

implants

the international C.E. magazine of oral implantology

3²⁰¹²

_c.e. article

Graftless
solutions in
implant dentistry

_events

AAIP and AAID
gear up for
annual meetings

_industry

The InterActive
evolution of conical
connection implants



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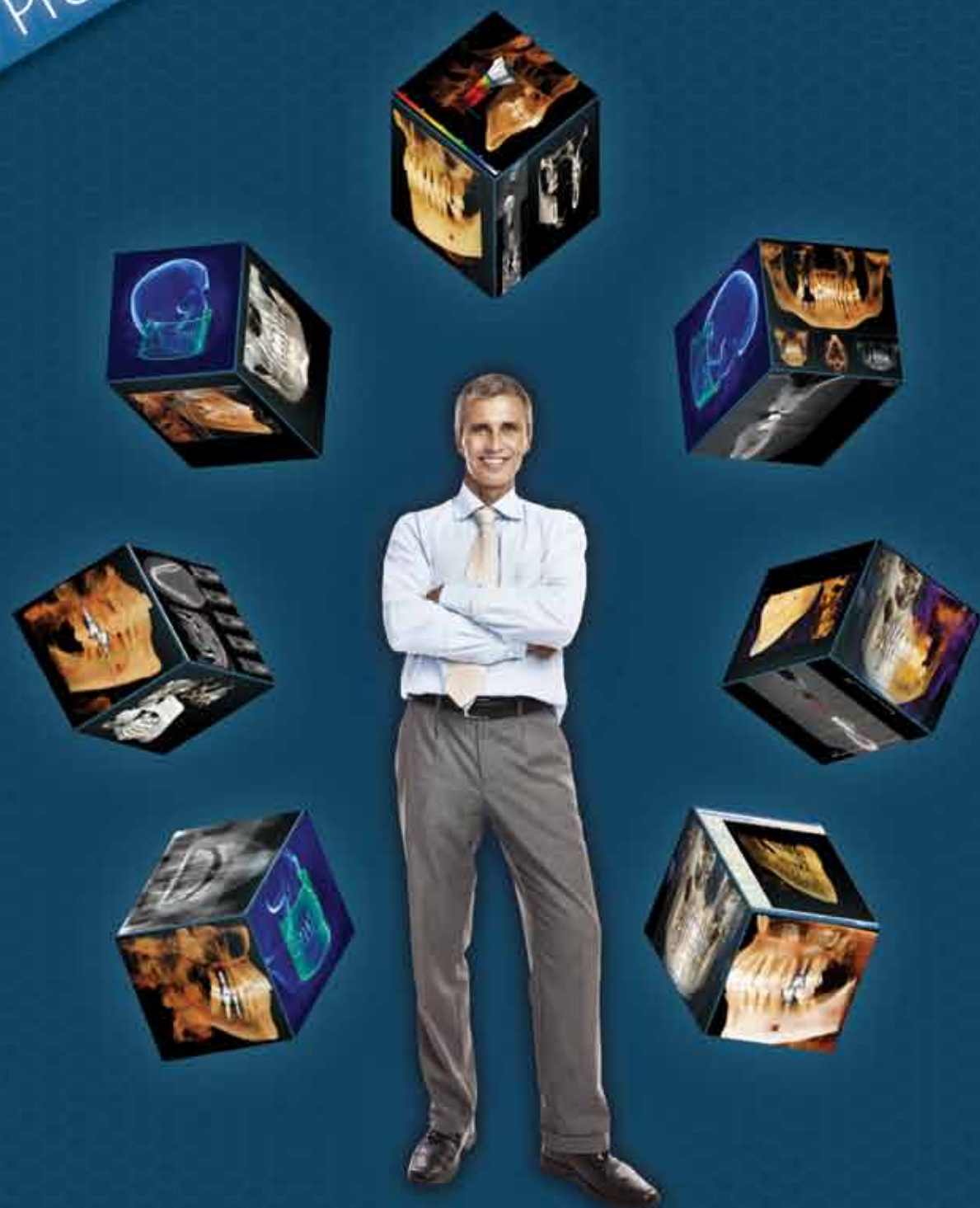
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_Thanks to rapidly advancing technology, the field of implant dentistry is always changing and evolving. Clinicians must be vigilant in their efforts to keep up with new techniques, new products and new technology that could affect their treatment planning.

