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Long-term clinical success in the management of compromised intertooth spaces utilizing small-diameter implants

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Thanks to continuous advancing technology, the field of implant dentistry is always growing, changing and evolving. Clinicians need to be vigilant in their efforts to keep up with the new techniques, new products and new technology that could affect how they plan implant treatment.

That’s just one reason the publication you are holding right now is so valuable.

As always, in this issue of implants, we’ve assembled a collection of articles from a variety of respected names and companies in dentistry. These expert clinicians are sharing their first-hand knowledge and expertise with you. In this issue, you can read about small-diameter implants, and you can also learn about immediate implant placement and provisionalization. We also have news on implant events and technology.

But that’s not all.

Every issue of implants magazine also contains a C.E. component. By reading the articles (beginning on Page 6) on "Long-term clinical success in the management of compromised intertooth spaces utilizing small-diameter implants," by Dr. Paul Petrungaro, and "Immediate implantation and provisionalization: Single-tooth restoration in the esthetic zone," by Dr. Susan McMahon and Karrah Petruska, and then taking short online quizzes on the articles at www.DTStudyClub.com, you will gain one ADA CERP-certified C.E. credit.

Keep in mind that because implants is a quarterly magazine, you can actually receive four C.E. credits per year out of your already busy life without any 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.

Finally, if you are interested in becoming a published author, we are always looking for experienced clinicians to write C.E. articles and offer their expertise to our readers. Contact Managing Editor Sierra Rendon at s.rendon@dental-tribune.com for more information on submitting an article.

I hope you enjoy this issue of implants and that it enhances your daily life in the dental office.

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Long-term clinical success in the management of compromised intertooth spaces utilizing small-diameter implants

Author: Paul S. Petrungaro, DDS, MS

Management of edentulous sites in the oral cavity with dental implants has been well documented in dental literature during the past 25-plus years. Patients seeking tooth replacement for partial or totally edentulous situations have been able to enjoy natural appearing and functioning prostheses that are fixed, stable and, in some cases, so natural it’s difficult to ascertain a dental implant restoration from a tooth restoration.

Using dental implants to replace the natural tooth system in the esthetic zone has also seen an increase in restorative treatment plans and, with the advent and perfection of immediate restoration protocols initially reported in the literature, achieving natural soft-tissue esthetics around dental implants can be predictable and successful. However, certain clinical situations can complicate or negate the procedure altogether.

One of these complications is insufficient intertooth spacing between natural teeth and, most commonly, with congenitally missing lateral incisors following orthodontic treatment. Often as a solution to this, the dentist chooses a removable partial denture or some type of resin-bonded bridge, both of which may not be appealing to younger individuals. In extreme cases, the dentist may elect to proceed with a fixed bridge, which would cause excessive destruction to the natural teeth serving as abutments and, for a young individual, this could be devastating to these teeth during a 40-50 year period, if not sooner.

To properly form an ovate pontic type emergence profile in the soft tissue, which is required for a fixed bridge to have a natural clinical appearance, consideration must be given to the intertooth edentulous space. This is also very important when choosing dental implants for natural tooth replacement. Wallace, Misch and Salama, et al. stated that for a normal two-piece implant, the implant should be placed at least 1.5 mm from the adjacent teeth. As a result, using a 3.5 mm diameter implant, the minimum intertooth space to support interproximal bone and natural soft-tissue papillary contours should be 6.5 mm, and with a 3.0 mm diameter implant, 6.0 mm for the edentulous space. Often, the intertooth space in these types of cases is smaller than 6.0 mm.

Taking these parameters into account, small-diameter implants (3.0 mm is the smallest from most dental implant manufacturers) should not be used in cases with less than 6.0 mm of intertooth space, to prevent potential tooth root damage, crestal bone loss and unnatural-appearing gingival tissues and papillae.

Small-diameter, or mini, implants were de-
veloped more than 20 years ago and, initially, the recommended use was to support temporary removable prostheses during the healing phase for advanced bone-grafting procedures and/or conventional implant placement.12-13

Their use was later expanded into immediate conversion of full dentures into implant-supported dentures, support for partially edentulous cases and for anchorage of single tooth implant restorations in compromised intertooth spaces.14-15

Implants are available from 1.8 mm diameter to 2.8 mm diameter and offer a fixed permanent tooth replacement option for patients who otherwise would not be able to have implants placed and restored. Their ease of use and atraumatic placement utilizing a flapless approach, with only one coring procedure, as well as simplistic abutment transfer and provisional construction make the use of these implants in the aforementioned sites a must for the dental implant practice.

