Live from San Diego, it’s AAID!

Surgeries broadcast live are the highlight of this year’s annual meeting

By Sierra Rendon, Managing Editor

“I thought there was no way they were going to be able to pull it off…”
“I think they should do it every year.”
“I was really amazed at how well prepared they were — they came right in and the patients were ready to go.”

These were just a few of the glowing comments heard immediately following the first two live surgeries that took place the morning of Oct. 31 at the American Academy of Implant Dentistry’s 57th Annual Meeting at the Manchester Grand Hyatt San Diego.

Two live surgeries are shown side-by-side at the AAID’s annual meeting in San Diego on Oct. 31.

The ‘All-on-4’ implant concept for edentulous jaws

By Paulo Malo, DDS, and Miguel de Araujo Nobre, RDH

The efficacy of dental implant treatment is well-documented and its further development includes protocols for simplifying the procedures.

The immediate function protocol is a powerful simplification as it allows the complete rehabilitation to be finalized within the same procedure. The fact that four implants is an optimal number for complete-arch prosthesis is an important further simplification. Provided the implants are placed as “cornerstones” — two posteriorly and two anteriorly — and they are well-anchored, the probability for success is high. It has also been demonstrated that tilting of implants might be advantageous as longer implants may be placed with good cortical anchorage in optimal positions for prosthetic support and reducing the length of the cantilever.

Based on these principles the All-on-4 concept was developed for safe and simple treatment of totally edentulous mandibles and maxillas and has been shown to be a viable option. The advantage of the All-on-4 for the edentulous mandible is it avoids the use of bone graft or nerve transposition techniques even in severely resorbed situations. In the edentulous maxilla, where insufficient residual bone volume often makes implant placement posterior to the canine/first premolar impossible, the All-on-4 concept offers solutions in situations where other...
Sweden’s top students receive prestigious award

For the 19th year running, “The Henry G. Girardt Annemer Student Achievement Award” was granted at a ceremony on the opening day of FDI/Sweddental 2008 in Stockholm.

The prize, which is sponsored by Swedish company Dentatus, is awarded yearly to the top students of the four dental universities in Sweden.

This year’s recipients, selected by their respective university for their excellent academic achievements, were Nadya Esfahani, Ivana Franc, Jeanette Tveit and Gustaf Wiklund.

In keeping with tradition, the students were further acknowledged for their achievements during the traditional Dentatus breakfast meeting held on Sept. 25.

During the meeting, the newly awarded students had the opportunity to network with several prominent dental professionals from all over the world as well as representatives from the international dental industry.

ITI appoints Dr. Friedrich Buck as new executive director

The International Team for Implantology (ITI), a leading academic organization dedicated to the promotion of evidence-based research and education in the field of implant dentistry, announced the appointment of Dr. Friedrich Buck to the position of executive director of the ITI. He will be joining the organization on Feb. 1, 2009.

Buck comes to the ITI from Ivoclar Vivadent AG, a leading international manufacturer of dental materials and equipment headquartered in Schaan, Liechtenstein. With a graduate degree and doctorate in dentistry from the University of Ulm, Germany, Buck began his career in general practice in 1991. He then joined Ivoclar Vivadent in 1995, where he rose to the position of marketing director worldwide for clinical products in 2001.

In his new position as executive director of the ITI, Buck’s main task will be to assure the smooth organization and administration of all ITI activities in order to support the implementation of the objectives, philosophy, policy and procedures of the ITI. He will also oversee the management of the ITI Center, the administrative headquarters of the ITI in Basel, Switzerland.

“During the last few years, the ITI has evolved to become a leading academic authority in the field of implant dentistry with its more than 6,000 members from more than 90 countries,” said Professor Dieter Weingart, president of the ITI. “As a dentist by education, who brings a wealth of experience in marketing and business administration in a globally operating enterprise, Dr. Buck is an ideal choice for the position of executive director of the ITI. Additionally, his deep understanding of the field of dentistry and his excellent relationship to the scientific community will be very valuable for the future growth and success of our organization.”

Buck takes over from Rolf Hafner, who oversaw the ITI’s administration for the past six years and left the organization at the end of August 2008. Professor Weingart commented: “On behalf of the ITI Board of Directors, I would like to thank Rolf Hafner for his vision, ideas and contribution, which were instrumental in making the ITI what it is today. We wish him every success in his future endeavors.”

The International Team for Implantology unites professionals around the world from every field of implant dentistry and dental tissue regeneration.

For more information, see www.it.i.org.
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Tooth loss may increase risk of kidney disease

According to the National Kidney Foundation, one out of nine Americans suffers from chronic kidney disease (CKD), and millions more are at risk. A debilitating disease, CKD can affect blood pressure and bone health, and can eventually lead to heart disease or kidney failure.

A latest study published in the Journal of Periodontology (JOP), the official publication of the American Academy of Periodontology (AAP), suggests that edentulous adults may be more likely to have CKD than dentate adults.

In the study, conducted at Case Western Reserve University, endodontism was found to be significantly associated with CKD, indicating that oral care may play a role in reducing the prevalence of chronic kidney disease in the U.S. population.

The study examined the kidney function and periodontal health indicators, including dentate status, of 4,053 U.S. adults 40 years of age and older. After adjusting for recognized risk factors of CKD such as age, race/ethnicity and smoking status, the results revealed that participants who lost all their teeth were more likely to have CKD than patients who had maintained their natural dentition.

“The rationale for examining edentulous adults in this study is to observe the long-term effects of periodontal disease on the presence of chronic kidney disease,” states study author Monica Fisher, PhD, DDS, MPH. “Periodontal disease is a leading cause of tooth loss in adults; therefore endodontists are considered a marker of past periodontal disease in the study’s participants.”

