Aesthetic management of a single dental implant

Dr Michael Sonick details a case involving both form and function in the aesthetic zone

**Treatment Plan**

1. Extraction of tooth #9 and socket preservation
2. Three-month healing period
3. Placement of implant #9 and connective tissue graft
4. Three-month healing period
5. Implant #9 exposure, placement of healing abutment and connective tissue graft
6. Three-month healing period
7. Final implant #9 crown restoration

**Extraction and Socket Preservation of Tooth #9**

After oral sedation with 0.25mg triazolam and local anesthetic induction using two per cent lidocaine with 1:200,000 epinephrine and 0.5 per cent buccovecaine with 1:200,000 epinephrine, a sulcular incision was made circumferentially around tooth #9. The remaining root was extractedatraumatically using a piezoelectric periosteum device (Fig 2). Thorough degranulation of the extraction site with a pear-shaped carbide finishing bur and Prichard curette proceeded. No dehiscence or fenestration was detected. Freeze-dried bone allograft (FDBA) was used to obturate the site with two vertical releasing incisions made on the buccal, both avoiding the mesial and distal papillae. A full-thickness flap was raised past the mucogingival junction. Debridement of the site with a pear-shaped carbide finishing bur and Neumeyer bur revealed adequate apico-coronal, bucco-lingual and mesio-distal dimensions for implant placement. After ostectomy preparation, a rough-surfaced, internal hex 4mm (diameter) x 15mm (length) implant was placed into the filled site (Nano-Tite® Parallel Walled Certain® Implant, Biomet 3i, Palm Beach Gardens, FL) (Fig 5). Primary stability was achieved, and a cover screw was placed.

In order to form an aesthetic soft tissue profile by expanding mucosal dimensions, a connective tissue graft was harvested from the palate and placed on the buccal aspect of the ridge overlying the implant. The graft was stabilised using 5-0 chromic gut sutures (Fig 6). After periosteal release via lateral scalpel incisions, the flap was primarily closed with 4-0 ePTFE sutures in an interrupted and horizontal mattress fashion (Fig 7). The area was re-temporised with a resin-bonded fixed partial denture.

**Implant Exposure with Connective Tissue Graft**

The #9 site healed well and without incident after three months (Fig 8). After using a tissue punch technique to remove the mucosa immediately coronal to the fixture (Fig 9), a one-piece 4.1mm platform x 6mm (height) healing abutment (Certain® EP® Healing Abutment, Biomet 3i, Palm Beach Gardens, FL) was placed on the #9 implant. To further augment the buccal ridge dimension, another connective tissue graft was harvested from the palate. A pouch-like envelope flap was raised over the labial ridge aspect into which the connective tissue was transplanted and fixed using 5-0 chromic gut suture (Fig 10). The healing abutment remained exposed. A periapical radiograph revealed sufficient bone height around the fixture (Fig 11). The resin-bonded fixed partial denture was replaced.

**Final Prosthetics**

Final restoration of the #9 implant was performed three months post-exposure (Fig 12). The marginal height and contour of the #9 implant crown matched that of adjacent tooth #8, and a periapical radiograph showed suitable peri-implant bone height (Fig 13). The patient was satisfied with the functional and esthetic result (Fig 14).

**Post-Operative Instructions**

After each surgical procedure, the patient was instructed to take ibuprofen 600mg every 4-6 hours, hydrocodone 7.5mg/acetaminophen 750 mg every 4-6 hours as needed for pain, and doxycycline 100 mg every day for 10 days. The patient was instructed not to brush at or near the surgical site but instead to rinse with 0.12 per cent chlorhexidine or warm saline twice daily. The patient was also directed not to chew in the affected area for at least two weeks. Suture removal occurred at 10-14 days post-surgery.
Tissue Management

New product introduction: ShortCut™

The new all-in-one retraction cord delivery system that allows hassle-free, scissor-free cord dispensing!

- All-in-one hygienic delivery system, easy to use with one hand
- The same amount of cord (1cm) dispenses each time with a simple click
- Practical built-in cutter, no need for scissors
- Durable and hygienic waterproof label, easy to cleanse

Dispensing cord with ShortCut is less cumbersome and definitely more efficient and hygienic than the cord in the bottle method!