And that's what makes the publication you are holding right now so valuable.

For this issue of *implants*, we've assembled a collection of articles from a variety of respected names in dentistry. These expert clinicians are sharing their first-hand knowledge and expertise with you. In this issue, you can read about graftless solutions in implant dentistry, and you can also learn about the reseal implant impression technique.

We also have important information on upcoming implant-focused events, such as the AAIP and the AAID, and about new implant products and technology.

But there's more.

Every issue of *implants* magazine also contains a C.E. component. By reading the set of articles (beginning on Page 8) on "Graftless Solution in Implant Dentistry: Part One" by Drs. Jivraj and Zarrinkelk and "The reseal implant impression technique" by Dr. Kalman and then taking short online quizzes about these articles at www.DTStudyClub.com, you will gain one ADA CERP-certified C.E. credit per article. Keep in mind that because *implants* is a quarterly magazine, you can actually chisel *at least* four C.E. credits per year out of your already busy life without any more lost revenue and time away from your practice.

To learn more about how you can take advantage of this C.E. opportunity, visit www.DTStudyClub.com. Annual subscribers to the magazine (\$50) need only register at the Dental Tribune Study Club website to access these C.E. materials free of charge. Non-subscribers may take the C.E. quiz after registering on the DT Study Club website and paying a nominal fee.

I know that taking time away from your practice to pursue C.E. credits is costly in terms of lost revenue and time, and that is another reason *implants* is such a valuable publication.

I hope you enjoy this issue and that you get the most out of it.

Sincerely,



Torsten Oemus
Publisher



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Introduction to Implants
A 2-day Course for the Dentist New to Implant Placement

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CE CREDITS

COURSE DESCRIPTION AND OBJECTIVES

This is an introductory course for dentists who want to integrate both the surgical and restorative phases of dental implants into their daily practice. Upon completion of this course, attendees will understand:

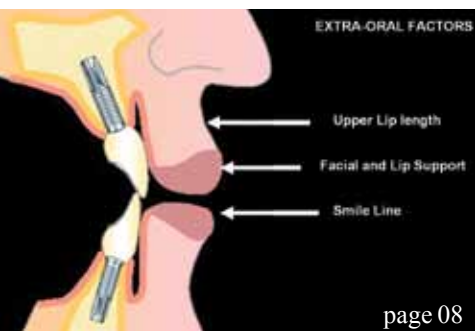
- The importance of offering implant treatment as an option to their patients
- How to select patients for straight forward implant surgery and restoration
- How to treatment plan basic implant cases
- The fundamentals of surgical and restorative principles and techniques
- Restorative options of the Camlog Dental Implant System
- Appropriate pre- and post-operative care for implant patients

For a course outline, visit www.camlogus.com.



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Graftless solutions in implant dentistry: Part 1

Authors_Saj Jivraj, BDS, MSED, and Hooman Zarrinkelk, DDS

_c.e. credit part I

This article qualifies for C.E. credit. To take the C.E. quiz, log on to www.dtstudyclub.com. The quiz will be available on Aug. 10.

Diagnosis, treatment planning and delivery of the immediate load prosthesis

The predictability of successful osseointegrated implant rehabilitation of the edentulous jaw as described by Branemark et al¹ introduced a new era of management for the edentulous predicament. Implant rehabilitation of the edentulous patient remains one of the most complex restorative challenges because of the number of variables that affect both the esthetic and functional aspect of the prosthesis.

The routine treatment for edentulism has been complete dentures. Epidemiological data has reported that the adult population in need of one or two dentures would increase from 35.4 million adults in 2000 to 37.0 million adults in 2020²; and the researchers warn that their estimates may be

"significantly conservative." Clinical studies have reported that patients with dentures have shown only a marginal improvement in the quality of life when compared with implant therapy.³ The common reasons for dissatisfaction in patients using dentures are pain, areas of discomfort, poor denture stability and difficulty eating as well as lack of or compromised retention capability.⁴

A review of the literature noted that prostheses supported by osseointegrated implants significantly improved the life of edentulous patients when compared with conventional dentures.⁵

