A Comparison of Graft Techniques for the Alveolar Ridge Prior to Oral Implant

Success of a dental implant can be affected by the width of the alveolar ridge—an indication of the amount of bone available to hold the implant. An article in the most recent issue of the Journal of Oral Implantology offers a comparison of two commonly used techniques, the ridge-split and the block bone grafts.

Lawrence, KS (PRWEB) July 25, 2014 -- Journal of Oral Implantology—Success of a dental implant can be affected by the width of the alveolar ridge—an indication of the amount of bone available to hold the implant. A variety of methods exist, each with their own advantages, to determine bone loss and subsequent augmentation techniques. The ridge-split graft is highlighted as a strategy for treating horizontally collapsed alveolar ridges.

The Journal of Oral Implantology offers a comparison of two commonly used techniques, the ridge-split and the block bone grafts. The oral surgeon must choose the best technique for bone augmentation based on an assessment of the patient’s condition and the oral surgeon’s own skills and experience.

Diagnosis of alveolar bone should first be assessed visually for width and height and the relationships of teeth to one another and to the dental arch. Radiographic images can distinguish two-dimensional versus three-dimensional bone deficiency. A three-dimensional or volumetric bone evaluation with cone-beam computed tomography allows for precise measurement of the ridge and evaluation of both the cortical and medullary portion of the bone, which are imperative for the stability of the implant.

A 10-point comparison of the two graft techniques, ridge-split and block bone, is offered within this article. Issues discussed include graft resorption, donor and recipient site morbidity, wound closure, buccal soft tissue flap, immediate or delayed implant insertion, and long-term stability of the graft.

Both methods are used primarily for horizontal alveolar ridge augmentation, or bone widening. Block bone grafting is effective for severe anterior atrophy in the upper and lower jaw. However, morbidity at the donor site and later-term graft resorption can occur with this method.

Some advantages of the split-ridge procedure include the lack of a donor site and that the buccal flap is not compromised but left attached. A post-operative injury while chewing is less likely with the ridge-split method because the graft is positioned more internally, protecting the area.

While the choice of graft technique must ultimately be decided by the experience and comfort level of the operator, the author asserts that the ridge-split treatment has many advantages and produces a stable graft over time.


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The Journal of Oral Implantology is the official publication of the American Academy of Implant Dentistry and of the American Academy of Implant Prosthodontics. It is dedicated to providing valuable information to general dentists, oral surgeons, prosthodontists, periodontists, scientists, clinicians, laboratory owners and technicians, manufacturers, and educators. The JOI distinguishes itself as the first and oldest journal in the world devoted exclusively to implant dentistry. For more information about the journal or society, please visit: http://www.joionline.org/.
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