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Every issue of implants magazine also contains a C.E. component. By reading the articles (beginning on Page 6) on “Decisions in implant treatment planning” by Dr. Kalman and “Simultaneous implant placement and provisionalization using a CATA in an avulsion site,” by Drs. Ross, Pette and Ross, and then taking short online quizzes on the articles at www.DTStudyClub.com, you will gain one ADA CERP-certified C.E. credit.

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Decisions in implant treatment planning

Author: Les Kalman, BSc (Hon), DDS

Introduction

Dental implant treatment represents an elective phase that requires a significant effort in diagnoses and treatment planning. Numerous decisions must be made, from surgery to laboratory prescription, to predictably guide the patient to the final stage of rehabilitation. An overview of the decisions required is presented to equip the practitioner with the appropriate information necessary to successfully render treatment.

Treatment sequencing

Dental implants represent an elective surgical and prosthetic component of dentistry. Prior to treatment, the oral cavity must be in optimum condition to accept this treatment modality. Extraction of selected teeth should be performed. Endodontic therapy should be initiated or finalized. The periodontium should be stable and free of active disease. Carious lesions should be filled or at least temporized to prevent the progression of disease (Fig. 1). Once essential oral cavity maintenance has been performed, implant treatment may then proceed. There may be situations that veer from this recommendation, such as immediate implant placement in an extraction site, but elective treatment should follow essential treatment.

Patient assessment

Prior to treatment, a thorough patient assessment should be made. This is rather extensive but should be reviewed prior to the surgical and prosthetic phase. The clinician should review the commitment of the patient, to ensure that treatment can be completed in a timely fashion. The clinician should provide a comprehensive informed consent, including treatment estimate, in terms of total time and cost. Explore the expectations of the patient, in reference to time and esthetic outcome. Assess the life factors of the patient to determine if treatment should be planned, postponed or avoided.

A thorough medical history is not only a legal but also an ethical requirement. Whether the health questionnaire is complex or simple, the relevant factors must be reviewed. Crucial factors that may impact treatment include but are not limited to: anticoagulants, biophosphates and diabetes. Studies have shown that patients experiencing periodontal bone...
loss prior to treatment are at higher risk of implant failure.2

An extraoral examination should then be rendered. Assess all factors, putting a specific focus on facial symmetry, the smile line, gag reflex and mandibular opening. The smile line and symmetry will guide esthetic concerns. The gag reflex and mandibular opening will predict the ease of surgery and delivery of the restoration.

A detailed intraoral assessment must be performed to assess oral hygiene, biotype, occlusion and any parafunctional habits. Good oral hygiene and resilient biotype are crucial for predictable surgical outcomes.3 Occlusion and parafunction are indicators for the consideration of a post-surgical occlusal appliance.

Particular attention should be made to site-specific factors (Fig. 2). These factors include basic anatomical considerations, such as the quantity of both horizontal and vertical bone, the quality and quantity of soft tissue and the possible need for hard- and/or soft-tissue augmentation.

A physical examination with ridge measurements should be employed. This will estimate quantity of both hard and soft tissues. If augmentation is expected, consideration should be made to the tissue type, whether auto or allograft material would be selected (osseous) and from what anatomical site.

Records

Records are an essential part of implant treatment and the clinician should decide what records to employ. Photographs, radiographs (panorex, periapical, occlusal) and cone-beam computer tomography are all viable options. Impressions, models and articulated casts represent the traditional simulation approach (Fig. 3) but virtual simulation has become popular (Fig. 4). A diagnostic wax-up predicts the number and location of teeth. Radiographic and surgical stents should be prosthetically driven and may be made in-house or outsourced. Radiographic assessment determines position and angulation of the proposed implant(s) and identifies accurate bone measurement.4 Make note of magnification.

