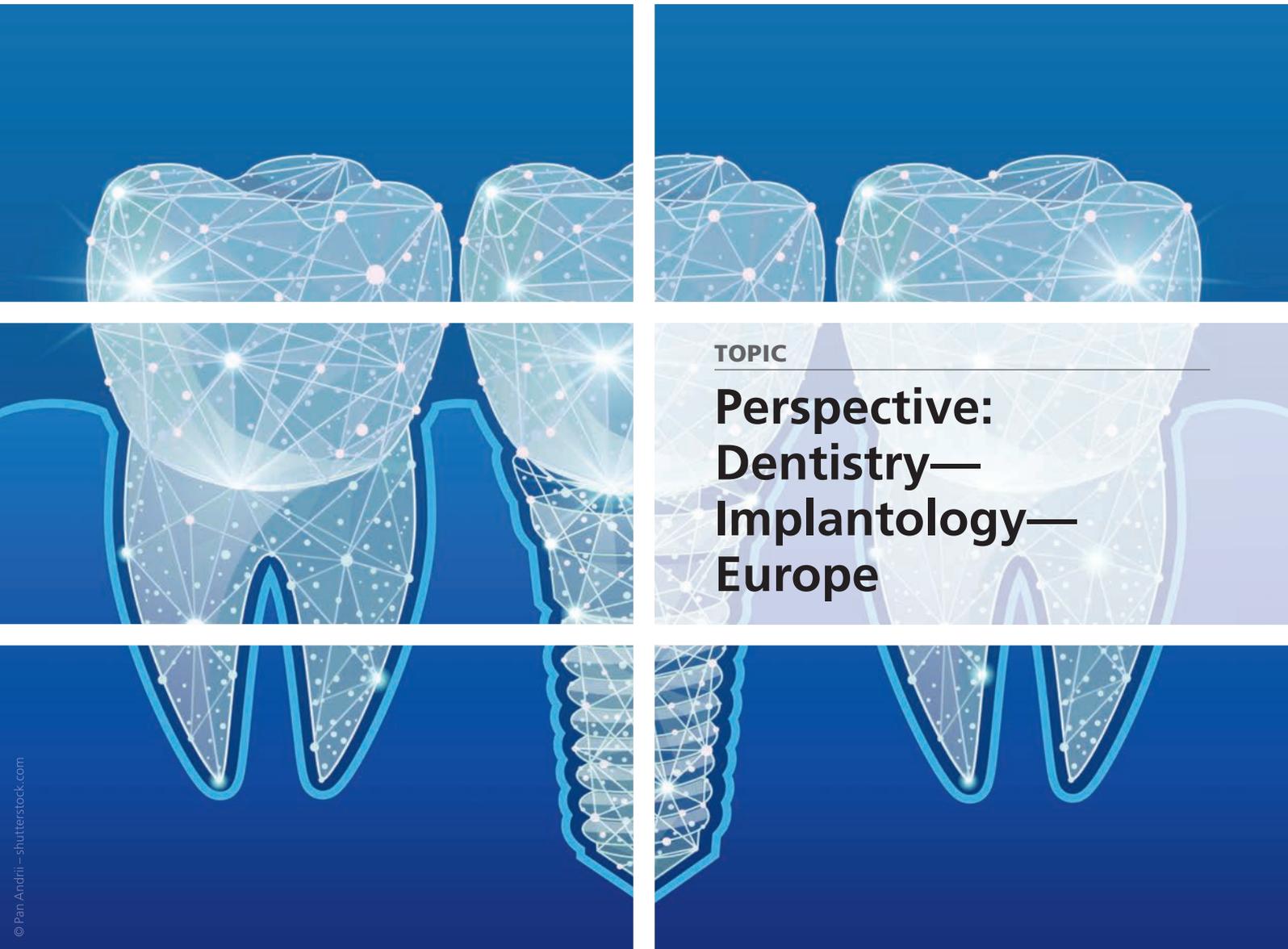


EDI Journal

European Journal for Dental Implantologists



TOPIC

Perspective: Dentistry— Implantology— Europe

»EDI News: European dentistry at a glimpse · Partnership of BDIZ EDI and OEMUS MEDIA AG · Solidarity with people in Ukraine »European Law: ECJ on tie-in transactions with prescriptions »Case Studies: Minimally invasive implant placement with internal sinus floor elevation · Graft volumetric changes of collagenated xenograft · Partial extraction therapy and implant treatment · The modified coronally or laterally displaced tunnel for the treatment of singular and multiple recessions in the maxilla



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Solidarity

Dear reader,

We are living in precarious times. COVID-19, which has held the world in thrall since February 2020, is caused by a non-sentient virus. But the current war in Ukraine is human-induced, and it is close to laying waste to an entire country, just a few hours away from us by air.

Unabated and undeterred, Vladimir Putin and his war machine are pressing ahead to subjugate Ukraine—mercilessly and seemingly unimpressed by the horror with which he is perceived outside Russia.

“Day after day, the suffering inflicted by the invading Russian army on its cousins in Ukraine is growing”, as the German broadsheet *Frankfurter Allgemeine* put it. The more people are killed, lose their beloved ones, lose their homes, lose their livelihoods, have to flee, the further Russia is departing from this historically and ethnically close relationship, from the perceived commonality of the Soviet era. And Russia is increasingly isolating itself from the rest of the world.

There are no winners in war, only losers.

What can Putin gain by invading and subjugating Ukraine? Even his own people are paying a high price in blood. And Russia will be isolated—politically, economically, socially and culturally.

We, the rest of Europe, will also be among the losers. The Russian artillery’s shelling of the Zaporizhzhya nuclear power plant has spread fear and terror within and beyond the borders

of Ukraine. The fallout of the 1986 Chernobyl disaster has not been forgotten. How far will this egomaniacal president go to assert his power? Russia itself will also be affected by the consequences of a nuclear attack—as will the entire continent.

A prolonged period of peace in Europe is now over. Our continent is trembling with the repercussions of belligerence. We at BDIZ EDI and our partner associations declare our solidarity with the people in Ukraine—just like many other European organizations do. You will find our official statement in this issue.

There are several ways you can help: You can donate money directly. Or you can have urgently needed supplies—especially medical supplies—delivered via aid transports. We at BDIZ EDI are also active. Dr Markus Tröltzsch, Member of BDIZ EDI Board, organizes humanitarian transports to Ukraine.

BDIZ EDI also, and specifically, supports the Relief Organization of German Dentists (*Hilfswerk Deutscher Zahnärzte, HDZ*). You can find out more at www.stiftung-hdz.de.

Thank you very much for your attention and for any assistance you can provide.

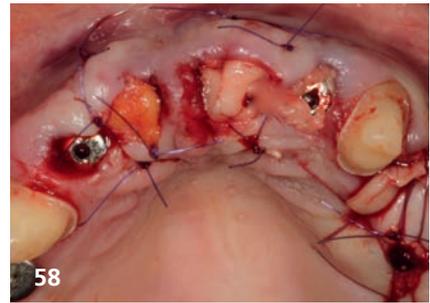
Anita Wuttke
Editor-in-chief



The European view of the situation of dentistry



Jörg Neugebauer – new vice president of AO



Clinical situation after completion of first-state-surgery

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Partner Organizations of BDIZ EDI



Association of Dental Implantology UK (ADI UK)

ADI UK, founded in 1987, is a registered charity committed to improving the standards of implant dentistry by providing continuing education and ensuring scientific research. It is a membership-focused organization dedicated to providing the dental profession with continuing education, and the public with a greater understanding of the benefits of dental implant treatment. Membership of the ADI is open to the whole dental team and industry, and offers a wealth of benefits, education and support for anyone wishing to start out or develop further in the field of dental implantology.



Ogólnopolskie Stowarzyszenie Implantologii Stomatologicznej (OSIS EDI)

OSIS EDI, founded in 1992, is a university-based organization of Polish scientific implantological associations that joined forces to form OSIS. The mission of OSIS EDI is to increase implant patients' comfort and quality of life by promoting the state-of-the-art and high standards of treatment among dental professionals. OSIS EDI offers a postgraduate education in dental implantology leading to receiving a Certificate of Skills (Certyfikat Umiejętności OSIS), which over 130 dental implantologists have already been awarded.



Sociedad Española de Implantes (SEI)

SEI is the oldest society for oral implantology in Europe. The pioneer work started in 1959 with great expectations. The concept of the founding fathers had been a bold one at the time, although a preliminary form of implantology had existed both in Spain and Italy for some time. Today, what was started by those visionaries has become a centrepiece of dentistry in Spain. SEI is the society of reference for all those who practice implantology in Spain and has been throughout the 50 years, during which the practice has been promoted and defended whereas many other societies had jumped on the bandwagon. In 2009 SEI celebrated its 50th anniversary and the board is still emphasizing the importance of cooperating with other recognized and renowned professional societies and associations throughout Europe.



Sociedade Portuguesa de Cirurgia Oral (SPCO)

The SPCO's first international activity was the foundation—together with their counterparts in France, Italy, Spain and Germany—of the European Federation of Oral Surgery (EFOOS) in 1999. The Sociedade Portuguesa de Cirurgia Oral's primary objective is the promotion of medical knowledge in the field of oral surgery and the training of its members.



Udruženje Stomatologa Implantologa Srbije-EDI (USSI EDI)

USSI EDI was founded in 2010 with the desire to enhance dentists' knowledge of dental implants, as well as to provide the highest quality of continuing education in dentistry. The most important aims of the organization are to make postgraduate studies meeting the standards of the European Union available to dentists from Serbia and the region; to raise the level of education in the field of oral implantology; to develop forensic practice in implantology; and to cooperate with countries in the region striving to achieve similar goals.



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All case reports and scientific documentations are peer reviewed by the international editorial board of EDI Journal.

Chair is Professor Jörg Neugebauer.

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Dentistry, oral implantology and Europe

Where we stand now

On the occasion of the first 2022 issue, the editorial team of EDI Journal takes a closer look at our current situation. What is the status quo in oral implantology? And the status quo in dentistry as a whole? What keeps us preoccupied in terms of legal and accounting issues? But we will also be looking beyond the oral cavity. Where does dentistry stand in terms of sustainability? Let our experts explain.



The BDIZ EDI today and tomorrow

Christian Berger

President of the BDIZ EDI

The BDIZ EDI is usually ahead of its time: in 2001 with the enforcement of the TSP (certification of proven qualifications and experience in implantology) before the Federal Constitutional Court, in 2013 with the lawsuit of six dentists against the GOZ 2012 (German fee schedule), 2015 with the alternative bill against the anti-corruption law in the health sector.

Meanwhile we published the GOZ compendium and every year the BDIZ EDI table, which compares the different dental fee schedules and also points out the different business aspects in dental practices. This year, for the first time, the table will include new positions of the periodontology guideline, which was launched in 2021. Our weekly billing hotline provides unbureaucratic support for many questions regarding private liquidation.

In cooperation with the University of Cologne, the implantology curriculum is being part of the BDIZ EDI year. The Legal Expert Conference on behalf of the Consensus Conference Implantology is also held every year, organised with alternating German dental chambers.

Of great importance are our Expert Symposia in Cologne and the associated European Consensus Conferences, which will be developing a practice guideline as a recommendation for dental practice operations. The planning of the Expert Symposium in Cologne, Legal Expert Conference in Frankfurt/Main and the European Symposium in Karlovy Vary is already in progress.

Our founders always wanted a strong guild that was way more than just an implantological professional society. In the pandemic, we have literally stepped up a gear. Since 2020 and in times where most live events were cancelled, we have offered and continue to offer online training courses regularly: by the end of 2021 there were 46 webinars with 12,000 participants and an overwhelmingly positive response to the quality of the webinars.

The webinars include topics such as billing, legal issues in practices as well as current changes in law and special regulations. In the continuing education we will be tackling the topics implant surgery and implant prosthetics and shine a light on possible tomorrow issues as well.

The webinars of course will continue to take place in the future. The program for the first half of 2022 has already started its course and covers the entire spectrum of our diverse work at BDIZ EDI. With the webinars and their promotion on different social media channels, we also reach those colleagues who did not know us before.

The board, elected in October 2021, has made big plans. In 2022 we will intensify collaborating with our associated partners in Europe and beyond. The webinar program for the second half of the year is in progress. We remain true to our principle: every dentist whose professional qualifications accordingly contribute should have the ability to work in the field of implantology in their own respective practices.

Where does dentistry stand today, and where is it headed tomorrow?

Prof Roland Frankenberger

Director, Polyclinic for Tooth Preservation at Philipps University Marburg and University Hospital of Gießen and Marburg, Germany

The status quo of German dentistry is described in detail in the position paper *Perspektive Zahnmedizin 2030* (“Perspectives in Dentistry 2030”), which also forms the basis of the present statement.¹

At the beginning of the 21st century, dentistry successfully initiated a paradigm shift, from focusing on repairs to focusing on prevention within the framework of oral medicine.² For decades, most everyday treatments and treatment decisions were firmly rooted within the scope of the German dental licensing regulations, in force since as far back as 1955. However, these regulations were based on the epidemiological foundations of the post-war period, complete with the limited technical possibilities of the time, especially in the field of tooth preservation. Of course, classic dentures formed the core of dental efforts back then.

However, today—67 years on—this is simply no longer the case. Regardless of this, the average age of our patients continues to rise, and multimorbidity and morbidity compression increasingly impact our profession. Improved horizontal transparency between the dental and medical realms is therefore a fundamental prerequisite for any successful and future-proof education and training of young dentists. These aspects have been successfully addressed in the amendment to the new German dental licensing regulations from 2019. However, on closer inspection, three significant problems arise:

1. For cost reasons, important considerations suggested for guidance when drafting the new training regulations for dentists (AOZ) were disregarded by politicians without justification.
2. AOZ reform has been completed for the clinical education phase only. The preclinical phase has not been significantly amended, except the number of hours dedicate to dental technology was reduced. A second reform step is required but has still not been addressed. This step has been described in a position paper of the Medical Faculty Congress (MFT)—and yes, this will also cost money.³
3. In its current form, the immensely important competence-based national catalogue of dental learning objectives (NKLZ) remains a so called “paper tiger”, as it is not anchored in the AOZ and is therefore unenforceable.³ Conclusion: Only when these three points have been addressed responsibly—which includes adequate funding!—will dental training successfully embark on a promising course.

Sources:

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3. Medizinischer Fakultätentag: *Das Zahnmedizinstudium der Zukunft (2021)* [Medical Faculty Congress: The Future of Dental Studies].





Position statement: oral surgery

Prof Joachim E. Zöller

Director, Department of Oral, Maxillary and Plastic Facial Surgery, University of Cologne, Germany, and Interdisciplinary Clinic for Oral Surgery and Implantology.

In present-day oral implantology, a broad variety of implant designs are available that advertise safe and rapid healing and restorability. For a provisional or definitive restoration to be able to present lasting results, a sufficient stability of the bone bed will be required. Unfortunately, this stable bone bed is often absent. Various protagonists recommend different procedures or materials that are supposed to enable fast and safe bone augmentation. In all events, however, the basic principles of osseointegration and bone regeneration must be respected.

Cell growth cannot be accelerated by marketing, and autologous bone is still the gold standard. Next to biology, the quality of surgical performance is a key factor for success. Thus, surgical practitioners must follow their own personal learning curve, and that entails thoughtful patient selection.

Finally, the overall health status of the patient must never be neglected. In an aging society in a highly developed industrialized country, state-of-the-art pharmaceutical preparations help maintain a high quality of life. Their influence on bone healing, however, often remains unknown. Thus, in a complex environment, the surgeon is under strict scrutiny, yet natural risks and complications are often misunderstood and are considered treatment failures

Position statement: prosthodontics

Prof Jörg Neugebauer

Professor, Digitalization in Dentistry, Steinbeis University, Berlin, Germany, Transfer Institute for the Management of Dental and Oral Medicine

The desired subjective and objective outcome of any prosthetic implant treatment is a restoration that fits accurately and is aesthetically pleasing. The use of CAD/CAM technologies in particular has made it easier to manufacture restorations to a precise fit, since a more precise connection geometry can be achieved when the design data for the implants are known. Unfortunately, the everyday workflow is not yet that simple, as it will often be necessary to define the interfaces precisely. Since digital workflows can be very highly standardized, it is often impossible to deviate from the standard procedure even if a special situation would require this. This is not only a problem of closed systems; even in supposedly open systems, a multitude of settings and parameters may trigger failures.

But once the learning curve has been mastered and a workflow has been established and adapted to the individual practitioner, implant restoration can be stable and long-lasting. CAD/CAM technologies in particular also allow the use of new materials that make new and additional treatment options available. So even if the digitalization of the implantological treatment sequence across all steps involved in the process has not yet been universally established, this is where the future lies for effective and accepted prosthetic restorations.





Sustainability in dentistry

Dr Markus Tröltzsch, Ansbach, Germany

Chair of the Academy of Dentistry and Oral Medicine (APW) and of the German Society of Dentistry and Oral Medicine (DGZMK), Board Member of BDIZ EDI since 2021

Society is increasingly moving in the direction of more resource-conserving and more sustainable lifestyles—a development that has so far made little impact on medicine and dentistry. Yet the ecological footprint of medicine is very relevant, accounting for over 5 per cent of the total human footprint.

Sustainability is a fairly broad concept. Some people believe that sustainability means using bamboo toothbrushes, some people discuss paper cups, and yet others think it means putting all operations to the test of resource efficiency and environmental compatibility. One thing is for certain: isolated activities will not yield the desired result, and individual products that appear sustainable will not necessarily be sustainable.

Dentistry in general is facing more and more demands from angles at the same time—e.g. business management, to patient's desire, to data protection—and all this without increase in remuneration. Since true sustainability ranges from the selection of materials to process optimisation to compensation with serious projects, this is costly and a project that is almost impossible to manage seriously in the practice alone.

Sustainability in dentistry can only be achieved jointly and concertedly in small steps, must be scientifically based and we should always keep in mind that the collectively, cooperatively of the processes and the symbiotically of the practice procedures are not jeopardised.

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What does the EU have in store from a dental perspective?

Dr Alfred Büttner

Head of the Department for Europe/International Affairs of the German Dental Association (BZÄK) in Brussels, Belgium

Even though European Union has only limited competencies in the health sector, it increasingly exerts its influence on the dental professional environment. The General Data Protection Regulation (GDPR) and the EU Medical Devices Regulation (MDR) are only two of the more recent examples. In the coming months, additional EU health, environmental and single-market policy initiatives are expected to impact our dental practices—and the overall political climate seems to favour this development. In the wake of the COVID-19 pandemic, health policy at the EU level has left the largely unobserved niche it had occupied in previous years.

