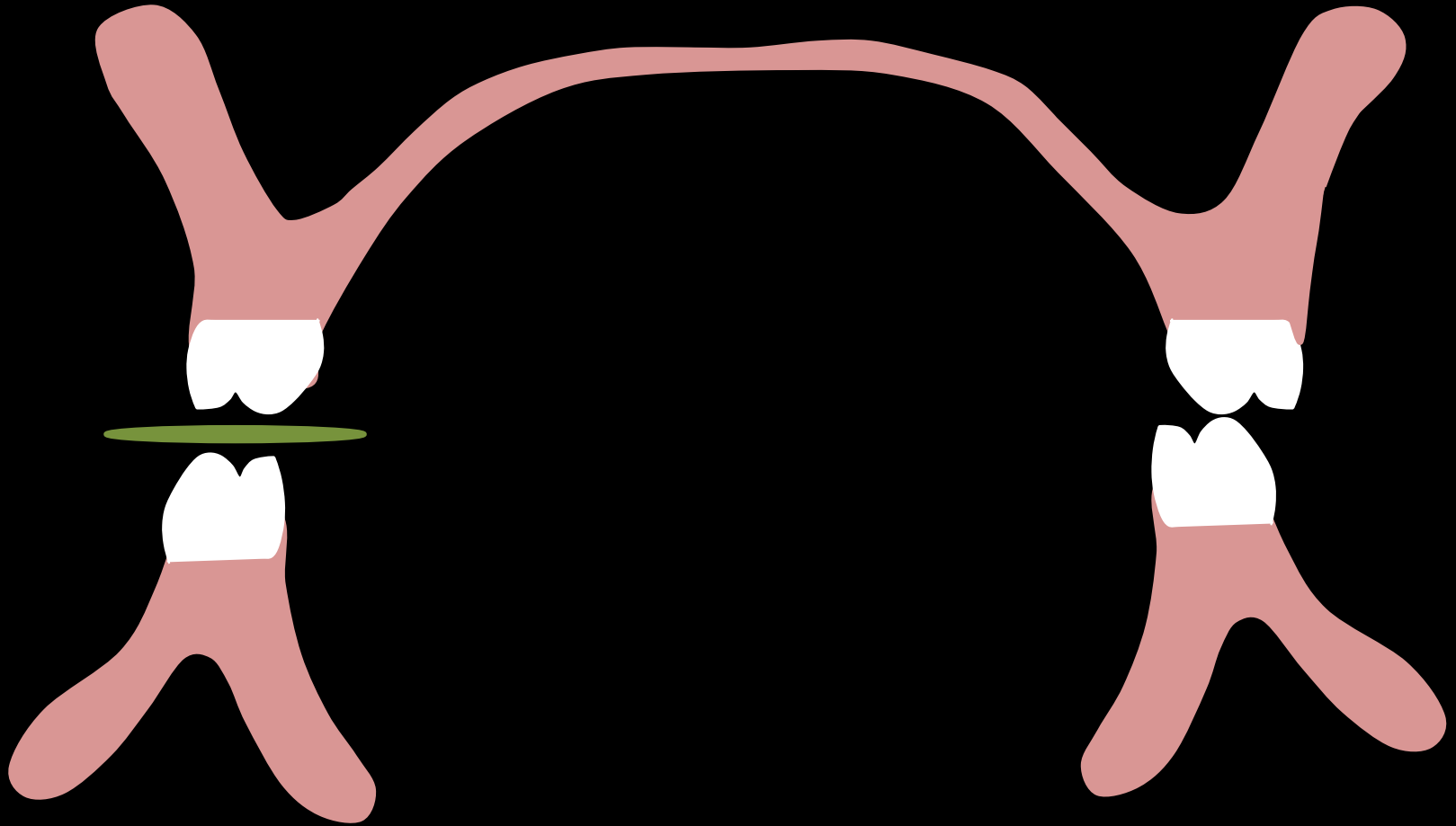
Maximum Intercuspation



Balancing Interference



Balancing Interference



Dealing with difficult denture cases

Determining case complexity

Treatment planning to avoid common problems

Impressions

Vertical dimension

Tooth arrangement

New materials and techniques

Flexible denture base resins

Flexible denture base resins

Polyethylene terephthalate

Polyamide

Polycarbonate

Polyamide resins



Flexite Supreme



Valplast®

*Durable & Esthetic Thermoplastic
Removable Partial Denture*




www.ordervalplast.com

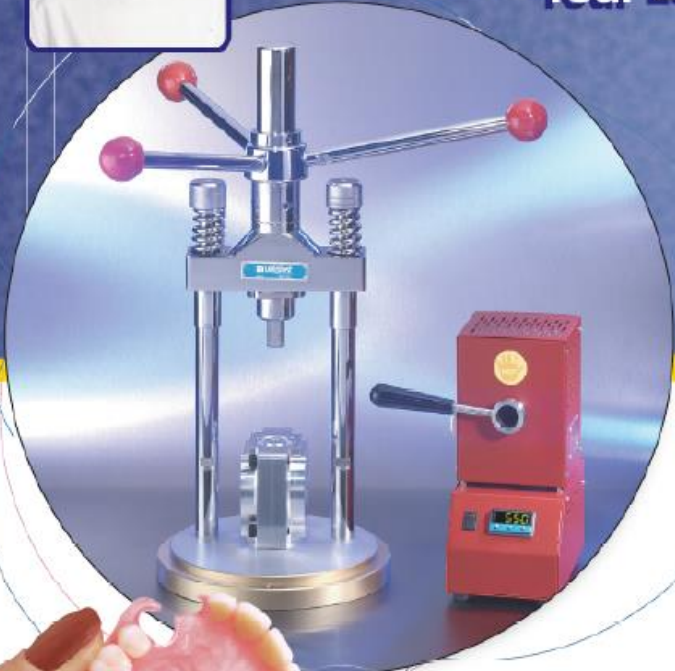
Valplast®



laboratory information



**Inject
Greater Profits
Into Your Lab.**



valplast
International Corp
Flexibility is Our Strength.

The advertisement features a central circular image showing a dental press machine and a red Valplast injection machine. The press machine is silver with red handles, and the injection machine is red with a digital display. A hand is shown holding a pink Valplast denture in the foreground. The background is a blue gradient with white lines.







Flexite[®]



Flexite Supreme

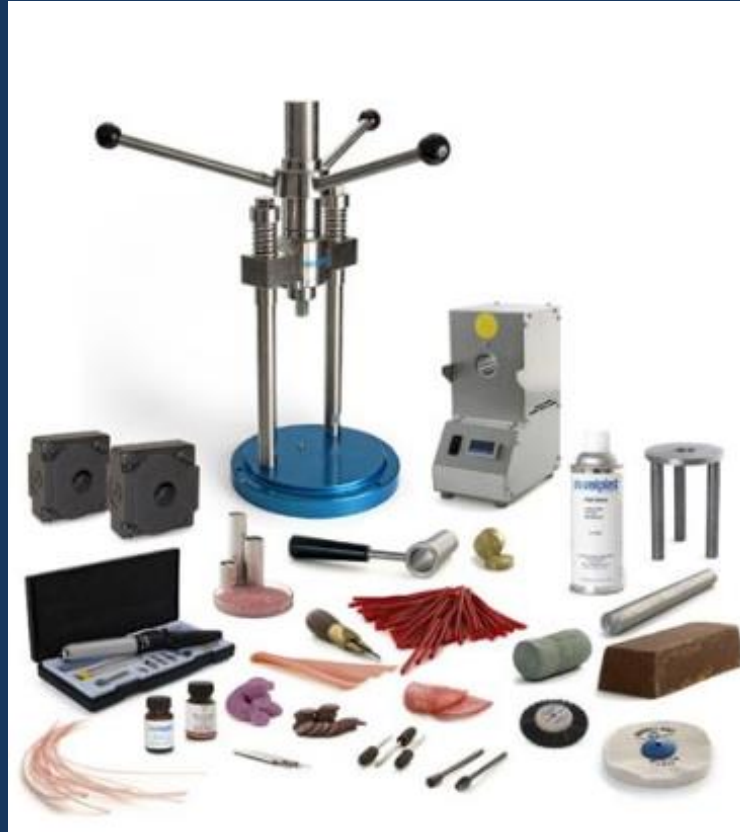


Flexite Repair Kit



Flexil Soft Liner Kit

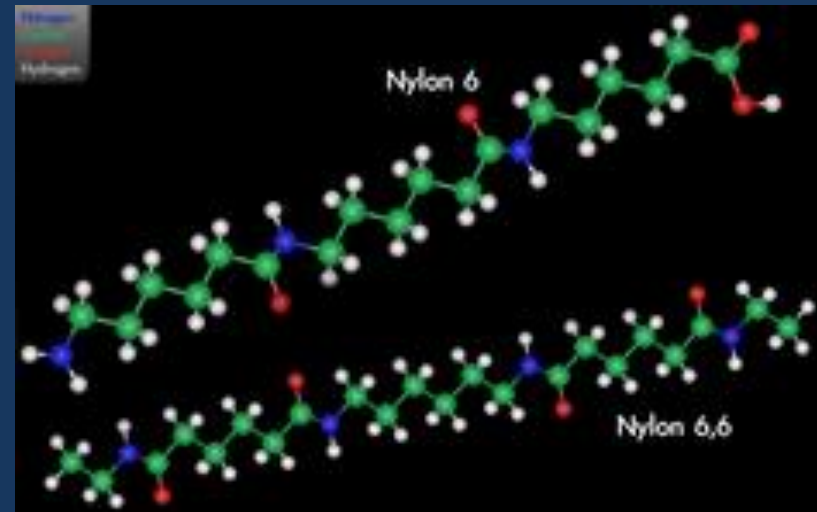
Valplast®



Flexible Denture Base Resins

Things to know

Polyamides (ie nylon)



Flexible Denture Base Resins

Things to know

Polyamides (ie nylon)

But other products in range!



