

Restorative Steps for the All-On-Four Teeth-In-A-Day Conversion

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This technique can be used for a completely edentulous patient or one who is to be edentulated. There are five restorative appointments encompassing from 6-8 hours of clinical chair time. This treatment does require some unique lab support. It is advisable to use a lab that is experienced in this technique. Contact Nobel Biocare if you need a recommendation. Some labs will join you in your office for assistance with the acrylic work. This is worth the \$400-500 fee I've heard quoted for this service.

The outline is broken down into steps identified here:

1. VISIT NUMBER, Procedure and Schedule Time Estimate
 - 1.1. This level introduces the **treatment** that will be completed at this visit
 - 1.1.1. This level is a Step-By-Step outline of the restorative clinical techniques
 - 1.1.1.1. This level outlines the *Lab steps* that need to be completed

Clinical and Laboratory Procedures for an All-On-Four TIAD Provisional

1. FIRST VISIT: Data Collection including Photos, Measurement of Incisal Edge position, Rudimentary CR Record and Facebow with Immediate Denture Final Impression (1 hour)
 - 1.1. **Data Collection** begins with a **determination of the desired incisal edge**.
 - 1.1.1. Choose the desired incisal edge position for the provisional bridge. If the incisal edge is in a good position for esthetics and phonetics we will reproduce it in the provisional restoration. It could be that one of the four incisal edges is in an ideal position and can be used as a reference for all. If the incisal edge is missing we will require a baseplate and wax rim to determine the proper location during the second visit. If the incisal edge is present but in a supra-erupted or a splayed position that is the most difficult and strong consideration must be made to extract the incisors now, place a provisional partial and provide the opportunity to use a wax rim to determine the proper incisal edge position.
 - 1.2. We will **measure lip mobility** and determine the **exposure of the 8//9 papilla**.
 - 1.2.1. Measure the distance from the upper lip to the incisal edge at rest and during a high smile. The difference is lip mobility. (10 mm of incisor displayed at high smile – minus – 1 mm of incisor display at rest = 9 mm of lip mobility) You do not need to use the desired incisal edge for this – any incisal edge is acceptable. High lip mobility increases the ridge reduction you and your surgeon will need after the extractions in step 3.1.2.6 in the lab and 4.2 for the surgeon. To determine the amount of ridge reduction right now, evaluate the exposure of the 8//9 papilla. During a high smile, if the 8//9 papilla is not visible, then only 13 mm of ridge reduction is necessary. If the papilla is visible in a high smile, but the mucosa beyond the centrals is covered by the lip then 15 mm of ridge reduction would be appropriate. When the smile line is very high and the mucosa is evident beyond the height of the central incisors, then 17 mm of ridge reduction is necessary. The ridge reduction is determined from the incisal edge of the surgical guide.
 - 1.3. We will **photograph the face and the smile**.
 - 1.3.1. Photos of the face need to show the eyes so we can determine the appropriateness of the occlusal plane. Shoot the patient's biggest smile, a light smile and repose. Shoot the same three photos full face and of the mouth alone.
 - 1.4. Make a **CR record and facebow transfer**.