“Creating a health union” is the EU’s slogan that is driving the process of improving its ability to react to cross-border health threats. Another key topic at the EU level is the digitization of healthcare and the promotion of eHealth. These efforts are being supported by initiatives to regulate the use of artificial intelligence. For 2022, the European Commission has also announced a proposal to create a European health data space. Antibiotic resistance is to be combated much more consistently. A revision of the EU Mercury Regulation is also planned for 2022. In this context, the EU Commission would like to conclude the Europe-wide phase-out of silver amalgam for environmental reasons by the end of this decade.

Health policy today and tomorrow—what can we expect?

Peter Knüpper

Solicitor at the Ratzel law firm in Munich, Germany; former CEO of the Bavarian Dental Chamber (BLZK). He is teaching history of dentistry, professional law and professional ethics at the Ludwig-Maximilians-University (LMU) in Munich.

For the past three decades, government health care policy has been oriented toward containing cost, despite an expanded catalogue of benefits. And given the demographic situation, this will continue to be the case in Germany in future. On the other hand, medical progress is forcing a reorientation. Leaps in innovation in medicine and medical technology are putting conventional approaches towards financing the healthcare system to the test. Moving in the direction of increasing individualization within medicine requires new economic approaches. Politicians, the state—or even a “European Health Union”—cannot meet the upcoming challenges on their own.

Social health insurance has so far been our guiding star on our travels between general and specialist medical treatment, pharmacy and physiotherapy, to inpatient care and ultimately to nursing care. But in the future, this journey will mean travelling new and more efficient routes, in the interest of sustainability—much like the internal combustion engine is being replaced by the electric drive. We can all make a responsible contribution to greater sustainability. In addition, science and research, digitalization and automation will be the future drivers of health care policy. But just like society as a whole, everyone in need of medical or nursing care will continue to require the assistance of physicians in their role as professional, personal and social authorities, as empathetic and patient-oriented conduits in an increasingly complex system, as helpers and partners on the way to continued health or to recovery.





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Portrait: BDIZ EDI—European Association of Dental Implantologists

Getting involved

BDIZ, the German Association of Implant Dentists, was founded in 1989 to lend a strong voice to dentists in private practice active within the field of implant dentistry in their efforts to negotiate reasonable individual fees for private dental treatments. As early as 2002, the Association changed its name—and focus—to become BDIZ EDI, where EDI stands for “European Association of Dental Implantologists”.



Each year, the European Consensus Conference (EuCC) under the auspices of BDIZ EDI issues a consensus paper on a current practical topic within oral Implantology. To download the guidelines, use QR code below.



This early pan-European orientation of BDIZ EDI was based on the realization that the increasing influence of “Brussels” on the healthcare sector does not stop at the door of the dental office. Many guidelines and policies, for example those governing professional recognition, medical devices etc, originate at EU level. Accordingly, regular meetings are held with partner and associated organizations of BDIZ EDI to devise and implement continuing professional development (CPD) events, to keep members updated on new laws and guidelines and to intervene where appropriate. In doing so, BDIZ EDI maintains close contacts to Brussels, in particular with the Council of European Dentists (CED), but also with the dental chambers of the member states.

5,800 members

The number of BDIZ EDI members is increasing continuously. At this point, the association serves 5,800 dentists in Germany and all over Europe. The primary goal of BDIZ EDI is to protect the freedom of therapeutic choice and to promote the field of oral implantology. Any dentist with the requisite qualification should be able to practice dental Implantology in his or her own practice.

The focus of the work of BDIZ EDI when it comes to German dentists is on private dental billing issues. The BDIZ EDI has compiled its interpretation of the GOZ—the German fee schedule for dentists that is recognized and accepted by public corporations, health insurers and related institutions.

Continuing professional development

With its Curriculum Implantology, developed and held in cooperation with the University of Cologne, and the webinar programme, BDIZ EDI shows that it cares deeply about the next generation of implant dentists. As part of its commitment to CPD, the association organizes internationally recognized symposia at home and abroad. The annual highlight is the BDIZ EDI Expert Symposium in Cologne that addresses one specific topical issue in oral Implantology every year. This is also where the European Consensus Conference (EuCC) is regularly held under the auspices of BDIZ EDI, issuing a new guideline annually. For example, the topic of 2021 was “Update Ceramics in Implantology”. All guidelines can be downloaded in English from the BDIZ EDI website.

In addition, BDIZ EDI is an active member of the Consensus Conference Implantology, cooperating with all other professional societies within oral Implantology—for example in guideline conferences targeting technical and medical aspects. To support individual dentists in their clinical work, the association has published patient guides on implant treatment and implant maintenance.

BDIZ EDI has also established a comprehensive network of technical and legal experts, as only experts with practical experience in oral Implantology are in a position to prepare state-of-the-art opinions with practical relevance. Quality improvements in implant dentistry, in everyday clinical prac-



Nos Helping patients—educating dentists— active in Europe: Members of the BDIZ EDI receive an official membership certificate stating the association's objectives and slogan.

tice as well as in material/technical terms, are the responsibility of the Quality and Research Committee.

It regularly examines and tests dental material in collaboration with renowned research institutes (for example on surface contamination on implants in sterile packaging).

About ...

The primary objectives of the BDIZ EDI are:

- to preserve the free exercise of the dental profession in the best interest of both patients and professionals.
- to strive for continuing further development of the oral implantology and to support the dental practice to keeping oral implantology as a part of day-by-day dental treatment.
- to provide continuing education in the discipline of oral implantology Europe-wide.
- to support dental clinicians with relevant clinical guidelines for the daily implant practice and treatment recommendations.

Become a member of the BDIZ EDI family and participate in a lot of benefits.



You will find all important details on our website www.bdizedi.org. The adjacent QR code will lead you directly to the members' area.

Getting involved in legislation

Advocacy also extends to healthcare policies relevant for dentists. For example, BDIZ EDI developed draft alternative legislation on combating corruption in health care, where the government draft by the German Ministry of Justice was totally inappropriate in terms of its potential consequences for German dentists. This work also regularly gives rise to guidelines for the dental office.

AWU



European Consensus Conference of 2020 in Cologne.



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Intermarriage secured family's influence

Habsburg jaw's background

The "Habsburg jaw," a facial condition of the Habsburg dynasty of Spanish and Austrian kings and their wives, can be attributed to inbreeding, according to new results published in the *Annals of Human Biology*.

The study in 2019 combined diagnosis of facial deformities using historical portraits with genetic analysis of the degree of relatedness to determine whether there was a direct link. The researchers also investigated the genetic basis of the relationship.

Generations of intermarriage secured the family's influence across a European empire including Spain and Austria for more than 200 years but led to its demise when the final Habsburg monarch was unable to produce an heir. However, until now no studies have confirmed whether the distinct chin known as "Habsburg jaw" was a result of inbreeding.

"The Habsburg dynasty was one of the most influential in Europe, but became renowned for inbreeding, which was its eventual downfall. We show for the first time that there is a clear positive relationship between inbreeding and appearance of the Habsburg jaw," says lead researcher Professor Roman Vilas from the University of Santiago de Compostela.

The researchers recruited 10 maxillofacial surgeons to diagnose facial deformity in 66 portraits of 15 members of the Habsburg dynasty. Despite differences in artistic style, the portraits are characterised by a realistic approach to the human face. The surgeons were asked to diagnose 11 features of mandibular prognathism, otherwise known as "Habsburg jaw," as well as seven features of maxillary deficiency, the most recognisable of which are a prominent lower lip and an overhanging nasal tip.

Portraits in museums all over Europe

The portraits, which can be viewed online, are preserved by some of the most important art museums in the world, including the Kunsthistorisches Museum in Vienna and the Prado Museum in Madrid.

The surgeons gave scores for the degree of mandibular prognathism and maxillary deficiency in each

member of the Habsburg family. Mary of Burgundy, who married into the family in 1477, showed the least degree of both traits. Mandibular prognathism was most pronounced in Philip IV, King of Spain and Portugal from 1621 to 1640. Maxillary deficiency was diagnosed to the greatest degree in five members of the family: Maximilian I (regent from 1493), his daughter Margaret of Austria, his nephew Charles I of Spain, Charles' great-grandson Philip IV and the last in the Habsburg line, Charles II.

Extent of inbreeding

The study authors detected a correlation between the two conditions, suggesting that "Habsburg jaw" is in fact characterised by them both and that they share a common genetic basis. The extent of inbreeding was calculated from a large-scale family tree, including more than 6,000 individuals belonging to more than 20 generations. Analysis was carried out to determine if it was connected to the degree of facial deformity. The researchers detected a strong relationship between the degree of inbreeding and the degree of mandibular prognathism. The relationship to maxillary deficiency was also positive, but it was only statistically significant in two of the seven features diagnosed.

The causes of the relationship between inbreeding and facial deformity remain unclear, but the authors suggest it's because the main effect of mating between relatives is an increase in the chances of offspring inheriting identical forms of a gene from both parents, known as genetic homozygosity. This reduces people's genetic fitness, so "Habsburg jaw" should be considered a recessive condition.

However, the authors note that the study involves only a small number of individuals so it's possible that the prevalence of Habsburg jaw is due to the chance appearance of traits, or genetic drift. They suggest this scenario is unlikely, but can't rule it out.

"While our study is based on historical figures, inbreeding is still common in some geographical regions and among some religious and ethnic groups, so it's important today to investigate the effects," says Vilas. "The Habsburg dynasty serves as a kind of human laboratory for researchers to do so, because the range of inbreeding is so high."

Source: *Science Daily*

Reference:

Román Vilas, Francisco C. Ceballos, Laila Al-Soufi, Raúl González-García, Carlos Moreno, Manuel Moreno, Laura Villanueva, Luis Ruiz, Jesús Mateos, David González, Jennifer Ruiz, Aitor Cinza, Florencio Monje, Gonzalo Álvarez. Is the "Habsburg jaw" related to inbreeding? *Annals of Human Biology*, 2019; 1 DOI: 10.1080/03014460.2019.1687752

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Register now: Curriculum 24 in Cologne

A must—not only for beginners

The BDIZ EDI Curriculum Implantology is a must for beginners—but not only. BDIZ EDI regularly offers profound basic training in oral implantology in cooperation with the University of Cologne, which stands out for the great emphasis it places on hands-on exercises. A special feature is that training modules that were not acquired at BDIZ EDI can be integrated into the BDIZ EDI Curriculum Implantology if their scientific character is recognized.

Eight modules

Each module is designed to systematically build on previous modules, so that Curriculum participants will receive a complex total implantological package for their future practical work, ranging from simple standard protocols to 3D augmentation techniques and elaborate implant prosthetics.

To ensure easy access to oral implantology as a whole, coverage will be broad—deliberately including even seemingly self-evident aspects such as pro-

ocols, different implant systems, required instrument sets, simple and advanced diagnostics and implant-prosthetic restoration concepts. The accompanying workshops facilitate subsequent implant surgical and prosthetic training.

In addition to the scheduled live surgeries, and following previous joint preparation, implant surgery may be performed on patients presented by participants by one of the Cologne-based speakers, assisted by the participant who introduced the case. To complement the learning results, participant cases will regularly be presented within the group. Towards the end of the Curriculum, the techniques acquired will be practised on human specimens.

The integration of current topics and treatment methods (3D-supported surgery, bone preparation using ultrasound, CAD/CAM technology for bone regeneration, etc.) round off the practical benefits of the Curriculum Implantology.

For the final examination, candidates are expected to present and discuss two surgical and/or prosthetic implantological cases. Certificates will be presented immediately once the exam has been passed.

Ed.

Course schedule

Day 1: Thursday, 2 pm to 8 pm

Day 2: Friday, 8 or 9 am to 6 pm

Course fees and registration

€4,500 for BDIZ EDI members*

€5,800 for non-members

Registration: office@bdizedi.org,
+49 2203 8009-339
or visit www.bdizedi.org/curriculum

* The reduced fee applies to new members only if they agree to join for at least 36 months.

The 8 modules of the BDIZ EDI Curriculum Implantology

Module 1

Fundamentals of oral implantology

- Anatomy and histology of the stomatognathic system
 - General diagnostics in oral implantology
 - Patient education
 - Cologne ABC Risk Score
- + external presenters

Module 2

Indications, diagnosis and treatment planning

- High-risk patients and monitoring
 - Description of indications
 - Avoiding malpositioning
 - Patients with coagulation disorders
- Workshop I: Surgical and prosthetic protocols*
+ external presenters

Module 3

Implant systems, instruments, advanced diagnosis

- Diagnostic tomography
 - Fundamentals of 3D diagnostics
 - Surgical templates/guide sleeves
 - Choice of implants
 - Comparison of implant systems
- Workshop II: 3D workshop with interactive planning*
Demonstration of different instrument sets
Case presentations by participants I

Module 4

Implant prosthetics I and minimally invasive surgery

- State-of-the-art in tooth extraction
 - Implant prosthetics (instruments, impressions, abutments)
 - Minimally invasive procedures (flapless surgery, 3D bone splitting, sinus floor elevation)
 - Emergencies in the dental practice
- Workshop III: Surgical and prosthetic protocols, instrument sets*
Modified bone splitting using Piezosurgery
Case presentations by participants II

Module 5

Augmentation I: Regional bone augmentation

- Unfavourable biomechanics vs augmentation
 - Immediate implant placement
 - Sinus floor elevation
- Workshop IV: Sinus floor elevation training on models and animal specimens*
Exercise in customized bone regeneration
Case presentations by participants III
+ external presenters

Module 6

Implant prosthetics II and soft-tissue management

- Antibiotic therapy
 - Implant re-entry and soft-tissue corrections
 - Implant prosthetics II: Teeth and implants
 - Implant prosthetics III: Removable restorations
- Workshop V: Hard- and soft-tissue management: Exercises on porcine jaws*
Soft-tissue techniques I and II for augmentation, implantation and exposure
Case presentations by participants IV
Written examination

Module 7

Augmentation II: Bone grafting and distraction

- Iliac-crest transplants
 - Fundamentals and results of distraction osteogenesis
 - Implant prosthetics in the anterior region
- Practical exercises on human specimens; practical training of the acquired surgical techniques*
+ external presenters
Case presentations by participants V

Module 8

Recall—coping with complications—future perspectives

- Recall
 - Peri-implantitis therapy
 - Oral implantologists in court
 - Ceramic coating of implants
- + external presenters

Final exam

15th European Symposium to be held in Karlovy Vary end of May

Joint venture with dental chambers

One of the highlights of the BDIZ EDI year is certainly the European Symposium, held annually with changing partners in changing European countries. The 15th European Symposium will be held in Karlovy Vary, Czech Republic, from 27 to 28 May 2022.

BDIZ EDI is the cooperation partner of the following Dental Chambers: Saxony, Bavaria, Upper Austria and the Czech Republic. This southern Dentist's Day will be characterized by a short scientific programme with an official part ahead. Doc. MUDr. Roman Šmucler, CSc., president CSK will be opening the ceremony together with his colleagues Christian Berger, BDIZ EDI president and president of the Bavarian Dental Chamber, and vice president Dr Christoph Meißner, president LZKS (Saxony). The official programme will be starting at 9 a.m. on Friday. After welcoming address doc. MUDr. Otakar Brázda, CSc., Stomatologická klinika in Prague, will be talking about relations between Czech and German dentists during the last century.

Scientific part starts at 1 p.m. with BDIZ EDI vice president Professor Joachim E. Zöller, University of Cologne. Together with Christian Berger he will be lecturing on modern implant dentistry. This lecture will be followed by the topic: removable dentures on teeth and implants by Dr Sebastian Hahnel, University of Leipzig.

Second part starts with Dr Katrin Pertold, Austrian Dental Chamber, on periodontal treatment in com-

parison with treatments in Czech Republic, Bavaria, Saxony and Upper Austria.

Doc. MUDr. Roman Šmucler, CSc., president of the Czech Dental Chamber, will cover laser, botulinum toxin and injection filler in today's dentistry and facial surgery.

Last lecture of the congress will be: autotransplantation of teeth by MUDr. Jan Streblov, Prague.

The joint venture congress will be taking place at Grandhotel PUPP Karlovy Vary in Karlovy Vary, <https://www.pupp.cz>

For more information, please scan qr code:



The European view of the situation of dentistry

At a glimpse

What is the situation of dentists in the countries of the associated partner associations? In this format we publish in loose succession the reports from the countries. In this issue we start with the United Kingdom, Germany, The Netherlands, Serbia, Hungary, India and Macedonia.

United Kingdom

The governments in the UK have unhelpfully decided on different rules for dentists and their teams. The introduction of fallow time was conceived as a way of mitigating disease spread and this concept effectively made the throughput of dental patients so limited that practices wouldn't have survived without the government supporting them. The governments of the different countries agreed to pay a proportion of the normal NHS incomes for the practices to survive. There is now a backlog of patients and lots of treatments haven't been carried out and there doesn't seem to be a straightforward pathway back to access for patients.

Dentists are disillusioned and disappointed that oral healthcare still doesn't seem to be a priority for governments.

Due to many patients opting for private dentistry and deciding to invest in implant therapies there has been somewhat of a rise in these treatments.

This has been a good thing for the practices that provide care under this system.

There is ever more of a divide between the two systems with no sign of any change for the benefits of the majority any time soon.

As ever, the issue of subsidised care for patients is always fraught with challenges between getting value for money and adequately rewarding those on the frontline and at the moment there are no easy solutions.



Dr Eimear O'Connell
President ADI UK

Germany

German dentists are confronted with a new act concerning COVID-19 vaccination. As of March 15, 2022, the obligation to demonstrate immunity to COVID-19 has been in place in health and care facilities. Employers must have a proof of vaccination, proof of recovery or a medical certificate of a medical contraindication shown. With the changes in the Infection Protection Act, the provision of proof of immunity against COVID-19 in health and care facilities is a mandatory employment requirement. It does not depend on the type of employment. Unvaccinated employees in the health sector could now face consequences. The Government may impose fines, prohibitions on activities and entry. However, the implementation is handled by the federal states. In Bavaria, for example, the corona vaccination require-

ment for employees in nursing and health care is being implemented and enforced only slowly and gradually.

Overall, dentists in Germany also fear that unvaccinated practice employees will look for a new job for this reason.



Christian Berger
President BDIZ EDI

The Netherlands

In general, in The Netherlands almost all general Covid restrictions are released, except the advice to test when having symptoms and a minimum of five days self isolation when tested COVID positive.

For example all bars, restaurants, clubs and festivals are permitted, also without a negative test result or any form of 2G/3G. In the public transport also a face mask is not obligated anymore. The hospital numbers although still quite high (except IC) but are manageable and declining.

