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An interview with EAO presenter and University of Bern professor Dr Martin Schimmel, Switzerland

“Age per se is not a contra-indication”

Prof. Dr Martin Schimmel

During a Friday morning session at EAO 2015 in Stockholm, Prof. Martin Schimmel from the Division of Gerodontology at the University of Bern will be discussing some of the ethical and financial challenges related to implant treatment of the elderly. Today spoke with him about these issues and the importance of offering this vulnerable population the benefits of implant therapy.

Today international: Implant manufacturers seem to be exclusively targeting younger age groups nowadays. Do you think the silver generation is being overlooked when it comes to implant therapy and, if so, what could be the reasons for this?

Prof. Martin Schimmel: I do not think that statement is true. Tooth loss is increasingly associated with elderly people. In my opinion, most manufacturers of dental implants are aware of the fact that people in the Western world are retaining their own teeth for longer owing to the successful implementation of preventive measures.

The treatment of trauma cases in younger people is rather limited. At the same time, the clientele for implant treatment is becoming increasingly older. Data from the Department of Oral Surgery and Stomatology at the University of Bern’s dental clinic clearly demonstrates this. Narrow-diameter implants are also explicitly marketed as “Gero” implants nowadays.

Why do older patients benefit from implant therapy in particular?

Prof. Schimmel: Particularly fully edentulous patients and those with an edentulous mandible benefit the most. Stabilising mandibular complete dentures with the help of endosseous implants is one of the greatest achievements in dentistry. Scientific studies have found many positive effects, including improved quality of life, satisfaction with dentures, masticatory functionality and reduced bone atrophy.

Partially edentulous patients can benefit from fixed implant prostheses functionally, as well as structurally. Conventional removable dentures have proven to be inferior, especially in free-end situations.

During a panel discussion at the EAO congress last year in Rome, it was found unanimously that there is no age limit for implant therapy. What is the maximum age at which dental implants could reasonably be used?

Age per se is not a contra-indication. Even in palliative care, implants may still play a valid role. Excluding people from the benefits of this therapy owing to their statistically lower remaining lifespan is unethical. However, one must consider exactly the point at which implants in the mouth do more harm than good – particularly in situations where cleaning is no longer possible and implants become merely a surface to which biofilms adhere. Furthermore, the possibility of medical contra indications does increase with old age.

What factors play a crucial role in the implant treatment of elderly patients, and what factors do clinicians need to consider compared to treatment of other age groups?

Prof. Schimmel: Of course, the interindividual variability between patients increases with age, meaning that the older the patient, the more personalised treatment strategies have to be. The planning and implementation need to be constantly adjusted to medical, psychological and social individualities. Minimally invasive surgical approaches and prosthetic treatment methods that take the reduced adaptability and other physiological changes due to age into account have proven successful in this respect.

In Western countries, the gap between rich and poor is ever widening. Elderly people are increasingly falling into the latter group. What measures can help to ensure their access to dental implant treatment?

Prof. Schimmel: The only path to broad access to these therapies for financially less well-off patients lies in private or public insurance systems. These are political issues. However, dentists, dental technicians and the industry are constantly working on industrial production structures and thereby reducing costs. Digital developments in dentistry will surely help to provide patients with otherwise expensive treatments for a much more reasonable price. Nevertheless, oversimplified production methods are often not suitable for the complex treatment needs of the elderly.

You have pointed out the benefits of digital production methods. What other measures could also facilitate access to dental implants for the elderly?

Prof. Schimmel: Nowadays, the bulk of the costs incurred is due to the hours of work performed by the dental team and technicians. Digital processes can help to shorten treatment times through innovative workflows. Moreover, quasi-industrial production methods can be used in less complex cases, thus reducing costs further.

It is important to note that implant manufacturers have maintained or even lowered their prices for quite some time. However, it remains important to evaluate the economic value of using low-cost implants, because they can have a much higher failure rate, as demonstrated by a recent Swedish study (Derks et al. 2015).

From a health policy standpoint, do you see any deficits in the subsidisation of dental implants for the elderly?