Dux Dental
Zonnebaan 14
NL-3542 EC Utrecht
The Netherlands
Tel. +31 30 241 0924
Fax +31 30 241 0054
Email: info@dux-dental.com
www.duxdental.com

NEW!
£11.99 excl. VAT
The choice between cement and screw-retained implant-supported prosthesis may be a matter of clinicians’ preference or dictated by particular clinical situations. This case report presents a clinical situation and the guidelines that led to the ultimate prosthetic treatment decision based on implant angulations, interocclusal relationship and arch position. The clinical considerations are presented to aid the clinicians in determining the most appropriate method of retention for a screw-retained implant-supported fixed partial denture (FPD).

A screw-retained implant-supported fixed partial denture (FPD) has certain physical advantages. However, according to several studies they require precise positioning of the implant for optimal location of the screw access hole. Also, obtaining passivity of frameworks that are screw-retained is difficult due to dimensional discrepancies inherent in the fabrication process.

Anchorage of prosthetic fixed partial dentures to implants can be achieved in two ways: some clinicians cementing the prosthetic construction to implant abutment, while others suggest that screw retention is preferable. Screw-retained implant restorations have an advantage of predictable retention and retrievability, and the lack of potentially retained excessive sub-gingival cement. Screw-retained implant restorations also have the potential to compensate for any minor dimensional discrepancies in the fit of restorations to abutments, which can contribute to lack of passivity. It has the potential to reduce stress to splinted implants, since...
the effects of minor misfit of the framework are not transferred directly to the implants, as is the case with prosthesis-retaining screws. In addition, the exposure of screw access holes in esthetic areas of the mouth can be avoided. On the other hand, any excess retained cement extruding from the prosthesis/abutment interface, especially when located sub-gingivally, can cause inflammation, infection, and periodontal complications.

As more and more dental practitioners are focusing on implant-supported fixed partial dentures (FPD), restoring dentists need to understand the restorative options they may have to deal with. Many dental practitioners and labs will persistently use a screw-retained implant-supported fixed partial denture, and thereby promote the utmost choices of serviceability, cosmetic result and maintenance of optimised bite possible.

At the same time, in recent years the utilisation of advanced Cone Beam CT and technologies and 3-D derived virtual planning software solutions altered the manner in which we pull together diagnostic data, plan and execute both simple and complex implant cases. As a result, more and more implant trajectories are consistent with the planned prosthetic trajectories. Yet, some cases are still driven by the residual bone trajectories and are left to the restoring dentists’ decision as far as the final restorative option. In other words, when the implant trajectories are inconsistent with the planned prosthetic trajectories, the screw-retained implant-supported fixed partial denture systems offer an opportunity to minimise any controversy between the surgeons, restorative dentists and laboratories, creating greater understanding, appreciation and professional camaraderie.

Case Report
Patient presented for implant supported FPD after having teeth #8, #9, #10 extracted with socket preservation. A CBCT study was performed with the iCAT CBCT machine (Imaging Sciences International, Hatfield, Pa) and revealed reasonable alveolar dimensions, both vertical and horizontal. However, by utilising ImplantMaster™ software (iDent Imaging, Inc., Foster City, CA, 94404-1294), it was discovered that the residual bone trajectory (RBT) and the planned prosthetic trajectory (PPT) were in conflict, that is, projecting a compromised restorative trajectory lingually in implant site #9 and buccally in implant site #11 (Fig 1). Nevertheless, following a treatment planning conference, rather than considering bone grafting, a decision was made to proceed with these angulations and a 3-D reconstruction of a patient’s anatomy was attained and a virtual surgical guidance template was designed and computer manufactured with precise drilling holes’ distribution and trajectory for implants #9 and 11.

The palatal trajectory of the implant in tooth position #9, the patient’s deep bite which resulted in severely limited space for prosthetic components, dictated a screw-retained prosthetic FPD construction solution for the case. The extremely buccal angulation of the implant replacing tooth #11 resulted in a buccal located screw access opening, which compromised aesthetics, and potentially weakened the porcelain around the screw opening in the proposed screw-retained three units FPD. The aesthetic dilemma could be solved by either gold plating of the metal portion of the screw chamber, which can reduce the need for opaque composite material, or by metal cut back to hide the non-aesthetic metal. We chose to overcome this aesthetic and structural obstacle by using a separate telescopic crown design to cover the metal sub-
Figure 2a, 2b & 2c: Figure 2: The screw-retained restoration was made by CQC a DTI Dental lab in Rochester, NY. Different views of final screw-retained restoration emphasize the extreme lingual trajectory of implant #9 (a) and extreme buccal trajectory of implant #11 (b). Note telescopic design crown on #11 (b).

