Implant News & Views

"Keeping you up-to-date on implant dentistry"

January/February 2007

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IN THIS ISSUE

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Crown Up Implantology

Dr. Andrew W. Kelly

According to Millennium Research Group the US market for dental implants and final abutments experienced strong growth in 2003, with 815,000 implants being placed. This number is expected to rise to well over 1 million by the end of 2006[1]. In the United States several million Americans are missing one or more teeth and many of them are completely edentulous[1]. According to the Mc Gill consensus statement the standard of care for completely edentulous patients are a mandibular two implant overdenture and a conventional upper removable denture[2]. Patients are becoming more aware of dental implants and their benefits. As dentists it is our responsibility to increase our level of awareness about dental implants.

We must also acquire the proper training so that we may adequately diagnose and treat our patients. Since GP's are usually the first dentist to see the patient it is important that, at a minimum, a working knowledge of dental implants be acquired. Without this knowledge and a simple, reproducible system for implant placement and restoration, we will be unable to adequately treat or patients.

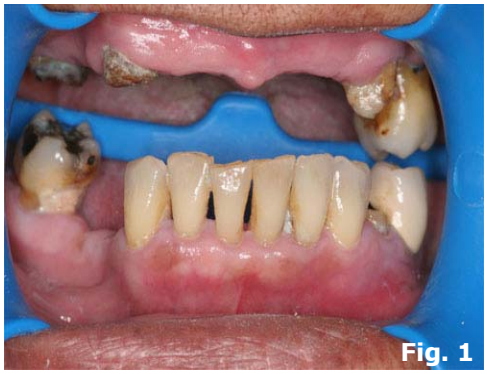

Fig. 1

Before 1984 seventy percent of the implants placed were placed by general dentists. After 1984, implant training was given in the dental schools but only in the specialty programs and the team approach started to become popular[3]. The team approach simply means one practitioner places the implant and another restores it. The irony of this concept is that implant dentistry is prosthetically driven and those placing the implants rarely have the knowledge and experience in restorative dentistry to be able to properly plan the prosthetic phase of implant dentistry.

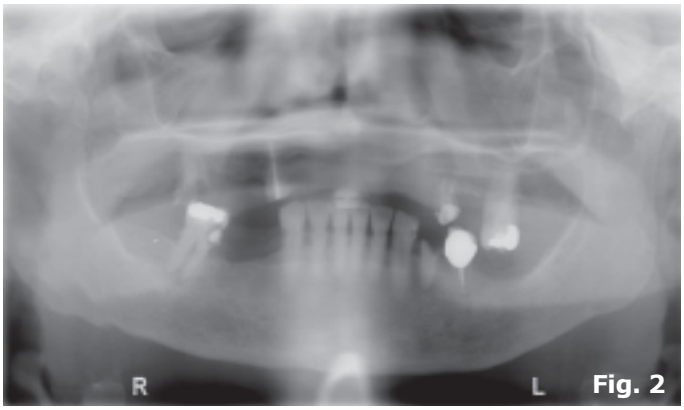

Fig. 2

continued on p. 6

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"Keeping you up-to-date on implant dentistry"

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New AAID Officers

The American Academy of Implant Dentistry, the oldest implant organization in the world, has elected **Frank LaMar, DDS** of Pittsford, NY as President at its recently concluded 55th Annual Meeting. Elected as President-elect was **Jaime Lozada, DDS**, who is with the School of Dentistry at Loma Linda University in California. Other newly elected officers are Vice-President **Beverly Dunn, DDS** of West Palm Beach, Fl, Treasurer **Joel Rosenlicht, DMD** of Manchester, CT and Secretary **Joseph Orrico, DDS** of Elmwood, IL. AAID's membership is over 3,100, and it is the only implant organization that offers implant credentials protected by federal court decisions. For more information about the Academy or how to join, visit them online at www.aaid.com or call 312-335-1550.

Implant Systems

We try to monitor various online discussion groups to share their views on implants with our readers. Recently, there was a discussion of implant systems on acesthetics@lists.acesthetics.com. To learn about the benefits and how to join, go to **www.ACEsthetics.com.**

I am adding implants to my list of services and am looking at all the different systems out there and trying to decide which to use in my office. Our local OMFS office uses Straumann and Nobel Biocare. For sake of keeping things simple and interchangeable, I was thinking of using both of these. However, I have also been looking at Astra and really like their system as well. Any comments on either of these systems? Any other systems out there that I should look at?
Craig O'Donoghue
Fairbanks, Alaska

All systems you mentioned are good systems. Keep in mind, however, that the percentage of successful cases you will be able to achieve with any implant system is more dependent on your experience than on any other variable.

Having that in mind, Nobel Biocare makes good implants. Its sales force has been dramatically reduced as a measure to reduce operational costs. Depending on where you are support from your local sales reps may or may not be any better than that from other implant companies.

Straumann's ITI is a solid system. It hasn't introduced as many "new" concepts as some of the other competitors have but it has in its favor the fact that its implant system is one of the easiest to restore. The ITI implant is not an implant for every situation but neither are any of the other systems. There is no single system in the market that can possibly address "all" of your clinical needs and be used in every possible implant placement scenario.

Astra is a very good system that has gained momentum in the past few years. Worthy of consideration is the fact that Branemark himself, once linked to Nobel Biocare, has recently participated along with some other speakers of a world implant congress organized by Astra and

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Converting an Overdenture as an Interim Prosthesis over 30-year-old Blade Implants

Dr. Stephen Markus

In 1968, Linkow introduced a flat titanium endosteal blade implant, which often served as a means of using the narrow and/or shallow areas of remaining alveolar bone where dimensions do not permit the use of the cylindrical or root-shaped implants. These implants primarily form a connective-tissue interface, a process called fibro-osseous integration. Connective tissue forming around the implant takes the form of collagenous fibers that are parallel to the dental implant surface. [Slavkin - http://maryland-implants.com/slavkin_implants.htm]

Having been in practice over 30 years, I can count on one hand, the numbers of these I have seen survive for any length of time. Linkow, was in fact, a pioneer, blazing the trail for others who came after him. The stories about the difficult surgeries to remove failed blades, and the lesions they left behind in bone were manifest back in the seventies, but are but a glimmer in the minds of most of us today. Certainly younger dentists may have no clue what they were looking at, if a patient came in and radiographs revealed what we saw.

