For nearly 100 years, dentists have relied on 2-D radiographic imaging for diagnosis and treatment planning. With the 1999 introduction of cone-beam computed tomography (CBCT), all dentists now have tools available for more accurate diagnosis and treatment. The ability to look at a tooth in any direction and orientation, as well as in 3-D, eliminates much of the guesswork commonly experienced with 2-D radiographs.

We have been limited in most cases to only a buccal-lingual view provided by periapicals, bitewings and panoramic radiographs with the occasional axial view of an occlusal film. Medical CT scans and images began in the early 1970s and were sometimes used by dentists, offering our first multi-planer views. The adoption of 3-D cone-beam imaging is appropriate and has important advantages for all modalities of dentistry. From every specialist to the general dentist, the increased amount of radiographic information as well as increased accuracy will aid in the most sound diagnosis possible.

CBCT description

CBCT is a single or partial rotation of an X-ray source around the head, capturing X-rays on various flat panel arrays and sensors. The information is converted to a series of axial slices by computed tomography and stored as 2-D arrays and sensors. The information is converted to a series of axial slices by computed tomography and stored as 2-D arrays and sensors.

The health of the surrounding tissue affects the success of a dental implant. Identifying and reducing risk factors is therefore a key step in the implant process. Now a combination of genes has been identified as a possible indicator of greater tissue destruction leading to negative outcomes for implants.

The authors of an article in the Journal of Oral Implantology report on a study of individuals with the combination of interleukin (IL)-1 allele 2 at IL-1A–889 and IL-1B+3954. These people are “genotype positive” and susceptible to increased periodontal tissue destruction. Peri-implantitis, or the process of tissue inflammation and destruction around failing implants, is very similar to periodontal disease. The researchers sought to find any association of these genotypes with the severity of peri-implantitis progression and the effect of this combination on treatment outcomes.

This study compared two groups of patients, all of whom had implants. The first group consisted of 25 patients with peri-implantitis, while the second group of 25 patients had healthy tissue. Seventeen patients from the first group and five from the second group were genotype positive.

Patients in the first group, those with peri-implantitis, took part in a treatment and maintenance program. The genotype-positive patients in this group experienced greater periodontal tissue destruction and increased discharge from tissues. The genotype-negative patients responded better to treatment. Statistically significant differences were noted between the groups.

The combination of these two alleles in patients with inflamed periodontal tissues denotes a risk factor that can lead to further tissue destruction. Patients with the specific genotype can have exaggerated local inflammation. Gene polymorphism may affect the outcomes of treatment for peri-implantitis in genotype-positive people and affect the long-term success of implants.


About the Journal of Oral Implantology

The Journal of Oral Implantology is the official publication of the American Academy of Implant Dentistry and of the American Academy of Implant Prosthodontics. For more information about the journal or society, visit www.joionline.org/orimonline/?request=index-html.
aspects of implant dentistry, with a focus on expanding technologies that enhance the daily practice for the GP, the specialist, dental auxiliary and dental laboratory technician.

The scientific program will begin on Thursday afternoon, Aug. 18, with a focus on the latest in esthetics and prosthetic reconstruction techniques. Friday will feature recent innovations in guided surgery applications and treatment of the atrophic patient as presented from the clinician and laboratory technician perspective.

The program will conclude on Saturday with presentations on occlusion, over-denture concepts, complications and advancements in restorative components.

Dr. Scott Ganz has arranged the scientific program, which features speakers including Drs. Natalie Wong, Michael Moskovich, Philippe Russe, Lampert Stumpel, Thomas Balshi, Dwayne Kareteew, Michael Pikos, Jack Krauser, Konstantinos Valavanis, Barry Goldenen, Aldo Leopard, Carl Misch, Paul Wiegel, Marius Steigmann, Hom-Lay Wang, Ady Palti, Zeev Ornianian, Roberto Marra and dental technicians Stephen Balshi, Renzo Casellini and Ulrich Hauschild and many more.