About the situation for the dentistry here: There is no questionnaire (triage) in advance for patients anymore except for the possibility of a (proven) COVID infection. Patients with (proven) COVID infection receive only emergency treatments, with full hygienic protocol (gowns, hat, FFP2). Otherwise it's the normal HIP protocol, surgical mask etc. Unfortunately,

since coves transmission is still quite high, many healthcare workers are in quarantine causing a high number of absence (>5%). Also patients are missing their appointments more often than in the past, which has as effect a lower turnover than pre-COVID.



Dr Jan Willem Vaartjes
EDI Netherland
President of the Association of Dutch Dentists (ANT)



Serbia

Taking into account the epidemiological situation, which has improved significantly, dentists in Serbia have entered the year 2022 relaxed in terms of the strict epidemic measures that have been in force since the beginning of the COVID-19 pandemic. Immunization against COVID-19 in Serbia is not an obligation, however, strict protection measures are still in force. If it can be said that something good came out of the COVID-19 epidemic, it is that dentists are now taking protection measures much more seriously.

Unlike the private practice in medicine, which simply thrived during the epidemic because state health institutions were mostly engaged in the treatment of the Corona, private dental practices were suppressed with a reduced influx of patients. This trend occurs mainly for two reasons. First, however, patients fear that they may be infected with the Coronavirus, and thus leave complex dental reconstructions for "better times." Also, not a small number of surgeries in Serbia provide dental services to patients living abroad, although they are mostly citizens of Serbia. It is well known what problems people encountered regarding travel during the COVID-19 epidemic.

Another global problem that affects the reduced number of patients has appeared in Serbia in the last month, and that is, of course, the war between Russia and Ukraine. Although life in Serbia is going on almost normally for now, without any restrictions or shortages, world crises such as Ukraine's are generally negatively affecting people who are worried about what will happen in the future. This, of course, is also repercussed on dental practices, because pa-

tients certainly do not prioritize dental services, except, of course, emergencies.

However, not everything is so upsetting. The Dental Chamber of Serbia, in co-organization with the School of Dental Medicine, University of Belgrade, is once again, seventh years in a row, organizing the 21st Serbian Dental Congress in Belgrade, October 6-9-2022, the largest event of its kind in the region. This year, the congress will be organized in a hybrid form, unlike last year, which was organized using the online web platform. We hope that the epidemic, as well as world situation, will allow the congress to be held live, et least, for the most part. Besides this Congress, the most important dental event in the region, various types of continuous medical education are also organized, to which dentists gladly respond, especially since they are held live again.



Vitomir S. Konstantinovic, DDS, MD, MSc, PhD

Maxillofacial surgeon, Professor of Maxillofacial Surgery and Implantology
School of Dental Medicine, University of Belgrade, Serbia
Immediate past director of Serbian Dental Chamber

Hungary

In Hungary all health care professionals needed to be vaccinated three times. (also students in the faculty), otherwise they are not allowed to work/study. Mask is obligatory in health-care institutions only, nowhere else.

The oral hygiene in general is much worse than before COVID, in many cases selfcare is totally missing (incl. oral selfcare) due to the fact, that mask was covering everything for a long time. More patients intend to go for extraction than before, and patient's turnover is much lower...

That is also reported by dental hygienists colleagues recently. We suspect a long term negative effect on oral health.



Prof Dr Katalin Nagy DDS; PhD; DSc

Head of Oral Surgery, Faculty of Dentistry University of Szeged
President of the Hungarian Dental Association
Co-President of the Hungarian Implantology Association

India

Due to the significant decline in Coronavirus cases in India, the Ministry of Home Affairs has abolished all existing COVID restrictions from March 31st except for wearing face masks and maintaining social distancing. Nevertheless, it is also stated that the Disaster Management Act will no longer be invoked for COVID safety measures. Surprisingly, a few states have also declared that masks are not mandatory for the general public.

We as dentists are expecting both, the positive and negative impacts of this decision on dentistry. The good thing about this is that after the relaxation in the COVID norms there will be a free flow of the patients who no longer will be hesitant to approach the dentist for their dental issues in contrast to the COVID times when they were too afraid to approach the dentist. Eventually, this will motivate the demotivated dentists and regain their confidence in dentistry.

On the other hand, the threat of COVID-19 has not ended completely. Its novel variant is still prevalent in our neighbouring country China. If all of a sudden a new COVID-19 wave emerges then it will be very difficult to tackle the situation due to the

already discontinued COVID regulations. The end resort could be imposing a nation-wide lockdown which is the last thing that a dentist wants. It might hit us even harder. So, overall the decision of abolishing COVID norms has brought a lot of uncertainties in the field of dentistry. But, on a positive note, we are looking forward to live in a COVID free world.



Dr Vikas Gowd

EDI India
Hyderabad

North Macedonia

The situation in North Macedonia related to dentistry is characterized by many points of interest, starting with education, which results in overproduction of general dentists, of which about 1/4 do not work in the dental health system or have left the country; on one hand we face an overproduction of dentists and specialists, on the other hand there is a decrease in number of dental nurses/assistants, for whom there are not even enough educational institutions. There are also shortcomings in several laws, primarily in the Law on Health Care, which refer to the dental activity with all its specialties, as well as laws in the field of education.

Regarding the COVID-19 pandemic: Due to the restrictive measures and special protocols imposed on dentists, for the safety and protection of both patients and staff in dental offices during the COVID-19 pandemic, the cost of purchasing pro-

tective equipment and disinfectants in dental offices has increased. The dentists were not affected by any anti-crisis measures adopted by the Government of the Republic of North Macedonia.



Dr Fisnik Kasapi

EDI Macedonia
President of AIAM (Albanian Implantology Association of Macedonia)



New tasks for the Secretary General of BDIZ EDI

Jörg Neugebauer new vice president of AO

General Secretary of BDIZ EDI Professor Jörg Neugebauer, DDS, PhD, is the new vice president of the Academy of Osseointegration (AO).

During the annual meeting of the Academy of Osseointegration new president Amerian D. Sones, DMD, MS, welcomed the AO members in San Diego, California. The AO is one of the world's leading scientific implantological associations. During the elections of the board of directors, Professor Jörg Neugebauer, Landsberg (Lech)/Germany, was elected vice president. During the past two years he served voluntarily as treasurer of the AO which counts 4.000 members in 70 countries.

"This international professional society has members from all over the world", said Professor Jörg Neugebauer. He described the objectives of the Academy of Osseointegration as follows: "Ensuring the highest standards in patient care, research and training in implant dentistry." Neugebauer is the first and only German oral surgeon on the AO's twelve-member board of directors. He was first appointed in 2015.

History of AO

The AO's first annual meeting was held in Chicago in 1986. A pro-tem executive board was elected to include representatives from oral surgery, periodontics, prosthodontics and general practice. The Academy and its affiliate, the Osseointegration Foundation, were incorporated in 1987.

For more than 35 years, the Academy of Osseointegration has met throughout North America at its annual meetings and local study groups. AO members from countries around the world gather through AO charter chapters that offer local educational programs and networking sessions. The AO annual meetings have continued to increase in attendance and are now considered to be among the premier international educational conferences for dental implant clinicians, researchers and auxiliary



For the next summit in summer Professor Neugebauer announced in his strategy to formulate guidelines in the future in such a way that they give the practitioner recommendation for action for different indications, but do not restrict the freedom of therapy.

professions. AO membership now exceeds 4,000 professionals in more than 70 countries. Following the introduction of osseointegration to North America in 1982, a group of dental clinicians from the greater New York area participated in a course entitled, "Osseointegration in Clinical Dentistry".

Subsequently, the group formed a study club to share research and information. This local study club eventually concluded that a national organization was essential to foster education and advancement in this field. As a result, the Academy of Osseointegration (AO) was formed.

In 2019 the first German chapter meeting of the Academy of Osseointegration was held in Heidelberg as part of the "clinical afternoon" of the Department of Oral and Maxillofacial Surgery at the University of Heidelberg with more than 120 participants.

AWU



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Medicinal product advertising law and sweepstakes campaigns by mail-order pharmacies

Tie-in transactions with prescriptions?

The pharmaceutical market is booming. For quite some time now, this market has no longer been strictly controlled and devoid of competition. At the same time, the national legislator is—understandably enough—interested in preventing any kind of improper influence on consumers when it comes to their individual health. German ideas of what the concept of controlled trade in pharmaceuticals should entail are far less liberal than those of some of its European neighbours. It is therefore not surprising that cross-border trade in medicines is a particularly sensitive area of competition law. The European Court of Justice (ECJ), in its judgment dated 24 July 2021 (C-190/20) had to decide whether a mail-order pharmacy can be legally prohibited from offering a sweepstakes to recruit customers where entering the sweepstakes is contingent on filling a prescription for a prescription-only medicine.

The case

The decision was based on a German legal dispute. The North Rhine Chamber of Pharmacists (Apothekerkammer Nordrhein), which is tasked with monitoring pharmacists' compliance with their professional duties, took action against DocMorris, a mail-order pharmacy based in the Netherlands. This same mail-order pharmacy had already been a defendant in cases brought by various German associations in the past. According to the ECJ, the operation of a mail-order pharmacy is permissible in principle, even if this business model contradicts the traditional German approach to selling pharmaceuticals because it does not offer the possibility of an on-site personal consultation. In this specific case, however, the issue was not the operation of the mail-order pharmacy as such, but a sweepstakes that DocMorris advertised in March 2015. The main prize was to be an e-bike

worth €2,500; other prizes offered were high-quality electronic toothbrushes. To enter the sweepstakes, a consumer needed to send in an order form for a prescription medicine and the corresponding prescription to DocMorris by post.

The North Rhine Chamber of Pharmacists held this to be a violation of the German Drug Advertising Act (Heilmittelwerbegesetz, HWG) and therefore considered the action to be an anti-competitive practice. The Chamber unsuccessfully applied to the Frankfurt/Main Regional Court (Landgericht) for an injunction to stop the defendant from advertising the sweepstakes. The Regional Court concluded that the HWG was not applicable at all in the specific case, as EU law took precedence. However, the Frankfurt/Main Higher Regional Court (Oberlandesgericht) upheld the action on appeal. In its appeal to the Federal Court of Justice (Bundesgerichtshof, BGH), DocMorris sought the reinstatement of the judgment of first instance. Like the Higher Re-

gional Court, the BGH assumed a violation of the general prohibition of advertising pursuant to Section 7(1)(1) of the HWG. The sweepstakes would entice pharmaceutical consumers to forego a personal consultation at the pharmacy, creating an “abstract danger” of improperly influencing patients. Nevertheless, the BGH was not completely convinced of the regulations of the HWG being compatible with EU Directive 2001/83 on the Community Code relating to medicinal products for human use. In the event that a specific case falls within the scope of this Directive, the HWG may be non-applicable. Unlike the HWG, the Directive does not contain any specific provisions on advertising for pharmaceuticals in the form of a sweepstakes. The BGH therefore stayed the proceedings and referred the following question to the ECJ for a preliminary ruling:

“Is it consistent with the provisions of [...] Directive 2001/83 for a national provision (in this case, Section 7(1)(1) of the HWG) to be interpreted as prohibiting a mail-order pharmacy established in another member state from soliciting customers by advertising a prize draw where participation in the draw is linked to the submission of a prescription for a prescription-only medicinal product for human use [...]?”

The judgment

This question was essentially answered in the negative by the ECJ. The ECJ first clarified that Directive 2001/83 referred only to advertising for certain medicinal products, but not to advertising for online sales as such. The sweepstakes held by the mail-order pharmacy could, however, at most be regarded as an advertising measure for the entire product range of DocMorris, since the prize offered was not a specific different pharmaceutical but a completely different commodity. The offending campaign therefore did not fall within the scope of the Directive, so that the Directive would not preclude the application of the HWG in this specific case.



Inken Huschke

But the ECJ also examined, beyond the specific questions referred to it, the compatibility of the HWG provision with other EU law. However, in the end, the court was unable to establish a violation. The scope of application of Directive 2000/31 (the eCommerce Directive) was not affected, since the advertisement was not for an electronically provided service, but for sales by mail order. The ECJ thus concluded that the ban on holding sweepstakes to advertise the sale of pharmaceuticals by mail order was not in agreement with harmonized European law. Any such regulations would therefore fall within the legislative realm of the individual member states.

In doing so, however, they would—as always—have to ensure that the European fundamental freedoms are protected. Looking at the present case, the guarantee of free movement of goods in particular was relevant. However, according to the ECJ, no violation of this fundamental freedom was recognized in the case at hand, since the HWG regulation refers to advertising the sale of pharmaceuticals by mail order as such, independently of whether the pharmaceuticals originated in Germany or in some member state. In this respect, trade between member states would not

be impeded. The ECJ thus concluded that Union law did not preclude the application of the HWG as a national provision.

Summary and outlook

The sweepstakes held by the mail-order pharmacy was therefore an advertising measure to be assessed in accordance with national law, in this case the HWG. No provisions of EU law were relevant in this context. Consequently, in its final ruling dated November 18th, 2021, the Federal Court of Justice concluded that advertising the sweepstakes constituted a violation of the prohibition of advertising gifts pursuant to Section 7(1)(1) of the HWG, in effect rejecting the appeal by the mail-order pharmacy. This judgment is likely to have gone some way towards countering any fears on the part of pharmacists' Chambers that the German pharmaceuticals market would increasingly be dominated by foreign mail-order pharmacies such as DocMorris. The result of the ECJ ruling is to strengthen on-site sales of pharmaceuticals by pharmacies at physical locations. The German legislator continues to have the power to protect this business model, at least in connection with the advertising of the entire range of pharmaceuticals sold. In this respect, mail-order pharmacies domiciled in other European countries must comply with the stricter German regulations.

Comparable advertising bans also exist for medical devices, so the ruling must be applied in this area as well.

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BDIZ EDI konkret and EDI Journal: the association and its publishers

Partnership of BDIZ EDI and OEMUS MEDIA AG

BDIZ EDI konkret and EDI Journal, the specialist journals for implantological practitioners, have been published by OEMUS MEDIA AG since January 1st, 2022. The European Association of Dental Implantologists (BDIZ EDI) and the publishing house signed the contract in December 2021.

BDIZ EDI konkret, the association's member journal, and its European counterpart, the English-language EDI Journal, are published four times a year, enjoying a circulation of approximately 7,000 each. The two titles appeal to a diverse readership in Germany and Europe. It includes association members, subscribers, universities, professional associations and societies, dental professional bodies and dental chambers, partner associations of BDIZ EDI in Europe and beyond, insurance funds and companies, legal experts, medical billing companies, dental laborato-

ries, members of the European Parliament, the EU Commission, the Council of European Dentists (CED), the World Dental Federation (FDI), the German Federal Ministries of Health, Justice and Finance, lobbyists in Brussels and Berlin and the dental industry.

The association and its publishers

Christian Berger, President of BDIZ EDI, explained: "The Board of Directors have unanimously



above: Christian Berger, President of BDIZ EDI and Professor Jörg Neugebauer, Chairman of the Scientific Board
below: Stefan Thieme, Project Manager, Anita Wuttke, Editor-in-Chief and Lutz V. Hiller, Board Member OEMUS MEDIA AG.



decided to place even greater emphasis on European issues and European topics. This is why we have agreed to partner with OEMUS MEDIA AG, which has a strong European orientation and is positioned more broadly, well beyond the narrower more technical publishing tasks. Continuous development and advancement of these two specialist titles is important to us, and networking across traditional media boundaries will carry great weight. Munich-based trade journalist Anita Wuttke will continue to serve as Editor-in-Chief for BDIZ EDI konkret and EDI Journal in this new constellation. She has been impressively demonstrating her skills at heading the editorial desk since 2013."

Lutz V. Hiller, Member of the Board of OEMUS MEDIA AG, added: "As a publishing house, we are pleased with the decision of the Board of BDIZ EDI to entrust us with publishing these two highly renowned titles. The two journals are an excellent match for our existing portfolio, as they represent a professional policy point of view that we had not previously covered in comparable depth. We look forward to an intensive, fruitful and trusting cooperation with BDIZ EDI."

The team leaders

The collaborative project is managed by Stefan Thieme as project manager on the publisher's side, who will ensure that the structural and editorial processes run smoothly. He is responsible for media consulting at OEMUS MEDIA AG, the point of contact for the dental industry at EDI Journal and BDIZ EDI konkret. Stefan Thieme can look back on more than 20 years of publishing experience with OEMUS MEDIA AG.

Editor-in-chief Anita Wuttke remains at the helm of both professional journals. Her job includes the design and conception of the magazines' content: healthcare policy as well as association policy, but of course also the innovative focus that characterizes BDIZ EDI konkret and EDI Journal.

As head of the scientific advisory board, Prof Jörg Neugebauer, Secretary General of BDIZ EDI, keeps a knowledgeable eye on the articles submitted to the continuing-education sections of both journals. He is responsible for maintaining the consistently outstanding quality of all content related to implant surgery and implant prosthodontics.

ED./AWU



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Statement on e-evidence proposal

CED calls for exemption

At their meeting in September 2021, the board of directors of the Council of the European Dentists (CED) examined the developments related to the European Commission's Proposal for a Regulation on European Production and Preservation Orders for electronic evidence in criminal matters COM(2018) 225 (e-Evidence Regulation).

They concluded that the draft of the Regulation as it stands violates patient privacy and presents a serious threat to the ability of dentists to abide by the principles of professional ethics and medical confidentiality which form the core of the patient-dentist relationship.

The CED states in a press release to fully support the Standing Committee of European Doctors (CPME) in their position on the draft e-Evidence Regulation as laid out in the CPME Statement. The consequences of the draft Regulation for dentists would mirror the consequences faced by the medical profession. The CED joins the CPME in calling for an exemption to the scope of the Regulation for professions subject to professional secrecy.

The European Parliament's position on the cross-border gathering of "e-evidence" is confusing, unclear and inconsistent, according to the European Judicial Network, which is made up of EU member states' national contact points for criminal justice cooperation.

The proposed rules on "e-evidence" are intended to make it simpler for national authorities to obtain digital or electronic information held in another jurisdiction for use in criminal proceedings.

It is widely recognised that new rules on this issue are needed, but only with strict safeguards to ensure that data is only handed over in duly justified and necessary cases, and that strong safeguards exist—for example, for doctors, lawyers, journalists, and others with professional secrecy and confidentiality requirements.

The European Parliament adopted its position for negotiations with the Council of the EU in December 2020, making numerous amendments to the Commission's original proposal. Secret negotiations between the Council and the Parliament began recently.

The outcome of the parliamentary procedure was criticised by EDRI for potentially putting at risk the rights of journalists, doctors and lawyers, amongst other things. Meanwhile, the organisation warns, it is likely that the text will be further watered down, as "the Parliament will now have to accept further compromises in its negotiations with the Council."

