The International Congress of Oral Implantologists (ICOI) will educate attendees at its 2012 Winter Symposium with a focus on implant practice, you will benefit from this comprehensive course. “Emphasis has been placed on advanced implant placement and in-office bone graft surgical procedures. The core curriculum is clinically focused on the latest research and clinical science to provide the participant with an understanding of the rationale and scientific basis for implant and bone-graft success.”

Main podium speakers include the following clinicians: Drs. William Dapper, Abdelsalam El Askary, Rick Ferguson, Yvan Fortin, Michele Jacotti, Sonya Leiz, Henriette Lerner, Burt Melton, Carl Misch, Hari S. Prasad, Devorah Schwartz, Nicholas Shubin, Dennis Smiler, Yukihito Takagi, Ilser Turkylmaz, Natalie Wong, Hoda Yousef and Andre Zetola as well as Jeffery Carlson and Renzo Casellini.

The focused lectures will deal with the areas of solving surgical challenges for bone-graft success; solving prosthetic challenges of the implant-supported restoration, applying new key concepts of bone graft and implant design, mastering concepts that continue to work; and, finally, mastering concepts of esthetic implant restoration. Whether your practice is focused on surgical or prosthetic disciplines, this comprehensive course will provide you with the knowledge and understanding of the integrated surgical and prosthetic requirement for implant success.

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A full range of sponsored workshops will be conducted on the Thursday morning (8 a.m. to noon) prior to the commencement of the general session.

Drs. Joel Berger and Ian Aires will hold a session on “The Use of 3-D Stereolythic

*Continue on Page B2

ICOI goes ‘Back to the Future’ for annual Winter Symposium

The International Congress of Oral Implantologists is hosting its annual Winter Symposium from Feb. 16–18 in San Diego. The dates for the meeting are Feb. 16-18. ICOI’s winter symposium, “Back to the Future of Implantology 2012 and Beyond,” has been designed by Program Chairman Dr. Dennis Smiler. As described in his mission statement: “This unique, interactive course will provide you with the knowledge and understanding of the integrated surgical and prosthetic requirement for implant success.

Whether you are looking to develop a strong implant practice or want to refine your skills and expand your existing implant practice, you will benefit from this comprehensive course. “Emphasis has been placed on advanced implant placement and in-office bone graft surgical procedures. The core curriculum is clinically focused on the latest research and clinical science to provide the participant with an understanding of the rationale and scientific basis for implant and bone-graft success.”

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*Continue on Page B2

ICOI study: Surgery protocol for heart patients shows positive results

Cardiac patients who take anticoagulant medications and need a tooth extraction face an increased risk of bleeding that must be addressed by the treating clinician. Therefore, a protocol for heart patients is needed that will avoid significant bleeding after dental extractions without suspending anticoagulant therapy.

A study reported in a recent issue of the Journal of Oral Implantology evaluated the use of leukocyte- and platelet-rich fibrin biomaterial. This material is commonly used in dentistry to improve healing and tissue regeneration. It was tested as a safe filling and hemostatic material after dental extractions in 50 heart patients undergoing oral anticoagulant therapy.

These heart patients had mechanical valve substitutions and then were placed on anticoagulant oral therapy with warfarin. It is not recommended that the anticoagulant be suspended and replaced with heparin before a minor surgery, although this substitution may control the risk of bleeding.

One method of controlling bleeding without suspending the anticoagulant is the use of platelet-rich plasma gel placed in post-extraction tooth sockets. Although this protocol has been successful, there are barriers to its daily use. The platelet concentrates are expensive and take a long time to prepare.

Platelet-rich fibrin offers an alternative biomaterial that is simple and inexpensive to prepare. Blood is collected in tubes without anticoagulant and centrifuged. It divides into three layers, creating a strong platelet-rich fibrin clot in the middle layer. Platelet-rich fibrin has proved useful in daily dental practice as filling material for regeneration in order to place implants.

In this study, 50 heart patients following an anticoagulant therapy were treated with leukocyte- and platelet-rich fibrin clots placed into post-extraction sockets. Complications of bleeding were reported in only two patients, and 10 had mild bleeding.