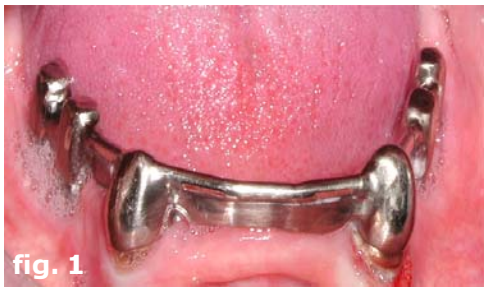
fig. 1

I remember back to my days at the University of Pennsylvania School of Dental Medicine, in the lectures of Cohen, Amsterdam, Abrams et.al. that there was little reliance on, or respect for, blade implants. Most of the cases we saw took the retention of even the most labile tooth seriously. My father, now a retired endodontist, reviewed pending litigation for a malpractice carrier. He showed me two stacks of charts, one much larger than the other. One stack was the charts in review for all the dentists in the five boroughs of New York City, the second and taller stack was Linkow's. And so it is that today, much like the La Salle and the Edsel, we see very few blade implants running around. But those that are, one would expect to be in fair to good condition.

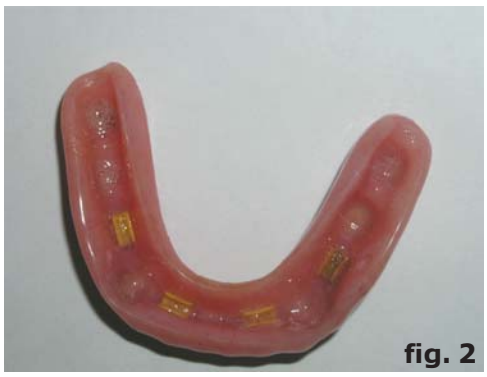
fig. 2

Recently, a new patient came to my practice from about 40 miles away. She was extremely anxious, so anxious in fact, that she was crying before I even entered the room. It seemed that five years ago she had started with a new dentist in her area, and after radiographic evaluation told her that her blades were failing, and needed to be removed. He referred her to a surgeon who explained the risks of the surgery and needed her informed consent. She never went back; she was that afraid.

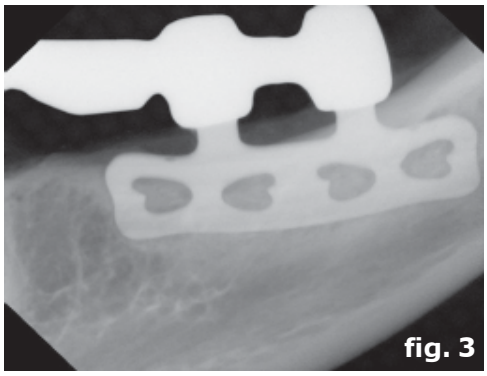
fig. 3

Clinical Findings

So it was, with that mindset, that she arrived at my office, girded for the eventuality of this extreme surgery, and wondering how she would be able to go without teeth for whatever period of time healing would mandate. On examination I found that she had been wearing the same set of dentures, a full upper and a lowerHader bar-retained overdenture **[figs. 1-2]** for thirty years, since she was 21 years old and never had them relined.

The teeth were well worn; the upper denture was loose, but not so loose there was need for adhesive, and she had been diligent about removing the denture every night, so there was no hyperplastic tissue beneath it. My radiographs did not indicate that the implants were failing, although they did show that the medial superior aspect of the bars were supracortical **[figs. 3-6]**. I let her know that the two

continued to p. 4

Converting an Overdenture as an Interim Prosthesis over 30-year-old Blade Implants

continued from p. 3

natural cuspids, which were attached to the bar were extremely questionable due to decay and circumferential infrabony pockets.

I assuaged her fears, letting her know that I thought the bars were still functional, and that we should be able to salvage them. The bad news was her two remaining natural teeth would be contributing to the eventual loss of the prosthesis. Further deterioration might compromise the stability of the blades, if the bar were to begin to fail around one of them. I sensed that trust was an issue for her, and determined to proceed extremely cautiously in the beginning to build her confidence.

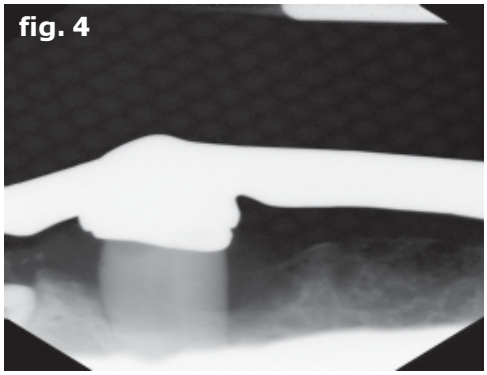
fig. 4

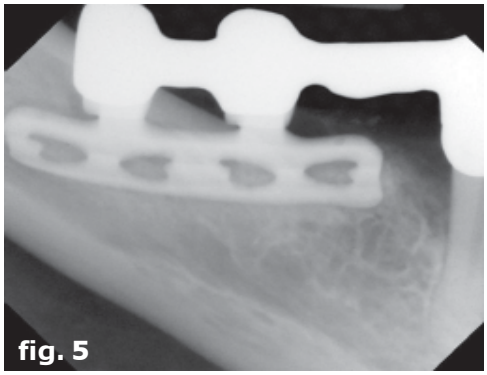
fig. 5

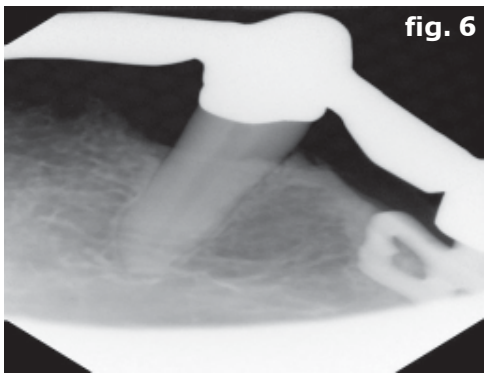
fig. 6

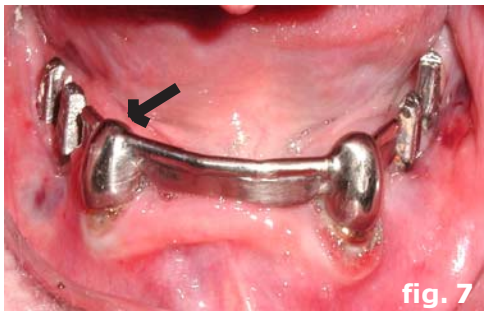
fig. 7

Treatment Plan

We agreed, at that visit, that she needed a new full upper denture - one that fit better and looked whiter with unworn teeth. I took a centric relation bite, with the intention of opening the vertical dimension of occlusion about 2 mm with the upper denture (when we retreat the lower, we will open her up another 2 mm) to eliminate the obvious collapse at the commisures.

The new full upper was completed by relining the existing denture and putting it in a Lang duplicating flask. My lab mounted it using a facebow, opened the guide pin 2mm, and set new teeth for a try in. The denture was delivered and has been receiving rave reviews from her friends and family, roughly 2 weeks after her first visit, using the technique as outlined by my good friend Dr. Charles Barotz. [Drop Dead Gorgeous Dentures - http://www.barotzdental.com/cosmeticdentures/doctors.html]

In the interim, she had been referred to a well-regarded periodontal colleague of mine who practiced much closer to her domicile. The CT scan revealed that there was adequate bone in the mandibular anterior region to place 4-5 conventional implants. She would need to have the cuspids extracted, and bone grafted to that area prior to fixture placement.