Prof. Schimmel: This might differ from country to country. In Switzerland, for example, the subsidisation of patients with low income is evaluated individually by local authorities. The treatment of persons who receive social security benefits or needs-based minimum benefits is subsidised if implant therapy can be performed in a simple, economical and appropriate way. Two inter-oral implants, for example, will be reimbursed if conventional prosthetic treatment is not able to restore a patient’s chewing ability.

In the statutory health insurance system, there is an obligation to perform the therapy if the loss of teeth was due to the occurrence or treatment of a severe disease, or to an accident or birth defect. There is certainly room for other indications, but one also has to consider the burden for the social security systems. In my opinion, Switzerland has established a sufficient and balanced system.

Thank you very much for the interview. «
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Ongoing opposition to pricing trends to influence Asia Pacific dental implant market

The various countries in the Asia Pacific region are all expected to demonstrate an increasing demand for dental implant treatment, driven by growing consumer awareness, the ageing population, growing accessibility (such as through the National Health Insurance Service coverage in South Korea), as well as greater product availability and other influencing factors. Traditionally, premium implant companies have dominated the dental implant market globally. However, in recent years, discounted implants have become increasingly popular, especially in the Asia Pacific region.

The growth of the discount implant segment will emerge at the expense of the premium segment and as a result is set to limit market growth of the dental implant fixtures by lowering the market’s overall average selling price (ASP). In contrast, the premium abutment market is set to experience an increasing ASP owing to the growing adoption of CAD/CAM abutments in the place of stock abutments. While commoditisation of stock abutments has greatly depressed the ASP of the final abutment market, growing adoption of CAD/CAM abutments is set to stimulate the final abutment market by pulling the ASP upwards. Therefore, the dental implant market is set to grow in all four countries included in the Asia Pacific region in the report, namely Australia, South Korea, Japan and China, despite varying pricing trends.

In the Asia Pacific dental implant market, consumer awareness, cultural tendencies and domestic regulations vary greatly. South Korea presents the most highly developed dental implant market as a result of being home to a number of global leading dental implant companies. This in turn has led to a high level of consumer awareness and early accessibility to a variety of dental implant products. However, the dental implant market in South Korea is also highly discount dominant and led by domestic implant producer OSSTEM IMPLANT and was expected to demonstrate the lowest regional ASP of US$86 in 2014.

In contrast, the Australian market remains highly dominated by leading premium implant companies, which collectively held over 70% of the domestic market. Consequently, Australia demonstrated the highest dental implant fixture ASP in the region at US$455 in 2014. An increasing number of general practitioners are being trained in dental implant procedures in Australia, and general practitioners have been observed to be more cost sensitive relative to specialist plant Research and Education Center. All segments of the dental implant market in China are expected to demonstrate double-digit annual growth. However, the discount market is set to grow far more dramatically throughout the forecast period. By 2021, discount implant fixtures are set to represent over 50% of the overall units in the Chinese dental implant market.

The shift towards discount implants in Japan is expected to be far less dramatic, especially owing to cultural barriers that limit the success of Korean dental implant companies. The premium implant segment is expected to remain the dominant dental implant market throughout the forecast period.

The Japanese and Chinese markets for dental implants are also dominated by premium companies. In recent years, OSSTEM IMPLANT has had a significant impact on the Chinese market, however, especially as a result of the training programme offered by the company’s Advanced Dental Implants. As a result of a growing number of general practitioners in the market, consumer preferences are shifting towards discounted solutions. Discount implant companies from the US and South Korea have recently been gaining market share in Australia. Throughout the forecast period, the premium segment of the market is expected to grow at far lower annual growth rates relative to the discount and value segments in Australia. By 2021, it is expected that discount implant fixtures will represent 43% of the overall units in the Australian market.

Growing CAD/CAM abutment adoption vs increasingly popular discount implants

Growing popularity of its products. Throughout the forecast period, OSSTEM IMPLANT and other discount implant companies, such as MegaGen, Dentium and Neo-biotech, are expected to capitalise on the growing popularity of disposable implants.

Growing CAD/CAM abutment market vs declining unit share of stock and custom cast abutments.

