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 implant cases 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 ‘RELAX’ 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 straightaway 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 implants simple, efficient and pain-free in a relaxed and contemporary environment”.

More than 300 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 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. 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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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.

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Case study

A patient with a non-contributory medical history was referred to my office for evaluation of the maxillary left first molar. The patient was asymptomatic and the tooth had been endodontically treated by a general dentist approximately seven months prior to the consultation and had never been restored.

Clinically it presented no temporary restoration, extensive decay, probing depths of three mm all around, and exposure of the obturation 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 dental rubber dam, the use of 4.5x magnification and suplementary illumination provided by the use of a fibre optic headlight, some excavation was performed to determine the integrity of the tooth structure. After removing the same decay, a bitewing X-ray was taken (Figure 2) and the following was determined: a) the floor of the pulp chamber was too shallow b) it was too close to perforation and c) the periradicular dentin was not strong enough to support a permanent restoration. These were critical factors, in my opinion, rendered the tooth non-restorable.

A cotton pellet and Cavit were placed in the access cavity and a follow-up call with the referring dentist was conducted to update him on the condition of his patient and to determine what recommendations should be given in regards to the tooth. It was recommended to the patient that the tooth be extracted and the socket preserved through a minor 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 orthodontic treatment prior to the implant being placed so that all the diastemas were close and the dentition properly aligned for this procedure. The patient clearly understood the concept and the logistics of the orthodontic treatment that was being recommended.

Figure 1: Pre-operative radiograph prior to extraction.
Figure 2: Bitewing radiograph after decay was removed.
Figure 3: Grafted socket following extraction.
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.

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 interdental 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 ers and sinus-lift area were then grafted with a mixture of DBX ers 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) a tissue punch access was done using a 3.8 tissue punch Xive drill. (Figure 3). The pilot drill from the Anklos implant system (DEN- TSP3 Friadent) was then used to drill six 6mm, just short of the sinus floor. (Figure 6)

A series of Xive osteotomes (DEN-TSP3 Friadent) starting from size 2.0 and going up to 5.4 were used to perform a sinus lift applying the Summer’s technique. The osteotome was prepared up to a depth of 11mm. (Figure 7)

A Valsalva test was performed to ensure that the sinus had not been perforated. An Ankylos implant A11 (3.5mm x 11mm) was placed and primary stability was obtained. The density of the bone perceived as D-5 during the drilling stage, more than likely changed to D-2 with the use of the osteotomes. The implant-transfer mount was removed as was the cover screw which came pre-mounted inside the implant and a 1.5mm sulcus former (healing abutment) was placed into the implant. (Figures 8&9)

This case clearly shows one of the reasons why endodontists are getting more and more involved in implant dentistry. They are able to provide a comprehensive evaluation of the tooth in question and they are able to present the patient with the best options based on clinical assessment.

About the author
Dr Jose M Hoyo graduated from the University of Puerto Rico School of Dentistry in 1984. He practiced General Dentistry in Puerto Rico for eight years and in Spain for two years. He received his Certificate of Advanced Graduate Studies in Endodontics from Boston University’s Henry M Goldman School of Graduate Dentistry in 1994. He practices as a specialist in Endodontics and Implant dentistry in south-eastern Massachusetts, with locations in Stoughton and Taunton. He is a member of the American Dental Association, The American Association of Endodontists, The Massachusetts Dental Society, and has a Fellowship with The International Congress of Oral Implantologists. Dr Hoyo is also the founder of Northeastern Implant Seminars. His lectures typically include in-office surgical demonstrations of bone graft placement, sinus lift procedures and implant placement.