- 1.4.1. An accurate CR record will be necessary in the second visit and if that can be obtained at this time go ahead and do so. Use a Leaf Gauge or Lucia Jig to create an accurate CR record. For the facebow transfer, I really like the simple Kois Occlusal Analyzer if you are using a Panadent articulator. If not, make the appropriate facebow for your articulator.
- 1.5. **Immediate Denture Final Impression** – The TIAD provisional will be fabricated from this model and requires an accurate adaptation to the mucosa.
 - 1.5.1. Simple techniques suffice as long as accuracy of the tissue bearing area is not compromised. System 2 syringable alginate is excellent for the patient to be edentulated while System 1 syringable alginate is ideal for the completely edentulous patient.
- 1.6. A **perio chart** is necessary to determine the ridge reduction on the cast in the lab.
- 1.7. A **choice needs to be made now**. If your patient is completely edentulous the baseplate and wax rims will be fabricated to determine incisal edge position, occlusal plane and vertical dimension of occlusion. If your patient is partially edentulous, the baseplate and wax rims will be used to determine some of those three issues.
 - 1.7.1. The choice is determining if you will you need to use a wax rim to determine the incisal edge position then you'll need to send the models to the lab for wax rim fabrication. If you have determined the incisal edge position without the use of a wax rim the, you'll move ahead to the labwork that gets completed at the end of the SECOND VISIT below.
 - 1.7.1.1. The lab will fabricate and return baseplates and wax rims.
2. SECOND VISIT: Wax Records (can take as little as 30 minutes for the partially edentulous patient with a good maximum intercuspation, or 90-120 minutes for the completely edentulous patient) Armamentarium – Wax Rim(s), Bunsen Burner and Spatulas for Shaping Rims, Intra-Oral Tracing Device, Bite Registration Material, Tooth Selection Materials.
 - 2.1. During the second patient visit you will complete **wax records** in just the same manner as you would for any completely edentulous patient. This is true if they are nearly edentulous since there isn't enough information to determine the occlusal plane or incisal edge position from the remaining teeth. In this visit, you'll shape the wax rims to the size and shape you'd like to use as the arch form and occlusal plane. Select tooth shade and mold. Be certain to include a bite registration. With any completely edentulous patients, it is advisable to use **an intra-oral tracing device like a Coble Balancer or a Massad Balancer for the CR record**.
 - 2.1.1. Wax Rims: Similar for a completely edentulous patient. Esthetics and phonetics come into play. Create the size and shape desired for optimal results. When completing a case in the upper arch, the "f" sound helps to determine the length of the upper central incisor. Esthetics plays a large role in the final position of the upper central incisors as well. Evaluate the incisal edge location with repose, light smile and high smile views. Repose and light smile take precedence over the high smile. When completing a case in the lower arch, the lower incisal edge position is determined using the "s" sound, sibilant sound, to determine the closest approximation of the upper and lower incisors. Esthetic considerations don't come into play for the lower incisal edge position.
 - 2.1.2. Centric Record: Use an intra-oral tracing device when possible. For the patient to be edentulated, this could simply be Maximum Intercuspation for CR and VDO.
 - 2.1.3. Tooth Selection: Determine tooth type, shade, shape and posterior tooth form. The anterior tooth mold can be determined from an old photo, facial measurements or esthetic considerations. Posterior tooth mold is determined by the opposing occlusal form as well as the opposing arch restoration. Lingualized occlusion is typically easy to deliver and provides excellent stability if the opposing arch is a removable prosthesis. Vita

Physiodens and Ivoclar tooth molds are in the Procera tooth library and may provide some future simplicity when fabricating the definitive bridge.

2.1.3.1. Send to the lab: Wax Records, Centric Relation Record, Tooth Selection, Shade and Facebow. The lab will return *a wax trial for all missing teeth*. The lab should set teeth around the teeth that remain. That will allow for a wax trial.

3. THIRD VISIT: Wax Trial (Typically 30 minutes unless major changes are needed)

Armamentarium: Wax trial, wax spatula, Bunsen burner, camera, fox plane, shim stock

3.1. Now complete a **wax trial**, confirming phonetics, occlusion and esthetics. For the patient to be edentulated, complete a wax trial for as much of the arch as is possible (missing teeth).

3.1.1. Evaluate the occlusal contacts, the occlusal plane and excursive movements.

Evaluate the speech, then the esthetic display of the incisal edge at rest, under a light smile and a high smile. Make any improvements and then have the patient confirm.

3.1.2. The lab will need to know the desired occlusal plane and the new incisal edge position. Send to the lab the wax trial and information about how much reduction you need on each tooth to be removed from the master cast. This could be gleaned from the perio chart. If there are 4 mm pockets or less then remove 2 mm of “bone” from the working cast after the tooth is removed to the gingival crest. If there are pockets 5 mm or greater then 3 mm of “bone” is removed from the working cast. In the end, the bridge can be fabricated with as little as 10 mm of space between the opposing occlusion and the new residual ridge, but 13 mm is the minimum in the anterior and 11 mm in the posterior. Each of these measurements can also be increased by 2 or 4 mm for moderate and high smiles to ensure that the junction of the artificial gingival and real gingival doesn't show.

3.1.2.1. The lab will now *set the remaining teeth* as if they are fabricating an immediate denture. I work on one-half of the arch at a time. They will remove the remaining teeth some amount of the cast that is associated with bone and soft tissue.

3.1.2.2. This step **MUST** be done. The lab needs to set the denture wax up on the articulator and make a *strong bite registration* to help with the delivery of the TIAD after surgery. I prefer to use heavy body putty for this, but any bite registration will do well. I also like to do this at the wax up stage before processing rather than after.