If the blades could be relied upon, then the treatment plan would be to remove the anterior section of bar and the cuspids, graft bone, and reline the anterior segment of the lower overdenture. Four to five fixtures would be placed in the mandibular anterior region once the bone was ready. At the time of grafting, 2 or 3 mini-implants would be placed in between the future implant sites and adapted to the lower denture providing anterior support and unloading the blades.

Once the permanent implants were osseiointegrated, the mini's would be removed and the prosthesis would be converted once again to snaop to the new fixtures, while the three-part prosthesis was constructed. New crowns would then be fabricated over the twin-headed blades for posterior support. A lower fixed, high-water prosthesis over the anterior fixtures would complete this triad.

The key element in all this is that neither treating dentist knew whether the blades were viable. In discussion with the patientprior to the visit, we determined that she wouldn't need to be sedated for this treatment, although I did find as the procedure progressed, that copious amounts of Septocaine buccal and lingual to the bar made the visit more comfortable for her, and thus, more relaxing for me.

Treatment

The bar was easily sectioned anterior to the blades **[fig. 7].** It was a relief for me to realize that this bar was made before the time when dentists needed to economize due to the price of gold, and use semi or

non-precious alloy. After slicing through the bar on the right, I tested the blade for mobility and found that while not rigid, as one would expect for today's fixtures, the mobility was minimal. I wondered what effect the extension of the bar to the posterior might have had in torquing the fixtures due to the flexion of the mandible on opening.

This precious alloy also meant that the effort of slitting the dual telescopes that were cemented to each blade would be easier on me, the patient, and my electric handpiece. The most demanding part of the procedure was about to begin. I needed to separate the cemented dual castings from the dual head of each blade. A primary cut was made from lingual to buccal across the head of occlusal of the casting until cement was visible, and then was extended down the buccal of the casting. At that point it became evident that the cement was brick red in color. I suspected Zinc Phosphate, which I knew would make this a long and tedious process.

The area was continually debrided with sterile water and high speed evacuation. I did not want any remnants of this excavation or grinding to find their way beneath the tissue.

Using a Hu-Friedy crown remover, I gently tried to peel the metal away from the head. At that point the patient felt discomfort, and I anesthetized the area around the bar. My understanding of the fibrous nature of the connection of the blade to the mandible mandated that no extreme torquing forces be used. I got some Hollenback carvers, and used them to tunnel through the cement. All prying actions were directed apically, by attempting to pull up on the occlusal portion of the splinted castings.

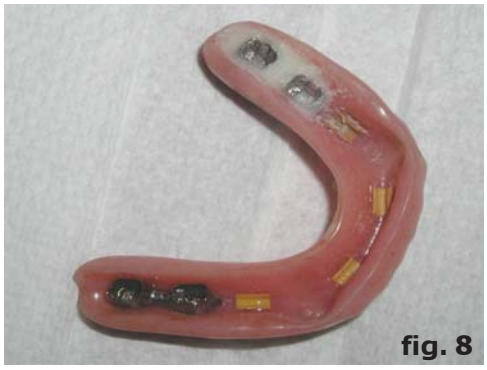
fig. 8

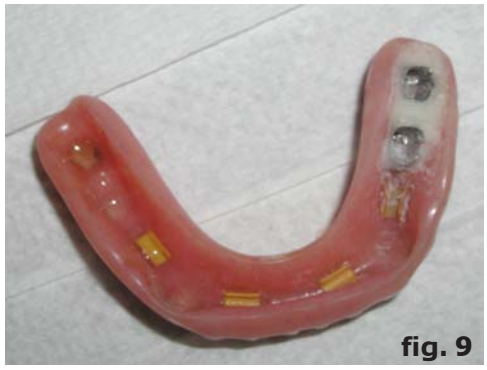
fig. 9

Castings

Each casting took about 40 minutes to remove. At that point the blades were again checked for mobility and found to be unchanged from the pre-operative condition. I then reseated the casting after removing all cement from it, and from the serrated heads of the blade **[fig. 8]**. A copper band contouring pliers was used to crimp back the bent buccal edges so that the castings fit the heads passively. It was necessary to relieve the castings internally on the right side but not on the left. This was not surprising, because if you study the radiographs of the bar carefully on the right side, you will note that the bar never did fully seat on that side.

Retrofitting

Once the castings were freely seating, the underside of the denture in that area was relieved. Cavit (Premiere Dental) was placed in the slit on the buccal to prevent the flow of cold cure acrylic from getting into the casting and locking in on the serrations of the heads. Cold cure acrylic (Jet, Lang Dental) was painted into the area of relief, and the denture was seated atop the castings which were passively seated on the heads. When the material was cured, the denture was relieved, and the process was repeated on the contralateral side. Any voids around the castings were then back-filled with cold cure resin. The result: a casting was turned into a telescope for the conversion of this overdenture into an interim prosthesis **[fig. 9]**. The patient was covered with penicillin for seven days after the procedure to prevent infection. Follow up phone calls indicated that within 36 hours she had no residual effects of the procedure.

Grafting

The occlusion was verified as unchanged from the pre-operative condition. The patient was counseled on the proper cleansing of the revamped prosthesis, and was sent to the periodontist later that week for the removal of the anterior bar segment, and cuspid teeth. Bone grafting was performed, and a hard reline of the anterior portion of the denture was done. The patient will be followed until the bone graft is ready for implants, and then the lower prosthesis will be converted. At that point, PFM crowns will be made for the dual headed blades.

Stephen Markus, DMD has maintained a practice for over 30 years in Haddon Heights, New Jersey with an emphasis on advanced restorative, reconstructive and esthetic dentistry. He is a Fellow of the Academy of Comprehensive Esthtetics (F.A.C.E.), a graduate of the Dawson Continuum, a member of D.O.C.S., and a Lifetime Qualified member of the Crown Council. He can be reached by email at drmarkus@cent4dent.com.

Crown Up Implantology

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Surgical Guide

Therefore, it is the responsibility of the restorative dentist to provide the surgeon with a template that clearly shows where the implants are supposed to be. Also it is imperative to inform the surgeon of the number and size of the implants needed to properly restore the case functionally and esthetically. The restorative dentist must assume the role of team leader. Most cases fail after osseointegration because of prosthetics rather than surgery. The last one to touch it is it.

It is widely accepted that implantology is prosthetically driven. Therefore any implant technique should have prosthetics at its foundation. Using this axiom I will describe Crown Up Implantology. This concept defined is determining where the teeth need to be and then determining what type, size and the appropriate location of the implant(s).