Judicial practitioners are not happy either—although not necessarily for the same reasons. The European Judicial Network thinks that the Parliament's amendments "are not consistent within the Regulation and in the context of other legal instruments applicable in the EU Member States," and contains potentially confusing, unclear and inconsistent terminology.

sources: CED press release, Statewatch, EDRI

About EDRI

EDRI is calling itself the biggest European network defending rights and freedoms online. The EDRI network is a dynamic and resilient collective of 45+ NGOs, as well as experts, advocates and academics working to defend and advance digital rights across Europe and beyond. Together, they build a movement of organisations and individuals pushing for robust and enforced laws, informing and mobilising people and promoting a healthy and accountable technology market. Among them is amnesty international.

Did you ever know ...



...that the 2021 Guideline

of the European Consensus Conference (EuCC) held under the auspices of the BDIZ EDI is available for download in both English and German? Topic is update ceramics in Implantology and implant prosthetics. In addition to abutments and superstructures, one-piece and two-piece ceramic implants were also scrutinized.

For more scan QR-code:



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EDI NEWS

Female dentists in Europe

Profiles

This edition marks the start of a new series of reports: We want to introduce female European dentists who "stand their ground" as they balance their work, their family and their pro-bono activities.



Name:	Dr Nathalie Khasin	prestigious film industry award. He comes from a family of dentists who emigrated to Germany from Russia in 1981.
Profession:	Dentist, implantologist	
Office:	Berlin, Germany	Nathalie quickly became interested in dental surgery and completed a two-year Curriculum Implantology, which she today says was an important experience for her – not least because she very
Age:	41	
Family:	Married, 3 children	
Active:	Member of the BDIZ EDI board	

...that the BDIZ EDI

is introducing female dentists throughout Europe in a loose succession of interviews in its EDI Journal? The new format documents their lives and careers and shows how they assert themselves at work and in their private lives. The interviews can also be read online:

For more scan QR-code:



...that the EDI Journal

is sent out to all members of the partner associations of the BDIZ EDI? The only requirement is membership of the respective association in the BDIZ EDI. The partner associations and their work are regularly presented in our journal. Back issues (PDF files) of the EDI Journal are also available online.

For more scan QR-code:

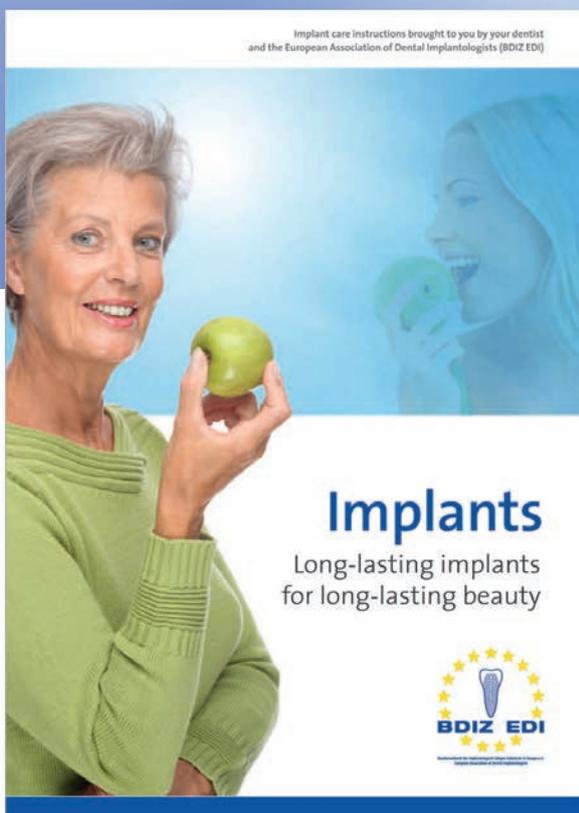


Implant care instructions brochure for patients

Implant maintenance is a team effort

The European Association of Dental Implantologists (BDIZ EDI) has published an English edition of its implant maintenance brochure. In easy-to-understand language, the brochure entitled “Implants—longer-lasting and longer beautiful” offers well-illustrated instructions and general information about oral health.

Teamwork of patient and the dental office is the most important aspect of the brochure. The maintenance brochure is intended for distribution to patients by dental practices and was written to assist them in teaching their patients take care of their dental implants in the appropriate manner. The 24-page patient information brochure in A5 format consists of a general section about oral hygiene and a main section on implant maintenance—all about the right cleaning tools and their use with single-tooth implants as well as fixed and removable im-



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plant-supported restorations. "Good to know" provides background information on choosing the right toothbrush and using the proper brushing technique, describes the process of professional tooth cleaning and educates readers about risk factors. A checklist intends to alert implant patients to possible changes in the mouth and around the implant. This is the first English edition of the brochure, which has been completely redesigned with large images and short texts in easy language that patients can understand. The preface states: "It is up to you to ensure careful oral hygiene, and this is a prerequisite for a long implant life. Teamwork is of the essence!"

AWU

Bibliography

Implant care brochure of BDIZ EDI for patients
Long-lasting implants for long-lasting beauty

A5 format, 24 pages, 32 images
Prize: 1,50 € + VAT + shipping (minimum order: 10)

Contact BDIZ EDI in Cologne/Germany
office@bdizedi.org · www.bdizedi.org > English

Via Phone: +49 89 720 69 888
Fax: +49 89 720 69 889



INTRODUCTION

Why is normal oral hygiene not good enough?

The threat of bone loss

Dental plaque is home to numerous bacteria. As long as the plaque deposits are removed at regular intervals before they cause damage to the teeth or gums, the biological balance in the oral cavity will be maintained. But as soon as the plaque bacteria multiply, there will be an increasing risk of tooth decay and periodontal disease. Severe inflammatory conditions such as periodontitis (inflammation of the gums around a tooth) or peri-implantitis (inflammation of the gums around an implant) pose a significant risk for bone loss and may cause the loss of the tooth or implant.

What tools can and cannot do

- ▶ Toothbrushes (even the most futuristic electric ones) cannot clean the teeth everywhere because they do not get into the interdental spaces.
- ▶ Dental floss, interdental brushes or toothpicks are essential (there is even "thick" dental floss especially for use around implants). They are the only way to remove the bacterial plaque between the teeth.
- ▶ Oral irrigators are of limited use around implants and certainly not a substitute for proper tooth cleaning.

6



INTRODUCTION

Why do implants need particularly intensive care?

There is a natural protective barrier between each natural tooth and the surrounding gums. The transition zone between an implant and its surrounding gums can be passed more easily, so the risk is greater that bacteria can penetrate it and cause inflammation of the mucous membrane around the implant (peri-implant mucositis).

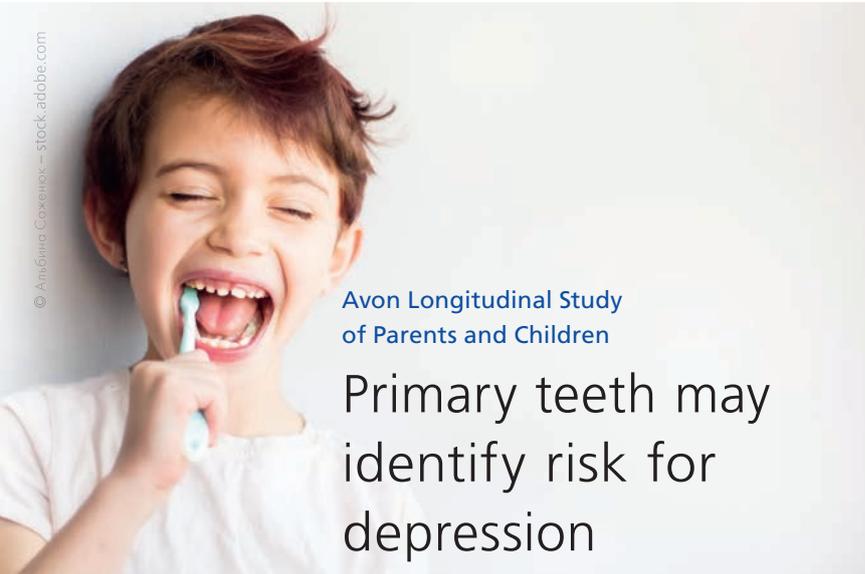
gressing, attacking the supporting jawbone and breaking it up or destroying it. The implant may work itself loose or even to fall out.

The many different types of bacteria in the mouth (in the oral cavity) will colonize implant roots in the same way as natural tooth roots.

Since implant surfaces are usually rough and may be designed in screw form (depending on the system), invading bacteria can settle down easily and will be difficult to remove even by an experienced professional. Unless it can be stopped, the inflammation will keep on progressing.

But if you follow a few simple rules, things will not have to come this far. Proper maintenance is the be-all and end-all of implant care. You should invest a bit more time and effort than with "normal" tooth care. In this guide we show you how to maintain your implants carefully and gently.

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Avon Longitudinal Study
of Parents and Children

Primary teeth may identify risk for depression

The thickness of growth marks in primary (or "baby") teeth may help identify children at risk for depression and other mental health disorders later in life, according to a ground-breaking investigation by the University of Bristol. The team of the University of Bristol/UK analysed 70 primary teeth collected from 70 children enrolled in the Children of the 90s study (also known as the Avon Longitudinal Study of Parents and Children) based at the University of Bristol. Parents donated primary teeth (specifically, the pointed teeth on each side of the front of the mouth known as canines) that naturally fell out of the mouths of children aged 5 to 7. The results of this study could one day lead to the development of a much-needed tool for identifying children who have been exposed to early-life adversity, which is a risk factor for psychological problems, allowing them to be monitored and guided towards preventive treatments, if necessary.

Reference:

Rebecca V. Mountain, Yiwen Zhu, Olivia R. Pickett, Alexandre A. Lussier, Jill M. Goldstein, Joshua L. Roffman, Felicitas B. Bidlack, Erin C. Dunn. *Association of Maternal Stress and Social Support During Pregnancy With Growth Marks in Children's Primary Tooth Enamel*. *JAMA Network Open*, 2021; 4 (11): e2129129 DOI: 10.1001/jamanetworkopen.2021.29129

Source: *Science Daily, UK*

Video conference of European health ministers

How to ensure medical care of refugees

Health ministers met for an informal video conference to agree on a coordinated and inclusive EU response to the health consequences of the war in Ukraine. Health ministers recalled the right of access to healthcare guaranteed by the Temporary Protection Directive. Full implementation of these rights is all the more important for these people given the effects of war on their mental and physical health. Some of them have been injured or suffer from chronic or severe diseases. Ministers referred to actions in the different countries by public authorities, health institutions, health professionals and organised civil society that will allow for emergency or longer-term responses. It is in this context that health ministers have considered how to ensure the medical care of these people and to prepare, from today, for responses to this unprecedented health and human challenge. Ministers welcomed the establishment of the EU solidarity mechanism to facilitate medical evacuations of persons in need of specialised hospital treatment and care. Ministers also agreed in particular on the need to give priority to sick children in the medical evacuation of refugees by ensuring that they remain surrounded by their families, to update in real time the reception capacities for acute care of refugees in order to ensure continuity of care, to consider the means of transport of persons requiring medical evacuation in order to meet needs based on the scale of the situation and to consider the deployment of temporary hospitals in Poland to facilitate the evacuation of patients according to their pathologies. At the heart of the discussion was the medical treatment of refugees suffering from chronic and acute illnesses in border states or member states hosting refugees and people displaced by war. Ministers also discussed resilience of the health systems of all EU member states, already significantly hit by the COVID-19 crisis and now facing a new—and potentially longer lasting—health crisis.

Source: *European Council*

Expert panels on medical devices

Handover to EMA

On March 1, the coordination Secretariat of the Commission's expert panels on medical devices and *in vitro* diagnostic medical devices has been handed over from the Commission's Joint Research Centre (JRC) to the European Medicines Agency (EMA). The JRC had been entrusted by DG Health and Food Safety (DG SANTE) to establish the panels, define guidance documents, operational workflows and necessary IT tools as well as to launch their main advisory functions. During the last four years, JRC and DG SANTE have collaborated intensively to establish these 12 expert panels, which play an important role in improving the clinical evaluation of specific high-risk devices (e.g. implantable heart valves or SARS-CoV-2 assays) under the revised EU legislative framework for medical devices (Regulations [EU] 2017/745 and 746). The background of the handover is the extended mandate of EMA on crisis preparedness and management of medicinal products and medical devices (Regulation [EU] 2022/123), developed as a reaction to the COVID-19 pandemic in the EU. It is expected that EMA's extended mandate will lead to a more integrated, synergistic and coherent approach to the management of availability of medicinal products, medical devices and *in vitro* diagnostic medical devices at Union level, and of the scientific panels for medical devices, thus improving public health protection for the entire Union.

Source: European Commission

New regulation on clinical trials

Improve safety and increase transparency

As of Monday 31, January, the assessment and supervision of clinical trials throughout the EU will be harmonised, notably via a Clinical Trials Information System (CTIS) run by the European Medicines Agency. On this date the Regulation on Clinical Trials will enter into application. This Regulation will improve conducting clinical trials in the EU, with the highest standards of safety for participants and increased transparency of trial information. Welcoming this important step, European Commissioner for Health and Food Safety, Stella Kyriakides, made the following statement: "The Clinical Trials Regulation marks an important and positive step for European patients and brings us closer to a stronger European Health Union. It will allow us to have swifter authorisation of clinical trials across our Member States, thus improving the efficiency of clinical research as a whole. At the same time, the high quality and safety standards already set for such trials will be upheld. While almost 4,000 clinical trials are already carried out each year in the EU, the Regulation will make vital research even more beneficial to the researchers and patients who depend on fast and reliable trials the most. Over the coming years, the Regulation will create a framework for a more agile clinical trial approval process that will bring Member States closer together in the area of clinical trials..."

Source: European Commission

Health workers in Turkey

Strike for better working conditions

Turkish health workers have gone on a three-day nationwide strike. Prior to the action President Erdoğan, commenting on the large number of doctors leaving the country, had said that those who wanted to go should go. Many of those who are leaving cite long working hours, low income, increasing violence and political pressure as reasons. Some outlets find the demands for better working conditions legitimate, others are less conciliatory. "The state has the task of keeping its doctors in the country. It must listen to their concerns and try to develop solutions for them, as well as improve their working conditions and raise their living standards to those of doctors in Europe", requests the Turkish paper *Habertürk*.

Source: Eurotopics





Bundesverband der
implantologisch
tätigen Zahnärzte
in Europa

European
Association of
Dental
Implantologists

Joint press release from BDIZ EDI and associated partners

Representative statement on the war in Ukraine

March 10, 2022

As a European-oriented professional association, the Federal Association of Implantology Dentists in Europe (BDIZ EDI), together with its associated partners, takes a stand on the acts of war in Ukraine.

The BDIZ EDI and its associated partners from Great Britain (ADI UK), Spain (SEI), Poland (OSIS EDI), Serbia (USSI EDI), Portugal (SPCO), Macedonia (EDI Macedonia), the Netherlands (EDI Netherlands) and India (EDI India) as well as friendly associations from France, Italy, Greece, Hungary, the Czech Republic, Slovakia and Austria strongly condemn the illegal invasion of the Ukraine.

Our thoughts are with the citizens of the Ukraine—including members (dentists) of the BDIZ EDI. The medical situation in the war zone is devastating. People are dying from these acts of war, but also due to a lack of medical care. In Ukraine, there is a lack of medical goods and goods of daily use.

Dr. Markus Tröltzsch, board member of BDIZ EDI, is already organizing and supporting regional aid transports to the Ukraine. "We offer our support to our members in Ukraine, who are providing medical and organisational help on the ground. You can contact us if necessary, we are happy to help in any way," says Dr. Troeltzsch.

The BDIZ EDI also explicitly supports the fundraising campaign of the German Dentists' Aid Foundation (Hilfswerk Deutscher Zahnärzte, HDZ) and its patrons the German Dental Association (Bundeszahnärztekammer).

Those who wish to donate will receive a donation receipt if they provide their address:

Hilfswerk Deutscher Zahnärzte
Keyword: Ukraine
Deutsche Apotheker- und Ärztekammer
IBAN: DE28 300 60601 000 4444 000
BIC: DAAEDED333

For further information Anita Wuttke, press officer BDIZ EDI, E-Mail: wuttke@bdizedi.org

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GERMANY

The European Association of Dental Implantologists (BDIZ EDI) is a professional dental association with around 5,800 members throughout Europe. The core tasks are the professional support of its members in legal affairs and private dental billing as well as highly valued continuing education in the fields of implant surgery and implant prosthetics. The BDIZ EDI often takes on the pioneering role when it comes to questioning laws and regulations for dentists.

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Common statement of CED and ERO

Solidarity with dental colleagues and all people in Ukraine

It is with great dismay and concern that dentists in Europe, represented by the Council of European Dentists (CED) and the European Regional Organization of the World Dental Federation (ERO), look at the events in Ukraine. After more than seven decades of peace and security, no one would have believed just a few days ago that they would have to witness a war of aggression in Europe. The images of the people tightly packed in the metro stations of the capital Kiev, seeking shelter from the bombings, painfully remind us all of how fragile and in need of protection even our long taken-for-granted state of peace really is. Russia's attack has turned the wheel of history far back. The fear of a third world war, perhaps even waged with nuclear weapons, has returned.

All over the world—on the streets as well as on social media—there is an impressive show of solidarity these days with Ukraine and its people, who are fighting with great bravery to be able to continue as a free country governed by democracy, and

the courage and determination demand the greatest respect from all of us.

The leading organizations of European dentists, on behalf of their member organizations in the countries of the European Union and—in the case of the ERO—other countries outside the Union, declare their full solidarity with the dentists in Ukraine, their practice teams and all the inhabitants of this embattled country. In many member states of the CED and the ERO, fundraising and relief actions have already been launched, also by the dentists, and we ask you to support these actions in the interest of all those who are affected by the consequences of the fighting.

Dr Freddie Sloth-Lisbjerg
President CED

Dr Michael Frank
President ERO

Federation Dentaire Internationale

FDI calls for medical neutrality to be observed in Ukraine

FDI World Dental Federation (FDI) stands in solidarity with the healthcare community and our National Dental Associations to express deep concerns about the war taking place in Ukraine. We call for the international principle of medical neutrality and human rights to be upheld and respected.

The escalating health crisis in Ukraine has deeply alarmed FDI. We want to stress that medical facilities and health workers must not become military targets. Protection of healthcare workers, including dentists and dental teams must be ensured. The security of health personnel must be guaranteed, and health professionals should not be prevented from performing their professional duties.