Many patients tolerate complete dentures despite the dissatisfaction. Reasons for this could be:

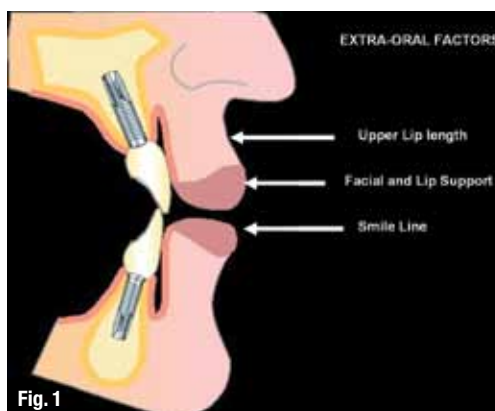


Fig. 1_Extra-oral factors in diagnosing the edentulous patient.

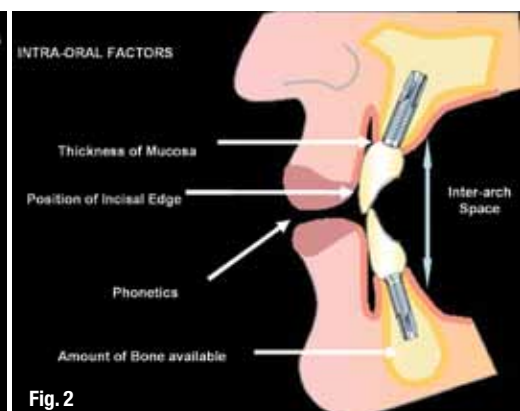


Fig. 2_Intra-oral factors in diagnosing the edentulous patient.



Fig. 3



Fig. 4



Fig. 5

• *Anatomic.* They have been told they are not implant candidates because of pneumatized sinuses and severe resorption of the posterior mandible.

• *Cost.*

• *Lack of education.* They have not been educated about dental implants and do not visit a dentist because they feel nothing can be done for them.

Restoration of the edentulous patients with dental implants is costly whichever method is used to restore the patient. Fixed reconstructions require more laboratory assistance and implant parts and, thus, are a lot more expensive.

Due to economic factors, many patients have been provided with implant- and mucosa-supported overdentures.

However, cost needs to be considered not only during fabrication of the prosthesis but also during maintenance. Overdentures seem to have more post-insertion maintenance than their fixed counterparts. If this is consistent, it could be questioned whether an economic indication for choosing an overdenture could be justified when there is sufficient bone to support implants for a fixed prosthesis. The patient must be made aware that maintenance costs for removable prostheses on implants will be higher than that of a fixed prosthesis.

Today, clinicians are seeing an increasing number of dentate patients where the dentition is terminal. These patients would have been edentulous a long time ago if it had not been for the efforts of skilled

restorative dentists. Clinical treatments have involved maintaining non-restorable teeth for as long as possible to avoid a removable appliance. Patients understand that maintaining a terminal dentition has consequences on the bone. However, the fear of edentulism forces them to ignore failing oral conditions.

In spite of the increasing numbers of edentulous or soon-to-be edentulous patients, there still appears to be many reasons why patients avoid treatment with dental implants. These reasons could include:

- The fear of wearing a removable appliance in the transitional phase.
- The notion that the proposed treatment is time-consuming and unpredictable.
- The number of visits involved and the fear of pain.
- Cost.

Most patients will look toward an implant rehabilitation hoping to acquire a fixed prosthesis. Treatment planning of edentulous patients with fixed restorations on dental implants has undergone a paradigm shift since the introduction of graftless solutions, and in particular, the All on 4 method.[™]

Today, patients have options whereby in the *right indication* complete rehabilitation can be accomplished by the use of four implants per arch. The huge advantage of this procedure is reduced number of implants and the ability to bypass extensive grafting procedures. This rehabilitation not only satisfies esthetics and function but also considerably reduces

Fig. 3 Lip support with denture in place.

Fig. 4 Lip support without denture in place.

Fig. 5 Lip support with denture in place.

Fig. 6 Lip support without denture in place look at collapsed facial architecture.

Fig. 7 Minimal resorption. Patient is missing teeth and minimal bone



Fig. 6



Fig. 7