The following case report will demonstrate the use of the Dentatus ANEW (Dentatus USA, Ltd, New York, N.Y.) implant for the management of the compromised, congenitally missing lateral space in a 17-year-old young woman with a 10-year clinical follow up.

_Case report_

A 17-year-old, non-smoking female presented for tooth replacement in the congenitally missing maxillary left lateral incisor site (Fig. 1). The patient had recently completed orthodontic therapy, and the orthodontist and general practitioner had agreed this was the final obtainable result in regard to the remaining intertooth space between the maxillary left central incisor and maxillary left canine (Fig. 2).

The resultant intertooth space was less than 5.0 mm, and conventional two-stage implants with abutment options were ruled out. The patient and her parents ruled out conventional tooth-replacement options and chose the minimally invasive procedure: a small-diameter implant, Fig. 1. Pretreatment clinical view. (Photos Provided by Dr. Paul S. Petrungaro) Fig. 2. Preoperative periapical radiograph. Fig. 3. Ovate pontic type defect created. Fig. 4. Dentatus ANEW implant seated minimally invasive protocol.
1.8 mm in diameter, which would allow for natural papillary contours to be developed.

After administration of an appropriate local anesthetic, an ovate pontic contour was created utilizing a football-shaped diamond in the attached, keratinized tissue of the edentulous site (Fig. 3). This scalloped-type tissue contour helps in the creation of the natural-appearing papillary contours.

The small-diameter implant chosen, a 1.8 mm x 14 mm Dentatus ANEW Implant was then placed after a single coring of the site with a 1.4 mm needlepoint CePo to full depth, within the sculpted tissue emergence profile previously created (Fig. 4). Conversion to an esthetic provisional restoration was completed by placing an abutment coping with a delrin retention screw (Dentatus USA, New York, N.Y.). An ion shell provisional crown was then hollowed out and retrofitted to the abutment coping with flowable composite. The margins of the provisional were corrected and provisional contoured out of the mouth.

The restoration was polished and seated with the set screw from the palatal. The immediate postoperative clinical view is seen in Fig. 5. The immediate postoperative periapical view is seen in Fig. 6.

The patient then went through the three-month healing and observation phase prior to construction of a lab-processed provisional restoration (Fig. 7). One year later, the patient underwent final restoration fabrication at the left lateral incisor site. A 10-year postoperative clinical image can be seen in Fig. 8 and a 10-year postoperative CT scan of the implant in Fig. 9.

Please note the beautiful soft-tissue esthetic result obtained and excellent maintenance of the crestal and lateral contours.

**Conclusion**

The management of compromised intertooth spaces presents a challenge for the contemporary dental implant team. These spaces have limits on how they are handled and require implants 3.0 mm wide or less, as was demonstrated in the text of this article. Availability of smaller-diameter implants allows patients who normally would have to proceed with a fixed bridge, or resin-bonded bridge, the luxury of dental implants with no preparation and/or reduction to the adjacent natural dentition.
Proper placement procedures and restorative techniques can lead to very esthetic results, allowing for natural tissue contours and emergence profile formation, reminiscent of the natural tooth.

_Acknowledgement

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_References


_About the Author

Paul S. Petrungaro, DDS, MS, FICD, FACD, DICOI, is internationally recognized for his educational and clinical contributions to modern dentistry. He graduated from Loyola University Dental School in 1986, where he completed an independent study of periodontics at the Welsh National Dental School in Wales, U.K. He completed his residency in periodontics and has a specialty certificate in addition to a master’s of science degree in periodontics from Northwestern University Dental School. He is the former coordinator of implantology, Graduate Department of Periodontics, Northwestern University Dental School. Petrungaro has been in the private practice of periodontics and implantology since 1988 and holds a license in both Illinois and Minnesota.

He has given numerous seminars and lectures on advanced periodontal, prosthetic and implant interrelationships, bone regeneration and esthetic tissue formation, the use of transitional implants, the immediate restoration of dental implants and the use of platelet-rich plasma in bone grafting throughout the United States, Europe, Canada, Australia, South America and Israel. In addition, he has written numerous articles on all of the above along with the topics of cosmetic bone grafting and esthetic implant procedures.