3.1.2.3. I have the lab go ahead and *process the denture*. While I don't plan on using it, it is nice to have as a back-up in case something went wrong during surgery.

3.1.2.4. The lab will fabricate *a duplicate of the denture* (wax up if you don't process) to be used as the TIAD provisional bridge. This duplicate will have tooth colored teeth and pink colored flanges. I request the flanges are thick and long and a full palate. The patient will never wear this duplicate as a denture, but those flanges will aid in seating and stabilization during the conversion procedure. A *second duplicate* should be made in *clear acrylic as the surgical guide* to assist the surgical dentist in implant positioning.

3.1.2.5. The clear acrylic surgical guide should be adjusted in the flange area of the four implant positions. The length of the facial or buccal flange should be removed in sections where the implants will be placed to the desired height of the crest. This will facilitate the ridge reduction prior to implant placement. The vertical height of the stent could be confirmed here to be 13 mm for the posterior and 15 mm due to overbite in the anterior. This is influenced by the lip mobility and high smile. Look back to the data collection section for insights.

3.1.3. The lab or the restorative dentist needs to send the clear acrylic surgical guide to the surgeon. It would be beneficial that the surgeon also use the bite registration although it is

imperative that the restorative dentist has it for their steps so consider making a second bite registration for the surgical dentist.

- 3.1.4. Once the lab steps are completed, the surgical dentist, restorative dentist and sometimes the lab technician should all get together for treatment planning the implant locations. The posterior, angulated, implant site is chosen first with preference that it engage the good quality bone apical to the canine in the maxilla and be placed as posteriorly as possible in the mandible. The posterior implants are often 13 or 15 mm long. The anterior implant sites should be selected for the longest implant placement medial to the posterior implant apex. The canine location would likely provide the most ideal bone with the lateral incisor region being preferred over the central incisor region. It is acceptable to place one anterior implant in the central incisor region, but every attempt should be made to avoid placing both anterior implants in the central incisor region as they act as a single implant biomechanically in this tight pattern. It is acceptable to have one side implant site in the canine region and the other side place asymmetrically in the lateral incisor region.
- 3.1.5. The ultimate goal is to have the posterior implant placed directly below the mesial marginal ridge of the first molar and the anterior implant placed in the canine location.
- 3.1.6. The implant representative, surgeon and technician should help the restorative dentist ensure that they have the appropriate prosthetic screws, guide pins, temporary titanium cylinders and/or titanium abutments.

4. **FOURTH STEP:** This is a double booked day. (Plan for 4 hrs in the restorative dental office)
Armamentarium: Straight handpiece with a variety of acrylic burs, permanent marker, denture repair acrylic, disposable syringe, rubber dam material, rubber dam punch and scissors. Duplicate denture, temporary titanium cylinders for each abutment, temporary abutment cylinders for each implant location, prosthetic screws for each cylinder and long guide pins for each cylinder. The prosthetic screws and guide pins vary for each implant type and temporary cylinder – ensure you have the correct materials. Polishing protection caps and/or replicas are also necessary.

- 4.1. The patient will see the surgeon first, and then move to the restorative dentist's office. Prior to beginning any treatment, the surgical dentist should have the clear surgical stent and a bite registration to assist in seating and aligning the stent. The restorative dentist should have the processed denture available as a back-up, the duplicate denture that will be used to fabricate the TIAD provisional bridge, the strong Bite Registration, prosthetic screws and guide pins for every implant that will be placed as well as the temporary titanium cylinders for each connection to an abutment or temporary titanium abutments where connecting to the implants.
- 4.2. The surgical dentist will see the patient, extract any remaining teeth and level the ridge. The surgical stent will be used to ensure the ridge is reduced appropriately so that the artificial gum junction to the mucosa is not visible in the smile. See step 1.2 for a discussion of lip mobility, 8/9 papilla exposure and how this influences ridge reduction. The reality clinically is that many times the surgical guide is not fully seated against the palate in the maxilla due the model surgery being more aggressive than the ridge reduction. This needs to be evaluated by pressing the clear acrylic surgical guide and ensuring the rugae area is blanched. If the rugae is not blanched, then the final prosthesis will have the incisal position moved down altering the vertical and the incisal display. This is a common complication. Ensure the ridge is properly reduced before placing the implants. The implants will be placed in the planned positions. The posterior implants are placed first. In the maxilla they are placed parallel to the medial wall of the sinus and long enough to engage the high quality bone in the cuspid piriform. In the mandible, they are positioned as far posterior as possible to ensure they finish in front of the mental foramen. How far posterior they are placed is entirely dependent upon

