Basic information on the insertion of miniscrews

Preparing for insertion

The insertion of a miniscrew is a very simple and rapid therapeutic measure. Although there are several methods that will yield good results, successful insertion requires adherence to a few important considerations. A fresh socket of a goat animal model, each of five goats was fitted with two titanium implants immediately after tooth removal. A poly DL-Lactide-co-Glycolide scaffold was fitted around each implant, but the control received only the scaffolding. The experimental implant received scaffolding seeded with bone marrow-derived mesenchymal stem cells (BMSCs). All implant sites showed some level of tissue development at 10 days after the operation. At one month after, the control side showed no signs of tissue development, whereas the experimental side had developed cementum, bone and periodontal ligament, the three tissues required for regeneration of periodontal tissue.

Past studies have demonstrated positive results with BMSCs in periodontal defects around natural teeth. Others have shown promising results without BMSCs, using pro-

Stem cells may improve the adaptability of dental implants

A procedure using stem cells may provide a more thorough regeneration of periodontal tissue around dental implants, according to a new report published in the Journal of Oral Implantology.

Dental implants closely resemble natural teeth, but an implant’s ability to react to patient growth, pressure from chewing and future orthodontic work is diminished if it is not surrounded by sufficient periodontal tissue. In this study, the authors engineered this periodontal tissue in a fresh socket of a goat animal model.

Each of five goats was fitted with two titanium implants immediately after tooth removal. A poly DL-Lactide-co-Glycolide scaffold was fitted around each implant, but the control received only the scaffolding. The experimental implant received scaffolding seeded with bone marrow-derived mesenchymal stem cells (BMSCs). All implant sites showed some level of tissue development at 10 days after the operation. At one month after, the control side showed no signs of tissue development, whereas the experimental side had developed cementum, bone and periodontal ligament, the three tissues required for regeneration of periodontal tissue.

Past studies have demonstrated positive results with BMSCs in periodontal defects around natural teeth. Others have shown promising results without BMSCs, using pro-

Miniscrews: a focal point in practice

Basic information on the insertion of miniscrews

Preparing for insertion

The insertion of a miniscrew is a very simple and rapid therapeutic measure. Although there are several methods that will yield good results, successful insertion requires adherence to a few import-

Avoiding the pitfalls of implants with 3-D imaging

Once only a solution for the rich and famous, dental implants have become a popular option for people across all economic categories. Along with the popularization of this procedure, while implants were usually delegated to specialists, technology, such as in-office cone-beam scans and digital imaging allow general practitioners to offer this type of service while also avoiding the pitfalls that result from a lack of precise information.

Research illustrates both the growing popularity of implants and the increasing desire of general den-

(HomePage)
tists to provide their patients with this procedure. A recent survey cites that 19 percent of general dentists have placed implants for three years or less. Many practitioners want to add this procedure as a response to requests from their patients. The study also showed that 77 percent of general practitioners said the number of patient inquiries about implants in their practice has increased during the last three years.

For the general dentist, the proper technology can reduce stress and expand the comfort zone, as well as increase the safety and comfort of the patient during implant planning and surgery.

A successful implant surgery is dependent upon many details, a majority of which are hidden beneath the gingiva. A 2-D X-ray or pan cannot discern certain anatomical conditions of the dentition that may determine the direction and scope of the treatment plan. Without a 3-D scan, the dentist needs to devise several “just-in-case” options, to provide for the various possible scenarios taking place under the gum tissue. While this may seem to you like “covering all bases,” it may decrease the patient’s confidence in your diagnostic ability.

A comfortable and positive experience will determine whether you retain a loyal patient or get bad press among his/her friends.

Beginning an implant without a 3-D scan is like trying to navigate through a dark room without a flashlight. You are sure to bump into something that will stop your progress. A 2-D pan alone cannot clearly establish the dimensional shape of the bone. Without the exact measurements of the width and height of the bone provided by the cone-beam image, it is likely that you may flap back the tissue only to find insufficient bone to support an implant. The patient ends up with pain, stitches, and an additional appointment to complete the next stage.