The ICOI is an ADA CERP and AGD PACE Recognized Provider. This symposium is designated for 19 continuing education credits.

Preceding the general session, there will be six pre-symposium workshops on Thursday morning offered by the two Gold sponsors, Nobel Biocare and Osstell, and the five Silver sponsors, BioHorizons, Dentsply Tulsa Dental Specialties, Implant Direct, Osteogenics and Prexion. For complete information on these courses and on the meeting in general, visit ICOI’s web site at www.icoi.org.

In addition, ICOI will continue to hold its Table Clinic/Poster Presentation competition for delegates at all levels of experience. These will take place Thursday evening during the Welcome Reception in the Exhibition Hall.

ICOI’s auxiliary section (ADIA) will also hold a two-and-a-half-day program (in tandem with the doctors program), which will include its full-day certification programs for hygienists, dental assistants and practice management staff members.

Delegates should make sure to contact the host hotel, the Downtown Marriott on Michigan Avenue, as rooms are filling fast.

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virtual anatomy in the computer.

With the use of sophisticated software, the dentist is able to view information in several different views, including: axial slices (head-to-toe orientation), coronal slices (front-to-back orientation), sagittal slices (side-to-side orientation) all known as multi-planer reconstructions (MPR). The thickness of each slice can be varied to include more or less information.

Because the voxels (volumetric pixels 5-D) are isotropic, other MPR images can be generated by slices drawn at any angle, curve or thickness through the scan to view areas critical to the final diagnosis. The final view offered by CBCT is a 5-D view that can be rotated and viewed in any direction.

Once again through software manipulation, 5-D images can be viewed as conventional radiographs, maximum intensity projections (MIP), soft-tissue projections and a variety of other views.

This nearly endless ability to manipulate the data aids in the diagnosis and identification of disease, nerve canals, sinus morphology, dental caries, bone density, fractures, endodontic pathology, implant placement criteria, periodontal defects, bone pathology, fractured teeth, iatrogenic trauma, TMJ morphology and disease, third molar position and many more healthy or diseased conditions.

Fig. 2: Periapical does not show the sinus anatomy or the width of the bone.

Fig. 3: MPR showing post op of sinus graft and implant placement.

Fig. 4: The 3-D CBCT showing anatomy of the maxillary sinuses.

Fig. 5: Axial MPR showing mesial buccal roots in first, second and third molars.

Early CBCT adoption with implants

The first and primary use of CBCT for early adopters was implant placement. As the scope and the value of the information became better known, dentists of all branches began to see the value of MPBs and 3-D renderings including periodontics, endodontics, oral surgery, treatment of TMI, orthodontics, implantology and general dentistry. Clinical peri-apical and panoramic examinations. These images can be used by the dentist to evaluate bone density of the edentulous ridge and surgical site. These images can also be used for surgical planning and simulations.
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ic radiographs for the placement of implants can be misleading with elongation, foreshortening, superimposition and geometrically incorrect data. A look at the implant in the periapical shows no obvious disease to an existing integrated implant. Clinically, a buccal fistula was present with exudate and slight pain. The CBCT scan (Fig. 1) reveals a more accurate view showing a buccal defect on a sagittal MPR. A surgical flap revealed a dehiscence of the coating of the implant. Removal of the foreign body resulted in an asymptomatic and healthy patient.

The evaluation of the available bone for the initial implant placement can be crucial for the long-term success of the case. If there is inadequate bone available, grafting may be a necessity. CBCT studies render the most accurate information available at a low radiation dose. The periapical shows an obvious lack of bone height, but does not show the buccal-lingual dimensions or an accurate view of the sinus morphology (Fig. 2). The MPR view of the CBCT shows all necessary measurements to perform the sinus lift and grafting with the inferior placement of the implant fixture (Fig. 3). 3-D views show the floor of the sinus and any soft-tissue pathology (Fig. 4). Having accurate measurements in all dimensions is an advantage of CBCT scanning.

