The Implant Centre helps more GDPs restore cases for their own patients

One-day events in Crawley help general dental practitioners gain the confidence to undertake the restoration phase of their patients’ implant treatment

More than 150 general dental practitioners attended two one-day events in Crawley at the end of November 2009 to learn more about restoring dental implants for their own patients. Presented by Mr Bill Schaeffer, Mr Guy Barwell, Dr Tony Rose and the team from The Implant Centre Haywards Heath, the events featured the ANKYLOS implant system and were supported by DENTSPLY Friadent.

Currently placing 1,000 implants per year, The Centre has grown rapidly, with increasing referrals from dentists who restore cases for their own patients. It holds regular free courses to introduce colleagues to dental implant treatment and help them learn how to undertake the restoration phase. The courses include ‘R²LAX’ evenings and whole day restoration conferences, with three-six hours of verifiable CPD. Because of the growing numbers of dentists referring and restoring cases, The Implant Centre has already outgrown the premises in which the practice was established only three years ago.

According to Bill Schaeffer, “We’re seeing more and more implant cases referred every week, with around 40 per cent currently being restored by the patient’s own dentist. Many more local dentists are enjoying the excitement and satisfaction of restoring dental implants, and are finding them to be an easy, fun and profitable part of their practices. Most dentists who attend the training feel completely happy to begin restoring dental implants straightforwardly after one of these courses”.

General practitioners don’t need to buy any costly equipment, because The Implant Centre provides everything else needed to take implant-level impressions. Guy Barwell explains: “All that’s required by the GDP is the usual crown and bridge materials, impression trays and impression materials. An Ankylos restorative kit is supplied completely free by DENTSPLY Friadent, when dentists restore their first implant case. The GDP is always provided with detailed letters, photographs and the correct impression components for each case. We even partially complete the lab sheet needed for the specialist dental implant laboratory that we recommend”.

The Implant Centre offers a dedicated dental implant service to provide a permanent solution to missing teeth. Located in Haywards Heath, Mid Sussex, the state-of-the-art facility was designed specifically to provide dental implant surgery for dentists and their patients across southeast England. According to Bill Schaeffer: “Our team of doctors, dentists, nurses and support staff are committed to making the experience of dental implant surgery simple, efficient and pain free in a relaxed and contemporary environment”.

More than 500 local dentists refer cases to The Implant Centre, an increasing proportion of which are restored by the patient’s own general practitioner. Following initial assessment and implant surgery, as soon as each dental implant has osseointegrated, the patients are returned to their own dentist with the appropriate impression components. Guy Barwell adds: “Simple dental implant cases can be even easier to restore than natural teeth. Let’s face it, dental implants don’t have a pulp you need to avoid and you don’t even need to use fiddly retraction cord! For dentists involved with implants, bridges are fast becoming a thing of the past”.

Implant Restoration in General Practice is a course designed for dentists who are considering advancing from simply referring patients for treatment to becoming involved in the restoration of natural teeth. The day includes hands-on training using models and provides attendees with a sound knowledge of cases that are suitable for implant treatment. The programme shows numerous cases that have been restored by GDPs. It covers treatment planning, impression taking, restoring straightforward cases and avoiding complications.

The Advanced Implant Restoration course examines the next level of implant restoration for more experienced practitioners. It is aimed at dentists who have already attended the Implant Restoration in General Practice course and have restored at least one case. Attendees examine more advanced treatment planning and more complex restorations, including screw retained restorations, bridgework and full arches.

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The Endo-Implant Algorithm

Dr Jose Hoyo explores the concept of endo-implant Algorithms and the surprising importance of endodontists in dental implant treatment planning

There’s a new vision in dentistry which is slowly being recognised and referred to as the “Endo-Implant Algorithm”. This new approach sees the role of the endodontist as a critical one when considering whether a tooth can be saved or whether extraction and replacement with a dental implant is the correct treatment protocol.

An endodontist is in a unique position to evaluate critical factors leading to endodontic failures to determine whether another endodontic procedure will lead to a predictable and successful outcome. If the outcome is not favourable, then extraction and replacement with a dental implant will be the protocol to follow.

When considering what the ideal treatment plan should be, it is imperative to provide the patient with all treatment options as well as the financial cost and procedures associated with each treatment option. In doing this, the patient is then being given the opportunity to make an educated decision as to what is the best treatment protocol for him or her. The information presented to the patient should include what, in the endodontist’s opinion, is more practical and predictable.