While additional research is needed to fully understand why tooth loss is associated with a higher prevalence of CKD, the destructive nature of chronic inflammation may play a role. Both periodontal disease and chronic kidney disease are considered inflammatory conditions, and previous research has suggested that inflammation may be the common link between these diseases. Since untreated periodontal disease can ultimately lead to tooth loss, edentulous patients may have been exposed to chronic oral inflammation.

According to David Cochran, DDS, president of the American Academy of Periodontology and professor and chair of the Department of Periodontics at the University of Texas Health Science Center at San Antonio, treating periodontal disease can do a lot more than save your natural teeth.

“Researchers have long known that gum disease is related to other adverse health conditions, and now we can consider chronic kidney disease to be one of them. It is exciting to think that by controlling periodontal disease and therefore helping to preserve natural dentition, the incidence and progression of CKD may be reduced.”

Periodontists recommend regular brushing and flossing and routine visits to a dental professional in order to maintain comprehensive oral health. If gum disease develops, consulting a periodontist is an effective way to determine the most appropriate course of treatment.

About AAP

The American Academy of Periodontology is an 8,000-member association of dental professionals specializing in the prevention, diagnosis and treatment of diseases affecting the gums and supporting structures of the teeth and in the placement and maintenance of dental implants. Periodontics is one of nine dental specialties recognized by the American Dental Association.

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wise bone grafting would have been indicated.

This paper aims to explain the indications for the All-on-4 system treatment, which maneuvers around the anatomical limits and risks and allows in a small amount of time to accurately perform implant treatments for fully edentulous jaws.

Materials and methods

The All-on-4 concept is based on the optimal number of four implants for supporting an edentulous jaw with a complete arch prosthesis. The concept benefits from posterior tilting of the two distal implants, which offers a minimum of 10 teeth in the immediately placed prosthesis with a maximum of a one-tooth distal cantilever. The procedures are described elsewhere and here we offer a summary of the protocol.

- Inclusion/exclusion criteria

The patients undergo medical history, clinical observation and complementary radiographic exams of panoramic X-ray (bone height) and a CT-scan (bone quality and bone volume). For the mandible, the anatomical inclusion criterion is a bone ridge of a minimum 4 mm width and maximum 8 mm height in the interforamina area.

For the edentulous maxilla, the height and width of the residual crest bone available between the anterior walls of the maxillary sinus for the maxilla and between the mental foramina for the mandible will establish the type of All-on-4 surgical approach: All-on-4 Standard, All-on-4 Hybrid or All-on-4 Extra-Maxilla.

For the All-on-4 Standard, the anatomical inclusion criterion is a bone ridge of a minimum 4 mm width and maximum 10 mm height from canine to canine. The All-on-4 concept can be used at different degrees of maxillary atrophy as the position of the posterior implant is the determining factor for the interimplant distance.

Depending on the degree of resorption, the posterior implant head will emerge at different positions at the bone crest, normally between the first premolar (high resorption) and the first molar (moderate resorption). If the above criteria are not met, then an All-on-4 Hybrid or All-on-4 Extra-Maxilla should be considered. In the All-on-4 Hybrid rehabilitation, maxillary anchored implants are used in conjunction with extra-maxillary anchorage implants (anchored in the zygomatic bone) (Fig. 5), whereas in All-on-4 Extra-Maxilla, only four extra-maxillary anchorage implants are used (Fig. 4).

Surgical protocol
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• Medication
The surgical procedures for both jaws were performed under local anesthesia with mepivacaine chloride with epinephrine 1:100,000 (Scandinibsa 2 percent®, Inibsa Laboratory, Barcelona, Spain). All patients were sedated with diazepam (Valium® 10 mg, Roche, Amadora, Portugal) prior to surgery. Antibiotics (amoxicillin 875 mg and clavulanic acid 125 mg, Labesfal, Campo de Besteiros, Portugal) were given one hour prior to surgery and daily for six days thereafter. Cortisone medication (prednisone [Meticorten® Schering-Plough Farmà, Lda, Agualva-Cacém, Portugal], 5 mg,) was given daily in a regression mode (15 mg to 5 mg) from the day of surgery until four days postoperatively. Antiinflammatory medication (ibuprofen, 600 mg, Ratiopharm, Lda, Carnaxide, Portugal) was administered for four days postoperatively starting on day four. Analgesics (clonixine [Clonix®, Janssen-Cilag Farmaceutica, Lda, Barcarena, Portugal], 300 mg,) were given on the day of surgery and postoperatively for the first three days if needed. Antacid medication (omeprazone, 20 mg, Lisboa, Portugal) was given on the day of surgery and daily for six days postoperatively.

• Flap procedure
The implants and abutments are placed in one position at a time, starting with the two posterior locations. The implant placement is assisted by a special guide, designed by the author (P.M.) (Fig. 5). The guide is placed into a 2 mm hole made at the midline of the jaw and the titanium band is bent so the occlusal centerline of the opposing jaw was followed. By this, it is possible to guide the implants to be placed in the center of the opposing prosthesis and at the same time to find the optimal position and inclination for best implant anchorage and prosthetic support.

The insertion of the implants (Brånenmark System®; Nobel Speedy®, Nobel Biocare AB; Gothenburg, Sweden) follows standard procedures, except that under-preparation is used when needed to get a final torque of more than 40 Ncm before the final seating of the implant. Countersinking is used only when needed to create space for the head of the tilted implants and/or to secure both buccal and lingual cortical bone contact at the implant head in thin bone crests. The preparation is typically done by full drill depth with a 2 mm or a 2.5 mm twist drill (depending on bone density), followed by a widening of the entrance in the cortical bone with a 3 mm twist drill and an adjustment with the countersink, if needed.

