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Bone Defect, Correction and Digital Design for Implant Reconstruction

Timothy Kosinski, DDS, MAGD

Implant dentistry has advanced greatly where general dentists are able to diagnose and treatment plan cases efficiently. Restoring dental function in edentulous spaces can be done predictably with a wide range of prosthetic options. Each patient has unique situations that should be thoroughly evaluated. This includes anatomic concerns or limitations, surgical considerations and final prosthetic design. Soft tissue and implant integration into bone sites must be understood prior to any surgical intervention. The short term and long term prognosis must be understood. Any approach that does not fully consider all these factors puts our patient's acceptance and final restoration at risk.

Often times we see significant bone loss in the posterior mandible as a result of an extraction that fractured the facial bone. With the advent of dental implant predictability and patient desire to have an edentulous space restored with a single unit implant crown, rather than conventional bridgework, it is important for the practitioner to be able to recognize these complications and understand the techniques to correct them.

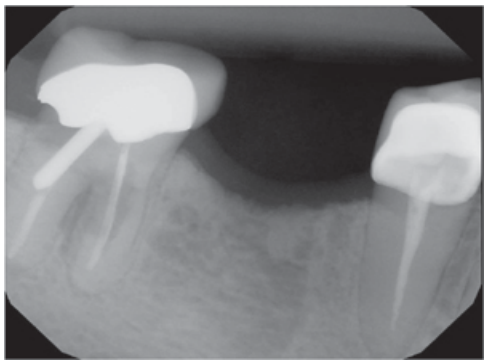


Fig. 1: Digital radiograph illustrating normal bone contours following healing of the mandibular right first molar site. The extraction was done many years prior to the patient requesting replacement.

Criteria

There are two basic criteria for patients who would like to have a dental implant surgically place. First there must be no uncontrolled medical conditions which would hinder proper healing of the site and integration of the dental implant. These include no uncontrolled diabetes, uncontrolled hypertension or any of the many immunosuppressive diseases. Smoking can prohibit proper blood supply to the healing site.

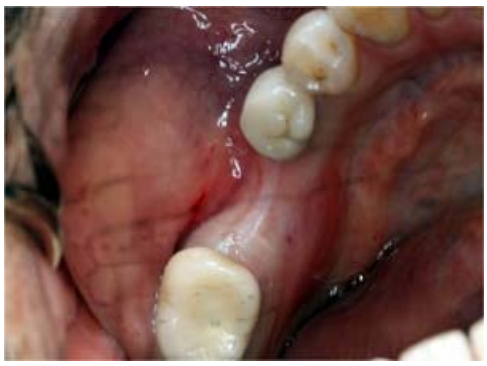


Fig. 2: Occlusal view of a significant concavity on the facial aspect of the edentulous space making ideal implant placement difficult. Note the position of the mucogingival line at the crest of the edentulous ridge. There is currently no attached gingiva on the facial aspect of this defect.

Second, there must be enough bone to support the implant. This includes both mesial-distal and facial-lingual dimensions of bone support. As teeth are lost, bone necessarily shrinks down and in, thus sometimes resulting in a lack of attached gingiva on the facial aspect of the defect and the mucosal tissue relocates to the crest of the edentulous site. This is not good for the final implant and implant retained crown, and the patient may experience extensive bone loss over time and improper tissue response to the new restoration.

The position of the mucogingival junction must be evaluated prior to simple surgical implant placement. Stable gingival margins, approximating about 3mm of attached gingiva on the facial aspect of any dental implant, is important to the long term health of the dental implant.

The attached gingiva provides protection to external injury and is critical to proper tissue healing around a dental implant. Without keratinized tissue, food impaction and tissue shrinkage may occur. Attached gingiva is also important when plaque control is compromised, as plaque can invaginate to the implant surface.

If the mucosal tissue is near the crest of the edentulous ridge, as demonstrated here, an apically positioned flap will help to create a zone of attached gingiva. This will certainly help in the final restorative steps and increase the patient's ability to clean the area well.

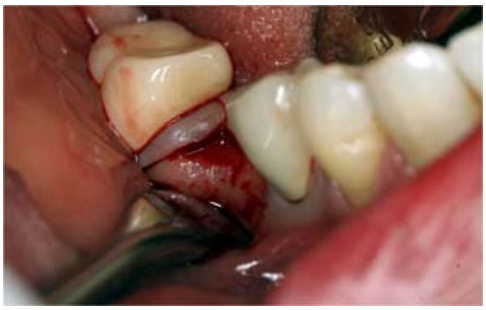


Fig. 3: A full thickness periodontal flap is made exposing the significant facial defect on bone.

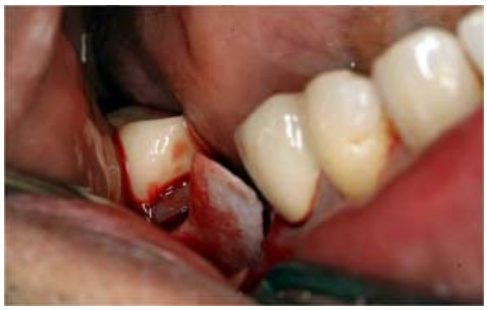


Fig. 4: A resorbable barrier is cut to the proper size and shape (Epiguide, Curasan, Corp.).

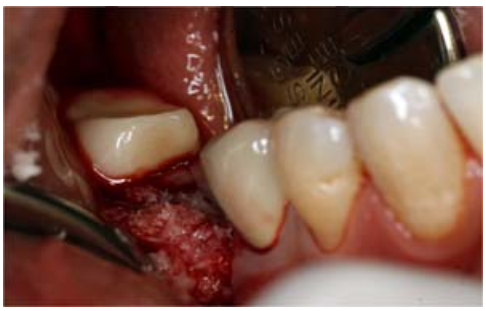


Fig. 5: Allograft material (Curasan, corp) is packed onto the facial defect area. Note that the site is bleeding well, as small indentations are made into the cortical bone with a small round bur.

