Välkommen till Sverige, Welcome to Sweden

European Association for Osseointegration celebrates premier meeting in Stockholm

Join us for breakfast tomorrow to discuss ‘Dental membrane technology in today’s practice’

‘Dental membrane technology in today’s practice’

(From GTR Through GBR To Peri-Implantitis Cases)

GUEST SPEAKERS: Dr Ion Zabalegui (Bilbao) & Dr Jean Louis Giovannoli (Paris)
Malmö University receives funding for research on tooth and implant infections

A research project on chronic oral infections, led by Prof. Cornel Svensäter from Malmö University, has been recently awarded a grant of SEK12 million (€1.3 million) by the Swedish Knowledge Foundation. The researchers aim to develop new clinical tools to diagnose and treat such infections.

In a statement, the foundation acknowledged that research on chronic oral infections offers immense potential and could be of considerable benefit for patients, the dental care system, industry and society in general. To date, there are no reliable methods in dental care for identifying individuals with an increased risk of serious tooth and implant infections. Therefore, the Malmö researchers are targeting the development of new clinical tools in order to enhance diagnosis and treatment of such conditions.

“We are searching for proteins that exist in biofilms around teeth and implants. The proteins can originate either from bacteria or from human cells. If these proteins could be found it would be possible to identify the site as a potential source of infection and treatment could be initiated at an early stage,” Svensäter, Professor of Oral Biology at the university’s Faculty of Odontology, said.

The lead researcher further-more foresees potential financial benefits from developing diagnostic tools that could be used worldwide, for both the health care system and companies.

“The problem we are endeavouring to solve is significant and exists on a global scale. Some 10 per cent of the Swedish population could experience serious problems involving chronic infections,” he said. “We now have the right research group and the right companies in place and we are extremely pleased.”

Adding to donations of about SEK12 million by companies, as well as the university’s contribution of SEK6 million (€0.6 million), the grant by the foundation brings the project’s total budget to SEK30 million (€3.2 million).

The Knowledge Foundation is a funding body for universities and serves to strengthen Sweden’s competitiveness. Since its formation in 1994, the foundation has invested about SEK8.7 billion (€942 million) in more than 2,500 projects.

New study suggests many dental implants may be prone to fracture

An examination of biologically failed dental implants conducted by researchers in Israel has found that more than 60 per cent of these implants showed signs of mechanical flaws such as crack-like defects and full cracks. In publicising these results, they aim to encourage dental implant manufacturers and dentists to find ways to reduce the structural damage that occurs when a metal is subject to repeated applied loads.

In the study, the researchers from the Technion—Israel Institute of Technology in Haifa examined 100 discarded dental implants, which had been extracted owing to peri-implantitis, made of a titanium alloy and commercially pure titanium using energy dispersive X-ray analysis and scanning electron microscopy. They found mechanical defects in 62 per cent of the specimens. In addition, the inspection showed that the pure titanium implants had more cracks than did the titanium alloy implants.

“Embedded particles appear to be linked to the generation of surface defects that evolve into full cracks,” explained Dr Keren Shemtov-Yona, who conducted the study as part of her Master of Science degree. Furthermore, the wear and tear of daily use also seem to contribute towards the potential of manufacturing flaws to develop into cracks and subsequently lead to failure of the material, she said.

It was also found that the width and length of the different implants in this study were not correlated with the observed defects. Shemtov-Yona is now aiming to conduct further studies to investigate the reasons for the development of cracks to determine whether the causes lie in manufacturing, use or both.

Dr Ker<sup>e</sup>n Shemtov-Yona (© Technion—Israel Institute of Technology)
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“There is a general sense of frustration throughout the world”

An interview with CoDent founders Profs. Dov Sydney, USA, and Mauro Labanca, Italy

Our role is to bring the concept to the dental field, and this involves defining the first topic, finding the moderators and generally advancing the project. We thought it good to start with implants because it is one of the most difficult issues we are faced with as dentists. In this regard, the first congress will address the topic of controversies in dental implantology and will be held in Barcelona from 3 to 5 November 2016.

What distinguishes this congress concept from other meetings?

Prof. Mauro Labanca: We hope to promote real discussions and interaction between practising physicians and researchers on unresolved pressing clinical issues. We do not want to be a substitute for any other existing meeting. For the first congress, we will be discussing implants, but future topics do not have to be surgical ones. Congresses could address adhesive and restorative dentistry or different kinds of treatments in orthodontics. We are not an academy or a scientific society; we already have so many and we do not want to compete with them. We are doing something totally different.

What will the programme cover?

Prof. Labanca: Right now, we have eight topic modules that we feel are very interesting and will foster debate, as well as greater knowledge at the end of the meeting, hopefully. The programmes are designed to provide an effective forum for debate by allowing ample time for speaker–audience discussion. There are not going to be long presentations by one single speaker. Instead, we will have very short addresses of about 10 to 15 minutes during which the speakers will seek to answer a specific question. The result will be that, after approximately 1.5 hours, the audience will have had a summary by some of the most important speakers on that topic.
Prof. Sydney: It will be the first time that dental companies will be on the podium together, presenting their best speakers but without the restrictions of having to identify that they work for the company etc. Afterwards, the companies will be able to debate with each other on a number of points. We also aim to initiate an interactive exchange between speakers and the audience with questions via microphone and social networks, in order to cover all the questions that may arise. At the end of each small session, the aim is to have achieved a fair and balanced coverage of the respective subject.

What impact do you hope to have with this idea?
Prof. Sydney: We expect to make news. Up to now, dental companies have mostly marketed their products in a way they think is most appealing to their target customers, but the individual dentist who is going to buy the products, quite frankly, does not have all the information to make a decision. And even if he or she does have a sense of direction regarding which implant system to choose, he or she is often not totally sure of the optimum selection. Our concept provides an opportunity to cut through the indecision and doubt. All the companies sitting up on the podium will have the opportunity to explain why their implant is great and the other companies will be able to join in and explain to the audience about their product’s features. The dentist in the audience will then be able to participate as well to obtain the answers that they are really interested in, bottom line—what’s best for me?

Prof. Labanca: In the long term, we hope to initiate an annual meeting that will cover different topics in dentistry. There are many issues that are not so clear and dentists wish to become more informed about these.

So this is an opportunity for dentists to obtain a market-independent view of a certain product or topic in general?
Prof. Sydney: Right. Moderators will monitor the scientific level of speakers and the information they provide. Among the criteria for selecting moderators are that they be well respected in their fields and well known in the academic world. In particular, they should not be connected in any significant manner with a particular company. That is the way we qualify them and that is also what draws the companies in. We represent a programme of a uniquely remarkably high level, and this means that when speakers present and say something that might not be evidence-based or may leave some questions, the moderators, in a polite and non-offensive manner, will be step in. I believe this will make the audience extremely receptive to the results.

Prof. Labanca: We would define ourselves as a sort of supervisor in this project. In many countries, dentistry is generally a private practice industry. How can a busy and especially non-academic practitioner properly compare all the information that is available? What we will offer is the scientifically accurate information in order to help them interpret the efficacy and applicability of the message they receive from companies.

You are both dentists. Have you experienced this problem yourselves?
Prof. Labanca: Exactly. When I started with implants many years ago, I had this idea to bring the most important companies together to initiate open and honest debate between them. At that time I probably didn’t have enough cards to play, but now it is the time! The reality dentists are facing today is that companies are approaching them and claiming to have something special and something new. This could be true, but you do not have the means to compare or to confirm whether it is. You could try the products on your patients, but that would not be the right thing to do.