Implant Team

One of the major problems that occurs in implant dentistry is getting the implant team on the same page. The restorative dentist rarely understands the surgical side enough to be able to adequately determine which implants should be used. On the other hand the implant surgeon is usually so far removed from restorative dentistry that they are not adequately prepared to suggest to the restorative dentist which prosthetic options are best for the patient. The patient is the one who pays the biggest price. Using Altadonics Dentition for Life and Denture for Life [1-866-221-7061] in conjunction with the modified Pick Up Technique[4] it is quite simple to get everyone on the same page and keep them there.

The Altadonics system is used to capture and store proprioceptive, centric vertical and esthetic information **[fig. 6]**. Once the information is captured you can produce an unlimited number of first generation models. These models can be made of clear acrylic for surgical stints. Barium sulphate can be added **[fig. 7]** to make radiographic stints. A temporary prosthesis can be made of esthetic acrylic **[fig. 8]**. The information can be restored as many times as is needed. Altadonics also has a system that will allow the doctor to capture the dentition of a person that has periodontal disease and is scheduled for extractions. This way it can be determined at a later date where the implants are to be placed so that the implants can be placed to restore the patient to their original centric and vertical position of occlusion. How many times have you lost or broken a study model? Other duplication methods require that you have the denture.

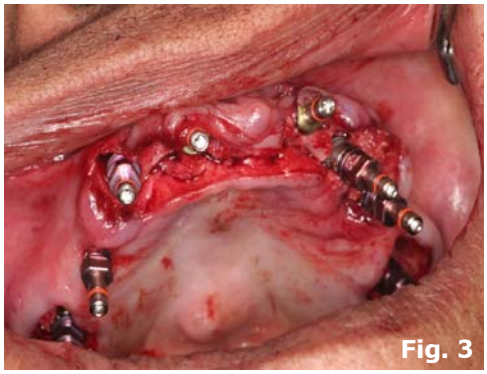
Fig. 3

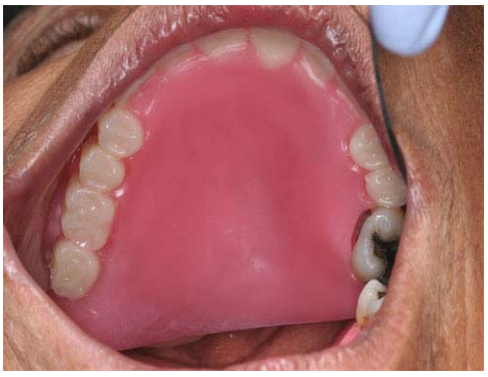
Fig 4 - Diagnostic wax up. Occlusal view of the diagnostic wax up during clinical assessment of the occlusion, maxillomandibular relationship, emergence profile, and esthetic aspects. During this clinical step, the patient's opinion is important, particularly in regard to acceptance of the esthetic aspect.

Case Study

The patient is a 71 year old woman. She presented to the office with an ill fitting removable partial denture **[fig 1]**. The patient had no significant medical findings. After radiographic analysis **[fig. 2]** and evaluation of mounted study models it was determined that the patient was a candidate for a fixed prosthesis. Two days prior to surgery the patient was placed on Keflex 500 mg and was instructed to continue taking the medication 3 times per day for a total on ten days. On the day of surgery the patient was given 800 mg of Ibuprofen and 0.5 mg of Halcion.

The patient was anesthetized with 4 carpules of Septocaine and 3 Carpules of Citanest Forte. Teeth numbers 2, 6 ,13 and 15 were removed atraumatically with periotomes to preserve the bone so that implants could be placed immediately. Eight Camlog [1-877-537-8862] implants were placed four of which were immediately placed in position 2,6,13 and fifteen **[fig. 3]**. After the implants were placed

The provisional prosthesis was attached with light cured acrylic. The prosthesis was removed and finished. It was then re-inserted and the patient was given 8mg of Dexamethasone IM and the released. The patient was recalled weekly for one month. After which the patient was recalled bi-weekly. After 6 months

healing time a permanent prosthesis was constructed. The prosthesis has currently been in function for 2 years at the time of publication.

Methodology

The first step is to start with a "Happy Denture" or "Happy Dentition"[5]. In other words the patient is comfortable with their dentures or the natural teeth as it relates to occlusion and function **[fig. 4]**. By using the Altadonics system it becomes very easy to develop a system that is simple and reproducible. After it has been established that the patient is comfortable with esthetics and function, it is time to take an impression, which will be used to store their esthetic, centric and proprioceptive information permanently **[figs. 5-6]**.

The material used in the Altadonics system is a platinum based Polyvinylsiloxane. This material has very little distortion over long periods of time. This will allow the general dentist to provide first generation models to the implant surgeon and lab technician. By doing this the patient can have continuity of care that is unparalleled. The general dentist will have the information needed to inform the implant surgeon which diameter and the exact location of the implants which will be necessary to adequately restore the case. Also, this information can be passed on to the lab so that a temporary and a permanent prosthesis can be constructed.

In some instances it may be necessary to start from scratch by doing complete centric records and constructing a prosthesis to the wax try in stage. After this is done, the rest is simple.

Pickup Technique

"The pickup technique" for the adaptation of a screw-retained immediate provisional restoration. (a) The provisional template was a duplicate of the diagnostic wax up. Perforations were made to match the implant positions. (b) Peek Abutments were attached to the implants **[fig. 9]**. (c) The implants were isolated from the fresh wound with rubber dam. (d) The provisional template in the mouth. Perforations were sufficiently widened to achieve only mucosal contact at the palatal/lingual aspect. This permitted repositioning of the provisional template in accordance with the pre-established tooth location and occlusion. (e) During connec-tion of the Peek Abutmentsand the provisional template, the wound was protected with rubber dam to avoid any contact with nonpolymerized acrylic resin **[figs 10-13]**.

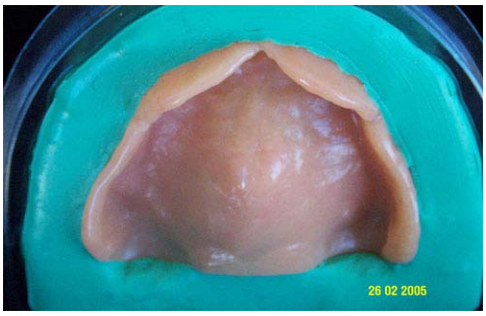

Fig 5 - Wax up in the Altadonics shell tissue side up.