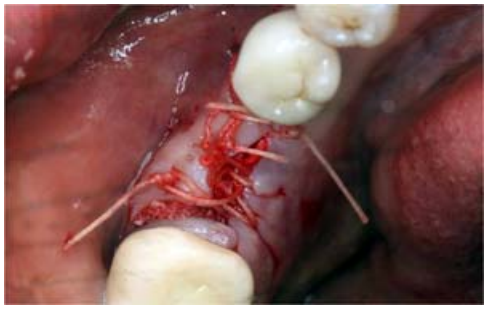


Fig. 6: A repositioning flap is sutured back into place with Vicryl sutures. Note how the attached gingiva from the crestal and lingual of the ridge was repositioned to the facial, allowing for at least 3mm of keratinized tissue on the facial aspect. These sutures are removed in approximately 7 days.

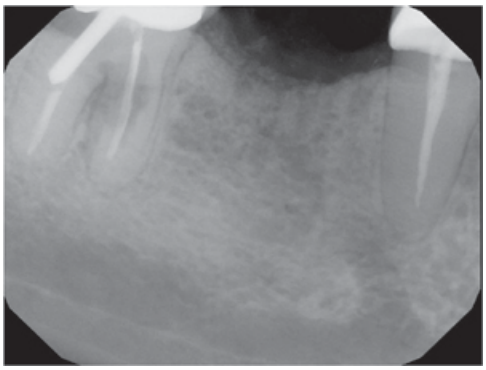


Fig. 7: Post operative digital radiograph of the grafted site.

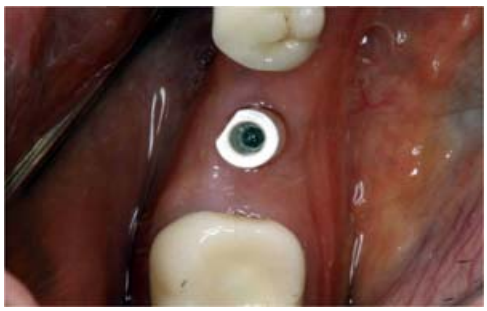


Fig. 8: After approximately four months of integration of the graft, a single Glidewell tapered implant was surgically placed into the repaired site. A flapless procedure was done allowing the keratinized tissue on the facial aspect to remain intact. A digital impression using the IOS digital impression technique was completed at the time of implant placement (Glidewell Laboratories) An opaque impression coping designed specifically for this optical scan is threaded into the dental implant.

Digital Scanning

Recent advances in digital scanning provides a nice, clean method to make a final impression of this implant impression coping. A digital file is produced through the intraoral scanning and will serve as our final impression, without the use of conventional impression materials like polyvinylsiloxane or polyether. The digital fine is used to CAD/CAM design the final abutment shape and position and final implant retained crown fabrication. These designs can be evaluated by the clinicians during the process. The techniques of optical impressions reduce the potential for material distortions which may occur using conventional techniques.

Advantages

Accuracy of any impression technique is critical to establish proper abutment contours and fit and design of the final implant retained

crown. With efficient digital scanning, chair time is reduced at the time of impression and seating because of the ability to create ideal contours, interproximal contacts and occlusal design. We no longer rely on polysiloxane material inaccuracies. These optical impression techniques reduce the potential for material distortion, especially when dealing with implant impression copings that may pull or tug.

The model-less restoration are more affordable than conventional model based restorations, both in the fact that impression material is not used and laboratory costs are decreased.

Materials

Bruxir solid zirconia (Glidewell Lab, Newport Beach, CA) is an ideal material for posterior dental implant restorations because of its high durability, and ideal flexural strength. Dental implants do not have a periodontal ligament and take on a lot of occlusal force. Porcelain fracture on conventionally layered crowns can occur, especially on posterior teeth. The Bruxzir material is esthetic with adequate translucency and color. The restoration provided here is both esthetic and functional.

Discussion

Proper diagnosis and planning for implant restorations is critical. I like to say that implant dentistry is prosthetically driven, since we have the tools and materials to grow bone to make our cases more ideal. Understanding anatomy and bone contours as well as periodontal health is an important aspect of total dental implant therapy. None of the factors

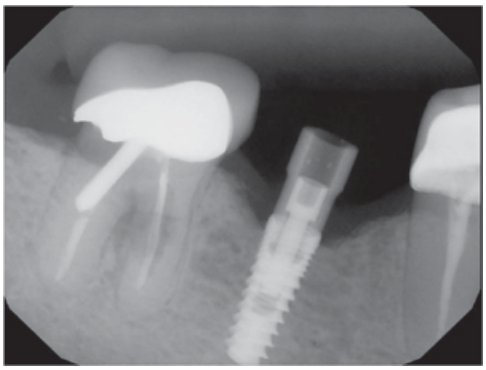


Fig. 9: A digital radiograph is made to insure a complete seat of the impression coping.

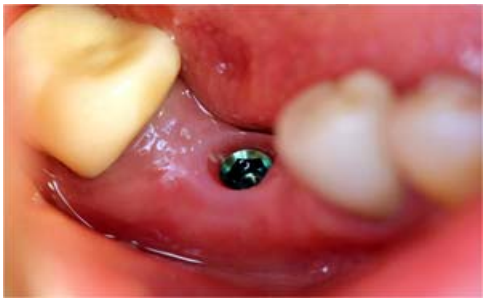
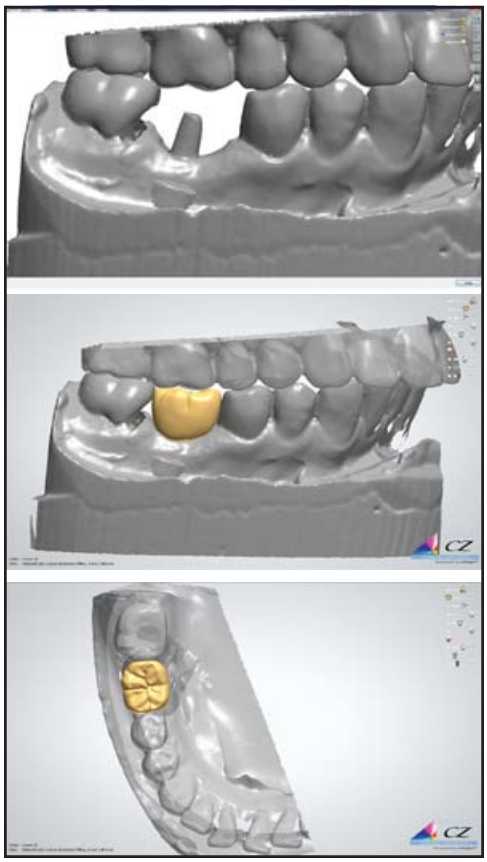
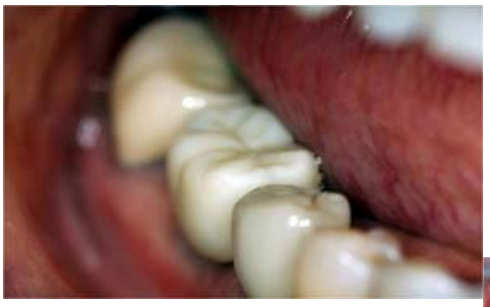