Diagnoses

A complete list of diagnoses should be completed, listing all medical and dental conditions. Dental may include osseous and soft-tissue diagnoses. The prognosis for treatment plan should be reviewed, with emphasis on patient compliance. The classification of the case should be established. The ITI provides a simple online tool to classify according to simple, complex and advanced.

The patient should be made aware whether the implant treatment will be a limited approach, part of a larger comprehensive plan and whether the plan may be compromised due to limiting factors. Treatment expectations, financial obligations and consent should be presented to the patient in a realistic and understandable manner.4 At this stage, the clinician has the option to render all of the treatment, completely refer to a specialist or colleague or a combination of the two.

Surgical considerations

If surgery is planned, assess whether osseous and/or soft-tissue augmentation is required and if augmentation and implant placement will be
Implant treatment planning considerations include the choice between a flap or flapless approach, bone or tissue level placement, implant type, length, diameter and coating. Each choice has its own merits. A decision should be made whether surgery will be completed freehand, template assisted (Fig. 5) or template guided (controls alignment and depth). Templates should allow implant positions to be easily transferred to the site during surgery.

Following placement, consideration should be given to the healing period, loading protocol and provisional phase. Post-surgical assessment should evaluate implant location, angulation, stability and absence of pathology. Assess oral hygiene and patient compliance. Provisionals play a crucial role in guiding the soft tissue, and options include: partial transitional dentures (flipper), Essex retainers and single-unit abutments (Peek, titanium, Tempcap and custom lab fabricated) (Fig. 6). Tempcap allows for optimal gingival healing and prevents contamination of the surgical field.

Restorative considerations

Following healing, final impressions are required and may be executed either conventionally or virtually (with a scan). For conventional impressions, consider whether it will be an open- or closed-tray technique and the coping type. If scanning, note the specifications of the system and ensure your laboratory is compatible.

Digital impressions are gaining popularity because of ease and efficiency. Decisions regarding abutments include: stock, custom (Fig. 8), angled, what angle and what material.

Other choices include whether platform switching is required and whether pink material is necessary. Restoration options include: choice of material, retention type (screw vs. cemented), shade and color (pink), occlusal table size, type of occlusion, guidance and location of interfaces.

If results are compromised, consider delivering the abutment, impressing or scanning for the final restoration and fabricating a provisional. The final restoration would be delivered at a subsequent appointment.
Delivery and follow-up

Delivery considerations should include a standard prosthodontic evaluation to assess fit, form, function, esthetics and path of insertion and withdrawal for both the abutment and prosthesis. If results are compromised, should either the abutment and/or prosthesis be modified or remade?

Consider placing the abutment with light torque, then seat the crown to ensure optimal fit and esthetics. Once confirmed, verify abutment placement radiographically and then torque to specification. Then place the prosthesis. If the crown is cement-retained, clean all of the excessive cement. If the crown is screw-retained, seal the screw access.

Provide adjustments to establish ideal prosthetic relationships. Consider a final radiographic image (Fig. 9). Assess the patient and implant at post-delivery appointments to verify the outcome. Consider an occlusal splint option, if required. Provide recall intervals to assess and monitor the situation and identify potential complications.

Conclusions

With the appropriate diagnoses, treatment plan and decision making, implant therapy can be delivered in a predictable and successful manner. A carefully formulated plan will provide an optimal outcome, providing satisfaction to both the clinician and the patient.

Disclosure: Dr. Les Kalman is the co-owner of Research Driven and the developer of the Tempcap.

References


about the author

Les Kalman graduated from the University of Western Ontario with a DDS degree in 1999. He then completed a GPR at the London Health Sciences Centre. He has been involved in general dentistry within private practice since 2000. He has served as the chief of dentistry at the Strathroy-Middlesex General hospital. In 2011, he transitioned to full-time academics as an assistant professor at the Schulich School of Medicine and Dentistry. Kalman’s research focuses on medical devices, including the Virtual Facebow and the Tempcap. Kalman is also the director of the Dental Outreach Community Services (DOCS) program, which provides free dentistry within the community.