Flexible Denture Base Resins

Things to know

Polyamides (ie nylon)

Other products in range!

Repairs complex

Relining ?



Flexible Denture Base Resins

Things to know

Polyamides (ie nylon)

Other products in range!

Repairs complex

Relining

Silicone



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Difficult to adjust



valplast Adjustment Kit

Chairside Adjustment Made Easy!

Simple 3-step process includes the *right* tools:

Cross Cut Carbide Bur – For rough cutting

Green Mounted Stone – For refined cutting

Green Silicone Polisher – For smoothing



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Repairs complex

Relining

Silicone

Difficult to adjust

Cleaning

Information through franchisees

Home | Patients | Dentists | Laboratory & Technician

--Domestic Dealers --International --Search

FLEXIBILITY IS OUR STRENGTH

Today's dentists are prescribing flexible material for removable partial dentures

Today's dentists are prescribing flexible material for removable partial dentures (RPDs) because it makes a better, stronger appliance faster. Flexible material reduces chair time, eliminates invasive procedures and the cumbersome materials associated with rigid partials. In short, there is no longer any need for metal. Metal-based RPD design is complex because it has to adapt rigid materials to a flexible environment. This leaves room for error particularly under conditions where ideal designs and clinical preparations are challenged. In contrast, the material in flexible partials is perfectly...

[read more](#)



Patient Care
Flexible partial dentures are the comfortable, beautiful, and affordable choice. It was long thought that removable...



Patient Care Information
You'll be glad to know that most patients become immediately accustomed to their delicate and light-weight...



Labs & Technicians
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Dealing with difficult denture cases

Determining case complexity

Treatment planning to avoid common problems

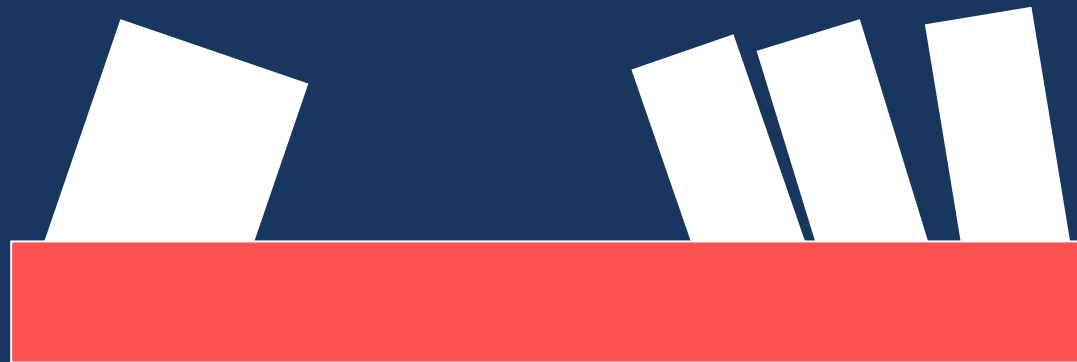
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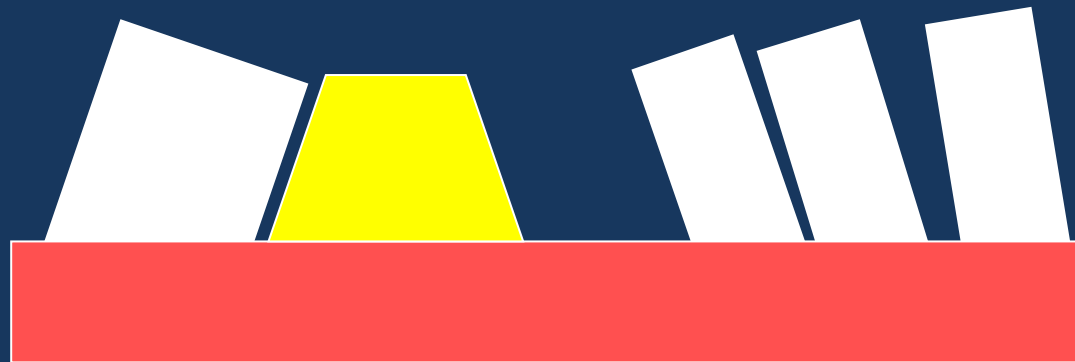
Tooth arrangement

