



ISSN: 2277- 7695

TPI 2015; 4(2): 47-49

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www.thepharmajournal.com

Received: 15-02-2015

Accepted: 27-03-2015

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## Treatment of dental implant migration of the maxillary sinus. case report

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### Abstract

The implant rehabilitation of maxillary posterior defects involves a number of possibilities ranging from short implants, sinus lift in one or two phases, atraumatic lift with or without filling, pterygoid or zygomatic.

Complications of dental implants occur despite of good planning of surgery and if it happens, you have to know how to solve and is informed of how the specific case of migration of the maxillary sinus implant resolved to immediately resolve the or refer situation and also how to rehabilitate the space. Rehabilitation of a subsequent partial maxillary defect with extraction implant in 13, 15 and 16, with wide implants and atraumatic sinus lift occurs because our disposal 6 mm in height. With sufficient primary stability of 16 as 35Nw the healing abutment is placed, but the tightening by the 15d by insufficient initial setting thereof, the sinus implant migration occurs, immediately resolved with the opening thereof, expanding the alveolar defect and extraction, placing a pterygoid implant. It is concluded that implantology near sinus involves risks that the patient should know and professional knowledge to solve them, that pterygoids implants are adequate to extreme cases of posterior edentulous maxillary alternative and not to rely on the initial primary stability as the bony apposition and changes in bone resorption are continuous immediately after implant placement.

**Keywords:** Atraumatic sinus lift, edentulism, oral surgery, primary stability, dental implant, pterygoid implant.

### 1. Introduction

Different forms to treat the posterior maxillary edentulism are described in many papers and books as short implants (1), sinus lift (2) in one or two phases, atraumatic lift with or without padding (3), threaded bone dilators (4), silicone balloon (5) or zygomatic (6) or pterygoids (7). Complications can happened as infection, bleeding, sinusitis, non-osseous integration and as our case report the migration to maxillary sinus everything supported by a review of 15 articles.

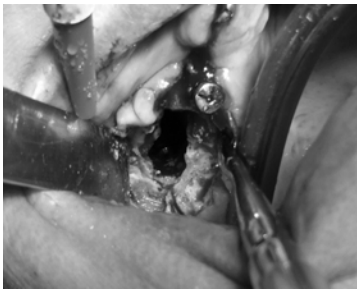
### 2. Case Report

We present a case of an ancient woman with a right partial edentulism after dental extraction of 18, 14, 12, 11 because of periodontal disease and a lack of 17, 16, 15 and 13. With local anesthetic three dental implants are putted in position 16 with a large of 10 mm and diameter of 4, 1 in a space of 4\*6 mm getting a torque of 25Nw with an atraumatic sinus lift, in 15 with 13\*4, 1 in 4,1\*5 getting 15Nw with another atraumatic sinus lift and another, in 13, with 15\*3,75 in 5mm and getting 25Nw, everyone with enough primary stability to bear in mind that is upper maxillary.

After discharge from the clinic with an antibiotic and antiinflammatory, analgesic and stomach protector treatment is reviewed after 15 days to get out the points. With a rx of control; we detect a lack of adjustment between the implant and the healing screw. At this moment the screw is turned and the implant move to sinus (Fig 1). Making a big crestal window (fig 2) to get it out (fig 3) and placing a Pterygoid implant (fig 4) and the case clinical finished (fig 5) and rx too (fig 6).



**Fig 1:** Immediately after migration.



**Fig 2:** Augmentation of alveolar bone with the implant depth.



**Fig 3:** Taken away with forceps.



**Fig 4:** Placement of a pterygoid implant.



**Fig 5:** Clinical finished.



**Fig 6:** Rx evolution.

### 3. Discussion

Some authors think that sinus lift must be done by those surgeons who make this surgical technique more than 200 cases per year because of the possible complications as acute maxillary sinusitis (8) or the case of this paper: the sinus migration and the limit between indirect (or atraumatic) and direct (or lateral window) (9) showed as 7mm and the necessity of filling up could not be so clear above all in indirect sinus lift.

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