Besides the amount of bone, the 3-D scan avoids other possible obstacles to a successful implant. The ability to view abnormalities of the roots, the tooth’s proximity to adjacent teeth, supernumerary teeth and the proximity to the nerves and sinus provides valuable insight, avoiding surprises once the surgery is underway.

The cone-beam scan improves patient communication, avoiding misunderstandings and improving patient acceptance. Back to the survey scene, more than 98 percent of those surveyed were involved in patient education on implants. Education is easy with a 3-D image. The dentist can point out the possible trouble spots on the 3-D model, slicing, rotating, enlarging and exploring the patient’s dental anatomy from all angles.

Whether you are a general dentist or a specialist, no one wants the stress of a possible failed implant, or a disappointed patient.

In conjunction with 5-D imaging, many surgical guides are available that provide even more direction during the surgery, and 2-D digital images taken during the surgery can offer a quick check of drill lengths and placements.

While success in any surgical endeavor cannot be totally guaranteed, having all of the facts before-hand does stack the odds in your favor. With cone-beam technology, general dentists can keep their existing patients in-house, attract new patients and expand their dental horizons. There’s no need to do surgery in the dark because 3-D imaging is available to shed light on all the pertinent facts.
The Future Is Now.

A Bone Matrix Product Containing Stem Cells.

The Properties of Autograft without Associated Risks
The proprietary processing technology that produces Osteocel® results in a viable bone matrix product that preserves the native stem cells found in marrow-rich bone. It is the only product available today that has the desired beneficial properties of autograft - osteoconduction, osteoinduction and osteogenesis - and that allows surgeons to provide their patients with optimal bone growth conditions without the added risk and cost of a secondary procedure.

Low Immunogenicity
Mesenchymal stem cells are IMMUNE-PRIVILEGED cells that do not stimulate a cellular immune response. Osteocel does not activate T cell proliferation, as shown in vitro from Mixed Lymphocyte Reaction (MLR) testing.

Histologic Evidence
Positive clinical use of Osteocel since 2005 demonstrates bone forming ability. Histology from a human sinus augmentation study using Osteocel shows substantial vital bone content at 16 weeks, with very low residual graft material.

Bone Formation
Stem cells contained in Osteocel are capable of differentiating into bone cells. Every lot of Osteocel is tested for bone forming potential.

Viability Cell Content
The osteogenic potential arises from the stem cells in Osteocel. Following processing of marrow-rich bone, release testing demonstrates osteogenic potential according to the following criteria:
- Rich supply of stem cells: Greater than 50,000 cells/cc
- Viability: Greater than 70% cell viability
- Positive osteogenesis: In vitro cell culture assay


For more details or to register go to: www.acesurgical.com/cadaver.html

ADVANCED TISSUE GRAFTING
2-DAY HANDS-ON CADAVER WORKSHOP

BOSTON • October 2009
LAS VEGAS • December 2009

Limited Availability
Last 2 Courses Sold Out! Reserve Your Space by Registering Today.
Ant principles. The following text details those insertion steps that offer a high degree of safety for both patient and dentist (see checklist for insertion on page 8). It should be noted that this information is generalised and must be adapted to individual circumstances.

**General notes on insertion**

Accurate pre-operative planning is a basic requirement for successful treatment with miniscrews. Such planning includes a comprehensive anamnesis and an accurate assessment of the findings. It is essential that the treatment be thoroughly explained to the patient.

Proper hygiene must be ensured throughout the entire operation.

Both the dental chair and the treatment process must be prepared with this in mind. During the insertion of a miniscrew, adherence to all hygiene measures required for an invasive procedure, such as a sterile work environment and gloves, must be ensured.

