Charlie Nicholas, realised that the founders, Jason Bedord and D2D Endo three years ago after they were often recommending products to delegates on their endodontic courses. They decided to put together a range of equipment together that they were happy with - no big sell, the guys can just say ‘this is what we use, it works for us and if you want to buy it you can get it at this price’.

“What’s fairly unique about D2D is that it’s owned by dentists for dentists. Any clinician who has a query about a product can pick up the phone and talk to a fellow clinician about it; this means they will get relevant practical answers from someone who truly understands their needs.”

The formula seems to have worked well for D2D Endo, and late last year they teamed up with implantologist Willie Jack to provide the same sort of service on the implant side. “When the opportunity came along to go into the implant side, with Willie Jack (who has been placing implants since 1992) the same sort of system worked. He saw that the market was growing, that more people were becoming aware of implants and he thought ‘well I’m an implantologist, I would like people to have more of their implant work done in the UK by UK dentists’. So, he looked for a system that was competitive in price with the bigger dental implant brands but still offered the same quality and reliability as the well established brands.

“There are so many people selling cheap implant into the UK because dentists want to be able to deliver an implant system at a low cost. The way we’ve approached it is we need to know from a clinical perspective that the products we are offering are 100 per cent reliable. The thing with D2D is that the directors are dentists, they do not want their reputation to be tarnished by any dentists saying ‘look this product that you’ve sold us, it doesn’t do what it’s supposed to do’. We’ve gone with Euroteknika because they represent quality. Also there is about a 40-60 percent difference in price if you compare Euroteknika to the established brands, but as far as we can see they are comparable especially in terms of quality. Not only that, but the prosthetics can be up to 80 per cent of the cost of the big brands so if you put all that together it’s a very powerful argument for D2D.

“In the beginning people are used to placing what they have been using (ie Straumann, Astra, Nobel) because they are good products, they have been on the market a long time and they have all the surgery equipment to do it. So to change systems, well there needs to be a good reason. Those that have taken on board the Euroteknika product have honestly not had one problem. All we have had are pleasant on the ease of how it works and the ability to match the prostheses. So, the labs like us – they like the prosthetics – the dentists like us because the products are of good quality at the right price. They also like the fact that if they have an issue they can talk to Willie and he can answer them clinician to clinician.”

Ninety per cent of the equipment that clinicians have to place Straumann/Astra/Nobel implants can be used with Euroteknika implants. We also do promotions such as once someone had placed 20 implants we give them a free Euroteknika surgical kit. And from what dentists tell me it is a very good surgical kit!

John added: “The relationship between Euroteknika and D2D Implants is crucial as it is a long term partnership. We have got the ability to talk to them at every level right up to the MD about things we’d like to change or things we can get involved in - I think we’ve ticked all those boxes. I think they are prepared to listen, I think they are prepared to change things and it seems to be their aspiration to make us a part of their business. So it really does work, we will help them develop things on the clinical side as Willie is highly qualified and experienced clinical implantologist, and they are a very good manufacturing company – put the two together and you have a winning formula.”
I recently was able to add implantology to my ever growing list of dental skills after a very insightful day at the UK headquarters of Straumann.

The day was entitled ‘An insight into the world’s leading dental implant company’ and it gave the dental press an chance to get to know the team at Straumann, find out what the company does beyond its implant offerings and hear about its association with the ITI (International Team for Implantology). It also allowed us to have a chance to place an implant for ourselves, though fortunately our patients were nothing more than a small plastic disc.

The event began with a welcome from head of Marketing Vanessa Elwill. Following her was managing director of Straumann UK Stephen Booth. He gave a background to the company, from its beginnings as a family-owned research institute in 1954, through to the present where it is claimed as a global leader in replacement, restorative and regenerative dentistry.

Straumann UK has established itself at its offices in Crawley as not only a base for UK operations but also a first-class training facility for internal and external clients. In the last year there have been 75 courses at the centre and 45 external courses, with more than 1500 delegates.

Stephen also pointed out that Straumann are more than just implants. The product portfolio covers solutions for preserving, restoring and replacing teeth, including: Emdogain – regeneration product in periodontal; Bone Ceramic – synthetic bone replacement; CAD/CAM – in partnership with Ivoclar Vivadent, this includes the Cadent digital scanner; Digital implant systems and guided surgery; Implant surface technology – Roxolid, SLA Active.

Following Stephen was John Aiken, Straumann CADCAM Sales Manager. John gave further insight into the benefits to labs clinicians and patients of using digital scanning and CAD/CAM in the design and production of appliances such as crowns, bridges and onlays.

Then it was the turn of Phil Freiberger, clinician and Chairman UK & Ireland ITI Section. He explained who the ITI is as a global association in implant dentistry aiming to promote research, development and education in its field.

It currently boasts 7,500 members and 700 Fellows in its ranks. Education and research is key to the ITI, with study clubs, courses such as the ones run at Straumann and Scholarship programme at the Eastman.

Research-wise it is critical, with investment of CHF1.7m in 2009 alone into 60 different projects at 22 different institutes worldwide. Since 1988 283 research projects have been funded to the tune of CHF52.2m.

After the presentation it was time to play dentist! A few hardy souls sat down under the watchful gaze of the Straumann team and Phil. We were taken through the process of drilling the implant socket, having to be careful not to drill too far. My implant is now pride of place on my desk in the office.

Thanks to Straumann for a wonderful and informative day at their offices. I look forward to the next time!
Aesthetic challenge
Thorough examination and execution of treatment are key to carrying out immediate tooth replacement Dr Riz Syed explains

In our clinics, we often have to deal with patients who require a single implant to replace a failing tooth. Our aim should always be aesthetically driven, in that we should always strive to achieve the most stable aesthetic outcome.