The implant neck is positioned at bone level, and bicortical anchorage is established whenever possible (Fig. 6). The length of the implants varies from 10 mm to 18 mm. In case of immediate extraction, the sockets are made free from soft tissue remnants and cleaned to avoid infection. In case of periodontitis on the lower incisors, extraction, curettage and bone shaping is performed and virtually no socket is left. After closing and suturing the flap with 4–0 non-resorbable suture, the access to the abutments is opened by a punch and impression copings are placed.

Implant placement in the mandible: In the mandible, a mucoperiosteal flap is raised along the top of the ridge in the intermen- tonian area. The two most anterior implants follow the jaw anatomy in direction, which in severe resorption cases means a posterior tilting. Two
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additional implants are inserted just anterior to the foramina and tilted distally about 20 degrees relative to the occlusal plane. This arrangement allows for good implant anchorage, short cantilever length and large inter-implant distance. The posterior implants typically emerge at the second premolar position.

The posterior implants are of 4 mm diameter, while the anterior ones are either 4 or 5.75 mm in diameter. Angulated abutments (Bränemark System®, Nobel Biocare AB, Gothenburg, Sweden) are used. The angle is either 17 degrees or 30 degrees at the anterior implants and usually 70 degrees at the posterior implants (Fig. 7). These abutments were chosen such that the prosthetic set screw access holes were in an occlusal or lingual location.

Implant placement in the maxilla: In the maxilla, the posterior implant tilting allows a position shift on the implant head from a vertically placed implant in the canine/first premolar region to a tilted implant in the second pre-molar/first molar region, following the anterior sinus emergence at the second premolar position.

The positions of the implants are 4 mm in diameter. The anterior implants are orientated vertically by a guide pin replacing the special surgical guide (Fig. 8). Care has to be taken in the selection of the anterior positions not to come in conflict with the apex of the tilted posterior implants, which normally reach the canine area. The anterior implants are either 4 or 5.75 mm in diameter and typically placed in lateral or central incisor positions. This implant arrangement allows for good implant anchorage, a large inter-implant distance and short cantilever length with the posterior implants typically emerging at the second premolar/first molar position.

### Table 1 — Cumulative Survival Rate for the All-on-4 standard in the mandible

<table>
<thead>
<tr>
<th>Duration</th>
<th>Total</th>
<th>Failed</th>
<th>Withdrawn</th>
<th>Not yet too</th>
<th>CSR %</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 mo</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>124</td>
<td>97.6%</td>
</tr>
<tr>
<td>6 mo</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>124</td>
<td>97.6%</td>
</tr>
<tr>
<td>1 yr</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>124</td>
<td>97.6%</td>
</tr>
<tr>
<td>2 yr</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>124</td>
<td>97.6%</td>
</tr>
</tbody>
</table>

### Table 2 — Cumulative Survival Rate for the All-on-4 standard in the maxilla

<table>
<thead>
<tr>
<th>Duration</th>
<th>Total</th>
<th>Failed</th>
<th>Withdrawn</th>
<th>Not yet too</th>
<th>CSR %</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 mo</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>124</td>
<td>97.6%</td>
</tr>
<tr>
<td>6 mo</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>124</td>
<td>97.6%</td>
</tr>
<tr>
<td>1 yr</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>124</td>
<td>97.6%</td>
</tr>
<tr>
<td>2 yr</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>124</td>
<td>97.6%</td>
</tr>
</tbody>
</table>

### Table 3 — Cumulative Survival Rate of the Extra-Maxillary Implants

<table>
<thead>
<tr>
<th>Time Period</th>
<th>In Function</th>
<th>Failed</th>
<th>Withdrawn</th>
<th>Survival Rate CSR %</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Mo - 1 Yr</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>97.6%</td>
</tr>
<tr>
<td>1 Yr - 2 Yr</td>
<td>127</td>
<td>1</td>
<td>1</td>
<td>97.6%</td>
</tr>
</tbody>
</table>

Clinical IMPLANT TRIBUNE | November 2008

The planning is made in a computer on a 3-D model of the patient’s jaw. At surgery the implants are oriented by a precision guide (NobelGuide, Nobel Biocare, Gothenburg, Sweden), based on the planning data, and a pre-surgery manufactured provisional prosthesis is immediately delivered after surgery (Figs. 10, 11).

- **All-on-4 Hybrid/ All-on-4 Extra-Maxilla**

An alternative solution for oral rehabilitation in the atrophied maxilla is the use of implants placed in the zygomatic bone, alone or in conjunction with regular implants. However, the placement of zygomatic anchored implants through the standard technique often causes the implant heads to emerge too palatal for an optimal prosthetic solution (especially in cases of extreme atrophy), as the bone ridge retracts palatally when it atrophies.

The extra-maxillary anchorage technique aims to eliminate these difficulties by placing long implants external to the sinus, anchored in only the zygomatic bone and covered by soft tissue after emerging from the bone.

By doing so, the implant head will be positioned in a prosthetically correct position. The implants emerge in the positions between the lateral incisor and the first molar, on the crest at the ideal prosthetic position, while the foreseen prosthetic screw exits localize on the occlusal surfaces of the prosthetic teeth or on the internal wall of the bridge through the false gingiva.

As well as in the standard All-on-4 technique, complete-arch all-acrylic prostheses are delivered on the day of surgery.

