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on the cover
Cover image provided by Dentsply Sirona: Discover a new solution for sloped ridge situations. Instead of augmenting sloped ridges to accommodate flat-top implants, it’s time to discover a simpler solution by using an implant that follows the bone. With OsseoSpeed Profile EV, you can leverage the unique implant design to follow the natural contours of the sloped anatomy and maximize existing bone, for optimized esthetics and marginal bone preservation.
‘OsseoSpeed Profile EV: Challenge conventional thinking.’
OUR WORLD IS NOT FLAT

NEITHER IS THE ANATOMY OF YOUR IMPLANT PATIENTS

Your world is already full of clinical challenges so why work harder because of conventional thinking? Instead of augmenting sloped ridges to accommodate flat-top implants, it’s time to discover a simpler solution by using an implant that follows the bone. Because sloped-ridge situations call for anatomically designed sloped implants.

OsseoSpeed™ Profile EV
It’s time to challenge conventional thinking
The ultimate goal of tooth replacement in the esthetic zone is an inconspicuous transition from dental restoration to the patient’s natural, biologic tissues. This transition is evaluated at many levels. Color and contour of gingiva at the interface must mimic the natural contours and color of adjacent and contralateral teeth.

The dental restoration must match contour and blend seamlessly into the existing dentition. Color matching of final crown must be consistent with existing dentition. (hue, chroma and value) This case study explores the management and correction of a previously treated implant-retained maxillary central incisor.

The patient presented as a healthy, 48-year-old female with no contributory health history to prohibit dental treatment. Recent dental history revealed an Ankylos implant to replace tooth #9 had been placed approximately five months prior to this visit. The implant had been uncovered and a temporary abutment was placed.

A ridge lap provisional restoration was fabricated to fit the coronal portion of the abutment. The result-ant provisional was not only unesthetic but also was the source of considerable tissue inflammation and patient discomfort (Figs. 1-3). Patient reported dissatisfaction with the provisional treatment and was seeking a more desirable solution.

Clinical evaluation revealed a well-placed implant with acceptable position both facio-lingually and mesio-distally. Additionally, there was good volume of soft tissue and ridge form was ideal. Surgeon reported that the implant was well-integrated in bone. There was a poorly adapted provisional restoration over an inadequately contoured provisional abutment. Radiograph revealed excess acrylic that extended well into the dental sulcus all the way to the implant platform (Fig. 4). This acrylic did not provide any emergence profile support of transmucosal tissue.

The provisional restoration was poorly adapted to both the abutment and to the ridge crest soft tissue. Intaglio surface was rough and made in such a manner as to create a ridge lap profile. The facial and proximal surfaces of the provisional were fitted over soft-tissue crest. There had been no attempt to modify gingival tissue emergence profile or to create the environment for inconspicuous transition from restoration to biologic tissues.

Techniques for managing emergence profile are well-documented in the literature. Interproximal tissues will point and form papillae when appropri-
ate lateral pressure is applied with a temporary abutment when natural teeth are on either side of the implant. The adjacent bone height will dictate the level of the papillae assuming the restoration and its associated abutment properly support them. Facial contour can be manipulated to create appropriate gingival zenith height by increasing or decreasing facial emergence profile. Increasing the profile will move the gingival zenith apically and reduction of contour will move the crest incisally. Treatment plan consisted of removal of temporary abutment/provisional crown, fabrication of a temporary partial denture (Figs. 5,6) and placement of an appropriate temporary abutment that did not retain a provisional crown (Ankylos sulcus former) (Fig. 7).

This sulcus former, as its name implies, would provide soft-tissue emergence profile support. The partial denture was to be placed to avoid interference with the sulcus former when fully seated (Fig. 8). Patient was to be recalled in one-week intervals to evaluate the response to this treatment. Once healed, a final, customized abutment and cementable all-ceramic crown would be delivered.

The plan was followed per previous description. Postoperative visits were uneventful. Patient comfort was immediate. Tissue health and emergence profile were deemed appropriate at the second week recall visit (Figs. 9, 10). At a subsequent appointment, the sulcus-forming abutment was removed, a closed tray impression coping was placed and an impression (Identium, Kettenbach) was taken for fabrication of final restoration (Figs. 11, 12). Appropriate opposing model, bite registrations and facebow accompanied the case to the laboratory. A careful shade map and clinical photography were included. Clinically, it was determined that this would be a difficult shade because of surface characteristics and maverick colors of the adjacent central incisor. Arrangements were made to have a laboratory technician available at the delivery appointment. Sulcus former and temporary partial were reinserted and patient was dismissed and scheduled for delivery appointment. All model work was accomplished. The laboratory was given the option of fabricating a custom abutment or customizing a stock abutment. This Fig. 3. Provisional lateral intaglio.

