AO 2018 Annual Meeting aims to inspire imagination, enhance health

By Dr. Joseph Kan, 2018 Annual Meeting Program Chair

With a theme of “ Inspiring Imagination – Enhancing Health,” the Academy of Osseointegration’s 33rd Annual Meeting will be a reflection on how dental implant treatment impacts health care, while exploring future treatment concepts and modalities. To be held February 28 – March 3, 2018 at the Los Angeles Convention Center, the meeting’s Pan Pacific international focus will feature top speakers from this region to present with other world-renowned speakers.

The meeting will open on February 28th with Hands-on Workshops to upgrade your surgical and prosthetic skills. Two half-day pre-conference courses will also be held with Dr. Jaime L. Lozada, Loma Linda, CA, who will provide a comprehensive review of head and neck anatomy for implant related surgeries, and Dr. Charles J. Goodacre, Loma Linda, CA, presenting on implant complications and management.

Thursday’s program will kick off with the popular Corporate Forums, highlighting the latest innovations from a collection of the industry’s leading corporations, followed by the E-poster Session in the exhibit hall during lunch.

The Opening Symposium, chaired by AO President Dr. Michael R. Norton, London, England, UK, will include two keynote speakers: Dr. Harold C. Slavkin, Los Angeles, CA, who will discuss personal health care and the future of implant dentistry, while Dr. Stephen T. Chen, Melbourne, Australia, will shed light on socket wound healing concepts. Presentations from Drs. Matteo Chiapasco, Milan, Italy, Markus Hürzeler, Munich, Germany, and Otto Zuhr, Freising, Germany, will conclude the afternoon. AO’s traditional Welcome Reception and e-poster presentations will follow in the exhibit hall Thursday evening.

Friday will begin with ten “Morning with the Masters” sessions to provide attendees the opportunity to interact in a smaller setting with world renowned experts. Friday’s full-day main podium programs will consist of eight newly-formatted concurrent Surgical and Restorative Point – Counter Point sessions to delineate the reality and myths on current controversial topics in implant dentistry. After each panelist presents his or her viewpoint in a short presen-...continued on page 5
I recently returned from Chicago after our October Board meeting when we gather to assess the progress of the Academy as set against our strategic plan and review the program and events planned for our forthcoming Annual Meeting. The current strategic plan is soon to end, running as it does from 2015 – 2018 and I was delighted to report to the board that we have met the vast majority of our strategic goals, indeed exceeding some, while only two goals are yet to be met, but with one year left still to make progress in these areas.

As you might expect, a great deal of time was spent discussing the forthcoming meeting in Los Angeles, and I was able to report on my site visit with our Executive Director, Kevin Smith, and his staff. I must admit I boarded the plane from London with a significant degree of trepidation, worried that I would discover a less than optimal conference hotel and conference venue. I needn't have worried! The moment I arrived at the JW Marriott LA Live, I instantly relaxed as I walked into a modern clean, impressive lobby with lots of glass, high ceilings and plenty of “networking and socializing” space, with bars and a restaurant.

The LA Live area is a “WOW,” much like a miniature Times Square or Piccadilly Circus and literally within a stone’s throw from the hotel, as is the STAPLES Center. Certainly, delegates can expect one of the most convenient experiences, since I have selected the LA Live venue for my President’s Reception, so no buses! We are planning this party to be one with an Oscars theme, and I am sure you will all be excited to learn that our meeting is to be held on the same weekend as the Oscars, so LA will be buzzing and awash with celebrities.

The conference center is ideally situated, being a short walk from the conference hotel and the layout is such that the exhibition hall and main plenary session hall are side by side. The conference center benefits from its glass construction, being airy and bright and delegates will surely appreciate being able to see natural daylight and hopefully lots of sunshine as they walk from one session to another.

That all said, the most important feature of any conference is of course the program. I have been so very lucky that when I asked Dr. Joseph Kan to be my Program Chair, he agreed. Anyone who knows Joe knows what a busy man he is, very much in demand and constantly travelling the world. So it was a big commitment for him to agree to my request, and I am indebted to him. Together with our program committee, we have been able to put together a program that has something for everyone, covering all the specialties and interests to satisfy every delegate.

Our opening session promises to deliver some great lectures from world renowned experts Drs. Harold Slavkin, Stephen Chen, Matteo Chiapasco and the team of Marcus Hürzeler and Otto Zuhr. There will be an enhanced Morning, as well as Lunch with the Masters sessions, providing increased opportunities for delegates to benefit from the smaller, more intimate learning environment that these will afford.

Perhaps the most significant change will be to the regular dual track surgical and restorative sessions; they have been re-structured to allow multiple concurrent point-counterpoint debates. We have done this to help liven up the sessions, but also as a direct response to your feedback year on year where you express frustration at the lack of opportunity to ask questions and engage with speakers. So, these sessions will include a significant length of time dedicated to moderator-directed debate after the lectures, and delegates will be able to field questions to the moderator to further enhance interaction. As we speak, staff are working on an optimized method to allow delegates to send these questions from iPhones, Androids and iPads so that we avoid the embarrassment of you having to approach the microphone in the aisles, as in the old days.