Two clinical situations representing two patients eligible for a complete edentulous maxillary rehabilitation through the All-on-4 Hybrid and All-on-4 Extra-Maxilla solution are presented (Figs. 12-15). The extra-maxilla technique complements the All-on-4 concept by replacing one to four standard implants with an extra long implant placed in the zygomatic bone only, making it fit to rehabilitate any degree of maxillary bone atrophy.
Results

- Maintenance protocol
  The patients are instructed to have a soft food diet for two months. Ten days after surgery, the sutures are removed (if used), and hygiene and implant stability are checked. The procedure is repeated two and four months after surgery is performed until stability is achieved.
  - Final prosthetic protocol
    Final prostheses are delivered at six months (Fig. 16). If an adjustment of the angulated abutment was needed for better positioning of the screw access hole, the impression for the final prosthesis is taken at implant level. The abutment position is then decided at the laboratory and is adjusted in the patient’s mouth.
  - Implant survival criteria
    Survival was based on function, individual implant stability (checked manually), absence of pain and infection, and radiographic analysis at time of evaluation.
  - Marginal bone level
    The marginal bone level relative to the implant platform was read from periapical radiographs taken at the time of last follow-up within the study frame and at the additiona1 follow-up for the present study. A conventional radiograph holder was used, and its position was manually adjusted for an estimated orthog-nathic position of the film. For a few patients, panoramic radiographs were used due to access problems.

- Implant survival
  The implant survival rates are presented in life tables. Tables I and II show the results for the All-on-4 standard, for the rehabilitation in the mandible and maxilla, respectively. The data concerns the routine groups as presented in the previous clinical studies50 plus the result from the subsequent follow-up until today.

These results show the incidence of implant losses for both the maxilla and mandible rehabilitation are low and decrease dramatically after the first six months of function, rendering high survival rates.

The preliminary results for the cumulative survival rate of the extra-maxillary anchorage implants are shown in Table III. The results indicate high survival rates with a follow-up of up to two years for the All-on-4 Hybrid and All-on-4 Extra-Maxilla implants.

- Marginal bone level
  The average bone levels relative to the implant platforms at one year of follow-up were 0.9 mm (SD 1.0 mm) for the maxilla and 0.7 mm (SD 0.5 mm) for the mandible. The average bone levels for the mandible at five years of follow-up were 1.7 mm (SD 1 mm).

Discussion

These results and the outcome from the present study indicate that immediate function for the maxilla and mandible can be highly pre-dictable treatments (high survival rates and low marginal bone resorption), provided an optimal placement of the implants. The All-on-4 concept with implant tilting utilizes the load carrying capacity of the bone in an optimal way; the implants are spread anteriorly-posteriorly, giving an optimal prosthetic base and are well anchored in dense bone structures (anterior bone with higher density) due to the freedom of tilting.

By reducing the number of implants to four, each implant can be optimally placed without any compromise to adjacent implants. The data supports that this biomechanical optimization of the implant positions is clinically effective. The fact that the prostheses survival could be kept at 100 percent, even with less than four implants supporting the prosthesis, also demonstrates the efficacy of the implant positions.

Moreover, using finite element analysis, it is possible to conclude that there is a biomechanical advantage in using splinted, tilted distal implants rather than axial implants supporting distal cantilever units when comparing the coronal stress.41

The use of only four implants simplifies many aspects of the treatment: a more aesthetic prosthesis can be manufactured, it simplifies the manufacture of the prosthesis, it reduces the risk for prosthetic complications, and it simplifies the patient’s dental hygiene procedure.

Conclusions

In conclusion, the All-on-4 immediate function concept for complete edentulous jaws has proven to be clinically effective, patient pleasing and applicable in many situations where otherwise more complicated procedures would have been indicated.

It is a standardized treatment procedure than can be routinely applied to most edentulous patients with a short treatment procedure and prostheses in place and func-tional a few hours after the start of surgery.

It’s well adapted to further simplifications such as flapless surgery based on computer planning and can be recommended as a method of choice for rehabilitation of completely edentulous jaws.

References are available upon request from s.rendon@dtamerica.com.

Fig. 16: Final prosthesis with a titanium CAD/CAM infrastructure and ceramic teeth.

About the author

Paulo Malo, president and CEO of the MALO CLINIC Health Group, graduated in 1989 from the Faculty of Dental Medicine, University of Lisbon, and founded MALO CLINIC in 1995. The large success and exponential growth of his clinic has prompted an exten-sive international expansion and the birth of an International Health Group, present in five continents. He is a co-author of several books and has published several scientific articles, as well as been a frequent guest speaker in numerous international confer-ences on health-related issues or management. Aside from his clinical practice and corporate management, he is a visiting professor in several prestigious universities, as well as a leading consultant in four major den-tal medicine international companies. Throughout his career he has also received several distinctions and awards, either for his medical break-throughs, or for his managing, leader-ship and entrepreneurial skills.

References are available upon request from s.rendon@dtamerica.com.
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‘The best investment in myself’

Dr. DeFrancisis shares how the PreXion 3-D scanner changed his practice for the better

By Dr. Domenick DeFrancisis

Undoubtedly, over the years, there have been advancements in technology that were not even thought of when I was a student in dental school almost 50 years ago. The advancements transverse from restorative materials we use day-to-day, to hard- and soft-tissue lasers, to advancements in the field of implant dentistry, to name a few. But by far, and probably the most significant of all the advancements to me over the years, are the diagnostic advancements.

There are many diagnostic advancements that have been introduced into the field of dentistry over the past decade. The one in particular that has significantly impacted my practice capabilities is 3-D cone beam technology. For me, the specific cone beam CT scanner from PreXion has been the best purchase and investment in myself since the inception of my dental practice.

When I purchased my PreXion 3-D scanner approximately two years ago, the scanned images it reconstructed of my patients allowed the diagnostic and treatment planning to be achieved with greater certainty and more resolve. No longer did I depend on two-dimensional radiographs, but I now had a diagnostic aid that enabled me to step into another “dimension” of unimaginable dental views.

The PreXion 3-D has afforded me much flexibility with my dental care. As a CBCT scanner, it has enabled me to perform endodontics, periodontal therapy, oral surgical procedures and everyday general dentistry at a higher level and with more predictability. For example, a 3-D scan can pinpoint the exact location of each canal within a tooth and the root(s) morphology prior to initiating endodontics that a 2-D radiograph could never give you. The point here is that a CBCT scanner is a valuable tool for general dentists—not just specialists who focus on surgical modalities.