Kalman has authored articles ranging from pediatric impression to immediate implant surgery in both Canadian and American journals. He has been a product evaluator for several companies, including GC America and Clinician’s Choice. Kalman is a member of the American Society for Forensic Odontology, International Team for Implantology, Academy of Osseointegration, American Academy of Implant Dentistry and the International Congress of Oral Implantology. He has been recognized as an academic associate fellow (AAD) and diplomate (ICOI). In his spare time, Kalman enjoys photography as an accredited MotoGP photojournalist. He can be contacted at lkalman@uwo.ca.
Simultaneous implant placement and provisionalization using a CATA in an avulsion site

Authors: Scott B. Ross, DDS, Gregory A. Pette, DMD, MS, and Bradley A. Ross, DMD

Abstract

As implant dentistry has continued to evolve, so have success parameters that now focus not only on implant survival but also esthetics, health and stability of the hard and soft peri-implant tissues. A novel approach utilizing a customized anatomic temporary abutment (CATA) for immediate implant placement and provisionalization procedures allows for a more traditional crown and bridge method for both the surgeon and restorative dentist in order to maintain peri-implant hard and soft tissues.

In addition, platform-shifting implant systems have proven to be superior to butt-joint connection implant systems for long-term maintenance of hard and soft peri-implant tissues.

This technique article shows an approach toward achieving superior esthetic outcomes by utilizing ideal tri-dimensional immediate implant positioning, proper tissue augmentations, a CATA with a cement-retained provisional crown, a platform-shifting implant system and a minor restoration on the contra lateral tooth.

Key words

Dental implants, gingival recession, gingival biotype, immediate implant placement, immediate provisionalization, immediate loading, platform shifting

Introduction

Dental implant design and surface improvements have helped clinicians direct their treatment approach toward a more immediate timetable as well as a more esthetically driven one. Numerous reports on immediate implant placement and immediate provisionalization, as well as on early and immediate implant placement and loading protocols, have shown high degrees of success.1-4

Immediate implant placement and provisionalization protocols have been applied to the esthetic zone with the goal of maintaining and even enhancing the gingival architecture over time. Reports have shown excellent results with immediate implant placement and provisionalization by maintaining or developing the gingival contours and proper architecture in the...
anterior esthetic zone in fresh extraction sites.5-8 However, some studies have shown that marginal gingival recession does occur on a significant number of sites over time.9,10 With aesthetic concerns being at the forefront, clinicians are now focusing on five key parameters that are related to the risk of recession following dental implant restoration in the anterior esthetic zone.

- The location of the immediate dental implant platform should be palatally positioned in an incisor extraction socket or edentulous site.11-14
- The buccal bone should be maintained near the implant platform and mid facial line angle. When the implant is positioned toward the palate, the implant platform is at a farther distance from the buccal bone, resulting in a larger horizontal defect dimension (HDD). This larger HDD has been shown to better maintain the buccal bone and, thereby, reduce the risk of gingival recession.15-17
- The gingival biotype thickness plays a role in the potential recession that occurs; a lesser degree of recession has been associated with a thicker gingival biotype.18-20
- Flapless surgery has been shown to result in better hard- and soft-tissue stability, and can minimize marginal gingival recession.21-24 However, despite this focus on reducing surgical manipulation and its correlation on changes in gingival margin heights, recent studies are now reporting that gingival recession can still occur even with a flapless approach.25-27
- The implant–abutment final restoration interface and/or the temporary abutment and provisional restoration complex play a role.28-30 The shape, size and contour of the temporary abutment and provisional restoration complex can influence the development and management of the soft tissue. This then can determine the final emergence profile.31-33 Also by modifying the implant to abutment connection with an implant system that has the capability to platform shift, it has been shown to maintain long-term hard and soft peri-implant tissue stability.34-38 This further helps to enhance long-term stability of the gingival complex and the aesthetic outcome.9 These five key parameters should be the foundation for the protocol for immediate implant placement and provisionalization in the anterior esthetic zone, with the goal of maintaining hard and soft peri-implant tissues over time.