FDI President, Professor Ihsane Ben Yahya says, "In times of armed conflicts and civil unrest, medical services must be permitted to continue without any interference. FDI calls for healthcare providers, such as dentists and dental teams to be able to continue their duty of care safely. All required measures must be taken to ensure patients and casualties have secure access to healthcare. My deepest thoughts and prayers are with my Ukrainian colleagues with whom I stand in solidarity."

FDI condemns the use of force on medical facilities and emphasizes that preventing dentists and other healthcare providers from performing their duties clearly violates international law, in particular the Geneva Convention and its additional Protocols. It also puts countless civilian lives at risk. FDI calls for the work of healthcare providers and the neutrality of healthcare institutions to be respected.



Professor Ihsane Ben Yahya, FDI president.

If you would like support humanitarian efforts in Ukraine and neighbouring countries, you can donate to the International Committee of the Red Cross (ICRC) and/or UN Refugee Agency (UNHCR).*

Additionally, you can send emergency medical supplies (local anesthetics, medical masks, medical gloves, disposable sterile surgical covers, anesthetics, suture material, antipyretics, antibiotics) to the following address:

I.Horbachevsky National Medical University Ternopil
1 Maidan Voli, Ternopil, 46001
Ukraine
www.tdmu.edu.ua/en

**Please note there may be some delays before the links open.*

Source: FDI Press release

Certification as an EDA Expert in Implantology

Qualification for experienced implantologists

For many years, BDIZ EDI has been catering to experienced and well-versed oral implantologists by offering the certification exam for EDA Expert in Implantology. Jointly with the European Dental Association (EDA), BDIZ EDI regularly invites interested dentists to take the certification exam, which we would like to present in this article.

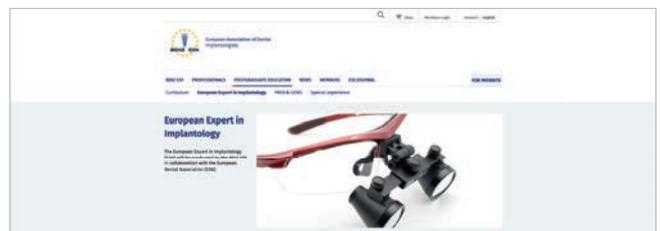
That quality is of paramount importance to BDIZ EDI is no secret. BDIZ EDI has demonstrated this in many different areas – legal and accounting, materials testing, postgraduate education, the annual Guidelines of the European Consensus Conference (EuCC) on current implantological issues and finally the qualification of court experts. BDIZ EDI also supports dental education with its Curriculum Implantology that introduces aspiring dentists and young implantologists to this dental specialty in eight well-organized modules.

Admission requirements for the certification exam

Certification as Expert in Implantology requires very good to excellent skills and knowledge. Candidates must meet the following admission requirements:

- 250 EDA-recognized continuing education/training hours in various sub-disciplines of implantology
- Submission of ten documented, independently performed implantological treatment cases
- At least five years of professional activity, primarily in the field of implantology.

Specific experience and primary activity in the field of implantology must be documented by at least 400 implants inserted and



150 implants restored within the past five years. Candidates who already obtained qualifications in oral implantology (eg from other professional societies) may submit the appropriate credentials with their application for certification as EDA Expert in Implantology.

The exam

Candidates meeting all the requirements will be admitted to the examination. The examination board of BDIZ EDI and EDA consists of recognized specialists. The exam has a theoretical and a practical part, both of which must be completed successfully. The procedure is as follows: The theoretical part of the exam will start with a discussion of the documented cases. In addition, candidates are expected to answer questions related to oral implantology and closely associated fields. The theoretical examination usually takes no longer than 60 minutes; it may be administered to candidates in groups. The practical part of the examination covers one or more recognized, state-of-the-art treatment method or methods and/or treatment plans covering some aspect of oral implantology. Candidates will be informed of the respective topic two weeks before the exam date. Candidates are responsible for providing the required materials and instruments on the day of the exam. The examination as a whole is subject to a fee to cover the cost incurred by the examination board.

New EDA Experts in Implantology are nominated by the president or vice president of the EDA certification committee.

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More information

To register for the next certification exam, please go to www.bdizedi.org and select English > Professionals > Expert or write to the BDIZ EDI office in Cologne at office@bdizedi.org.



Scientific survey of ESCI supported by BDIZ EDI

Results of the clinical approach of ceramic dental implants

Ceramic implants are already established in modern dental implantology as a supplement to the treatment spectrum with titanium implants. An increasing interest can be observed not only on the part of health-conscious patients, but also in the dental profession due to biological advantages. Promising short- and medium-term data on the successful use of ceramic implants are already available. .

Nevertheless, the topic of "ceramic implants" is still controversial in part due to the lack of longterm data. Systematic reviews refer to specific experiences with individual systems. Comprehensive findings from the general practical use of ceramic implants and experience from daily dental practice are still lacking. The European Society for Ceramic Implantology (ESCI) contributes with this survey to a deeper insight into the general daily handling of ceramic implants and to answer questions concerning ceramic implantology. This survey provides valuable information for the further development of ceramic implants and makes an important contribution to their reliable use—ultimately for safe use in our patients.

Method

The questionnaire was designed by the ESCI Scientific Advisory Board in German/English and was addressed to users of ceramic implants as well as users of titanium implants and dental technicians. The results of the survey were evaluated by the ESCI. The survey was not conducted for commercial purposes, and no financial resources were provided by partners or other third parties. This questionnaire was implemented in an online survey tool and sent as an online link via email, among others to the members of the ESCI, published on the homepage of the ESCI, published via print media of the dental press, as well as distributed via various other channels of the survey partners from April to November 2021. This included social media activities and newsletters from collaborating professional societies and the ESCI Company Partners.

The number of 316 received responses from all over Europe and the whole World shows the impor-

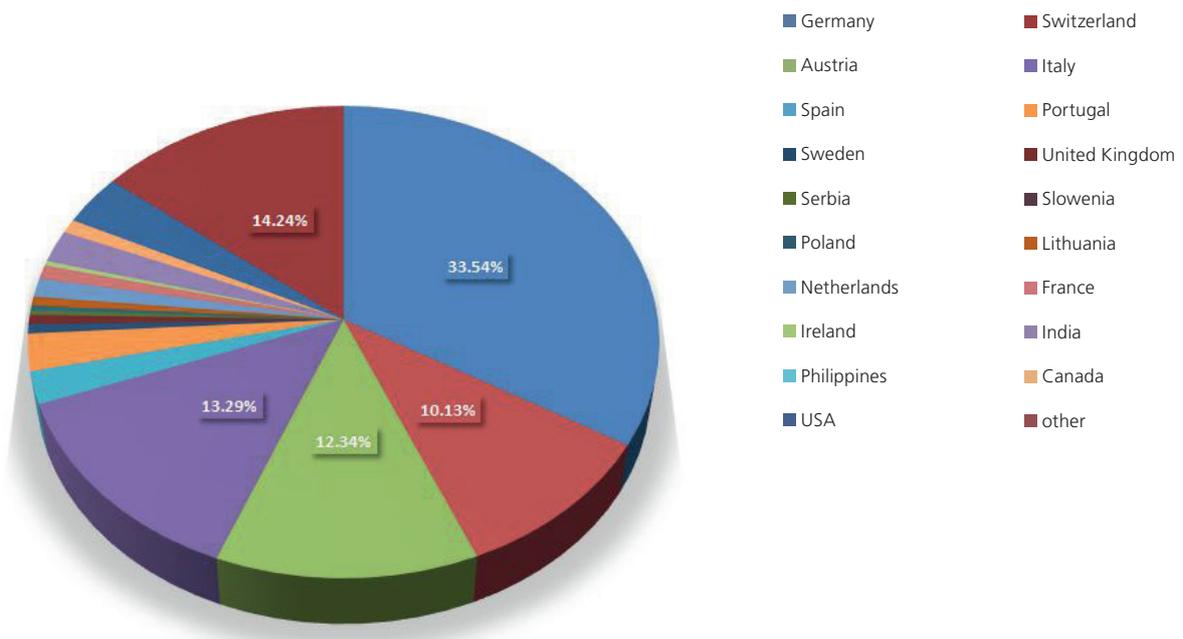
ance of the topic "ceramic implants" and allows to draw relevant conclusions (Fig 1).

Distribution of responses from 45 countries

In addition to the general demographic information (Part A), the questionnaire was divided into three sections (Parts B, C and D). Each of the target groups was directed to a part of the overall catalogue with questions specific to that target group. (42 questions in total): Part B: Dentists, oral surgeons, maxillofacial surgeons with experience in ceramic implantology Part C: Dentists, oral surgeons, maxillofacial surgeons without experience in ceramic implantology Part D: Dental technicians

Conclusion

The large number of participants in an extensive survey shows the interest in the topic of ceramic implants in dentistry and oral surgery. The comparison of the answers given by practical experienced participants to those who acquired theoretical knowledge of the subject is quite interesting. The assessments coincide in some areas but drift apart in others. The possible advantages of the material zirconia dioxide in terms of biocompatibility and low tendency to inflammation were confirmed and are in line with our view. In particular, a significantly lower tendency to peri-implantitis seems to be observed in free practice, which should be confirmed by the initialization of corresponding clinical studies. The fear of the past regarding stability could at least be relativized for the newer systems since fractures are not in the foreground in the data on the reasons for loss. The potential for osseointegration was rated equally for



both materials. In particular, the proportionally most frequently mentioned “early loss” during the healing phase gives cause for further evaluation. Since various factors such as overloading, incorrect loading, surface design, bone degeneration due to overheating can play a role, further differentiation should be made here in order to reduce failures. All responses indicate a clear tendency towards two-part systems, which allow a broader range of indications and offer more flexibility. Solutions are requested which simplify the application compared to titanium implants. See also “ESCI official scientific statement two piece ceramic implants” at www.esci-online. The clearest requirement, however, runs like a red thread through the survey: users of ceramic implants should convey their experiences and make them accessible to all interested parties. There should be broad, scientifically sound and objective information on the subject. The data on ceramic implants must be improved and long-term evidence-based studies initiated, then ceramic implants will increasingly establish

themselves for a broad user group in the interest of our patients. Implementing this requirement is a clear call from the survey to all manufacturers and research institutes - and a core topic of the European Society for Ceramic Implantology ESCI

For a detailed overview of all questions and results please visit www.escionline.com or request the full Data Summary directly at ESCI office by mail to info@esci-online.com

ESCI

Thanks to...

At this point, the ESCI would like to thank all supporters for their efforts. These are the Austrian Society of Implantology (ÖGI), European Association of Dental Implantologists (BDIZ EDI), PEERS, the German Society for Environmental Dentistry (DEGUZ), the “Zahngipfel”, as well as the companies Straumann AG, Camlog Biotechnologies AG, Nobel Biocare AG, Dentalpoint AG, Z-Systems AG, COHO Biomedical Technology, Ceramtec AG, Zircon Medical AG and the Dental Campus Association, as well as the publishers Quintessence Publishing, PIP Verlag, Dentale Implantologie DI Spitta Verlag, ZZ Schweiz, OEMUS MEDIA AG and others.



Professor Axel Karenberg about dentistry in the cinematographic oeuvre

Dentists in motion pictures

Portraits of dentists in films represent an important source of historical images. The dentist motif captures scientific and technological developments and reflects common interactions—complete with existing and changing social values. They represent the profession and its popular image—visually as well as sociologically.

Part 1 (1907–1963)

A number of doctoral dissertations [Gerhards, 1991; Riescher, 2001; Petzke, 2009] have tried to describe the world of dentistry as depicted in the borderlands between reality and fiction. In an in-depth analysis of cinematic representations, we would initially be interested in some rather banal facts: Where did the films come from? When were they made? What film genres could they be assigned to? Next, we would look at the dentistry aspect proper: What is diagnosed or treated, where and how? Is the account authentic? Furthermore, aspects of gender and status would have to be

considered. And looking at the surviving cinematographic oeuvre in its entirety, the most important points of interest would be: How has the image of dentistry in this medium been construed over the decades? What continuities can we trace? What fracture lines can we detect? Organized to examine six time periods in two instalments, this paper attempts to find some answers to these questions.

German Empire and Weimar Republic (1907–1932)

Looking at Germany, the motion picture industry and modern dentistry are children of the same period: Imperial Germany and the Weimar Republic. The original “cinema of attractions”, consisting mainly of one- to three-minute flicks, was gradually superseded by a “cinema of storytelling” that valued longer narratives. It attracted the attention of production companies and gave rise to job descriptions that are still used today, such as film director and actor [Toeplitz, 1979; Balázs, 1980]. During these years, the dental profession transcended its previous predominantly surgical orientation by integrating restorative and preventive aspects. The growing popularity of infiltration anaesthesia (after 1905) and the introduction of radiodiagnostics (after about 1920) constituted further modernization steps [Hoffmann-Axthelm, 1985]. Dentistry became an academic discipline in Germany during this time, although the dualism of dentistry as an academic pursuit and dentistry as a craft persisted into the 1950. However, after World War I, the status of the fledgeling academic discipline was elevated by the introduction of the academic degree of “Dr med dent” [Groß, 2006].

Silent films of the era reflected almost none of this. Only very few German short films with dental



Fig. 1: Beim Zahnarzt (“At the Dentist’s”, 1907), still image. Internationale Kinematograph- und Lichtbild-Gesellschaft (Berlin). Image citation of a publicly available copy, Deutsches Filminstitut (DIF).



Fig. 2: Hundstage Zahnarzt (“The Dog Days of Summer”, 1944), still image. Deutsche Forst-Filmproduktion GmbH and Wien-Film. Director: Géza von Cziffra. Rolf Wanka and Wolf Albach-Retty as dentists. © Wien-Film. Courtesy of Herbert Klemens, Filmbild Fundus.

motifs have survived (Table 1) – which is not that surprising, given the fact that 80% of all “silent movies” ever made in the world were never archived or have been destroyed [Nowell-Smith, 1998]. Unfortunately, *Fräulein Zahnarzt* (“Miss Dentist”; 1919)—the first film showing a female dentist—is among those which have been lost. One early film that is accessible demonstrates a complete dental treatment in three minutes: *Beim Zahnarzt* (“At the Dentist”, 1907). The technical term is “sound picture” because the hand-cranked projector had to be synchronized with a gramophone playing back a shellac record.

The audience was shown the scene, set in a salon, through the lens of a stationary camera (Fig. 1). The

practitioner wears a professional outfit and has a dental chair, a foot-treadle drill, a tray and a kind of spittoon, and he has a housekeeper around (but not an assistant). He takes a quick look into the mouth of the pain-stricken patient, decisively seizes a forceps and quickly pulls out the first tooth. Then the story gets weird: The practitioner reinspects the surgical area, laughs and quickly removes a second tooth—this time, apparently, the correct one. In the end, the patient, relieved of his pain, pays the fee and leaves the “studio”.

Another work, created shortly after World War I, takes us all the way into the realm of slapstick. The protagonist of *Emil hat Zahnschmerzen* (“Emil Has a Toothache”, 1921) unsuccessfully tries to treat his own complaints with heat. Of sheer necessity, he has to consult a dentist, who with a devilish grin immediately reaches for his forceps. The rest of the procedure remains hidden to the audience, even though contemporary cameras were already able to pan and zoom. To create a comical situation, the dentist extracts the wrong tooth again. This is followed by fisticuffs on the part of the patient, who refuses to pay and chases his tormentor into the street.

These are the only two German silent films on the subject that are still accessible today. The second one in particular established the image of the dentist of a comic, an image that had come to German cinema from Hollywood. The dominant motif was extraction without anaesthesia—a common representation of dentistry at the time in many countries [Gierok, Mirza and Karenberg, in press]. The existing focus on the surgical aspect reflects the general entertainment setting, where sensation-hungry spectators gloated over the sorry fate of afflicted fellow souls, being greatly (and grossly) entertained by drastic visual effects and coarse situational comedy.

Nazi Germany (1933–1945)

The early 1930s were a time of many profound changes. The National Socialists, the Nazi party, set out to call all the tunes, not only in cinematic art but also in the medical and dental associations, which were quickly brought into political line. The professional dualism within the dental profession continued, and non-academic dentists (18,000 in 1933) clearly outnumbered academic dentists (10,000) [Rinnen/Westemeier/Groß, 2020]. Innovations mainly concerned the radiological field (with panoramic images) and dental technology (where a heat-curing acrylic, Paladon, was introduced in prosthetics).

No.	Title	Year	Director
1-1	Beim Zahnarzt ("At the Dentist")	1907	?
1-2	Zahnarzt wider Willen ("Dentist Against his Will"; film has been lost)	1917	?
1-3	Karlchen beim Zahnarzt ("Karlchen at the Dentist's"; film has been lost)	1919	Emil Albes
1-4	Fräulein Zahnarzt ("Miss Dentist"; film has been lost)*	1919	Joe May
1-5	Wenn Zahnarzt Krause spazieren geht ("When Dentist Krause Goes for a Walk"; film has been lost)	1921	(animated film)
1-6	Emil hat Zahnschmerzen ("Emil Has a Toothache")	1921	Albert Lastmann
1-7	Weekend im Paradies ("Weekend in Paradise"; film has been lost)	1931	Robert Land

Table 1: Feature films with dentist motif (1907–1932).

* Featured dentist is a woman

Today, Nazi films are commonly associated with propaganda, but in fact the "light entertainment" produced on the assembly line in the UFA studios, depicting a world far away from people's quotidian toils, played a much greater role in Nazi film policy in quantitative terms [Lowry, 1994]. The eleven films on the subject of dentistry that were shot during the "Third Reich" fall into this entertainment category. Seven of them have survived (Table 2); a female dentist appeared at the very end of this period, in *Meine Herren Söhne* ("Dear Messrs. Sons", 1945). However, the director did not show her practicing her profession.

In 1937, the fast-paced screwball comedy *Kapriolen* ("Capers") brings well-known actors Gustav Gründgens and Marianne Hoppe together in a dentist's waiting room, where they spontaneously fall in love. During the subsequent treatment of the young man, there is no talk of an extraction but of a "gold filling". The dentist himself became the source of erotic sizzle in a shallow comedy that opened in theatres nine months before the end of the war. The main characters in *Hundstage* ("The Dog Days of Summer", 1944) are Peter and Paul, two friends and colleagues. Paul has married his assistant, and his stand-in Peter is flirting with a patient (Fig. 2). In both films, the hyper-realistic contemporary-looking surgeries with hydraulically adjustable dentist's chairs, treatment units with Doriot articulated linkage, a tray, lamp, spittoon, etc., have a remarkable effect—a big leap forward from the silent film era. Technology as a secular trend in dentistry had arrived in the feature film. In retrospect, however, the attempt by the set designers to maintain the illusion

of normality and progress in war-torn Germany by depicting an ultra-tidy and almost futuristic practice on the set seems frightening.