The guaranteed image quality that the PreXion 3-D produces with each scan is unattainable with any other cone beam scanner in the industry. The PreXion 3-D features the highest resolution images as well as the fastest processing time of those images once the actual scan on a patient is complete. This is quite useful when you want to illustrate to a patient a specific problem or need without having him or her wait. I can quickly show my patients their anatomic structures (around 30 to 90 seconds after scan is complete) and with an image quality of resolution that has not been reproduced yet by any other CBCT scanner to date.

The PreXion 3-D scanner’s flexibility allows me to perform four different scanning modes and two different field-of-view options. This enables me to specifically tailor each scan based on my need as a practitioner.

When I first placed the PreXion CBCT scanner into my dental office, the understanding I had of its value was clear to me as a dentist. As I started before, it has certainly been a valuable tool for me in my multidisciplinary general dental practice. The quality and predictability of oral surgical procedures because of the scan’s diagnostics, from exodontia of teeth to implant placement, has made my life easier knowing exactly what I am up against, each and every time, with certainty, before commencement of a procedure.

But what also has transpired within my rural dental practice was unforeseen.

The PreXion scanner has created a “buzz” with people in and around the community in which my dental practice is located. It seems to be one with a rippling effect. The number of new patients that have become part of my dental practice has dramatically increased. The reaffirmed commitment of my already established patient base and retention of them has also been impacted.

The response seems to be “wow” to the capabilities this new technology offers and to their understanding of how it can benefit their dental care. They are commenting how glad they are that I “keep up with the new technology for their benefit.”

Although we as professionals have seen this type of technology at dental meetings, and it is still impressive to us, imagine the visualization of 3-D data to a non-dental person; it can be truly remarkable.

I would encourage any dental practitioner to look closely at incorporating a CBCT scanner into your practice—in particular the PreXion 3-D. The company’s training enabled me to start taking scans and properly using its diagnostic software very quickly.

You owe it to yourself to look closely at the PreXion 5-D and see how it can make your dental life easier and more enjoyable.

About the author

Dr. Domenick DeFrancisis is a 1982 graduate of Temple University School of Dental Medicine. He is a member of the ADA and PDA, an associate fellow in the American Academy of Implant Dentistry and a fellow in the International College of Oral Implantology. He has been in private practice in Pennsylvania for 26 years.
How to achieve total success

By Roger P. Levin, DDS

We all know implants are the best possible option for edentulous patients. Implants clearly enrich a patient’s life, both physically and psychologically. However, let’s not forget what implants do for the practice. Implants can be a gold mine. However, like any gold mine, the gold isn’t necessarily sitting on the ground waiting for you to pick it up. It takes time and effort to uncover the treasure.

There are highly successful implant practitioners placing hundreds of implants a month — even in this economy. Yes, they are out there and Levin Group has worked with many of them. However, for every highly successful implant practice, there are many practitioners working hard to build their implant production but facing obstacles that hinder total implant success. Let me share with you the progress of one such practice.

Case study: finding the hidden potential

When Levin Group first met Dr. O, he had been in practice for nearly 25 years and just built his dream home. His wife was hoping he could spend more time at home now that their daughters had finished college and started their own careers. This was something of a problem. He didn’t want to work more hours yet he was worried about increased debt because of the new home.

On top of that, he wanted to pursue his dream of one day vacationing in the Caribbean on his sailboat. He couldn’t see any way of meeting all of his objectives. At that point, Dr. O decided that practice management and marketing consulting was the answer to help him get where he wanted to be.

Practice production had grown an average of only 2.5 percent during the previous three years. Dr. O knew that growing the implant side of his practice was a good way to increase production, but he was not sure how to make that happen. Many of his restoring practitioners never sent more than a handful of cases to him each year. He didn’t have a solution to the problem, which frustrated him greatly. Consequently, he was settling for just going through the schedule each day and hoping things would change. Upon closer inspection, we discovered it wasn’t just the low number of implant cases hindering the practice; there were other significant issues as well.

During an on-site visit, we identified roadblocks that limited efficiency and practice capacity. Inefficient systems were having an adverse affect on Dr. O, his team and his patients. After our on-site analysis and subsequent conversation with his consultant, Dr. O came to realize that implementing new systems would reduce stress, improve practice performance and increase productivity.

Like many implant practitioners, Dr. O had procrastinated about redesigning his systems. This is hard- ly surprising. It’s human nature to put off change when things are going fairly well. Over the years, Dr. O took the position of: “We can’t do it now, we’re too busy.” Now, he realized that he had to do something.

We recommended a straightforward strategy to get the most out of Dr. O’s practice and his life — an Implant Life Map.

Dr. O’s Implant Life Map™ — building the practice and creating more free time

A Life Map is a year-by-year blueprint of a practitioner’s professional and personal life, now through retirement. Having created hundreds of Life Maps for clients, we focus on key events that will affect an implant practitioner’s life and practice.

In 2004, Dr. O was a 52-year-old periodontist with one practice location. He was generating $700,000. He was disappointed that his practice had grown at only 2.5 percent for the past three years. As mentioned earlier, he was having difficulty paying down debt, finding more time to spend with his wife, Susan, and pursuing other interests including sailing and community activities.

Here are some of the elements that were included in Dr. O’s Life Map:

• 2004: Faced with a lack of growth and lower profitability than he wanted, Dr. O enrolls in Levin Group’s Total Perio Success™ Management and Referral Marketing Year-1 Programs.

After several in-depth conversations about the state of his practice with his management consultant, Dr. O discovers that he needs to improve case acceptance, referrals and his implant production.

He realizes that the internal management systems are not fully implemented because of his lack of leadership and commitment to drive change in the practice.