New materials and techniques

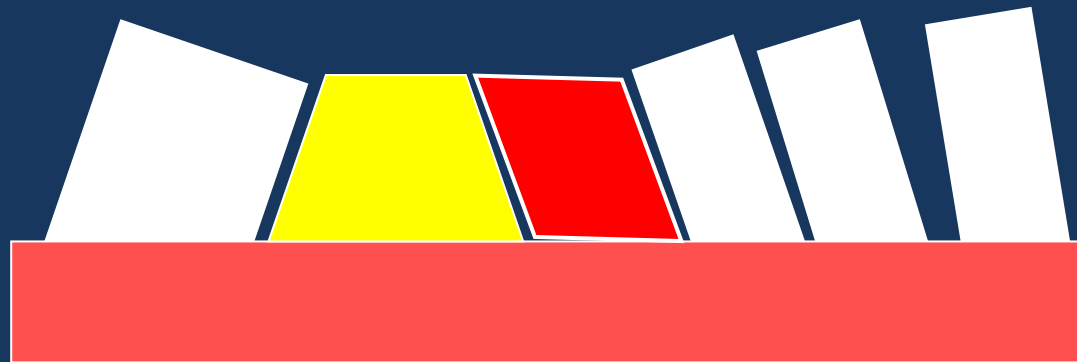
Sectional Dentures



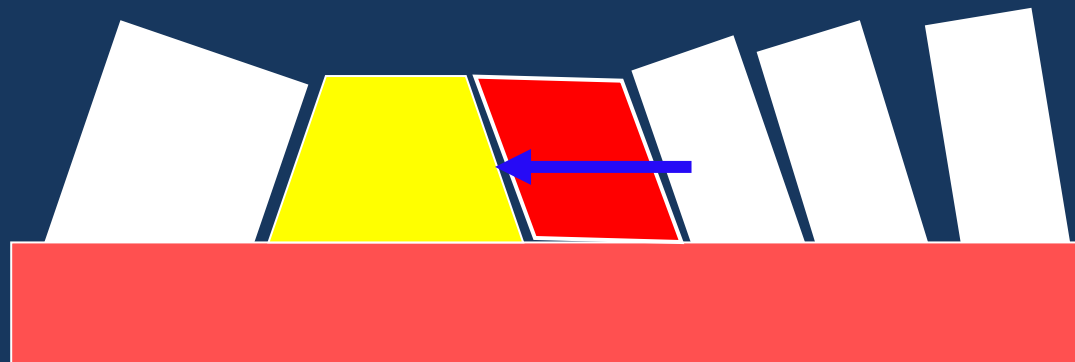
Sectional Dentures



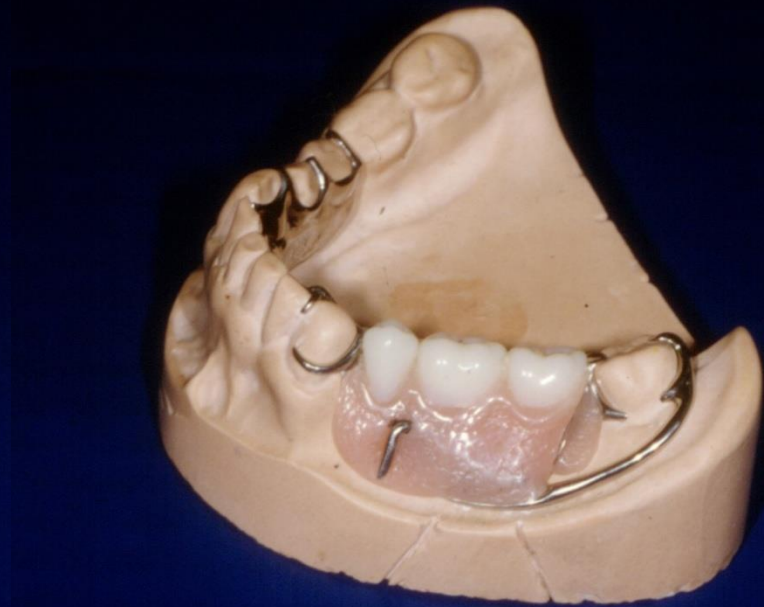
Sectional Dentures



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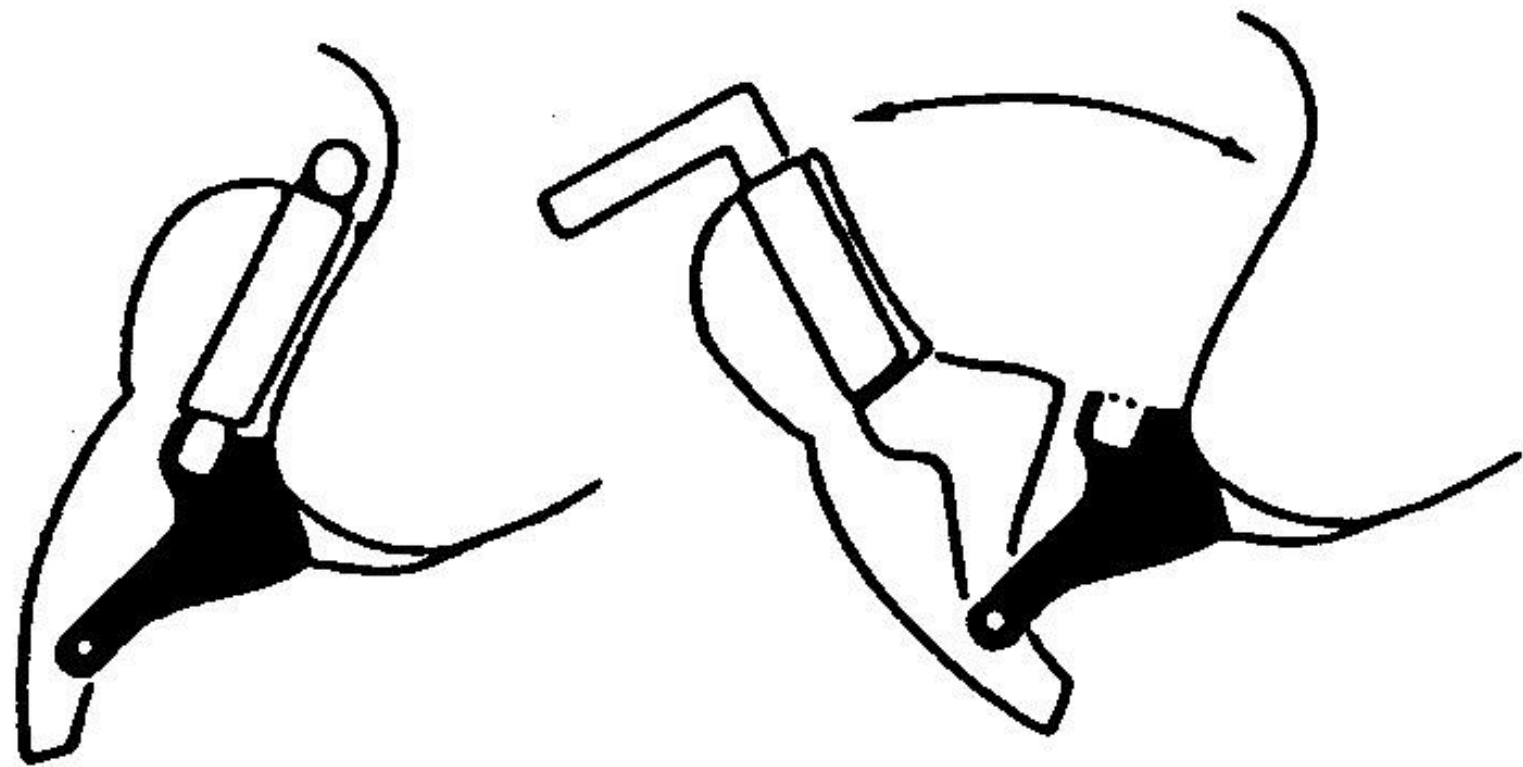


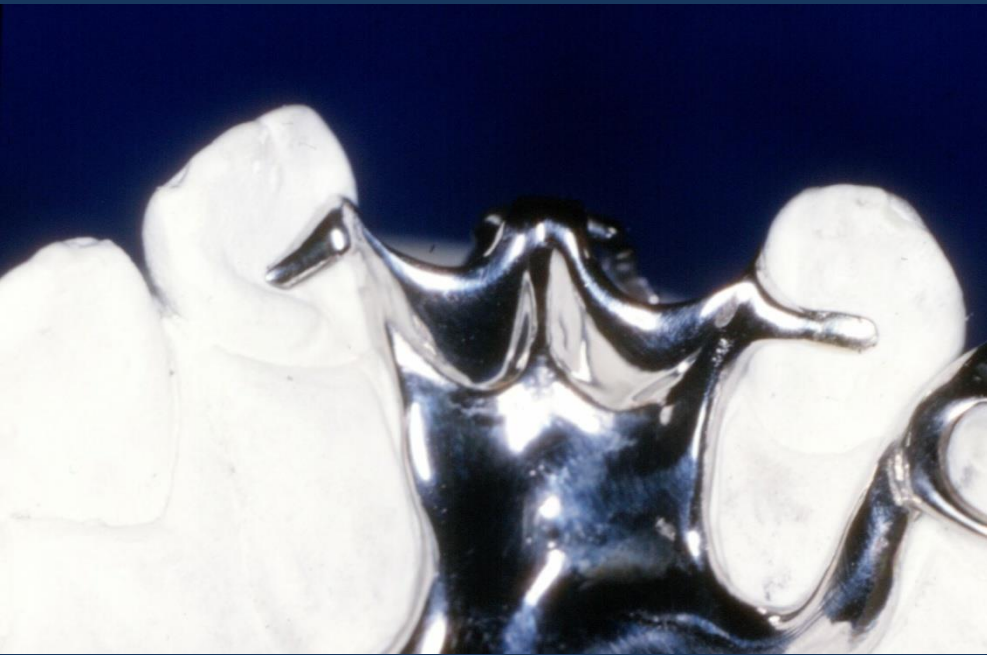
Sectional Dentures







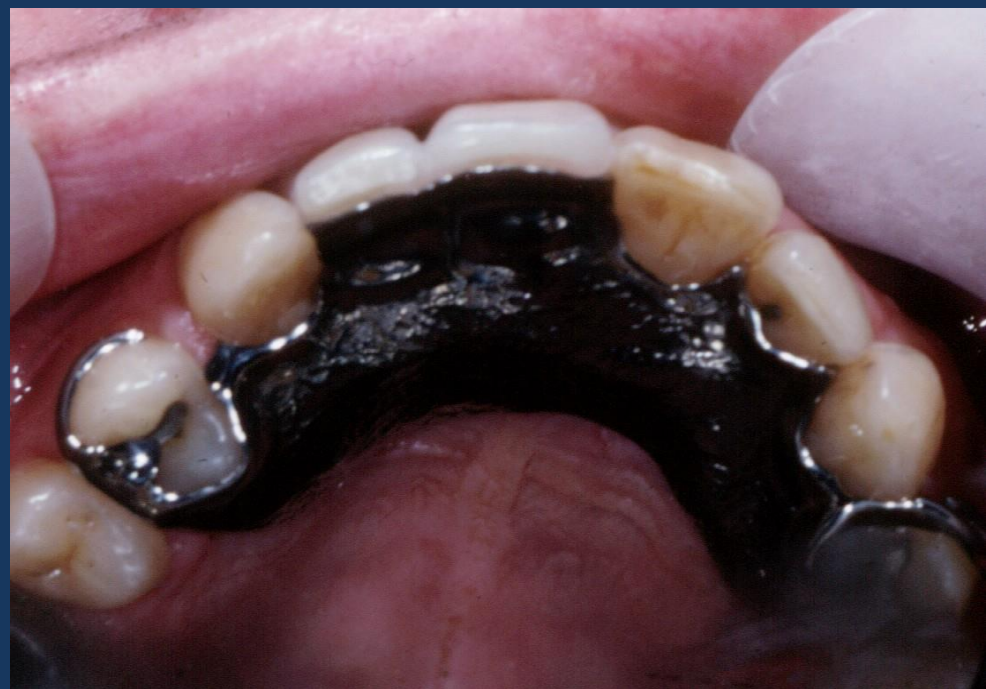












Dealing with difficult denture cases

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Difficult people

Refractory patient

a patient who has chronic complaints following appropriate therapy

These patients continue to have difficulty in achieving their treatment expectations despite the thoroughness or frequency of the treatment provided.



Case Study

Ms C****

72 year-old lady

Denture-base allergy (?)

Aesthetic concerns



3rd August 2009

Notes for Dr Lindsay Richards from Carolyn R [REDACTED]

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On reading your account, which I received last week, I notice you list "First Impression" and "Second Impression" – you never took an impression of my upper gum, and I never understood this. How could you achieve a good firm fit if no impression was taken? But I made no comment about this because you are the expert in this field. You did take an impression of my current denture, also surprising, seeing that it was about nine years old – and my gums had no doubt shrunken away in that time.

I have also suffered from biting of my cheeks on both sides, and at the front corner of my mouth on my left side, which I presume means that I am lacking lip support (ie height) The protrusion of the teeth, since you pulled the denture forward, is causing the bottom teeth to be outside the top teeth when my jaw falls back into its proper position.