All instruments required for insertion must be checked for completeness, functionality and sterility. The patient may rinse with a disinfectant solution, or a suitable disinfectant can be locally applied. The patient should then be positioned to ensure a clear view of the operational area and ergonomically facilitate insertion for the treating dentist.

**Pre-operative planning**

To function correctly, a miniscrew requires firm anchorage in the bone (primary stability) and the positioning of its head in the denser gingival tissue (gingiva alveolaris). The selection of the insertion site must take clinical and para-clinical findings into account (X-ray image, model), as well as the goal of the treatment and the resulting orthodontic appliance. For interradicular insertion, a bone thickness of at least 0.5 mm around the miniscrew is required. This means that for a miniscrew with — for many reasons — an optimal diameter of 1.6 mm, the roots must be at least 2.6 mm from each other. Thus, the bone status and the longitudinal axis of the insertion site must be carefully evaluated.

Basic information regarding this is obtained by carrying out measure-
Discover A New Dimension Of Predictability, Precision, And Affordability

Experience more advanced anatomical views by capturing 3-D images right in your office. Achieve accurate, immediate assessments with the GXCB-500® powered by i-CAT®. This breakthrough, Cone Beam 3-D Imaging technology is now incorporated into a system featuring ground-breaking affordability.

Provide reassurance through considerable radiation reductions, in comparison to traditional CT scans. Build patient confidence in treatment plans with a clear diagnosis. Best of all, this evolution in imaging is easily implemented! The GXCB-500 is a technological plus for both patients and practices.

Gendex Dental Systems
www.gendex.com
Call toll-free: 1-888-275-6386

Gendex
Imaging Excellence Since 1893
ments on the model. It often helps to mark the vertical axis of the teeth and the progression of the muco-gingival line on the model, based on the clinical and radiological findings. This will allow for an improved assessment of the spatial circumstances in combination with the X-ray image. To assist the accurate determination of the insertion site, X-ray aids (Fig. 1) are available.

Although their use facilitates the selection of the insertion site, they cannot replace other diagnostic measures. This is because, depending on the positioning of the X-ray tube, object, film, and/or sensor, all types of X-ray devices and images may yield some optical distortion. Interpretation of images can thus lead to false-negative or false-positive results (Figs. 2a–c).

Therefore, the placement of a miniscrew should always be based on the clinical findings. If a miniscrew is to be inserted into an area in which there is no risk of damage to roots, nerves or blood vessels (e.g., into the palate just behind the transverse line linking the two canines), the position of the screw may be freely chosen (Figs. 3a–c).

Anaesthetic

During the interradicular insertion of a miniscrew, the sensitivity of the peridental tissue of the adjoining teeth should be retained. For this reason, the following two procedures are recommended:

a) a low-dose injection of approximately 0.5 ml anaesthetic (Figs. 4a and 4b); and
b) the induction of superficial anaesthesia of the mucous membrane at the insertion site, for which a topical anaesthetic gel is suitable (Figs. 5a and 5b). No general anaesthetic is ever required for this procedure.

Choice of screw

Measuring the thickness of the mucous membrane (optional)

A pointed sensor with an attached rubber ring is used to measure the thickness of the gingival tissue in the direction of insertion (Fig. 6).

This information may be useful when determining the final length of the screw and possibly when inserting the miniscrew.

When choosing the length, the bone repository and the thickness of the mucous membrane in the direction of insertion play a role; in the retromolar section of the lower jaw and in the palate, the thickness of the mucous membrane is often more than 2 mm.

The part of the miniscrew inside the bone must be at least as long as the part outside the bone. The various dimensions must be taken into account.

The thickness of the bone in the direction of insertion determines the required length of the miniscrew:

- bone thickness > 10 mm: miniscrews with a length of up to 10 mm are to be used;
- bone thickness < 10 mm and > 7 mm: miniscrews with a length of 8 mm or 6 mm are to be used; and
- bone thickness < 6 mm: miniscrews cannot be used.