A consultant to numerous surgical companies and laboratories, Petrungaro contributes to many new innovations in the aforementioned disciplines of surgical dentistry. He is a fellow of the International & American College of Dentists and a diplomate of the International Congress of Oral Implantologists.
Immediate implantation and provisionalization: Single-tooth restoration in the esthetic zone

Authors: Susan McMahon, DMD, and Karrah Petruska

Anterior tooth loss and restoration in the esthetic zone is a common challenge in dentistry today. The prominent visibility of the area can be especially distressing to the patient and requires a timely and esthetically pleasing solution.

Immediate single-tooth implantation followed by immediate provisionalization is becoming an increasingly desirable treatment that offers numerous benefits over conventional delayed loading.

In the past, the non-restorable tooth was extracted and possibly grafted for site preservation. A removable partial denture (or flipper) was fabricated and placed for use during healing. After an adequate healing period, an implant was placed and buried under the gingiva, and the patient continued to wear the flipper until the implant had osseointegrated and was ready to be uncovered and restored. The patient would therefore wear the removable partial denture for upwards of six to eight months.

This course of treatment often results in a less than desirable gingival architecture surrounding the final restoration. There are also clear indications that partial removable dentures are an important causative factor in the alveolar bone resorption process.¹

Today, immediate treatment offers a better solution. Immediate implantation and same-day provisional replacement of single anterior teeth minimizes treatment time and cost while enhancing esthetic quality.²

In addition to alleviating patient trauma, this technique decreases resorption of hard and soft tissue and results in better function.² Overall, this leads to greater patient satisfaction.

In this process, the implant is placed and a provisional is quickly loaded. A nonfunctioning, also known as non-occluding, provisional is used in a protected occlusal scheme.

The placement of the non-occluding restoration must occur within 48 hours to be considered immediate loading.³ Both of the following cases received same day provisionalization.

The clinician faces several challenges when restoring teeth in the esthetic zone. Major cosmetic concerns in the fabrication of the immediately placed provisional are the retention of the interdental papilla and prevention of alveolar bone collapse.⁴ Research has suggested that immediate provisionalization following implanta-
implants

Immediate implantation and provisionalization allows for greater clinical control over the regeneration of tissue surrounding the site of extraction.5

Unfavorable alterations to the alveolar bone structure must be avoided using ridge preservation techniques and precautions in terms of osseous exposure.5 Immediate placement of the implant into fresh extraction sockets prevents the post-extraction resorption that occurs commonly with alternate forms of treatment, preserving the integrity of the alveolar ridge.6

A compromised implantation site is also a concern when dealing with tooth loss. Bone resorption may leave insufficient bone for implantation. Furthermore, a deteriorated gingival architecture produces an inferior esthetic. Immediate implantation into the fresh extraction socket allows the clinician to maintain the gingival tissue and create a more esthetically pleasing restoration.2

Minimum criteria for implant placement have been established for successful immediate loading. Rough quantitative values for insertion torque and implant stability quotient (ISQ) as well as surgical assessment play a role. Values as low as 15N-cm for insertion torque and 50 ISQ both resulted in successful provisionalization.

Additionally, the surgeon must assess where there is adequate bone support at the apex, at least 3 mm of circumferential bone, and primary stability of the implant. Research has shown that “early loading of dental implants does not appear to interfere with osseous modeling of a developing osseointegration as long as significant micromovement does not occur.”7

In addition to providing both esthetic and functional benefits, immediate implantation and loading of a nonfunctional provisional has also been found to result in comparable implant survival outcomes to more traditional techniques.

A recent study measuring clinical success, survival, and satisfaction found the technique to be “not less favorable than conventional loading.”9 In consideration of this, current literature is now purporting immediate implantation and non-occlusal loading to be the “treatment of choice” in cases of single anterior tooth restoration.8

The following are two case studies involving immediate provisionalization. In both cases, the maxillary right central incisors had sustained trauma, were endodontically treated and functioned for a number of years. Approximately 15–20 years later, the teeth in each case failed due to internal resorption. The failing teeth were extracted and implants were inserted immediately and restored the same day with a non-functional provisional.