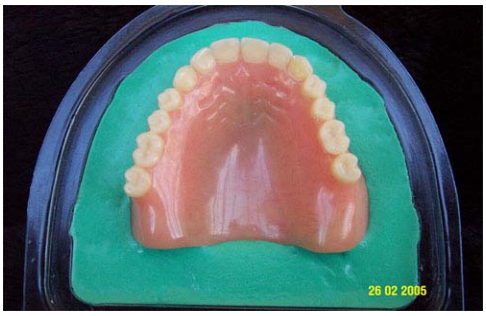

Fig 6 - Wax up in the Altadonics shell tissue side down

Fig 7 - Surgical guide.

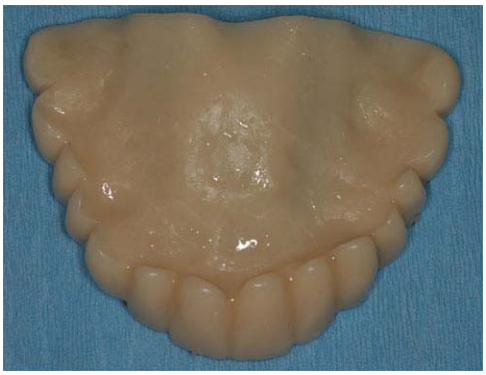

Fig 8 - Provisional restoration prior to placing drilling holes for attachment to Peek abutments.

Coordination

This represents a major innovation in the field of implant dentistry. It is the first time that a system has been designed that will allow the general dentist to confidently head the implant team. This will make the system predictable, reproducible, defensible, and verifiable. This is the first time that all four of these parameters can be provided by a single system. By using this system general dentists and specialist will have the opportunity to place and restore dental implants with a high degree of difficulty.

The Journal of The California Dental Association [Nov. 2001] states the following: The original, or Brånemark, concept of the "team

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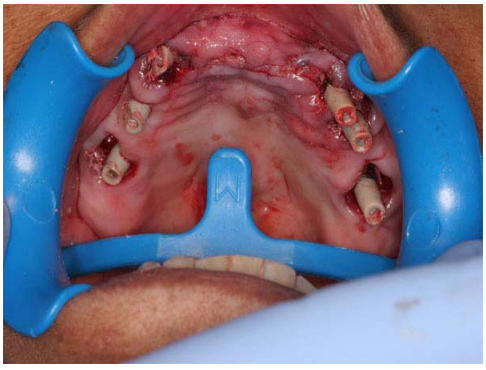

Fig 9 -Screw-retained Peek provisional abutments (Camlog) were connected to each implant.

Crown Up Implantology

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approach" to implant dentistry promoted the notion that implants be placed exclusively by oral and maxillofacial surgeons and restored by prosthodontists. This model was understandably helpful in the past, given the complexity of the surgical and prosthodontic procedures of earlier implant systems. This exclusive and elitist orientation has impeded the pervasiveness of implant dentistry in general practice by restricting education to a privileged few. However, it did allow the science of implant dentistry to be extensively studied, documented, and perfected. Regardless of its restricted availability and foreign origins, implant dentistry has flourished into what is today an extremely predictable treatment for edentulism. Dental implants have become an appropriate part of the general as well as specialty dental practice.

Fig. 10 - Frontal view of maxillary immediate provisional restorations placed the day of surgery.

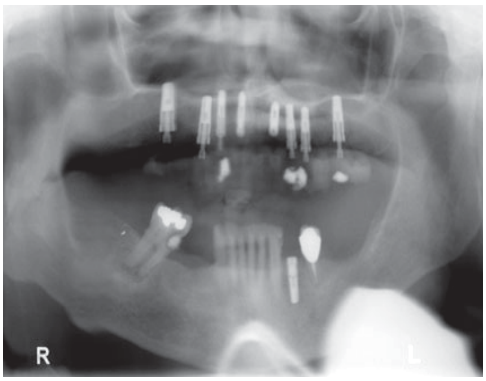

Fig. 11 - Radiograph after placement of the provisional restoration.

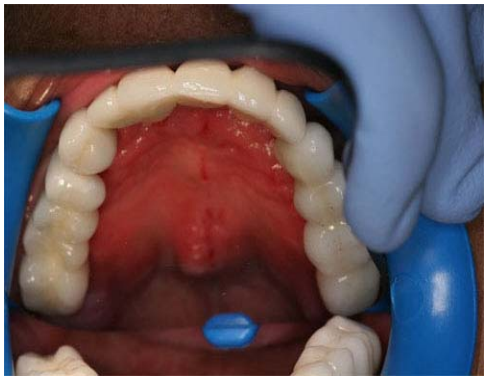

Fig. 12 - Occlusal view of final prosthesis.

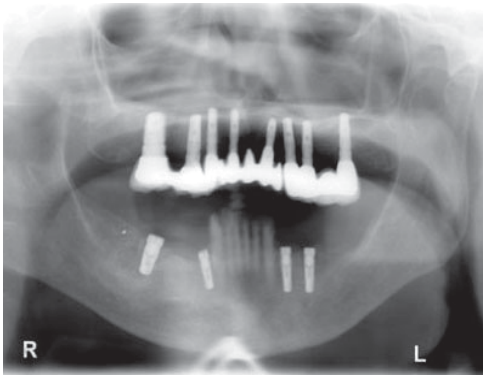

Fig 13 - Radiograph of final prosthesis.

References

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2. MC Gill Consensus Statement 2002
3. Why Should General Dentists Place Dental Implants? Dr. Jack Hahn
4. Immediate Loading with Fixed Screw-Retained Provisional Restorations in edentulous Jaws: The Pickup Technique German O. Gallucci, DMD INT J ORAL MAXILLOFAC IMPLANTS 2004; 19:524–533
5. www.altadonics.com

Andrew W. Kelly, DDS maintains a cosmetic and implant dental practice in Clemmons, NC. He is an Associate Fellow of the AAID, a Fellow of the American Academy of General Dentistry, a member of ICOI and a member of the American Academy of Cosmetic Dentistry. Dr. Kelly was the dental director at Vencor Hospital in Los Angeles, CA. Dr. Kelly presents implant and cosmetic workshops at his own training center. He can be reached at 336-766-7966 or dctr2th@msn.com.

Tibits 

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seems to be lending his support to this system. Astra has very interesting features. The rough surface treatment brought all the way to the implant platform is working well for bone preservation and seems to be preventing the crestal bone resorption seen during the first year after placement and usually associated with most other systems. It has also been designed so that the implant body has a larger diameter than the abutment. This step that has been coined in the industry as "platform switching" creates an obstacle to the ingress of bacteria and seems to also help in the elimination of the initial crestal bone resorption associated with implant placement. In all, it is a very good system, and I would highly recommend it. Try to look for work published by **Lyndon Cooper** or to contact him at UNC Chapel Hill. It works with Astra and has done some amazinganterior cases where he has been able to maintain the osseous and gingival architecture in such a way that you simply can't tell the teeth have been restored with implants. I also believe he has published some of his experiences with Astra implants.