Prof. Sydney: Both of us travel quite a bit. Mauro and I have a global understanding of dentists’ concerns in many parts of the world. There is universally a common sense of frustration regarding the different implant systems. I regard our role as providing a safe, scientifically enabled and controlled environment for implant companies to proactively present the advantages of their systems directly to the end users.

Will there be follow-up documentation after the meeting?
Prof. Sydney: The existing congress model involves a journal issue that is published afterwards and compiled in such a way that it is relevant not only to the event, but also to anybody interested in reading about what was discussed and summarised by creating a permanent and easily-reference resource.

Prof. Labanca: We are not just trying to look for something different; we have seen that there is a need for this congress. We want to achieve a high level of academic acceptability, as well as accessibility for the general dentist population. That is the balance that we hope will lead to success.

Thank you very much for this interview.
A Swedish perspective on osseointegration

Remembering the work of Per-Ingvar Brånemark. By EAO presenter Prof. Tomas Albrektsson, Gothenburg/Malmö, Sweden

Brånemark treated his first patient in 1945 and his continued implant activities led to perhaps the greatest academic struggle we have had in Sweden in modern times. Finally, in 1977, the Swedish National Board of Health and Welfare nominated three independent professors from Umeå University to investigate the matter. They submitted a report with positive findings on osseointegrated implants that was presumably the first independent piece of academic writing ever published that supported the use of these devices.

From 1977 onwards, we then started training dental specialists from Scandinavia in placing dental implants. Over time, an increasing number of private practitioners in Sweden began working with them too. Some 20 years ago, Sweden placed more implants per capita than did any other country, partly owing to government support for implant treatment, peaking at about 125,000 implants placed annually in a population of approximately nine million inhabitants.

I remember the first patient with dental implants I personally met, in 1948. He was an opera singer in his forties who was unable to perform professionally owing to poor retention of his dentures. Aged 95, he recently returned for treatment to a nearby clinic, where radiographs revealed that only one of his implants had failed, but the rest have remained in good function after 47 years.

Sweden has four dental schools, at the universities of Gothenburg, Stockholm, Umeå and Malmö. Undergraduate training in implants is provided at all four schools and students are encouraged to place implants under supervision. The majority, at least at my alma mater, still has a rather critical attitude towards implants, which can be attributed to some scholars here reporting the development of peri-implantitis in 50 per cent of patients. Students then take this knowledge with them when they join an implant clinic, where most practitioners only see five per cent or so of patients with peri-implantitis.

Graduates leave university with a balanced view on the threats and promises of dental implants. For many years, postgraduate training in basic implantology in Sweden has concentrated on private practitioners who had not been allowed to work with implants earlier in their career. In addition, we have ongoing specialty education in subjects such as dental surgery, prosthodontics and periodontics. However, implant dentistry is not a recognized specialty in Sweden. Training courses in the field are provided by several commercial companies, which represent all of the major dental segments today.

Nowadays, far fewer implants are placed in Sweden. Recent calculations point to an annual use of some 75,000, probably because many of our totally edentulous patients have already been treated. The predominant scenario in Sweden today is replacement of single teeth or treatment of partially edentulous cases, which means that the number of patients treated has not decreased to the same extent as the number of implants placed annually.

I have a word for this phenomenon. Based on histopathological research, we now regard osseointegration as a foreign body response. Jokingly, we may consider renaming the EAO the “European Association of Foreign Bodies.” Even if the EAO board proves negative to this suggestion, we expect many guests from abroad to visit Stockholm in September. Although the EAO has had two annual gatherings in nearby Copenhagen in Denmark, its 2015 conference is the first meeting ever to be held in Sweden. As a representative of the Swedish members, I welcome all of the visitors to Stockholm in what we hope to be rainy weather, so that the lecture rooms will be filled every day.

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Peri-implantitis: Is it a crisis?

By Dr Michael R. Norton, UK

In the US over 500,000 implants are placed each year, whilst in the UK that figure was around 140,000 for 2010. The prevalence of peri-implantitis has been reported to be up to 29 per cent most notably in patients whose implants are placed within a partial dentition. This yields potentially vast numbers of implants, possibly as many as 185,000 in the US and UK alone that might succumb to some form of peri-implant disease on an annual basis.

The bacteria found within peri-implant lesions are similar to those found in deeper periodontal pockets and/or cross infection by periodontopathogens as a primary aetiology has been implicated as a possible pathway. However the wide variety of implant designs, surfaces etc make the treatment of peri-implantitis much more predictable and subject to much greater variability than periodontal disease, where natural teeth present a known anatomy and well defined surface structure.

In 2008 a systematic review of the literature regarding peri-implantitis using PubMed and the Cochrane library revealed little consensus on the treatment of this troublesome condition. One study reported on the efficacy of sub-mucosal debridement using ultrasonics or carbon fibre curettes, while two others compared the effect of an Er:YAG laser against mechanical debridement, that of mechanical debridement against laser debridement, and the latter showed limited or no clinical improvements. Finally, a study comparing two bone regeneration procedures reported clinically significant improvements mediated by both.

Nonetheless a multitude of other studies have also been published reporting on the efficacy of tetracycline, CO2 laser, and phototoxicity decontamination amongst others in the treatment of peri-implantitis. Such a plethora of therapies makes it difficult for the clinician to choose a regimen that is both within the reach of the average clinician and has some documented reliability.

Risk factors

There have been a number of risk factors cited for peri-implantitis. Recently, in a study published in the Journal of Clinical Periodontology, a clear association was demonstrated through multi-level statistical analysis between risk of peri-implantitis and location, specifically the maxilla, while overt peri-implantitis was shown to be highly correlated to patients with a pre-existing history of periodontitis, and being male. Surprisingly in this particular study no correlation was demonstrated with smoking, yet this has been a consistently cited risk factor in many other studies. Indeed in a study published in the Swedish Dental Journal in 2010, the percentage of implants with peri-implantitis was significantly increased for smokers compared to non-smokers (p = 0.04).

Other factors that have been implicated include excess cement, poor oral hygiene, and prosthesis design which are of course inter-related with some prostheses making effective oral hygiene unattainable, while others present deep margins that make removal of excess cement almost impossible.

Warning signals

Peri-implantitis rarely presents unannounced unless of course the patient fails to be placed on a regular recall programme or fails to attend for regular review. Early signs are often apparent in the form of peri-implant mucositis. This condition is characterised by mucosal oedema, rubor and bleeding on probing (BOP). By definition it is not associated with purulence or bone loss. However this condition is often asymptomatic to the patient and as such is typically only diagnosed at routine recall. Hence there is a need to recognize that when implant treatment is completed the patient should remain on annual reviews for at least the first five years, and thereafter once every two years.

However once peri-implant mucositis has taken hold it is unfortunately that it is often exacerbated by the design of implants today. The presence of a rough surface, taken to the top of an implant, and the application of microthreads or grooves have been proposed as potential confounding factors for the advance of the lesion due to biofilm formation and bacterial contamination of the surface which leads to bone loss and further surface exposure. With advancing bone loss it often results in colonisation of the deeper pockets with well known periodontopathogens and infection ensues. This then is peri-implantitis.

Peri-implantitis is characterised by the presence of vertical or crater-like bone defects and spontaneous purulence and bleeding on palpation (Figs. 1 & 2). It is typically associated with deep peri-implant pocketing > 5 mm.