Figure 1: Pre-operative radiograph prior to extraction.

Figure 2: Bitewing radiograph after decay was removed.

Figure 3: Grafted socket following extraction.
Case study
A patient with a non-contributory medical history was referred to my office for evaluation of the maxillary left first molar. The pa-
tient was asymptomatic and the tooth had been endodontically treated by a general dentist approxi-
ately seven months prior to the consultation and had nev-
er been restored.

Clinically it presented no temporary restoration, extensive decay, probing depths of three mm all around, and exposure of the obturated material to the oral cavity. Radiographically, no periapical lesions were detected, and the bone levels around the tooth were adequate. (Figure 1)

Under the isolation of a den-
tal rubber dam, the use of 4.5x magnification and supplemen-
tary illumination provided by the use of a fiberoptic head-
light, some excavation was per-
formed to determine the integ-
rety of the tooth structure. After removing the decay, a bi-
tewing X-ray was taken (Fig-
ure 2) and the following was determined: a) the floor of the pul-

dp chamber was too shallow, b) it was too close to perforation and c) the periradicular dentin was not strong enough to sup-
port a permanent restoration. These were critical factors, in
my opinion, rendered the tooth non-restorable.

A cotton pellet and Carv it were placed in the access cavity and a referring the referring dentist was conducted to update him on the condition of his pa-

tient and to determine what rec-


tomendations should be given in regards to the tooth. It was recom-

mended to the patient that the tooth be extracted and the socket preserved through a


doctoring grafting procedure. This
would allow for an ideal amount of bone to receive a dental implant approximately four to six months down the line.

It was also recommended that he receive some orthodon-
tic treatment prior to the implant being placed so that all the di-

astems were close and the den-

operation properly aligned for this procedure. The patient clearly
understood the concept and the


logistics of the orthodontic treat-

ment that was being recom-

mended this but expressed no

interest in this approach.

The bigger picture
It is very important when getting involved with implant dentistry to look at the whole dentition and not just the space or tooth in question. We should keep in mind that implants unlike teeth do not move, so if there are any misalignments in the dentition the recommendation of ortho-


dentist is critical.

Mary UK dentists choose not to provide dental implant

surgery either because they are not familiar with the technique or because they perceive the costs to be too high for their patients. However DIO is quickly demonstrating that the cost is rapidly becoming less of a problem and, by using the company’s range of dental implants, even dentists that are relatively inexperienced in implant surgery can quickly learn to perform the procedure successfully. What’s more, DIO will assist dentists in mastering their surgical skills and help their practice to publicise and market their services to patients.

To prove how easy the new DIO implants are to use, Dr. Arif Lalani, principal of Smile Dental Implants and the dental advis-

or for the Kingston vocational training scheme at Kingston Hospital, will be performing live implant surgery at The Den-

tistry Show 19-20 March at the NEC. This will be the first
time live implant surgery will have been shown in public

in the UK. Although Dr. Lalani is comparatively new to implant surgery he says that working with the DIO implants makes the process relatively easy. “Working with DIO’s implants is so simple and straight forward. They have no quirks,” he said. “They are the perfect way to start for those dentists considering offering implants as an extra service to their patients.”

Dr Lalani learned the techniques necessary from one-on-
one training with Dr David Fairclough, an experienced DIO

trainer and a founder member of the Association of Dental Im-

plantology. “I’ve been using dental implants for over 20 years now and I’ve tried most systems. When I came across DIO’s system it seemed to be the easiest to use at an affordable price. The implants are very easy to place and they have very good primary stability which is important,” he said. He added that the back-up service he received from DIO was very valuable to him. “One of my big criticisms of implant companies is that they sell you the implants and then you get very little back-up from them afterwards. This hasn’t been the case with DIO.”

DIO’s UK Managing Director, Iain Forster, said that DIO and Dr Lalani were a perfect fit. He said, “Arif is one of the refreshing breed of implant surgeon who is not blinkered by convention and happy to do whatever is best for his patients and his business. It is freethinking pioneers like Dr Lalani who will lead the new generation of implant care.”

The best implant on the market?
The simplicity of the process is largely attributed to the

innovative design of the implants fixtures them-

selves. The advanced tapered design features a dou-
uble thread to increase primary stability, achieve high

stability even with low bone density, prevent cortical

hole loss, significantly reduce stress and increase the

opportunity for immediate loading. The self tapping

cutting edge allows easy insertion and automatically

removes cut bone. The design also promotes fast heal-

ing and gingival recovery.