CBCT and endodontics
Endodontics is a field that is rapidly adopting the use of CBCT and for good reason. The inherent geometric deficiencies of 2-D radiographs make the CBCT scan a valuable adjunct to investigate the root morphology in both 3-D and MPR. The typical periapical will show superimposed canals in the anteriors, bicuspids and molars as well as unwanted bone densities both buccal and lingual to the affected tooth making the image quality poor. The ability to view MPR slices in cross-section, long axis and oblique directions gives the ability to follow all canals in any direction and show their relationship and measurements from other known structures. This virtual tour of the root morphology is a great benefit to the final treatment outcome (Fig. 5).6

Post root-canal infection can be difficult to diagnose with the standard periapical. The endodontic fills may appear to be normal even though other clinical findings and symptoms are abnormal. The patient presents several months post root-canal treatment with pain on palpation and pressure and avoids this side of the mouth. A periapical radiograph shows minimal pathology (Fig. 6). The roots appear to be filled and a small puff of sealer extends through the apex of the mesial roots. The distal root structure and fill appear normal. There is little indication of periapical radiolucency only a widening of the periodontal ligaments of the mesial roots.

A CBCT scan reveals a completely different picture. The coronal MPR reveals a short fill near the apex of the mesial lingual root and a large radiolucency (Figs. 7, 8) not visible on the periapical radiograph (Fig. 6).

Missed canals are difficult to see in a buccal-lingual projection of the periapical radiograph as on canal is superimposed on the other (Fig. 9). Often, as viewed in this radiograph, we see periapical pathology with an apparent normally filled canal. CBCT scans allow dentists to look for pathology in MPR planes to identify the actual problem before invasive procedures are performed on the patient. The axial view shows a lingual canal exists and is untreated. The coronal view confirms the diagnosis and treatment can be completed (Fig. 10).

Today’s endodontists, as well as general dentists, are benefiting from the diagnostic capabilities of the high-resolution CBCT scanners available over conventional 2-D periapical.

Oral surgery
Oral surgery, with its inherent invasive nature, can be better served using CBCT with MPR as well as 3-D images. The ability to perform virtual surgery is a benefit to both the doctor and the patient. Doctors have the advantage of seeing morphology and landmarks in real time and space with accurate measurements, and patients will gain a better understanding of the problems and the solutions their doctors are offering them.

Third-molar extractions can be risky based on 2-D and panoramic radiographs. These radiographs can often superimpose nerves and sinuses over root structures. Dentists using 2-D radiographs must often rely on experience to assess the risks of iatrogenic trauma. The use of CBCT with MPRs and 3-D images reduces any guessing as well as the chance for any permanent damage to the patient. With the adoption of CBCT, the judgment is based on solid
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evidence and the risk will decrease. A panoramic view of the superimposed third molars gave no solid evidence the canal lies between the roots. It is only with the use of CBCT and the MPRs that the nerve can accurately be seen traversing between the mesial buccal and mesial lingual root (Fig. 11).6

Other surgical advantages include the identification and the position of supernumerary or impacted teeth. The images show accurate positions and show definitive morphology that will aid in removal of the proper teeth (Fig. 12). Knowing the exact position of many of these teeth is a benefit to both the doctor and patient. It will lead to the most precise surgical path and the least invasive procedure.

Orthodontics

The explanation of periodontal problems are often misunderstood by the patient. As orthodontists we talk about joints, point to X-rays and propose treatment only to have patients refuse treatment because they do not understand what we are clinically describing. Using the 3-D portion of the CBCT scan can improve the understanding and acceptance of treatment plans. The images are a picture of the problem that is owned by that patient and much easier to understand by the layperson, illustrating periodontal defects and pockets allows the patient to better participate in the process (Fig. 15).