_Case report_

The following case report focuses on a technique that, beyond achieving implant integration, aims to achieve proper emergence profile development with the goal of maintaining hard and soft peri-implant tissues in the esthetic zone. This case also highlights simple restorative procedures used to overcome aesthetic challenges on a patient who declined ideal comprehensive treatment.

A 28-year-old male presented to the authors’ office after having tooth #8 traumatically avulsed eight days earlier while on his honeymoon. The residual edentulous ridge (post avulsion area) had a significant concavity on the buccal aspect, indicating a deficiency of...
The patient was given 2 grams of amoxicillin one hour prior to surgery and instructed to take 500 mg t.i.d. for five days. For postoperative analgesia, Dolobid (500 mg) was utilized two times a day (b.i.d.) for two days following completion of surgery. Under local anesthesia, a full-thickness flap was elevated on the labial aspect for access to the entire alveolar ridge and associated labial defect.

Preparation of the implant site was then completed following NobelActive (www.nobelbiocare.com) surgical drilling protocol along with the use of a surgical guide for precise restoratively driven implant placement. The surgical guide was fabricated from an impression taken preoperatively. Implant placement location was based on the tri-dimensional implant protocol.8,11,30

The implant platform was placed 1 mm to 2 mm to the palate and was centered mesial distally and approximately 3 mm apical to the proposed cemento-enamel junction (CEJ) of the final restoration as it relates to the existing gingival margin.40-43

Excellent initial implant stability was achieved (greater than 35 Ncm).8,12 The implant placed (Fig. 2) was a 4.3-mm x 13-mm NobelActive® (Nobel Biocare), with a significant portion of the implant body being exposed due to the deficiency on the labial dehiscence. The exposed threads of the implant were grafted with a freeze-dried bone allograft (FDBA) (Fig. 3) (Puros®, Zimmer Dental, www.zimmer.com) and a collagen resorbable barrier membrane (Fig. 3) (Ossix® Plus, OraPharma, Inc., www.orapharma.com).

Restorative protocol

Following the placement of the implant and completion of the surgical phase of the treatment, a stock polyether ether ketone (PEEK) temporary abutment (Nobel Biocare) was used with an auto-cured composite (Systemp®, Ivoclar Vivadent, www.ivoclarvivadent.com) to develop a CATA for a cement-retained provisional restoration (Fig. 4).29
The composite was added to extend over the entire length of the temporary abutment and allowed to auto-cure to a solid state.

The CATA was then contoured for the desired emergence profile as it was passively seated into the implant without encroaching on the osseous crest interproximally. With the desired contours established, along with the location of the gingival margin, the desired length for occlusal clearance and room for a provisional restoration in mind, the unfinished CATA was then removed and finished, exactly mimicking that of the tooth to be replaced or the normal physiologic shape at the CEJ area.

In establishing the desired emergence profile, the focus was to not over-contour the composite and thus compromise the gingival contours, as this could lead to future gingival recession and gingival changes.30,31,33,43 The facial contour of the CATA was either flat or under-contoured. The majority of the contouring was completed out of the mouth.

Once finished with the desired shape, the CATA was then hand-tightened to approximately 15 Ncm to the implant. Then, 5-0 chromic gut sutures were placed to adapt the surgical flap in the desired position against the CATA (Fig. 5). Using either a diamond or a fissure bur with copious water, the final preparation of the CATA was then completed, achieving gingival margin contour on the labial, interproximal and lingual for final restorative margin placement.

The composite margin was prepared to approximately 0.5 mm supragingival for the provisional crown margin access to ensure total removal of excess cement. Vinylpolysiloxane (VPS) impression material was then placed into the abutment chimney and covered with a composite material to create a solid abutment complex.