Reviewing his investment portfolio, he understands that he needs a comprehensive approach to financial independence. He decides to work with a certified financial planner.

• 2005: Growth — 12 percent

Referrals increased by 35 percent. This is attributed to a referral marketing program.

Wishing to take control of his practice, Dr. O enrolls in a second year of marketing and management programs.

He is finally starting to pay down the considerable debt he had accumulated when he built his dream house.

• 2006: Growth — 21 percent

The practice continues to experience substantial growth.

Implant practitioners have become a primary focus in the practice with a growth of 50 percent.

Dr. O elects to participate in Levin Group’s Total Implant Success™ Management and Referral Marketing Program and continue his Periodontal Marketing Program.

He designs an Implant Treatment Coordinator to effectively handle communication between restorative doctors and his office.

With Levin Group’s help, Dr. O begins a campaign of organized Lunch ‘n Learns for his restorative practitioners to increase their education level regarding implants.

Having developed great confidence in his leadership skills, Dr. O hires an office manager to help bring together the right team.

• 2007: Growth — 27 percent

Implant referrals have increased exponentially. His restorative doctors are now sending five times as many implant cases his way. He is also beginning to get more new implant referrals — something he had wanted for a considerable length of time.

With the help of his new office manager, they have assembled their dream team and Dr. O decides to participate in Total Perio Success™ Management, Year 3 so he can take his team to the next level.

Dr. O and his wife are finally able to live their dream of sailing in the Caribbean. It’s the best two weeks of their lives.

• 2008

Faced with much tougher economic conditions and increased competition, Dr. O enrolls in Levin Group’s Total Perio Success™ Management and Referral Marketing Year-1 Programs.

After several in-depth conversations about the state of his practice with his management consultant, Dr. O discovers that he needs to improve case acceptance, referrals and his implant production.

He realizes that the internal management systems are not fully implemented because of his lack of leadership and commitment to drive change in the practice.

Reviewing his investment portfolio, he understands that he needs a comprehensive approach to financial independence. He decides to work with a certified financial planner.

• 2009: Growth — 12 percent

Referrals increased by 35 percent. This is attributed to a referral marketing program.

Wishing to take control of his practice, Dr. O enrolls in a second year of marketing and management programs.

He is finally starting to pay down the considerable debt he had accumulated when he built his dream house.

Dr. O hires an associate, Dr. Adams. Dr. O hopes Dr. Adams will eventually become a partner and take over the practice when he retires.

A Life Map begins with understanding the implant practitioner’s vision and goals, which change over time. In many cases, once clients have started working with Levin Group, we see them set and reach new goals that they never thought possible. This is a process of identifying short- and long-term goals and placing these on an Implant Life Map™ to help practitioners and their spouses create a roadmap for total success.

Conclusion

Dr. O had high hopes for his practice, but he didn’t know how to turn his dreams into reality. Only after an on-site analysis, a carefully planned and implemented Implant Life Map™ and customized management and marketing solutions did his practice begin to experience the total success that he wanted. His success continues today, despite a slow economy.

As Dr. O found out, a Life Map will help you to identify and achieve comprehensive success in all areas of your life, both personal and professional.

1. Case study based on actual Levin Group client information.

Implant Tribune readers are entitled to receive a 50 percent courtesy on a Levin Group Practice Potential Analysis™, an office evaluation of your practice systems conducted by a Levin Practice Development Specialist. To schedule the next available appointment, call (888) 973-0000 and mention Implant Tribune or email customerservice@levingroup.com with “Implant Tribune” in the subject line. Readers can also visit www.levingroupimplant.com for more information.

About the author

Dr. Roger P. Levin is founder and chief executive officer of Levin Group, Inc., the leading implant practice management firm. Levin Group provides Total Implant Success™, the premier comprehensive consulting solution for lifetime success to implant practitioners in the United States and around the world. For more than two decades, Dr. Levin and Levin Group have been dedicated to improving the lives of implant practitioners.

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Hyatt in San Diego.

The morning started out with two pre-recorded surgical procedures performed at Loma Linda University, from which all of the day’s surgeries were located.

The first pre-recorded procedure demonstrated surgical application of recombinant human bone morphogenic protein (rhBMP-2) for sinus grafting. Successful repair of a sinus membrane perforation was also demonstrated during this first clinical procedure. The second pre-recorded surgery showed successful implant placement within the BMP-2 graft complex following six months of healing and revealed graft consistency and success.

Next came two live surgeries broadcast side-by-side on a mega-screen with Dr. Don Clem moderating. The first was “Radical Vertical Bone Augmentation” with Surgeon Istvan Urban, DMD, MD. Broadcast via the Internet, the live surgery demonstrated techniques to achieve successful vertical bone augmentation. With the use of e-PTFE membranes in combination with particulate grafts and soft tissue grafts, Dr. Urban demonstrated how to predictably regenerate extremely challenging vertical defects using relatively conservative procedures and minimize complications.

Simultaneously, Alan Herford, DDS, MD, showcased “RhBMP in Implant Dentistry.” Herford said surgical procedures for the treatment of mandibular continuity defects, preprosthetic atrophic alveolar ridge deficiencies, trauma and maxillary clefts have demonstrated extraordinary osseous regeneration induced by rhBMP-2. The application of rhBMP-2 was presented in the live case.

As the two surgeries drew near to an end, audience members were offered the opportunity to present questions that the moderator would ask the two surgeons. About a dozen questions from the audience were asked, creating an even higher level of audience participation from the standing-room only group.

The final live surgery by Joseph Y.K. Kan, DDS, MS, a professor at Loma Linda University, focused on “Surgical Biotype Transformation During Immediate Implant Placement in the Esthetic Zone: You Be the Judge.”