Dental root resorption involves the loss of hard tissues that compose the teeth (dentin, cementum and enamel).9 In most cases, tooth resorption is the result of trauma or irritation to the periodontal ligament and/or tooth pulp. These conditions may occur as a result of injury, inflammation or chronic infection of the pulp, periodontal conditions, orthodontic tooth motility or tooth eruption.9,10 Internal resorption is generally asymptomatic and is discovered most frequently through radiographic examination.9,10

If internal root resorption is left to progress untreated, it may result in extension to the periodontal ligament through a crown or root perforation.9

Case study 1: failing maxillary right central incisor

The patient is a 30-year-old healthy male who was examined in our office for a failing maxillary right central incisor. His history involves a soccer accident in 1993 that resulted in an elbow to the face with trauma to the right maxillary central incisor. Approximately one week subsequent to the accident, the patient’s tooth was treated endodontically. It eventually became discolored and grew increasingly out of alignment (Fig.1). Radiographic examination revealed internal resorption.

Clinically, all other maxillary and mandibular teeth were in good condition. Periodontal examination revealed healthy gingival tissue. The patient was con-
concerned that his anterior tooth would fracture unexpectedly and desired an immediate replacement.

_Treatment options_

Several treatment options were considered. The first was extraction of the maxillary right central incisor and fabrication and placement of a conventional fixed bridge of porcelain fused to metal or an all-ceramic system. The second option was extraction of the tooth followed by placement of a removable partial denture. The next option was extraction, provisionalization with a removable partial denture (flipper) followed by implant placement, healing while wearing the flipper and, finally, restoration of the implant.

The best alternative was extraction and immediate replacement of the extracted tooth with an implant, followed by immediate loading with a nonfunctioning provisional. After adequate osseointegration, a final restoration would be fabricated. Advantages and disadvantages of all options were explained to the patient. He decided to continue treatment with an immediate implant restoration. The patient was then referred to a periodontist for further evaluation and implant consultation.

_Implant evaluation_

Implant examination revealed adequate bone height and width for implant placement immediately following extraction of the failing tooth. A surgical date was scheduled with the periodontist for extraction of the tooth and placement of the implant. An appointment was coordinated with our office for the patient directly following the surgical procedure for provisionalization of the implant.

_Surgical protocol_

The right central incisor was removed and a Nobel Replace Tapered Groovy (internal connection) 5.0 mm x 13 mm implant was placed. An osseous graft of demineralized freeze-dried bone and a collagen membrane were utilized to augment the surgical site. The fixture received an emergence profile, healing abutment.

_Provisionalization_

The patient presented in our office after the implant placement with a healing abutment in place. The healing abutment was removed. A Nobel Biocare immediate temporary abutment was placed and a provisional was fabricated.

Care was taken to contour the emergence of the provisional as to best support the gingival architecture. The plastic coping for the immediate temporary abutment was roughened with a 56 carbide bur to enhance adherence of the integrity provisional material used.

The provisional was polished and placed on the immediate temporary abutment with a small amount of flowable composite to enhance retention. The provisional crown was fabricated to be completely out of occlusion and non-functional to ensure the implant adequate osseointegration time undisturbed by occlusal forces. The provisional restoration was observed periodically during the six-month healing process to monitor gingival adaptation (Fig. 2).
Six months post surgery, the patient was scheduled for placement of the final restoration. After removing the provisional crown and the immediate temporary abutment, an implant impression post was placed, radiographic verification was made to assure complete seating and a final impression was taken with a polyether system. Complex shade-mapping was carefully performed to match the existing contralateral natural teeth. The provisional was then reinserted.

A Procera zirconia custom implant abutment was chosen. Zirconium implant abutments have not only been noted for their tooth-like color and esthetic appeal but also for tissue tolerability, high load strength and intrasulcular design enhancement.11 The extraordinary load strength of the oxide ceramics is not compromised by high bending and tensile strength, and fracture and chemical resistance.11 Zirconium abutments are mechanically equivalent to their metal counterparts but boast greater biological compatibility.11 Results of a recent study provide evidence that the ceramic oxide abutments can be safely utilized in the incisor region of both the maxilla and mandible as determined by maximal bite forces in the esthetic zone.11 Due to excellent restorative properties in terms of strength and color conformity, the zirconium implant-abutment is becoming increasingly favored by clinicians for esthetically pleasing anterior implant restorations.12 A Procera zirconia crown was fabricated for this patient with Noritake CZR porcelain (Fig. 3).

