Quick Up method eliminates risk of accidental locking of dentures to implant, cuts procedure time in half

_Millions of Americans wear dentures. Unfortunately, the majority of denture wearers are dissatisfied with their prosthesis— their chief complaints being poor retention, discomfort or difficulty speaking and eating. Supporting and stabilizing dentures with small diameter implants (mini-implant retained dentures) can resolve these problems and significantly improve denture retention, offering long-term clinical success.

The procedure involves creating a removable connection between the implants and the corresponding attachments, or secondary components, of the denture. Attachment bonding can be done by a lab in the indirect procedure, which causes a second appointment and is inconvenient for patient and clinician. As an alternative, it can be done directly in the pick-up method. The direct pick-up method has the advantage that it can be done in one appointment and is more accurate. However, the biggest fear of clinicians is the accidental locking of the denture to the abutment. VOCO now introduces Quick Up, a complete system that virtually eliminates the risk of interlocking and cuts chairside time in half.

_The Quick Up product_

With everything in one system, Quick Up improves workflow and chairside efficiency, saving time and money. The system includes Quick Up self-curing composite in the QuickMix syringe. Designed specifically for bonding attachments, such as ball, Locator® and telescopic attachments as well as other attachments in acrylic-based dentures, Quick Up self-curing composite can also be used for reattaching secondary elements in a denture, such as bar retainers.

Easy to use, Quick Up self-curing composite demonstrates exceptionally high strength, a physical attribute that’s essential for the long-term stability of denture attachments.

Other components of the system include: Fit Test C&B, used to check whether the openings in the denture base provide enough space to receive the attachments and for blocking out undercuts in the overdenture; Quick Up adhesive, a strong adhesive material that is applied to the underside of the denture to improve composite retention; and Quick
Fig. 3, Apply Quick Up self-cured material. Fig. 4, Fill deficiencies with Quick Up LC.

**The Quick Up method**

After the mini-implants have been placed into the jaw, a recess is prepared into the denture. The Quick Up method does not require vent holes. To ensure that the openings in the denture base provide enough space to receive the attachments, the kit includes Fit Test C&B, a control silicone (Fig. 1). This step is optional, but highly recommended for best results. Fit Test can also be used to block out any undercuts around the attachments, teeth or implants (Fig. 2).

Quick Up adhesive is applied and then recess filled only 2/3 full with the fast-setting Quick Up self-curing composite using the Quick Up automix syringe (Fig. 3). By under filling the recess, the risk of interlocking the denture with the intraoral attachments is virtually eliminated.

Furthermore, it saves time by eliminating the time-consuming step of removing excess composite material later. After seating the denture in the patient’s mouth, the material will set intraorally in only 2.5 minutes. After removal, any deficiencies can easily be filled with the light-cured Quick Up LC (Fig. 4).

**Optimized work flow improves the bottom line**

The new Quick Up method not only improves the clinical success rate, but also optimizes work flow. In difficult economic times, it becomes more and more important for clinicians to optimize work flows without compromising quality. The Quick Up method is a great example how a product can not only improve results, but improve the work flow, save time and, therefore, money.

Compared to indirect lab-processed bonding of denture housings, the clinician saves impression material, disinfection, chairside time and lab fees. Yet even if the direct pick-up method is chosen, there are differences.

The new Quick Up method can cut the procedure time in half and save the clinician up to $125 in chairside time for each procedure.

<table>
<thead>
<tr>
<th>Table I</th>
<th>The example at right illustrates two implant pick ups. According to the American Dental Association, the average chair time cost is $300 per hour. Depending on each clinician’s skills and cost structure, the results may be different than those shown in this table. VOCO recommends doing your own calculation based on your experience and individual office costs.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Classic Method</strong></td>
<td><strong>Minutes</strong></td>
</tr>
<tr>
<td>Prepare recess</td>
<td>10</td>
</tr>
<tr>
<td>Prepare two vent holes</td>
<td>4</td>
</tr>
<tr>
<td>Block out attachment parts with silicone or wax</td>
<td>8</td>
</tr>
<tr>
<td>Apply primer</td>
<td>1</td>
</tr>
<tr>
<td>Apply pick-up material/reline by over-filling and let it set</td>
<td>8</td>
</tr>
<tr>
<td>Remove excess material</td>
<td>10</td>
</tr>
<tr>
<td>Polish</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total Minutes</strong></td>
<td>51</td>
</tr>
<tr>
<td><strong>Total Chairside Cost ($5 per min)</strong></td>
<td>$255</td>
</tr>
</tbody>
</table>
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Using CBCT imaging in the diagnostic phase of the implant process offers clinicians many advantages. These high-resolution 3-D images offer details about the bone structure, tooth orientation, buccolingual dimensions, bone height and concavities that are unattainable with 2-D imaging methods.