The following guidelines aid in selecting the length:

- in the buccal region of the upper jaw: 8 mm or 10 mm;
- in the palatinal region (depending on the region): 6, 8 or 10 mm; and
- in the lower jaw: usually 6 mm or 8 mm.
Determination of the type of thread

Self-cutting miniscrews require pre-drilling (also known as pilot drilling) appropriate to the length and diameter of the screw, as well as to the quality of the bone. A self-tapping miniscrew will find its own way into the bone and requires no pre-drilling (Figs. 7a and 7b).

Bone is more or less elastic depending on site, age and structure. Without pre-drilling, the screw will be strongly compressed during insertion and thus suffer related tension stress. This may result in the cracking of the bone around the insertion site.

When the screw is screwed into the bone, it is subjected to high loads. Depending on the bone quality, the resistance against insertion and the continuity of the rotational movement, high torsional forces can result.

In regions with thick cortical bone and a much looser bone structure (e.g., the upper jaw), the use of self-tapping screws is recommended.

In regions where the cortical bone is thick and the bone structure is dense (e.g., the anterior lower jaw), both self-cutting and self-tapping screws may be used, in each case following perforation of the compact bone.

Benex®- Control Professional

- Safe and simple extraction of roots
- Maximal protection of the tooth socket
- Possibility of drilling even if minute root fragments or foreign bodies are present in the root
- Possibility of drilling independently of anatomic root canal

Meisinger USA, LLC. 2742 South Tucson Way • Suite 136 • Centennial • Colorado 80112 • USA Tel.: +1 (303) 688-6400 • Fax: +1 (303) 368-1407 • E-Mail: info@meisinger-usa.com www.meisingerusa.com • www.bone-management.com • www.actusatirstick.com
Transgingival penetration

The miniscrew must penetrate through gingival tissue, which may thus be perforated during insertion. Two methods are used for the perforation of the gingival tissue:

a) excision of the gingival tissue; or
b) direct insertion of the screw through the gingival tissue.

There are currently no published studies that investigate the effect of these two methods on postoperative problems, histological effects and/or the loss rate of miniscrews.

Preparation of the bone site

Protection of the bone is an important aspect. Insertion without pre-drilling results in tensile stress within the bone, which may lead to postoperative complications. Particularly in the case of crestally placed screws, bone displacement may result in a severe expansion of the periosteum. The thickness of the cortical bone, especially in the lower jaw, can have a significant effect on the torque of the screw. To ensure that the screw is not overloaded during insertion, the compact bone of the anterior lower jaw should be perforated by pre-drilling, as mentioned earlier. Pre-drilling should be done at a maximum of 1,500 rpm, using a short pilot drill and water-cooling to reduce the risk of damaging the root (Figs. 8a and 8b).

Insertion of the miniscrew

The miniscrew must be removed from its sterile packaging (Fig. 9) or the work rack (Figs. 10a–d) without contamination. The thread of the screw may not be touched. The screw should be inserted at a constant rotational speed (at approximately 50 rpm) and with as uniform a torque as possible.

Manual insertion

Manufacturers supply various screwdrivers and blades in several lengths for the manual insertion of the screws. Because of their dimensions, long blades pose the risk of attaining a very high torque during insertion.

Thus, insertion must be carried out carefully to avoid breaking the miniscrew. Torque ratchets are available for use with some systems (e.g., tomas, DENTAURUM; and LOMAS, Mondeval), which provide a certain amount of control over the insertion torque.

Machine insertion

Machine insertion requires a surgical treatment unit (the torque of which can be controlled) or at least a low-rpm dual green handpiece. Accurate setting of the torque and the number of rotations is required; the rotation rate should not exceed 50 rpm, and the torque must be restricted to the maximum load limit of the screw.