A provisional restoration was then fabricated and cemented using routine crown and bridge procedures. The radiograph of the implant, CATA and provisional restoration showed a radiolucent space at the implant–abutment interface. This radiolucent space at the implant–abutment connection was due to the lucency of the PEEK material of the temporary abutment and allowed to cure to a solid state.

The patient was given oral hygiene instruction and was advised to avoid any function on this implant provisional restoration for approximately three to five weeks.49 At the first follow-up at 14 days, the patient stated that he was extremely unhappy with the esthetic appearance of the over-contoured crown and wanted a better solution without irreversibly changing or touching the adjacent teeth.

Therefore, the cemented immediate provisional crown was easily removed from the CATA. This left the CATA intact and connected to the immediately placed implant, not affecting or disturbing the healing of the gingival complex, bone grafting or compromising the stability of the implant during the initial phases of osseointegration (Fig. 7).45,46

With new consent from the patient, composite resin was bonded to the mesial of #9 to establish a more symmetrical and better shaped central incisor that could be matched with a new provisional crown on the implant #8. The new provisional crown was completed without touching or changing the existing CATA or disturbing peri-implant soft-tissue complex.

With this technique of placing a CATA and a cement-retained restoration, the development of the emergence profile and soft-tissue contours is never disrupted nor is the process of osseointegration of the implant. The new provisional crown was then cemented with a radiopaque provisional cement, and excess cement was easily removed due to the supragingival margins (Fig. 7).47

With the new provisional restoration, the patient was very satisfied. The patient then returned to the office for follow-up visits at four weeks, six weeks and at three months. At the three-month post-op visit, implant restorative procedures for the final implant crown were initiated. Waiting three months enabled the emergence profile to develop and achieve stability, ultimately allowing for excellent soft-tissue contours (Fig. 8).48-51

At this time the CATA and provisional crown were removed, revealing excellent soft-tissue development. A fixture level impression technique was used to capture the emergence profile developed with the CATA; this was the first time that the CATA and provisional restoration were removed. This allowed for maximum stability and maturation of the gingival complex and emergence profile.48-51

A closed-tray fixture level impression coping (Nobel Biocare, NobelActive) was then passively placed into the fixture without compressing, expanding or changing the emergence profile created in any way, capturing the exact shape of the emergence profile created for duplication in the laboratory phase. If significant space between the emergence profile and the impression coping exists, then placing light-cured flowable composite in the gap between the impression coping and the gingival
complex or the subgingival contours of the provisional were replicated and transferred to the impression post.

The laboratory was given an impression that exactly matches the developed emergence profile. A patient-specific Proceras® Zirconia abutment (Nobel Biocare) was then fabricated to exactly replicate the specific emergence profile. The abutment was then placed and torqued into the implant (35 Ncm) without putting pressure on and compromising the gingival complex. An optimally contoured ceramic crown was fabricated and cemented. The four-year follow-up showed excellent stability of the hard- and soft-tissue complex with no gingival recession (Fig. 9) and maintenance of crestal bone levels (Fig. 10). The immediate functional and esthetic result was beyond satisfactory to the patient.

**Discussion**

Success of implant dentistry in the esthetic zone is now judged by the integration of the restoration with the gingival complex, along with the development of the soft-tissue emergence profile and sustaining it over time. Various techniques, both surgically and restoratively, are being developed to accomplish this goal. Strong consideration should be given to the implant-abutment-restoration interphases. This aspect can greatly alter the shape of the emergence profile and ultimately affect the esthetic outcome.

The purpose of this article was to present a technique utilizing a platform-shifting implant and a CATA to enhance proper subgingival contours with immediately placed implants in the anterior esthetic zone. By doing so, the proper emergence profile can be developed and sustained in the peri-implant gingival complex. This technique has a significant clinical effect when an implant is immediately placed with an immediate provisional in a fresh extraction site.