This condition is undoubtedly of increasing concern due to some principle factors, such as the almost exclusive use of roughened implant surfaces, the treatment of partially dentate patients with a history of periodontal disease, the placement of implants with inadequate bone volume resulting in hace dehiscences, as well as the use of cement retained prostheses.

Implants with a micro-roughened surface texture have presented excellent long-term data and until recently there has been very little published in the literature demonstrating a susceptibility of these surfaces to this condition. However recent work by Albug et al. has received widespread attention with concern for the evidence that suggests some modern micro-textured surfaces may be completely resistant to decontamination.

Ultimately, if left unchecked and untreated, it may become impossible to arrest the condition, leading to wholesale failure of the case (Figs. 3 & 4). Such failures impose a tremendous strain and burden on the clinician (let alone the patient), destroying the confidence of a patient who has endured significant expense and trauma and occasion-ally results in a breakdown of communication between both parties that all too often sadly results in a legal claim of negligence. Such claims can be hard to defend for patients where no warnings and/or supportive periodontal/peri-implant therapy have been undertaken.

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to the implant for surface decontamination. The author’s preference until now has been to use chlorhexidine and tetracycline solution for this purpose while others have reported the use of citric acid and hydrogen peroxide amongst others. The use of lasers has also been extensively reported. However in a recent systematic review a meta-analysis could only be done for Er:YAG laser as the literature on all other laser types was weak or heterogenous. Nonetheless this methodology remains outside the reach of most general practitioners and has yet to be proven predictably effective. As such most attention therefore remains focused on physical debridement via surgical intervention and topical antimicrobial therapies. Open flap debridement, defect decontamination, and repair as well as pocket elimination have all become the mainstay of those treating this condition.

So is there a crisis? The problem is that there is no clear consensus on the prevalence of the disease since this will vary according to the cut off values for the clinical parameters measured and to date there appears to have been little consensus of these cut off values. As such estimates of incidence of the disease appear to vary from 28 to 56 per cent of subjects and 12 to 43 per cent of implant sites.

Furthermore there is an ongoing controversy about the initiating process of peri implant disease since it is potentially considered a primary infection of periodontal origin and others hold that it is a secondary opportunistic infection subsequent to bone loss caused by other etiologic factors such as a provoked foreign body reaction or iatrogenic dehiscence of the bone, exogenous irritants such as dental cement, bone loss through occlusal overload etc. If the latter is true then controlling the disease is theoretically made more simple by controlling the conditions for the implant, such as ensuring adequate buccal bone thickness, avoiding or controlling more carefully the use of dental cement, and paying closer attention to the occlusion.

In an effort to gauge the rate of mucoitis and peri implantitis requiring surgical intervention, the author audited his patient pool in the year 2014. Out of a total of 191 patient reviews constituting 795 implants only 15 patients (7.9 per cent) required triple therapy at 20 implants (2.5 per cent) for mucoitis while 10 patients (5.2 per cent) required surgical decontamination at 10 implants (1.3 per cent).

As can be seen this is well below the figures proposed in the article by Zitzmann & Berglundh (2005). This may of course reflect a more liberal approach to cut off values for parameters such as pocket depth and bleeding on probing as proposed Klinge in 2012.

Nonetheless after over 20 years running a practice dedicated to implant dentistry the author’s own audited failure rates indicate that less than 1 per cent of implants present as late failures, owing to peri implantitis or fixture fracture as a result of bone loss. This would corroborate the findings by Jemt et al in which a cohort of patients already diagnosed with peri implant bone loss showed a slow rate of additional progressive bone loss over a 9 year follow up with an implant failure rate of 3 per cent.

In all likelihood it is the author’s view that peri implantitis is only a crisis if we allow bad implant dentistry to persist where there is a lack of control of the initiating factors as described above, and that it is more rather than less likely that it is the result of a secondary opportunistic infection rather than a direct susceptibility to primary infection of periodontopathic origin. However, there will clearly be some patients with a high genetic susceptibility with other predisposing factors such as the presence of untreated periodontal disease, smoking and diabetes who may well succumb as a result of primary infection.

Further there remains a clear need to better define the different types of peri implant disease and to establish a consensus as to the cut off values for the different parameters used to evaluate the disease so that future figures for incidence and prevalence are comparable.

Editorial note: A complete list of references is available from the publisher.
Dental implantology: Evolution or the road to ruin?

By Dr Aws Alani, UK

Teeth are highly evolved structures that have developed progressively over millions of years in attempts to protect the great tooth stock from caries and periodontal diseases. Over the years many advances have been made which can treat these various diseases predictably. Various strategies have been developed to prevent or slow down these problems given enough patient compliance and appropriate personal and professional maintenance. Despite these very significant improvements there are still instances when patients get told ‘this tooth or these teeth need to go’. It is the obvious sadness, heartache or despair that patients are caused by this bad news, and this is why those who have driven caring clinicians to find ways to replace teeth with various devices from dentures, to bridges to implant retained prostheses.

P. I. Brånemark, now sadly deceased, famously quipped ‘No one should have to die with their teeth in a glass of water beside their bed’. Brånemark’s original inspiration coupled with determination, intuition, passion and an ability to surround himself with individuals with differing skills made osseointegration much more predictable. Brånemark’s landmark studies changed prosthetic dentistry dramatically but a careful look at the design of these protocols and the implants themselves reveal were hugely different to the patient and the implants themselves reveal nowadays.

Once exposed to the environment of a susceptible patient the macro topography of the threads provide an ideal ecolalic niche for bacterial proliferation. Further nano-level features make the implant surface a veritable ‘iLlAmAnno'-ticoN super highway’ for the pathogenic organisms. Predictably enough the micro-organisms found on the rough surface are usually the common pathogenic ones but also some species are found that have previously never been discovered in the oral cavity.

Patient selection issues

We need to consider the types of patients for whom we are now accepting for implant provision. At KiTel there are three criteria for state sponsored implant provision largely involves patients with hypoplasia and those who have suffered trauma. Usually both cohorts are likely to present with an unknown risk factor until it is too late. The more implants that are placed usually the fewer teeth are present resulting in a net reduction in physiological feedback and thereby creating an increased chance of failure of some type.

Ethical, moral and legal issues

These problems become much more worrying when viewed from ethical, valid consent and medico-legal perspectives. This is particularly so when patients are convinced to undergo elective extractions of teeth which often seem reasonably intact and/or treatable with conventional proven treatment strategies. It seems that there is a worrying drift towards aggressive treatment with extractions in order to provide a supposed ‘full mouth rehabilitation’ with multiple implants. The increasingly dubious practice of sacrificing teeth for the sake of implants seems to many concerned clinicians to be quite irrational. As ethical oral health practitioners, deliberately removing savable teeth for prosthetic replacement using implants as support seems to be consciously flying in the face of increasingly apparent evidence of various complications with implants and many would consider that approach to be foolish. How many ‘implantologists’ doing that to others would genuinely have it done to themselves or done to some close family member?

Planned obsolescence

A state of the art implant today is likely to be obsolete tomorrow. Eliminately removing teeth is irreversible and replacing teeth with implant retained devices means that patients that are trapped in the era of Implantology in which these were placed and restored, that means issues of machining, surface blasting, roughness, platform switching, design and attempts at bone augmentation by cow, coral or Californian substances. The list goes on and on and will probably continue to expand with what many would call “human experimentation without licence”.