I have re-read my notes to you dated 3rd August and 24th September 2009, and notice that I specifically asked for no ridge behind the front of the new denture. And as I mentioned (24th September) I never had a ridge behind the front of the denture until one was put there by [REDACTED] with my prior denture. Ridges, of course, are a safety net as it allows for an element of error. This practice should not be taught by you or any other instructor at the University of Adelaide. And as I have a mere 50 years experience on "this side of the tracks" I think that experience should count for something. The ridge makes it difficult to talk, makes it difficult to pronounce "s"s", alters the position of the tongue as the tongue is forced back into the mouth, affects the mussels, and profoundly and detrimentally affects the jaw. If the ridge is used as a biting area (which means the front teeth are protruding excessively, this reduces the height in the mouth, and detrimentally affects the jaw. It causes jaw crushing and dislocation of the jaw, aching jaw, and lock jaw. The lowering of height by several millimeters can cause grinding away of the jaw and lock jaw. This is easily measured in my case as the denture teeth overhang the bottom teeth considerably.

Since installing this new denture I have suffered both lock jaw and I am aware that my jaw has been grinding because my bite is altered and my bite has been compressed owing to the ridge. My natural bite is right back on the inner side of the ridge so I have lost at least four to ten millimetres in height.

Notes on Denture

The appointment where the denture was pulled forward, has affected the interior fit of the denture – this has left the denture short in depth.

Fitting at the back is too short in depth and does not encompass back gums both right and left.

~~Right side of teeth (when looking straight at)~~ need to be dropped a fraction as they slope up at the right and are not perfectly aligned straight with mouth. The right side front tooth needs to be turned clockwise to straighten it.

left (21)

(21-24)

Fitting at back of mouth is not flush with gums. Moulding at back of mouth needs to be graded smoothly where it meets gum – currently is ended bluntly with abrupt drop to gum

The ridge behind the front teeth needs modifying – I cannot talk properly or say my “s’s” the ridge is far too deep

➤ The bump along the front gum of the denture needs to be smoothed.

After set ~ (c.o.c. keeping base

merely received →

Notes on Denture

The appointment where the denture was pulled forward, has affected the interior fit of the denture – this has left the denture short in depth.

no A dam will fix

Fitting at the back is too short in depth and does not encompass back gums both right and left.

left just do it

Right side of teeth (when looking straight at) need to be dropped a fraction as they slope up at the right and are not perfectly aligned straight with mouth. The right side front tooth needs to be turned clockwise to straighten it.

left (21)

(21-24)

Fitting at back of mouth is not flush with gums. Moulding at back of mouth needs to be graded smoothly where it meets gum – currently is ended bluntly with abrupt drop to gum

smooth and replace labial palatal ridge
reduce festooning →

The ridge behind the front teeth needs modifying – I cannot talk properly or say my "s's" the ridge is far too deep

The bump along the front gum of the denture needs to be smoothed.

Alter ret ~ (c.o.c. keeping base

merely received →

Notes on Denture

The appointment where the denture was pulled forward, has affected the interior fit of the denture – this has left the denture short in depth.

no A dam will fix

Fitting at the back is too short in depth and does not encompass back gums both right and left.

left just do it

Right side of teeth (when looking straight at) need to be dropped a fraction as they slope up at the right and are not perfectly aligned straight with mouth. The right side front tooth needs to be turned clockwise to straighten it.

left (21)

(21-24)

who cares?

Fitting at back of mouth is not flush with gums. Moulding at back of mouth needs to be graded smoothly where it meets gum – currently is ended bluntly with abrupt drop to gum

smooth out the ridge labial palatal reduce festooning

The ridge behind the front teeth needs modifying – I cannot talk properly or say my "s's" the ridge is far too deep

The bump along the front gum of the denture needs to be smoothed.

Other notes ~ (c.o.c. keeping base



9 June 2015



9 June 2015





9 June 2015



Government of South Australia

SA Health



THE UNIVERSITY
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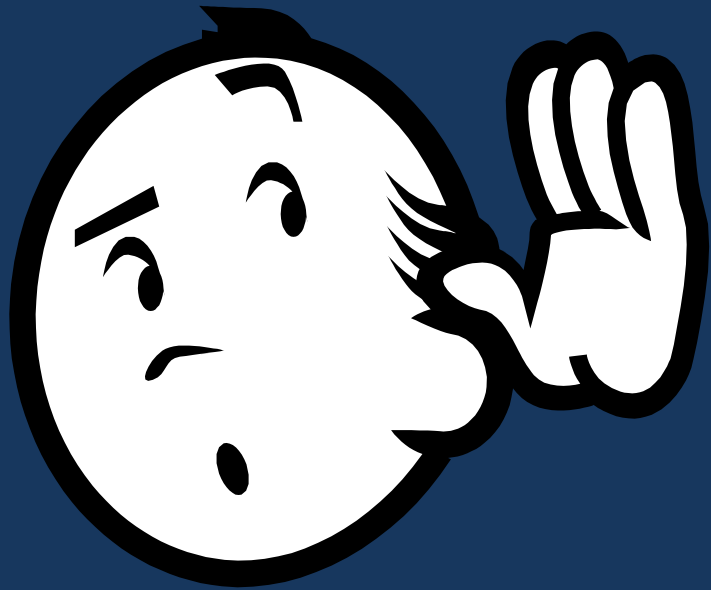
Things I wouldn't do again

Lindsay Richards

Don't ever try to treat Ms C

Don't forget to give patients a
“good listening to”

Active Listening



Remember

Question

Reflect

Clarify

Summarise

Personality types



Indecisive



Know-It-All



Agreeable



Complainer



Silent



Aggressive



Negativist



How much were you bothered or distressed over the past 4 weeks by

- | | | | |
|----|---|-------|----|
| 1 | Headaches | [_] | 15 |
| 2 | Nervousness or shakiness inside | [_] | 16 |
| 3 | Unwanted thoughts or ideas that won't leave your head | [_] | 17 |
| 4 | Faintness or dizziness | [_] | 18 |
| 5 | Loss of sexual interest or pleasure | [_] | 19 |
| 6 | Feeling critical of others | [_] | 20 |
| 7 | The idea that someone else can control your thoughts | [_] | 21 |
| 8 | Feeling others are to blame for most of your troubles | [_] | 22 |
| 9 | Trouble remembering things | [_] | 23 |
| 10 | Worried about sloppiness or carelessness | [_] | 24 |
| 11 | Feeling easily annoyed or irritated | [_] | 25 |
| 12 | Pains in heart or chest | [_] | 26 |
| 13 | Feeling afraid in open spaces or on the street | [_] | 27 |
| 14 | Feeling low in energy or slowed down | [_] | 28 |

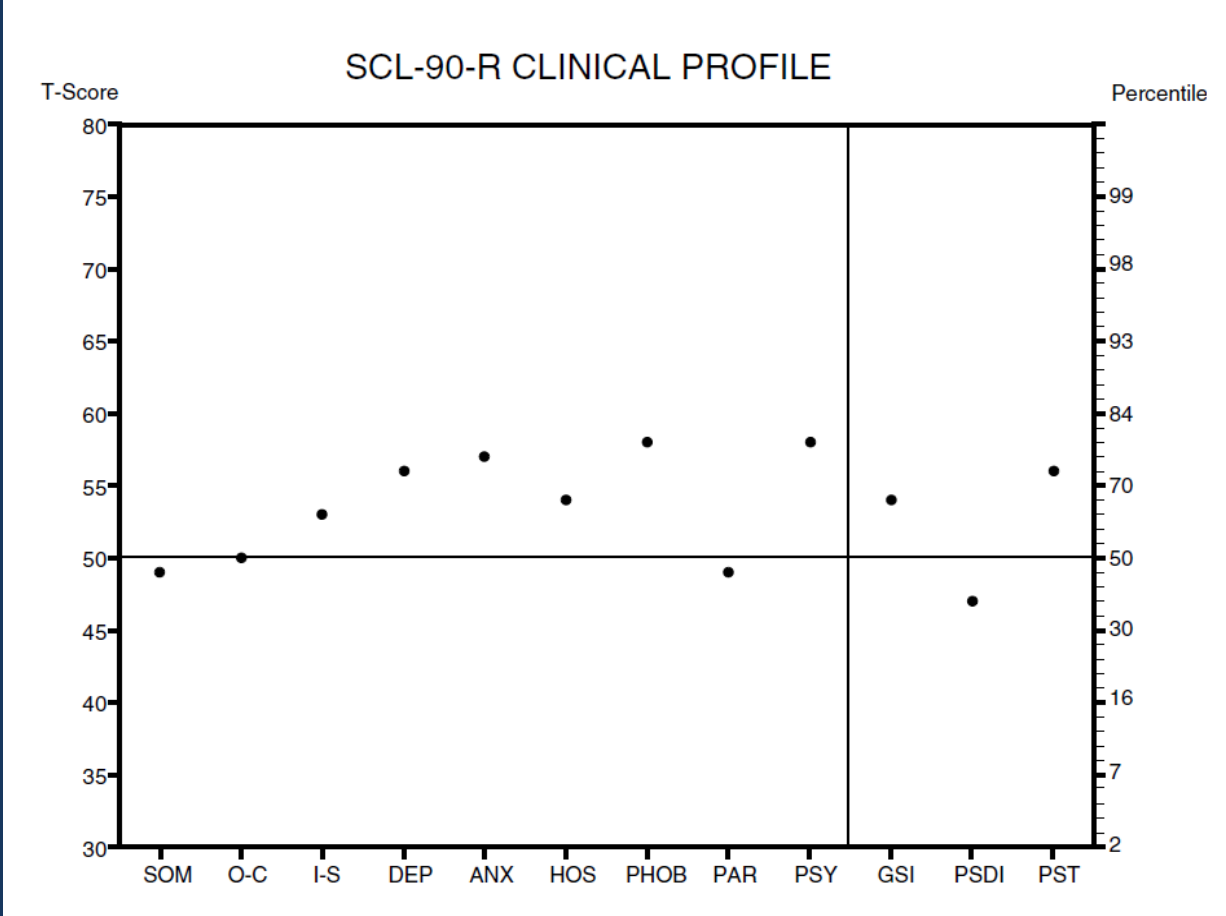


- Somatisation
- Obsessive-compulsive
Inadequacy
- Depression
- Anxiety
- Hostility
- Phobia
- Paranoia
- Psychosis