Finally, I am very excited to be “hosting” the Saturday afternoon session, which we have called a “Reflections Panel.” This session will be conducted much like a chat show with Prof. Tomas Albrektsson and Drs. David Cochran, Ole Jensen, Stephen Parel, and Dennis Tarnow as my special guests. Together we will debate controversies in current implant therapy, tapping into their vast wealth of experience with careers...continued on page 5
Los Angeles offers exciting activities for everyone

By Kevin P. Smith, MA, MBA Executive Director

A new report ranks the ten best cities in the United States based on how “Mobile Millennials” (Americans aged 20-36) have traveled in the past year. Based on six factors: place, product, programming, people, prosperity and promotion, Los Angeles was rated number three next to New York City, and Chicago.

It’s not a surprise that the AO Board of Directors selected Los Angeles for its 33rd Annual Meeting. It will be held February 28 – March 3 at the Los Angeles Convention Center in L.A.’s exciting downtown sports and entertainment district. Known as L.A. Live, the district includes the STAPLES Center, Microsoft Theatre, restaurants, night clubs, sports and music venues, a bowling alley, a movie theatre, and the Grammy Museum. This dynamic area caters to people of all ages.

Friday evening, Dr. and Mrs. Michael Norton will host the President’s Reception at Microsoft Square within the L.A. Live area, complimentary to all registered attendees. The event promises to be one of the most festive social gatherings AO has ever assembled. Bringing a bit of Dr. Norton’s English spirit to LA, “Britishmania”, one of the nation’s most popular Beatles tribute bands, will be taking center stage with their exciting act. Here’s a fact you probably didn’t know: all of the Beatles, with the exception of John Lennon, performed at the LA Convention Center. The night will be filled with many surprises, as we convene our meeting during the weekend of the Academy Awards for best movies and performances.

Hollywood celebrities won’t be far away in LA, but you can stroll the Hollywood Walk of Fame, where more than 2,400 figures from the entertainment world are immortalized in pink terrazzo with symbolic gold lettering. You can also look out for the famous hand and footprints at the Chinese Theatre.

Shop like Julia Roberts on Rodeo Drive or you can just window-shop along the $200-million ersatz European cobbled walkway, with Anderson Court, the only shopping mall designed by Frank Lloyd Wright nearby.

For astronomy buffs, the Griffith Observatory offers its popular Hall of the Sky and Hall of the Eye, a pair of complementary displays that explore the connections between people and space. The star attraction is the building itself, where the famous dancing scene from the movie “La La Land” was filmed, along with many other notable movies.

A short drive from downtown is the Getty Center, conceived as a home for the J. Paul Getty Trust, the world’s wealthiest art institution. Architect Richard Meier was hired to build the museum in 1984, but it took 13 years and $1 billion to complete. The center includes an electric tram ride up the hill from the parking lot, a café, a restaurant and the circular Research Institute, which houses one of the world’s largest art and architecture libraries, and a roster of public exhibits.

Plan a trip to Universal Studios where you can explore the mysteries of Hogwarts™ Castle at the Wizarding World of Harry Potter and go behind the scenes by taking the world-famous studio tours for a closer look where movies are made. For the more venturesome, don’t miss the King Kong 360-3D experience or the fun adventure ride with America’s favorite animated family, The Simpsons.

If you missed the AO Annual Meeting in Orlando last year, you can always make up the Walt Disney experience at Disneyland, spread over seven lands and the adjacent Disney California Adventure, by going to the original Disneyland in Anaheim, CA, where the same attractions are awaiting your experience.

If attending theme parks, touring movie sets and exploring Hollywood celebrity venues aren’t your thing, the Nokia Center is just outside the back door of the JW Marriott Hotel, AO’s headquarters hotel, where an array of professional hockey and basketball games are scheduled throughout AO’s annual meeting week.

STAPLES Center’s Schedule of Events during the AO Meeting includes:

**Basketball**
- Wednesday, February 28th Clippers vs Houston Rockets 7:30 pm
- Friday, March 2nd Clippers vs New York Nicks 7:30 pm
- Sunday, March 4th Clippers vs Brooklyn Nets 6:00 pm
- Monday, March 5th LA Lakers vs Portland Trail Blazers 7:30 pm

**Hockey**
- Monday, February 26th LA Kings vs Las Vegas Golden Nights 7:30 pm
- Thursday, March 1st LA Kings vs Columbus Blue Jackets 7:30 pm
- Saturday, March 3rd LA Kings vs Chicago Blackhawks 1:00 pm

There’s something for everyone in LA this year, so take advantage of your time while away from the office and enjoy the Los Angeles experience.
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AO builds FDI partnership

This fall, AO continued building on its partnership as an Affiliate Member with the FDI World Dental Federation through its inaugural regional engagement in the FDI Global Continuing Education Program (FDI GCEP) in September at the FDI GCEP meeting in Shanghai, China.