In case you wish to look at some other interesting implant systems I would highly suggest the XiVe from **Friadent** (Dentsply), **Ankylos** from Friadent (Dentsply), and **Pitt Easy Bio-Oss** from Innova (formerly from German Oraltronics - Innova is now a division of Kerr). These are outstanding implant system each with unique design characteristics that can be advantages in certain clinical situations.

Last but not least you must consider a few things when making your choice.

First you state that you have been thinking about **Nobel** and **Straumann** because your local OMFS uses these systems. There has been a great paradigm shift in the last decade or so in regards to implant placement and implant treatment today is restorative-driven. In other words your surgeon should be using the systems that are more convenient for you and not the other way around. Trust me as this is coming from an OMFS. Today you dictate the way treatment is to be performed by using a diagnostic wax-up and other planning tools while it is the surgeon's responsibility to place the implants where you or any other restorative dentist determines they need to be for the most ideal result.

Second don't ignore the "clones". There are numerous companies out there that have waited for patents to expire in order to be able to duplicate implant designs at a fraction of originals' costs. Take a look at **Lifecore**, for instance. It has a perfect clone of the ITI named Stage-1 that sells for a much lower price. It also has a perfect replica of the Branemark external hex implant also for a fraction of the Nobel Branemark implant. **Gerald Niznick** just opened his company Implant Direct and based on his experience in this industry (he has been behind some of the largest implant ventures including Corevent, Paragon, and others) his implants are bound to be a success. His approach this time is different. He wishes to sell implants at a reduced cost by selling direct and eliminating a large sales force and paid speakers. It is my understanding that his company is also manufacturing legacy components (components for legacy systems that can be copied as patents have expired) with good quality for a fraction of the price. I remember reading somewhere that he is fabricating Nobel Replace components among others.

Keep you eyes open, evaluate your options and don't be seduced by the big players as you may pay more for the name and end up with the same results.

Joseph Chamberlain, D.D.S.

We have been using **Lifecore** implants for a while now. Great results!
Dr. Tim Hale

You may wish to look at **Thommen Medical** implants (www.thommenmedical.com) they have a USA office in Ohio. I have been using them for 14 years. The benefit here is implants are high quality but lower cost them Nobel, Straumann or Astra. Other added benefits of Thommen are the prosthetics are inter-changeable between the 3 implant lines - meaning if the crestal diameter is 4.2, the same abutment will fit no matter which of the three implants was placed. They offer the Locator attachment. If you like a one stage approach then the Onetime gives that approach. They offer a single implant restorative kit (SPI*EASY) that has an abutment (your choice of straight or angled and various cuff heights) with an analog, snap on impression cap, waxing copings and temp comfort cap for a lower price then purchasing the parts separately. And recently added a Zirconia abutment (SPI*ART)

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I like **Nobel Biocare**. Have been using them for years and the results have been great. All systems work well, however some have more parts than others. You may need to familiarize yourself with a lot of different systems as you begin to do more implants and draw those types of patients to you who may have other products already in their mouth. You've got a pretty good list going. The only other companies I'd suggest you look at are 3I and Lifecore.
Dr. Mike Maroon

Editor's Note: If you go to our website at **www.implantnewsandviews.com** and click on "Links" and then on "Implant/Component Manufacturers," you will find 124 different implant websites for review - do your due diligence on the various available implant systems.

Impression Material

Dr. Scott Tillman of Woodbury Dental Design on Long Island, NY writes in to tell us that he highly recommends the **Zhermack Elite® Implant impression** material [www.zhermack.com]. It is sterile and certified for surgical application. He finds it excellent for tissue level impressions at the time of implant installation. It's radiopaque, so any excess that might be left in the tissue will be apparent. Also, Elite has high dimensional stability, so an accurate model will be obtained whenever it is poured.

Implant Market Size

According to the **Millennium Research Group**, the US dental implant market reached almost $550 million in sales last year and is expected to go over $600 million this year. It is estimated that by 2009, US implant sales will exceed $900 million. Full mouth implant-supported restorations cases can range from $12,000-$50,000. Do the math. What part of this do you want for your practice?

CE Programs
CE Programs
CE Programs

January 2007

19 - NobelGuide - Dr. J. Kopman and Dr. H. Kopman Farmingdale, NY - $2800 - Marotta Dental Studio, 631-249-7520.
19 - Implant Mentor Program - Dr. Russell Baer, Chicago, IL - $1495 - 312-704-5511.
19- 20 - Dental Implants in My Practice - Now is the Time - Dr. Steven Kukunas and Dr. Mark Ochs, Pittsburgh, PA U. of Pittsburgh SChool of Dental Medicine - CDE, 412-648-8370.
20 - Intermediate Mini-Implants: A Hands-On Live Patient Course - Dr. Peter Karsant, Dr. Eugene LaBarre and Dr. Alexei Mizin, San Francisco, CA - $3500 - University of the Pacific School of Dentistry, 415-929-6400.
22 - Implants for the Auxiliary Staff - Meghan Weed, RDH Boston, MA - $250 - Bicon, 800-882-4266.
22- 24 - Surgical and Prosthetic Principles - Drs. Shadi Daher, Vincent Morgan, Urdaneta Rainier, Drauseo Spertti and Joseph Leary, San Diego, CA - $1600 - Bicon, 800-882-4266.
25- 27 - ICOI Winter Symposium - Various Clinicians Orlando, FL - 800-442-0525.
26- 27 - Blending State-of-the-Art Techniques with the New ERA Implant for Overdenture Support - Drs. Joe Carrick, Robert Cohen and John Tucker, Buffalo, NY - $1495 Universtiy of Buffalo, 800-756-0328.
31- February 3, 2007 - Advanced Implant Surgery and Bone Regeneration - Dr. Massimo Simion, San Francisco, CA - $6900 - IDEA, 866-700-4332.

