ment options available were:

1) Vertical and horizontal bone augmentation with a healing time of at least five months and an implant placement with an additional surgery.

2) Horizontal ridge widening with immediate implant placement and bone grafting. Of course, there were advantages and disadvantages of each treatment option.

Advantages of bone augmentation and implant placement in two stages:
- Direct full control of bone augmentation procedure.
- Predicable bony support at implant placement time.

Disadvantages of bone augmentation and implant placement in two stages:
- Treatment delay by healing time of at least five months.
- Two surgical procedures needed.

Advantages of bone augmentation and implant placement at the same time:
- Single surgical procedure.
- Reduced healing time.

Disadvantages of bone augmentation and implant placement at the same time:
- Bone management knowledge skills for the surgeon requested.
- Additional technical equipment required.

Meisinger offers a so-called Split Control instrument kit it described as a “[…] minimally invasive alternative to osteotomies. Bone spreading and bone condensing with special screw-like instruments (spreaders) achieve a controlled and standardized dilation of horizontally resorbed bone and a gentle densification of cancellous bone.”

The Split Control Kit by Meisinger (www.bone-management.com) contains different sized screws, built similarly to a Hed-
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Fig. 12: Direct view of the Biohorizons implant. The neck of the implant is seated exactly at the crest of the bone level.

Fig. 13: To improve the local blood perfusion, small and superficial bony defects were added to the regeneration area.

Fig. 14: Bio-Oss® Spongiosa small granules in place.

Fig. 15: Direct view of the augmented area and the BioGide membrane still reflected. The excellent blood perfusion from the bone is visible.

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Case Acceptance Frustrations?
Who Else Wants Predictable Case Acceptance in the Emerging New Dental Economy?

Who is this implant dentist and why is he telling the harsh truth about the secrets to case acceptance in 1990s practice?

1. Not knowing what to present with cases (problems, solutions, photos, technology, videos, etc.) to get yes
2. Patients not "connecting" their problem + "valuing" oral health
3. Not having the financial ability to accept complete care or patients having "sticker shock"
4. Preventing patients who are not ready for treatment?
5. Difficult getting acceptance on large cases and more optimal costly treatment plans
6. Not patients not willing to accept more complex care
7. Time investment issues (work-up, diagnosis, preparation for justification)
8. Counseling patients who aren’t ready emotionally or financially?
9. Patients accepting least costly care
10. Patients feeling overwhelmed by treatment plans and options
11. Difficult gaining patient trust?
12. Not knowing how to follow-up or when

Fig. 16: Flap sutured in place.

Fig. 17: The pontic of the temporary restoration appeared overextended due to the three-dimensional augmentation. The needed reduction was marked.

Fig. 18: Temporary restoration after resizing.
stream file, but reversed. Initial small-sized drills are offered within the kit intended for use as markers and access instruments, and to be followed by the spreaders in increasing dimensions.

The implant guiding system (by Innovative Implant Technology) was used to two-dimensionally position the primary marker drill. To begin with, an 010 followed by an 018 pilot drill was used, complemented by an expansion burr in the size of a 023 burr. The bony spreading was performed using the following spreaders: 027, 029, 031, 033.

As a next step, the guided bone regeneration was performed. To augment the buccal resorption, Bio-Oss Spongiosa small granules, 0.25 mm (Geistlich Biomaterials), were used and covered with Geistlich Bio-Gide resorbable bilayer membrane 25 x 25 mm both soaked in wound blood.

With the membrane covering the augmentation material, additional fixation of the membrane was avoided because of the available fixation and immobilization using the soft tissue.

The flap was sutured in place crestally using Gore-Tex suture because of its mechanical performance. The lateral-releasing incisions were closed using 6x0 Prolene suture material.

Conclusion

The buccal bone plate can resorb to a severe degree as a result of tooth loss. Conventional implantologic reconstructive therapy supposed until recently a two-stage approach: guided bone regeneration followed by a five-month healing time and a second surgery for fixture installment.

Using advanced minimal-invasive instruments for extremely thin-ridge expansion allows for concomitant implant placement and regenerative procedures.