At the time of insert, the provisional crown and immediate temporary abutment were removed. The Procera zirconia custom abutment was seated, the screw was hand tightened and the screw was torqued to 35 Ncm with the manual torque wrench. The access was filled with a small cotton pellet and topped with a thin layer of flowable composite.

The Procera zirconia crown was then seated; margins, contacts and occlusion were confirmed; and the crown was cemented in place with 3M ESPE RelyX luting cement (Fig. 4).

Case study 2: fractured maxillary right central incisor

This patient, a healthy male in his late 30s, was examined in my office for a fractured maxillary right central incisor. The patient had Feldspathic porcelain restorations on his upper central and upper lateral incisors that were placed several years ago. He had a history of trauma to the anterior teeth from a sports injury and subsequent endodontic treatment.

Recent periapical radiographs showed internal resorption in the upper incisors (Fig. 5). The patient sustained additional trauma to the maxillary right central incisor through a fall, which resulted in complete fracture of the crown (Fig. 6). The tooth was nonrestorable.

After reviewing the different treatment options, the patient decided on an immediate implant restoration. Although the maxillary left central incisor also exhibited signs of internal resorption, it was decided that treatment of that tooth would be performed at a later date. Consideration was given to the poor gingival architecture that results from placing adjacent implants in the esthetic zone.

He was then evaluated by the periodontist for the surgical placement of the immediate implant for the maxillary right central incisor. The patient’s treatment was similar to that of the patient in the first case study. The right central incisor was removed and a Nobel-Replace Tapered Groovy (internal connection) 5.0 mm x 13 mm implant was placed. An osseous graft of demineralized freeze-dried bone was utilized to augment the surgical site. The fixture received an emergence profile, healing abutment. The patient then received an immediate non-functioning provisional.

Final restoration

After the six-month healing period the final res-
Implants

Fig. 9

**_about the authors_**

Susan McMahon, DMD, is in private practice in Pittsburgh. She is accredited by the American Academy of Cosmetic Dentistry and is a six-time award winner in the AACD Annual Smile Gallery. She has served as a clinical professor in prosthodontics and operative dentistry at the University of Pittsburgh, School of Dental Medicine. McMahon is a guest lecturer in cosmetic dentistry at West Virginia School of Dentistry and lectures to dentists in the United States and Europe. You may contact McMahon at www.enviwsnsmile.com.

Karah Petruska is a graduate of the University of Wisconsin-Madison. She is in the dual master’s program, post-baccalaureate premedical program and master’s of health management systems at Duquesne University.

**_References_**


**_Conclusion_**

In the cases cited above, both patients had sustained injuries to their anterior teeth as young adults while engaging in sports. Each of the patients had been treated endodontically and experienced approximately 15 years later. Both of their careers and lifestyles demanded immediate replacements that were non-removable and esthetically pleasing.

The failing teeth were extracted and implants were inserted immediately and restored the same day with a non-functional loaded provisional. Immediate placement and restoration of a single implant offers a highly aesthetic and timely treatment option in the case of internal resorption and tooth failure in the maxillary central incisors.

Furthermore, this treatment eliminates the need for a removable partial denture while maintaining the gingival architecture and preventing alveolar bone loss in the extraction site.

As esthetic expectations of patients and the desire for a convenient and timely treatment continue to increase, instantaneous replacement of failing teeth is becoming more routine. Not only does placing the implant immediately following extraction maintain the alveolar architecture and retain the interdental papillas, placing the provisional immediately there-
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.

Whether he or she works in a solo practice or in a group setting, every doctor can start the process of creating comprehensive care experiences for his or her patients.

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.

A successful restorative practice should not be built on insurance reimbursement schedules. An independent business should stand not on the whims and distractions of a fee schedule but rather on the ideal benefits of comprehensive care balanced by the patients’ needs and desires.

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AAID wants you to feel the magic at 63rd annual meeting

Author-AAID Staff

The American Academy of Implant Dentistry’s 63rd Annual AAID Implant Dentistry Educational Conference aims to shine a light on the magical artistry and science of dental implant practice in a naturally magical location: Orlando, Fla.

Beginning on Wednesday, Nov. 4, the AAID conference aims to set the curve in implant dentistry. This year’s AAID Implant Dentistry Educational Conference Keynote Speaker, Nina Tandon, PhD, will intrigue, motivate and challenge the current thinking of implant dentistry and more.