- General Symptom Index

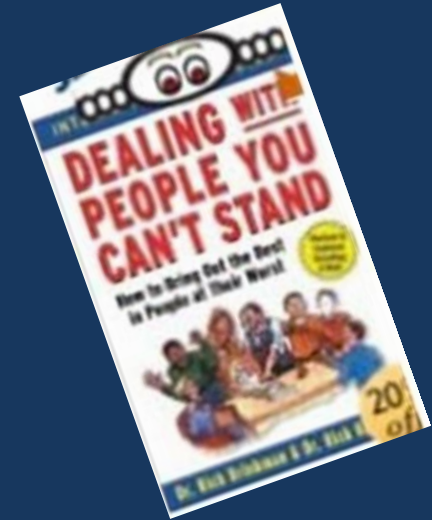
- Positive Symptom
Distress Index

- Positive Symptom Total



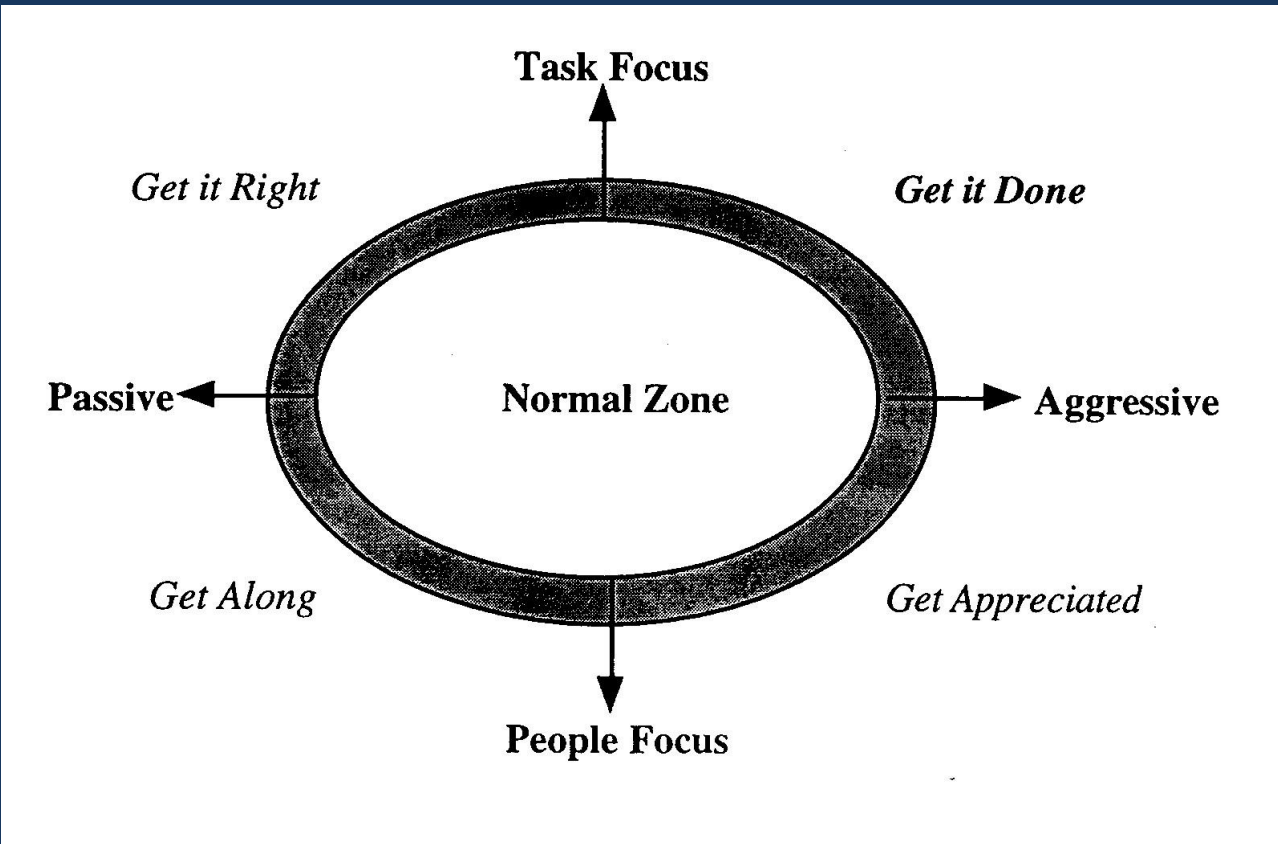
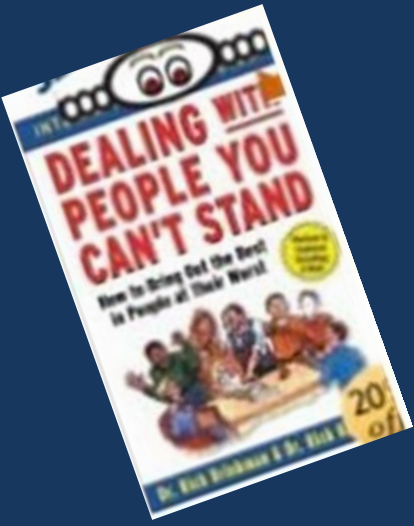
Dealing with People You Can't Stand

(Brinkman and Kirschner)



Dealing with People You Can't Stand

(Brinkman and Kirschner)



What about implants?

What about implants?

Avoid common
problems



Patient rapport

What about implants?

Avoid common
problems

Implants



Success

Patient rapport

How successful are mandibular overdentures retained by two implants?

J Dent Res 85(6):547-551, 2006

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RESEARCH REPORT **Clinical**

A Randomized Controlled Trial of Implant-retained Mandibular Overdentures

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² University of Newcastle upon Tyne, UK

* corresponding author, University Dental School & Hospital, Wilton, Cork, Ireland; f.allen@ucc.ie