The session began with an explanation of the patient’s history and video from surgical preparation earlier in the day for the implant placement. During this surgery, the audience again was asked to submit any questions for Kan via the moderator, which many participants did, and, later in the session, the audience “voted” through audience response keypads on the question Kan asked regarding the techniques shown in the surgery.

The question was: “How many of you believe this (tissue graft) technique is able to enhance the periodontal biotype and improve implant esthetics?”

(To many people’s delight, the theme from “Jeopardy” played in the background during the 30 seconds the audience was given to answer the question.)

The vote showed a 95 percent agreement with the technique Kan demonstrated.

The moderator joked Kan should run for president with numbers that good.

Friday’s afternoon sessions also used the audience response keypads during controversial topics such as mini implants and platform switching.

A sampling of other lectures that took place throughout the weekend includes:

- “Computer Aided Technology for Implant Prosthodontics” by Scott D. Ganz, DMD.
- “Can Dentists Feel How Much Torque They Are Exerting on Implant Components?” by Bill Holden, BSc, DDS.
- “The Zygomatic Implant. A Graftless Solution for the Edentulous Patient” by Edmund Bedrossian, DDS.
- “Loading Protocols for Grafted Bone: Immediate, Early and Delayed” by Craig M. Mich, DDS, MD.
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GNYDM: Discover new specialties

By Robin Goodman, Group Editor

People from around the world flock to the annual Greater N.Y. Dental Meeting, and with very good reasons beyond the fact that there is no registration fee.

This year, Dental Tribune America has partnered with the meeting’s organizers to offer four days of symposia in various areas of dentistry. Each day will feature a variety of lectures on topics, which will be led by experts in that field.

The afternoon sessions introduce attendees to Dental Tribune America’s educational concept of “Getting Started in ... ”.

The concept follows a proven European model in which leading specialists provide a general overview of their area of expertise for those who are interested in “getting started in” that specialty. The sessions will provide a thorough introduction to the techniques, products and practice management impact for each dental specialty.

On Nov. 30, Dr. Gene Antenucci will kick the Symposia off with a session on “CE REC 3-D CAD/CAM — The Power of Technology in Clinical Restorative Dentistry” from 10 a.m.–1 p.m.

At 1:30 p.m., Dr. John Schoeffel will discuss “Endodontic Irrigation via EndoVac,” focusing on safety, efficacy and clinical techniques. Dr. Daniel McEwen will wrap up the day at 5 p.m. with his lecture on CBCT technology.

The second day of the Symposia, Dec. 1, boasts a premium panel of speakers, starting with Dr. Neal Patel from 10 a.m.–1 p.m. presenting on 3-D imaging. His lecture will focus on “Using 3-D X-ray Imaging and Planning to Increase Patient Treatment Acceptance.”

After a short lunch break, Dr. Daniel McEwen will discuss “Endodontic Irrigation via EndoVac,” focusing on safety, efficacy and clinical techniques. Dr. Daniel McEwen will wrap up the day at 5 p.m. with his lecture on CBCT technology.

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After a short lunch break, Dr. Daniel McEwen will discuss “Endodontic Irrigation via EndoVac,” focusing on safety, efficacy and clinical techniques. Dr. Daniel McEwen will wrap up the day at 5 p.m. with his lecture on CBCT technology.
This presentation is designed to provide not only an overview of the role of CAD/CAM and CEREC 3-D in clinical dentistry today, but also provide attendees with practical clinical information on how CEREC 3-D literally transforms the practice of restorative dentistry.

Join your colleagues for Dr. Antenucci’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting from 10 a.m.–1 p.m. on Nov. 30.

CEREC 3-D CAD/CAM: the power of technology in clinical restorative dentistry

Tissue care in the maxillary anterior: Ankylos — a new paradigm

Bone preservation: one of the keys to esthetic success in immediate implant therapy

High-resolution cone beam with PreXion 3-D

Catch Dr. DiGiallorenzo’s lecture at the Dental Tribune Symposium at the Greater N.Y. Dental Meeting from 1:30–2:30 p.m. on Dec. 1.

This lecture will provide a systemic, biologic and evidence-based approach to ensure success in the class I to class IV case utilizing the “Tissue Care Concept by Ankylos,” PRGF, lasers and piezo surgery.

Don’t miss Dr. Levin’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting from 3–4 p.m. on Dec. 2.

Surgeons must now appreciate the importance of preserving surrounding bone and maintenance of soft tissue and understand the necessity of modern instruments designed to facilitate, if not enable, esthetically pleasing results.

Don’t miss Dr. McEwens’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting from 3–4 p.m. on Nov. 30.

This symposium will cover the basics of CBCT: field of view (FOV), focal spot, flat panel types, processing time and gray scale. PreXion 3-D high resolution images will be discussed and time spent with real scans for all specialties.

Earn C.E. credits! Attendance is free for all GNYDM visitors! For information and registration, contact Julia Wehkamp: j.wehkamp@dtaamerica.com.
VELscope photography for any user

By Martin B. Goldstein, DMD

Those of you having purchased LED Dental’s VELscope may have discovered that while it appears to be a very useful tool for assisting in early oral cancer detection, documentation of your findings requires a bit of photo wizardry.

Fortunately, a number of photo equipment vendors have taken note of the VELscope and now provide several approaches to capturing the oral cavity through the lens of this diagnostic tool.

It’s worth noting that LED Dental now ships a set of Doctorseyes adapters with its new Vantage VELscope that allow for easy mating with today’s popular SLR cameras.

If you’ve a previous model VELscope, this set can be had directly from Larry Blosser at (800) 200-5394 or www.jlblosser.com. This kit provides an assortment of adapters and a rudimentary list of camera setting recommendations. A certain amount of experimentation will allow you to dial in the settings that are right for your camera.

