



Flapless Approach to Maxillary Sinus Augmentation Using Minimally Invasive Antral Membrane Balloon Elevation

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Posterior maxillary implant placement is often complicated by the lack of quality and volume of available bone. Types 3 and 4 bone tend to predominate in the posterior maxilla, generally exhibiting the least dense bone of the oral anatomy.¹ The height and width of the residual ridge can significantly be reduced or eliminated by postextraction resorption patterns, use of a removable prosthesis, physical trauma, periodontal disease, and pneumatization of the sinus. In the atrophic posterior maxilla, longer and wider implants are needed to enhance long-term survival. This often requires bone augmentation beneath the sinus to increase the vertical bone height.

Tatum² was the first to report the subantral augmentation or “sinus lift” procedure, which has evolved over the past 25 years. A lateral window (modified Caldwell-Luc) approach to the maxillary sinus is used. Because this has shown favorable results, the posterior maxilla is often considered one of the most predictable regions for grafting before or simultaneously with implant placement.^{2–7} Basically, a hinged window is created in the lateral wall of the maxilla.⁸ When completed,

In the atrophic posterior maxilla, successful implant placement is often complicated by the lack of quality and volume of available bone. In these cases, sinus floor augmentation is recommended to gain sufficient bone around the implants. Sinus elevation can be performed by either an open lateral window approach or by a closed osteotome approach depending on available bone height. This case series demonstrates the feasibility and safety of minimally invasive antral membrane balloon elevation, followed by bone augmentation and implant fixation in 20 patients with a residual bone height of 2 to 6 mm below the sinus

floor. The surgical procedure was performed using a flapless approach. At 18 months follow-up, the implant survival rate was 100%. Absence of patient morbidity and satisfactory bone augmentation with this minimally invasive procedure suggests that minimally invasive antral membrane balloon elevation should be considered as an alternative to some of the currently used methods of maxillary bone augmentation. (Implant Dent 2011;20:434–438)

Key Words: *antral membrane, posterior maxillary implants, bone augmentation, dental implants, maxillary sinus*

the window is gently pressed inward and upward into the sinus cavity, which lifts the Schneiderian membrane and serves as a new sinus floor. The void between the elevated tissues and the original sinus floor is filled with bone graft material. Implants may be simultaneously placed or the graft may be allowed to heal before implant placement.^{9–12}

The “osteotome technique,”¹³ also called bone-added osteotome sinus floor elevation (BAOSFE), is an alternative approach for sinus elevation where a small amount of bone height is missing. It is not suitable for patients with markedly reduced initial bone height.¹⁴ BAOSFE can be complicated by membrane perforation and tear,¹⁵ which can be reduced with expert technique and specially designed instrumentation.¹⁶ The lateral maxil-

lary window offers an average implant survival rate of 91.8% (range, 61.7%–100%)⁶ but involves potential complications (membrane tear, bleeding, infection, and sinus obstruction), swelling and discomfort, and relative contraindications (sinus convolution septum or narrow sinus and previous sinus surgery). Considerable surgical skills, equipment, and time are also required. A modification of the BAOSFE method is the minimally invasive antral membrane balloon elevation (MIAMBE). Antral membrane elevation is performed through the osteotomy site (≤ 3.5 mm) using a specially designed balloon. The use of this technique as an alternative to conventional procedures has been shown.^{17–20}

Advantages of using a flapless approach for dental implant placement

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are well known^{21–27}—demonstrating predictability, preservation of crestal bone and mucosal health surrounding the implants. A flapless approach combined with MIAMBE has never been described. In this study, a MIAMBE balloon-harboring device (Miambe LTD, Netanya, Israel) was used. This is a stainless steel tube, 3 mm in diameter, that connects on its proximal end to the dedicated inflation syringe and on its distal portion has an embedded single-use silicone balloon. The balloon is inflated with diluted contrast fluid that pushes up the Schneiderian membrane, creating the desired height for implant placement.

The purpose of this study was to describe a case series using this new treatment modality with its advantages through a flapless approach with 18 months follow-up.