AO member and prosthodontist Dr. Brian Fitzpatrick, Brisbane, Australia, was a key presenter. In addition, AO hosted its fifth annual symposium within the 2017 FDI World Dental Congress in August in Madrid, Spain, just prior to the Spain Charter Chapter meeting. The symposium was organized and moderated by Dr. James C. Taylor, AO President-elect, Ottawa, Ontario, Canada, and AO Ambassador to the FDI, with the assistance of AO Board Member Dr. Joerg Neugebauer, Reichling, Germany.

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AO anticipates outstanding Annual Meeting...
Who are we?

By Dr. Paul A. Fugazzotto, Academy News Editorial Consultant

When introducing the Model T, Henry Ford was asked what colors the vehicle would come in. He famously replied, “Black, and black”. If one wished to avail himself (it was inconceivable that a woman would drive!) of this technology, he would buy what was available and not complain. One type of vehicle would have to meet all needs.

Clinicians (including women, of course) wishing to treat their patients with osseointegrating implants in the early 1980s faced a similar dilemma. Implant materials and designs, as well as restorative components, were essentially “one size fits all.”

Much like the automobile industry, the field of implant therapies has changed rapidly. The triad of conceptual evolution, material development, and technical advancement has made implantology an integral, and in truth, indispensable part of comprehensive patient care.

As automobile use became more widespread and technological advances resulted in faster, more powerful vehicles, mishaps became more commonplace, even in such bastions of cautious driving as Boston. The result was the development of the industry of auto repair and acceptance of the fact that one’s automobile would not last the driver’s lifetime.

Unfortunately, a similar mindset is gaining ground in dentistry in general, and implantology, in particular.

The all too often reckless placement of implants in clinical practice has led to an increase in implant complications and failures. Programs at scientific meetings include an ever-increasing number of presentations discussing “treatment of peri-implantitis,” “saving the failing implant,” “establishing healthy hard and soft tissues around compromised implants,” etc. Our refereed journals abound with articles documenting implant failures, and techniques for “salvaging” compromised implants.

We cannot even agree upon an appropriate definition of implant success, forcing us to speak of “implant survival.” Discussion of treatment outcomes in terms of implant survival is an actuarial exercise fraught with danger, and is a disservice to all but our most elderly patients. Cited publications speak of an implant survival rate of 92-95 percent. Equating survival with success, which is generous to the extreme, even a 95 percent success rate would be unacceptable in today’s clinical practice. If you have a reasonable size clinical practice, and place 1,000 implants per year, you would be faced with 50 failures. Unacceptable!

Would Drs. Danny Buser, Urs Belser, Burt Langer, Michael Norton, Anthony Dickinson or Dean Morton (to name a few of our “elder guard”), or Stephen Chen, Will Martin, Laureen Langer, Clark Stanford or Ed Lorenzana (to cite a few “youngsters”) accept such treatment outcomes? Of course not.

Esteemed speakers caution we need to expect to replace implants multiple times during a patient’s lifetime, depending upon the age of the patient when treatment is initially performed.

This fatalistic approach has infected our field like a cancer, and is threatening to metastasize.

While speaking at a corporate gathering a few years ago, I stated that, following appropriate diagnosis, insightful diagnosis, interdisciplinary treatment planning, performance of comprehensive care with the highest quality materials and appropriate long-term follow-up, implant failure after 10 years in function should be less than 1 percent. I was met with silence. I turned to Dean Morton and asked if he agreed. The response: absolutely!

When I repeat this claim at consensus conferences or in small groups, I uniformly encounter incredulity at best and disbelief at worst. I am told that such claims are unrealistic, and not what clinicians are experiencing.

The fault is ours as the treating clinicians. As technological advances have resulted in narrower implants of sufficient strength to stand alone following restoration, as newer, cheaper, “just as good” implants and regenerative materials flood the market, we are reared with unfounded claims of success. One or two year results are quoted; follow-up and true documentation are nonexistent; and our patients suffer.

Fortunately, as educators and clinicians, who can call upon committed corporate partners dedicated to research and responsible product development, we are uniquely suited to meet this challenge.

We must:

• Continue to stress the need for appropriate diagnosis and comprehensive care at all levels of therapeutic complexity;
• Provide appropriate education in both the fundamentals and advanced therapies;
• Present unbiased assessments of materials and treatment modalities; and
  – continue to penetrate dental schools to help train future dentists; dental societies to assist developing dentists; and refereed journals to inform all dentists;
  – continue to test and challenge the efficacy of all technological advances;
  – formulate clinically based treatment protocols for integration of newer materials and therapies into everyday treatment armamentaria;
  – develop a realistic definition of success.