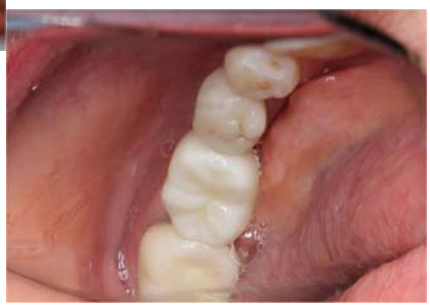
Fig. 13: Following 3 months of implant integration, the patient is brought back to the office for final abutment placement and crown seating. The healing abutment is removed illustrating very nice tissue health and a definitive 4-5mm band of keratinized tissue on the facial aspect of the ridge. Note too that the facial defect has been corrected with the graft technique.



Figs. 10-12: The optical scan information is electronically sent to the dental laboratory (Glidwell Lab) and a digital design of the abutment and final implant retained crown is evaluated and approved prior to CAD/CAM creation of both.

Fig. 14: The prepared custom abutment is torqued into position to 25Ncm. Note tissue health around this custom abutment.





Figs. 15-16: The final Bruxzir (Glidewell Lab) implant retained crown for the mandibular right first molar is cemented into position.

involved can be trivialized or ignored. If you want an ideal restoration, then bone contours need to be corrected and tissue health determined or repaired.

Using the advanced optical scanning techniques available, non invasive surgical techniques and CAD /CAM design of our prosthetic components, we are able to provide our patients with nice results with control of our treatment costs. The art of implant dentistry, it is said, is being able to visualize the case finished prior to any surgical intervention. The advent of digital design and preparation allow us all to do this is a much more efficient manner.

Timothy Kosinski, DDS, MAGD maintains a private practice in Bingham Farms, MI with an emphasis on cosmetic and implant dentistry. He is an Adjunct Clinical Professor at the University of Detroit Mercy School of Dentistry, serves on the editorial review Board of Reality, and is a Diplomat of the American Board of Oral Implantology/Implant Dentistry, the International Congress of Oral Implantologists and the American Society of Osseointegration. He is a Fellow of the American Academy of Implant Dentistry.Dr. Kosinski has published over 87 articles on the surgical and prosthetic phases of implant dentistry and was a contributor to the textbooks, Principles and Practices of Implant Dentistry, and 2010's Dental Implantation and Technology. He can be reached at drkosin@aol.com or 248-646-8651.

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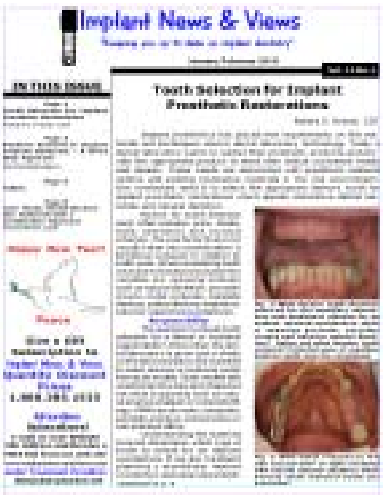


Regeneration of a Periodontal Defect with Straumann® Emdogain and a Straumann® Soft Tissue Level Implant with SLActive® Surface, in Combination with Straumann® BoneCeramic

Dr. Marlene Teo and Dr. Joanne Uy

A 38 year old Singaporean Chinese woman, non-smoker with no relevant medical history, was referred for replacement of tooth #14 (FDI) with an implant. It had been extracted 3 months previously by a general dentist due to a fractured root. She had no other complaints.

At the clinical examination, it was noted that tooth #15 had a mobility of II with 5 mm probing depths on the mid and mesio-buccal aspects and a 6 mm probing depth on the disto-buccal aspect. There was initial caries on the distal aspect of #15. The rest of the probing depths in the mouth were within normal limits.

The #14 implant site showed good bucco-lingual and mesio-distal width **[Figs. 1- 2]** with a slight bone concavity apically. The radiographic examination showed 40 % angular bone loss on the mesial and distal surface of #15 and a healing socket at #14. The sinus floor was more than 12 mm away from the crest of the ridge at #14 **[Fig. 3]**. The intermaxillary relationship was normal.

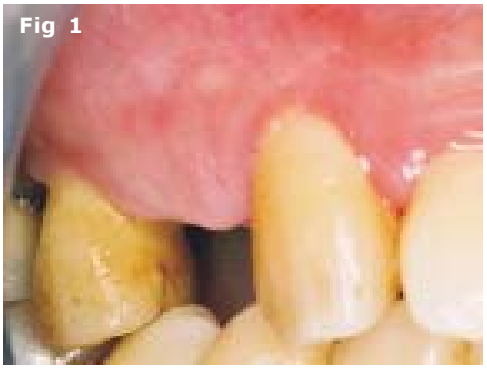
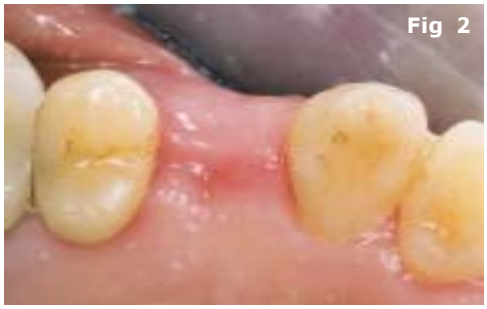