February 2007

1- 3 - Placing Implant Surgery into Your Comfort Zone - Dr. Keith Phillips, Seattle, WA - $2995 - 800-457-9165.
2 - Closing the Deal - Dr. Michael Smilanich Lake Elmo, MN - $1595 - Institute for Advanced Dental Education, 651-351-9660.
2 - Puros/J Block Certification Course - Dr. Joel Rosenlicht, Manchester, CT - 877-649-7374.
2- 3 - NobelGuide Teeth in an Hour, 3D Computerized Planning & Live Guided Implant Surgery - Dr. Tom Balshi, Dr. Glenn Wolfinger, Dr. J. Thaler, Mr. R. Winkelman, Mr. S. Balshi,II, Ft. Washington, PA - $3800 - 215-643-5881.
3- 4 - Advanced Implant Dentistry and Bone Grafting - Dr. Joel Rosenlicht, Manchester, CT - 877-649-7374.
5- 7 - Implants: Fixed Retained - Dr. John Kois Seattle, WA - $4195 - 800-457-9165.
7- 9 - Advanced Surgical Workshop - Dr. Dennis Smiler, Los Angeles, CA - $3675 - 818-995-7971.
8 - New Approaches to Bone Grafting for the General Dentist - D. Randal Rowland, Sacramento, CA - 916-446-1211.
8- 9 - Implants 101: Integrating Implant Surgery into your Dental Practice - Dr. Michael Sonic, Fairfield, Ct - 203-254-2004.
8- 10 - Implants: Removable Retained - Dr. John Kois, Seattle, WA - $4195 - 800-457-9165.
9 - The Single tooth Implant Success - Dr. David Sarment, Troy, MI - $185 - Michigan Dental Association, 517-372-9070.
9 - Basic Implant Surgical Skills - Dr. H. Kopman and

Dr. J. Kopman, Farmingdale, NY - $2800 - Marotta Dental Studio, 631-249-7520.
9 - Restorative Opitions in General Dentistry - Dr. T. Urbanek, Franklin, TN - 800-718-5157.
9 - Ridge Split Techniques - Dr. Shadi Daher, Boston, MA - $750 - Bicon, 800-882-4266.
9- 10 - Block Grafting - Dr. Paul Petrungaro, Lake Elmo, MN $1695 - Institute for Advanced Dental Education, 651-351-9660.
9- 10 - Comprehensive Training in Implant Surgery- Live Surgeries - Dr. J. Piermatti and Dr. M. Rothman, Voorhees, NJ $3500 - 856-309-8000.
9- 10 - Basic Implant Plaecment for the Restorative Dentist - Drs. S. Winkler, M. Mehranfar, J. Day, J. DiPOnziano, M. Passell, and D. Law, Phoenix, AZ - $1450 - 928-774-5050.
9- 11 - 20th Annual Symposium an Reunio - Past, Present and Future of Dental Implantology - Dr. Ed McGluphy et al and Dan Becker et al, Columbus, OH - $595 - Midwest Implant Institute, 614-451-7233.
9- 11 - Implant Surgery: Autografts & Phlebotomy - Dr. Ron Zokol, Vancouver BC Canada - $3500 - Pacific Implant Institute 800-668-2280.
10 - Sinus Lift Techniques - Dr. Shadi Daher, Boston, MA - $750 - Bicon, 800-882-4266.
10- 13 - Comprehensive Implant surgery Training for Novice & Experienced Implant Surgeons - Dr. Anthony Sclar, Dr. Larry Grillo, Ms. Elizabeth Suarez, Dr. Joseph Niamtu Miami Beach, FL - $2500 - 305-913-2466.
15- 17 - Advanced Bone Grafting I - Dr. Michael Pikos, Palm Harbor, FL - $3650 - MAP Seminars, 727-781-0491.
16 - Narrow Body Implants to Retain, Stabilize and Cushion Mandibular Dentures - Dr. Keith Rossein, Houston, TX - $995 - CDE Studies Institute, 800-323-3136.
16- 17 - Dental Implants in My Practice - Now is the Time - Dr. Steven Kukunas and Dr. Mark Ochs, Pittsburgh, PA U. of Pittsburgh SChool of Dental Medicine - CDE, 412-648-8370.
16 - Complete Denture and Implant Overdenture Therapies - Drs. Vicki Petropoulous, Behnoush Rashedi and Arnold Rosen, Lafayette Hill, LA - $360 - University of Pennsylvania-School of Dental Medicine, 215-573-9098.
20- 25 - Dental Implant Surgery: Fundamentals to Details and Advanced Implant Site Development on Cadavers - Dr. Robert London, Ft. Lauderdale, FL - $5895 - 3i Innovations, 619-297-5466.
22- 23 - 79th Annual Meeting of the American Prosthodontic Society - Dr. Harold Preiskel, President, Chicago, IL - 877-499-3500.
23 - The Pro-Visional Technique - Dr. Michael Smilanich Lake Elmo, MN - $2595 - Institute for Advanced Dental Education, 651-351-9660.
23- 24 - American Academy of Fixed Prosthodontics Annual Meeting - Contact Don Garver, Chicago, IL - (800) 880-5184 or aafpgarver@cox.net.
23- 24 - Hands-On Intermediate Implant Skill Workshop Dr. Cliff Starr, Oldsmar, FL - $1875 - 904-244-7051.
24 - Mini Implants in Removable Prosthodontics - Dr. Peter Karsant and Dr. Eugene LaBarre, San Francisco, CA - $450 - University of Pacific School of Dentistry, 415-929-6400.
26 - Implants for the Auxiliary Staff - Meghan Weed, RDH Boston, MA - $250 - Bicon, 800-882-4266.
26- 28 - Surgical and Prosthetic Principles - Drs. Shadi Daher, Vincent Morgan, Urdaneta Rainier, Drauseo Spertti and Joseph Leary, Boston, MA - $1600 - Bicon, 800-882-4266.