In the absence of a more comprehensive definition of biologic (not esthetic) implant success, I use the following cri-
The 5 things I cannot do without in my implant practice

By Clark M. Stanford, DDS, PhD

This article is part of a continuing series in which Academy News asks distinguished implant practitioners to discuss 5 things they cannot do without in implant practice.

1 Communication. Fluid and open communication between the staff, the referrals and especially our patients is vital to understanding the risks and benefits of implant care. *Implant therapy is a replacement for no teeth, not a replacement for teeth.* We cannot lose sight of this. As such, a consistent communication of the risks and benefits of tooth replacement therapy by the entire team in my office, clinic or university is vital to our success. Consistency means we must have a constant dialog with all staff, students or faculty coming in contact with each patient. One breakdown potentially ruins the system. Yet, one message, one connecting communication, one consistent message from your team, solves many issues.

2 Patient Care Coordinator. This person guides workflow and assures a uniform and smooth patient experience. Patients arrive at our clinics, confused and concerned. Our clinics are foreign and induce anxiety, no matter what we try with wall colors, TVs or couches. Yet, a warm and friendly face is a great salve to anxiety. A great patient care coordinator embraces our patients as family, enables them to feel what the practice wants to achieve; a focused outcome to resolve his or her concerns, allowing patients to continue on their life’s journey. They also assure communication throughout the patient’s encounter, and retain a communication circle with third parties and our referral colleagues.

3 Organization. Given the complexities of implant care, knowing the procedures specific to an implant system and having a standardized inventory and workflow is essential. The most frustrating aspect is opening a tray and having things unorganized while in a surgical and prosthetic field. The only unorganized thing should be the challenges the patient presents, not the systems used to provide care. Complications should be handled in a smooth and seamless manner, with the appearance of “normality” (okay, the blood pressure goes up a few notches…).

4 Colleagues. Many people have made mistakes before me, who are now my mentors. They guide me through everyday challenges. Engaging a wide range of providers occurs all the time. Talking with and learning from the challenges of others allows our team to understand the “pain points” in our systems and allows the entire team and our networked colleagues to learn from each other. System learning is the name of the game.

5 Manufacturers. People who care about high quality products and devices and assured care through well documented implant systems and devices. Great manufacturers are key partners to successful treatment of our patients. A challenge in today’s world is opening a package we have spent a large sum to obtain, and we having strong assurance that the medical device we are laying our professional reputation on will perform in a manner consistent with our brand and the ethical framework we base our practice on in implant dentistry. This only occurs with clear, open and honest communication through peer-reviewed science and communication of the implant system’s performance.

In the end, we can do many things in implant practice, but we can do nothing without our patients. This is a human trade, a trade in reputation, respect and ongoing diligence to assure the best in patient care. We can only do this with Communication, Coordination, Organization, Colleagues and Manufacturers as partners in our quest for the very best. As I heard recently from a great colleague, we strive for perfection and we settle for excellence. This only occurs with the team we frame around us.

Currently AO’s Treasurer, Dr. Clark Stanford is UIC Distinguished Professor and Dean, University of Illinois at Chicago.

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teria, both in clinical practice and when compiling statistics for publication:

- The criteria of Albrektsson, et al;
- All implants are bone sounded buccally and palatally/lingually;
- Every measurement is taken by me or my coauthors.

As our profession becomes intoxicated with new treatment options, simplification of therapy, and greater financial reward, we must not lose sight of the basic tenets of successful clinical practice: treating patient needs, while fulfilling patient desires, in as predictable a manner as possible.

To those who say such a goal is nothing more than a chimera, I repeat the words of my mentor, Dr. Gerald Kramer:

**Our definition of success is limited by our perception of possibilities.**

**Who are we?**
Dental implantology has become one of the most widely accepted methods of tooth replacement for hopeless and missing natural teeth. Although the literature has shown that this option for tooth replacement is highly predictable, with high survival rates¹, complications do occur. One of the more serious complications that can occur is alteration of sensation after implants are placed in the posterior mandible. Altered sensation occurs as a result of injury to the inferior alveolar (IAN) or lingual nerves due to a variety of factors, such as trauma from local anesthetic injections, implant osteotomies, and/or impingement of the dental implant into the IAN space. Prevalence of these complications has been reported to be as high as 13%².

Depending on the extent of injury to the nerve bundle, altered sensation can vary from mild, transient, dysesthesia, to complete anesthesia of the affected area. Because of the clinical and legal implications of paresthesia induced by implant therapy, many safeguards have been created in order to preclude nerve injury. Stop drills, surgical guides, cone beam computer tomography (CBCT) tracing, guided satellite imaging, and changing anesthetic technique have all been advocated as methods to avoid trauma to the IAN³. This article will discuss the rationale, efficacy, and practicality of using mandibular infiltration as an alternative to block anesthesia prior to posterior implant placement.