Fig 1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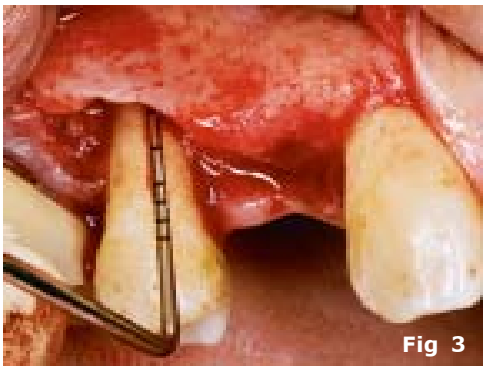
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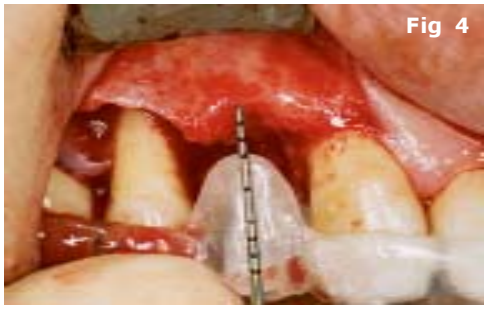


Fig 4

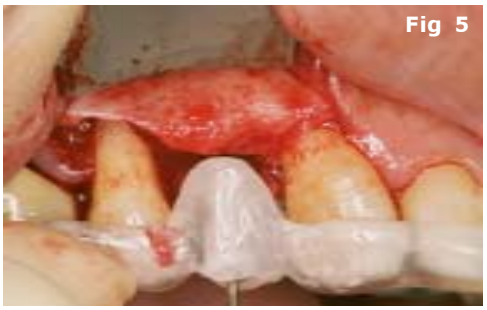


Fig 5

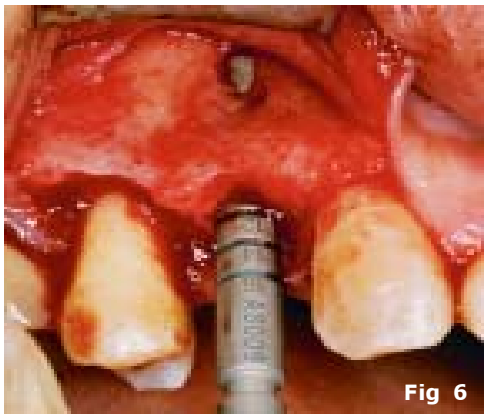


Fig 6

Treatment Planning

The patient was put through initial therapy with full mouth scaling, and localized scaling and root planning was done on tooth #15. Concentrated fluoride was applied on #15 in an attempt to remineralize the carious lesion. Oral hygiene was adequate six weeks after initial therapy but the localized probing depth of 6 mm on the distal aspect of #15 persisted with bleeding on probing. It was thus decided that regeneration of #15 with Straumann® Emdogain would be done simultaneously when the implant at #14 was placed.

Surgical Procedure

A full thickness flap was raised from #'s13 to 15. Only a buccal flap was reflected as the angular defect only affected the buccal surface of #15 and left the palatal surface intact.

Granulation tissue was removed and #15 was root planed, leaving a narrow, 3.5 mm deep 3-wall intrabony defect on the buccal surface of #15 **[Fig. 4]**.

When the surgical stent was placed at #14, it was noted that the crest of bone was only 1 mm from its future cervical margin **[Fig. 5]**. Bone was removed from the crest **[Fig. 6]** to ensure that the implant would

be seated at least 3 mm below the future cervical margin.

Implant bed preparation was done according to the Straumann protocol and was restoratively driven, guided by the surgical stent **[Fig. 5]**. As there was a slight buccal undercut, the final 3.5 mm drill resulted in an apical perforation of the buccal plate measuring 5 mm by 4 mm in diameter **[Fig. 6]**.

A Straumann® Soft Tissue Level Implant (Standard Plus, Ø 4.1 mm, SLActive 12 mm) was placed in the #14 site in a good restorative position and with good primary stability **[Figs. 7-8]**. The Straumann SLActive® surface was chosen to enhance bone formation during GBR and also to speed up the osseointegration process for early loading. A Straumann® RN Healing Abutment was placed on the implant to allow transgingival healing.

The buccal plate around the exposed implant threads was then decorticated to enhance GBR **[Fig. 9]**. Straumann® PrefGel was placed on tooth #15 for 2 minutes to treat the root surface, then rinsed off with saline.

Straumann® BoneCeramic was hydrated with saline and placed on the exposed #14 implant threads and the decorticated area **[Fig. 10]**. The bone graft area was covered with a resorbable collagen membrane **[Fig. 11]**.

Straumann® Emdogain was then mixed with the remaining Straumann® BoneCeramic. The exposed root surface of #15 was coated with Straumann® Emdogain **[Fig. 12]** and the Straumann® Emdogain/ BoneCeramic mix was placed into the periodontal defect surrounding #15 **[Fig. 13]**.

The flap was sutured with Vicryl 5/0 sutures and Straumann® Emdogain was syringed around the incision lines to enhance soft tissue healing **[Fig. 14]**. The immediate postoperative X-ray shows good angulation of the implant **[Fig. 15]**. One week later, the patient presented with good soft tissue healing with little inflammation **[Fig. 16]**.