When placing an implant, just estimating the location or measurement of bone is not prudent and can be stressful for both the doctor and the patient. The precise knowledge of the bone and surrounding anatomical structures obtained with a CBCT scan is imperative, in my opinion, for the successful placement of an implant. Armed with this information, and with a 3-D image that I can rotate or slice in any direction, I can make knowledgeable decisions necessary regarding whether to place the implant or whether other solutions are necessary, such as bone grafting or even a different prosthetic solution.

As CBCT imaging continues to evolve, I find my system offers applications that extend beyond diagnosis — to treatment planning and placement — becoming an integral part in the entire process from start to finish.

A new and very helpful step in the 3-D implant placement process in my implant centers is the Tx STUDIO software that is integrated into my i-CAT® system. With the tools in this software, I can measure bone, find pathology, automatically map the nerve canals, determine tooth positioning and impactions and location of the implant site to other vital anatomical structures.

Within a few minutes, and with just a few mouse clicks, I can plan the surgery and also place virtual implants, abutments and restorations into the 3-D image. The software also contains an implant library, and scans are compatible with all major surgical guide systems. This not only helps me to start treatment with more details, it also helps me to educate the patients in a visual way that they can understand. Because the software allows all of this planning to be done chairside, I can show the patient exactly what has to be done to place his/her implant.

3-D technology also allows me to work with other specialists for the patients’ best interests. For example, when working with orthodontists, if a patient has a congenitally missing or traumatically lost tooth, the data obtained with my scan allows us both to maintain the space necessary to receive an implant at the right time during treatment. Without this, teeth can drift, requiring longer orthodontic treatment.

Once my clinical objectives are met, another very important aspect — the esthetic objective — is also aided by the 3-D scanning process. I custom mill ceramic abutments and use IPS e.max® crowns using my E4D crown milling machine. Software called E4D Compass integrates the 3-D data from my CBCT with E4D scan data for formulation of my entire restorative plan. When the data from the 3-D scan and the
E4D Compass is integrated, it is possible to view a specific type of implant, adjust abutment alignment and view bone and soft tissue to better anticipate the implant process. The whole process of digital radiography, CBCT and CAD/CAM milling provide for a smooth implant process.

The information from the CBCT is an aspect that I would not want to do without, and now, I can obtain that wealth of information while controlling the radiation dose within the limits of ALARA (as low as reasonably achievable). My CBCT also affords me control over radiation dosage through scan settings. With each scan, I am able to tailor the radiation exposure to the individual needs of the patient. When taking a CBCT scan, the i-CAT allows me to focus on a particular area of interest. The 4.8-second scan allows the clinician to expose the patient to a minimum amount of radiation while still achieving the diagnostic information necessary for optimal treatment.

An article published in the Journal of the American Dental Association noted that CBCT scans are “accurate and cost effective and can be used to improve communication and coordination of a multidisciplinary team to achieve the desired clinical outcome.” It is very beneficial to be able to virtually run through multiple treatment scenarios until I discover the best treatment plan for the patient, and then use my other compatible software tools for clinical implementation.

From diagnosis to treatment planning to implementation, one 3-D scan provides all of the information necessary for better implant placement — for patients and dentists, the benefits of this imaging method touch all parts of the implant process — from start to finish.

Reference


About the Author

Justin Moody, DDS, graduated from the University of Oklahoma, College of Dentistry. As a supporter of organized dentistry and continuing education, he maintains membership with the American Dental Association, American Academy of Implant Dentistry and Academy of Osseointegration, as well as state and local societies. Additionally, Moody is a diplomate with both the International Congress of Oral Implantologists and the American Board of Oral Implantology/Implant Dentistry and a fellow with the American Academy of Implant Dentistry. He also holds mastership and fellow status at the Misch International Implant Institute. Moody has been in private practice in Crawford, Neb., since 1997 and is the director of the Rocky Mountain Dental Institute.
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Yankee Dental Congress 2013 will bring together thousands of brilliant minds to learn about the most innovative approaches, practices, and resources in dentistry.

Here is a sneak peak at a few education highlights:

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Loretta LaRoche
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Kenneth Hargreaves, DDS
ENDODONTICS

Roger Levin, DDS
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Laney Kay, JD
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IngeniOs HA Synthetic Bone Particles, left, and IngeniOs β-TCP Bioactive. (Photo/Provided by Zimmer Dental)

IngeniOs HA Synthetic Bone Particles, left, and IngeniOs β-TCP Bioactive. (Photo/Provided by Zimmer Dental)
Intra-Lock® is proud to introduce BLOSSOM™, a new technology in self-tapping screw-type dental implant architecture.

This engineering breakthrough (patent pending) eliminates the need for conventional flutes and vents that traditionally define self-tapping implants. Implants augmented with BLOSSOM self-tapping technology feature a fully integrated tapping configuration that is distributed along the implant.

They are angled and augmented by evenly spaced, crescent-shaped, helical cutting segments. This design is intended to mitigate the high compressive forces that build up when conventional tapping segments become clogged with bone debris (crowding), which can unnecessarily increase insertion torque.

BLOSSOM self-tapping implants continually cut through the bone with remarkable efficiency and lower insertion torque; a result of greater cutting efficiency, the elimination of crowding and less friction.