Times of crisis bring new plans for craniofacial medical care

Medical care for cleft lip or palate is typically offered in stages, with carefully timed surgeries and long-term comprehensive care provided by a team of professionals. When a crisis occurs, such as a natural disaster or political unrest, this standard of care is disrupted. There is a need to establish standards for continuing care for children with craniofacial anomalies during times of upheaval.

Several articles in the November 2011 issue of Cleft Palate–Craniofacial Journal address issues surrounding this topic. One article centers on craniofacial care in locations where disaster and unrest have created difficult conditions. Another addresses an emerging trend of a higher incidence of craniofacial anomalies after a disaster. A third article suggests that guidance is needed for domestic and global crisis relief programs.

When Hurricane Katrina struck New Orleans, in 2005, Children’s Hospital housed one of the two craniofacial teams in the city. Lessons learned during the hurricane’s aftermath have led to new policies for the hospital. When evacuating its facility became necessary, the hospital set up a temporary location at a Baton Rouge, clinic 80 miles away and a satellite clinic in Lafayette, La., two hours away. The hospital has continued to work with these locations as satellite sites in case future evacuations are required.

Communications with patients were found to be lacking after Hurricane Katrina. Hospital staff were unable to contact many patients’ families to inform them when and where they could expect medical care for craniofacial anomalies.

Before this disruption, the mail had served as the primary means of communication. Now mobile phone numbers and e-mail addresses are collected as part of routine patient information.

Researchers report in another article that the number of new cleft cases showed an increase in greater New Orleans about nine months after Hurricane Kat- rina. This study found that the increase, particularly among African-Americans, could be attributed to higher levels of te-ratogenic agents or elevated stress levels following the hurricane.

Hurricane Katrina and other catastrophic events in recent years have shown a need for guidance in crisis relief pro- grams. No such standards currently exist for cleft and craniofacial care. As presented in another article in this issue, principles set forth by the American Cleft Palate–Craniofacial Association may provide precisely such guidance.

The authors recommend using this document as a template for international clinical care programs. This would provide standards for examining the conduct of relief programs and ensuring that medical teams are effective, ethical, and culturally sensitive.


About Cleft Palate–Craniofacial Journal

The official publication of the American Cleft Palate–Craniofacial Association (ACPA), the Cleft Palate–Craniofacial Journal is a bimonthly international, interdisciplinary journal on craniofacial anomalies. The journal explores and reports on the study and treatment, including experimental and proven surgical procedures, of cleft lip/palate and craniofacial anomalies. It also keeps readers in touch with the latest research in related laboratory sciences. To learn more about the society, visit www.acpa-cff.org.
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Continuing education in dental implantology has traditionally focused on theoretical aspects. However, since 2003, the Trinon Collegium Practicum has organized practice-orientated dental implantology courses based on the model of surgeon training in European hospitals, enabling dentists to have a firmer grasp of implantology.

Entering implantology can be difficult for dentists to achieve successfully. It is not a subject of university education, and with international universities and courses being focused largely on theoretical orientation, it proves a time-consuming endeavor. Furthermore, in international education and training programs, the dentists almost never work on patients or might work on phantom cases, classified as hands-on.

This, according to Prof. Rainer Valentin, board member of the German Society for Dental Implantology (DGZI), led to education in implantology placing an increasing emphasis on theoretical training, which then results in a neglect of practical experience and, most importantly, the proof thereof.

This phenomenon is repeated globally and results in dentists often lacking in confidence and developing a fear of complicated cases, which essentially leads to long pauses between individual implants and a limited learning curve.

Learning by doing

The Q-Implant Marathon is one reaction to this situation in the continuous-education sector. Started in 2003 in Cuba, and since conducted more than 70 times in four countries worldwide, the course is designed to be purely hands-on with a real patient experience under strict supervision from internationally renowned surgeons and university hospitals. Participants with a strong theoretical foundation in implantology spend five days assisting in and performing surgery, placing approximately 30 implants within this short period.

“One only is confident doing what one knows,” said Dr. Harald Glas from Vienna, summarizing the positive effect of practical education. During the Q-Implant Marathon, Glas worked with international peers and supervisors on several cases a day. Every case is discussed beforehand with the supervising tutor and assisting surgeon; furthermore, even during the surgery, questions about surgical treatment are addressed.