Tackling the cost
DIO has made significant strides to reduce the cost of the implants themselves thereby reducing the overall cost of treatment making implant surgery a real option for many patients who would have considered it too expensive in the past. According to Dr. Iain Dandapat, the principal dentist at The Dental Implant Centre, Reading, British dental patients have been paying over the odds for dental implants for years with patients often travelling abroad to find treatment they can afford. In an interview Dr. Dandapat said that it’s now time for a change. “Either the implant companies are going to support us through this recession or we’ll learn from our experiences and move on,” he said, adding that the UK price to a patient for a dental implant, abutment and crown varies from around £1,800 to £5,000 per tooth. In Europe the same treatment is available for approximately £1,100. “We can’t compete with that unless the implant manufacturers help us.”

DIO has taken up the challenge and is marketing its popular DIO SM implant in the UK at prices that are less than half of most of the competition. Dr. Dandapat states, “The significant savings achievable are probably sufficient to stop patients buy-

ing a ticket to Delhi, New York or Paris to have the work done – thereby keeping the business at home for British dentists.”

Marketing help
DIO is very much aware that it’s all very well for dentists to

learn new skills and develop new services, but the effort

is often wasted if their patients are not made aware of what’s on offer. A few posters in the surgery don’t constitute a market-

ing plan.

So, to help dentists promote their implant services the com-

pany is providing advice and guidance on marketing tech-

niques that dentists can employ to spread the word. These

include help with local PR, website design, search engine

optimisation, brochure and leaflet design and production, the

use of social networking, etc.

Iain Forster explained that this is not simply altruism from DIO. “For us, it’s not enough to simply provide our high

quality implant systems for the UK market; we need to help our dentists to promote their services. By helping to in-

crease sales and marketing efficiency, whilst enabling them to simultaneously increase their margins, we’re helping the dentists to help their patients and increase turnover, which is helping us too. Everyone wins!”

DIO Implants

www.DIOUK.com

sales@DIOUK.com

08451235596

Arif Lalani

Smile Dental Implants

Cheam, Surrey

contact@smiledentalimplants.com

020 8064 1416

For more information on DIO implants and to see first hand how the surgery is performed, visit The Dentistry Show, 19-20 March at the NEC.
The sutures are removed two weeks later, and two weeks after the suture removal, the patient was seen again for the removal of the membrane. This step is done by gently picking at the membrane with cotton pledgets and just pulling on it – there is often no need for anesthesia.

The benefit of using this mixture of allograft is that the waiting period for re-entry is approximately four to six months versus six to nine if we had used a xenograft material. The quantity and the quality of the bone seem to be much better with the use of this (or a similar) allograft cocktail.

At the time of re-entry the patient’s blood pressure was 115/69, HR 64. (Figures 4 & 5)

Under local anesthetic (Lidocaine two per cent Hcl with epinephrine 1/50,000 x 2 cpl) with the use of the dental rubber dam, using magnification loupes, and the aid of supplementary illumination, the tooth was sectioned in three pieces.

The rubber dam was removed and with the use of PDL elevators (Salvin USA) all three roots were extracted without any complications. Spoons were used to curette the socket to clean any granulation tissue and to engage the cancellous bone. This very important step will create some bleeding therefore promoting angiogenesis.

The crest of the interradicular bone was engaged with the cupped part of a Xive osteotome (DENTSPLY Friadent) and a sinus lift was performed using the Summer’s technique. There were no signs of a sinus perforation based on the Valsalva test. The sockets and sinus-lift area were then grafted with a mixture of DBX particles, using a Marshmallow and MCP (mineral cancellous graft) mixture of allograft. The osteotomy was performed using a 3.8 tissue punch Xive osteotome and sinus-lift area were then prepared up to a depth of 13.5mm. (Figure 6)

The pilot drill from the Ankara drill (DENTSPLY Friadent) was then used to drill six 6mm, just short of 11mm. (Figure 7)

The patient was prescribed Amoxicillin 500mg, one every six hours to start two days before the next appointment, and Chlorhexidine rinses three times a day, also to start two days before the next appointment. The use of tartar-control toothpaste was also recommended to avoid staining of teeth. On the day of surgery, blood pressure was 119/75 with a heart rate of 76. Under local anesthetic (Lidocaine two per cent Hcl with epinephrine 1/50,000 x 2 cpl) with the use of the dental rubber dam, using magnification loupes, and the aid of supplementary illumination, the tooth was sectioned in three pieces.

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