RESEARCH REPORT
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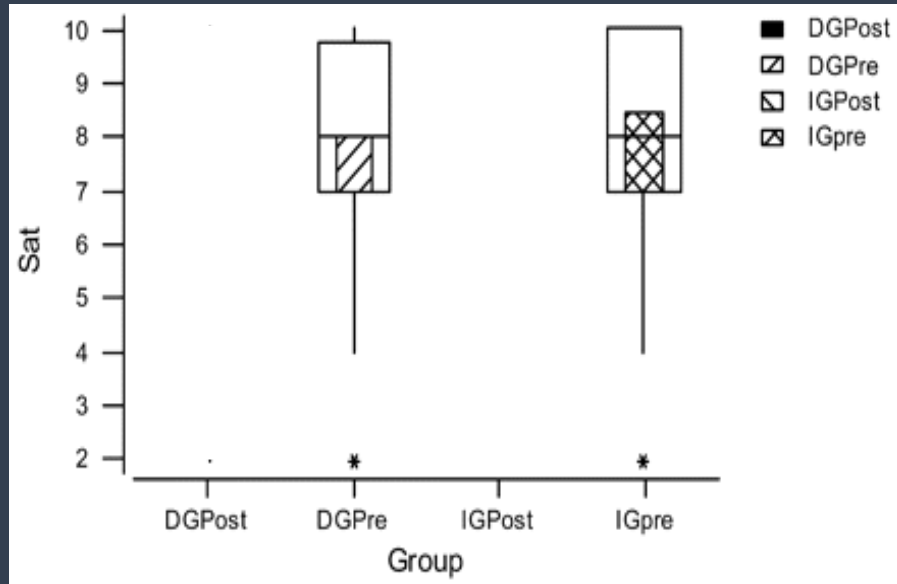
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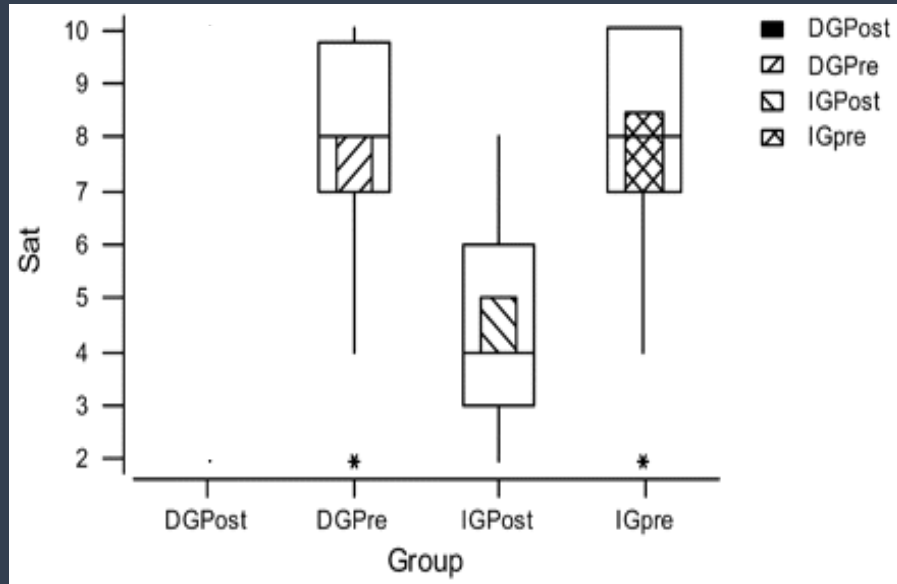
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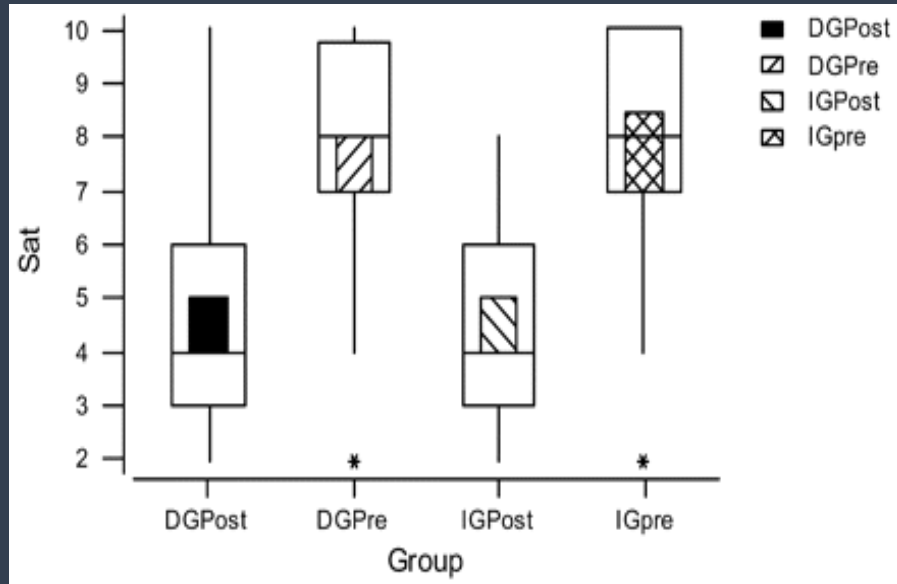
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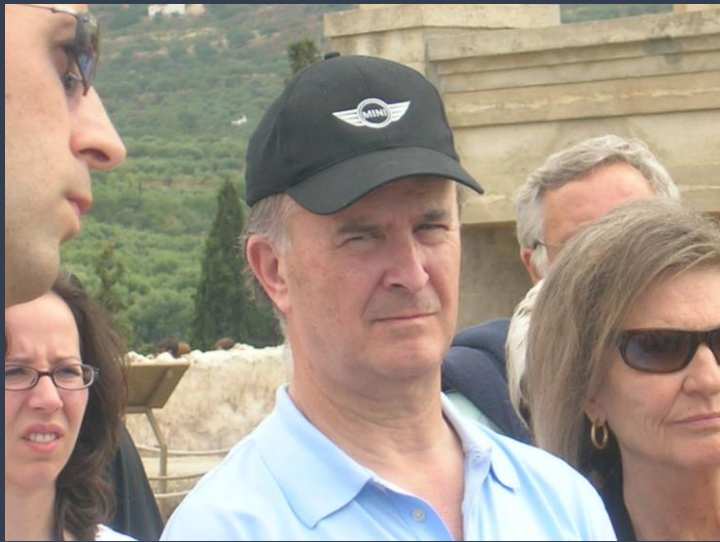
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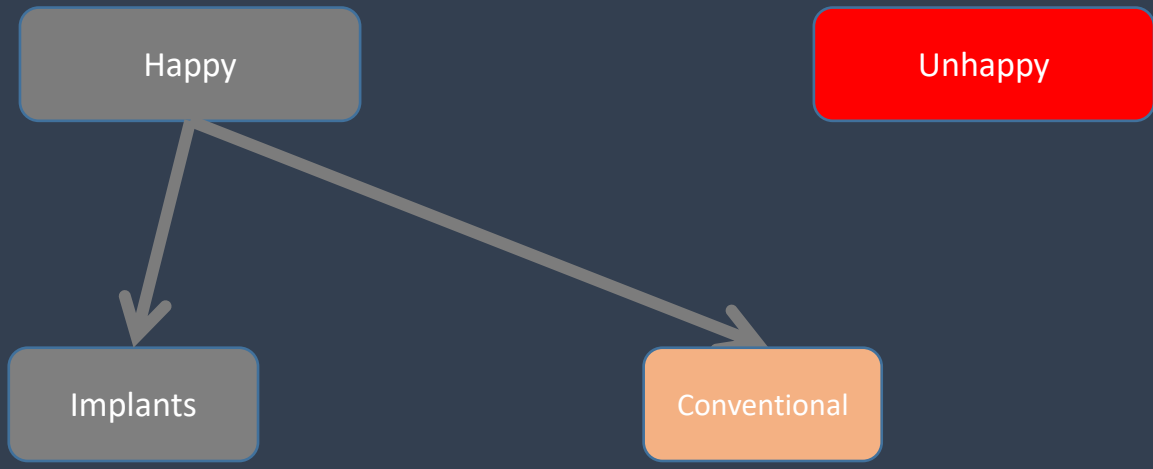