the height of bone above the mental foramen. In both arches, the anterior implants should be placed just medial to the terminus of the posterior implants with their screw access holes through the cingulums of the anterior teeth. Angulated abutments should be avoided at all costs in the anterior positions. Angulated abutments will likely be placed on the two posterior locations with their new screw access holes aligned with the path of draw of the two anterior implants. Angulated abutments are available in 30 degree and 17 degree options. The 30 degree option is often better because the implants are often placed at that dramatic of an angle. However, the 30 degree abutment has a higher metal collar and – when possible – a 17 degree abutment is desirable due to its smaller collar height. Either way, the angulated abutments should be placed by the surgical dentist prior to suturing the mucosa and positioned in such a way that the screw access hole is aligned within the arch form of the posterior teeth. The angulated abutments need to be torque to 15 Ncm with a torque wrench. Multi-Unit abutments (MUA) are sometimes placed in the anterior locations. MUAs need 35 Ncm with the torque wrench. Healing abutments will be seated gently on the implants if no MUA is being used (this is my preference to get a more subgingival margin and use a larger prosthetic screw for two of the four implants. Healing caps will be placed on any MUA or angulated abutments that were used. The patient will be sent to the restorative dentist with the surgical guide and BR.

- 4.3. The surgical dentist should provide written confirmation that the implants were placed with at least 35 Ncm of torque and the abutments were torqued to the appropriate final tightness.
 - 4.3.1. The restorative dentist will **convert the duplicate denture into a TIAD bridge**.
 - 4.3.2. The first step is to ensure the surgical guide fully seated once the ridge reduction was completed. If the surgical guide didn't seat completely, the case will still proceed fairly easily for the surgeon, but if the conversion denture doesn't seat completely (and it is a duplicate of the surgical guide) then the occlusion will be incorrect. Place pressure on the palate in the maxilla and on the buccal shelf in the mandible to ensure the rugae in the upper arch and the buccal shelf in the lower arch are blanching under the clear surgical guide. If not, the surgical guide needs to be adjusted before proceeding with the pick up of the titanium cylinders. Of course, any adjustments necessary to fully seat the surgical guide are also equally necessary on the conversion denture itself. Do these adjustments together – one after the other. Adjust the surgical guide, then the denture. Try the guide again – repeating until the surgical guide seats and blanches the appropriate areas.
 - 4.3.3. Use the surgical stent to view the implant locations associated with tooth position. If necessary, make a mark correlating to each implant location on the surgical stent with the permanent marker.
 - 4.3.4. Hold the surgical stent over the conversion denture and continue the permanent marker locations onto the conversion denture indicating where the implants are located.
 - 4.3.5. The step described here could have been done in the lab or by the surgeon in advance or chairside on the day of the conversion. We will need access to the implants through the conversion denture on the facial, buccal and occlusally. Since the access holes for the posterior implants are associated with the occlusion and the access holes for the anterior implants are associated with esthetics, I protect those two areas and drill them clinically and precisely. However, the occlusal holes in the anterior and the buccal holes in the posterior are holes that can be opened aggressively and pre-emptively. So, palatal to the canine and lateral incisor on either side, open an access hole that is oval in shape. If you are doing this chairside, after the conversion, use the surgical guide as a reference to improve precision and limit the size of the access hole. In the posterior, on the buccal,