A somewhat different approach is offered by Photomed International Inc. Its VELscope Photography kit, which is ordered camera-specific includes not only the coupler but a simple software application that allows the user to brighten the images for better viewing. (Please note: an SLR, to be appropriate for VELscope photography, requires an ISO capability of 1600 or better. Check your camera’s specs!) For more detail on the Photomed kit, please visit www.photomed.net and check under “accessories.”

For those not owning an SLR type camera and choosing not to do so at this time, an alternative solution is DLC’s DentalFoto VELscope system with LoLite adapter currently based upon the Canon Power Shot A650. This camera-complete system offers a convenient approach to VELscope photography with the added benefit of video capability. For more information on this system, visit www.dlcenters.com. Should you already own a Canon Powershot such as the A650 or a similar point-and-shoot camera and wish to use it with your VELscope, a Doctorseyes close-up adapter and coupling ring kit is also available from Larry Blosser at (800) 200-5394 or www.jlblosser.com.

This author has tried all of the above implementations and has found that each has its merits. Above all it has been possible to obtain diagnostic quality images with all applications listed.

The user need merely select the scenario which best describes his or her “camera ready” state as well as any budget requirements.

Dr. Martin B. Goldstein, a member of the International Academy of Dento-Facial Esthetics, practices general dentistry in Wolcott, Conn. as a Dentistry Today C.E. Leader for the last five years, he lectures and writes extensively concerning cosmetics and the integration of digital photography into the general practice. A regular contributing editor for Dentistry Today, he has also authored numerous articles for multiple dental periodicals both in the United States and abroad. He can be contacted at martyg924@cox.net. His current speaking schedule can be found at www.drgoldsteinpeaks.com.

Using 3-D X-ray imaging and planning to increase patient treatment acceptance

Catch Dr. Patel’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting from 10 a.m.–1 p.m. on Dec. 1.

Dr. Patel will share a practical perspective of cone beam technology and its multiple uses in “real world” private practice. He will shed light on what the future has to offer and give insight into the impact CBCT technology can have from a business standpoint — return on investment (ROI).

By the end of the presentation, attendees should:

- Understand how 3-D technology can benefit the modern dental practice.
- Learn how state-of-the-art 3-D digital dentistry is being done today.
- Acquire the tools for implementing 3-D X-ray imaging and software in their
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Zimmer Dental Inc., a leading provider of dental oral rehabilitation products and a subsidiary of Zimmer Holdings, Inc., is pleased to announce the release of the new and improved Zimmer Instrument Kit System. With its user-friendly layout and logical color-coding system, the Zimmer Instrument Kit System is designed to enable clinicians to get the most out of the popular Tapered Screw-Vent™ and Zimmer One-Pieceimplants.

The Zimmer Instrument Kit System is an easy to learn, well-organized product family that can be customized to meet individual clinical needs and maximize valuable time. A simple and unique color-coding system enables clinicians to intuitively follow surgical sequences, step-by-step.

In addition, the Tapered Screw-Vent Surgical Kit can be combined with an optional Zimmer One-Piece Implant Module for streamlined placement of all components of the renowned Tapered Screw-Vent Implant System — thereby creating a truly centralized, all-in-one kit.

Each Tapered Screw-Vent Surgical Kit includes instruments needed to place any Tapered Screw-Vent Implant, including the popular 4.1 mm line. All kit configurations also leave extra storage space for additional pieces. An accompanying Staging Block allows users to place a selection of instruments and implants needed for a procedure within reach.

A separate Zimmer One-Piece Kit is also available for new users who want to begin their experience with Zimmer Dental by treating tight interdental spaces.

Finally, to help clinicians get the most out of the Zimmer Instrument Kit System, cleaning and sterilization instructions for instruments and Driva™ drills as well as surgical sequences are included in a handy guide that comes with every kit.

Contact your Zimmer Dental Sales consultant or customer service at (800) 854-7019, for outside the United States, (760) 929-4300, or visit www.zimmerdental.com for more information.

Straumann Bone Level Implant with proven SLA®Active surface

A new generation of bone level implant from Straumann completes one of the best-known and most successful implant systems in the world, the Straumann® Dental Implant System. The new implant combines innovative concepts with proven design elements, such as Straumann’s unique SLActive implant surface.

Most implant failures occur in the critical early phase of treatment — in the first eight weeks after placement. They are the result of the delayed healing process of the bone and the application of techniques, such as early loading. The need for increased security — particularly in poorer quality bone — and for faster procedures led to the development of a technology that has revolutionized implant dentistry.

Some 10 years ago, Straumann introduced the SLA® (Sandblasting with Large grit followed by Acid etching) surface, which reduced implant healing times from 12 weeks (TPS surface) to six to eight weeks.

The new SLActive surface, a further development that was launched just over two years ago, now cuts healing time from just three to four weeks. This is achieved by the chemically active, hydrophilic surface, which facilitates direct cellular interaction in the first phase of osseointegration. With the bone formation process beginning immediately, SLActive reduces the dip in stability that occurs when conventional implants integrate with bone. SLActive has been shown to achieve osseointegration in poor quality bone and even to facilitate healing of large bone defects around the implant.

These benefits, together with the advantages of considerably faster osseointegration, open up new treatment options in addition to offering greater security and a new level of confidence.

Complemented by a comprehensive portfolio of surgical and prosthetic components, the new Straumann Bone Level Implant is available in three diameters (3.5 mm, 4.1 mm and 4.8 mm) and four lengths (8 mm, 10 mm, 12 mm and 14 mm). Its unique SLActive surface offers a new level of confidence at bone level, with early loading and shorter treatment times.


Morita announces new TwinPower Turbine Mini

Morita’s new ‘TwinPower Turbine® Mini’ packs up to 18 watts of power into a tiny 10.6 mm (height) head.

This extremely small design offers exceptional access and visibility without sacrificing power.

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