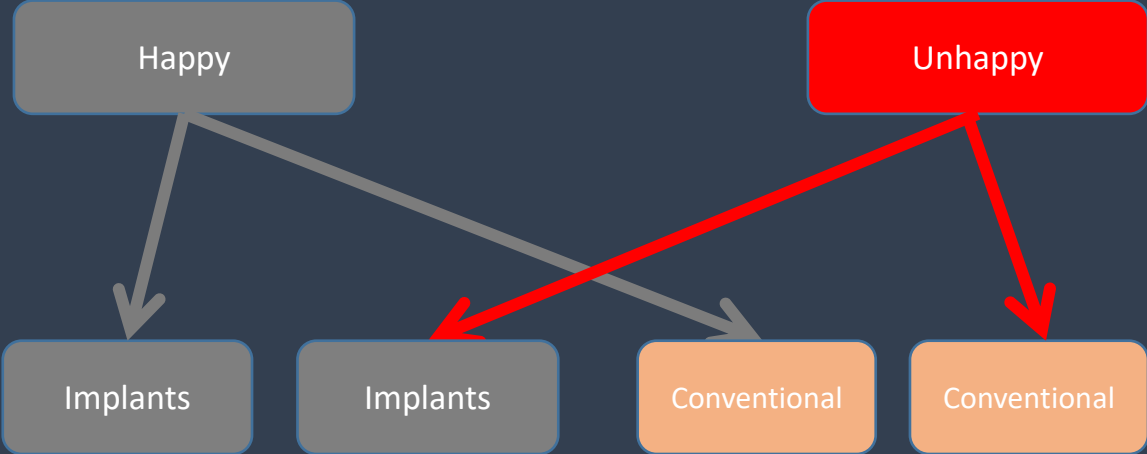
ICP Crete 2005



Happy

Unhappy





Happy

Unhappy



Implants

Implants

Conventional

Conventional

Happy

Unhappy



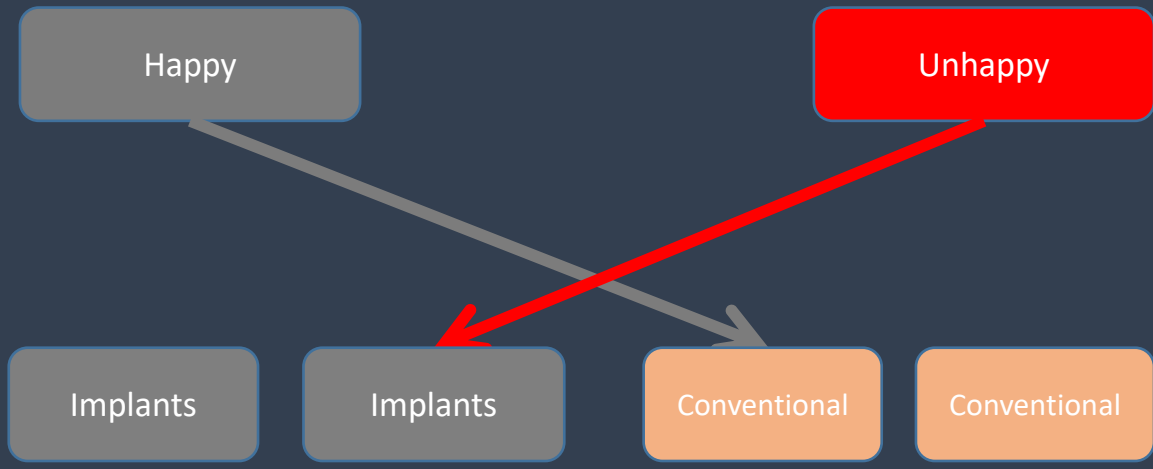
Implants

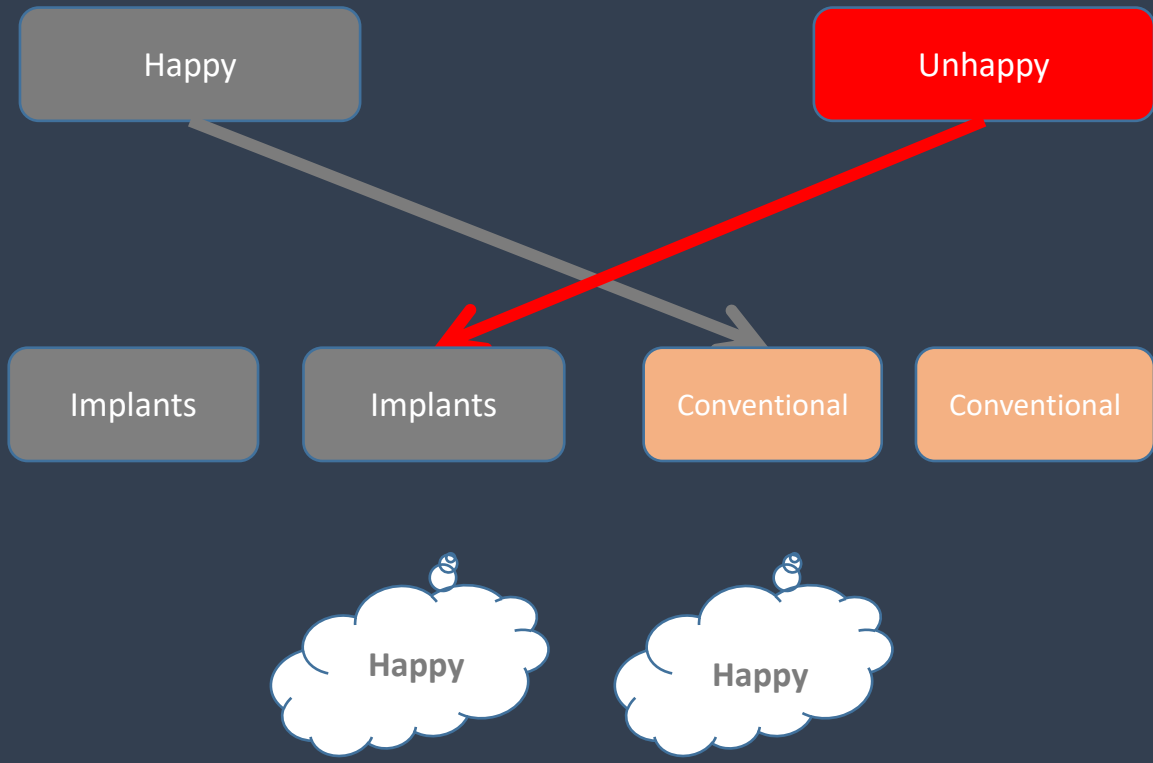
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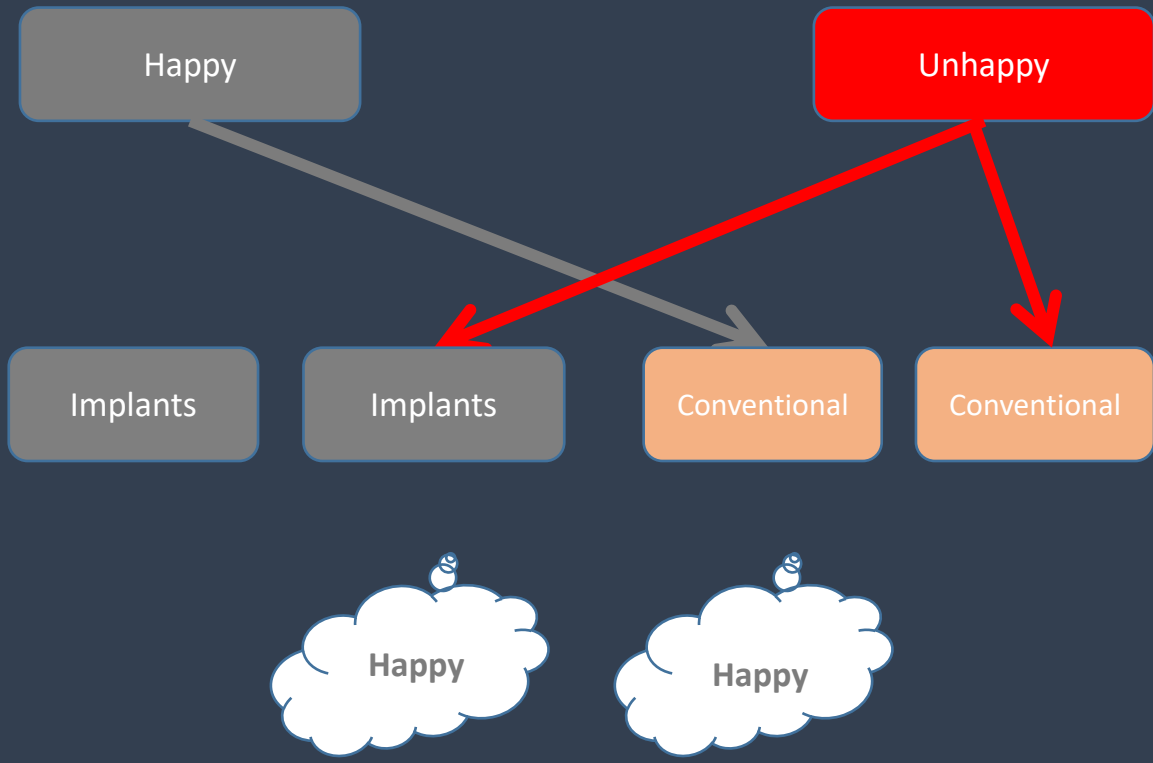
Conventional

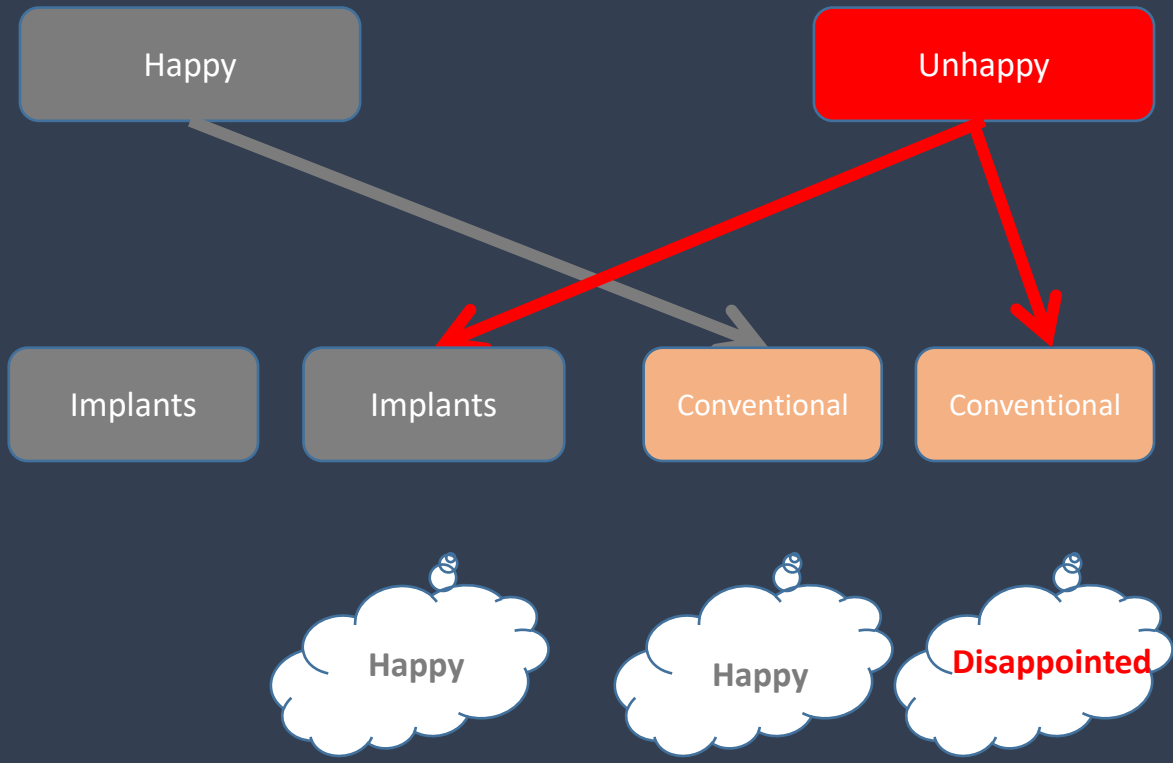
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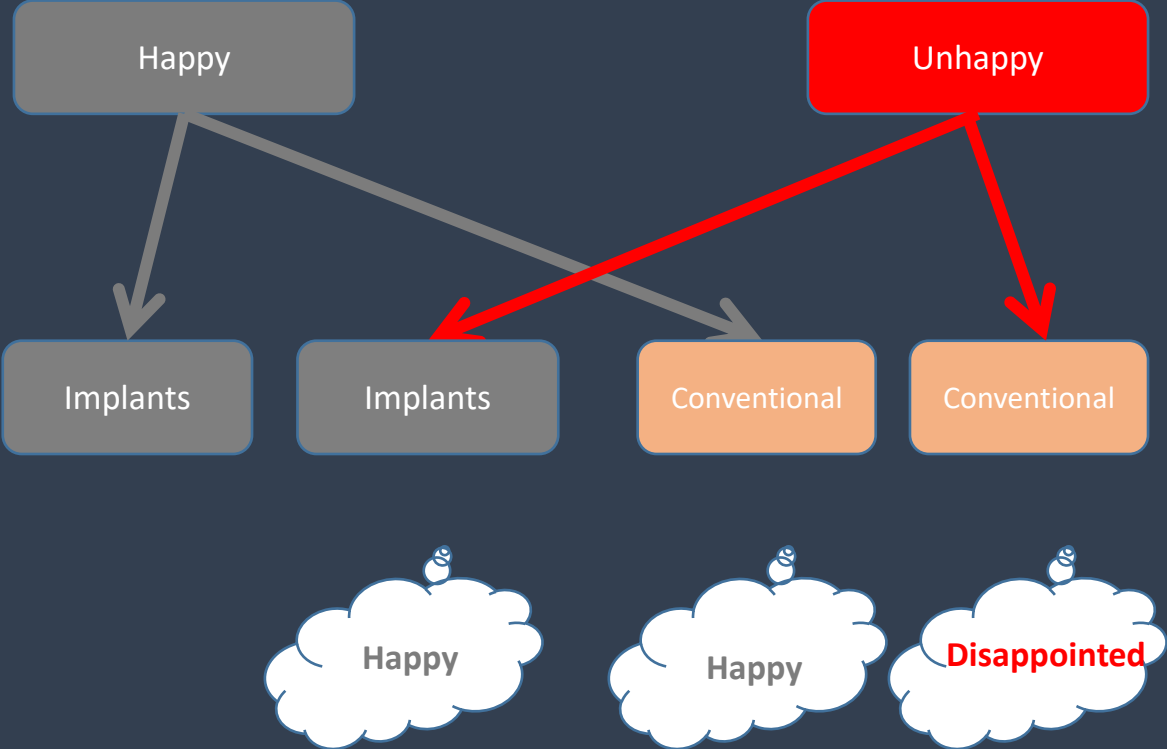