The growth of the discount implant market is expected to increase significantly from 11.5% currently to 14.6% by 2021. The growing acceptance of discount implants has been driven by Korean companies. The regional market leader, OSSTEM IMPLANT, has demonstrated the lowest regional dental implant ASP of US$86 in 2014.

Growing CAD/CAM abutment market vs declining unit share of stock and custom cast abutments. The various countries in the Asia Pacific region are all expected to demonstrate an increasing demand for dental implant treatment, driven by growing consumer awareness, the ageing population, growing accessibility (such as through the National Health Insurance Service coverage in South Korea), as well as greater product availability and other influencing factors. Traditionally, premium implant companies have dominated the dental implant market globally. However, in recent years, discounted implants have become increasingly popular, especially in the Asia Pacific region.

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Bisphosphonates: A threat or an option?

By Prof. Per Aspenberg, Sweden

Most dentists will be familiar with bisphosphonates mainly as a cause of osteonecrosis of the jaw (ONJ). ONJ is a complication of systemic treatment. In contrast, locally applied bisphosphonates have been proven efficacious for improving the fixation of dental implants. Theoretical reasoning, experimental data, and small clinical trials suggest that local application of bisphosphonates is safe and effective in periodontology and implant surgery.

Bisphosphonates have positive effects on many conditions in bone and few and rare side effects. Their efficacy in osteoporosis is well known, and there is evidence for improved implant fixation in an increasing number of applications. In dentistry, however, bisphosphonates are often regarded negatively, owing to the small risk of ONJ.

ONJ is indeed a problem. However, there is theoretical and clinical evidence to suggest that the risk of ONJ can be avoided by local treatment. Local bisphosphonate treatment has shown beneficial effects without complications in randomised blinded clinical trials in periodontology and dental implant surgery. How can this be? Here is an explanation:

Bisphosphonates either bind to bone mineral or are quickly excreted. Normally, they do not enter cells and are therefore not toxic. Only osteoclasts can resorb bone, and when they do so, the dissolved bone material passes through the cell. Therefore, bisphosphonates can reach the intracellular space of osteoclasts. Once inside the osteoclast, they will inactivate the cell and thus reduce bone resorption.

When bone is infected, the bone surrounding the infection will be quickly resorbed. The infected bone will therefore become surrounded by richly vascularised soft tissue that demarcates the infected area. Thus, a good resorption capability is important for preventing the spread of bony infection. This protection mechanism can be impaired if resorption is reduced by any potent anti-resorptive, leading to the spread of infection and established osteomyelitis.

In dentistry, this kind of osteomyelitis is called osteonecrosis. From a pathophysiological perspective, ONJ is a somewhat misleading term. The already well-known anti-osteoclastic effects of bisphosphonates are sufficient to explain ONJ without suppositions about other, less known mechanisms. Moreover, the theory fits with the observation that non-bisphosphonate anti-resorptives are associated with ONJ too.

When implants are inserted into bone, numerous studies have shown that—especially in cancellous bone—bisphosphonates reduce the resorptive response to the trauma without impairing the bone formation response, therefore having a net anabolic effect. This explains why both local and systemic bisphosphonates have been shown to improve the early fixation of knee and hip replacements in randomised blinded clinical trials.

Because bisphosphonates bind strongly to bone, local treatment will stay local. Bisphosphonates applied to a bone surface will stay there more or less forever, and thus not impair the resistance to infection anywhere else. In an animal model of dental implants at sites compromised by local woundind, the author’s group showed that systemic bisphosphonate treatment induced osteomyelitis (ONJ), whereas implants with a bisphosphonate coating improved implant fixation without problems in spite of the compromised insertion site.

Moreover, if an implant site in humans was infected, only the bone about one millimetre away from the implant surface would contain bisphosphonate and could be removed if necessary.

In a randomised blinded controlled trial of dental implants coated with a protein layer loaded with bisphosphonates, improved fixation was demonstrated. The resonance frequency was 6.9 ISQ units higher for the coated implants compared with the controls (p<0.0001; Cohen’s d=1.3). Radiographs showed less marginal resorption both at two months (p<0.012) and at six months (p=0.002). The patients were followed for five years without complications.