In her eye-opening keynote address, she will explain the process of growing tissue and transplants, and the future of medical science. With the help of manufacturing and information technology, we are on the verge of being able to grow human tissue. Her presentation, “Body 3.0,” is all about growing our own body parts.

The entire day on Wednesday will be devoted to the future of implant dentistry with a half-day session consisting of 14 different programs covering “New Trends, Techniques and Technology.” Following Tandon’s keynote, such luminaries in the field as Peter E. Murray, BSc (Hons), PhD, Tomas Albrektsson, MD, PhD, DDS, and Nelson Pinto, DDS, will provide in-depth and varied views of the future of implant dentistry.

Known as “the organization that provides practical education for the practicing implant dentist™,” the AAID conference delivers on that brand promise with two-and-a-half days of programming, including coverage of digital dentistry, soft-tissue management and treatment planning.

Through main podium programs, workshops, including a dozen hands-on opportunities, 10 concurrent sessions and dental team training, attendees can earn as much as 18 implant-specific hours of CE.

More than 1,000 implant dentistry professionals will be in attendance at the Hyatt Regency Orlando. In addition to learning from world-class clinicians and presenters, attendees will have the opportunity to interact with more than 125 vendors of products and services they utilize in dental practices across America every day.

Doctors and guests will also enjoy time to network and learn from each other in a variety of social functions including two group lunches, the Welcome Reception, Implant World Expo Reception and the always popular President’s Celebration at the conclusion of the conference.

Those interested in attending should plan to register onsite in the Regency Ballroom Foyer of the Hyatt Regency Orlando, located at 9801 International Drive. More information about the programs, speakers and activities at the conference can be found at www.aaid.com.

If you are unable to attend the 63rd annual conference, mark your calendar for AAID’s 64th Annual Implant Dentistry Educational Conference to be held Oct. 21–24, 2015, in Las Vegas.

Established in 1951, the AAID is the only dental implant organization that offers credentials recognized by federal and state courts as bona fide. Its membership, which exceeds 4,800, includes general dentists, oral surgeons, periodontists and prosthodontists from the United States and in more than 40 other countries. Contact AAID at www.aaid.com or at (312) 335-1550 or (877) 335-AAID (2243).
THE MAKING OF A GOLD STANDARD

ZEST’s LOCATOR® Attachment represents a rare occurrence in the implant field. Never before have industry players, clinicians, and patients come together to universally recognize the merits of a restorative solution. It has allowed the LOCATOR to become the most globally recognized and trusted brand for overdenture restorations.

CLINICIAN PREFERENCE
LOCATOR’s unique low profile design, pivoting technology, durability, and ease-of-use has propelled it to be the preferred choice of clinicians worldwide for tissue supported, implant-retained overdentures.

PATIENT SATISFACTION
Nearly two million patients are enjoying an improved quality of life by trusting their clinician to secure their restoration with LOCATOR.

INDUSTRY WIDE SOLUTION
The dental implant companies that collectively make up over 90% of the global implant market supply, partner with ZEST Anchors to make the LOCATOR Attachment compatible with their dental implants.

TOGETHER WE CAN MAKE TOMORROW EVEN BETTER

The trust and confidence placed in ZEST since its inception in 1972 is not taken lightly. It enhances our company’s commitment to clinicians, our implant company partners and your patients. Together we will continue to provide more options for the treatment of patients who suffer from the real-life problems associated with edentulism.

Stay close to ZEST for soon-to-be released innovations that can improve and expand the clinical solutions available within the LOCATOR Portfolio of products.

To experience for yourself how LOCATOR became the Gold Standard of resilient attachment systems, and for a listing of ZEST LOCATOR partners, please visit zestlocator.com/7 or call 800-252-2310.
Dental implant technology continues to evolve and grow through continued advancements in implant-to-abutment interface design, surface treatment, digital technology and patient-specific solutions. These developments have helped to simplify procedures, reduce treatment time, ensure more long-term and optimal outcomes and, ultimately, contribute to a higher level of patient satisfaction.

With these developments, new solutions and new companies are also continuing to emerge at a rapid pace, often making it more difficult to know what is the right choice for your practice and your implant patients. Some aspects to consider when choosing an implant partner may include:

- How long has the company been on the market?
- How much focus and resources does the company place on the research and documentation behind their products?
- What personnel and support are available to you in your product use and practice development?
- Is the company actively introducing new technologies and leading innovation and change?
- What type of warranty is in place should something happen?
- Will the company and products be around — not only today but tomorrow — when you need them?