About the author
Michael Nawrocki, DMD, MD, MS, Prosthodontist, VA New Jersey Health Care System (VANJHCS).
Dov M. Almog, DMD, Prosthodontist, Chief of the Dental Service, VA New Jersey Health Care System (VANJHCS).

Figures 3a & 3b: Figure 3: Intraoral views of the screw-retained restoration. Note the implants’ prosthodontic platforms (a) emphasizing the actual trajectories of implants #9 & #11 in the patient’s maxillary ridge. Note telescopic design crown on #11 (b).

Conclusions
As more and more dental practitioners are focusing on implant-supported fixed restorations, restoring dentists need to understand the restorative options they may have to deal with. Dental practitioners and dental labs need to be prepared to use a screw-retained implant-supported partial denture, and thereby promote the utmost choices of serviceability, cosmetic result and maintenance of optimised bite possible.

References

The MIS SEVEN implant has a highly advanced surface with a high rate of successful osseointegration (98%), which was validated by extensive worldwide research and clinical studies in cooperation with world-class universities and scientific research institutes. Its unique geometrical design gives the SEVEN implant the important features of simple, quick and safe insertion, high primary stability, and compatibility in the most complex cases in every area of the jaw.

Simplicity is The Key to Success

The MIS SEVEN implant is the only implant system in the world that comes with a specially designed and sterilized final drill, allowing a short and safe drilling procedure.
Single tooth anterior implant, the ultimate aesthetic challenge

Dr Richard Brookshaw discusses an interesting case presentation, placing a single tooth anterior implant in a young female patient

The patient, a 36-year-old female office worker, was initially referred for implant therapy (via one of my implant course delegates) for replacement of the missing upper right central incisor. The upper central incisor had been lost following accidental trauma when she was 17 years old; the resultant space had been initially restored with a removable denture, but more recently with an adhesive bridge.

The patient was strongly opposed to keeping her denture having tolerated it for almost 20 years; and afraid that the adhesive bridge would fall out, she now wanted a fixed solution. Understandably she did not want a conventional bridge as she was afraid of “cutting down” the adjacent healthy teeth. The rest of her dentition was largely un-restored.

At the time of the trauma, the patient had asked her dentist if she was able to have a dental implant, but was told that there was insufficient bone and that such treatment was impossible.

On examination the patient was fit and well, a regular attender, non-smoker with low alcohol consumption. Extraoral examination found nothing abnormal.

Intra orally, the patient had signs of widespread gingival recession, oral hygiene was excellent, with no deposits and BPE codes healthy in all sextants.

The patient presented with a composite occlusal restoration (UL6, LL6) and an adhesive “Maryland” bridge restoring UR1 with retainer wings UR2 UL1. There was Class 1 occlusion with general overcrowding, no interferences and canine guidance.

Radiographic assessment of UR2, UL2, revealed absence of periapical pathology, non-convergence of roots in adjacent teeth with good bone height.

The missing upper right central incisor had healthy adjacent teeth and a healthy, bony site. The edentulous area had reduced volume with respect to soft and hard tissue.

Following a formal discussion of her treatment options and advantages / disadvantages of each, a treatment plan was formalised in a detailed written patient report and verbal and written consent to treatment was obtained.

Treatment Plan
1. Two stage implant surgery was planned: Under LA, full flap elevation, implant placement (16mm NP NobelReplace tapered groovy) with hard and possibly soft tissue augmentation either simultaneously or at second stage surgery.
2. Second stage surgery; uncovering of implant +/- soft tissue augmentation and attachment of under contoured modified healing abutment.
3. Fixture head impression for lab construction of ideal design screw retained composite prototype crown.
4. Fit prototype implant crown with negatively contoured subgingival emergence profile
5. Pick up impression using modified impression coping
6. Fit definitive under contoured zirconium abutment and all ceramic procera crown
7. Maintenance of implant restoration and remaining dentition by GDP. Including continued hygienist support.

The treatment was carried out over a period of seven months.
months with visits.