Fig. 4. Provisional abutment and crown.

Fig. 5. Impression for temporary partial.

Fig. 6. Temporary partial.

Fig. 7. Ankylos sulcus former.

Fig. 8. Temporary partial placed.

Fig. 9. Tissue healed and emergence profile established at two weeks.

Fig. 10. Sulcus former removed.
decision was to be based on the trajectory of the abutment relative to the position of the implant. The placement of the implant was ideal and the use of a lab-modified, stock abutment was selected (0 degree Cercon Balance Abutment, Dentsply Implant).

The contour correlation between the sulcus former and the emergence profile of the stock abutment complement one another. The margins were placed 1 mm subgingivally on facial, mesial and distal. The lingual margin was placed at .5 mm.

Once the abutment was perfected, an all-ceramic crown was fabricated (eMax, Ivoclar). This crown was waxed to full contour, and then the facial was cut back to provide a field into which a customized facial surface could be developed from added porcelain. The wax pattern was invested and pressed. The resultant crown was then modified with additional application of porcelain and was left preglazed in anticipation of chairside staining7 (Figs. 13, 14).

The delivery appointment was uneventful. The lab provided a seating jig that simplified the positioning of the customized abutment (Fig. 15). The abutment was torqued to manufacturer’s specification (Figs. 16, 17).

The crown was tried in and adjustments were made to proximal contacts and to occlusion. A dental laboratory technician was enlisted to provide custom chairside staining to perfect the color match. Both patient and clinician were satisfied with the resultant restoration (Fig. 18). The patency of the abutment screw channel was protected with compacted silicone tape, and the restoration was seated with implant cement (Premier Implant Cement, Premier).

Great care was taken to avoid excess cement and to protect the sulcus from any incursion of residual cement extrusion from margins.8 A crown-seating jig was provided by the laboratory to be used for removal of excess cement prior to seating of the crown.

Patient was rescheduled at a two-week interval for a final evaluation and photography. She was extremely satisfied with both the esthetics and comfort of the definitive restoration. Clinically, the restoration met the criteria for an inconspicuous restoration (Figs. 19, 20).

**Conclusion**

Understanding of the soft-tissue interface with implant-supported restorations is critical, fundamental knowledge. All practitioners whose goal is to deliver inconspicuous restorations should practice these concepts. This case study revealed the stark contrast between tissue-management protocols. There is no place in contemporary implant dentistry for ridgelap crowns assuming appropriate pretreatment parameters are met.

The esthetic zone must be evaluated prior to implant placement and any modification of the ridge form should be taken into consideration well in advance of implant placement surgery.9-11
Surgery should be driven by prosthetic requirements. Once surgery is accomplished, it is imperative that restorative clinicians understand how to manipulate the peri-implant soft tissues.

All of this tissue management is critically important. However, then comes fabrication of the final restoration. The abutment must be designed in such a way as to conceal the crown/abutment interface. Furthermore, it must allow for adequate crown thickness to have appropriate strength to withstand mastication forces and still remain retentive. The final contours of the crown must be managed in such a way as to blend into the existing dentition.

This patient did not have a symmetrical arch form. The lateral incisors were not bilaterally symmetrical nor were the incisal edges consistent. Finally, the color match of the restoration, especially a central incisor, must be as identical as possible to the existing dentition. None of these parameters can be accomplished without precise communication and excellent laboratory workflow.

This case was a success based upon all previously described parameters. The gingival contour was essentially mirror image identical to the adjacent central incisor. Papillae were intact. The laboratory was skilled at modification of the abutment so that the margins were concealed within the sulcus. The axial and incisal contours of the abutment provided adequate clearance so that a proper thickness crown could be developed.

This is critical for both esthetics and for long-term strength and stability of the definitive restoration. The technician selected the appropriate ingot of ceramic material to serve as substrate for the subsequent application of modifying porcelain and surface staining. Final color matching could not have been accomplished without skilled hands and eyes of a technician at chairside.

Close communication and strong laboratory relationships, along with appropriate clinical understanding of soft-tissue management, leads to success. The inconspicuous final result of this case could never have been accomplished without strong support from the dental laboratory.

Note: Dr. Holt would like to extend thanks to the exceptional team at Drake Precision Laboratories for providing all laboratory support for this case.