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BLOSSOM technology is currently available on selected Intra-Lock Dental Implants. For more information, visit www.intra-lock.com.
In the event patients become edentulous, dentures offer many advantages compared to other alternatives. They are esthetically pleasing, easy to maintain and cost effective. However, these benefits are often hampered by patient discomfort and may lead to difficulty in chewing, pronunciation and freely expressing facial expressions such as smiling or laughing. To compensate, denture wearers often change their daily routine and diet in ways that expose them to greater health risks.

Clearly this situation often leaves dentists less excited about proposing dentures as a viable solution for their edentulous patients. Paul Homoly, DDS, president of Homoly Communications, suggests the shortcomings of a traditional denture treatment particularly in the mandibular arch, because of poor retention of dentures and continual bone resorption.

There is, however, a treatment option that can dramatically improve the patient experience with a lower denture and prevent bone resorption. Meijer et al., reports that patients with mandibular overdentures supported by implants are more satisfied compared to patients without the implants. With the advent of narrow-diameter implants, this treatment option is now more accessible than ever before. Dentatus has found that narrow-body implant retained overdentures can overcome many hurdles providing more patients with access to the latest and most beneficial treatments available.

Research

Atlas narrow-diameter implants are built and clinically proven for long-term use. They are tested with university-based research from around the world; the first results were published in 2004. In 2007, Dr. Sang-Choon Cho, Dr. Stuart Froum and his colleagues from the New York University Department of Implant Dentistry published a study in PPAD stating, “In this study, full mandibular dentures supported by nonsplinted, dome-shaped NBIs provided immediate occlusal loading and function with high survival rates of both the NDIs (i.e., 94.1 percent) and prostheses (i.e., 100 percent).”

In 2005, JOMI published Dr. Michael Rohrer’s histology study on Dentatus implants. Rohrer determined that the percentage of bone in contact with the body of Dentatus implants in “the same range and sometimes higher than what is usually seen with conventional implants.”
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These results support well-known literature about implant design and materials in the following ways: Atlas narrow-body dental implants are composed of grade V, titanium alloy; the threaded portion of the implant is mechanically roughened to increase surface area and maximize the bone-implant interface; and the tapered design better facilitates implant placement, promotes initial implant stability and better distributes occlusal loads along the body of the implant.

_Ease of restoration_

Site preparation in the atrophic anterior mandible often provides practitioners with challenging anatomic limitations such as exaggerated facial lingual bone angulation created by the submental fossa and the mentalis muscle insertion. As such, angulation of the implants may vary from site to site resulting in non-parallel implant placement. During the retrofit process, this can lead to attachments protruding out of the denture flange or may weaken the denture by drilling into the denture teeth.

With Atlas implants a silicone material of flowable nature (Tuf-Link, Dentatus) offers cushioned support designed to maximally engage the dome-shaped head to achieve clinically significant retention even in these less than ideal conditions.

The reline provides for an individualized custom fit every time, the first time. Additionally, the silicone based reline provides retention without rigidity, thereby reducing unwanted lateral forces further increasing integration potential, ultimately protecting the implant.

_Advantages_

The advantages of the Atlas narrow-body implants are several. First and foremost, they expand the patient population that is eligible for this treatment. Narrow-body implants make it easier to maintain adequate buccal-lingual bone dimensions and proper implant spacing without the need for ridge augmentation. The narrow-body diameter allows a thicker buccal bone because less bone is removed for the osteotomy. The tapered one-piece implant design eliminates the microgap, which is related to crestal bone loss, facilitates one-stage surgery, provides immediate restoration and is more conducive to a flapless implant placement. Utilizing a minimally invasive flapless procedure with an immediate restoration eliminates many postoperative challenges and reduces total treatment time.

Isn’t it time you looked into this treatment option to restore quality of life for your denture patients?

Dentatus makes it easy for you to get started with its half-day hands-on workshops. All the materials for your first case are included in the registration fee.

_Information_

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**Author** Straumann staff

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Comprehensive prosthetic options due to narrow Ø 3.5 mm prosthetic platform with internal connection including screw-retained and cement-retained restorations and your choice of implant-level or abutment-level impression workflow.

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The self-guiding CrossFit connection offers improved prosthetic flexibility and optimizes abutment insertion while the new transfer piece simplifies handling during surgical placement. This soft-tissue level implant is designed to save time and increase efficiency in your practice.

The Narrow Neck CrossFit Standard Plus Implant follows in the Straumann tradition of innovation. Straumann is a pioneer of innovative solutions for implant dentistry, including the introduction of the SLA® surface in 1998, the revolutionary SLActive® surface in 2006 and the technologically advanced Roxolid® implant material in 2009. Now, 2012, a new generation of small-diameter tissue level implant.

* Fatigue strength according to ISO 14801 internal tests, data on file (B679A/B567A)

References

1. Small diameter implants are not recommended for use in the molar region
2. Compared to SLA in an animal model
3. Compared to Straumann Narrow Neck Implant