The MPDs and the 5-D projections aid in surgical planning for periodontists, allowing for accurate measurements and bone analysis prior to osseous surgery that doctors can not get using the periapicals or panoramics. Studies have shown that CBCT images are more accurate than panoramic radiographs. For the periodontist placing implants, the ability to measure bone density and avoid important anatomy is important.5,6

Orthodontics

Orthodontists are beginning to adopt large field-of-view CBCT. Recent studies show that linear measurements of bony structures are more accurate using CBCT and have less distortion than currently used methods of measurement: lateral cephalometric, posterioranterior (PA) and submentovertex (SMVT).4,5 Accurate measurements of tooth volume and tooth position can aid in accelerated treatment times and more precise treatment.

With both position, density of bone and size of arches, the orthodontist also has an accurate evaluation of the temporomandibular joint and position of the condyles. Impacted teeth are easily identified and position either buccal or lingual can be confirmed prior to movement or removal. Both MPDs and 3-D projections give the doctor a complete picture of the problems and the treatment course. With a single CBCT scan, the orthodontist can produce all of the information they need: panoramic, cephalometric, PA, SMVT, tooth size and volume, crowding evaluation in any plane, TMJ evaluation and airway analysis, all with both soft-tissue and skeletal information.27

Conclusion

We treat our patients in 3-D, and now, with cone-beam computed tomography, we are changing the way we diagnose from 2-D to 3-D. The addition of this technology will increase your diagnostic skills with better and more complete information at your disposal. As with any type of invasive diagnostic tool, doctors should weigh the risk to benefit in using CBCT scans.

Judicious use of CBCT and knowledge of patient’s lifetime doses should always be considered as well as the availability of other diagnostic tests appropriate for the problems of the patient. When adopting new technology, training is paramount. Along with training comes the responsibility of the doctor to read and diagnose information from CBCT scans.

Do not avoid CBCT from lack of knowledge; instead, take this opportunity to become a better diagnostician and radiologist. As you review radiology and pathology, your use of CBCT will aid in making the most accurate diagnosis and the most complete treatment plans.6

References available upon request from the publisher.
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MIS Implants hosts global meeting

MIS Implants Technologies Inc. continues to offer its existing and new clients valuable products and service. For close to eight years, the company has established itself in the United States as a leader in the implant community. Not only does it offer exceptional implants, the company asserts, but it is also known for having exceptional customer service and innovative surgical products.

Recently, its parent company, MIS Implants Technologies Ltd., held its first global meeting in Cancun, Mexico, with more than 25 international speakers. Also, hands-on courses were offered at the event by two continuing education companies. About 800 doctors attended the global conference.

“The response by our clients and clients around the world exceeded our expectations,” said Motti Weisman, CEO of MIS Implants Technologies Inc.

One of the systems offered by MIS certainly is responsible for some of the popularity MIS is experiencing, the company says. The Seven system from MIS Implants creates a simple solution for dentists with all levels of experience in implantology. These self-tapping implants are available in diameters ranging from 3.3 to 6.0 mm and in varying lengths from 6 mm to 16 mm with an internal hex connection.

Micropores and macropores on the surface of the implant, created by particle blasting and acid etch treatment, allow for excellent osseointegration. Each of the implants is packaged with a sterile final drill made to the specifications for the length and diameter of each implant, ensuring a sharp and clean drill for each surgery along with an ideally sized osteotomy. The implants’ thread thickness changes along the length of the implant, which compresses the bone as the implant is inserted, maximizing initial stability. These features combine to produce an implant ideally suited for immediate or accelerated loading.

While the Seven implants have a full range of prosthetic options, a popular product is the CPK (Complete Prosthetic Kit) which includes everything a restorative dentist needs for a single implant restoration and is available in varying abutment and collar heights.

Other prosthetic options include gold and plastic custom abutments, Zest Locators, ball attachments, multi-unit two-piece abutments, temporary plastic cylinders and a wide range of prefabricated titanium abutments.

In addition to implants and superstructures, MIS also offers its clients bone-augmentation materials. 4-Bone is a fully synthetic bone substitute made of HA and TCP. Its microporosity and macroporosity promotes invasion of osteogenic cells as well as allowing biological fluid diffusion. More recently, MIS started to market BondBone. This product is a unique biphasic calcium sulfate material which can be used on its own or combined with other granular bone substitute products to form a cementable composite graft.