To conclude, systemic anti-resorptives may impair protection against osteomyelitis, thereby increasing the risk of ONJ in patients with other risk factors. Local bisphosphonates seem not to confer this risk, and improve implant fixation by their net anabolic effect. Local bisphosphonate treatment could become an important tool in dentistry and maxillofacial surgery.

Editorial note: A list of references is available from the publisher.

Conflict of interest declaration: The author has shares in AddBIO.
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”Patients tend to go to court more often nowadays”
An interview with Dr Andy Wolff, Israel

Dr Andy Wolff talking to Group Editor Daniel Zimmermann. (© Kristin Hübner/DTI).

With the consequence that patients partially lose sensation in the mouth or face?
Yes. Another consequential damage is that the patient now has to live with chronic pain for the rest of his life. If I had to choose one, I would say an impaired patient files charges for something that happened to him 20 years ago that would have been preventable with the latest medical treatment. He can, of course, make a claim, but the dentist could not be sued for it if he or she treated the patient according to the best knowledge available at that time.

That is an important aspect when writing expert reports on dentists and their treatment. It is the dentist’s act to the best of his or her ability and according to the current knowledge or with gross negligence that is what makes the difference.

What can medical professionals do to protect themselves against legal disputes arising from high-risk procedures they intend to perform?
Patients should not only be warned of the possible consequences of a certain procedure, but also be advised of the alternatives—and one of those alternatives is not proceeding with treatment at all. In my opinion, the patient should always understand both options: the risks of a particular treatment and what could happen if nothing is done. Only then should the patient be asked to sign a declara- tion of consent.

Unfortunately, the reality is often quite different. Patients are often asked to sign declarations of consent on their way into surgery or while already on the dental chair. Even if they had questions then, there would be no time to answer them properly. Although it should be of major concern for everyone involved to perform the patient’s risks, as well as alternative treatment methods, before he or she is asked to sign a consent form, I am constantly confronted with the opposite.

So, you are saying that consultation should be of similar importance to treatment?
Absolutely. In my opinion, building mutual trust between doctor and patient is key for avoiding malpractice claims and contractual charges. If patients feel that their condition is being properly treated, and that money is not the dentist’s first concern, this alone can prevent litigation in many cases. Of course, there will always be instances where bad news has to be communicated, but competent advice and mutual trust can prevent unnecessary complications.

I certainly see many cases in which dentists have carried out a treatment for which they were not qualified. I remember an incident in which a general practitioner Injected nerves on both sides of the mouth during a dental treatment. That is truly unbelievable. I have seen many cases over the years, but nothing quite like that.

In another case, a dentist extracted a third molar without the requisite training. He should have referred the patient to a specialist, but he chose to do it himself—possibly because it earned him another US$200–300 (€130–190) with the result that the patient now has to live with chronic pain for the rest of her life.

Can injured nerves regain normal function eventually?
Mostly, damage is irreversible. There are exceptions, of course, either if the damage was not too severe or if the nerve was inside a canal. Potentially, an injured nerve can regain function over time. However, if it is an exposed nerve, such as the lingual nerve, the damage is generally irreversible, although there are some microsurgery procedures that may improve the situation. Interventions like this, however, carry extremely high risks themselves and might even aggravate the situation.

It is perhaps comparable to plastic surgery. There are many complaints filed for cases in which the result was not what the patient expected it to be. Compensation payments range from US$10,000 to 100,000, which is much lower than those in other medical disciplines.

Do more cases of overtreatment or cases of error on behalf of the dentist end up in court?
These cases have an almost equal occurrence. Of course, overtreatment of the dentist in a bad position. It raises the question of why he or she treated the patient in this way—and in the first place and did so poorly in the sec- ond; it leaves him or her doubly guilty: If a reasonable treatment plan had been formulated, it was comparably less bad. Sometimes, even if a patient dies while undergoing therapy, this does not need to involve a distinct fault of the clinician.