Machine insertion helps to achieve a consistent torque during insertion but means that the operator loses perception of the bone. During manual insertion, it is possible to perceive the interaction between the screw and the bone by tactile senses. Insertion by machine is shown in Figures 11a–f.

Fig. 11a–f: Preparation of the instruments and insertion of two miniscrews into the palate by machine.

Attaching the orthodontic linking elements

As no healing phase is required, load may be placed on the miniscrew immediately after insertion. The selected linking element must be prepared accordingly and attached to the head of the screw (Fig. 12).

To avoid damage to the teeth to be moved, the load on the linking element should be between 0.5 and 2 N (about 50 and 200 g).

Basic postoperative care

The healing of the gingival tissue and hygiene status after insertion must be regularly reviewed during the entire time that the miniscrew remains in place. The patient must be informed that any manipulation of the screw head with the fingers, tongue, lips, and/or cheeks should be avoided, otherwise the screw may be prematurely lost.

Removal of the miniscrew

A miniscrew can be removed under local anaesthesia. After the linking elements have been removed, the miniscrew may be removed with the same tools used for insertion. The resulting wound requires no special care and usually heals within a short time.

Checklist for insertion

Pre-operative planning and preparation:

- planning documentation (X-ray, situational model(s));
- marking of the muco-gingival line and tooth axes on the model;
- determination of the site of insertion;
- sterilisation of the instruments and preparation of the workstation.

Anaesthetic and assessment of the insertion site:

- anaesthetic;
- use of X-ray aids;
- control image.

Selection of the screw:

- measuring of the thickness of the mucous membrane (optional);
- determination of the length;
- determination of the type of screw.

Transgingival penetration:

- excision of the mucous membrane or perforation with the screw.

Preparation of the bone site:

- optional marking of the bone;
- perforation of the cortical bone or deep pilot drilling, depending on the type of screw.

Insertion of the miniscrew:

- manually or by machine.

Start of orthodontic measures:

- attaching and fixing of the linking elements.

Postoperative care:

- notes on care and behaviour;
- check-up dates.

Removal of the miniscrew:

- removal of the linking elements;
- removal of the miniscrew.
The American Academy of Periodontology (AAP) will host its 95th Annual Meeting in Boston, Mass., from Sept. 12–15 at the new Boston Convention and Exhibition Center. Attendee registration is now open, and dental professionals from all specialties are encouraged to register to learn about the latest advancements in periodontology. More than 5,000 dental professionals and participating vendors are expected to attend.

The four-day meeting will include a variety of educational and scientific sessions in seven distinct program tracks, covering topics such as dental implants, periodontal-systemic relationships, practice development and management, and regeneration and tissue engineering. Traditional continuing education courses, as well as hands-on workshops and clinical technique showcases will be offered. In total, more than 50 educational and scientific sessions will be offered.

Of particular note is this year’s Opening Ceremony, which will officially kick off the meeting on Sept. 12 with welcome remarks from the 2009 AAP President, David Cochran, DDS, PhD. The academy is also pleased to announce Paul M. Ridker, MD, as the opening ceremony’s keynote speaker. Ridker is a leading researcher in inflammation and cardiovascular disease, and was an important contributor to the recent joint consensus paper on cardiovascular disease and periodontal disease published by The American Journal of Cardiology and the Journal of Periodontology.

“This is an exciting time in periodontics, so I am thrilled to invite the dental community to join us in Boston,” Cochran said. “It has become critical that all dental professionals understand the connection between periodontal disease and other chronic diseases of aging, such as cardiovascular disease, and especially the role inflammation plays in this connection. Our 2009 Annual Meeting offers an exciting and informative forum to learn about these important advances.”