Reflection

The patient had an optimal result at the end of treatment, which she was extremely delighted with. Her management throughout was planned and executed with the utmost detail to attempt to deliver the most comfortable experience possible considering the nature of the treatment involved. She was offered a denture, which she had endured for the past 20 years and refused; a conventional bridge, which would have been destructive to the adjacent virgin teeth; or an adhesive bridge which she preferred to her denture but did not instil her with confidence. The patient was determined to undergo implant therapy if possible, and she had sought advice as to the feasibility 10 years ago but was dissuaded. She was willing to undergo any necessary treatment to augment the site ready for optimal implant therapy and was consented for the potential treatment sequence which may even involve block bone grafting and repeated soft tissue procedures.

As it was, she responded extremely well to treatment and her treatment was more simplified than expected. The utilisation of a laboratory made prototype restoration was a good policy which greatly improved the final result, although the patient’s finances were limited and it was carried out free of charge. The under-contoured adjustment of the standard healing abutment at the minimally invasive second stage procedure encouraged more soft tissue growth, which also helped the final result. The patient was very amenable to the philosophy employed and never complained about the extra visits involved. Her focus was trying to gain the best possible final outcome. Translation of all of the information worked so hard to achieve in the prototype was also communicated to the laboratory in as accurate a way as possible, which helped ensure the final result.

The use of a narrow platform implant (3.5mm diameter) helped to keep the hard and soft tissue dimensions to a maximum and therefore perhaps allow greater long-term aesthetic success, which is why these implants are often utilised in the aesthetic zone.

Lengthy discussion was also had regarding root coverage procedures on the other recessions, which the patient is now considering following the good result achieved with the adjacent UR 2.

Reflection

The patient had an optimal result at the end of treatment, which she was extremely delighted with. Her management throughout was planned and executed with the utmost detail to attempt to deliver the most comfortable experience possible considering the nature of the treatment involved. She was offered a denture, which she had endured for the past 20 years and refused; a conventional bridge, which would have been destructive to the adjacent virgin teeth; or an adhesive bridge which she preferred to her denture but did not instil her with confidence. The patient was determined to undergo implant therapy if possible, and she had sought advice as to the feasibility 10 years ago but was dissuaded. She was willing to undergo any necessary treatment to augment the site ready for optimal implant therapy and was consented for the potential treatment sequence which may even involve block bone grafting and repeated soft tissue procedures.

As it was, she responded extremely well to treatment and her treatment was more simplified than expected. The utilisation of a laboratory made prototype restoration was a good policy which greatly improved the final result, although the patient’s finances were limited and it was carried out free of charge. The under-contoured adjustment of the standard healing abutment at the minimally invasive second stage procedure encouraged more soft tissue growth, which also helped the final result. The patient was very amenable to the philosophy employed and never complained about the extra visits involved. Her focus was trying to gain the best possible final outcome. Translation of all of the information worked so hard to achieve in the prototype was also communicated to the laboratory in as accurate a way as possible, which helped ensure the final result.

The use of a narrow platform implant (3.5mm diameter) helped to keep the hard and soft tissue dimensions to a maximum and therefore perhaps allow greater long-term aesthetic success, which is why these implants are often utilised in the aesthetic zone.

Lengthy discussion was also had regarding root coverage procedures on the other recessions, which the patient is now considering following the good result achieved with the adjacent UR 2.
KaVo – Dental Excellence

KaVo, 100 Years Young!
www.100-years-kavo.com

ESTETICA E80
Rise above the rest with KaVo.

- Outstanding ergonomics and attractive, highly functional designs.
- Innovation at its best.
- State of the art technology reliability and functionality at amazingly low prices.

From as little as £286* per month excl VAT

*Finance is subject to status and for business purposes only.

Contact your local KaVo or Gendex supplier for more details!
OsseoSpeed™ TX implants

At Astra Tech Dental we continuously strive to enhance products and simplify procedures to provide reliable long-lasting successful results and, at the same time, make your day-to-day work a little bit easier. OsseoSpeed™ TX is designed to do just that:

- Predictable results for all patients, including compromised cases, where implants with other surface treatments may be less effective
- The tapered apex makes implant installation easier in all indications
- Improved biological support for immediate installation and early loading protocols
- Clinically proven to maintain marginal bone levels

Superior long-term bone maintenance

In more than 40 published articles*, the mean marginal bone level reduction when using the Astra Tech Implant System™ is only 0.3 mm during the first year of loading and stable thereafter. This result is at least four times better compared to the current standard norm of 1.5 mm of bone loss after five years.