Prosthetic Procedure

The patient healed uneventfully. No provisionalization was done at the patient's re-


Fig 7

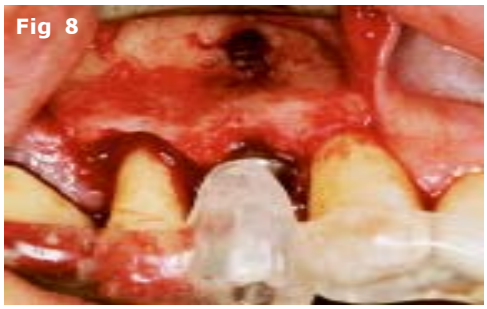
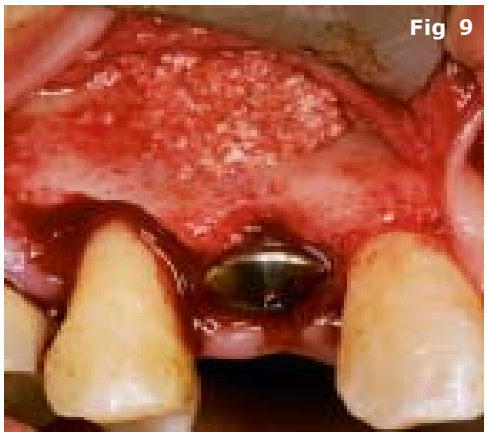


Fig 8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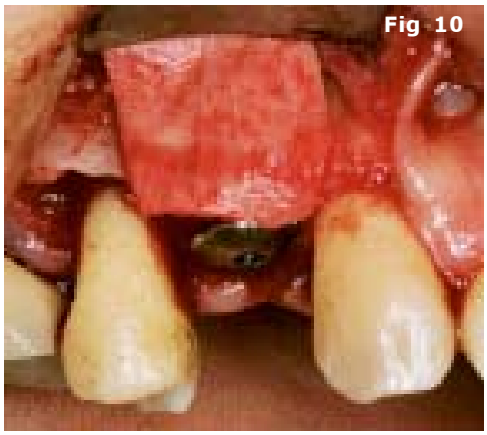
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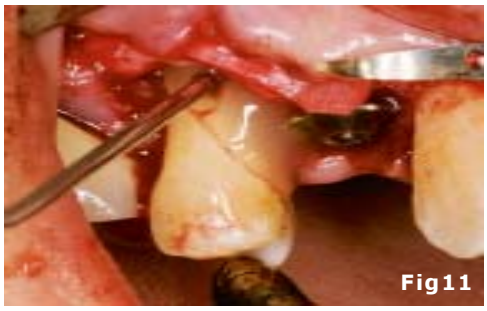
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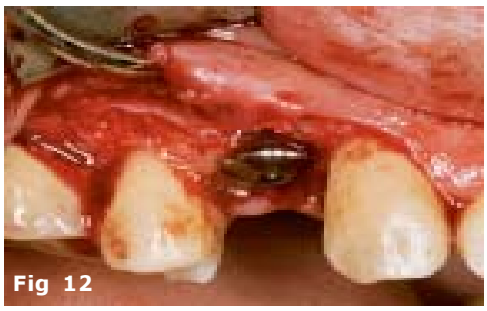
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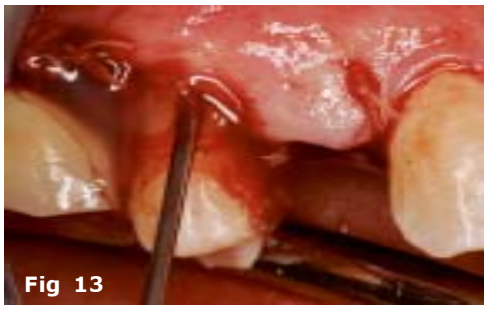
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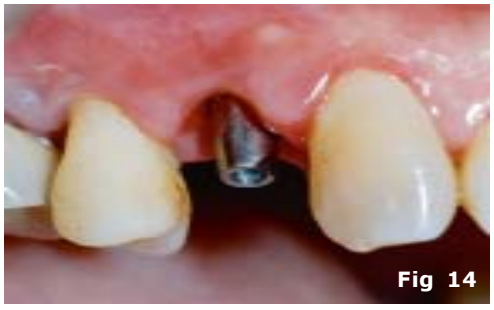


Fig 14

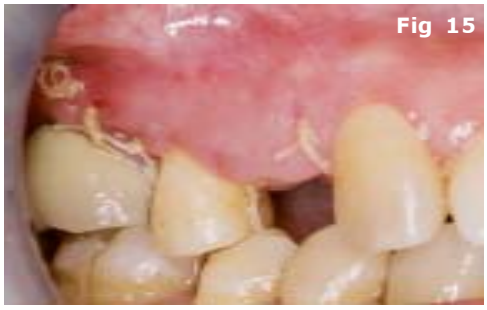


Fig 15

quest as she was not bothered by the temporary edentulous space.

Due to personal reasons, the patient only came for the restorative procedure 5 months after surgery. By then, osseointegration was achieved and the soft tissue profile was ideal. The impression was made using the open tray technique. As the implant position was good, a Straumann® synOcta® Abutment (cementable) was used **[Fig. 17].**

The abutment was torqued down to 35 Ncm and the access hole covered. The final restoration was a metal-ceramic crown **[Fig. 18].** At this point, the carious lesion on #15 distal was also restored with a composite filling as it appeared to be getting larger. On the day that the #14 final crown was issued, it was noted that the distal papilla had not filled in completely **[Fig. 18].** However, it was expected that the papilla would regenerate since the distance between the interdental bone crest and the contact point was less than 5mm[1].

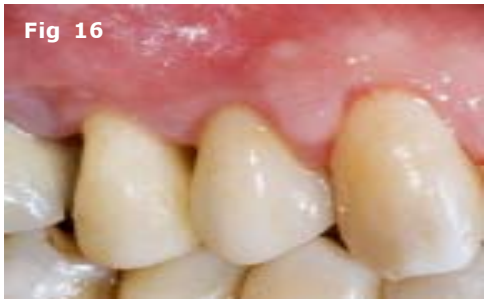


Fig 16


Fig 17

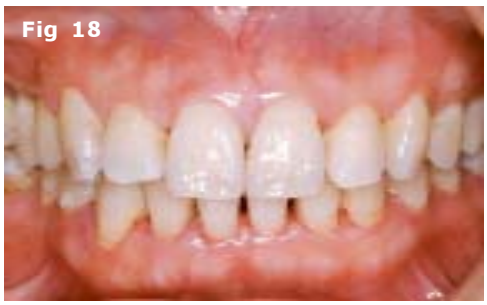
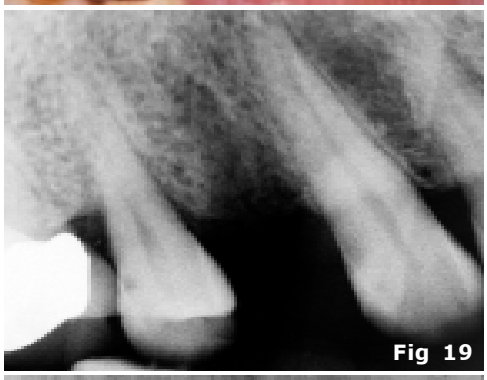