Patients are prepared and followed-up by the resident team of the university hospital and, in most cases, are immediately provided with long-term temporary restorations so participants can see the result of the treatment and complete their photographic documentation.

The phased approach of the Q-Implant Marathon, which accounts for 45 dental CMF points, divides participants in three levels: Beginner, Advanced I and Advanced II.

This gives dental practitioners an opportunity to learn the relevant practical knowledge they require at their home clinics. Beginners’ courses are working on basic implant cases whereas surgeons with considerable experience can venture into more complicated cases with the knowledge and safety of having a supervisor to discuss the case and assist during surgery.

The concept of hands-on courses has been influenced by surgeon training in European hospitals where emphasis on practical surgical training of young doctors is at the center from day one. The experienced surgeon guides the hand of the assistant physician and gives him the feeling for working on patients while in a safe and controlled environment.

“Learning by doing is the most successful way to gain experience in implantology and that is why we do it that way,” said Dr. Alfredo Valencia, the scientific director of the Q-Implant Marathon program.

A focus on the United States

Today, the concept has been rolled out throughout three permanent locations worldwide with one in Dominican Republic and two courses in Asia. In the last eight years, the Trinon Collegium Practicum has seen more than 2,000 dentists participate in the Q-Implant Marathon with more than 12,000 patients treated and more than 30,000 implants placed.

The decision to conduct these hands-on courses in Dominican Republic stems from the rising number of dental implantologists in the United States and its surrounding regions, a growing number of patients demanding a high level of care and the overall lack of practice-orientated courses in close proximity to American dentists. The course in Dominican Republic is based in Santo Domingo and has been conducted more than 26 times. This course collaborates with private clinics, where the clinic equipment is comparable to U.S. standards; similarly, the infrastructure is more or less comparable to the situation in the United States. All of the Trinon Collegium Practicum courses have ensured that conditions under which surgeons work have appropriate standards including surgical equipment, professional tooth scaling for patients, digital X-ray equipment and modern dental treatment chairs.

The head instructor for the Q-Implant Marathon in Santo Domingo is Valencia, who studied human medicine at the Oviedo University in Spain and specialized in stomatology, oral-maxillofacial surgery and implantology over the years. Valencia is supported by a team of assisting tutors, whom he personally recruited. Most of these tutors have learned implantology from him.

“So I know them well and it is easy for me to work with them,” Valencia said.

The atmosphere is harmonious even after 12 hours in the surgery room, the groups still like to meet for an evening meal. Courses in Santo Domingo have developed even further over time with regard to patient care and technical aspects of surgery. One of the most important improvements has been patient selection. The local team is now able to assign patients to suit the ability and the needs of participants.

Contact information

The Q-Implant Marathon is conducted six to eight times a year in the Dominican Republic and Asia. To find out more about the Q-Implant Marathon, contact Optimum Solution Group, Mac Kubiak, call (877) 705-1002, e-mail info@optimumsolutiongroup.com or see www.implantologycourses.com
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Scenes from the AAP

The American Academy of Periodontology holds its annual meeting in Miami in November

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Scenes from the AAP

Zimmer Dental representatives introduce AAP attendees to the availability of the Zimmer CurV™ Pre-shaped Collagen Membrane — stemming from an exclusive distribution agreement with Osseous Technologies of America (OTA).

What is it worth to you to avoid an implant from failing because of premature restoration? Nazanin Ghafouri of Osstell AB explains to an AAP attendee how the company's technology can help clinicians objectively and noninvasively judge implant stability. For more information on Osstell AB instruments, see www.osstell.com.

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Laser-Lok microchannels is a proprietary dental implant surface treatment developed from more than 20 years of research initiated to create the optimal implant surface.

Through this research, the unique Laser-Lok surface has been shown to elicit a biologic response that includes the inhibition of epithelial downgrowth and the attachment of connective tissue (unlike Sharpey fibers). This physical attachment produces a biologic seal around the implant that protects and maintains crestal bone health. The Laser-Lok phenomenon has been shown in post-market studies to be more effective than other implant designs in reducing bone loss.