*References available upon request.
A medically and peri-odontally stable 50-year old woman presented with failing #8 and #9 teeth that exhibit asymmetry, lack of interdental papilla and a history of failing root-canal therapy and apicoectomy (Fig 1).

**Treatment Plan**
1. Extraction of teeth #8 and #9, immediate implantation of #8 and #9 and immediate non-functional provisionalisation of #8 and #9
2. Three-month healing period
3. Gingivectomy to create mucosal symmetry
4. Six-month healing period, during which contour adjustments to interim restoration will be made to manipulate papillary regeneration
5. Placement of final single PFM crowns on implants #8 and #9

**Treatment Plan Rationale**
Implant rehabilitation for sites #8 and #9 boosts long-term prosthetic success, which diminishes future costs and permits more future restorability options.

The patient is an ideal candidate for immediate implant placement and temporisation due to her thick biotype, which resists recession, as well as the inherent coronal positioning of the gingival drape around #8 and #9 compared to the adjacent teeth, which allows any minor recession post-treatment to remain within aesthetically-pleasing bounds.

**Extraction of Teeth #8 and #9, Immediate Placement of Implants #8 and #9, and Immediate Non-Functional Provisionalisation of Implants #8 and #9**

After oral sedation with 0.25mg triazolam and local anaesthetic induction using two percent lidocaine with 1:100,000 epinephrine and 0.5 per cent bupivacaine with 1:200,000 epinephrine, sulcular incisions were made circumferentially around teeth #8 and #9. To create room for extraction instructions, the crowns on teeth #8 and #9 were reduced (Fig 2a). Teeth #8 and #9 were extracted atraumatically using a piezosurgical insert and serrated universal maxillary forceps (Figs 2b-2c). Degranulation of the sockets was performed using a carbide finishing bur and Neumeyer bur. A surgical guide was used to prepare the implant osteotomies, and proper positioning was attained (Fig 3). After finalisation of the osteotomy sites, rough-surfaced, internal hex 4 mm (diameter) x 13mm (length) implants were placed into the #8 and #9 sites (NanoTite® Tapered Certain® Implant, BIOMET 3i, Palm Beach Gardens, Fla.) (Fig 4).

Healing abutments were placed on the implants to prevent soft tissue and bony collapse during the period that extraoral fabrication of the temporary prostheses occurred (Fig 5a). The orientation of the implants was ideal,
Flu Season Special

Protect against Airborne Viruses, Bacteria & Fungi

The unit emits a constant stream of hydroxyl radicals that fight airborne organisms. Proven against bacteria and viruses in trials.

Special Price

£279

rrp £499.99

• Natural effective disinfection
• Continuously attacks airborne pathogens to 99.9999% effective
• Reduce post surgical risk
• Used in hospitals worldwide
• Protects staff and patients
• Quiet & easy to use
• Wall mounted or floor standing

Two Requirements....One Solution

Cleans and Disinfects

• Detergent integrated in the wipe
• Removes Bio-Film
• Effective in less than one minute
• Chosen by world rated University Hospital Leuven

Perspiration Free Gloves with Odaban!

Guaranteed to keep skin dry, supple and hydrated. Does not contain allergenic substances.

Formulated for all who wear gloves for an extended period.

• Keeps skin dry & hydrated
• Free from allergic substances
• Economical and easy to apply
• New unique formulation

Trycare because...

Call Today 01274 881044
Dental implantology is a team speciality and the 2011 Congress programme continues to uphold and endorse this ethos. The team programme includes sessions for dental nurses, dental hygienists/therapists, and practice managers, with the dental technicians being included in the plenary programme where two world-class technicians will be speaking.