For restorative doctors, MIS’ Prosthetic Planning Kit is a helpful addition. Duplicates of the superstructures are presented and color-coded to differentiate between the standard and wide platforms.

The MIS factory in Israel is a state-of-the-art facility. Quality control is ensured by visual and laser inspection of the products meeting stringent international standards. MIS’ world-class scientists and engineers are committed to continuous research and development of new and progressive products and technologies for the global dental implantation field.

Laboratory and clinical studies in the areas of tissue culture and tissue engineering are jointly conducted with prestigious universities and scientific research institutes.

* Available August 2011

(Source: MIS Implants Technologies)
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Committed to practitioners
Enrolling in ChaseHealthAdvance is easy and quick. There are no enrollment fees, monthly minimums or required equipment to buy or lease. Every practice gets a knowledgeable practice consultant who trains doctors and their staff and continues to work with the practice throughout the life of the relationship.

Our providers also can visit HealthAdvance Online to download free resource guides written by top professionals in the dental industry. These guides were printed as a courtesy of ChaseHealthAdvance and cover topics pertinent to implant dentistry, such as treatment innovations, practice management and marketing.

ChaseHealthAdvance is a great option for practices that haven’t offered third-party financing in the past and those currently providing financing in-house. While some implant dentists may believe paying a service fee for financing is an unnecessary expense, they fail to consider that not offering third-party financing may actually be costing them money.

Our providers pay a small service fee that gives them the opportunity to offer no-interest financing to their patients. Even with these service fees, our financing can greatly reduce a practice’s costs and help increase profitability. With in-house financing, for instance, dental practices spend a significant portion of their budget on financing administration and implementation costs.

Plus, unless a patient has paid in full, dentists must often “float” the costs of treatment until payment can be made — an average of 72 days. ChaseHealthAdvance directly deposits the treatment fee into the practice’s account in as little as 24 hours after the transaction, which can help improve cash flow in the practice.

With ChaseHealthAdvance, patients are accountable to us and not the clinician for payments. This means dental implant offices can stop spending valuable time and resources on financing administration and collection, and focus on providing the best care possible for patients. And, because patients are responsible to us for repayment and not the practice, patients will be less likely to skip or delay follow-up treatments because of an inability to pay.

Committed to patients
ChaseHealthAdvance has done everything possible to make it fast and easy for patients to apply for financing. Whether patients are applying on their own or through the dentist’s office, our streamlined process speeds up the application process and helps patients say “Yes” to getting the care they need. And with our clear and simple language, patients will never be surprised by an unexpected payment.

The credit application can be completed right in the doctor’s office or at home, on the phone or online. The approval process is automated, so in most cases patients know their approval status, financeable amount and repayment options within just a couple of minutes.

We’ve also developed a Present and Apply tool for the iPad, which allows practitioners to walk patients through the case presentation process in a visual format that communicates affordability and helps remove the cost barrier for the patient.

The ChaseHealthAdvance difference
ChaseHealthAdvance uses a custom credit score formula to determine credit eligibility. We never require a down payment, and up to 100 percent of the treatment costs can be financed.

Once approved, patients can choose from a broad range of “No Surprise” financing plans. For the dental implant market, patients can choose a no-interest repayment plan of 12, 18 or 24 months, as well as extended plans as long as 48 months. Patients will know what to expect from the first payment to the last. Every loan we approve has a generous minimum credit line, allowing patients to fully fund the entire cost of treatment. Dental implant patients can qualify for extended credit up to $20,000.

ChaseHealthAdvance also lets patients reuse credit lines for themselves or anyone in the family.

Osteogenics Biomedical offers free implant site development booklet
Osteogenics Biomedical, through its educational division, Osteogenics Clinical Education, is currently offering its “Implant Site Development and Extraction Site Grafting” booklet free to clinicians.