Now comes the time for implant manufacturers to take stock of their many “market driven” miss-takes including “fast initial integration with the roughest possible surfaces”. Instead they need to produce proven (i.e. not speculatively) designs to better prevent these now well known problems of infection and breakages.

A wiser, pragmatic approach seems to be to concentrate everyone’s efforts on saving teeth and thereby eke out their usefulness for the patients’ lifetime. Recently, the legendary Jan Lindhe writing in the British Dental Journal summarised the state of play as there is an overuse of implants in the world and an underuse of teeth as targets for treatment.”

Why and where?

The searching question needs to be asked, “where has this technology in dental implantology and what are the real reasons why this was and is happening?” Increasingly, the shadow of perimplantitis looms like a spectre over the provision of implants. Unlike caries or periodontal disease there is very little consensus or research that can provide a predictable cure for what now is now a new breed of diseases. Perimplantitis is relent-lessly once established within fine threads of the implant and the bone resorption and soft tissue problems that follow can result in spectacu-lar problems. Part of the key issue probably lies in the surface ex-posed to the susceptible patient’s oral environment, as most microbi-ologists will agree. The bacterial content and make up of the bio-film is a reflection of the surface that it resides on. Implant surfaces have become progressively rougher in order to hasten the early osseointe-gration processes and to try to pro-vide patients with their restoration quicker in an ever more competi-tive world. How ever speed is not always helpful. Ex-perience shows that some things are better taken slowly over time - rather similar to making love.

Over time the components of im-plants have shown notable weak-nesses. Screw loosening, fractured screws, loose abutments and the cracking of ceramic can be labori-ous and expensive to manage. One aspect, which may be lost on some is that, lacking a periodontal ligament dental implants, cannot and will never be able to acclimatise to the changing occlusal and non-axial stresses within the masticatory system thereby resulting in breakages. These forces are very likely to cre-ate stresses within the masticatory system resulting in breakages. These forces are compounded greatly if patient’s parafunction on a daily basis and that is sometimes
Thursday, 24 September

12:30–12:35
Welcome Address
Speaker: Björn Klinge

12:35–13:00
Osseointegration and brain control of prosthesis
Speaker: Rickard Brånemark

13:00–14:15
50 years of clinical osseointegration—The early contributions and current effectiveness in implant dentistry
Per-Ingvar Brånemark concept
Speaker: Thomas Akerström
André Schroeder concept
Speaker: Daniel Buser
Willy Schulte concept
Speaker: Jörg Mykle

Effective in implant dentistry
Speaker: Jan Derks

14:45–16:15
Tissue reconstruction/regeneration—What the dentist needs to know about tissue reconstruction/regeneration
Speaker: Luca Cardoro

Extracts from the video “Cell to cell communication”
Speaker: Bernd Steding

Regeneration/reconstruction of peri-implant soft tissues
Speaker: Thomas Linkbeir

Tissue regeneration via the use of L-PRF
Speakers: Marc Quirynen & Andy Tenmaner

14:45–16:15
Oral Communications

Friday, 25 September

08:45–10:15
Challenges for implant treatment of the ageing population
Biophosphonates—A threat or an option?
Speaker: Per Aspengren

No teeth, no money: what to do in the elderly patient?
Speaker: Martin Schimmel

Minimal number of implants in the upper jaw?
Speaker: Anja Zemic

Minimal number of implants in the lower jaw?
Speaker: Gerry Raghoebier

CAD/CAM, precision of fit
The future implant crowns—chairs vs. labside
Speaker: Per Vult von Steyens

Is ceramic the material of choice for future implants?
Speaker: Eric van Dooren

CAD/CAM in removable prosthodontics
Speaker: Daniël Wismeijer

Oral Communications

10:45–11:15
New cells in old bodies
Speaker: Jonas Fratén

11:15–12:30
Consensus conference 2015

13:15–14:45
To learn from complications
Maxillary sinus grafting complications and how to avoid them
Speaker: Pascal Valenti

The surgeon as the complicating factor
Speaker: Franck Renouard

On the evolution of complications in implant prosthodontics
Speaker: Bjarni Pjurtsson

What have we learned from mucogingival complications?
Speaker: Rino Burkhardt

What have we learned from immediate implant placement and immediate restoration?
Speaker: Markus Häuserer

Virtual planning, 3D printing and more
The virtual patient: How far away are we?
Speaker: Thabo Bester

The origin, present and future of 3D printing
Speaker: Dianne Rekow

3D printing in maxillofacial surgery
Speaker: Lawrence E. Brecht

13:15–14:45
Oral Communications

15:15–16:30
Treatment and outcome challenges
The current use of patient-centered/reported outcomes in implant dentistry
Speaker: Jan Cosyn

Quality of life in patients undergoing bone grafting procedures
Speaker: Guido Heydecke

Management of bone defects in the aesthetic zone
Speaker: Dehua Li

15:15–16:30
EAO Junior Committee
Discover how to obtain the EAO’s prestigious Certificate in Implant-based therapy

13:45–15:15
Consensus conference 2015

15:15–16:30
Immediate implant placement and restoration in patients with severe periodontal disease (potentially edentulous patients)
Speaker: Ye Lin

Osseointegration as a foreign body reaction
Speaker: Christer Dahlén

Brain signalling from teeth and dental implants
Speaker: Mats Trulsson

Poster presentation competition

10:45–12:15
Periimplantitis
The relevance of implant materials for periimplantitis
Speaker: Andrea Mombelli

The patient and the problem awaits Monday morning: what do I do?
Speaker: Stefan Revert

Do we still need to use Hounsfield scores in presurgical planning?
Speaker: Reinhilbe Jacobs

Creating the virtual patient: How to integrate facial, optical and radiological imaging components
Speaker: Ali Tahmasb

Invited societies programme

13:30–13:30
How to select a Nobel Prize Laureate in Medicine or Physiology
Speaker: Urban Lendahl

13:45–15:15
Emerging surgical concepts
Do we still need autogenous bone for ridge augmentation or can we use growth factors?
Speaker: Ronald Jung

Soft tissue grafts out of the box, what can we expect in clinics?
Speaker: Otto Zähr

Emerging concepts in maxillofacial surgery: indications for graft materials
Speaker: Henning Schleipbach

The future of wound healing: can it still be improved?
Speaker: Nelson Pinto

15:15–15:30
Closing ceremony

Saturday, 26 September

08:45–10:15
Successful supportive treatment—evidence for clinical efficacy
Speakers: Hugo De Bruyn, Lisa Heitz Mayfield & Mariano Sanz

Imaging (Radiology) in treatment planning and follow-up
Presurgical imaging in implant treatment: from guidelines to clinical use
Speaker: Michael Borstean

Radiographic bone quality aspects in planning implant surgery
Speaker: Christina Lindh

Creating the treatment of peri-implantitis
Speaker: Olivier Carcasson

A comparison between periodontitis and periimplantitis lesions
Speaker: Tord Berglund

08:45–10:15
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Preserving crestal bone stability around implants remains one of the most important features of successful implant treatment. Besides major clinical advantages for the patient, stable marginal bone provides the clinician with psychological comfort and satisfaction, because of the positive long-term outcome (Fig. 1). Therefore, we all need to be aware of possible causes of loss of crestal bone stability and exercise every method to prevent bone resorption.