An American dentist was recently sued because his patient died after he extracted 20 teeth in one procedure. I find it odd that he did such an extensive treatment in the past; it depends on the need for the treatment in question. Hopefully, that case in the US was the result of a combination of many factors. For instance, did the dentist act in accordance with state-of-the-art practice? If not, he is at fault. If he did, one has to remember that dentists cannot rise above today’s level of knowledge and technology. Let us say an impaired patient files charges for something that happened to him 20 years ago that would have been preventable with the latest medical treatment. He can, of course, make a claim, but the dentist could not be sued for it if he or she treated the patient according to the best knowledge available at that time.

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course, if a nerve is damaged, there needs to be a settlement of some kind, but if a bridge fails, for example, instead of filing charges the patient will return for further treatment if there is a solid, trust-based relationship.

Time, communication, trust—what else is important when it comes to preventing malpractice?

One more basic rule every dentist should follow is adhering to evidence-based dentistry. This means not performing a certain treatment just because in the dentist's experience it is considered to be right. External scientific evidence should be implemented. Also, every single finding should be taken into account in determining how to treat the individual patient: diagnosis, radiographs, periodontal analyses, age, health status, literature and so on. Neglecting these related aspects can very likely lead to misconduct.

Do you see basic problems in dentistry that need to change?

Nowadays, we face the problem of “cheap” dentistry. Owing to the amount of competition with the large number of dentists in the market, there are many cases of overtreatment. Cheap dentistry needs to be fast, yet I have documented cases in which patients have returned for retreatment of a simple problem up to 70 times in two years. If you add up the time those patients invest only to have a poor outcome, it is striking. However, it is not possible for there to be elite dental practices solely. For legal purposes, dental treatment does not need to be exquisite, but it has to be reasonable.

Maybe it is a problem of today that patients have increasing expectations regarding the service or technologies their dentist should be using.

That is certainly part of the same problem. Advertising that promises people a new Hollywood smile in 2 hours forms the basis of patients’ beliefs or expectations regarding treatment. Dentists should not be tempted to involve themselves in this kind of misguided pressure. Honest communication is key when aiming to avoid disappointing patients.

Measures to prevent malpractice should begin as early as possible, but where should prevention start?

Personally, I think legal regulation should be extended, such as specific laws or by-laws concerning the amount of experience and training, for example, required in order to perform certain procedures. Basically, it is just what common sense calls for and everybody will agree with if they think about it: should one be allowed to place an implant after attending a speakers’ corner talk or looking over a colleague’s shoulder? No, yet this is often what happens.

A second measure could focus on undergraduate education. Dental schools should devote more time to prevention of lawsuits. This aspect is neglected in the curriculum, although it is an essential part of dentistry. General awareness of the subject needs to be raised and this alone would help prevent mistakes. As I said earlier, mistakes are not always avoidable, but they should at least not arise out of negligence, hubris or greed. Apart from that, there will always be cases of medical malpractice. Dentists are humans too; only he who does nothing makes no mistakes at all.

Thank you very much for the interview.
Congress programme of the EAO Congress 2015

Friday, 25 September

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

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

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

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

CAD/CAM, precision of fit
The future implant crown—chairside vs. labside
Speaker: Per Vult von Steyern

Is ceramic the material of choice for future implants?
Speaker: Dianne Rekow

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

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

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

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

3-D printing in prosthetics
Speakers: Irena Sailer & Vincent Fehmer

13:15–14:45
Oral Communications

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

Consensus conference 2015
13:15–14:45
To learn from complications

Maxillary sinus grafting complications and how to avoid them
Speaker: Pascal Valentinzi

The surgeon as the complicating factor
Speaker: Franck Renouard

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

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

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

VA0 planning, 3-D printing and more
The virtual patient: How far away are we?
Speaker: Thabo Beeler

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

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

3-D printing in prosthetics
Speakers: Irena Sailer & Vincent Fehmer

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: Ian Couyn

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

Management of bone defects in the aesthetic zone.
Speaker: Debus Li

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

Saturday, 26 September

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

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

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

Do we still need to use Hounsfield scores in presurgical planning?
Speaker: Reinhold Jirosch

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

Invited societies programme
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

10:45–12:15
Poster presentation competition

13:00–13:30
Closing ceremony

How to select a Nobel Prize Laureate in Medicine or Physiology
Speaker: Urban Lundahl