Overall, in Nazi cinema, the appearance of the dentist figure in comedy solidified. Without the professional activity itself appearing as a comic element. In almost half of the surviving films, the dentist even played the lead. Nevertheless, treatment scenes were brief—something that also characterized later productions. Tooth extractions, previously dominant, were replaced by a tooth-preserving therapy, and in one case, even a prosthetic treatment was suggested. In Nazi film policy, comedies were meant to distract from a grim reality and to simulate a normal life, which included visits to the dentist.

Post-WW II (1946–1963)

In the years immediately following the war, the two parts of Germany started moving in different directions. This also included the beginning of the coexistence of two film worlds, with a Hollywood-oriented film industry in the West and Deutsche Film AG (DEFA) in the East. Although many productions seem rather shallow and affirmative in retrospect—"amusement without depth"—these were still golden years. Peak figures of almost 10,000 film theatres with more than a billion visitors nationwide speak for themselves; the average German went to see a picture more than ten times a year, helped by the breakthrough of colour [German Film, 1945–1990]. The reconstruction of dental care also proceeded separately in the West and in the East [Gross, 2019]. There were the Federal Associa-

No.	Title	Year	Director
2-1	Liebe und Zahnweh ("Love and Toothache"; film has been lost)	1934	Georg Jacoby
2-2	Wette um einen Kuss ("Bet You a Kiss"; film has been lost)	1936	Jürgen von Alten
2-3	Vier Mädels und ein Mann ("Four girls and one man"; film has been lost)	1936	Peter Paul Brauer
2-4	Der Prüfstein ("The Touchstone"; film has been lost)	1937	Ernst Martin
2-5	Kapriolen ("Capers")	1937	Gustaf Gründgens
2-6	Der Maulkorb ("The Muzzle")	1938	Georg Jacoby and others
2-7	Großalarm ("General Alarm")	1938	Robert Land
2-8	Die unheimliche Wandlung des Alex Roscher ("The Uncanny Transformation of Alex Roscher")	1943	Paul Ostermayr
2-9	Gefährlicher Frühling ("Dangerous Spring")	1943	Hans Deppe
2-10	Hundstage ("The Dog Days of Summer")	1944	Geza von Cziffra
2-11	Meine Herren Söhne ("Dear Messrs. Sons")*	1944	Robert A. Stemmlé

Table 2: Feature films with dentist motif (1933–1945)

* Featured dentist is a woman

tion of German Dentists in the West and its counterpart, the German Society of Stomatology, in the East. On both sides of the Iron Curtain, the academic/non-academic dualism, with non-academic dentists being integrated into the dental profession. Technical developments once again centred on radiology (panoramic radiographs), and functional orthodontics also took off [Baltes, 2013].

The frequency pattern of about "one dentist film" per year continued unchanged in post-war cinema, preponderantly in the West (Table 3). This was the beginning of the era of famous film dentists (Werner Finck, Heinz Rühmann), even more famous film patients (Romy Schneider, Hans-Joachim Fuchsberger) and dentist scene in dramaturgical focus, for example in the comedies *Witwer mit fünf Töchtern* ("Widower with Five Daughters", 1957) or *Die Zürcher Verlobung* ("The Zurich Engagement", also 1957). At last, active female film dentists appeared in two everyday comedies—50 years after women were first admitted to the study of dentistry.

Senator Thomas' visit to the dentist in *Buddenbrooks* ("The Buddenbrooks") will be familiar mainly to literature aficionados. The novel had first been adapted for the screen in 1923, but without the notorious dentist Brecht making an appearance [Pommer, 1923]. A historicising remake followed in 1959, which now took up the dental treatment—or rather

attempted treatment. It is almost common knowledge among dentist readers that it was not a genuine oral problem that had prompted Thomas Buddenbrook's visit to the practice, but rather some cardiac pain that projected into the right mandibular region. Dr. Brecht could therefore possibly be blamed for a misdiagnosis and an extraction that was not performed *lege artis*, with fracturing of a molar and three broken roots—but hardly for the senator's cardiac death shortly thereafter. In this filmic representation of the rare "Buddenbrook syndrome" [Moog, 2003], slight discrepancies arise between the literary model and medical reality: in the novel, four residual roots remained *in situ*, while in reality, the pain more often radiates into the left mandibular region.

In the comedy *Meine Tochter und ich* ("My Daughter and I", 1963) (Fig. 3), Heinz Rühmann, playing dentist Dr Robert Stegemann, not only restores the teeth of his anxious patient in one sequence, but also heals her wounded soul: "Bravery is the overcoming of our fear", "Now we're almost there", "it already looks quite nice", "just a few minor corrections".

It is somewhat daring but nevertheless plausible to compare a rehabilitated dentition with the rebuilt Federal Republic and the post-war reconstruction, with a dentist taking stock of the post-war years—

No.	Title	Year	Director
3-1	Affaire Blum ("The Blum Affair"; DEFA)	1948	Erich Engels
3-2	Die Frau von gestern Nacht ("The Woman from Last Night")*	1949	Arthur M. Rabenalt
3-3	Peter als Zahnarzt ("Peter as a Dentist"; film has been lost)	1950	Hans Böhlke
3-4	Meine Nichte Susanne ("My Niece Susanne"; film has been lost)	1952	Wolfgang Liebeneiner
3-5	Liebe im Finanzamt ("Love at the Tax Office"; film has been lost)*	1952	Kurt Hoffmann
3-6	Heute heiratet mein Mann ("Today my Husband is Getting Married")	1956	Kurt Hoffmann
3-7	Besondere Kennzeichen: keine ("Distinguishing Marks: None"; DEFA)	1956	Joachim Kunert
3-8	Alter Kahn und junge Liebe ("Old Barge, Young Love"; DEFA)†	1957	Hans Heinrich
3-9	Die Zürcher Verlobung ("The Zurich Engagement")†	1957	Helmut Käutner
3-10	Witwer mit fünf Töchtern ("Widower with Five Daughters")	1957	Erich Engels
3-11	Der Maulkorb ("The Muzzle")	1958	Wolfgang Staudte
3-12	Die feuerrote Baroness ("The Scarlet Baroness")†	1958	Rudolf Jugert
3-13	Ein Engel auf Erden ("An Angel on Wheels")†	1959	Géza v. Radványi and others
3-14	Buddenbrooks ("The Buddenbrooks")†	1959	Alfred Weidenmann
3-15	Drei Kapitel Glück ("Three Chapters of Happiness": DEFA)	1961	Walter Beck
3-16	Die Türkischen Gurken ("Turkish Cucumbers"; film has been lost)	1962	Rolf Olsen
3-17	Meine Tochter und ich ("My daughter and I")	1963	Thomas Engel

Table 3: Feature films with dentist motif (1946–1963).

DEFA = Deutsche Film AG, East Germany
 * Featured dentist is a woman
 † Film appears to actually have shown in English under this title [translator's note]

full of privation but a stunning economic success. Or in other words: a successful restorative treatment becomes a symbol for the successful political and social restoration in the Federal Republic of Germany and the values associated with it.

Looking back at the years 1948–1963, we can conclude that the dentist role in films remained moderately popular in both parts of post-war Germany, with the comedy genre remaining at centre stage. In the West, the figure of the mature, jovial but competent practitioner emerged; this too is definitely a reflection of the times. Tooth preservation was now in focus, extractions were rarely shown, almost being considered an anachronism.

(Read Part 2 in our next issue.)

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Minimally invasive implant placement with internal sinus floor elevation

Mahssa Arjmandi, Dr med dent, Mannheim, Germany

The surgical oral rehabilitation of elderly patients with pre-existing conditions, sometimes exacerbated by an insufficient bone supply, requires a minimally invasive procedure that avoids inflicting strain on the patients. Even if the amount of available bone in the maxillary sinus region is limited, denture retention in senior patients can be significantly improved by a simple and uncomplicated procedure. MIMI—which stands for “minimally invasive method of implantation”—in combination with an internal direct maxillary sinus lift, shortens treatment times and causes virtually no postoperative discomfort. This article presents the MIMI procedure as exemplified by a case report.

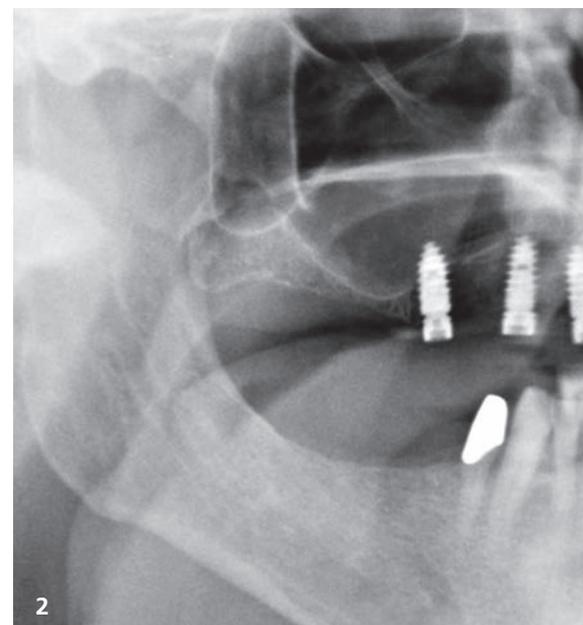
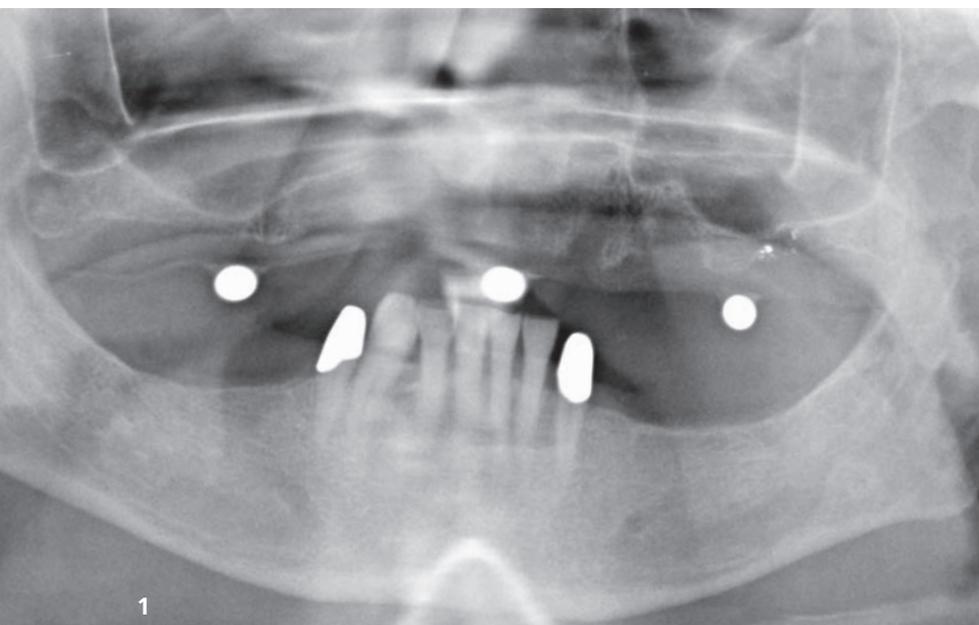
Baseline situation

An 88-year-old male patient presented with a maxillary telescopic denture whose retention was insufficient. The patient wanted a new restoration. The two remaining abutment teeth showed massive widening of the periodontal space and grade 3 mobility and were not considered salvageable, so their extraction was indicated. The patient did not want to accept any further decline in denture retention after tooth extraction and opted for a prosthesis supported by six implants and retained with ball attachments. The patient suffered from multiple afflictions, including diabetes. He was taking various medica-

tions, including the ASA 100 thrombocyte aggregation inhibitor.

Procedure

The vertical bone height was measured on a panoramic radiograph (Fig. 1). The magnification factor was determined with three measuring spheres attached to a template. Six two-piece Champions (R) Evolution implants (4.0 × 10 mm, 3.5 × 10 mm or 3.5 × 8 mm) were placed between sites 15 and 25. For local anaesthesia, Ultracain D-S was distributed in small doses across the area to be implanted. The cortical navigated implantation procedure (CNIP)

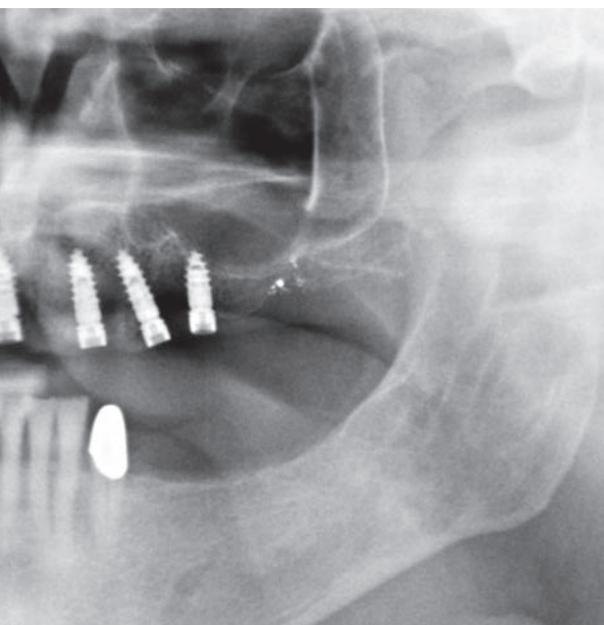


was minimally invasive, effected by transgingival low-speed drilling with guidance through the cortical bone.

Given the low drilling speed, irrigation with saline solution could be dispensed with. After each drilling step, the integrity of the bone walls of the resulting cavity was checked on all sides with a blunt probe of appropriate length (bone cavity test). An internal direct sinus lift was performed at site 14 using a conical triangular drill bit (\varnothing 2.3 mm) to pre-drill to about 1 mm short of the floor of maxillary sinus. The remaining bone of the maxillary sinus floor was compacted with condensers.

The membrane was raised with another condenser (\varnothing 3.0 mm) with a rounded tip. A collagen fleece (CollaWin) was inserted into the bone cavity and compacted with a very short round drill (\varnothing 3.7 mm) rotating counter-clockwise. Bone stability was verified with condensers of ascending diameter, and the 4 × 10 mm implant was inserted with a primary stability of 30 Ncm. The margins of the implant shuttles that double as gingivaformers/healing abutments were placed level with the gingiva.

Following implant placement, a control panoramic radiograph was taken (Fig. 2). There was some blurring in the anterior region, so individual radiographs were taken for better visualization (Figs. 3a and b). The radiograph image of the first quadrant (Fig. 3a)



About ...



Dr Mahssa Arjmandi

Dr Arjmandi, you are an associate dentist at the practice of Dres. Weickum in Mannheim, Germany. What is it that you find so fascinating you about oral implantology?

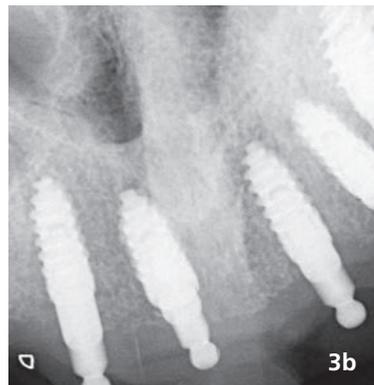
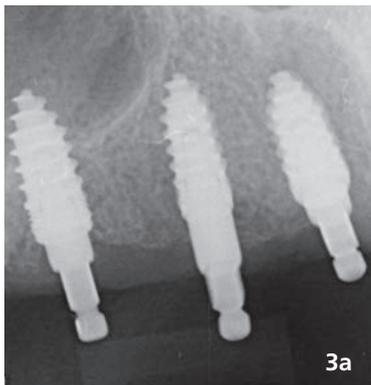
Oral implantology is a dental specialty that opens up a wealth of possibilities for patient care. Patients can be treated quickly, minimally invasively and with little pain—to the point where individual resilience and patient age hardly play a role once patients decide to improve their quality of life.

You have completed the curriculum “Expert in Oral Implantology and Implant Prosthetics”. What do you think was your greatest learning success?

Above all, the curriculum has helped me build more self-confidence. I had already planned and performed a few minor implantological treatments before attending the curriculum, but I would never have ventured into more complex rehabilitations. The curriculum was very much “hands-on”, and I was thoroughly familiarized with cases with different bone qualities, an inadequate bone supply and also narrow ridges. And what I learned about sinus lifts, for example, did not stay at the theoretical level. I was given the opportunity to assist fellow dentists with implant cases and to perform implantological treatments in my own practice, under their guidance. My greatest learning success was that the range of patients for whom I can recommend and offer implant treatment has increased—because I had had the opportunity to handle more and different anatomical situations.

What are the recurring challenges in your daily implant work?

Suboptimal bone conditions are probably the greatest day-to-day challenge, especially in patients with major bone defects due to previous inflammatory disease.



clearly documents the results of the sinus lift. Figure 4 shows the intraoral situation directly after implant placement, highlighting the advantages of the MIMI procedure.

Immediate result

The patient left the practice with six new implants and no wound in the oral cavity. Ibuprofen 600 was prescribed to be taken if and when needed. The patient reported needing only one tablet, on the day of placement. Due to the patient's multimorbidity and his diabetes, postoperative antibiotic prophylaxis was also prescribed (Augmentan 875/125 mg for five days). A temporary restoration was realized made by reworking the patient's telescopic denture. Around the implants, the prosthesis was relieved to the point where the implants would not be subject to any loads during the healing phase.

Follow-up

After ten weeks, an impression was taken for a conventional maxillary complete denture. The dental technician relieved the denture to accommodate the

MMT female components (matrices) in the implant region area of the denture. In the final step, the shuttles were removed, and the ball attachments were screwed in at approximately 20Ncm. The MMTs were attached to the ball attachments and connected to the finished denture with acrylic resin. The finishing steps were performed by the in-house laboratory (Fig. 5).

Once the denture had been delivered, the patient was shown how to handle and clean the restoration and implants. At the initial follow-up two days later, the patient was highly satisfied; only a minor pressure point had to be attended to. Figure 6 shows the implant situation at the eight-month follow-up. The patient has adapted well to caring for his new restoration, reporting a significant increase in terms of his quality of life. In particular, he once again enjoys his food and has with pleasure accepted invitations to meals with his family and friends.