Laser-Lok microchannels is a series of cell-sized circumferential channels that are precisely created using laser ablation technology. This technology produces extremely consistent microchannels that are optimally sized to attach and organize both osteoblasts and fibroblasts. The Laser-Lok microstructure also includes a repeating nanostructure that maximizes surface area and enables cell pseudopodia and collagen microfibrils to interdigitate with the Laser-Lok surface.

Unique surface characteristics
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Different than other surface treatments
Virtually all dental implant surfaces on the market are grit-blasted and/or acid etched. These manufacturing methods create random surfaces that vary from point to point on the implant and alter cell reaction depending on where each cell comes in contact with the surface. While random surfaces have shown higher osseointegration than machined surfaces, only the Laser-Lok surface has been shown using light microscopy, polarized light microscopy and scanning electron microscopy to also be effective for soft-tissue attachment.

The clinical advantage
The Laser-Lok surface has been shown in several studies to offer a clinical advantage over other implant designs. In a prospective, controlled multi-center study, Laser-Lok implants, when placed alongside identical implants with a traditional surface, were shown at 37 months post-op to reduce bone loss by 70 percent (or 1.35 mm). In a retrospective, private practice study, Laser-Lok implants placed in a variety of site conditions and followed up to three years minimized bone loss to 0.46 mm. In a prospective, university-based overdenture study, Laser-Lok implants reduced bone loss by 63 percent versus NobelReplace™ Select.

Latest discoveries
The establishment of a physical, connective tissue attachment (unlike Sharpey fibers) to the Laser-Lok surface has generated an entirely new area of research and development: Laser-Lok applied to abutments. This could provide an opportunity to use Laser-Lok abutments to create a biologic seal and Laser-Lok implants to establish superior osseointegration — a solution that offers the best of both worlds. Alternatively, Laser-Lok abutments could support peri-implant health around implants without Laser-Lok. In a recent study, Laser-Lok abutments and standard abutments were randomly placed on implants with a grit-blasted surface to evaluate the differences. In this proof-of-principle study, a small band of Laser-Lok microchannels was shown to inhibit epithelial downgrowth and establish a connective tissue attachment similar to Laser-Lok implants.

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(Source: BIOMET 3i)

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ChaseHealthAdvance utilizes Facebook Tab to help clinicians increase case acceptance

The landscape of healthcare and healthcare financing is changing: consumers are taking more control of their healthcare decisions. A February 2011 poll by Pew Research Center’s Internet and American Life Project reported that 80 percent of Internet users search for health-related information. Consumers are using the web to look up symptoms, find and research providers and even explore options to make elective procedures affordable.

ChaseHealthAdvance, a leader in healthcare financing, has embraced the growing influence that technology, the Internet and social media have had on the field. As part of its commitment to helping providers increase case acceptance and improve cash flow, ChaseHealthAdvance has led the market in technological innovation and advocacy.

Since its founding in 2005, ChaseHealthAdvance has worked to be the most digitally advanced company in the marketplace. Building a strong online presence for its products and services, ChaseHealthAdvance has, more recently, integrated technological innovations into its marketing and presentation platforms, all with the goal of making it easier for providers to offer ChaseHealthAdvance financing options to patients.

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Through chasehealthadvance.com, practices can manage their entire patient-financing portfolio. Clinicians and office staff can quickly and easily submit new patient transactions, track current open accounts and even produce custom reports. Not only does this help practices better manage patient accounts, but it also reduces the amount of paperwork in the office.

ChaseHealthAdvance was the first healthcare financing company to recognize the opportunity to use mobile devices in the practice. The ChaseHealthAdvance Present and Apply tool for the iPad allows practitioners to walk patients through the case presentation process in a simple, easy-to-understand visual format. It communicates affordability and helps remove the cost barrier for the patient. The tool allows the patient to apply for financing right from the iPad so the provider can schedule the procedure before the patient leaves the office.

One innovation ChaseHealthAdvance has developed recently is its new Facebook Tab, which lets providers share ChaseHealthAdvance financing options with patients through Facebook. Patients can learn about financing options, estimate monthly payments for procedures and treatments, and even apply for financing right from the practice’s Facebook page.