Three major postoperative issues can occur when using block anesthesia prior to placing implants in the posterior mandible. Toxicity of the local anesthetic solution can occur, if injected mistakenly into the artery. Because soft tissues remain anesthetized longer compared with mandibular infiltration, patients undergoing block anesthesia can have self-inflicted, macerating wounds to the tongue and lip. Lastly, injury to the mental nerve and IAN can physically occur by encroachment of the osteotomy drills and/or dental implant during placement⁴.

Although there is no consensus, the idea has been proposed in the literature that by substituting mandibular infiltration anesthetic for block administration, the patient will still have enough sensation to determine when the implant armamentarium is close to the nerve and therefore able to give feedback to help prevent nerve damage. In a 2001 retrospective analysis⁵, Heller et al looked at 8,000 implant cases placed in the posterior mandible over a 32-year period in private practice. They used 1 carpule (1.8ml) of 2% lidocaine deposited into the lingual tissues and 1 carpule deposited into the buccal tissues prior to implant therapy. They used standardized periapical radiographs to determine the location of the IAN canal and mental nerve.

Their results showed that of 8,000 implants placed under mandibular infiltration, only 3 patients experienced permanent paresthesia. The affected areas were 15x15mm in diameter on the lower lip, and all three patients reported feeling a pin prick on the buccal surfaces. Heller claimed that “none of the three patients feel the anesthetized area is objectionable nor does the loss of sensation alter their routine of daily living.” In addition, Heller reported that 85-100 patients had transient paresthesia lasting 3-6 months, which typically dissipated 3-4 weeks after surgery. Heller concluded that mandibular infiltration was a safe and effective way to place dental implants that still allows the patient to have enough sensation to alert the surgeon when the implants were in close proximity to the nerve bundle. He suggested that mandibular infiltration replace block anesthesia when placing implants in the posterior mandible.

In a similar study in 2011⁶, Etoz et al placed 52 implants in the posterior mandible (posterior to the mental nerve) of 29 patients using 2 carpules of articaine to anesthetize the buccal and lingual tissues. Only 2 patients required additional nerve block anesthesia due to pain during implant placement. Both patients had implants placed in the second mandibular molar sites. Once again, the location of the IAN canal was determined by standardized periapical radiographs and none of the patients in the study experienced paresthesia. An important point to note from these studies, as well as other, older studies where mandibular infiltration was used when placing posterior mandibular implants, is the use of periapical radiography instead of CBCT as a means of IAN identification. In the time since the Heller and Etoz studies were published, radiographic technology has improved greatly. From CBCTs, we now know variations exist in the path taken by the IAN. Improved three-dimensional imaging has shown variations in the anterior loop can occur between 7-88% of the time, with a mean prevalence of 28%⁷. In addition, up to 40% of the main IAN canal can have accessory branches. If these branches are large enough, they can form two (bifid) or even three (trifid) canals⁸. These anatomic variations are often difficult to discern on standard two dimensional radiographs.

Many clinicians argue that in the era where CBCT should be used as a ‘standard of care’ method to detect the IAN canal, block anesthesia is the best option when placing implants in the posterior mandible. From a patient management perspective, having a totally pain-free implant experience, while not having to stop the procedure to further anesthetize, is desirable for both patient and clinician. Block anesthesia, many would argue, is a more predictable technique for achieving that goal as compared with mandibular infiltration.

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AO Board Member Joseph Fiorellini elected Chair of ADA CEPR Commission

The CCEPR is charged with authority to formulate and adopt requirements, guidelines, and procedures for the recognition of continuing dental education providers, and to approve providers that meet rigorous standards for quality. With its core values of: Improvement of Oral Health, Excellence, Integrity, Science/Evidence–Based, and Life-long learning, CCEPR serves to promote excellence in continuing dental education to support professional competence and continuous improvement of patient care.

“As Chair, I look forward to maintaining the ‘gold standard’ of high quality continuing education, so that providers have the best education for dentists in the field,” said Dr. Fiorellini, entering his fourth year on the Commission.

Established by the ADA in 2014, CCEPR oversees the ADA Continuing Education Recognition Program (CERP). Through the ADA CERP National Recognition Program or the Extended Approval Process, approximately 500 providers of continuing dental education, including AO, have been approved. Annually, CERP recognized providers offer a combined total of more than 28,000 unique continuing dental education activities.

As an ADA CERP recognized provider, AO generally offers more than 30 hours of ADA CERP credit to registered Annual Meeting attendees, and has awarded more than 300 hours of CE credit to over 150 participants of its comprehensive webinar program since January 2016. AO’s E-Learning Center Video Library currently has over 78 archived video presentations from webinars and previous AO Annual Meetings, complementary to members only. CE credit is available for 90 days once a video is posted. Following the 90-day period, the video is then placed into the video library, where it is still accessible to members but not available for credit.