For more information or to register for the Annual Meeting, visit www.perio.org/meetings or call (312) 573-5216 or send an e-mail to angela@perio.org.
SUCCESS IS EASY
Press Here

“Just got back from LVI and my world has changed. I can’t possibly look at dentistry the same way again!”
– Dr. Balaji Srinivasan

“My LVI education has enabled me to not only survive, but to thrive.”
– Dr. James R. Harold

“There is nothing out there that even comes close to the LVI experience. The amount of enthusiasm I am bringing home with me is unbelievable. What an experience and a treat!”
– Dr. Robert S. Maupin

REGISTRATION IS JUST A CLICK AWAY!

www.lviglobal.com
888.584.3237
SimPlant World Congress focuses on 3-D in Monterey

Materialise Dental event featured leading experts

By Sierra Rendon, Managing Editor

The 2009 SimPlant® Academy World Conference, held at the Monterey Marriott in coastal Monterey, Calif., from June 25-27, concluded with many high points regarding the advancement of implant dentistry for the several hundred periodontists, oral surgeons, restorative specialists and general practitioners in attendance.

“Materialise Dental is thrilled to offer a fantastic program at the SimPlant Academy World Conferences,” said John Thomas, General Manager of Materialise Dental USA and Canada. “We assembled the finest group of implant dentistry experts and industry patrons one could imagine, and those in attendance have been treated to three days of unsurpassed education in our never-ending quest to make implant surgery even more successful.”

Just a sampling of the speakers at the event include Drs. Lyndon Cooper, Mazen Dagher, Doug Erickson, David Guichet, Randolph Resnik and many more.

The conference’s mission was to provide a comprehensive understanding of the use of 3-D digital dentistry in order to improve implant treatment planning services.

Clinicians who had limited knowledge about SimPlant and SurgiGuide® drill guides congregated to take their knowledge of this state-of-the-art technology to the next level.

Delegates participated in intensive hands-on SimPlant software training workshops, high-quality lectures by renowned speakers in the field and hands-on laboratory sessions where participants learned how to use SurgiGuide drill guides and create all types of scanning prostheses.

“I can say without reservation that the quality of the guest lecturers and their presentations was absolutely tops; and I’ve taken home many ‘pearls’ that I will be able to put into immediate use in my implant practice,” said Dr. Lynn Pierri, a board-certified oral and maxillofacial surgeon from Long Island, N.Y.

“It was extremely rewarding to exchange experiences, both surgically and prosthetically, with Materialise Dental users in the international implant community in a common effort to take our practices to an unparalleled level of precision in both planning and execution.”

Software training was available for all levels of participants. Participants were also offered rotating workshops, in which everyone had the chance to learn about all of the components that go into CT Guided surgery, including:

- dental laboratories
- CBCT
- SurgiGuide selection and design
- SurgiGuide functionality using CT-guided surgical kits.

Also at the conference were 12

Dr. Doug Erickson hosts a very interactive group discussion on ‘CT Data and Processing Cases on the Fast Track’ at the SimPlant Academy World Conference in Monterey, Calif., from June 25-27.
Clinical Video Downloads
Lecture-on-Demand
DVD and iPod Education
Video Interviews
1-Year Master Program Hands-on-Training

World Renowned Dental Faculty including

Dr. Pascal Magne, Dr. Ed McLaren, Dr. Brian LeSage,
Dr. Sascha Jovanovic, Dr. Massimo Simion, Dr. Frank Celenza,
Dr. Bernard Touati, Dr. Joseph Kan, Dr. Todd Scheyer,
Dr. Sam Strong, Dr. Galip Gurel, Dr. Ron Jackson,
Dr. John McSpadden, Dr. Peter Wöhrle and many more

esthetic dentistry | implant dentistry | periodontics | endodontics | prosthodontics and more...
Dr. David Guichet speaks on ‘Computer-Guided Treatment and the Immediately Loaded Prosthesis’ in a Plenary Session at the SimPlant Academy World Conference.

An attendee gets some information at the PreXion booth during a refreshment break at the SimPlant Academy World Conference. A total of 12 companies supported the event and exhibited products on site.