**Thursday 14 April**

**PLENARY PROGRAMME FOR CLINICIANS AND TECHNICIANS**

- Professor Tomas Albrektsson, Sweden
- Professor Maurice Amirim, Brazil
- Dr Stephen L Wheeler, USA

**DENTAL IMPLANT TEAM PROGRAMME**

- **Morning**
  - Programme for Hygienists, Nurses, Practice Managers and Therapists
  - The team approach to implant dentistry: a blueprint for success
  - Mr Arika H Daniels, USA

- **Afternoon**
  - Programme for Hygienists, Nurses, Practice Managers and Therapists
  - The role of the dental hygienist in implant treatment
  - Ms Anita H Daniels, USA

**Practice Managers’ Programme**

Ringing the changes: turn every patient enquiry into an appointment
- Ms Anthony Lane, UK

**Nurses’ Programme**

An update for dental implants; Effective communication with patients; Advanced surgical techniques; Instruments & prosthesis; Medical emergencies in implant surgery; HYMINS and implant dentistry; Screw lites
- Miss Helen McIlvain, UK
- Miss Helen Bond, UK
- Miss Helen Frost, UK
- Dr Susan Wright, UK
- Miss Karen Woody, UK

**Friday 15 April**

**PLENARY PROGRAMME OPEN TO THE WHOLE TEAM**

- Professor Joseph Kan, USA
- Ms Michelle Bari, London
- Professor Torsten Jenney, Sweden

**Congress Exhibition – Thursday 14 & Friday 15 April**

Opportunities to view and discuss the latest innovations face to face with the industry experts.

**Optional Congress Social Event – Thursday 14 April**

*A Hard Day’s Night* at Lancashire County Cricket Club: The Point

**BOOK ONLINE NOW**


**£555 for member Clinicians**
**£305 for member Technicians**
**£165 for member Hygienists, Therapists, Nurses, Practice Managers, Students**

(Non-member rates available)

**£795 for non-member Clinicians**
**£595 for non-member Technicians**
**£275 for non-member Hygienists, Therapists, Nurses, Practice Managers, Students**

```text
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Simon Wright</td>
<td>Member Clinician</td>
<td>UK</td>
</tr>
<tr>
<td>Miss Kara Moody</td>
<td>Member Hygienist</td>
<td>UK</td>
</tr>
<tr>
<td>Mr Oliver Bari</td>
<td>Member Therapist</td>
<td>Germany</td>
</tr>
<tr>
<td>Miss Helen McIlvain</td>
<td>Member Practitioner</td>
<td>USA</td>
</tr>
<tr>
<td>Miss Helen Bond</td>
<td>Member Practice Manager</td>
<td>USA</td>
</tr>
<tr>
<td>Dr Stephen L Wheeler</td>
<td>Member Therapist</td>
<td>USA</td>
</tr>
<tr>
<td>Ms Anita H Daniels</td>
<td>Member Therapist</td>
<td>USA</td>
</tr>
<tr>
<td>Mr Arika H Daniels</td>
<td>Member Therapist</td>
<td>USA</td>
</tr>
<tr>
<td>Mr Oliver Bari</td>
<td>Member Therapist</td>
<td>Germany</td>
</tr>
<tr>
<td>Miss Helen McIlvain</td>
<td>Member Practitioner</td>
<td>USA</td>
</tr>
<tr>
<td>Miss Helen Bond</td>
<td>Member Practice Manager</td>
<td>USA</td>
</tr>
<tr>
<td>Dr Stephen L Wheeler</td>
<td>Member Therapist</td>
<td>USA</td>
</tr>
<tr>
<td>Ms Anita H Daniels</td>
<td>Member Therapist</td>
<td>USA</td>
</tr>
<tr>
<td>Mr Arika H Daniels</td>
<td>Member Therapist</td>
<td>USA</td>
</tr>
<tr>
<td>Mr Oliver Bari</td>
<td>Member Therapist</td>
<td>Germany</td>
</tr>
</tbody>
</table>
```

**About the author**

Dr Michael Sonick
- A full-time practicing periodontist and implant surgeon in Fairfield CT
- A renowned educator, author, and clinical researcher
- He is a Guest Lecturer for the International Dental Program at New York University School of Dentistry
- A former Clinical Assistant Professor in the Department of Surgery at Yale University School of Medicine and University of Connecticut School of Dental Medicine, and a frequent lecturer on periodontics, dental implants and practice management for educational programs around the world.
- Locally, he is the founder and director of the Fairfield County Dental Club, an advanced continuing education organization that provides courses on the latest development in dentistry to clinicians and their staff.
- Dr Sonick is also founder and director of Sonick Seminars, LLC, a multidisciplinary teaching institute located in his clinical office and teaching center. Courses are given on all surgical aspects of periodontics and implant dentistry. Unique to this program is the three part consensus, doctors to observe live surgery participate during the Hands-On portion and attend lectures. Interested participants can contact Carole at 203 274-2006 or visit the website at www.sonickmd.com.