To block or not to block... from page 8

According to Dr. Geoffrey Bauman, a periodontist in private practice, who relies on CBCT as an accurate method of detecting the IAN:

“I’ve been doing implants for 27 years. The first six of those I blocked the IAN for mandibular implants in the posterior. Then I took an externship in which we were taught to just take care of the long buccal and lingual and that provides a “back up safety margin” by leaving the IAN sensate. If you’re bumping up against the IAN, the patient will feel it. I have the utmost respect for my externship trainers and did that for a while. But occasionally, I would get shock-like sensitivity and be 2-4 mm away from the IAN based on radiographic findings. Of course, when that happens, then I have a decision to make: do I place the implant at that depth if possible, abort, or ignore and press on. After a couple of years, I just went back to blocking the IAN because when I didn’t and the patient felt me working I started just blocking the IAN and proceeding. When I just blocked the IAN ahead of time it was never a problem. I’ve never, in 27 years had any IAN pathosis afterwards. Every once in a while, I decide to “play it safe.” But it is so frustrating to get in the middle of the procedure and have to advise the patient and then either abort or block and press on.

A second important point to note is that many studies show that infiltration with 4% articaine is equivalent to 2% lidocaine10. Because of this equivalency, clinicians should be careful not to have a false sense of security when infiltrating the posterior mandible with articaine for implant placement, because it may be similar to blocking the area with lidocaine.

In conclusion, many studies that advocated the use of mandibular infiltration instead of block anesthesia for the purposes of posterior implant placement did not utilize CBCT for nerve detection. In addition, studies suggest that, despite being 3-6mm away from the IAN canal (as determined by periapical radiography), patients are still able to feel sensation following mandibular infiltration and require subsequent nerve block. This scenario is especially true in the mandibular second molar region. Although periapical radiographs and mandibular infiltration may have been an historical method of nerve trauma prevention, modern technology allows us to be much more accurate. Because CBCT radiographs are easy to obtain, any question about the location of the IAN or mental nerves can now be easily answered.

References


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AO Charter Chapter program reaches Asia and Europe

During September and October, the Academy of Osseointegration’s global outreach footprint made its first strides with the Chinese dental community, held its third meeting in Spain, partnered with the Italian Academy of Osseointegration (IAO), and saw a sellout crowd in the United Kingdom.

AO’s China Outreach Symposium on September 23 was in conjunction with the China Stomatological Association’s (CSA) 19th Annual Meeting and in partnership with the BYBO Dental Group, a leading national dental group in China. The schedule of impressive international speakers at the Symposium included AO member speakers Drs. Brian J. Fitzpatrick, Brisbane, Australia, David L. Guichet, Orange, CA, James Kwok Fai Chow, Hong Kong, Christopher Ho, Chatswood, Australia, Lambert J. Stumpel, San Francisco, CA, and Hom-Lay Wang, Ann Arbor, MI.

The symposium in China was significant as China represents the most important pillar of its global outreach strategic plan, according to AO President Dr. Michael R. Norton, London, England, UK.

“To have a symposium within the CSA annual congress is critical to our acceptance within the Chinese dental community. From this beginning, we hope to see a growing awareness of the AO with an increasing presence in China,” says Dr. Norton.

As a sign of that acceptance, more than 30 Chinese dentists submitted their applications for membership in the Academy.

In Madrid, more than 150 dentists attended the third meeting of AO’s Spain Charter Chapter, a very successful endeavor thanks to the efforts of AO Ambassador Dr. Fernando Rojas-Vizcaya, an oral surgeon and prosthodontist from Castellon, Spain. He was joined on the program by AO member speakers Drs. Rui Figueiredo, Barcelona, Spain, Pablo Galindo-Moreno, Granada, Spain, Patrick Palacci, Marseille, France, Franck Renouard, Paris, France, and Joan Pi Urgell, Barcelona, Spain. The scientific meeting was under the heading of “Reconstructing Biology or Replacing for Prosthesis.”

“AO’s Charter Chapter meeting was a very enriching experience. It offered a high-class scientific debate with a diversity of opinion. We seldom have the chance to join forces with first-rate researchers and sincerely appreciate AO launching and bringing this conference to other countries,” said Dr. Rojas-Vizcaya.

In October, the 1st International Congress of the Italian Academy of Osseointegration (IAO) kicked off with an anticipated 1,400 dental colleagues attending in Milan. AO’s Italian Charter Chapter was there for the final day on October 21, with a half-day program, “Complications in Modern Osseointegrated Implant Dentistry: Prevention, Management and Treatment.” The event, organized by Dr. Ruggero Rodriguez y Baena, Pavia, Italy, featured renowned presenters Drs. Tiziano T. Testori, Como, Italy, Pascal Valentini, Paris, France, and Tomaso Vercellotti, Genova, Italy.