The ChaseHealthAdvance Facebook Tab is fully customized to every practice. The page only displays the procedures and treatments offered at the practice. Providers also elect which financing options are seen by patients on the page. Adding the ChaseHealthAdvance Facebook Tab to a provider’s Facebook page takes only minutes. Providers are walked through a simple, five-step process that customizes the tab for their practice and uploads the application to their practice’s Facebook page.

Providers first enter their practice’s provider ID and select their field of service, then identify the procedures they perform and enter the cost range for each.

Next the provider selects the ChaseHealthAdvance financing options offered by the practice. The last two steps allow the ChaseHealthAdvance Facebook Tab to access the provider’s Facebook page and then add the tab to the page. Once installation is complete, the tab is live on the provider’s Facebook page. Providers can immediately get better acquainted with ChaseHealthAdvance and its experience in healthcare financing. They are also able to see the No Surprise Financing options offered by the practice.

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Natural, Adaptable & Durable
Champions Implants: an ideal solution for the general dentist

By Armin Nedjat, DDS

Given the great success and ease of use of the Champions one-piece implant system, the question of why the development of a two-piece implant system was necessary has been raised. More than 2,000 dentists and clinics have found the one-piece system provides great results, particularly when used with Prep-Caps, which compensate for any insertion divergences. So, why the addition of a two-piece system?

While it is true that the one-piece Champions implant system represents a major design breakthrough, the development of the new two-piece Champions (R)Evolution allows the implants to be used on those patients who cannot be treated with the one-piece system (in some dental offices the percentage of patients whose condition is unsuitable for treatment with the one-piece system may reach as high as 20-30 percent).

Additionally, some dental surgeons, for whom temporary prosthodontic restorations are not an area of expertise, will find it easier to work with the two-piece implants, which often make these temporary restorations unnecessary.

The two-piece Champions offer all the same advantages provided by the one-piece system. Produced in Germany of the highest quality materials, the new system remains affordable for dental offices, dental technicians and, most of all, for our patients!

While traditional two-piece implant systems have had problems with micro-gaps, which are vulnerable to bacterial penetration, the two-piece Champions (R)Evolution solves this problem with our newly developed, patent-pending inner cone with its rotation-proof “Hex-adapter.”

The implant has a micro-close gap of only about 0.6 μm. In addition, these two-piece implant types are suitable for the minimally invasive method of implantation (MIMI® procedure), which is also used with our one-piece implants.

With this method, only a few dental tools are necessary for implantation, greatly reducing dental office expenses. The temporary prosthodontic restoration, which is necessary for one-piece implants for single teeth in the first two to eight weeks post surgery, is no longer absolutely necessary when two-piece implants are inserted.

The success story of the non-traumatic key-hole surgery MIMI will continue. Dentists will be able to incorporate the implantation with this Champions (R)Evolution system in their day-to-day work in dental offices.

Surgical procedure

After taking the implant out of the box, this two-piece implant type — like the one-piece Champions’ implant — can be inserted without the need to touch the sterile implant. Thus, a contamination of the implant surface is avoided.

However, we do not just insert the implant itself, but also the integrated “Gingiva-Shuttle,” which is delivered with the implant and is tightly screwed to the implant at a torque of 5-10 Ncm. In this way, there is no risk of contamination inside the screw.

By Armin Nedjat, DDS, is the general manager and founder of Champions Implants GmbH in Germany. Nedjat had his own private clinic from 1994-2010 near Frankfurt am Main. He has been a specialist in implantology (DGZi) since 1999 and an ICOI diplomat since 2000. Nedjat has inserted more than 20,000 implants, including prosthodontic work, and has received training from many dental institutions in the world (including Harvard University in Boston, Jumeira Dental Clinic Dubai, University in Paris, France). Between 1994 and 2010, he developed the Champions Implants system, and he has been the CEO of Champions Implants since 2006.
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When inserting the Champions (R)Evolution implant in practice, you implant the ‘Gingiva Shuttle’ and... that’s all! There is no closing cap where you see bleeding or gingiva-contaminated inner threads.