This provisionalization technique can also be applied to most anterior implant cases even when the implant protocol is delayed. The exact shape of the pre-existing emergence profile (extraction site), or the proposed emergence profile desired can be optimally contoured with the use of a CATA, and ultimately transferred into the final abutment. This stability of the peri-implant hard- and soft-tissue complex then increases the potential for a more acceptable and desirable esthetic outcomes.

**Conclusions/outcomes**

This technique of utilizing an immediate cement-retained provisional restoration and a platform shifting implant also resembles a more traditional crown and bridge approach, which is user-friendly to most restorative dentists. The success of this case is not only related to the proposed restorative techniques but also proper case selection for immediate placement/provisionalization in the anterior esthetic zone. Certain clinical situations, including inadequate primary implant stability, hard- or soft-tissue deficiencies requiring extensive augmentation procedures and poor patient compliance, may not be appropriate for this technique and must be recognized during treatment planning.

References are available upon request from the publisher.

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LVI Core I course is designed for doctors and their teams to learn together

Author: Mark Duncan, DDS, FAGD, LVIF, DICOI, FICCMO, Clinical Director, LVI

As a patient, I expect the best care I can find. As a doctor, I want to deliver the best care possible. That takes us to the power of continuing education, and as doctors we are faced with many choices in continuing education.

As a way to introduce you to the Las Vegas Institute for Advanced Dental Studies, or LVI, I want to outline what LVI is about and what void it fills in your practice. The alumni who have completed programs at LVI were given an independent survey, and unlike the typical surveys, 99.7 percent said they love practicing dentistry, and of those surveyed, 92 percent said they enjoy their profession more since they started their training at LVI. That alone is reason enough to go to LVI and find out more.

While the programs at LVI cover the full breadth of dentistry, the most powerful and life-changing program is generally reported as being Core I, or Advanced Functional Dentistry – The Power of Physiologic-Based Occlusion. This program is a three-day course that is designed for doctors and their teams to learn together about the power of getting their patients’ physiology on their side. In this program, doctors can learn how to start the process of taking control of their practice and start to enjoy the full benefits of owning their practice and providing high-quality dentistry.

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We will discuss why some cases that doctors are asked by their patients to do are actually dangerous cases to restore cosmetically. We will discover the developmental science behind how unattractive smiles evolve and what cases may need the help of auxiliary health care professionals to get the patient feeling better. The impact of musculoskeletal signs and symptoms will be explored and how the supporting soft tissue is the most important diagnostic tool you have – not simply the gingiva, but the entire soft-tissue support of the structures and not just in the mouth but also in the rest of the body.

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- 3.7
- 4.3
- 5.0

2 Platforms (mm)
- 3.0
- 3.4

6 Lengths (mm)
- 6
- 8
- 10
- 11.5
- 13
- 16

Nobel Biocare price
- $227
- $194
- $232
- $233
- $235
- $238

Implant Direct price
- $120
- $85
- $100
- $100
- $40
- $80
- $100
- $120

Reality Check Savings
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- $100
- $95
- $132
- $103
- $N/A
- $135
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As a readily available bone-grafting material, allograft solutions provide a stable framework for regeneration of bone without the morbidity associated with second surgical site. Specific to dental implant treatment, the sufficient quality and quantity of bone play critical roles in the long-term success of treatment outcomes. In many cases, buildup of missing bone before or at implant placement is essential for establishing a sufficiently dimensioned osseous base for predictable

Author: DENTSPLY Implants Staff

Fig. 1. Miller Class II recession defect (8 mm) on canine tooth #11. 
(Photos/Provided by David Wong, DDS)

Fig. 2. Thick PerioDerm is sutured over the exposed root surface followed by complete coverage. PerioDerm can be placed with either side facing the roots.
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_Planning for success_

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Surgical drive instruments face anatomical limits when extracting wisdom teeth: The cheek obstructs straight handpieces in the case of small mouths, or the distal molar makes burr access difficult for contra-angle handpieces. In either case, the new surgical contra-angle handpieces from W&H offer an intelligent solution — even for wide apical tooth sectioning.