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For the 3D reconstruction of atrophic maxillae

Graft volumetric changes of collagenated xenograft

Dr Livio Lo Faro, Dr Francesco Giachi Carù & Prof Tiziano Testori, Italy

Introduction

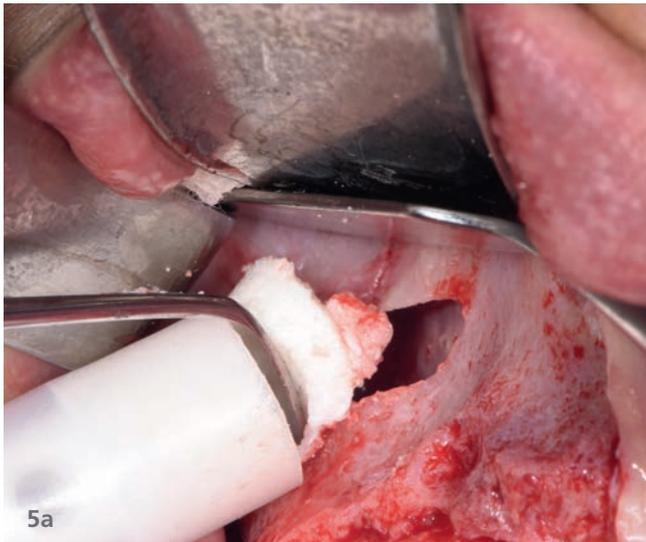
Placement of dental implants is an increasingly common approach to the replacement of missing teeth.¹ Implant-supported prostheses can be used as an alternative to traditional bridge-work or removable dentures in case of partially and completely edentulous patients. However, the posterior region of the maxilla is usually a challenge for surgeons owing to the bone resorption that occurs after tooth extraction.²⁻³ Moreover, the maxilla mainly consists of spongy bone, which is one of the least dense in the oral cavity.⁴ To compensate for atrophy and increase the bone volume available for the insertion of implants, various techniques have been developed.⁵ Maxillary sinus elevation is a predictable and well-documented method to increase bone volume for maxillary implant placement.^{6,7} This procedure may even increase bone quality by augmenting the sinus cavity

with a bone grafting material that generates a denser bone. The standard maxillary sinus elevation methodology involves creation of an external window, careful lifting of the sinus membrane and packing of the sinus floor under the lifted membrane with a bone graft. Its predictability and safety have been demonstrated since 1980 by evaluating bone formation, noting low complication rates and high implant success rates^{8,9} regardless of the residual crestal bone height.¹⁰

Instead, for minor and moderate horizontal ridge deficiency, guided bone regeneration (GBR) offers the possibility of restoring the bone architecture through the application of bone grafting materials in conjunction with barrier membranes to stabilise and protect the grafting materials placed.¹¹ Recently, GBR using resorbable membranes has been shown to correct or augment knife edge ridges.¹²⁻¹⁴ The PASS principle (primary wound closure, angiogenesis, space maintenance and stability



Fig. 1: Intra-oral image. **Fig. 2:** Pre-operative radiograph. **Fig. 3:** Antralostomy design by means of piezo-surgery. **Fig. 4:** Elevation of the Schneiderian membrane.



Figs. 5a & b: Placement of collagenated sticky bone substitute inside the antrostomy on the right side **(a)** and prehydrated heterologous bone substitute inside the antrostomy on the left side **(b)**.

of the blood clot) remains a cornerstone of successful GBR.¹⁵ A combination of ridge and sinus augmentation for partially edentulous patients has been documented to produce medium- to long-term implant survival.^{16–18} In the arena of GBR as well as sinus augmentation, a wide variety of materials have been investigated. So far, no consensus has been reached with regard to the clinical superiority of one material over another. The purpose of the current article is to illustrate how the combination of different techniques, the correct use of bone substitutes and soft-tissue management can restore a maxillary arch and deliver a fixed implant-supported prosthesis, as well as to evaluate the volumetric change of the bone substitute used over time.

Case 1: Maxillary sinus surgery and delayed implant placement

A 50-year-old female patient presented at Lake Como Institute in Italy needing complete maxillary rehabilitation. Careful clinical examination and radiographic (conventional and CBCT scan) assessment were carried out, and all the teeth were

deemed hopeless (Figs. 1 & 2). The patient requested rehabilitation of the maxilla with a fixed prosthetic solution. The treatment plan included four surgical steps: the extraction of all of the remaining teeth, bilateral maxillary sinus elevation with initial horizontal augmentation, implant placement with a second horizontal augmentation and the uncovering phase for the management of the soft tissue. After the extractions, a complete denture was delivered to the patient. It was decided to wait for four months before moving on to the next surgery in order to allow the post-extraction sockets to heal. The prosthesis was relined twice during this time to obtain correct adaptation.

Before performing the bilateral maxillary sinus elevation, a clinical and radiographic evaluation were carried out to determine the difficulty of the surgery.¹⁹ After local anaesthesia (4% articaine with 1:100,000 adrenaline) of the maxillary edentulous areas, two crestal incisions displaced towards the palatal sides were performed. Divergent releasing incisions were made buccally in the canine and tuberosity sites, and two full-thickness flaps were elevated at the buccal sides to expose the lateral walls of the maxillary sinuses. Two lateral osseous windows were then cut using different inserts of a piezoelectric device (Fig. 3). Care

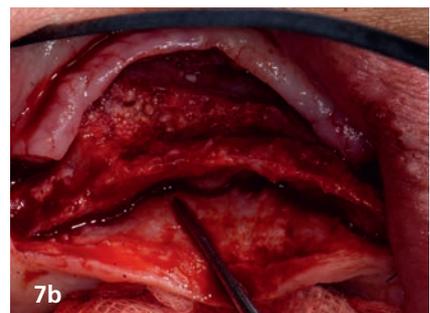
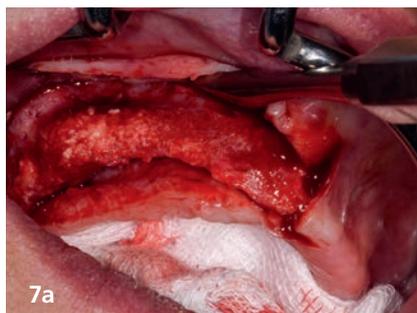
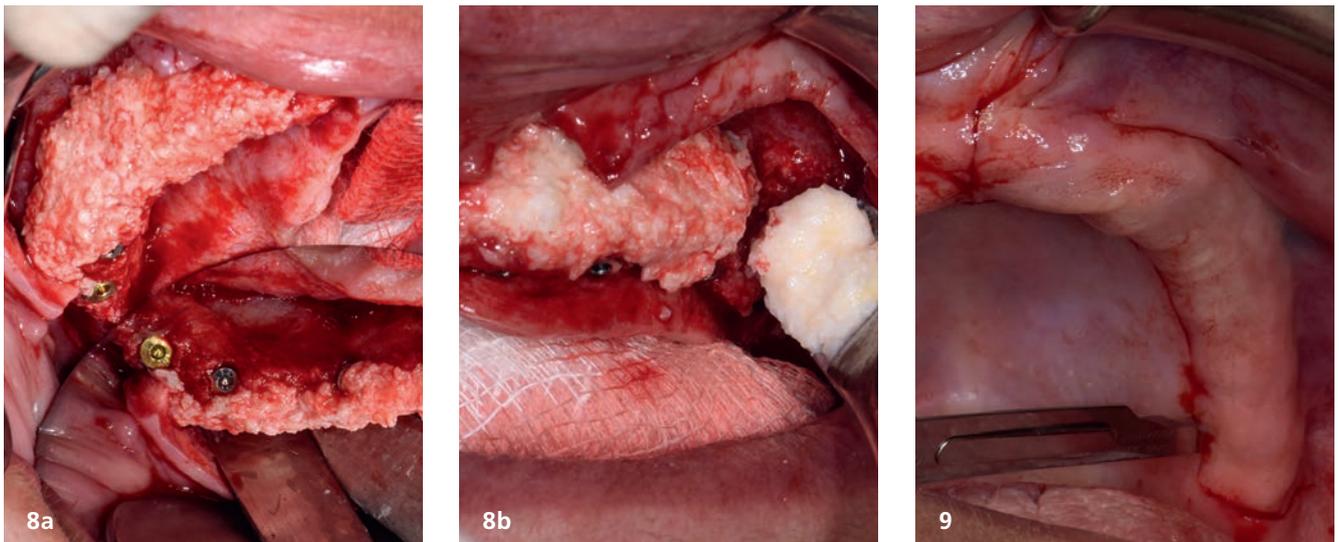


Fig. 6: Fixation of the collagen membrane with mini-screws. **Figs. 7a & b:** Result of the first horizontal augmentation of the right side **(a)** and the left side **(b)**.



Figs. 8a & b: Second horizontal augmentation of the right side (a) and the left side (b) with the implants already placed. **Fig. 9:** Flap design of the uncovering phase.

was taken to avoid perforation of the sinus membrane throughout the procedure.²⁰ The membrane was elevated using special sinus curettes until the sufficient height for the implants had been achieved (Fig. 4). A collagen sponge was inserted into the tuberosity to keep the sinus membrane elevated, and micro-holes were made to increase vascularisation and bone regeneration. A collagenated heterologous sticky bone substitute in a collagen matrix (OsteoBiol GTO, Tecnos) was then inserted directly into the antrostomy of the right sinus (Fig. 5a) and a pre-hydrated heterologous bone substitute (OsteoBiol mp3, Tecnos) into the left sinus (Fig. 5b), and both of them were compacted. A collagen membrane (OsteoBiol Evolution, Tecnos) was fixed through micro-screws above the antrostomies (Fig. 6), a first layer of bone substitute (GTO) was placed on the buccal side of the right sinus because of the horizontal atrophy and the membranes were folded beneath the palatal wall. Before suturing, a

layer of PRF membranes was arranged to protect and enhance the healing of the sites. Both of the sides were sutured, for healing by primary intention. Owing to the limited bone height under the sinus floor, implant placement was delayed for graft consolidation until three months later. A CBCT scan was taken to examine the degree of augmentation, and two other measurements on each side were taken in order to have a starting point for evaluating the future volumetric changes of the biomaterials.

The patient returned after three months for CBCT examination to decide whether the healing was optimal for the implant surgery. Unfortunately, owing to medical problems, she delayed the surgery. When the patient was able to come back, after three additional months, another CBCT scan was taken before implant surgery to assess the further volumetric change of the biomaterials and to plan appropriate implant surgery. A

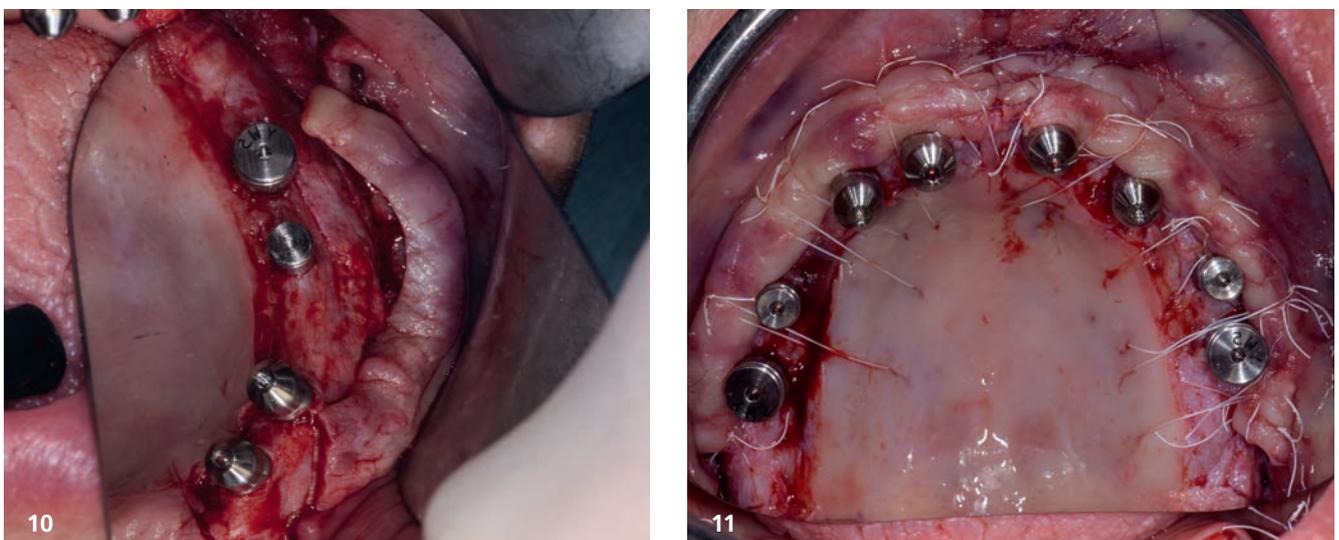
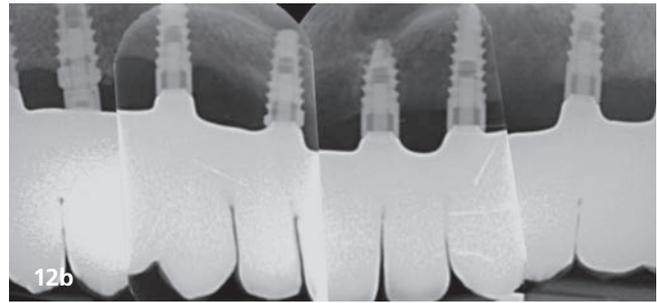


Fig. 10: Split thickness-flap during the uncovering phase with healing abutments placed. **Fig. 11:** Final sutures of the fourth surgical step.



Figs. 12a & b: Intra-oral image (a) and periapical radiograph (b) of the definitive prosthesis.

full-thickness flap was elevated to evaluate the results of the previous bone augmentation on both the right (Fig. 7a) and the left sides (Fig. 7b). Eight implants then were placed, and another layer of biomaterial (GTO) was placed on the buccal site of both sides. Thanks to the properties of this collagenated sticky biomaterial, there was no need to hydrate it because it adhered where it was placed, removing the risk of losing granules during the procedure (Figs. 8a & b). The biomaterial was then covered with a membrane (OsteoBiol Evolution) and both sides were sutured.

Four months later, the patient was scheduled for the final surgical step: the uncovering phase. Before proceeding with the final step, a last CBCT scan was taken to evaluate the positions of the implants and how the height of the new sinus floor had adapted to the implants placed. The uncovering phase was scheduled after implant osseointegration in order to recreate keratinised tissue on the buccal side and to re-establish the correct fornix depth. This time, a partial-thickness flap was elevat-

ed, starting from the palatal side (Fig. 9), to expose the cover screws of the implants while leaving the connective tissue around the implants. The cover screws were removed and replaced with healing abutments of the desired heights (Fig. 10). The flap was then sutured, leaving all the keratinised tissue on the vestibular side while allowing the palatal side to heal by secondary intention (Fig. 11). After complete healing of the tissue, after about eight weeks, an impression was taken and the provisional prosthesis was fabricated and delivered. After complete maturation of the tissue, after about four months, another impression was taken and a definitive prosthesis was fabricated and delivered (Figs. 12a & b).

Clinical outcome

Before the final surgical step (the uncovering phase), a CBCT scan showed the exact positions of the implants and the height

OsteoBiol GTO	First measurement	Second measurement
Post-op	22.20 mm	21.61 mm
3 months of healing	15.61 mm	15.40 mm
6 months of healing	12.88 mm	13.20 mm
At uncovering (after 10 months)	9.63 mm	9.60 mm
% shrinkage after 3 months	6.59 mm (22.20–15.61 mm; 29.7%)	6.21 mm (21.61–15.40 mm; 29.7%)
% shrinkage after 6 months	9.32 mm (22.20–12.88 mm; 42.0%)	8.41 mm (21.61–13.20 mm; 38.9%)
% shrinkage after 10 months	12.57 mm (22.20–9.63 mm; 56.6%)	12.10 mm (21.61–9.60 mm; 55.6%)

Table 1: OsteoBiol GTO: Graft volume evaluation over time.

OsteoBiol mp3	First measurement	Second measurement
Post-op	21.80 mm	25.20 mm
3 months of healing	17.60 mm	17.82 mm
6 months of healing	14.60 mm	14.82 mm
At uncovering (after 10 months)	10.81 mm	10.83 mm
% shrinkage after 3 months	4.20 mm (21.80–17.60 mm; 19.30%)	7.38 mm (25.20–17.82 mm; 29.30%)
% shrinkage after 6 months	7.20 mm (21.80–14.60 mm; 33.00%)	10.38 mm (25.20–14.82 mm; 41.20%)
% shrinkage after 10 months	10.99 mm (21.80–10.81 mm; 50.41%)	14.37 mm (25.20–10.83 mm; 57.02%)

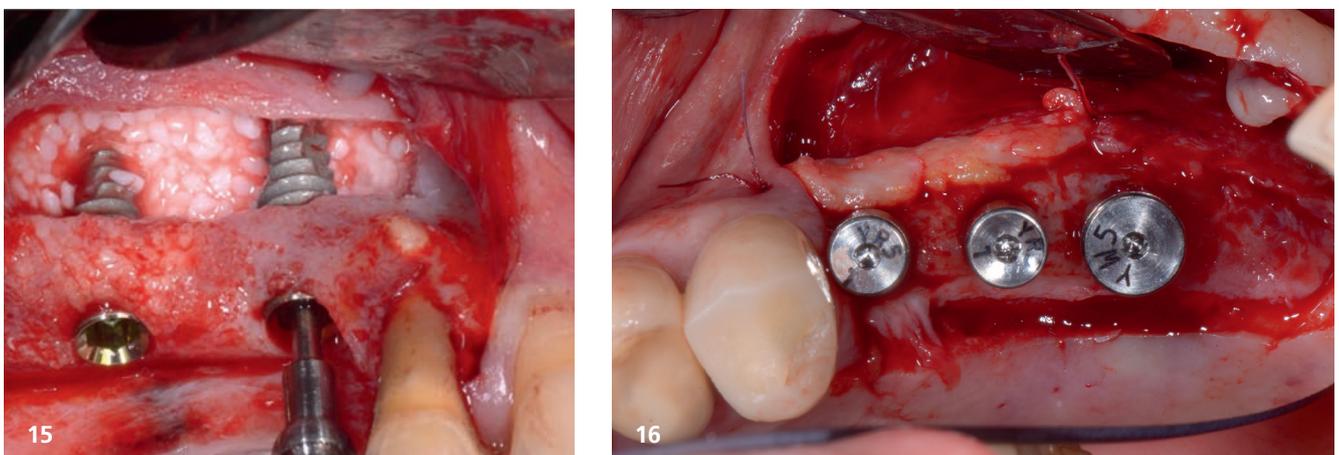
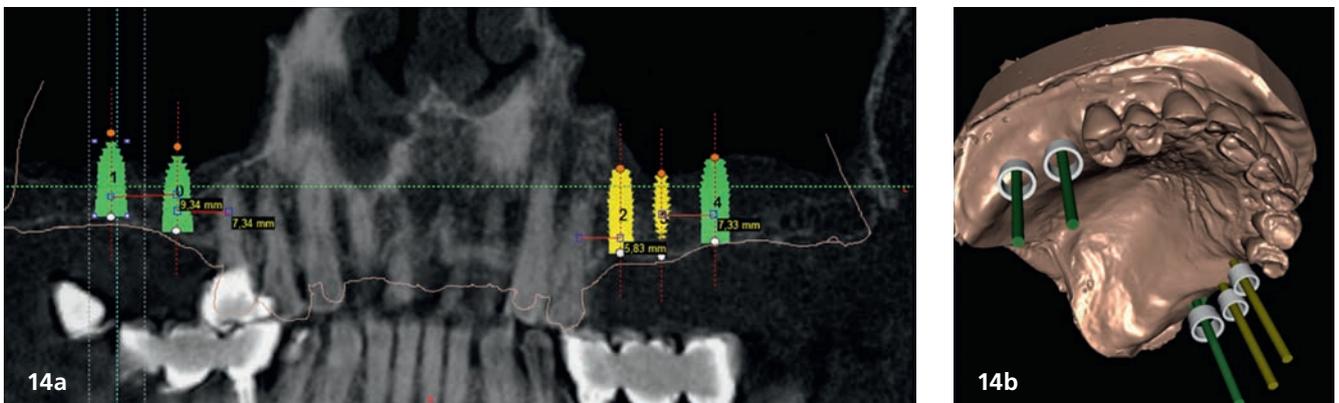
Table 2: OsteoBiol mp3: Graft volume evaluation over time.