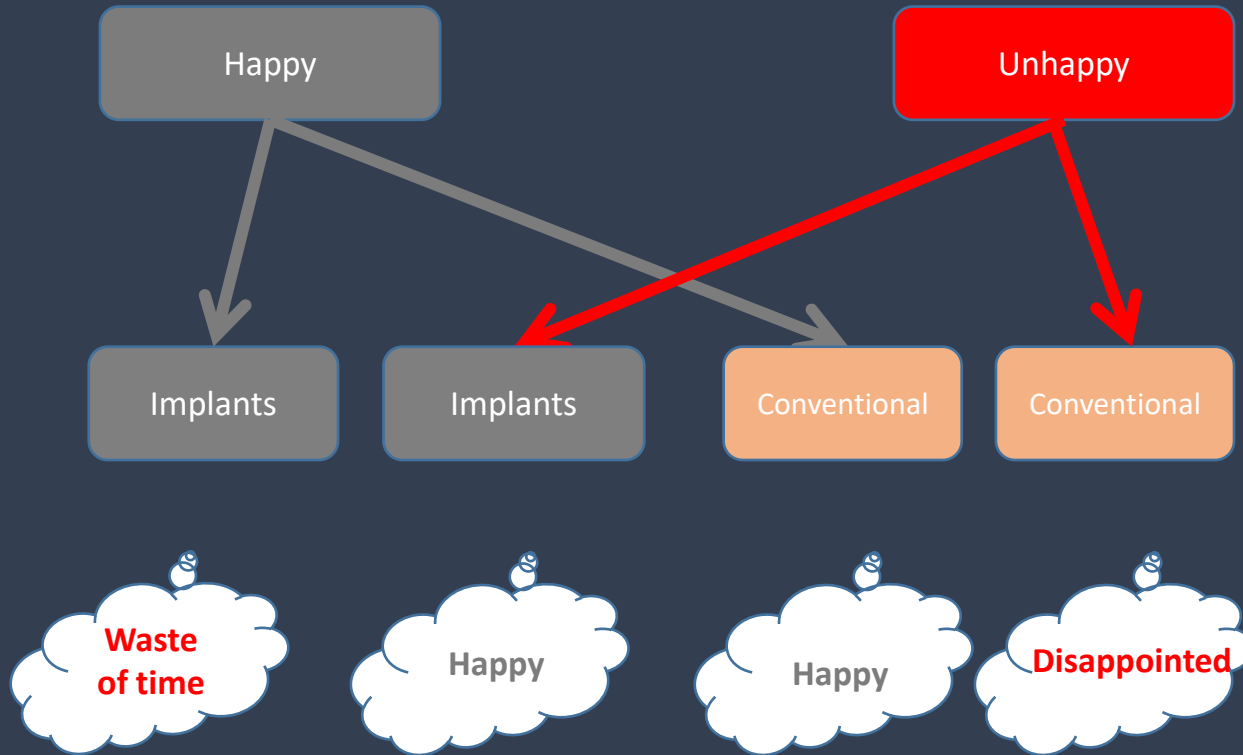






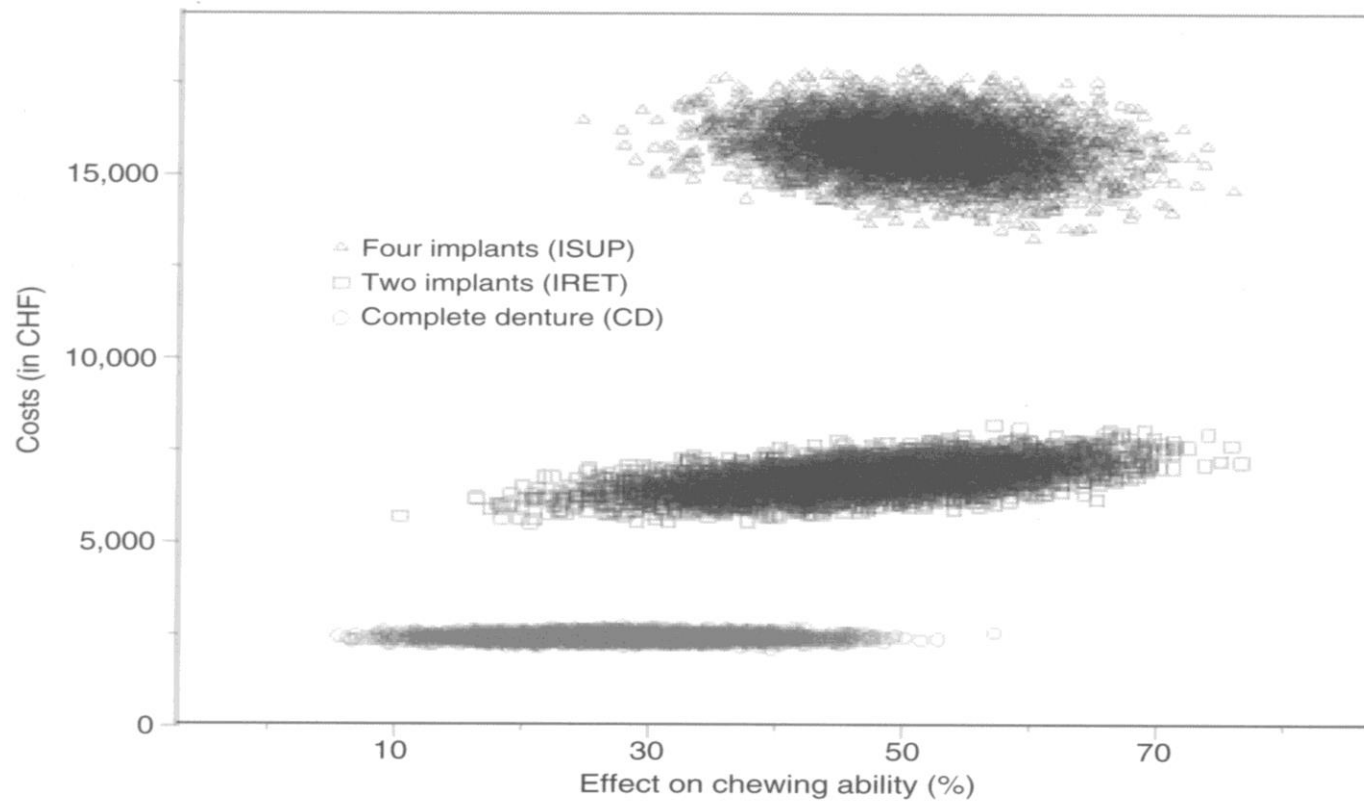






How successful are mandibular overdentures retained by two implants?

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THE UNIVERSITY
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Removable Prosthodontics

Things to do

... and not to do