Last but certainly not least, AO’s UK Charter Chapter brought an international slate of member speakers and a sellout crowd to the Royal Society of Medicine in London October 26 – 27, with a program theme of “Contemporary Implant Dentistry: Traditional Concepts and Sound Science Interfacing with the Digital Age leading to Comprehensive Patient Care.”

According to Dr. Norton, an oral surgeon with a practice in central London, topics of the meeting centered around the goal of discussing traditional concepts and sound science interfacing with the digital age leading to comprehensive patient care as part of the packed two-day schedule. The event was moderated by AO Ambassador to the UK, and chairman of the AO Global Program Committee, Dr. Stephen L. Jacobs, a general dental practitioner from Glasgow, Scotland.

An impressive lineup of 15 presenters included Drs. Norton, Adrian Binney, Cardiff, Wales, UK, Chris Butterworth, Liverpool, England, UK, Steve Campbell, Jameel Gardee, Kevin A. Lockhead, Edinburgh, Scotland, Jimmy Makiidissi, Jonathan Schofield, and David Winkler from the UK; Drs. Koichiro Kawasaki, Kiyotaka Umezu, Tokyo, and Yuichiro Yoshiiki from Japan; and Drs. Philippe Khayat, Franck Renouard, and Pascal Valenti, all from Paris, France.

To block or not to block…from page 9


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Member News

AAP honors AO’s Drs. David Cochran, Hom-Lay Wang

The American Academy of Periodontology (AAP) has honored two AO leaders with three awards.

AO Past President Dr. David L. Cochran, San Antonio, TX, received AAP’s 2017 Gold Medal Award, the highest honor conferred by the organization, for outstanding contributions to AAP through service (he is an AAP past president) and an understanding of the study, diagnosis, and treatment of periodontal diseases. The award citation commended Dr. Cochran, professor and chair of the Department of Periodontics at the University of Texas Health Science Center, for his “illustrious career in research, which includes work in the areas of morphogenetic proteins, osseous regeneration, and using evidence-based treatment modalities to create a deeper understanding of peri-implantitis.”

AO Director Dr. Hom-Lay Wang, Ann Arbor, MI, is the recipient of AAP’s 2017 Outstanding Periodontal Educator Award and its 2017 Distinguished Scientist Award. “With over 25,000 citations to his work, Dr. Wang has proven himself as a veritable authority in the specialty,” the award says. More than 30 scientific publications have invited Dr. Wang to serve on their editorial boards. Dr. Wang, endowed collegiate professor of periodontology and director of the graduate periodontal program at the University of Michigan School of Dentistry, has trained more than 85 graduate students, with many of them entering private practice or becoming educators themselves. “Dr. Wang exudes passion and excitement for periodontics, encouraging his students to appreciate, master, and contribute to the field,” one former student says.

Congratulations, Drs. Cochran and Wang!

Editor’s Email Box

Wholeheartedly agree with editorial viewpoint

Just wanted to drop you a note to tell you I wholeheartedly agree with the article you wrote in the most recent AO Academy News (“Why I do not and will not place dental implants,” Volume 28, Number 3, 2017).

I really don’t understand why the American College of Prosthodontists has made such a push to have all prosthodontists trained to also place their implants. This push has been happening for some years now, all while conferences after conference features “team” approaches to multidisciplinary, comprehensive treatment. This seems so hypocritical to me.

– Vincent Celenza, DMD, Prosthodontist, New York, NY

How AO got S.M.A.R.T. first...from page 14

HKM: Do participants in the course operate on models?

Dr. Lee: Yes, and every effort has been made to simulate clinical situations as closely as possible. CT scans were taken and models created to give participants a realistic experience. We even tested models with and without periosteum. Mimicking the handling characteristics of gingival tissue posed the biggest challenge. We continue to test new silicone formulations to further refine our soft tissue models.

HKM: It is no surprise that you are being very meticulous and careful in promoting S.M.A.R.T. Can you share any final thoughts on the technique?

Dr. Lee: My clinical experience with S.M.A.R.T. has been very rewarding. It has been a game changer. In my mind, the procedure has the potential to impact the future of implant dentistry/GBR pretty much in the same way angioloplasties and stents changed the field of open-heart surgery.

HKM: Thank you for sharing your thoughts with AO membership. We look forward to further updates.

In interviewing Dr. Lee, his passion for S.M.A.R.T. and its impact on implant dentistry was evident. During the course of our conversation, it became clear he was not seeking personal accolades. Instead, he showed great humility in emphasizing the procedure’s benefits for patients.

Having taken continuing education courses for decades, I’ve found that individuals on the lecture circuit are motivated by ego, money or a sincere desire to teach and share their knowledge with the profession. Dr. Lee falls into the last category. He is a credit to us all. How fortunate he considers AO a premier implant organization with which to share his expertise.