Dr. Lyndon Cooper discusses ‘Data In — Data Out: How Careful Case Preparation Can Influence the Scan, the Plan, the Guide and the Lab Fabrication for Esthetic Restoration.’

Events 13B

exhibiting companies, including Astra Tech Dental, BIOMET 3i, PreXion 3-D, Straumann, iCat and several others, all there to show support of this technologically advanced dental concept.

Implant manufacturers, CBCT manufacturers and surgical supply companies gathered to show the delegates how their companies could help improve their CT-guided implant practices.

New product highlights

Chief among the highlights of the event was the launch of the Universal SurgiGuide and surgical kit. Expanding on the SimPlant Compatability model, the Universal SurgiGuide system allows you to continue to use your standard surgical drills and the implant brand of your choice, while making the drilling sequence easier. One guide that can be fixated into place is used in conjunction with a series of drill keys in order to account for the increase in diameter as you drill to create an osteotomy.

A sneak preview of the SimPlant 13 and DentalPlanit, an upgraded version of world’s first interactive 5-D implant planning system and online communication portal that are scheduled to come out later 2009, were also on display.

“I find Materialise Dental a leader in computer-guided treatment planning for implants,” said attendee Dr. Faisal Aldujaili.

“If you are placing implants, you must have them on your side. I highly recommend the software; it’s user-friendly and their support is always there. The Materialise Dental World conference was a great educational experience for me in beautiful Monterey with an exceptional organization.”

For more information on SimPlant Academy events and courses, visit www.simplantacademy.org.

(Matt Tedrow of Materialise Dental contributed to this report.)

SAVE THE DATE!

25th Anniversary Meeting

Academy of Osseointegration

Highlights Include:

• Opening Symposium: 25 Years of Experience — The Formula for Predictable Implant Success
• Round Table Clinics
• Limited Attendance Lectures
• Two Track Program
• Commercial Exhibits
• Dental Hygiene Assistance Program
• Hands On Workshop (NEW)

THE FORMULA FOR PREDICTABLE IMPLANT SUCCESS

March 4-6, 2010

Walt Disney World Dolphin Resort — Orlando, Florida
What defines a successful relationship between an implant practice and referring offices? That’s simple — interdisciplinary teamwork! A strong systemized relationship with referring offices is essential to your continued success. In an uncertain economy, you must do everything necessary to grow your implant practice, and interdisciplinary teamwork will be key to that growth. Adding value and support is critical to your future.

Getting in sync
At a recent Total Practice Success™ seminar where I was speaking to several hundred restorative doctors, I pointed out that motivation — any sort of motivation — lasts about one week. For that reason, all new patients and big cases should be scheduled within seven to 10 days. Doing so greatly increases the likelihood of case acceptance.

At this seminar, a restorative doctor shared with me a problem he was having with his referring oral surgeon. This general dentist liked restoring implant cases, but the oral surgeon couldn’t see implant consults for about six weeks. The dentist found the waiting period was simply too long. By the time his patients were seen by the oral surgeon, motivation had waned and case follow-through was quite low.

Shortly after the seminar, I spoke with several oral surgeons about this subject. These doctors all acknowledged that the implant consults should occur as quickly as possible. For a team approach to work, both restorative and surgical practices must be on the same page.

A better implant team
To strengthen relationships with referring dentists, clear communication is essential. Remember, just because a surgical practice has been managing the implant process the same way for years, doesn’t mean it’s the most effective method. There’s always room for improvement. Levin Group recommends that restorative doctors and specialists reach agreement on these seven questions regarding interdisciplinary care:

• Who will provide patient care during each step of the implant process?
• How soon can the surgical practice see a referred patient for an implant consultation?
• Who will provide case planning input?
• How will communication occur between the restorative practice and the implant surgical practice?
• Who will present fees to the patient?
• When the situation is appropriate, who will arrange financing for patients?
• How soon can the patient expect to start implant treatment when a case is presented and accepted?