MATERIALS AND METHODS

Patient Selection

All patients were from the authors' private practices, selected after meticulous evaluation of their medical histories and dental examinations, including panoramic radiographs and dental cone beam CT (CBCT) scans. The mucosa thickness and pathology, bone height and thickness, sinus structure, and major blood vessels were assessed. Patients received an oral explanation regarding the procedure and signed an informed consent. A prerequisite included crestal bone height of 2 to 6 mm between the sinus floor and the alveolar ridge. In 20 patients, ranging in age from 37 to 72 years (mean, 49 years), a total of 24 sinuses were treated and 37 screw-type endosseous implants inserted. All patients were treated under local anesthesia in the dental office.

Clinical Protocol

The exact bone height between the alveolar crest and the sinus floor was assessed using preoperative CBCT scans (Figs. 1 and 2). A preprocedural nonsteroidal anti-inflammatory agent, Augmentin (GlaxoSmith Kline, Brentford Middlesex, United Kingdom) (clavulanate potassium), 875 mg, was administered twice, 24 hours before surgery.

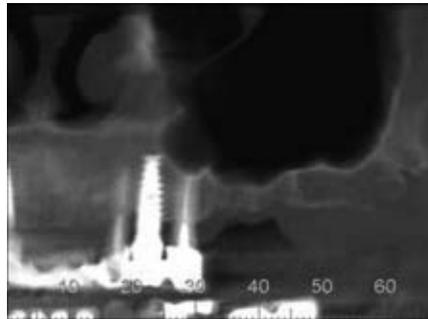


Fig. 1. Panoramic projection of the residual ridge underneath the sinus floor.

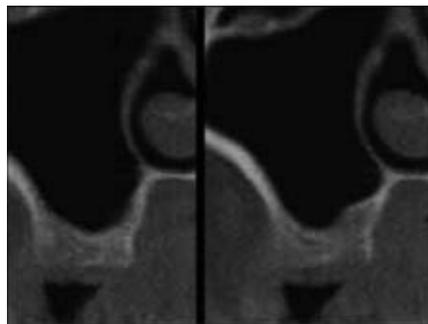


Fig. 2. CBCT axial cuts of the residual ridge underneath the sinus floor demonstrating 3–4 mm of alveolar bone height.

Local anesthesia (infiltration of posterior and middle superior alveolar nerve and greater palatine nerve) was administered using 2% lidocaine (Novocol Pharmaceutical Inc., Cambridge, Ontario, Canada). To obtain platelet-rich fibrin (PRF), 40 mL of blood was drawn by venous puncture and processed. Under local anesthesia, a 4-mm diameter punch was used to remove the epithelium with connective tissue and to expose the underlying bone crest at the precise future implant location (Fig. 3).

An ultrasonic Piezoelectric (Mectron S.P.A, Genova, Italy) round diamond tip drill was used in the center of the exposed alveolar crest up to 1 to 2 mm below the sinus floor. Depth was predetermined according to measurements obtained from the CT scan and periapical radiographs. The ultrasonic diamond insert was used to deepen the osteotomy until the sinus membrane was reached (Fig. 4). Bone graft material and PRF were inserted into the osteotomy, subsequently enlarging the osteotomy from 2 to 2.9 mm with the



Fig. 3. Underlying bony crest exposed using a 4 mm punch.



Fig. 4. Osteotomy preparation using the Piezosurgery device.



Fig. 5. The metal sleeve of the balloon-harboring device inserted into the mesial osteotomy, 1 mm beyond the sinus floor.

MIAMBE osteotome. After removing the osteotome, the membrane integrity was assessed by Valsalva maneuver.

The metal sleeve of the balloon-harboring device (Miambe LTD), specifically designed for sinus augmentation procedures, was inserted into the osteotomy 1 mm beyond the sinus floor (controlled by Teflon stopper) (Figs. 5–8). The balloon was slowly inflated with the barometric inflator up to 2 atm. Once the balloon emerged from the metal sleeve under



Fig. 6. Periapical radiograph demonstrating balloon inflation in mesial site.



Fig. 9. A mixture of xenograft grafting material + PRF is injected to the osteotomy sites after balloon removal.



Fig. 12. Periapical radiograph 6 months postsurgery.



Fig. 7. The metal sleeve of the balloon-harboring device inserted into the distal osteotomy, 1 mm beyond the sinus floor.