Fig 18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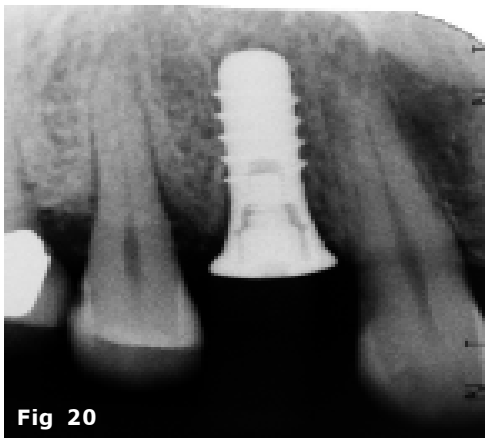
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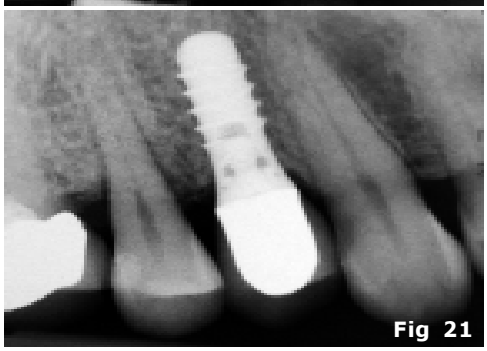
Fig 21

Results

The 20-month radiographic outcome shows stable bone height and increased radiopacity of bone around the SLActive® implant at #14 **[Fig. 19],** compared to the radiograph taken on the day of surgery **[Fig. 15].** There is also radiographic bone fill of the angular defect at #15 **[Fig. 19].** Clinically, the distal papilla of #14 has filled the interdental space and probing depths around #15 have decreased to 3 mm and below.

Mobility of #15 is now within physiologic limits. The 3-year post-operative exam shows stability of the soft tissues **[Fig. 20],** much like what was found at the 20-month post-op exam. The soft tissue profile of #14 replicates that of natural teeth and is symmetrical with the teeth in the upper left quadrant **[Fig. 21].** No 3-year radiograph was done as the patient was possibly pregnant.

Conclusions

The placed implant with the Straumann SLActive® surface shows good osseointegration and osteoconductivity. Straumann® BoneCeramic may also be placed on the exposed implant threads for Guided Bone Regeneration (GBR) and placed in the periodontal defect to act as a scaffold for regeneration. Importantly, this case demonstrates that it is possible to place an implant with the SLActive® surface with simultaneous GBR and treat an adjacent tooth with Straumann® Emdogain regeneration simultaneously. This reduced in this case the number of surgical procedures. Both procedures proved successful over the span of 3 years.

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Dr. Joanne Uy is a Prosthodontist at the National University Hospital, Singapore and an Assistant Professor of Restorative Dentistry at the National University of Singapore. She can be reached at rsdujn@nus.edu.sg.

Reference
1. Choquet V, Hermans M, Adriaenssens P, Daelemans P, Tarnow DP, Malevez C. Clinical and radiographicevaluation of the papilla level adjacent to single tooth dental implants. A retrospective study in the maxillary anterior region. J Periodontol. 2001 Oct;72(10):1364-71.

We would like to **thank Julian English**, BA (Hons), MCIJ, Executive Editor for permission to reprint this article

Online Discussion Groups

We found a great group with a wealth of ideas on **LinkedIn**. To learn about the benefits & how to join, go to **http://www.linkedin.com.** The group is called **Dental Implant Professionals** and has over 14,000 members; it was started by Eddy Burnett - Director, Information Technology - BioHorizons, Inc. You need to apply, but it's free membership. Here's a recent disscussion started by **Chris Smirthwaite.**

Can anybody tell me what the current thinking is on low dose Bisphosphonates and drug holidays in relation to implant placement?
Chris Smirthwaite, Owner, The Smile Centre

Although osteonecrosis occurs infrequently, it is most common in patients receiving intrave-nous bisphosphonate therapy. The risk of developing osteonecrosis in patients taking oral bisphosphonates is estimated to be about 1 per 100,000 person-years' exposure. For patients who are receiving intravenous bisphosphonate therapy for malignant neoplasms, it is recommended that the dentist avoid extractions unless critically necessary. *Yagiela*, Page 561.
Tatiana Pacheco, Experienced Dental Professional: Dentist, MBA and Strategic Planner, Dedicated Trainer and Teacher

Thanks for that Tatiana, I will read the paper that you quoted, I was specifically interested in whether or not colleagues recommended a 'drug holiday' for patients on oral bosphosphonates, and if so, what duration before and after implant placement.
Chris Smirthwaite

Bisphosphonate medications are often used orally for control of osteoporosis. These medications may also be used via an intravenous route as adjunctive therapy for certain malignancies. Although the impact of oral therapy on implant bone healing has not been established, it is clear that previous intravenous bisphosphonate therapy is an absolute contraindication to implant surgery. These patients have high risk of refractory bone necrosis when even minor surgery is performed (see Chapter 18). *Contemporary Oral Surgery Hup-Ellis*. 258.
Tatiana Pacheco