These are all critical aspects to consider because, in most cases, your patients will rely on you for their long-term care. In turn, you should have the confidence that your implant provider will be there for you throughout the entire journey.

DENTSPLY Implants is based on a solid foundation of 40 years of expertise, knowledge and experience in all relevant fields and technologies of implant dentistry. Its comprehensive portfolio of solutions for all phases of implant therapy is designed to support its commitment to providing simplicity to its customers and is backed by extensive documentation, the company asserts.

The convenience of a "one-stop-shop" for implant treatment is truly delivered through the availability of solutions for digital treatment planning (SIMPLANT®); regenerative preparation of the implant site (SYMBIOS®); implant system options that include an internal conical connection (ANKYLOS® and Astra Tech Implant System™) or an internal flat-to-flat connection (XiVE®); and patient-specific restorations (ATLANTIS™) for ce-
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industry

The design philosophy of this new system is based on the natural dentition utilizing a site-specific, crown-down approach and is supported by an intuitive surgical protocol and a simple prosthetic workflow, for increased confidence and satisfaction for all members of the treatment team. The versatile range of implants and site-specific components are designed for long-term biological and clinical performance, ease of use, versatility of indication and mechanical robustness. ASTRA TECH Implant System EV provides a number of enhancements and innovations that help simplify the implant process, including a user-friendly surgical tray with three interchangeable overlay options, self-guiding impression components where only one hand is needed for seating and a unique one-position-only placement design for ATLANTIS patient-specific abutments, according to the company.

Another key innovation being introduced is the addition of the new ATLANTIS Conus Abutment concept. Available for all major implant systems, this solution is designed to support the needs of the growing attachment-retained segment. It provides partial or fully edentulous patients with the stability of a fixed solution and the convenience of a removable prosthesis for easy cleaning and optimal chewing function and comfort.

As with all ATLANTIS solutions, ATLANTIS Conus Abutments are backed by a comprehensive warranty to provide added peace of mind, the company asserts.

So what are you looking for in an implant company? If a strong history of experience and expertise, documented success, comprehensive solutions for all your implant needs and products and services of the highest quality matter to you, take a closer look at DENTSPLY Implants.

Fig. 2 ASTRA TECH Implant System EV features a unique interface with one-position-only* placement of ATLANTIS patient-specific abutments.

* Patent pending.

Fig. 3 ATLANTIS Conus Abutment overdenture.

† Data on file
GOING NOWHERE FAST?

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- Dr. Gary Saunter, DDS | Edmonton AB

"Being right out of dental school and this being my first course with LVI, it was an absolute eye-opener. Great for both new and old dentists!"  
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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.
IMPLANT EXTRACTION KIT

KEXIM KIT:
- Five extractors of different widths and lengths.
- Counter-torque wrench.

CLINICAL CASE

An X-ray radiograph indicates the presence of a radiolucent lesion around the superior third of the implant.

Clinically, circumferential bone defect around the implant is observed. The diagnosis is a bone loss due to peri-implantitis. The BTI KEXIM kit is employed to extract the implant atraumatically.

INDICATED FOR:
- The extraction of malpositioned implants.
- Treatment of peri-implantitis.

UNIVERSAL EASY TO USE ATRAUMATIC

PERI-IMPLANTITIS
A NEW APPROACH FOR PREVENTION AND TREATMENT

Author: Dr. Eduardo Anitua

This book aims to transmit to the clinician new guidelines in the management of a pathology of increasing incidence: peri-implantitis. This assay provides a comprehensive discourse of essential prosthodontic aspects and surface characteristics in the etiology and progression of the disease. This book presents basic prosthodontic concepts to gain an excellent hermetic seal, the new concept of de-ossosintegration that goes beyond the current alternatives for the treatment of peri-implantitis.

After implant extraction, the accumulation of dental plaque on the implant surface is observed.

REFERENCES

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.

This new system with four implant diameters (3.2, 3.7, 4.3, 5.0 mm), six lengths (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 insertion while the rounded apex reduces risk of sinus perforation.

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...
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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 aids in reducing crestal stress.’
submissions

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Please note that all the textual elements of your submission:

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All images must be submitted separately, and details about how to do this appear below.

If you are interested in submitting a C.E. article, please contact us for additional instructions before you make your submission.

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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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