In the aesthetic anterior zone, we are often faced with an aesthetic challenge. Do we extract a tooth and delay the placement of an implant allowing the site to heal before implant placement and try to rebuild any bone and soft tissue loss following the healing process?

Gingival support
The main reason for placing an implant at the same time as extracting the tooth and possibly placing a provisional restoration is to support and maintain the gingival architecture of the failing tooth.

In order for us to place implants in immediate extraction sites, certain protocols have to be followed to achieve a successful outcome:

- Careful patient assessment should be undertaken both clinically and radiographically
- No active underlying pathology
- Gingival form: look at the whether the form is flat or scalloped and determine the marginal position relative the adjacent teeth. This is significant in deciding the degree of marginal discrepancy that may occur
- Gingival biotype: is the biotype thick or thin? We can often determine the biotype by probing the buccal tissue and seeing how much of the probe is visible through the tissue. The thinner the tissue, the higher the chances of soft-tissue recession.

Carrying out extraction
The tooth has to be extracted carefully using peritomes in order to avoid unnecessary trauma to the bone. The socket is then cleaned thoroughly and probed to determine the length of the socket from the soft tissue or bone margin. The ideal option would be to place an implant just a few millimetres longer than the socket to engage in the apical bone to achieve primary stability. Pressure should be avoided on adjacent interdental bone to maintain the papillae between the implant and tooth.

For incisal teeth, the mid-palatal socket is an ideal location for the initial twist drill. The final implant should therefore be placed in more palatal position. The remaining gap between the implant and the buccal plate, if it is less than 1mm, can be filled in with bone. If, however, the gap is larger, bone material should be used to prevent the collapse of the buccal bone and soft tissue.

The ideal depth of the implant in the majority of cases is three mm below the soft-tissue margin to ensure the biological width is not encroached. In areas where there is a bony wall defect, implants can still be placed at the same time as extraction and guided bone regeneration can also be carried out at the same time. In V-shaped defects, there is often minimal recession compared to U-shaped defects.

Placing an immediate provisional without encroaching on the tissue with a negative contour will help to support the tissues. Although immediate implant placements can result in a successful outcome, there is slightly higher risk of failure. Thorough examination and surgical execution are vital to ensure success.
Peri-implantitis: definition, etiology and treatment

By Vavalekas Michail of the Ashman Department of Periodontology and Implant Dentistry at New York University College of Dentistry

Peri-implantitis is an inflammatory process affecting the soft and hard tissues resulting in rapid loss of supporting bone, often associated with bleeding and suppuration. The etiopathogenesis of peri-implantitis is complex and is related to a variety of factors. The peri-implant environment and soft-tissue-implant interface has a major impact on the progression of peri-implantitis.

Patient-related factors include: 1) systemic diseases (for example, diabetes, osteoporosis), 2) social factors such as adequate oral hygiene, smoking, drug abuse, 3) parafunctional habits (bruxism) and previous dental history of periodontitis. In addition to the above etiologies, intragenic factors can also play a significant role in the development of peri-implantitis.

Although restorations of endosseous implants have demonstrated a very high survival rate, one study suggested that over a five-year period, 0 to 14.4 per cent of dental implants demonstrated peri-implant inflammatory reactions associated with crestal bone loss. The treatment modalities are: 1) administration of systemic antibiotics, 2) mechanical debridement with or without chlorhexidine oral rinses or antibiotics, 3) mechanical debridement combined with LASEK decontamination, 4) debridement combined with a flap access and more recently, 5) debridement was combined with guided bone regeneration (GBR) for repairing of osseous defects. GBR has limited predictability and some case series have demonstrated limited bone fill after GBR procedures. There is insufficient evidence to support any one of the aforementioned treatment strategies for peri-implantitis. Therefore, different treatment modalities for peri-implantitis will be compared from previously published studies.

Points for discussion

One study demonstrated the importance of bacterial plaque accumulation in the development of inflammation around implants (peri-implantitis) while another showed that, if this condition is left untreated and the surface is not decontaminated, it will lead to peri-implant pocketing, alveolar bone loss, and eventually to implant and antibiotic failure may be necessary for the treatment of peri-implantitis.

Bacteria on the implant surface are the target in treating infections around implants and traditional therapeutic approaches have been directed towards implant surface decontamination. Systemic administration of antibiotics were also used in the treatment of peri-implantitis with an immediate reduction of inflammation, bone re-growth and gradual reduction of pocket depth, but a three-month recurrence of peri-implantitis was observed due to bacterial re-colonization of the implant surface.

To date, there is no reliable evidence that suggests which intervention (chemical agents, mechanical debridement, surgical procedures, lasers or a combination of Guided Bone Regeneration (GBR) with the former techniques) is the most effective for treating peri-implantitis. Therefore, there is no gold standard approach for the treatment of peri-implantitis.

Some of the treatment modalities suggested for peri-implantitis are: 1) sub-mucosal mechanical debridement and antimicrobial minocycline spheres (Arestin), 2) mechanical ultrasound debridement without antibiotics, 3) laser ablation (Er:YAG) with mechanical debridement, chlorhexidine, with and without open flap surgery, 4) antimicrobial therapy with open flap debridement, access flap surgery and bone substitute or bone graft. Furthermore, it was compared the combination of oral hygiene instructions, mechanical debridement and topical application of minocycline microspheres (Arestin) in peri-implant lesions (with bone loss corresponding to no more than three implant threads) to the combination of oral hygiene instructions, mechanical debridement and one per cent chlorhexidine gel application.

The results obtained after a follow-up period of 12 months on sub-mucosal mechanical debridement and antimicrobial minocycline microspheres showed that only a