 Larry R. Holt, DDS, FICD, graduated from the UNC School of Dentistry in 1978. He was in private practice from 1978-2008. Since 2008, he has been the director of clinical education and research at Drake Precision Dental Laboratories in Charlotte, N.C.
Case report: Immediate loading of intraorally welded implants

Authors_Drs. Luca Dal Carlo, Paolo Squillantini, Mike Shulman, Sheldon Winkler, Enrico Moglioni, Roberto Donati, Marco Pasqualini and Franco Rossi

_The ‘Auriga Protocol’_

_Dr. Luca Dal Carlo developed the “Auriga Protocol” for general dentists and specialists. The Auriga technique is indicated for implant rehabilitation in edentulous patients. The purpose of the Auriga technique is to facilitate treatment from the partially or completely edentulous state to a full-arch fixed implant-supported restoration. There is no down time when the patient has a removable prosthesis. Through all phases of the Auriga treatment technique, the patient has fixed teeth. The Auriga protocol can also eliminate costly and complicated sinus augmentation procedures. Auriga protocol can be used for lower jaw rehabilitations as well.

This technique was presented for the first time in 2007 at the seventh AISI International Implant Congress in Bologna, Italy, and has been improved upon throughout the years.

Ten-year statistics for 14 full-arch cases with 121 implants and 193 prosthetic teeth, completed by the authors of this article, confirm the validity and reliability of this procedure. No failed cases were observed during this time period.

_Advantages of the Auriga Protocol for the clinician_

The need for a provisional denture, either complete or partial is eliminated. A maxillary sinus grafting procedure is unnecessary. Occlusal function will be restored with the benefit of a complete posterior tooth arrangement.

_Advantages of the Auriga Protocol for the patient_

All of the advantages of a fixed prosthesis as compared to a removable prosthesis apply, including primarily the added comfort and experience of not having to function with a removable appliance. The need for a maxillary sinus augmentation...
with its cost, possible discomfort and potential complications are eliminated.

Additionally, advantages include a restored physiological occlusion with improved masticatory efficiency results.

_Technical procedures_

The Auriga technique consists of placing one piece of submerged screw implants in the right and left tuberosity regions. After four to six months, the patient’s remaining periodontal involved teeth are extracted and replaced with implants.

All of the implants are stabilized by means of intraoral welding to a titanium bar and a provisional prosthesis cemented with temporary cement. There is no need for a removable interim prosthesis.

The definitive fixed prosthesis is fabricated and inserted after the implants’ integration.

_Case report_

A healthy 63-year-old Caucasian woman presented for treatment at the office of one of the co-authors (LDC) with a metal-ceramic fixed prosthesis supported by natural teeth on the upper center right side and an implant-supported prosthesis on the left side.

All of the teeth supporting the prosthesis had massive secondary decay and endo/peri problems. Patient’s remaining teeth were non-restorative.

The first step of the Auriga technique involved the insertion of endosteal implants in right maxillary tuberosity region (Figs. 1, 2).

After allowing for six month of healing, all remaining natural teeth were extracted along with the fixed prosthesis. Six root-form titanium implants were inserted immediately after extractions (Figs. 3a, 3b) and welded with the existing implants to a titanium bar (Figs. 4a, 4b). A provisional prosthesis was cemented with temporary cement (Fig. 5).

By inserting a prosthesis with adequate retention and stability the same day as the surgery, patient complaints and discomfort can be avoided or substantially reduced. The instantaneous sta-
The Auriga technique, which includes intra-oral welding, allows immediate loading of entire arches. Among the advantages are immediate stabilization of the implants, immediate provisionalization, reduced risk of failure during the healing period, elimination of errors caused by unsatisfactory impression making and a potential reduction in patient complaints and discomfort.

Conclusion

The purpose of the Auriga technique is to facilitate treatment from the partially or completely edentulous state to a full-arch fixed implant-supported restoration.
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American Academy of Periodontology to host 102nd annual meeting

The American Academy of Periodontology (AAP) will hold its 102nd annual meeting from Sept. 10–13, 2016, at the San Diego Convention Center in San Diego, Calif. This year’s event is presented in collaboration with the Japanese Society of Periodontology and the Japanese Academy of Clinical Periodontology.

The 2016 annual meeting provides more than 26 continuing education credits from an array of multidisciplinary courses relevant to those at all levels of the dental profession, from student to seasoned specialist. Sessions include hands-on workshops and state-of-the art practical courses on diagnosis and treatment methods, the latest technologies, clinical applications and practice management.

“This year’s annual session will welcome thousands of dental professionals from around the world, and we’re pleased to provide attendees with the opportunity to hear from periodontal thought leaders and innovators,” said Wayne A. Aldredge, DMD, president of the AAP. “All dental professionals are encouraged to join us in San Diego.”