The dental handpieces WS-91 and WS-91LG combine the advantages of surgical straight and contra-angle handpieces for the first time ever (Fig. 1). The extended angle between the shank and burr axis allows good access to the tooth row both buccally and occlusally (Fig. 4). Displaced teeth can be comfortably sectioned (Figs. 6 and 7).

The dentist also has a significantly better view of the surgical site than with the instruments previously available.

Dr. Mario Kirste from Frankfurt/Oder had this to say, “If I turn the contra-angle handpiece head slightly, I can work particularly quickly and safely in the retromolar region. The instrument has the potential to reconcile the contrasting positions taken up by the users of straight and contra-angle handpieces.” (Figs. 2-5)

Power plus hygienic safety

The new contra-angle handpieces WS-91/WS-91LG are real powerhouses at the same time. Their transmission ratio of 1:2.7 results in a speed of up to 135,000 revolutions per minute. The key factor, however, is their high power combined with a surgical motor.

The contra-angle handpieces achieve an effective power of more than 2 Ncm on the working part of the burrs, making them almost three times as powerful as standard dental contra-angle handpieces combined with an electric dental motor.

Biologically necessary and hygienically safe cooling is also taken care of: An external triple spray cools the rotating instrument with a sterile saline solution. As with all dental handpieces from W&H, the surface of the new contra-angle handpieces is...
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industry W&H

scratch-resistant and therefore easy to clean. They can also be easily disassembled without tools, according to W&H.

_Successful balance_

Apical resection is another indication for the contra-angle handpieces WS-91/WS-91LG. The sophisticated geometry ensures excellent vision in cases involving maxillary molars and small mouths. In the WS-91LG, a mini LED+ also illuminates the operating area with daylight quality.

“The new contra-angle handpieces are a really successful balance. This amazing technical achievement by W&H extends my viewing angle and my options in routine surgery,” Kirste said._

“If I turn the contra-angle handpiece head slightly, I can work particularly quickly and safely in the retromolar region.”
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ZEST Anchors introduces CHAIRSIDE, a new and unique attachment processing material

_ZEST Anchors, the manufacturer of the LOCATOR® Attachment and LOCATOR Overdenture Implant (LODI) Systems, introduces the company’s newest product for overdenture cases: CHAIRSIDE Attachment Processing Material.

ZEST has a long history of producing overdenture products, and clinicians will find that CHAIRSIDE Attachment Processing Material is no different, the company asserts.

CHAIRSIDE is designed for ease of use and predictability when processing attachment components into overdentures, including ZEST’s LOCATOR and SATURNO™ Denture Caps. Clinician input contributed to a formulation that has the most sought after handling characteristics. It requires no primer and is self-curing — all at a reduced cost per case.*

“CHAIRSIDE Attachment Processing Material by ZEST Anchors is a game-changer!” said Dr. Michael Scherer of Sonora, Calif. “Zest has developed a material that is perfect for processing attachments ... It’s so easy to use, no messy primer is required, and the material offers dual-curing flexibility [self or light], thereby making the time I spend connecting the denture caps to the overdenture highly efficient and effective.”

ZEST is convinced that you will quickly realize the benefits CHAIRSIDE will bring to your practice. For more information, please call (800) 262-2310 or visit the company’s website at www.zestanchors.com.*

* As compared with other leading brands.