The 45-page booklet covers topics such as bone biology and physiology, selection of grafting materials, selection of barrier membranes, surgical techniques and patient-management considerations. The booklet also contains illustrations, product scanning electron micrographs, histological references, terminology definitions, case reports, abstracts of published papers, a treatment decision tree for various grafting scenarios and a step-by-step guide to the Cytoplast Technique” for extraction site grafted.

“The implant site development booklet is a great resource for implant dentists, and many also find that it’s a great resource for their referring dentists,” said company President Shane Shuttlesworth. “The comprehensive section on the use and selection of grafting materials is a unique resource that most dentists find very useful.”

Osteogenics Clinical Education, provider of this booklet and other clinical resources, was established in 2008 with a mission of providing clinical literature and interactive, hands-on education in bone grafting and implant dentistry. The “Implant Site Development and Extraction Site Grafting” booklet, as well as other clinical literature and surgical videos, are available on the Osteogenics website.

To download an electronic version of the booklet, visit www.osteogenics.com/clinical_literature. To request a free hard copy of the booklet for your library, call (888) 796-1923.

(Photos/Provided by ChaseHealthAdvance)

(Photos/Provided by Osteogenics Biomedical)
For years, primary closure was considered a key principle for successfully grafting extraction sockets. However, with the introduction of the Cytoplast® Technique for grafting extraction sites without primary closure, thousands of surgeons now use dense PTFE membranes left exposed, thereby allowing the preservation of keratinized tissue while avoiding infection. Now, socket grafting without primary closure is not only more predictable, but results in the ultimate in esthetics.


Visit us at ICOI Booth 202 to pick up your FREE “Implant Site Development and Extraction Site Grafting” booklet.
AstraZeneca to sell Astra Tech to DENTSPLY International

AstraZeneca announced on June 22 that it has agreed to sell its Astra Tech business to DENTSPLY International for approximately $1.8 billion in cash. Astra Tech, headquartered in Mölndal, Sweden, has two main business divisions: a dental division, which is engaged in the research, development, manufacturing and marketing of dental implants, and a healthcare division, a business focused on medical devices for use primarily in urology and surgery.

In 2010, Astra Tech recorded worldwide revenue of $355 million and normalized EBITDA of $105 million, with net assets valued at approximately $0.3 billion at May 2011 rates of exchange. The transaction is anticipated to be completed during the second half of 2011, subject to receipt of relevant regulatory clearances. Upon closing, a gain will be recorded as “other operating income” in the AstraZeneca profit and loss account. The gain will be considered a “significant item” to be excluded from core financial measures. As a result, there will be no impact on the company’s full year 2011 guidance for core earnings per share.

CEO David Brennan of AstraZeneca said: “Following a comprehensive strategic review, we believe this transaction represents an excellent outcome for AstraZeneca shareholders. The high degree of interest and the competitive nature of this process is evidence of the value that the employees of Astra Tech have built in the marketplace. I want to thank them for their contribution and believe they are well placed to build upon this successful foundation under DENTSPLY’s ownership.”

About Astra Tech

Astra Tech AB, a company in the AstraZeneca group, is a global leader in dental and healthcare (urological and surgical) products, services and support. An innovation-driven company since its foundation in 1948, Astra Tech has continually developed market-leading solutions to meet healthcare needs based on user and medical community input. Ongoing research and development is aimed at finding new ways to support caregivers and improve quality of life for patients worldwide. Astra Tech headquarters are located in Mölndal, Sweden, with production facilities in Sweden and North America. The company is represented globally with marketing subsidiary presence in 21 countries and selected local distribution partners. Astra Tech has 2,200 employees worldwide.

About DENTSPLY

DENTSPLY designs, develops, manufactures and markets a broad range of professional dental products including dental implants, endodontic instruments and materials, orthodontic appliances, restorative materials, preventive materials and devices, and prosthetic materials and devices. The company distributes its professional dental products in more than 120 countries. DENTSPLY is committed to the development of innovative, high quality, cost-effective new products for the professional dental market.