It is generally recommended that you should always begin to implant with a 3.5 mm-diameter implant to achieve primary stability, even if an implant with a bigger diameter might eventually be suitable for the bone width.

From a bio-physiological point of view, it is not recommended that you begin to implant with a 4.5 mm-diameter implant or a 5.5 mm-diameter implant right away.

The 4.5 mm-diameter or 5.5 mm-diameter Champions (R)Evolution implants should only be inserted if primary stability cannot be achieved with a 3.5 mm-diameter Champion at a torque of at least 30 Ncm (in the D3 bone or sometimes in the D2 bone).

Fortunately, incisions of the mucosa or bone augmentation can usually be avoided when you perform an implantation according to the MIMI procedure.

However, this does not mean that an incision of the mucosa, an open or closed sinus lift or a bone augmentation will never have to be performed!

Additionally, other healing caps than those that are delivered with the implant (with a height of 3 mm) are available.

**Prosthodontic procedure**

Usually, some six weeks post-surgery, you click the impression coping to the ‘Gingiva Shuttle,’ which stays in the impression material. With a gingiva mask and a (two-part) laboratory analog, the master model is created by a dental laboratory.

The abutments for our implant system have the following design: the abutment have an inner conus with an integrated patent-pending “Hexadapter,” which ensures rotation protection. The platform with the inner conus is always the same for each diameter, whether you insert a 3.5 mm-diameter (R)Evolution implant, a 4.5 mm-diameter one or a 5.5 mm-diameter one.

**Conclusion**

One of the best periimplantitis prophylaxes is an intra-operative flapless implant treatment without a mucoperiosteal (especially buccal) flap.

The very small micro-close gap of less than 0.6 μm and the screw and abutment design (“Platform Switching”) have proven successful for years.

Moreover, due to the fact that the total treatment costs are reduced by 50 percent, more patients can afford this implantation treatment. High prices and low-quality would mean fewer patients!

The Champions (R)Evolution implant is one of the first two-piece implants that can be inserted according to the painless and uncomplicated “key-hole” MIMI implantation method.

MIMI will remain the implantation method of the future. This two-piece implant type will (r)evolutionize the daily routine of dentists and dental technicians!

For more information, call (952) 426-3071, e-mail info@championsinnovations.com or you can visit www.championsinnovations.com.

Figs. 1–5. The two-piece Champions (R)Evolution implant with the specially designed integrated ‘Trans-Gingiva Shuttle.’ This implant type is inserted minimally invasively. The ‘Trans-Gingiva Shuttle’ usually stays on the implant. Six weeks post-surgery, the impression coping is then clipped while the ‘Shuttle’ stays in the mouth. The time-consuming exposure and the screwing and unscrewing of closing caps, healing caps or impression copings are not necessary. The impression coping is set in the ‘Shuttle’ of the laboratory analog, and the master cast is made with a gingiva mask. Photos/Provided by Dr. Armin Nedjat.

Figs. 6–8. The minimally invasive implantation method is especially suitable for patients at risk. It is possible to perform the MIMI surgery and to set the metal matrices of the tulip-headed Champions Implants in an available prosthesis within just one day.

‘Additionally, some dental surgeons will find it easier to work with the two-piece implants, which often make temporary restorations unnecessary.’
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The MIS Bone augmentation materials include a line of fully synthetic bone grafts. BONDBONE® is a resorbable, osteoconductive bone grafting material, taking the best qualities of hemihydrate and dihydrate calcium sulfate and combining them into a unique product. It can be used on its own, or mixed with other granular bone grafting materials to form a composite that will help to prevent migration of particles and often eliminate the need for a separate barrier. 4BONE SBS is a fully synthetic bone graft composed of HA (60%) and βTCP (40%). Permeable interconnected micro and macro porosity promotes invasion of osteogenic cells by osteoconduction, which permits the diffusion of biological fluids, leading to fast formation of bone.

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Products allow for socket grafting without primary closure in the esthetic zone for implant placement

Socket grafting without primary closure is now predictable in the esthetic zone for implant placement, with Impladent’s new CollaForm™ Singles absorbable bovine collagen and OsteoGen® synthetic bioactive resorbable graft, which has been in the market for 26 years.