- drop the flange of the denture to within 2 mm of the cervical necks of the denture teeth in the area of the second bicuspid and overlapping slightly onto the teeth on either side.
- 4.3.6. To indicate where the exact locations of the implants, place a bead of fast set bite registration material inside the conversion denture in the premolar and molar region. Seat intra-orally over the healing caps. The bite registration material indicates the location of the posterior implants. Using a #10 round bur, drill straight through the bite registration and into the denture acrylic. Make strong indentations, but do not drill all the way through to the occlusion. Use the tip of the large acorn acrylic bur to open these indentations and repeat the process until you are sure the denture fully seats.
 - 4.3.7. To drill all the way through the posterior occlusion without destroying the occlusion, seat the surgical guide intra-orally and note where you believe the screw access hole will come through the occlusal surface. Notes will read like MP#3 and D13. Using a #10 round bur, drill straight through the occlusal surface in these areas and try to meet the indentations that were initiated from the intaglio with the bite registration.
 - 4.3.8. Use a long skinny acrylic bur or a thin acorn acrylic bur to open these holes directly over the implant locations. These holes do not need to be fully opened at this stage.
 - 4.3.9. Starting in the back of the mouth, remove the healing caps one at a time. One at a time, seat the temporary titanium cylinder or temporary titanium abutment and adjust the conversion denture to open a window and allow the cylinder to poke through. When adjusting, open a taper on the intaglio and preserve the acrylic on the occlusal surface. Repeat for all implant locations – again, working from back to front for access.
 - 4.3.10. Adjust the length on the titanium cylinders that appear to be too long and poke through the conversion denture encroaching on the opposing occlusion. It is ideal if the cylinders are just short of the occlusal plane and not long or overly short.
 - 4.3.11. Use the straight handpiece and acrylic burs to cut holes in the facial flange that correlates to each of the anterior titanium cylinders. In the posterior, modify the existing holes to be slightly mesial for access to inject the acrylic. These holes should be near the gingival crest and should be wide enough to see the full circumference of the titanium cylinders. Round the inside of the denture to join the occlusal hole you previously made to this buccal access hole so the acrylic flows easily for the next step. **BE VERY CAREFUL – THE CONVERSION DENTURE CAN FRACTURE IN THIS STEP.**
 - 4.3.12. Confirm the position of the conversion denture over the cylinders with the strong bite registration.
 - 4.3.13. Cut a rubber dam sheet in half. Cut a notch for the tongue if this is a lower arch case. Lay the denture over the rubber dam with the posterior aligning with an edge of the dam and an equal amount of excess dam material on either side. For a lower arch case, mark the locations just inside of the cylinders with a permanent marker. By marking just inside the cylinders, the rubber dam will be slightly tight. In the upper arch, mark the locations just outside of the cylinders. This will help to make a smooth surface when completed. Use the rubber dam punch to open the smallest holes possible.
 - 4.3.14. Lay the rubber dam over the arch around the cylinders by perforating the dam with the cylinders. This is quite easy. Once done, confirm again the conversion denture slides over this without obstruction. The excess material on the facial and buccal can be pulled laterally to ensure that the bridge is seating properly.
 - 4.3.15. It is critical to prevent acrylic from entering the screw access holes. Use small bits of cotton pellets, Fermit or wax to seal the screw access hole for the pick up procedure.
 - 4.3.16. Seat the conversion denture, seat the bite registration and prepare to connect this conversion denture to the titanium cylinders. Mix denture repair acrylic to a runny mix;