Bisphosphonates are a very interesting class of drug. IV and oral bisphosphonates is too general and the correct way to think about these drugs is nitrogen and non - nitrogen containing bisphosphonates. Nitrogen bisphosphonates are the most potent. Unfortunately there are nitrogen containing oral bisphosphonates that are commonly used worldwide to treat osteoporosis ie. Fosamax, Bonviva. In terms of potency, Zometa is an IV bisphosphonate and is the most potent at 10,000 times compared to 1000 times for alendronate (Fosamax). Overall oral bisphosphonates have incidence 7/100,000 person years. Looking at the literature in terms of evidence, there is no homogeneity is methods or reporting among articles so it is very difficult to draw definitive conclusions. It is probable that the incidence of BRONJ is higher than reported. There is no evidence for drug holiday, bisphosphonates have a half life of 11 years ! Potency is related to duration and dose. In general patients taking oral bisphosphonates less than 3 years can have dental treatment ie minor oral surgical procedures with less risk. The longer the duration of treatment the greater the risk of BRONJ. It

is currently believed that the therapeutic duration of treatment with bisphosphonates should only be 5 years. In reality this is not the case!! With implants there are early and late failures. As bisphosphonates effect bone remodelling, late failures have been seen in patients who have had implants placed prior to bisphosphonate therapy! It is important to take thorough medical history and dental examination and carry out any invasive procedures before the onset of BP treatment in order to minimize risk. Also be aware of comorbidities ie - corticosteroids. Hope this is useful.
Elliott Ballantyne, Principal Dental Surgeon at Ballantyne Dental Practice

If CTX test is less than 150, drug holiday for 3 month is recommended *Contemporary Implant Dentistry, Carl E Misch*.
Mohadeseh Heidari, Periodontist, Assistant Professor at Mazandaran University of Medical Science

Great book! Serum ctx can identify changes in bone remodelling within a couple of days to 2 weeks. Marx found that there are shortcomings in that it is affected by circadian variation and fasting. McLeod et al., 2012 ...any decision on drug holidays should be made with careful consultation with the prescribing physician because of the risk of adverse events if the treatment is stopped....
Elliott Ballantyne

As a precaution, we recommend stopping therapy with oral bisphosphonates, three months before the implant surgery ....
Dr. Gonzalo Miranda Darricarrère, Cirujano Dentista en Clínica Odontológica " Los Arcos "

As a rule the drug which is usually used oseoporotic person with history of osteoporotic fracture patient physician should be consulted for the possibility of stop taking the drug before implant installation for medico-legal problems and be in the safe side.
Dr Nuri Mraiwa, Head of Periodontology at Tripoli University

Unfortunately we do not completely understand the process by which bisphosphonates affect bone metabolism and cause a BRONJ. Some patients taking these medications do not present with an issue while others do. There appears to be a trimodal incidence of peak effects of the bisphosphonates at years 1, 5, 10 after taking the meds. Therefore, even years after taking them a BRONJ can appear. Careful surgical debridement of the necrotic bone and reducing the biofilm which colonizes the necrotic bone with chlorhexidine as well as systemic antibiotics is the treatment of choice.
Robert T. Cadalso Jr. D.D.S. - Owner/President Genesis Dental Group Mission Viejo, California

New FDA Ruling

The Food and Drug Administration (FDA) is issuing a final order to reclassify the blade-form endosseous dental implant, a preamendments class III device, into class II (special controls). On its own initiative, based on new information, FDA is revising the classification of blade-form endosseous dental implants, effective July 18, 2014.

This prompted a discussion on the **Implantology Internet Discussion List**, implant@enexus.com [implantology@lists.dental-implant-forum.com], moderated by **John Cliff, DMD**. To learn about the benefits & how to join, go to http://lists.dental-implant-forum.com/listinfo.cgi/implantology-dental-implant forum.com.

It's a done deal! I thank all of you that gave me advice for this endeavor!
Richard Hughes, DDS, FAAID, FAAIP, DABOI

Just curious. Are most or any of you still using blade implants? I have a few cases out there that have worked very well for going on two decades. I feel that preparing the osteotomy with a Mectron Piezo machine would be much less traumatic and more accurate than using a cross cut fissure bur on high speed which was generally "the way it was done" in years past. And, who are you obtaining your implants from? Ultimatics?
J. Jerome Smith, DDS

With this move from the FDA, one would hope and pray that many practitioners would learn to use these implants. Ralph Roberts makes ramus frames and several varieties of blades. I am going to be putting a STR in next week. It is an STR or single tooth replacement implant. Buy from Pacific Implants. I am putting it into a thin ridge at 29 site. It is one heck of a lot cheaper than bone grafting etc.
http://www.pacificimplantinc.com/Pacific_Implant/Doctors/Pages/Single_Tooth_Replacement.html
I put in a ramus frame not long ago and posted the results.
http://www.pacificimplantinc.com/Pacific_Implant/Doctors/Pages/Ramus_Frame.html I still use the ramus blade which is an excellent implant for the posterior edentulous mandible.
http://www.pacificimplantinc.com/Pacific_Implant/Doctors/Pages/Ramus_Blade.html
I cannot speak for the other list members, but these implants are fantastic implants and solve many problems that folks waste a lot of time and money because the only implant that they use is a multi-part root form. The use of a Piezo machine would work, but it is a lot slower than a high speed and it costs a lot more. Both are great reasons not to use it. For my part it is tragic in the extreme seeing some of the lengths folks go to because
they have a one implant modality mentality. I have posted several times that an STR took a rifle butt then a tire iron when restoring a central and did not fail.. The crowns on that implant shattered both times but not the implant. I do not know of another implant which could stand that kind of abuse and keep on working for 25 + years. Ralph and Richard did yeoman's work getting the FDA to wake up. Perhaps, Raul may still be providing some plate form implants but I do not know. You can always make your own as I have many times in the past from cast Vitallium and get them HA coated.
Douglas Martin DDS - FAAID, FICOI, MAIT, DABOI/ID

If you want these implant modalities to be accepted the key is getting articles published in the main stream journals showing them.
Gregori M. Kurtzman, DDS, MAGD, FPFA, FACD, FADI, DICOI, DADIA