The Editor’s Editorial is intended to contribute to the dialogue on issues important to implant dentists. The views expressed in the editorial do not necessarily reflect the policy of the Academy of Osseointegration or its Board of Directors. Readers who would like to comment or express a point of view on the editorial are invited to write to the editor via email at bkmcgavran@me.com. We will endeavor to publish pertinent comments or views when space permits.
How AO got S.M.A.R.T. first

By Harriet K. McGraw, DDS

One thing that stands out in Dr. Ernesto Lee’s presentations is his meticulous attention to detail. From the beautifully photographed images, to the evidence-based content, there is a consistently high quality to every aspect of the presentation. His lectures are learning experiences showing the planning, management, and treatment of complex cases, accomplished by blending the artistry and science of dentistry.

At the 2017 AO meeting in Orlando this past March, Dr. Lee formally introduced S.M.A.R.T. (Subperiosteal Minimally invasive Aesthetic Ridge augmentation Technique). It is a groundbreaking procedure, which piqued a great deal of interest. Dr. Lee graciously agreed to be interviewed by Academy News on the particulars of the procedure.

HKM: Dr. Lee, what was the genesis of the S.M.A.R.T. technique?

Dr. Lee: I have dedicated most of my career to treating complex cases, and was lucky enough to develop the S.M.A.R.T. approach to solve challenging clinical issues in the esthetic zone. One of the early cases was a young man who had a hopeless central incisor adjacent to an implant-supported crown. To complicate matters further, he had a very high smile line and CBCT imaging revealed an absence of facial bone. Rather than subjecting the patient to the traditional staged grafting approach and risk ending up with soft tissue defects and missing papillae, I elected to graft the site using a laparoscopic tunneling technique. From the work of Michael Block, Camelo, Marc Nevins, Massimo Simion, and others, I knew this was a possibility. Not opening a flap was very advantageous. Healing was improved and it allowed me to preserve the gingival architecture. Treatment moved faster and patients were happy. The results from these early cases were very positive, encouraging further development of the technique and its use in other applications.

HKM: Where and by whom were the surgeries you presented performed?

Dr. Lee: I performed all the surgeries presented at AO in my private practice.

HKM: Can you give another example of situations that would benefit from the technique?

Dr. Lee: The technique is especially advantageous for horizontal augmentation of narrow or knife-edge edentulous ridges. Currently, site development techniques for those areas involve block grafting or GBR. Compare a S.M.A.R.T. bone graft, which requires no tenting screws or membranes and can be completed in 45 minutes, with minimal discomfort and reduced morbidity versus the more invasive block grafting/GBR procedures. Another application with tremendous potential is bone grafting over implants with exposed threads, resulting from loss of the buccal plate.

HKM: As far as biotype, is there a threshold where you won’t use S.M.A.R.T.?

Dr. Lee: Yes, a minimum tissue thickness of 2mm is required, and my preference is to have keratinized gingiva. If the tissue is thinner than 2mm, I will place a soft tissue graft prior to augmenting the bone using the S.M.A.R.T. approach.

HKM: Is there special instrumentation required to perform the technique?

Dr. Lee: While developing S.M.A.R.T., I found that existing instruments were inadequate and actually limited the potential of the technique. New instruments had to be developed. Over 100 prototypes were tested prior to arriving at the current designs.

HKM: At the time of the S.M.A.R.T. publication (IJPRD March, 2017), 21 patients and 60 sites had been treated. How many sites have been treated to date? Will you be publishing or presenting current data anytime soon?

Dr. Lee: To date, I have treated over 100 sites. I am waiting to get more follow-up on specific applications – horizontal and vertical augmentations and coverage of exposed implant threads—prior to publishing the data. At this point, some of the colleagues I have trained have also started compiling their cases, and we may publish some of this work collectively.

HKM: Have you encountered any complications?

Dr. Lee: So far, there have been very few. You could have graft exposure or migration, but these are usually related to technique issues.

HKM: I understand an application has been made to patent the procedure. Why patent a procedure?

Dr. Lee: S.M.A.R.T. is a technique sensitive procedure. It offers the potential to help many of our patients and change the way we do GBR. But this will only happen if it is developed in a safe and ethical manner. A patent has been applied for to ensure that the proper training protocol is followed.

HKM: Are you teaching the technique at this time?

Dr. Lee: Currently, the technique is being taught at our education center adjacent to my practice in Bryn Mawr, PA. As mentioned previously, S.M.A.R.T. is very technique sensitive. For that reason, the course is only open to clinicians with documented surgical expertise. I want the technique done with proper training to make sure patients are protected. Education is also particularly important at this early stage, because we want to develop S.M.A.R.T.’s full potential as a minimally invasive treatment alternative. In fact, instruments are not available to anyone who has not taken the course.

…continued on page 13
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