Fig. 10. Self-threading implants, 5 mm in diameter and 13 mm long, inserted into the osteotomy sites.



Fig. 8. Periapical radiograph showing balloon inflation in the distal site.



Fig. 11. Healing abutments screwed into place.

the sinus membrane, the pressure dropped to 0.5 atm. Subsequently, the balloon was inflated with a progressively higher volume of contrast fluid. The same procedure was applied to the second osteotomy site.

Periapical radiographs were taken to evaluate balloon inflation and membrane elevation. After the desired elevation (11 mm) was obtained, the balloon remained inflated in the sinus for 5 minutes to reduce the sinus membrane elasticity. The balloon was

then deflated and removed. Membrane integrity was assessed by Valsalva maneuver and direct visualization assisted by applying a small suction tip.

A bone graft injector was filled with a mixture of bone substitute (Cerabone-Botiss, Berlin, Germany) + PRF and injected through the osteotomy into the sinus under the antral membrane (Fig. 9). Screw-type implants (Adin Touareg-Alon Tavor, Afula, Israel), 13 mm in length and 5 mm in diameter, were inserted (Fig.

10). The healing abutment was connected to the inserted implants and a periapical radiograph verified implant and graft positions (Fig. 11).

Patients were discharged with ibuprofen, 600 mg (single dose) for pain relief and Augmentin, 875 mg twice daily for 7 days. At 6 months postsurgery, patients were evaluated radiographically (panoramic and periapical) before implant exposure. Clinical criteria at the time of implant exposure included stability in all directions, crestal bone resorption, and any reported pain or discomfort. Prosthetic rehabilitation was initiated 3 weeks after implant exposure. Patients were monitored and followed-up for 18 months (Fig. 12).

RESULTS

All patients received the MIAMBE treatment with immediate implant placement. Healing was uneventful, with no symptoms of pain or edema, postsurgery. One patient, who was allergic to the antibiotic Augmentin (GlaxoSmith Kline, Brentford Middlesex, United Kingdom), was prescribed Clindamycin (Pfizer Pharmaceuticals, Poce Sur Cisse, France).

At 1 week postsurgery, patients were recalled and consequently followed up for 6 months. At 6 months, all implants were successfully integrated. Implants were restored with porcelain fused to metal crowns and followed-up for 18 months. The crestal bone height was maintained and verified by subsequent radiographs. No adverse effects were noted.

DISCUSSION

This case series supports the proposition that MIAMBE is a minimally invasive, single-sitting procedure of maxillary bone augmentation, and implant placement can be performed where previous conventional lateral window sinus augmentation had been recommended.¹⁷⁻²⁰

The “osteotome technique” (BAOSFE) is minimally invasive. However, if the initial height is ≤ 4 mm, this method is clearly inferior to the lateral window approach.²⁸ The BAOSFE yields modest antral membrane elevation and bone augmentation, requires considerable skills, and may frequently result in membrane tear, even when selectively applied²⁹ and endoscopically controlled. The use of the specific dedicated Miambe balloon enables the operator to predictably elevate the Schneiderian membrane and place implants that are 13-mm long. The successful use of the flapless approach actually requires advanced clinical experience and surgical judgment. The flapless approach together with the MIAMBE used in this study has several advantages over the lateral window approach and the BAOSFE techniques. These include reduced patient trauma, improved patient comfort and recuperation, decreased surgical time, faster soft tissue healing, and normal oral hygiene procedures immediately postsurgery.²³⁻²⁵ The use of preoperative CBCT measurements and direct visualization of the sinus membrane through the specifically designed suction tip, as well as illumination, can overcome the disability to directly visualize the sinus compartment as seen in the open lateral window approach.

CONCLUSION

When the advantages of flapless surgery are combined with MIAMBE, the surgeon is able to perform a procedure with minimal postoperative symptoms as well as reduced chair time.

DISCLOSURE

Dr. Ziv Mazor claims to be a consultant for Adin Implants, Miambe.

Dr. Efraim Kfir claims to be a Board Member and a consultant for Miambe LTD. Dr. Adi Lorean claims to have had, in the past, “administrative support.” The other authors claim to have no financial interest, either directly or indirectly, in any of the products or companies mentioned in this article.

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