Highlights of the AAP 102nd Annual Meeting include the following:

• Opening general session: Named one of U.S. News and World Report’s 14 pioneers of medical progress, Anthony Atala, MD, will share his insights on tissue engineering and clinical applications in regenerative medicine in “Technology and Innovation: Regenerative Medicine and 3-D Printing.” Atala’s work has been heralded twice by Time magazine, first in 2007 as one of the top 10 medical breakthroughs of the year and again in 2013 as one of the five discoveries that will change the future of organ transplants.

• Student/new periodontist series: These focused sessions are geared specifically toward those just beginning a career in periodontics, with topics highlighting pearls and pitfalls of residency, immediate implant placement and osseous surgery.

• Dental hygiene symposium: This interactive course will elevate the registered dental hygienist as a key partner in comprehensive periodontal care. Attendees can earn four continuing education credits during lectures on such topics as the use of lasers in periodontics, the detection of peri-implant disease and regenerative periodontics.

• CBCT Boot Camp: This intensive course will provide a comprehensive review of the concepts of imaging for implants, including image manipulation to produce clinically correct cross-sections and a systematic review of a CBCT volume.

To register for the AAP 102nd Annual Meeting or for more information, please visit www.perio.org/meetings, call (800) 282-4867, ext. 3213, or e-mail meetings@perio.org.

About the American Academy of Periodontology

The American Academy of Periodontology (AAP) is an 8,300-member professional organization for periodontists. Periodontics is one of the nine dental specialties recognized by the American Dental Association.
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‘The journey of innovating the clinical workflow has just begun’

From June 23 to 26, Nobel Biocare held its global symposium in New York City. The company held the event, which had a high-class educational program, at the Waldorf Astoria in Manhattan. As the official media partner of the event, Dental Tribune International had the opportunity to meet with Hans Geiselhöringer, president of Nobel Biocare and Dental Imaging, at the symposium for a short interview.

Dental Tribune International: Has the global symposium met your expectations?

Hans Geiselhöringer: We are extremely happy with the symposium because it has exceeded our expectations in every sense, regarding the record number of participants, the motivation of our team and customers to engage in discussions, as well as the quality of the speakers and their presentations. We have always had high standards at our meetings, but I must say that I was really thrilled by the way innovation was presented not only by our company but also by the clinicians and experts themselves.

In addition, I found the NEXT GEN forum in particular incredible, as it gave us confirmation that we are on the right track to doing more for the younger generation of implantologists. I was positively surprised to see how enthusiastic and open our young clinicians are to working hard with us to move this project forward.

Overall, we have seen at this symposium that the future is bright, and I strongly disagree with some critical voices that suggest that there will no longer be real innovations in implantology. In my opinion, the journey of innovating the clinical workflow has just begun.

With regard to training of the next generation of dentists, what role can or should Nobel Biocare play in implant education?

Education is key. We believe that it is very important that clinicians start the thought process for the clinical workflow early. We have some programs in place already and will promote these programs to help and support universities in the education of young dentists in implantology. For example, we support academic institutions and dental students through the provision of NobelClinician Software licenses for implant planning and patient communication.

How has the acquisition, which occurred at the end of 2014, by the dental platform of the Danaher Corporation affected Nobel Biocare’s business?

We have seen only positive effects. The transition into the dental platform has given us new opportunities to develop resources for innovation, marketing and sales that we would not have had without this partnership.

Collaboration with other brands within the platform has granted access to expertise that is allowing us to lead innovation in dentistry. We are learning from our colleagues and have gained tools that are helping us to refine our processes and accelerate results.

The new home of Nobel Biocare is a very good one.

The next big occasion in the dental event schedule is the International Dental Show in March next year. Are there even more innovations to come from Nobel Biocare?

I cannot disclose anything yet. However, I can tell you already that there will be significant innovations presented. The potential that we are going to bring to the market will be of the same magnitude as that experienced at the symposium over the past few days. Nobel Biocare will accelerate its delivery of significant and meaningful innovations, each developed with the well-being of the patient in mind.
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DRAKE [implant] DENTISTRY
AAID Annual Conference brings ‘Excellence in Implant Dentistry’ to New Orleans

Author_AAID Staff

The American Academy of Implant Dentistry’s 65th Annual Educational Conference will be held Oct. 26–29 at the Hyatt Regency New Orleans. Attendees have the opportunity to earn as many as 23.5 hours of continuing education credit focused on implant dentistry. More than 60 individual sessions, including nearly two dozen hands-on workshops and limited-attendance seminars, are offered. In-depth learning opportunities include full-day courses on implant placement and bone grafting on cadavers as well as a post-conference course on microsurgical principles in plastic periodontal and implant surgeries.