March 2007

1- 2 - Advanced Surgical and Prosthetic Techniques - Drs. Shadi Daher, Vincent Morgan, Urdaneta Rainier, Drauseo Spertti and Joseph Leary, Boston, MA - $1100 - Bicon, 800-882-4266.
2 - Implant Restoration & Treatment Planning - Dr. Lyndon Cooper, King of Prussia, PA - $235 - Valley Forge Dental Association, 800-854-8332.
2- 3 - Prosthodontic Training for the Dental Implant Surgeon - Dr. Frank Lamar, Jr., Rochester, NY - LaMar Dental Implant Training Center, 585-461-4350.
3- 4 - Simulated Implant Placement: A Hands-on Program - Dr. Paul Olin and Dr. James Swift, Carlsbad, CA - University of Minnesota School of Dentistry, 800-685-1418.
5 - Puros/J Block Certification Course - Dr. Joel Rosenlicht, Manchester, CT - 877-649-7374.
5- 7 - Cartagena Surgical Course - Live Patients - Dr. Shadi Daher and Dr. Mauro Marincola, Cartagena, Colombia - $8500 - Bicon, 800-882-4266.
8- 10 - Cartagena Surgical Course - Live Patients - Dr. Shadi Daher and Dr. Mauro Marincola, Cartagena, Colombia - $8500 - Bicon, 800-882-4266.
8- 11 - Aesthetic Implant, Block and Sinus Grafting Dr. Paul Petrungaro, Lake Elmo, MN - $5995 - Institute for Advanced Dental Education, 651-351-9660.
9 - Narrow Body Implants to Retain, Stabilize and Cushion Mandibular Dentures - Dr. Keith Rossein Indianapolis, IN - $995 - CDE Studies Institute, 800-323-3136.
9- 10 - Basic Implant Plaecment for the Restorative Dentist - Drs. S. Winkler, M. Mehranfar, J. Day, J. DiPOnziano, M. Passell, and D. Law, Phoenix, AZ - $1450 - 928-774-5050.
9- 10 - First Annual Winner's Circle Symposium - Dr. Arun Garg, Dr. Robert Marx, Dr. Joseph Kan and others Miami, FL - $795 - Implant Seminars, 305-944-9636.
10 - Proper Treatment Planning in Implant Dentistry Dr. Aysegul Siranli, Pittsburgh, PA - $230 - U. of Pittsburgh SChool of Dental Medicine - CDE, 412-648-8370.
14 - Implants for General Dentists: Maximizing the Rate of Success - Dr. Mohamed Hassan and Dr. Bassam Farouk Rabie, Boston, MA - $265 - Tufts University School of Dental Medicine, 617-636-6629.
15- 17 - Advanced Bone Grafting I - Dr. Michael Pikos Palm Harbor, FL - $3650 - MAP Seminars, 727-781-0491.
16- 17 - Implant Dentistry for General Practitioners in "Black and White" - Dr. J. Jerome Smith, Lafayette, LA - 337-235-1523.
19 - Narrow Body Implants to Retain, Stabilize and Cushion Mandibular Dentures - Dr. Keith Rossein NY, NY - $995 - CED Studies Institute, 800-323-3136.
22- 23 - Introductory Surgical & Prosthetic Implant Course - Dr. D.M. Vassos, Edmonton, Canada - $2000, 780-488-1240.
23 - Dental Assisting for the Implant Practice - Mrs. a. Callan, Mrs. B. Fasanelli, and Mrs. T. Pfiefer, Farmingdale, NY - $850 - Marotta Dental Studio, 631-249-7520.
23- 24 - Bone Grafting: Hands-on with Cadavers - Dr. James Rutkowski, Dr. Craig Cooper, Dr. Barry Loughner & Dr. Lee Silverstein, Dayton OH - $2695 - AAID, 312-335-1550.
24 - Sterile Techniques for Implantology Protocol/ Documentation for Proper Patient Consent - Vickie McCune an Dr. Duke Heller, Columbus, OH - $525 - Midwest Implant Institute, 614-451-7233.
30- 31 - Dental Implants in My Practice - Now is the Time - Dr. Steven Kukunas and Dr. Mark Ochs, Pittsburgh, PA - U. of Pittsburgh SChool of Dental Medicine CDE, 412-648-8370.
30- 31 - Basic Implant Surgery Workshop I - Dr. L. Lum, Dr. M. Chen and Dr. J. Wang, Dublin, CA - 800-718-5157.
30- April 1, 2007 - Implant Practice Management - Dr. Ron Zokol, Vancouver, BC Canada - $3000 - Pacific Implant Institute 800-668-2280.

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30- April 1, 2007 - NobelGuide Teeth in an Hour, 3D Computerized Planning & Live Guided Implant Surgery Dr. Tom Balshi, Dr. Glenn Wolfinger, Dr. J. Thaler, Mr. R. Winkelman, Mr. S. Balshi,II, Ft. Washington, PA - $3800 - 215-643-5881.

30- April 1, 2007 - Rome Practical Course: Hands-on Implant Surgery and Restoration - Dr. Mauro Marincola, Rome, Italy - $3500 - Bicon, 800-882-4266.

31 - Sterile Techniques for Implantology Protocol/Documentation for Proper Patient Consent - Vickie McCune an Dr. Duke Heller, Columbus, OH - $525 - Midwest Implant Institute, 614-451-7233.

April 2007

12- 13 - Implant Treatment in the Esthetic Zone - Dr. Michael Sonic, Fairfield, CT - 203-254-2004.

13 - Narrow Body Implants to Retain, Stabilize and Cushion Mandibular Dentures - Dr. Keith Rossein, Chicago, IL - $995 - CED Studies Institutte, 800-323-3136.

13 - Crossfire - An Interactive Treatment Planning Program - Dr. Michael Smilanich, Lake Elmo, MN - $1595 - Institute for Advanced Dental Education, 651-351-9660.

13- 14 - Comprehensive Introduction to Implant Surgery - Dr. Robert Listrom, Mississauga, ON, Canada - $1875 Straumann Canada, 800-363-4024, x3.

13- 14 - How to Perform the Simple Procedures of Implant Placement and Restoration - Dr. Duke Heller, and Vickie McCune, Columbus, OH - $950 - Midwest Implant Institute, 614-451-7233.

13- 16 - Implant Certification Examination - American Board of Oral Implantology/Implant Dentistry, Chicago, IL - 888-604-2264.

16- 18 - Traditional Two-Stage Protocol and One-Stage Teeth-in-a-Day - Dr. Tom Balshi, Dr. Glenn Wolfinger, Dr. J. Thaler, Mr. R. Winkelman, Mrs. A. O'Callahan, Ft. Washington, PA - $2450 - 215-643-5881.

19- 21 - Implant Surgical therapy - A Hands-On Demonstration & Live Patient Course - University of Illinois College of Dentistry, Chicago, IL - 312-573-1260.

19- 21 - Implant Surgical Therapy - A Hands-On Demonstration and Live Patient Course - Various Clinicians Chicago, IL - American College of Prosthodontics, 312-573-1260.

19- 21 - Foundational Implnt Surgery - Dr. Michael Pikos, Palm Harbor, FL - $3650 - MAP Seminars, 727-781-0491.

19- 21 - AAID Western District: Focus on the Sinus - Dr. Phil Boyne, Dr. Ole Jensen, Dr. Craig Misch, Dr. Dennis Smiler, Dr. Hilt Tatus, Jr. and others, Newport Beach, CA $1995 - 949-380-1955.

20 - Achieving Aesthetic Lab Results - Edgar Jiminez, CDT, Lake Elmo, MN - $1195 - Institute for Advanced Dental Education, 651-351-9660.

20- 21 - Implant Mentor Program - Dr. Cliff Starr Atlanta, GA - $1875 - 904-244-7051.

20- 21 - Comprehensive Training in Implant Surgery- Live Surgeries - Dr. J. Piermatti and Dr. M. Rothman, Voorhees, NJ - $3500 - 856-309-8000.

20- 21 - NobelGuide Live Surgery and Computer Training - Dr. B. Young, Ponte Vedra, FL - $2950 - 877-285-9505.

20- 21 - Solutions for Success: ImplantAbility - Dr. Mark Simpson and Dr. Byron Davis, Charleston, WV - $745 304-342-6162.

20- 21 - Basic Implant Surgery Workshop II - Dr. L. Lum, Dr. M. Chen and Dr. J. Wang , Dublin, CA - 800-718-5157.

21 - Endodontic Course - Incorporating Implants in Your Practice - Dr. Russell Kiser and Dr. Duke Heller Columbus, OH - $950 - Midwest Implant Institute, 614-451-7233.