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 Zuhri

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

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

Closing ceremony
15:15–15:30
Exhibition  Live Product Presentations  Hands-on Workshops
Printed Reference Guide  Coffee With the Experts

Moscow  Budapest  Istanbul  New York

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Floor plan

Floor plan and the exhibitors list are subject to change. Last update was 7 September, 2015.
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*Floor plan and the exhibitors list are subject to change. Last update was 7 September, 2015.*
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Welcome!
During the last five decades, TePe has evolved from a small-scale produc-
tion company into a high-
technology manufacturing enter-
pri
e此外,在各地区,这些公司已经
已
了口腔疾病的推广。所有生产
的
品
据
ten and for their high quality and effi-
ciency worldwide, accord-
ing to the company.

The original series includes
nine colour coded sizes to fit nar-
row and wider interdental paces
but there are also variants with
softer filaments or an angled
brush head and a longer handle.
The latest complement to the in-
terdental 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 in-
cludes floss, dental sticks and in-
ter
terdental gels, the company said.
TePe Mundhygienprodukter AB is
a family-owned Swedish com-
in
pany, its history began in 1965
when woodcarver Henning Eklund
developed an innovative tri-
angular
dental stick in collabora-
tion with the School of Dentistry
in Malmö. The user-
friendly TePe tooth-
brush was first in-
troduced 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 spe-
cific oral hygiene needs, such as
care of implants and orthodontic
appliances, alongside a range of
pedagogic materials, enabling in-
dividually tailored education and
instruction to patients.

Based on the vision of healthy
teeth for all throughout life, TePe
says to work for raised oral hy-
giene 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 King-
dom. It is certified according to in-
ternational quality and environ-
ment
standards, ISO 9001 and
14001. According to TePe, all prod-
ucts are clinically tested and eval-
uated to meet the demands of con-
sumers and professionals world-
wide. The wide product range is
developed in cooperation with
dentists 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 coun-
tries.

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ANTHOGYR PRESENTS FIRST INSTRUMENT FOR AUTOMATIC OSTEOTOME

A solution for performing osteotomies through impacted crestal access, OttoSafe 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 connected to a micromotor and is simple and quick to use owing to the sequence of four osteotomes for the placement of Axiom REG/PP implants. Reproducible and precise, OttoSafe 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 is automatic, it offers improved patient comfort and better safety, the company said.

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

ANTHOGYR, FRANCE
www.anthogyr.com
Booth G04
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TRI HIGHLIGHTS TRI ESTHETIC LINE IN STOCKHOLM

In the occasion of EAO 2015 in Stockholm, the up and coming Swiss dental implant company TRI Dental Implants is exhibiting its recently launched TRI Esthetic Line with restorative products for an optimised aesthetic management of soft tissue. A new member of the TRI product family is the TRI Octa Tissue Level Implant with gingiva coloured 1.8 mm tip that provides better levels of translucency. It is supposed to improve adaption of the implant to the gingiva thus preventing the latent risk of ‘gray shadows’ as well as recession of the gingiva in tissue level implants.

In a study conducted by the University of Zurich, the improved translucency levels for the implant shoulder were confirmed by the University of Zurich, the implant shoulder were confirmed. The implant shoulder was the powerful meso-facet of the implant, the S-shaped root in the gingiva, thus preventing the latent risk of ‘gray shadows’ as well as recession of the gingiva in tissue level implants.

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NEW V-CONCEPT BY MIS DELIVERS TRUE INNOVATION TO IMPLANT DENTISTRY

MIS Implants Technologies recently launched the new V3, a multi-use implant 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,” stated GR Oakley, MIS Global CEO. The new product line was the powerful meso-facet of the implant, the S-shaped root in the gingiva, thus preventing the latent risk of ‘gray shadows’ as well as recession of the gingiva in tissue level implants.

“The V3 is set to change the future by offering unprecedented biological advantages 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 2013 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 osteointegration 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, explained Ginat. “It’s all part of the innovative V-Concept, as a three-point universal approach to implant dentistry,” stated Ginat. The first point is the innovative V3 implant itself that comes with a single-use final drill for an exact osteotomy, shaped to provide optimal primary stability in all bone types. The triangular head of the implant reduces cortical bone compression without compromising cortical anchorage.

