Dear Editor,

With great interest, we have read the recently published case report on full mouth rehabilitation by implant-supported fixed prosthesis in your prestigious journal.1 It is always an avidity to know new facts in implant dentistry, especially relating to full mouth fixed prosthesis as this is one of the most preferred and promising treatment options in recent times. However, this is a technique sensitive procedure and requires appropriate clinical skills of the operator. A detailed and systematic presentation of procedure is must for the clinicians who are observant and learn from documented literature to handle similar cases. Although we commend the authors for their efforts, the following issues are worth considering regarding their treatment planning, case presentation and final aesthetic outcome.

Documenting preoperative photographs, factors to be considered for treating edentulous cases such as shape and quality of alveolar bone, availability of keratinized gingiva, gingival display and smile line, lip support, interocclusal distance, intermaxillary relation, and the reason for the loss of tooth are crucial requisites for formulating a treatment plan.2,3 Fabrication of a trial denture is also an essential step to get a brief idea on the interocclusal distance, the type of prosthesis design which can be selected in future (screw retained vs cement retained), esthetic outcome, and to fabricate radiographic and surgical templates which guide the clinician in precise placement of implants.4

It is appreciable that Cone beam Computed Tomography (CBCT) was included as a preferred investigation, but neither preoperative CBCT images along with the measurements of available bone height, width, and bone density nor postoperative images to show bone around placed implants have been incorporated by the authors. Figure 1 given by Bhandari et al.5 shows too far buccal placement of the most posterior implant in the 2nd quadrant of the maxilla. The information would have been more transparent and graspable if CBCT slice images of the respective implant sites, post-implant placement, and size of the selected implants were given.

Modern-day dentistry has adopted the concept of “teeth in a day” and digital workflow long back and it is preferred by many clinicians and the patients as well. Hence, immediate provisionalization could be considered in this case as authors have stated that sufficient primary stability was achieved although exact torque or ISQ values for individual implants have not been mentioned.5

With the conventional procedure, it would have been more profitable to the readers if mention on: Healing status of the tissues; duration between implant surgery and second-stage surgery; the method followed during jig trial; the technique used to check the passivity of the prosthesis; milled vs casted titanium framework; final torque values; radiograph to verify the fit of the final prosthesis; postoperative instructions; detailed findings at follow-up visits; patients expectations and satisfaction levels; note on surgical and prosthetic complications experienced; were included in this clinical report. Implant protected occlusion6 is the best recommended occlusal scheme for implant restorations while bilateral occlusal contacts in canine and premolars does not relate to any documented occlusal scheme in literature.

Moreover, the literature7 emphasizes on the maintenance of the buccal corridor with the final prosthesis; which seems to be obliterated in this particular case. This warrants the achievement of desirable esthetic outcomes and patient satisfaction, which are always the final goals for executing any treatment.

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Conflicts of interest
There are no conflicts of interest.

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