With the introduction of the “Tooth Extraction Kit”, CollaForm Singles and OsteoGen, averaging $55 per extraction, socket preservation is cost effective and a key principle for successful grafting restoration. CollaForm (12 mm by 20 mm by 3 mm thick) features handling advantages of soft non-sticky, exceptionally flexible and compressible in nature for ease of adaptability.

After tooth extraction or removal of any and all root fragments (Fig. 1a), debride and enucleate all fibrous tissue to the lamina dura (Fig. 1b). Medullary blood from the marrow works best for remodeling/modeling of new bone formation. Perforate lamina dura anatomically correct and collect blood to mix with OsteoGen resorbable bone graft. Control bleeding.

Pack OsteoGen synthetic bioactive resorbable bone graft into the extraction site. Note that the graft is radiolucent on day of placement (Fig. 1c).

Place a CollaForm Singles wound dressing over the graft and crisscross suture. Take an X-ray after grafting to compare with X-ray after six months. Depending on the defect site, patient’s age or metabolism, an X-ray can be taken five or six months after surgery to show radiopaqueness as OsteoGen converts to new bone formation (Fig. 1d).

The mechanical properties of OsteoGen are less than trabecular bone and will not compromise the host bone chemically or mechanically, making it an ideal graft material for implant placement (Fig. 1e).

For more product information and promotional discounts, contact Impladent Ltd. at (800) 526-9343, (718) 464-9620 fax or visit www.impladentltd.com

Zimmer Dental’s Angled Tapered Abutment expands restorative options for implantologists

Zimmer Dental Inc., a leading provider of dental oral rehabilitation products and a subsidiary of Zimmer Holdings, Inc., is pleased to announce the availability of the Zimmer Angled Tapered Abutment — a line extension that provides clinicians with the flexibility to place implants off-axis (i.e., tilted) and choose from multiple surgical protocols, including immediate load, screw-retained restorations to best meet the specific restorative needs of their patients.

Available in 15- and 30-degree angle configurations, the Zimmer Angled Tapered Abutment promotes angulation correction for off-axis implant placement, repositioning the restorative platform to facilitate insertion of the prosthesis.

The abutment’s 1.2 mm low-profile cone is ideal for use in cases with limited interocclusal space, while the cone’s 15-degree taper allows for additional angulation correction. The ability to place implants off-axis aids in maximizing the use of available bone, avoiding the alveolar nerve and sinus, and minimizing the cantilevers for the prosthesis in multi-unit, partially and fully edentulous screw-retained restorations.

The user-friendly Zimmer Angled Tapered Abutment’s multiple cuff heights enable the clinician to select the size that best meets the patients’ soft-tissue measurements. Furthermore, this new abutment has exhibited exceptional strength and durability in testing compared to other popular brands, according to Zimmer Dental, and is fully compatible with Zimmer Dental’s existing restorative components and the renowned Tapered Screw-Vent® Implant System, for greater convenience.

“These new angled tapered abutments broaden our restorative portfolio and give clinicians even more flexibility in choosing surgical protocols to best meet the needs of their patients, restore their mouth function and enhance their quality of life,” said Harold C. Flynn, Jr., Zimmer Dental president. “At the end of the day, our focus, first and foremost, is on giving our customers the tools they need to improve their patients’ lives.”

For decades, Zimmer Dental has gained the trust of thousands of clinicians worldwide who count on its comprehensive line of products to deliver successful patient outcomes, according to the company.

For more information on integrating the Zimmer Angled Tapered Abutment into your practice, contact a Zimmer Dental sales consultant at (800) 854-7019, (760) 929-4300 (for outside the U.S.), or visit www.zimmerdental.com
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* Size: 10mm x 20mm each

Artzi reports “What is important is the implant success rate over time, as reported by the Sinus Consensus Conference, a 98% cumulative success rate over 5 years has been found with pure alloplast OsteoGen®.” Artzi further noted that “OsteoGen® is physiochemically and crystallographically equivalent to human bone making it a pure alloplast. The spaces between the crystal clusters facilitate cellular and tissue proliferation within the grafted material, thus enhancing faster osseointegration.” *


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