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TITLE: Bilateral fibrous hyperplasia of the tuberosities

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Introduction: Fibrous hyperplasia of the tuberosities is a disorder characterized by enlargement of connective and keratinized tissue. These alterations can invade the lower plane to contact the postero-lower teeth, making it impossible to install a prosthetic device. The prevalence of these disorders in geriatric patients is associated with systemic involvement as possible factors, drugs or genetic. Clinical and radiographic diagnosis is fundamental for a correct surgical maneuver in order to correct these alterations achieving a physiologically ideal for the seat of a removable prosthesis contour.

Case report: A female patient of 65 years old, which comes to prosthetic treatment is presented for consultation. With no alarming personal and family history. Partially edentulous. Refers not be ported prosthesis. Clinical examination signs of advanced enlargement was observed in both height and width tuberosities, of uncertain behavior invading the lower plane to contact lower posterior teeth. Radiographically observed in normal bone crest height of approximately 5 mm from the lower cortical of the maxillary sinus which extends to the rearmost area.

Conclusion: The fibrous hyperplasia is an alteration tubers with high prevalence in older adults. A correct diagnosis multidisciplinary will help us make the correct surgical approach, despite of that, this hyper-growth clinically is confused with bone growth.

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Introduction. Successful implant-prosthetic rehabilitation of an atrophic maxillary requires recourse to bone augmentation techniques. Zygomatic buttress grafts allow to create sufficient quantity and quality of bone to ensure optimal functional and aesthetic in the placement of dental implants.

Clinical Case. Female, 23 years old, that presents clinically agenesis of lateral incisors and a horizontal bone defect in the alveolar ridge. The atrophy is resolved through “CoCoon” technique, placing two grafts of both zygomatic buttress.

A horizontal incision is made in the edentulous ridge that continues in the adjacent teeth, at a distance of 3–5mm of the mucogingival junction, and finally ends in a distal releasing incision, in the area of the tuberosity. A mucoperiosteal flap is lifted to expose the zygomatic buttress. A graft block is obtained with a piezoelectric device, leaving intact maxillary sinus membrane. The autograft is placed in the vestibular cortical fixed with two osteosynthesis microscrews. Due to the shape of the graft, one fixed to the receptor bone a cavity is formed, which is filled with autogenous bone chips obtained with bone scraper (Safescraper), also of the zygomatic buttress. Whole bone block is covered with a collagen membrane.

The flap is sutured in two layers without tension. Three months after surgery, the implant is placed.

Conclusion. The “CoCoon” technique allows to obtain sufficient volume of the bone ridge for implant rehabilitation with minimal morbidity.

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TITLE: Maxillary anterior implant rehabilitation with zygomatic buttress graft: “CoCoon” technique

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