For almost one decade, platform switching has been considered to be the most effective way to prevent bone resorption. It was determined that if vertical soft-tissue thickness is greater than 2 mm, the recipient site can be used for implant placement. However, it should be noted that the biological width around implants is approximately 4 mm, which is longer than the biological width of both jaws. Therefore, imagine the outcome of severe crestal bone resorption that is placed in the posterior of both jaws. However, the clinician will have to preserve the bone thickness and reduce crestal bone resorption to achieve this outcome. It is essential to preserve the bone around implants, which are increasingly being used. Today, an implant of length 8 mm in length width, as well as longer ones do in the posterior of both jaws. However, the clinician has to preserve the bone thickness around implants to achieve this outcome. It is essential to preserve the bone around implants, which are increasingly being used.

In conclusion, it must be emphasized that there are several options, some of them already researched clinically and some based on clinical experience without any objective evidence. An initial thought may be to place the implant deeper sub-crestally (Fig. 4). Firstly, there must be adequate distance from the alveolar nerve to position the implant sub-crestally in a safe manner. It is advised that the implant stops at least 1 mm from the nerve.

Fig. 1: Crestal bone stability around the implant and abutment (Tapered Plus, BioHorizons).
Fig. 2: Thin vertical soft tissues measured at the crest (0.3 mm).
Fig. 3: Crestal bone loss around an implant with platform switching.
Fig. 4: Sub-crestal placement of an implant (Tapered Plus, BioHorizons).
Fig. 5: Flattening of the ridge for the regeneration of bone around implants (a), vertical matching connection implant (green) increases soft-tissue thickness because the mucosal height and tissue stability are increased. A reduction of bone thickness around implants is approximately 4 mm, which is longer than the biological width of both jaws. Therefore, imagine the outcome of severe crestal bone resorption that is placed in the posterior of both jaws. However, the clinician will have to preserve the bone thickness and reduce crestal bone resorption to achieve this outcome. It is essential to preserve the bone around implants, which are increasingly being used.

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Further, it was clearly shown that even implants with platform switching could not maintain bone if at the time of implant placement vertical soft tissue was thin (Fig. 3). That returns us to the discussion of whether biological or implant design is more important. We will need to understand that vertical soft-tissue thickness is a prerequisite of the biological width around implants. Biological width around implants starts to form at the time of healing abutment connection and is completed after eight weeks. This biological seal is the only barrier protecting the osseointegrated implant, of course, does not prevent crestal bone loss, as the microgap at the implant-abutment interface will form an inflammatory infiltrate, which will cause bone resorption anyway; however, it is likely that the implant will not have soft-tissue recession or rough surface expression, which usually follow bone resorption. It is well known that the exposure of the rough implant surface enhances plaque accumulation and the development of peri-implantitis. In other words, the future of such an implant would only depend on the scrupulous cleaning abilities of the patient, which is usually not the case.

Another option might be reconstructing the bone during implant bed preparation, especially if a narrow ridge is present. Careful reduction and smoothing of the narrow ridge will not only provide a flat bone surface and a sufficiently wide area of bone for implant positioning, but will increase soft-tissue thickness as well (Fig. 5). While the concept of bone removal to preserve the bone might be acceptable to some clinicians, there is no strong clinical evidence that this procedure increases soft-tissue thickness and reduces crestal bone remodelling.

Consequently, we might think in another direction and consider a third option, vertical reconstruction of the soft-tissue thickness, which in my opinion is the most logical approach. Increasing soft-tissue thickness vertically compensates for the lack of vertical tissue. Already in a 2009 paper, we suggested that clinicians “consider the thickening of thin mucosa before implant placement”; therefore, this concept is not entirely new. The idea is to place some sort of autogenous, allogeneic or xenograft material over the implant to add soft-tissue thickness after healing.

A connective tissue graft is considered the gold standard for soft-tissue augmentation around implants. However, this technique has some serious disadvantages, such as donor site morbidity and the difficulty of the harvesting procedure. Therefore, allogeneic substitutes might be considered a viable option to replace autogenous grafts in vertical soft-tissue reconstruction. The use of an acellular dermal matrix is thus far the only approach backed by solid clinical research, including a controlled clinical prospective study. In this study, implants were placed in three groups of patients with (a) thin vertical tissue, (b) thick vertical tissue or (c) thin vertical tissue augmented with an acellular dermal matrix material (AlloDerm, BioHorizons). Radiographic assessment showed a reduction of crestal bone loss from 1.74 mm in the thin-tissue group to 0.32 mm in the augmented group. In addition, soft-tissue thickness increased by 2.33 mm, from 1.50 mm to 3.83 mm, after augmentation with the allograft (Figs. 6a & b). This research proves that the lack of vertical soft-tissue thickness required for biological width formation without crestal bone loss can be compensated for by the use of an acellular dermal matrix material at the time of implant placement.

In conclusion, it must be emphasized that diagnosis of thin vertical soft tissue is very important in implant treatment. Only by acknowledging that tissue thickness is an important factor can we follow protocols that allow us to reconstruct vertical peri-implant tissue and reduce crestal bone loss.
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Efficiently delivering full-mouth reconstructions
By Dr Ara Nazarian, USA

Having the ability to take a patient from point A to point Z in fewer appointments within one’s practice allows one to position oneself as a provider that can fulfill patient’s surgical and restorative needs. With the proper training, a dental provider may provide excellent treatment, grafting and implant placement within one appointment at one location. Not only does this allow the reduction of the number of visits for the patient, but this type of service also helps the patient stay within his or her budget. Most importantly, this enables the dental provider full control of the surgical and prosthetic outcome.

Depending on the patient’s desires, the clinical conditions of the oral environment and the skills of the dentist, the dentist may choose to extract teeth, level bone, and graft with simultaneous dental implant placement. In this case, a patient in his mid-sixties presented to the office with discomfort owing to multiple rampant caries and generalized advanced periodontal disease (Figs. 1 & 2). Having already visited multiple providers for a consultation, he was very frustrated with the treatment options offered with varying treatment plans that were segmented into different disciplines. Since many of these options did not complement the other, the patient decided to come to us for full treatment after being referred by one of our past patients who had undergone a Total Dental Solutions Reconstruction.

Before the surgical appointment, a CBCT scan was taken to accurately plan treatment for this case to make certain that no complications would arise from completing all of the procedures (extraction, graft and implant placement) in the Total Dental Solutions Reconstruction protocol. CoDiagnostiX software (Dental Wings) was used through 3D Diagnostix virtual assistance to precisely plan the placement of six Engage (OCO Biomedical) dental implants in the maxillary arch, as well as seven Engage dental implants in the mandibular arch using CT-based surgical pilot guides (3D Diagnostix; Figs. 3 & 4).

The final treatment plan was fixed bridges on implants in the maxillary and mandibular arches. Engage implants were selected (Fig. 5) because I have personally experienced their high implant stability at placement, which is a critical success factor during the early healing process of osseointegration with these types of cases. With the combination of its patent pending Bull Nose Auger tip and Mini Cortic-O Thread, this implant system offers practitioners a bone-level implant with high initial stability for selective loading options. In fact, the Engage implant body creates a tapping pattern when threaded for an enhanced mechanical lock in the bone. Other dental implant systems with aggressive threading may include, but are not limited to, NobelActive (Nobel Biocare), SEVEN (MIS Implant Technologies), IT III (Hiossen), I5 (AB Dental) and AnyRidge (Megagen).