_About ZEST Anchors

ZEST Anchors is a global leader in the manufacturing and distribution of dental solutions for the treatment of edentulous patients. For more than 40 years, ZEST Anchors has led the way in the overdenture market, receiving worldwide acclaim for pioneering the pivoting and self-aligning design of the LOCATOR Attachment System. Compatible with more than 350 implant products, LOCATOR is globally distributed in more than 45 countries. ZEST Anchors continues to build on its solid foundation and commitment to its customers by consistently introducing new product innovations, giving clinicians the tools to provide world-class overdenture solutions to their patients. ZEST Anchors is located in Escondido, Calif., and has global distribution through OEM implant companies and distributor networks.
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Implant Direct offers new InterActive Implant System

Author: Implant Direct Staff

With the introduction of the InterActive Implant System, Implant Direct’s portfolio of implant solutions featuring simply smarter design and industry compatibility has expanded to include a 12-degree conical connection that is compatible with NobelActive.1

This new system with four implant diameters (3.2, 3.7, 4.3, 5.0 mm), six lengths2 (6, 8, 10, 11.5, 13 and 16 mm) and a range of prosthetic options offers several design advantages to simplify both surgical and restorative procedures.

_Simply smarter surgery_

The InterActive implant design incorporates several popular features including flat-based buttress threads. Unlike other leading conical connection implants, the InterActive’s coronal portion is matched to the thread dimensions of the implant to seal the opening at the crest of the ridge, according to Implant Direct.

A combination of micro-grooves and microthreads improves tissue attachment and increases stability, which aids in reducing crestal stress. Three long cutting grooves facilitate self-tapping inser-

_Simplified soft-tissue management_

Included in InterActive’s convenient all-in-one packaging is a cover screw, 2 mm extender/healing collar, final abutment fixation screw and a patent-pending fixture-mount. The fixture-mount aids in delivery, impressioning and functions as a final abutment, the company says.

Both the fixture-mount and the 2 mm extender/healing collar feature a concave transgingival...
SNEAK PEEK OF SPEAKER LINEUP

Gordon Christensen, DDS, PhD
Restorative

Bruce Christopher
Practice Management

Karen Davis, RDH
Hygiene

Robert Edwab, DDS
Oral Surgery

Debra Englehardt-Nash
Front Desk

Kenneth Hargreaves, DDS, PhD
Endodontics

Niki Henson, RDA
Auxiliary Techniques

Paul Homoly, DDS
Practice Management

Tieraona Low Dog, MD
General Health

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profile allowing for a thickening of the soft tissue around the implant/abutment connection. This soft-tissue design has been said to promote improved blood supply and prevention of bone loss for a better long-term esthetic result, the company asserts.

Additional ancillary components and prefabricated abutment options feature a matched profile for consistent shaping of the soft tissue throughout treatment. InterActive’s versatile prosthetic selection also provides a variety of profile height choices as well as patient-specific CustomDirect™ titanium abutments and bars to treat a range of clinical situations.

IQity Impression Technique

Critical to implant treatment success is the transference of the three-dimensional spatial position of the implant platform from the mouth to the dental laboratory technician in order to create the final restoration, according to Implant Direct. While the digital workflow is gaining popularity in assisting this treatment process, there still remains the need to have an accurate method for traditional impressioning. The InterActive fixture-mount is designed to provide the accuracy of an open-tray transfer with the simplicity of a closed-tray transfer via the IQity Impression Technique.™ The square top of the fixture-mount detaches with the impression for metal-to-metal transfer accuracy (Figs. 1a, 1b, 2a and 2b).

Complete seat confidence

The need to take an X-ray to confirm full seating of an abutment can be common with conical connection implants because of the depth of the anti-rotational feature within the internal shaft. Some other conical connection implant systems even includes this step in its standard protocol.

InterActive abutments have been designed with a longer hex (anti-rotational feature) that will be visible above the top of the implant when not fully seated, thereby reducing the need for confirmation via an X-ray.

References

1) InterActive implants compatible with NobelActive titanium abutments up to 15-degree angulations. InterActive straight titanium, straight temporary and 15-degree angled titanium abutments compatible with NobelActive implants.
2) 6 mm length not available for 3.2 mm diameter implant.

‘A combination of micro-grooves and micro-threads improves tissue attachment and increases stability, which aid in reducing crestal stress.’
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