- back fill a disposable acrylic syringe. You'll not want to inject the acrylic in a runny state, but you'll need to fill the syringe in a runny state. So expect to allow the acrylic to bench set just a bit before progressing. This is where having a technician assisting you is helpful.
- 4.3.17. With the conversion denture seated and held in position with the strong bite registration, inject the acrylic through the buccal and facial windows around the titanium cylinders. If the cylinders are very near the bite registration, the screw access holes will be easy to locate once the acrylic has set and you can be aggressive with material – the bite registration will form the occlusal shape too – a great benefit. If the cylinders are a long distance from the bite registration then be careful not to overfill the screw access holes! Allow the material to set up and have the patient to hold their pressure throughout.
- 4.3.18. Remove the bite registration and use a curette or small round bur to expose the screw access holes. If they were covered with acrylic then you'll need to use a round bur to access the screw holes. Remove the screw access hole filling material (endo file works great) and then the screws. The entire prosthesis will come out with the rubber dam.
- 4.3.19. Seat the healing caps and/or healing abutments on the implants and abutments while the next step is completed on the bench. We give the patient a protein shake, close the blinds and cover them with a blanket. It has been a long day for them so far and they usually take advantage of the break with a short nap.
- 4.3.20. Remove and dispose of the rubber dam material. Attach lab protection replicas or standard replicas to the prosthesis with long guide pins. Using a brush, add acrylic around the guide pins to fill any voids around the occlusion. This will be refined when the case is delivered in a moment. Also use the powder and liquid to add acrylic and idealize the contour of the tissue contacting area of the bridge as well as the emergence of the titanium cylinders. This is under your control. It is known that immediate dentures shape the ridge post-extraction. We will do the same with our bridge. Add acrylic to a nice, even, level surface. This will put pressure in some areas more than others as the ridge heals and matures under this prosthesis. Fill the ridges from the rubber dam.
- 4.3.21. Place the entire prosthesis in a pressure pot for 20 minutes. **Don't skip this step!**
- 4.3.22. Keep the lab protection replicas on to protect the titanium cylinders and grind the flanges off of the conversion denture. Grind to eliminate all flanges from the facial, buccal and palatal surfaces with all surfaces being convex with no concavities. The bridge ideally will have a light contact in the pontic areas and a smooth emergence in the cylinder areas. Our goal is to have 4-6 mm of contact area to the healing ridge. I like to taper the facial and buccal flanges from tissue contact to tooth zeniths. You may need to try the case in the mouth to confirm your contours before final polishing. In the maxilla, the tissue contact area needs to be fairly palatal in the anterior to eliminate any palatal overjet which has a hugely negative impact on the speech. Keep the lab protection replicas, but replace the guide pins with small screws and polish the entire tissue bearing area with pumice and whiting on a lathe.
- 4.3.23. Once the prosthesis is finalized, though one would want to deliver it straight away, it is very beneficial if an index is poured. This will add 30 minutes to your treatment time, but will save a ton of future chairtime. This index will be used to streamline the fabrication of the definitive prosthesis. Place replicas on the TIAD provisional bridge with either guide pins or prosthetic screws. Use fast set mounting stone and a small jewelry box and pour an index of the implant positions. Label this index TIAD as it may not be 100% accurate and you won't use it as if it were. However, if for some reason the TIAD fractures during the osseointegration phase, this index is ideal for extra-oral repairs.

- 4.3.24. Remove the intra-oral healing abutments/caps and deliver the TIAD provisional bridge. If you have two implant level connections, they have much larger screws and they should be engaged first, but not tightened all the way. Engage all four screws before tightening them completely. The tissue may blanch from the contours created for the emergence profile of the titanium cylinders. It is actually easier to seat the prosthesis if there is a small space between the tissue and the prosthesis; however, this can have a negative impact with speech in the upper arch so I try to avoid that space.
- 4.3.25. Torque the abutment screws with 35 Ncm and all prosthetic screws at 15 Ncm.
- 4.3.26. Adjust the occlusion as needed and seal the screw access holes with a loose cotton pellet and Tellio (Rubberized composite from Ivoclar).
- 5. FIFTH VISIT: Post Operative, OHI, Photos (one hour)
 - 5.1.1. Don't open the screw holes, don't remove the prosthesis unless necessary to address an issue that can't be addressed otherwise. If there is an issue that necessitates removal of the prosthesis such as open tissue space that needs to be closed with a "Reline" or overcontours that need to be polished back, it is preferred that this be addressed sooner than later as implants actually get looser before they integrate during the first two months.
 - 5.1.2. Reconfirm the occlusion is appropriate and adjust as necessary to create an Implant Supported Occlusal scheme. In this scheme, there is centric contact on all teeth supported with implants and no centric contact on the cantilevers. Cantilever can be anterior as well as posterior in some instances so consider an anterior open bite if necessary. Eccentric contact is ideally created as a group function occlusion with all teeth supported by the implants participating. Additionally, there is no need for a steep group function so create a smooth cross-over onto the incisal edges to reduce anterior breakage risk. So, all implant supported teeth in centric and all implant supported teeth in group function in eccentric – thus, Implant Supported Occlusion.
 - 5.1.3. I like to use a Leaf Gauge at this visit and really get the CR occlusal adjustment refined now. The extra effort now will really pay off when we are fabricating the definitive bridge.
 - 5.1.4. For Oral Hygiene Instruction, brushing the gumline is appropriate. Flossing under the TIAD Bridge using a product like SuperFloss is also recommended.

Once the implants have osseointegrated you'll fabricate the definitive bridge. There are two different techniques available. The streamlined version would be used if you want to replicate the occlusal plane, incisal edge position and vertical dimension of the provisional TIAD bridge. Should you want to make any improvements or dramatic changes, then the comprehensive protocol is necessary. Both Step-By-Step guides are available online at DrSharifi.com.