About AstraZeneca

AstraZeneca is a global, innovation-driven biopharmaceutical business with a primary focus on the discovery, development and commercialization of prescription medicines for gastrointestinal, cardiovascular, neuroscience, respiratory and inflammation, oncology and infectious disease. AstraZeneca operates in more than 100 countries and its medicines are used by millions of patients worldwide. For more information, visit www.astrazeneca.com.

DMX Implants, subsidiary of Dentatus USA, announces formation of education team

DMX Implants is committed to hands-on training, and along with the Dentatus CDE Studies Institute, providing dental health professionals with quality, up-to-date continuing education to further their knowledge, skills and ability to offer comprehensive treatment to their patients.

The CDE Studies Institute courses are PACE-accredited by the Academy of General Dentistry. The recent formation of their education team offers dentists and their teams education opportunities throughout the United States.

The team includes:

• Dr. Robert M. D’Orazio, DDS, FAGD, MIF, ABOU/ID, is a 1984 graduate of the University of Detroit, School of Dentistry. In 1987, he obtained a fellowship in the Academy of General Dentistry. In 1991, D’Orazio completed a two-year externship at the Midwest Implant Institute, which included obtaining an ACLS certificate and intravenous conscious sedation training. He is a past president and board member of the Midwest Implant Institute Fellowship. D’Orazio is a fellow of the American Academy of Implant Dentistry. In 1999, he was program chairman for the American Academy of Implant Dentistry’s annual international meeting. He is a diplomate of the American Board of Oral Implantology. D’Orazio has taught and lectured on the subject of implant dentistry in Canada, Mexico and the United States. He currently maintains a referral-based implant dental practice located in Sterling Heights, Mich. He, his wife Linda, and their son, PJ, reside in Lake Orion, Mich.

• Dr. Mark A. Jacobelli, DDS, FAGD, FICD, graduated from Case Western Reserve University School of Dentistry in 1982. Since then he has completed postgraduate programs in orthodontics, neuromuscular and TMD treatments for jaw and head pain, esthetic and cosmetic dentistry, implant placement and restoration, and a one-year program on conscious sedation with Advanced Cardiac Life Support. He has been in private practice since June 1982 and holds licenses and sedation permits in the states of Ohio and Florida. Jacobelli is a fellow of the Academy of General Dentistry, the Midwest Implant Institute, and the International College of Dentists and is a member of many dental organizations. Jacobelli is teaching and presenting for the Center for Occlusal Studies, The Midwest Implant Institute Fellows Symposium and Outreach Programs, Jamison Consulting of Florida, the Midwest Implant Institute and the Camlog Corporation. Jacobelli attains balance in his life by being the best husband, father and little league baseball coach that he can be.

• Dr. Keith Rossein, a consultant, author and lecturer, has a unique combination of clinical, marketing and manufacturing dental experience. He received a DDS from New York University College of Dentistry in 1970 and went on to 23 years of clinical practice. Continuing education is the president of International Dental Consultants, the editor of Implant News & Views, is formerly an instructor at NYU College of Dentistry and an attending dentist at Triboro Hospital at Queens Hospital Center and has appeared on the program of national and international dental meetings. He is published in many dental journals, including Compendium, Dental Economics, Contemporary Esthetics and Quintessence International. Rossein is listed in the Seattle Study Club’s Speakers Bureau and has been a speaker for the ADA Seminar Services.

• Dr. Charles Schlesinger, FICOI, graduated from the Ohio State University College of Dentistry in 1996. Following graduation, he completed a GPR with the VAMC W. Los Angeles. During his time in LA, he received extensive training in oral surgery, implantology and complex restorative dentistry. Schlesinger lectures nationally on implantology and currently maintains a private practice in San Diego that focuses on cosmetic and implant dentistry.

(Source: Astra Tech)

(Source: DMX Implants)
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