For effectiveness and greater efficiency during the Total Dental Solutions Reconstruction procedures, intravenous sedation should be performed. Not only does it make the appointment easier, but patients also prefer to have the treatment completed in one visit. Since the patient is sedated, a mouth prop is needed to keep his or her mouth open. Because of this, teeth are extracted in quadrants, starting from the upper left to the upper right and then down to the lower right and lower left. This allows great time savings, as it is easier to keep the patient’s mouth open and be able to proceed around the arches safely. Once the teeth have been extracted, the tissue has to be reflected in order to seat the bone-level surgical guides and fix them with their respective retention pins. Using these pilot surgical guides, the osteotomies for...
the implants were begun with a 1.95 mm pilot drill utilising the Mont Blanc surgical handpiece (Anthogyr) and Aseptico surgical motor (ADU 7000) at a speed of 1,200 rpm with copious amounts of sterile saline (Figs. 6 & 7).

Paralleling pins were placed in the sites of the osteotomies to confirm the accuracy of the surgical guide and radiographs were taken to check the angulations of the pins within the maxilla and the mandible. Once the osteotomies were complete, an implant finger driver was used to place the dental implants until increased torque was necessary. The ratchet wrench was then connected to the adapter and the implants torqued to final depths, reaching a torque level of approximately 40-50 Ncm.

Adequate implant fixation was further verified using an Osstell ISQ (implant stability quotient) meter, which uses resonance frequency analysis as a method of measurement (Fig. 8). Several studies have been conducted based on resonance frequency analysis measurements and the ISQ scale. They provide valid indications that the acceptable stability range lies above 55 ISQ.

Extended healing caps were placed in the implants. A postoperative radiograph was taken of the implants and the healing caps to ensure complete seating. The immediate dentures were soft relined with a silicone-based soft denture relining material (Ufi Gel SC, VOCO). Some of the advantages I have personally experienced with this material are that it is biocompatible, tasteless and odourless. By using the extended healing caps with the soft relining, the immediate dentures were much more retentive. The soft tissue and implants were evaluated clinically after one week. The patient stated that he had had very little postoperative discomfort or swelling.

Within ten days, the patient returned to the practice. The soft tissue around the extended healing caps had healed very nicely with a healthy pink colour. Using impres- sion posts, full-arch impressions were taken with Instant Custom C&B Trays (Good Fit). These custom trays were inserted and left in place for a period of minutes, eliminating the need for models, light-cured materials, monomers and extra laboratory time for custom impression tray fabrication because they are made of a material (PMMA) that becomes mouldable when heated (Fig. 9) and maintains its shape while cooling.

Once the trays had been moulded for the patient, full-arch impressions were taken using a polyvinyl siloxane impression material (Take 1 Advanced, Kerr; Fig. 10). Bite relations, as well as instructions for size, shape and colour of the full arch provisionals, were forwarded to the dental laboratory. With only a five-day turnaround, the custom abutments and provisionals were forwarded to the dental office and inserted. The patient was very pleased with the aesthetics and function of these provisional restorations. He was instructed about their care and use in eating, speaking and biting.

Approximately four months after the initial placement of the dental implants, the patient returned for the definitive porcelain fused-to-metal restoration impressions. The provisional restorations were removed using the Easy Pneumatic Crown and Bridge Remover (Dent Corp). Any temporary cement was removed and the abutments inspected. If there was any settling or recession of the gingival tissue, the abutments were modified using a carbide bur with copious amounts of water not to overheat the abutments. This way, the margins could be brought right to or to slightly below the free gingival margin. A full-arch impression was taken in a similar fashion for the abutments and the provisionals. In addition, the relations between maxillary and mandibular arches were captured. Within three weeks, the porcelain-fused-to-metal restorations were inserted and a panoramic radiograph taken (Figs. 11 & 12).

In conclusion, an increasing number of patients are presenting to dental practices who seem to require this type of reconstruction. By providing multiple services in a shorter number of visits with the use of CBCT and other technologies, the dental provider will find that more patients will accept treatment. In doing so, not only are you helping your patients regain proper form and function, but you are also helping them achieve a Total Dental Solutions Reconstruction in fewer appointments.
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*Floor plan and the exhibitors list are subject to change. Last update was 7 September, 2015.*
Floor plan

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“The best way to restore lost structures is to regenerate”
An interview with EAO lecturers Drs Ion Zabalegui and Jean-Louis Giovannoli

Dr Ion Zabalegui: Especially in the 1980s, dental barrier membranes were of utmost importance for the profession to understand the biological principles that are involved in restoring the lost structures around teeth as a consequence of periodontal disease. This concept is widely applied in implantology.

Dr Jean-Louis Giovannoli: The best way to restore lost structures is to regenerate, and studies on periodontal healing have demonstrated that the proliferation of residual periodontal ligament cells has the potential to induce regeneration. Guided tissue regeneration (GTR) and guided bone regeneration (GBR) use membranes to create space and promote the proliferation of short- and long-lasting barrier membranes. These membranes reduce the risk of infection and failure. The GUIDOR Bioreabsorbable Matrix Barrier also has some advantages linked to its quality of tissue integration owing to the presence of two layers of material. This tissue integration gives good stability during the entire healing process and minimizes the risk of re-cession of the covering soft tissue.

What are the main advantages of alloplastic matrices compared with non-resorbable materials?
Zabalegui: Resorbable membranes were once the standard for GTR. However, the postoperative complications owing to membrane exposure and the fact that a second surgical procedure to remove the membrane was mandatory after four to eight weeks for the finalization of the procedure warranted new materials and protocols to address these problems. Alloplastic matrices that do not produce inflammatory responses and have a tissue-mediated metabolism have shown fewer post-operative complications and morbidity than have non-resorbable barriers.

Giovannoli: Resorbable membranes reduce the risk of infection and failure. The GUIDOR Bioreabsorbable Matrix Barrier also has some advantages linked to its quality of tissue integration owing to the presence of two layers of material. This tissue integration gives good stability during the entire healing process and minimizes the risk of re-cession of the covering soft tissue.

What components are generally considered mandatory with regard to favourable outcomes in regenerative practice?
Zabalegui: During the last three decades, there have been a fair number of papers that describe many of the factors that we think are involved in the favourable outcome of a regenerative procedure. For GBR procedures, stability, space maintenance and protection of the regenerative material without exposure during the treatment phase are probably the most important factors. However, the required time for barrier resorption to achieve good results is still not clear, since there have been reports of good results with both short- and long-lasting barrier membranes.

Giovannoli: For GTR and GBR, like for any other periodontal therapy, the priority is access in order to be able to prepare the root surface properly. The membrane should be porous enough to favour the nutrition, but it should be placed around the root to ensure good hemostasis and prevent the downgrowth of the epithelial cells. The material should be stiff enough to maintain a space, and this space will determine the amount of repaired tissue obtained at the end. In any case, the soft tissue conditions should lead to the establishment of a membrane that allows for submerging the product and keeping it submerged during the entire healing phase. For both GTR and GBR, the quality of the bleeding is important, since a dense clot must be obtained initially.

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TEPE CELEBRATES 50 YEARS OF INTERDENTAL CLEANING

During the last five decades, TePe has evolved from a small-scale production company into a high-tech manufacturing enterprise with distribution in 60 countries. Its close relation to the dental profession has been fruitfully explored, resulting in a wide range of oral care products such as the TePe Interdental Brushes. First introduced in 1993, they are now recognized for their high quality and efficiency worldwide, according to the company.

The original series includes nine colour-coded sizes to fit narrow and wider interdental spaces but there are also variants with softer filaments or an angled brush head and a longer handle. The latest complement to the interdental cleaning range is TePe EasyPick, which is efficient, easy to use and available in two conical sizes that fit most interdental spaces. The assortment also includes floss, dental sticks and interdental gels, the company said.