More than 1,000 implant dentistry professionals will hear keynote presentations from Leonard Bailey, MD, the pioneer in the field of newborn heart transplantation, and from Ed Zuckerberg, DDS, who will share his unique insights on social media for dentists. In addition, a live implant surgery will be broadcast to the conference with the opportunity to not only observe a procedure but ask the surgeon questions.

For three and one-half days, world-renowned clinicians will present and demonstrate excellence in implant dentistry. More importantly, attendees will be able to take what they learn back to their office and put into practice immediately. More information about the conference can be found at aaid.com.

Established in 1951, the AAID asserts that it is the only dental implant organization that offers credentials recognized by federal and state courts as bona fide. Its membership, which exceeds 6,000, includes general dentists, oral surgeons, periodontists and prosthodontists from across the United States and in 40 other countries.

The academy is known world-wide for its bona-fide credentialing program in implant dentistry. The rigorous requirements, coupled with AAID’s commitment to educate patients about implant dentistry and the importance of using a knowledgeable, experienced and trained implant dentist, such as an AAID credentialed member, sets the academy apart.

More information about AAID’s consumer outreach can be found at www.aaid-implant.org.
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Glidewell Laboratories’ ‘Inclusive’ magazine available digitally now

Author: Glidewell Laboratories Staff

Glidewell Laboratories announced recently that the latest issue of Inclusive™ magazine, its multimedia publication focused on implant dentistry, is now available in print and across multiple digital platforms.

The digital edition of the new issue, Volume 7, Issue 1, as well as past issues of the dental laboratory’s quarterly magazine, can be viewed from all popular desktop, tablet and smartphone platforms by visiting www.inclusivemagazine.com.

The new issue includes an assortment of prominent authors, clinical tips and case presentations. The featured Implant Q&A spotlights Dr. Neil Park, a former general dentist who has spent nearly 25 years leading practitioner education programs and bringing key implant innovations to market. Read the article and watch the exclusive video interview as Park shares his thoughts on a wide range of topics (http://glidewelldental.com/education/inclusive-dental-implant-magazine/volume-7-issue-1/implant-qa-an-interview-with-dr-neil-park), such as the state of implant training in and outside of dental schools and the growing role of GPs in the surgical aspect of treatment.

The latest issue also features an article by Dr. Siamak Abai (http://glidewelldental.com/education/inclusive-dental-implant-magazine/volume-7-issue-1/achieving-lifelike-restoration-esthetic-zone), who presents a case in which four maxillary incisors are initially replaced with Bio-Temps® prostheses and then definitively restored with Obsidian® Pressed to Metal crowns, showcasing how modern prosthetics can help achieve a restoration that mirrors the appearance of natural teeth.

Screw-retained all-zirconia appliances have become a top choice among dentists, and an article featuring Dr. Jeffrey Fleigel III demonstrates three patient types that can gain significant benefits from the BruxZir® Full-Arch Implant Prosthesis.

In another article, Dr. Perry Jones demonstrates a case in which, using the immediate loading technique and a predictable treatment protocol, a dual-arch reconstruction results in outstanding strength, durability, fit and function.

Dr. Jack Hahn provides his insights (http://glidewelldental.com/education/inclusive-dental-implant-magazine/volume-7-issue-1/tooth-replacement-emergency-implant/) in an article aimed at practitioners desiring to grow their implant caseload, with strategies for identifying, educating and treating current patients. In another article by Hahn, same-day tooth replacement is achieved using the “emergency” implant protocol to produce favorable results.

After reading the articles, viewing the case photos and watching the videos, readers have the opportunity to take free interactive continuing education (C.E.) tests through the Glidewell Education Center. Inclusive magazine is published by Glidewell Laboratories and President/CEO Jim Glidewell, CDT. For more information about Inclusive magazine, call (800) 521-0576 or e-mail inclusivemagazine@glidewelldental.com.
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We can run an extra long article in multiple parts, but this is usually discussing a subject matter where each part can stand alone because it contains so much information. In addition, we do run multi-part series on various topics. In short, we do not want to limit you in terms of article length, so please use the word count above as a general guideline and if you have specific questions, please do not hesitate to contact us.

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Insert figure references in your article wherever they are appropriate, whether that is in the middle or end of a sentence, but before the period rather than after. Our preference is to have figure references noted in the appropriate place within the text as it helps the readers to orient themselves when moving through the article. In addition, please note:

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Please do not hesitate to contact us for our International C.E. Magazine Author Kit or if you have other questions/comments about the article submission process:

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