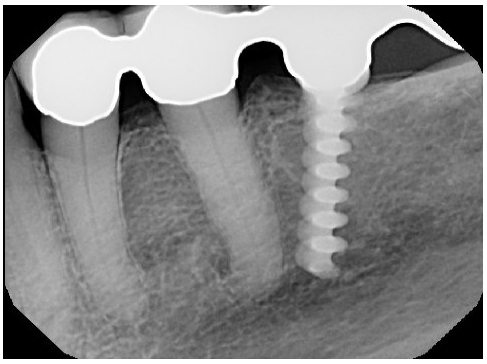
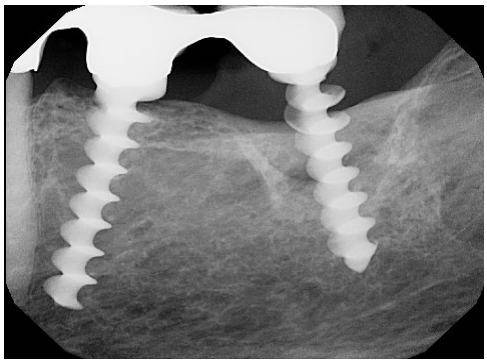
I want to thank Richard Hughes for the effort that he has done reclassifying the Blades. This should make it easier for obtaining 510 K for other companies. Our system was approved in the 80's by the FDA and thousands have been placed since by implantologists that practice Multy-Modal implantology
Raul R. Mena DMD

We will just wait and see how much interest there is. We had 1 & 2 stage blades, HA coated and heavy dual grit blasted in various forms for upper and lower that were/are very successful. Oh course interest dropped off with them as the subs when Branemark with an infusion of 25 million in marketing money to the Universities and AMOS along with the implant academies that a screw with osseous integration was the only ethical way to successfully archive long term implant treatment. We put our inventory of blades in quarantine to avoid the 2 or 3 FDA audits/yr we were getting being a class 3 manufacturing company. Try to convince the patients that still call me and come back from all over the country to have both the blades and subs checked after being told they had defective devices that had to be removed and replaced. In almost every case the implants are healthy and doing well. I think it will be a matter of re-educating the current crop of implant people as to their value in treating cases less traumatically and avoiding costly and less predictable bone grafting procedures. I think Doug is starting with Subs or COII. Our last chat indicated he was in the process of putting together a course. With blades, there will be differing opinions as there are with subs or COII so it won't be an overnight process. We could have a catalog of blades in a matter of months, already have the FDA approval to market. Perhaps this forum would be suited to start a string featuring Blade cases and opinions on design, placing procedures etc. We even developed circular internally irrigated cutters that cut in either direction for safety for those who think cutting a trough with a HS XXL surgical burr impossibly difficult. Or using a HS heresy when used in an implant procedure. If there's interest, let it be known on the list, I as well as I'm sure guys like you, Raul, Tom Chess and others have racks of slides that can be converted to JPEGS with cases to post. Many with 25 to 35 year follow ups on patients alive that we still see. I'd love to see a comeback of both modalities. I'm sure we could pull a full line of blades out of quarantine, repackage and sterilize and have available in no time. Remember, blades except our later HA coated as most early root forms including early Branemark were sold non- sterile. SteriOss started sterile thus their name and a great marketing tool.
David D. D'Alise, DDS, President, CEO OCO Biomedical, Inc.

I wish you all a very good luck in trying to undo the submerged implant brainwashing. Some time ago Dr. Tramonte was entertaining us with the tale of a patient who had healthy 35 yr

Tidbits

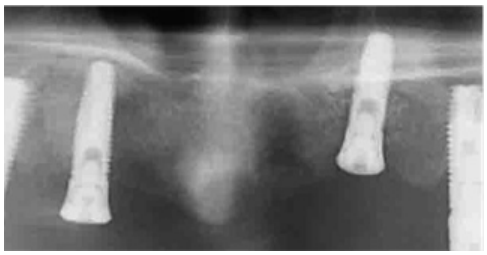
old Tramonte implants, and had been seen by another implantologist who told him that his implants had to be replaced because "they were too old".
Cristina Enrietti-Zoppo, Liaison with English Speaking Countries, Tramonte Science Society

I have a lady in her 90's who had 3 Tramonte implants placed some 40+ years ago by Dr. Bob Christiansen. I had to replace one (fractured neck) about 10 years ago. The other two are still going strong … very slight crestal bone loss.. Christina here are 2 current PA x-rays 2013 [above]; as you see bone levels have not changed since '97.. Patient is now 94 years old
J.Thomas Chess,DDS,FACD,ABOI/ID

Identifying Implants

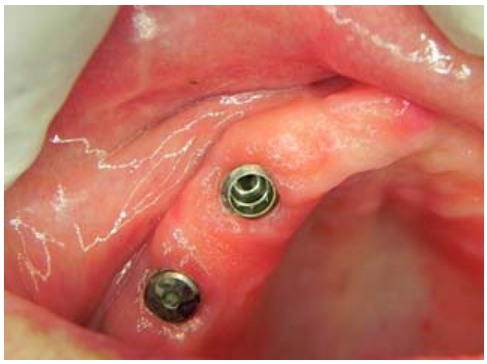
Anyone recognize this implant, please? Can't find an abutment for it; It has internal octagon fixture and it is possible to be Italian.
Dan Borteanu




Could it be a Straumann clone?
Gregori M. Kurtzman, DDS, MAGD, FPFA, FACD, FADI, DICOI, DADIA

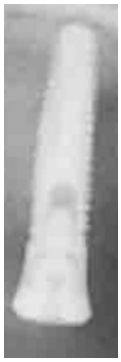
Osstem SS2 (Straumann Clone)
Milind Kulkarni - Pune, India

Is that implant ID site/database still functional? Is it being maintained? If you know... They should have a search criterion for the different internal connections.
George Schabes, NY

Agree that would help plus an occlusal shot of the implants connector would help clinically ID it.
Gregori M. Kurtzman

FYI - not only is it being maintained, it has been enhanced , and they recently released apps for it as well for mobile devices. There is also another site, osseosource, that it seems no one other than me ever talks about that actually predates the whatimplantisthat.com site, www.osseosource.com. I believe it was developed in Israel, functions similar to the other one, but includes more of the European implants. I cannot vouch for how often it is updated.
Gary L. Henkel DDS MAGD



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