Want to learn more about building superior relationships with referring offices? Make plans to attend Dr. Levin’s latest Total Implant Success™ seminar Sept. 24-25 in Baltimore. Implant Tribune readers are entitled to receive a 20 percent courtesy on this seminar. Call (888) 973-0000 and mention “Implant Tribune” or e-mail customerservice@levingroup.com with “Implant Tribune” in the subject line. For more information, visit www.levingroupimplant.com.
**SwissPlant**'s All-in-One packaging includes: Cover Screw, Healing Collar, Transfer and Straight Abutment with Snap-on Comfort Cap

SwissPlant USA price = $200
Straumann USA price = $632

---

**Features and Benefits:**

1. **Body Design:** Tapered with double-lead buttress threads
2. **Surface/Body:** SBM Medium Texture with 17 year history
3. **Surface/Neck:** SBM Light Texture for soft or hard tissue
4. **Diameters:** Standard 4.1mm and 4.8mm plus 3.3mm & 5.7mm
5. **Platforms:** Standard 4.8mm and 6.5mm internal octagon plus 3.7mm hex with Platform Switch
6. **Fixture-mount/Transfer/Abutment:** Engages square within octagon

---

**Tissue-Level**

- 6.5mm
- 4.8mm

**Bone-Level**

- 6.5mm
- 5.7mm

*The 4.1mm and 4.8mm SwissPlant implants can be inserted into soft bone using Straumann’s drills. An additional drill is required for dense bone or countersinking for bone-level placement. Implant Direct’s ratchet, insertion tool and 1.25mm Hex tool are also required.*

---

**Recommended Introductory offer for ITI Straumann® users:**

- 3 Free SwissPlant Implants with Internal connection, External Bevel, plus “Solid” Engaging Abutments and Transfers

---

**US List Price**

<table>
<thead>
<tr>
<th>Component/Attachment</th>
<th>Implant Direct</th>
<th>ITI Straumann</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ball Attachment</td>
<td>$107</td>
<td>$162</td>
</tr>
<tr>
<td>Screw Retaining</td>
<td>$85</td>
<td>$165</td>
</tr>
<tr>
<td>Straight Snap-On</td>
<td>$85</td>
<td>$165</td>
</tr>
<tr>
<td>Straight Solid Abutment</td>
<td>$85</td>
<td>$182</td>
</tr>
<tr>
<td>Protrusion Concave Shallow</td>
<td>$85</td>
<td>$182</td>
</tr>
<tr>
<td>Protrusion Platform-Transfer-Switches</td>
<td>$85</td>
<td>$203</td>
</tr>
<tr>
<td>15° Angled Bevel Plastic</td>
<td>$100</td>
<td>$211</td>
</tr>
<tr>
<td>Temporary Abutment</td>
<td>$535</td>
<td>$61</td>
</tr>
<tr>
<td>Locator Abutment</td>
<td>$138</td>
<td>$138</td>
</tr>
</tbody>
</table>

---

FREE Introductory Offers at www.implantdirect.com
Time to challenge old truths
Astra Tech Implant System™ – setting a new standard

How do you achieve optimal long-term treatment outcomes for your patients? The standard norm regarding dental implant treatment success from 1986 does not reflect what is possible to achieve today. There are no reasons why the clinician or the patient should accept a marginal bone loss of up to 1.5 millimeters based on a standard set 20 years ago. It has been proven in study after study that with the Astra Tech Implant System™ the mean marginal bone level reduction is only 0.3 millimeters over five years.

![Graph showing optimized marginal bone maintenance with the Astra Tech Implant System™](image)

- Astra Tech Implant System™ level based on data from more than 42 published articles presenting radiological data: Literature search April 2008
- Standard norm according to:

Isn't it time to upgrade?
The unique design of the Astra Tech Implant System™ helps to optimize marginal bone maintenance.

[Why settle for less?]