TePe Munhygienprodukter AB is a family-owned Swedish company. Its history began in 1965 when woodcarver Henning Eklund developed an innovative triangular dental stick in collaboration with the School of Dentistry in Malmö. The user-friendly TePe toothbrush was first introduced in 1973 and today comes in a variety of models and sizes for adults and children. TePe also offers a unique series of products for specific oral hygiene needs, such as care of implants and orthodontic appliances, alongside a range of pedagogic materials, enabling individually tailored education and instruction to patients.

Based on the vision of healthy teeth for all throughout life, TePe says to work for raised oral hygiene awareness and prevention of oral disease. All production takes place at the headquarters in Malmö in southern Sweden. The company has 250 employees and subsidiaries in Germany, Italy, the Netherlands and the United Kingdom. It is certified according to international quality and environment standards, ISO 9001 and 14001. According to TePe, all products are clinically tested and evaluated to meet the demands of consumers and professionals worldwide. The wide product range is developed in cooperation with dental experts to make good oral health possible for everyone. Thanks to the trust TePe has earned from professionals and consumers, the company claims to be market leader in many countries.

ANTHOGYR PRESENTS FIRST INSTRUMENT FOR AUTOMATIC OSTEOTOMY

A solution for performing osteotomies through impacted cre- atal access, OsteoSafe from Anthogyr can be used for all indications related to implant site preparation and bone remodelling in the context of vertical bone augmentation.

A pre-calibrated automatic impaction instrument, it is con- nected to a micromotor and is simple and quick to use owing to the sequence of four osteotomes for the placement of Axiom REG/PX implants.

Reproducible and precise, OsteoSafe allows controlled and regulated movement during impaction. Clinicians can also hold the instrument with just one hand for improved visibility during implant surgery. Since it isatraumatic, it offers improved patient comfort and better safety, the company said.

In addition to OsteoSafe, Anthogyr has a number of other instruments and dental implants on display at EAO.

ANTHOGYR, FRANCE
www.anthogyr.com
Booth G04

NOBEL INTEL INTRODUCES COMPLETE POSTERIOR SOLUTION

Adressing all problems a clinician faces when restoring a single tooth in the posterior, Nobel Biocare is trying to bring innovation back to the posterior region with its new complete posterior solution. Multiple Nobel Biocare nov- elities and solutions make up this solution complete, but the foundation for treatment success is the implant itself, the company said. Here Nobel Biocare offers several options, each engineered for the specific demands of the posterior.

A new variant offers the benefits of the NobelActive family but with dimensions ideal for the molar region. The NobelActive WP (wide platform) implant possesses a wider diameter implant body (5.5 mm) to better fit the large extraction sites in the molar region and a wider implant platform for an optimal emergence profile. NobelActive WP also comes in an option with a shorter body (7 mm) to avoid critical anatomical structures such as nerves.

Alternatively, clinicians can opt for NobelParallel Conical Connection (CC). Combining a parallel-walled implant body that is well documented with an advanced internal connection, this implant offers extraordinary flexibility. It is engineered for use in all bone qualities and for a wide range of indications. The 5.5 mm wide platform option is designed for an optimised emergence profile for large molar sites.

Both new implants also benefit from Nobel Biocare’s internal conical connection. This advanced connection’s conical seal and hexagonal interlocking mechanism provide high mechanical strength. It offers restorative flexibility too, being compatible with Nobel Biocare’s most innovative restorative solutions, including those designed specifically for posterior solutions. These include the new PEEK Healing and PEEK Temporary Abutments, which are anatomically shaped to match the molar contour exactly even under the high occlusal forces of the posterior.

There’s no worrying about chipping either, as the full contour nature of the NobelProcera FCZ Implant Crown to be placed anywhere in the mouth for easy access, even in the posterior. It also helps avoid placing the access channel on the cusps of a tooth, where it could affect occlusion. The associated Omnigrip Screwdriver further simplifies work on the restoration. Its effective pick-up function and secure grip on the screw help the clinician to work safely and efficiently.

Natural-looking tooth color is another benefit offered by the FCZ Implant Crown. Whichever of the eight available shades is used, the color is applied throughout the material. This means discoloration isn’t a concern when making adjustments. Cutbacks and staining can also be used to achieve the desired aesthetic effect.

NOBEL BIOCARE, SWITZERLAND
www.nobelbiocare.com/
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NEW V-CONCEPT BY MIS DELIVERS TRUE INNOVATION TO IMPLANT DENTISTRY

MIS Implants Technologies recently launched the new V3 implant, a multi-rooted design suitable for a wide range of surgical scenarios that is part of the company’s V Concept. “MIS Implants is now a frontrunner of innovation in implant dentistry,” this was the powerful message delivered by MIS at the product launch at EuroPerio8 in London.

“The V3 is set to change the future by offering unprecedented biological advancements not previously known in the dental implant industry specifically, the significant gain of bone- and soft-tissue volume where it matters most,” said Elad Ginat, Product Manager at MIS Implants Technologies.

He pointed out that this claim is supported by the placement of over 2,000 V3 implants in clinical cases performed and reported by some of implant dentistry’s most highly respected experts. The cases date back to 2012 and were treated in collaboration with numerous well-respected research institutes and universities around the world.

“The triangular coronal portion of the V3 is completely new in concept,” said Ginat. Its unique shape allows the formation of gaps between the sides of the implant and the osteotomy, creating open, compression free zones that immediately fill with blood to form a stable blood clot and accelerating osseointegration for more rapid bone regeneration, he explained.

The triangular shape further allows secure anchorage at three points and provides doctors with more flexibility in positioning the implant, either facing the flat side buccally or towards an adjacent implant as needed, to gain more bone. It is important to note that a wider V3 implant can be used in clinical situations in which a traditional circular implant would require a smaller diameter.

“With all the V3’s benefits, it is particularly effective in: bone loss situations, soft tissue conditions and difficult to communicate. In these cases, we believe that the V3 implant is the perfect option,” said Ginat.

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“In all situations, the V3 delivers a precise, aesthetic, and cost-effective solution to the implant dentistry market,” said Ginat.

The second point is aesthetics. The extra bone volume affects soft-tissue volume, which is further enhanced by the tuli-
The DTI publishing group is composed of the world’s leading dental trade publishers that reach more than 650,000 dentists in more than 90 countries.
FUTURE-ORIENTED SOLUTIONS FOR THE IDEAL DIGITAL WORKFLOW BETWEEN DENTAL PRACTICE AND LABORATORY ON DISPLAY BY HENRY SCHEIN

At the EAO congress in Stockholm, Henry Schein will present product and service highlights it has integrated into its Connect-Dental offering across Europe within the last few months. With Connect-Dental, Henry Schein offers a full solution that focuses on the digitalisation of dentistry and the optimum digital workflow between the practice and the laboratory. It includes a variety of components such as an extensive range of products and software, comprehensive services and profound training for the practice and laboratory team.

According to the company, Connect-Dental helps to improve the efficiency of the practice and laboratory and enhance the quality of patient care. Here is a brief overview of its power spectrum:

- Open architecture for individual solutions
- CAD/CAM systems from leading manufacturers serving the entire digital workflow—from digital impression to the finished restoration
- Comprehensive technology consulting and systems integration by the Henry Schein specialists with many years of CAD/CAM experience
- High-performance materials for CAD/CAM manufacturing, such as the comprehensive Zirlux range, including Zirlux FZ2®, a highly translucent zirconia, ex- clusive from Henry Schein—
- Optimum networking between practice and laboratory
- European-wide training and training events around open CAD/CAM solutions and new high-tech materials
- Individual consulting, leasing and financing services.