The second point is aesthetics. The extra bone volume affects soft-tissue volume, which is further enhanced by the tulip-shaped prosthetic connection, realising sustainable and healthy results. With more bone and soft tissue to work with from the start, clinicians can attain much higher aesthetic outcomes and reduced healing times.

The third point is simplicity, part of the MIS “Make it Simple” philosophy. Doctors can enjoy all the benefits of the innovative V-Concept benefits of greater bone and soft tissue volume without learning new protocols or procedures. In addition, individual surgical kits make procedures simple, safe and accurate.

“The V-Concept is an innovation MIS is very proud of, especially since it directly benefits our customers. It helps dental professionals all over the world simplify procedures, improve success rates, reduce chair time and achieve better aesthetic results,” concluded.

TRI PLANTS, SWITZERLAND www.tri-implants.com Booth S05

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 platform across Europe within the last few months. With Connect-Dental, Henry Schein offers a full-service solution that focuses on the digitalization 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 FZG, a highly translucent zirconia, exclusively from Henry Schein
- Optimum networking between practice and laboratory
- European wide information 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, abutment 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. Particularly, the Henry Schein Connect-Dental digital solutions around the implant workflow will be in focus:

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

Connect-Dental Digital solutions for practices and laboratories

ConnectDental is the comprehensive Zirlux range, including Zirlux FZG, a highly translucent zirconia, exclusively from Henry Schein. 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. The triangular head of the implant reduces cortical bone compression without compromising cortical anchorage.

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“The V-Concept is an innovation MIS is very proud of, especially since it directly benefits our customers. It helps dental professionals all over the world simplify procedures, improve success rates, reduce chair time and achieve better aesthetic results,” concluded.

Connect-Dental, Henry Schein provides several years of experience, individual consulting, high-class equipment and a wide range of consumables from different well-reputed supplier partners, comprehensive services and trainings—a concept that works and enjoys popularity among our customers all over the world.”

Henry Schein currently has 190 CAD/CAM and digital specialists in Europe, as well as 460 specially trained technicians. Over 50 Henry Schein Dental Information Centres are able to provide individual advisory service and comprehensive training with demonstration procedures adapted to individual requirements.
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**Balkan Night**
- **Opening date & time:** 25 September, 19:00
- **Venue:** Debaser, Hornstulls Strand
- [www.debaser.se](http://www.debaser.se)

Back from their successful tour of Serbia, Stockholm’s own Šuperstar Orkestar will spice up your Friday with their uplifting interpretation of Balkan brass music. Adding to the experience are Folklor Stockholm Saran, who want to entertain you with their Serbian dance extravaganza, as well as local DJ Sandra Choco Canel-Bergman, who will be playing some of the latest tunes from Zagreb, Belgrade and Sarajevo.

**FIM Speedway Grand Prix Sweden 2015**
- **Date & starting time:** 26 September, 19:00
- **Venue:** Friends Arena, Råsta Strandväg 1, 169 79 Solna
- [www.friendsarena.se](http://www.friendsarena.se)

In its 21st season, this speedway bike race series reaches its final phase with the Swedish Grand Prix to be held this weekend at Stockholm’s national football stadium. Last year’s champion Greg Hancock from the US has had a rough season and will try to gain ground on British rival and current championship leader Tai Woffinden in this decisive race before the series moves on to Poland and Australia, the last two dates in this year’s grand prix calendar.

**ABBA The Museum**
- **Opening times:** 10:00–18:00
- **Location:** Djurgårdsvägen 68
- [www.abbathemuseum.com](http://www.abbathemuseum.com)

A relatively new addition to Stockholm’s list of attractions, this

There is probably no better way to experience the city of a thousand islands than by water. Passing under 15 bridges, hence the name, the tour allows you to experience some of the city’s most famous places and sights, including the Old Town (Gamla Stan), Hammarby Sjöstad and the green areas of Djurgården. Some of the islands the tour will also pass are hipster hotspots Södermalm, as well as Lilla and Stora Essingen. The tour takes slightly under 2 hours and departs from the ferry terminal next to Strömbron bridge.
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