During the EAO Scientific Meeting in Stockholm, a wide range of highlight products from scanners, milling machines, abut- ment solutions and up to date consumables around digital dentistry will be showcased to demonstrate the new opportunities for high-quality implantology and the open architecture that Henry Schein provides to its customers under the umbrella of Connect-Dental. Especially, the Henry Schein Connect-Dental digital solutions around the implant workflow will be in focus:

- Individual screw retained abut- ments for all major implant systems produced chairside in the dental office
- Implant planning and guided surgery (3-D printed new service opportunity for dental labs and surgical guides: milled chairside in the dental office)
- Individual implant prosthetics lab side:
  - Digital impressions solutions and benefits for implant dentistry
  - 3-D Printing solutions for den- tistry

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Henry Schein currently has 190 CAD/CAM and digital special- ists in Europe, as well as 460 spe- cially trained technicians. Over 50 Henry Schein Dental Information Centres are able to provide indi- vidual advisory service and com- prehensive training with demon- stration programmes adapted to individual requirements.

HENRY SCHEIN
www.henryschein.com
Booth G17

CONFIDENT IMPLANT PLANNING WITH SOREDEX 3-D IMAGING DEVICES

At the EAO congress, Finnish manufacturer SOREDEX is present- ing easy-to-use imaging solu- tions for the most demanding prob- lematic and challenging restora- tion cases. Preoperative radi- ographic examination using a CBCT imaging device offers additional diagnostic information for confident surgery and implant planning. SOREDEX’s CRANEX 3D product line with 2D and 3D im- aging programmes is for implant- ologists and oral surgeons.

Dental imaging has never been as exciting as it is today, as 3-D im- aging is rapidly changing the way clinicians perform diagnosis and determine subsequent treatment. The SOREDEX CRANEX 3D and CRANEX 3Dx systems combine conventional 2D imaging with advanced 3-D imaging. The CRANEX 3D has two fields of view (FOV), i.e., 2D head and a 3D im- aging. CRANEX 3D has five FOV, of which 5 × 5, 5 × 8 and 8 × 8 cm are possibly the most suitable for implant and den- tal surgery planning. Larger FOV (8 × 15 and 13 × 15 cm) are op- tional.

Both units feature, along with high and standard settings, a low- dose programme called Miniodose. Miniodose 3-D scanning is recom- mended for radiation dose-sen- sitive cases, such as children, for implant planning plus imaging, and follow-up imaging, to name just a few applications. A specific endodontic programme ensures detailed diagnostic information for challenging cases. The units are integrated with OnDemand3D software, with all the required tools for successful surgery plan- ning, including automated arch, nerve mapping, implant pick and place, STL align and import, as well as the In2Guide surgical guide module.

SOREDEX provides tools and solutions for various procedures, courses around digital dentistry, endodontic and cephalometric imaging, as well as advanced 3-D head and neck and ENT imaging.

SOREDEX, FINLAND
www.soredex.com
Booth G17

3SHAPE RELEASES 2015 VERSION OF IMPLANT STUDIO, ADDS NEW FEATURES

The recently launched 2015 version of the digital implant planning and surgical guide solution offered by 3Shape offers several new features, including implant workflows for edentulous patients. It also comes with a new two-piece edentulous surgical guide design option in order to create split edentulous surgical guides with two separate connecting pieces. This will improve accessibility during surgery for the dentist, the company said.

The Implant Studio 2015 software provides flexible tools and workflows to support all major implant planning and treatment scenarios, as well as communications and snapshot tools to seamlessly share images and comments between dental practices and labs. Since it is an open platform, clinicians will have access to implant libraries from all major implant manufacturers, according to the manufacturer.

Introduced in 2014, Implant Studio enables dental practices and labs to plan and perform single or complex implant procedures by considering the aesthetics and intended final restoration as well as the overall clinical situation. Furthermore, dental professionals can design and output surgical drill guides ready for printing or milling thus making surgical drill guides more accessible and affordable. Implant Studio does this by merging CT/CBCT images with 3-D impression scans (STL files) from digital intraoral scanners such as 3Shape TRIOS, for example. The data sets are then used to create virtual tooth sets for prosthetic driven implant planning.

Data from Implant Studio can then seamlessly be shared with 3Shape’s dental lab solution Dental System for the restorative design and milling workflow steps.

“3Shape CAD/CAM solutions are so important because they enable us to work with and have confidence in all different patient data sets. From CBCT and intraoral scans to the clinical situation and restorative production, 3Shape has met our goal in allowing us to design cases with consistent data across a to- tally uniform platform,” commented Dr Alan Jurim, dentist and dental lab owner, New York, USA. “Implant Studio is the final key to this complete integration and for planning and achieving predictable implant proce- dures.”

Implant Studio 2015 is cur- rently available in the EU and several other countries. A re- lease in the US market will be an- nounced separately once avail- able, according to 3Shape.

3SHAPE, DENMARK
www.3shape.com
Booth G10

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BECOME THE 5th MEMBER

Buy your ticket at www.abbatemuseum.com or at the museum, Djurgårdsvägen 68.

Welcome!
Have you ever thought about how our lives might look in ten to fifteen years? This unique exhibition, which opened only last week, aims to provide answers with a number of artefacts and projects on display that show a future that brings biology and technology together and promotes a more self-sufficient domestic lifestyle. The potential for humans to live outside the earth is also explored.

Stockholm Beer and Whisky Festival
- Opening times: 14:00–midnight
- Location: Nåckas Strandsvägen, Augustenborgstorget 6, 131 52 Nåcka Strand
- www.stockholmbeer.se

Whether you like a good drop of beer, or whiskey is your thing, you should take the short trip to Stockholm’s nearby Nåcka Strand neighborhood. Held in a renovated former Volvo car factory, the 24th staging of this festival will stimulate your taste buds with some of the best local and foreign brews. Responsible drinking is advised.

Weird Al Yankovic
- Starting time: 19:00
- Venue: Gröna Lund, Lilla Allmanna Gränd 9
- www.gronalund.com

Michael Jackson, Madonna or Queen—there is probably no music icon in the world whose songs have not been parodied by this 56-year-old Californian comedian-singer. Having released his first single, a satirical version of Joan Jett and the Blackhearts’ “I Love Rock ’n’ Roll” in 1982, Weird Al has built up an impressive 14 studio albums over the last three decades, with his latest, Mandatory Fun, having just been selected the Best Comedy Album at the Annual Grammy Awards. His gig tonight at the Gröna Lund amusement park, the only one in Sweden, is part of a two-month epic world tour that will also see him perform in Norway, Denmark, the UK and Australia.

Spinning Jennies feat. Dan Berglund
- Starting time: 19:00
- Location: Stallet Folk & Världsmusik, Stallgatan 7
- www.stallet.se

Probably familiar to only a few select fans outside of Scandinavia, this Swedish bluegrass combo of five is a regular guest to the Stallet in Stockholm. Tonight, they are musically accompanied by Dan Berglund, who was a member of the award-winning Esbjörn Svensson Trio and is probably one of the country’s best upright bass and bass guitar players.
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— Ara Nazarian DDS

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