Figs. 13a–c: Pre-operative intra-oral images.

of the new sinus floor. The bone height augmentations were considered successful for implant placement under good conditions. After a healing period of four months, the CBCT scan showed that both sides had healed well. Recovery was uneventful, and there was no complaint of pain and no signs of infection. The same positive results could be deduced from the radiographic controls taken over time. All the measurements were collected in two charts, depending on the biomaterial used, to evaluate how the bone substitute used changed volume over time. The heights of the augmented sinuses decreased at a similar pace. Between the postoperative CBCT scan and the healing at three and six months, the right sinus, in which GTO was used, decreased from 22.20 mm to 15.61 mm (29.7% volumetric

change) to 12.88 mm (42.0% volumetric change) and from 21.61 mm to 15.40 mm (29.7% volumetric change) to 13.20 mm (38.9% volumetric change). Similarly, the left sinus, where mp3 was used, decreased from 21.80 mm to 17.60 mm (19.3% volumetric change) to 14.60 mm (33.0% volumetric change) and from 25.20 mm to 17.82 mm (29.3% volumetric change) to 14.82 mm (41.2% volumetric change). Therefore, the augmented sites were of sufficient volume for implant placement. It is worth noting that the bone remodelling did not stop after the implants had been placed. In fact, when the last CBCT scan was taken at ten months of healing (before the uncovering phase), further resorption, to the tips of the implants, corresponding to around 55% resorption, was found (Tables 1 & 2).



Figs. 14a & b: Digital implant planning: 2D (a) and 3D (b) view. **Fig. 15:** Insertion of the implants. **Fig. 16:** Connective graft sutured to the periosteum with healing abutments positioned.



Figs. 17a–c: Clinical and radiological follow-up at five years. (Images © P. Zappavigna DDS)

Nevertheless, it can be appreciated how both of the biomaterials allowed reconstruction of the crest height and how GTO allowed restoration of even the diameter of the crest. What is more, the morphology of these biomaterials resembled that of the natural bone. In fact, it was difficult to notice a difference between the bone grafts placed and the bone of the patient. However, it must be pointed out that GTO had a slightly greater resorption compared with mp3, probably due to its greater collagen gel component.

Case 2: Maxillary sinus surgery and simultaneous implant placement

This patient also presented at Lake Como Institute, having been referred by a colleague, requesting fixed rehabilitation of the edentulous areas of his posterior maxilla. A careful clinical examination was conducted (Figs. 13a–c) and a CBCT scan taken to plan proper implant surgery (Figs. 14a & b). The patient requested as few surgeries as possible and completion of the treatment in the shortest possible time. Bilateral sinus elevation with bilateral horizontal augmentation and simultaneous implant placement was the chosen treatment plan. The approach was similar to that of the first case: two flaps with two vertical incisions were elevated to expose the lateral sinus walls and then two antrostomies were opened with the help of piezo-surgery inserts. The sinus membranes were elevated, paying attention not to perforate them, and two collagen sponges were inserted into the posterior recesses to keep the membranes elevated so that the osteotomies could be made. The biomaterial (GTO) was inserted through the antrostomies and compacted. The implants were then placed, since this time there was greater residual bone height (Fig. 15), and a layer of biomaterial was used to compensate for the horizontal atrophies. To stabilise the biomaterial, a double layer of collagen membranes (Evolution) was used, a final layer of L-PRF (leukocyte- and platelet-rich fibrin) membrane was placed to enhance soft-tissue healing and the flaps were sutured. A CBCT scan was taken to evaluate the degree of vertical and horizontal augmentation, and the patient was scheduled for the last surgery four months later. During the uncovering phase, two split-thickness flaps were elevated, exposing the underlying implants, and a connective graft was collected by thinning the palatal flap. The cover screws of the implants were replaced with healing abutments, and the connective graft was

placed on the vestibular side to further expand the crest diameter (Fig. 16). A final layer of L-PRF was put around the healing abutments and the flaps were sutured. The patient then returned to his dentist for finalisation of his treatment.

Clinical outcome

The implants and the soft tissue healed uneventfully, and the patient underwent just two surgeries. The implants were still stable after five years of loading (Figs. 17a–c).

Discussion

The two cases demonstrate how there might be perfect timing for placing implants after the first vertical augmentation. The idea is not to let the bone substitutes remodel too much, in order to allow easier implant placement and the use of longer implants to obtain a correct implant–prosthesis proportion. Probably, as can be seen from Tables 1 and 2, four months would be the best time to proceed with the implant placement, because the biomaterials act like natural bone: they will continue to remodel over time if not stimulated by occlusal forces. Instead, when the implants are placed simultaneously with sinus elevation, the implants create a tenting effect that serves as support to the Schneiderian membrane, arresting bone physiological resorption. That is why, when possible, often the best treatment may be placing the implants simultaneous to sinus augmentation.

Edentulous maxillary segments have several anatomical and physiological limitations, such as deficiency of spongy maxillary alveolar bone and increased pneumatization of the maxillary sinuses. These factors render rehabilitation of the region challenging. In these two cases, maxillary sinus elevation procedures through lateral access were successfully performed using GTO or mp3. Horizontal augmentation was successfully performed using only GTO. These materials were able to increase vertical bone height and horizontal bone diameter and allowed for the placement of the requested implants. A follow-up panoramic radiograph was obtained at the delivery of the prosthesis and demonstrated what appeared to be new bone formation in the maxillary areas and the areas at the tips of the implants. It is important to emphasise the benefits of this approach for maxillary reconstruction via GBR and sinus augmentation over other treatments (e.g. autogenous block

grafting): no complications at the donor site, no need for hospitalisation and less postoperative discomfort. The current results are in agreement with those of previous studies,^{21,22} as well as systematic reviews,^{23,24} illustrating that implant survival rate and peri-implant bone level in the grafted bone are comparable to those of implants placed in native bone. A similar outcome has been observed for implants placed in augmented sinuses.⁷

Conclusion

Complete reconstruction of atrophied maxillae can be successfully achieved by means of GBR for horizontal and/or vertical bone gain, including bilateral sinus augmentation when GTO and mp3 are used. In fact, the morphology of these grafted sites resembles the anatomy of a natural sinus, the bone remodelling at the level of the tips of the implants, and has the same radiographic appearance as the natural lost bone of the patient. Moreover, it appears that the best time to place the implants after sinus augmentation, in a delayed approach, might be around four months, to ensure as little graft resorption as possible. Peri-implant bone level in the completely reconstructed maxilla showed minimal changes. Furthermore, proper training in hard- and soft-tissue management is imperative for achieving successful outcomes and avoiding potential complications.

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General assembly

Partial extraction therapy and implant treatment in the maxilla

Dr Snježana Pohl, Dr Mijo Golemac, Dr Daniela Grgić Miljanić, Dr Pantelis Petrakakis & Prof Jelena Tomac, Croatia & Germany

Introduction

Various techniques and methods based either on grafting of the fresh extraction socket (ridge preservation) with different materials and delayed implant placement or on immediate implantation with grafting of the gap between implant and socket wall have been applied in order to prevent ridge alterations after tooth extraction. However, insights concerning superiority of the type of grafting technique or material are scarce.^{1,2} Partial extraction therapy, leaving either the whole root (root submergence therapy) or the buccal part of the root (socket shield technique) of hopeless teeth inside the extraction socket, may have clinical significance as an alternative to conventional preservation procedures. These techniques are based on the observation, made already 80 years ago, that resorption of the bundle bone within the extraction socket may be reduced by leaving the root or a root fragment inside the socket, attached by a healthy periodontal ligament to the buccal socket wall, providing good blood supply to the hard and soft tissue.³⁻⁵ This procedure was forgotten until 2007, when Salama et al. published a case report showing an implant-supported bridge with perfectly maintained hard and soft tissue by leaving a root submerged in the pontic area.⁶ Likewise, the socket shield technique has been shown to be an efficient technique for reducing the amount of post-extraction ridge resorption as well.⁵ The present case report introduces ridge preservation with root submergence therapy and the sock-

et shield technique, as well as augmentation with particulate autologous dentine, in the course of an implant and prosthetic rehabilitation in a partially edentulous maxilla.

Patient situation

The 58-year-old, non-smoking and systemically healthy female patient was referred by her dentist to our dental clinic for implant treatment. The patient's main complaints were poor aesthetics in the upper jaw, including a high smile line and distinct tooth pattern anomalies in the anterior maxilla (Figs. 1 & 2), as well as masticatory discomfort. Teeth #17, 15 and 27 were missing and had not undergone any prosthetic treatment, whereas the five missing teeth in the premolar and molar areas on both sides of the mandible had been replaced with a removable partial denture. All remaining teeth were affected by Stage IV periodontitis according to the 2017 Classification of Periodontal and Peri-implant Diseases and Conditions, displaying a mean periodontal pocket depth of 5.6 mm.⁷ Mean bleeding on probing and mean plaque index were 70% and 80%, respectively. With respect to periodontal parameters, as well as to oral hygiene measures (visible calculus and dental plaque), the patient's oral hygiene was graded as poor. The patient had been treated elsewhere with two implants in the posterior maxilla in order to replace the right first premolar and first molar (Fig. 3). She had a thick flat biotype, according to a definition introduced in 1977.^{8,9}



Fig. 1: Patient's initial situation, extra-oral aspect. **Fig. 2:** Patient's initial situation, intra-oral aspect.

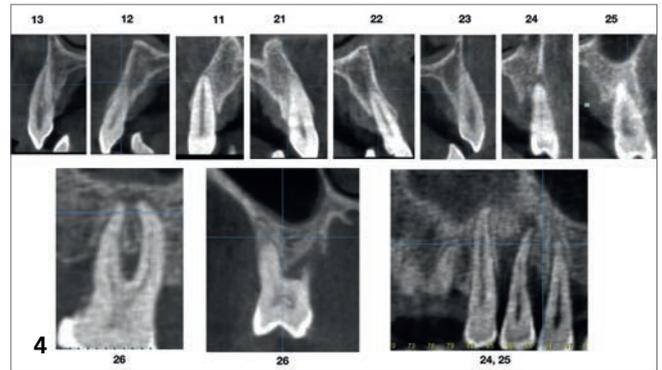
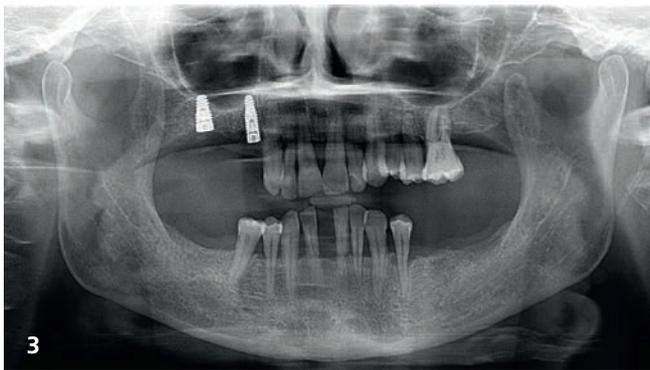


Fig. 3: Initial radiograph before treatment. **Fig. 4:** CBCT scan showing the bone condition of the maxillary teeth. Vertical resorption and reduced thickness of the buccal bone plate of the right and left central incisors were evident.

Diagnostics and treatment planning

After obtaining informed consent from the patient, we would start dental rehabilitation in the maxilla, and we opted for a two-stage surgical approach after initial therapy. Initial therapy would consist of systematic periodontal treatment and regular recalls with instructions and checks for dental hygiene over a period of three months. The first stage of rehabilitation of the maxilla would consist of partial extraction therapy in conjunction with Type 1 implant placement in the regions of the teeth #12 and 22 according to the Proceedings of the Fourth ITI Consensus Conference and ridge preservation in the region of teeth #24 and 25 with particulate dentine, obtained and processed from the two extracted left maxillary premolar teeth.¹⁰ Owing to increased tooth mobility and the obvious poor buccal bone volume, as displayed on the CBCT scan (CRANEX 3D Ceph, Soredex,

KaVo Kerr), regions #11 and 21 were not suitable for the socket shield technique in conjunction with implant placement (Fig. 4). Both central incisors were to be treated with the submerged root technique instead, in order to prevent damage of the buccal socket wall and volume loss of the alveolar ridge after tooth extraction. With both roots in place, a physiological pontic site development for the definitive restoration would be enabled. Based on periodontal re-evaluation after the initial therapy, only the two maxillary canines were considered worth preserving. The left first molar was to be temporarily retained in order to serve, in conjunction with the two canines, as an additional abutment tooth for fixation of the temporary bridge during the healing period. Crown preparation of the three remaining teeth would be done before surgical treatment, in order to prefabricate a temporary bridge for immediate fixed provisionalisation after the first surgery. The second surgical stage would consist of im-



Fig. 5: Clinical situation after partial extraction of tooth #12, extraction of tooth #22, and root submersion of teeth #11 and 21. **Fig. 6:** Clinical situation after extraction of teeth #24 and 25 and augmentation with autologous dentine. **Fig. 7:** Immediate implant placement into the fresh extraction socket of tooth #22 after ridge grafting with autologous dentine. **Fig. 8:** Clinical situation after completion of first-stage surgery.

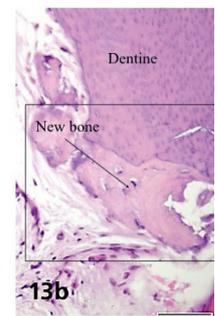
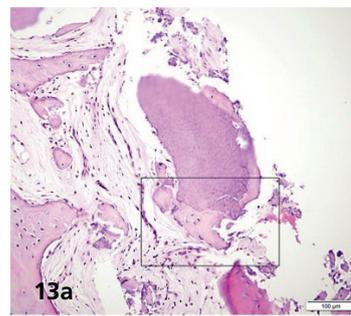
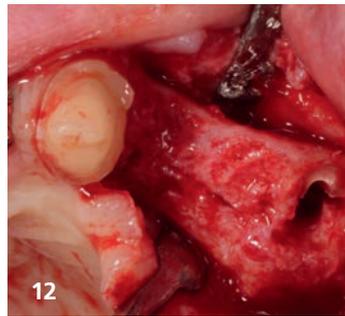
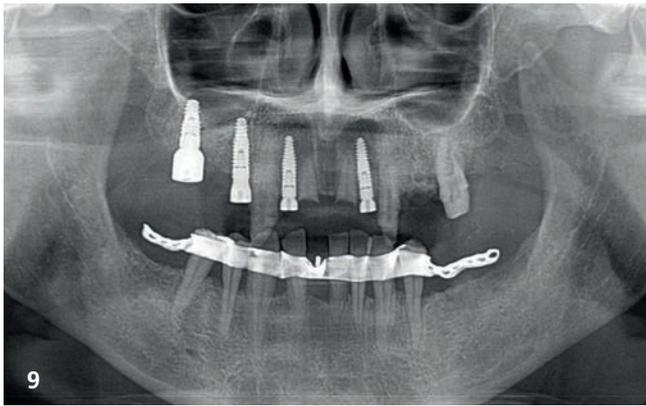


Fig. 9: Radiograph after first-stage surgery. **Fig. 10:** Temporary bridge. **Fig. 11:** Clinical situation after a three-month healing period, displaying proper volume of the alveolar ridge in the maxilla. **Fig. 12:** Clinical situation during second-stage surgery after flap elevation, displaying proper bone regeneration in the premolar area after ridge preservation with autologous dentine. **Figs. 13a & b:** Histological images showing new bone formation in close contact with dentine particles.

plant placement in region #24, performing of the socket shield technique on the mesiobuccal root, submersion of the distobuccal root and extraction of the palatal root of tooth #26 before immediate implant placement. Definitive prosthetic treatment would be performed after a transgingival implant healing period of at least three months, applying a conventional implant loading protocol with fixed bridges.¹¹

Surgical intervention

Both surgical interventions were performed under local anesthesia, and antibiotic medication (a single dose of 2 g of amoxicillin) was administered 60 minutes before surgery. The first stage of rehabilitation of the maxilla involved immediate implant placement in the post-extraction sockets of both lateral incisors in combination with the socket shield technique for the right lateral incisor. Owing to an increased tooth mobility of more than Grade II, the socket shield technique was contra-indicated for the left lateral incisor and both premolars. The clinical crowns of both central incisors were decapitated, and the roots were carefully prepared with a round diamond bur under rinsing with sterile saline solution, until both cranial root edges reached a distance of 3 mm from the gingival margin (Fig. 5). In the right lateral incisor site, a socket shield was prepared as described by Gluckman et al.¹² The extracted premolars were me-

chanically cleaned and then dried and processed with the Smart Dentine Grinder (KometaBio) according to the manufacturer's recommendations.¹³ After implant site preparation, particulate dentine was applied into the prepared left lateral incisor implant site, and both extraction sockets of the left premolars (Fig. 6). Implant placement was performed in the extraction sites of both lateral incisors with two BEGO Semados RSX implants (BEGO Implant Systems) with a length of 13.00 mm and a diameter of 3.75 mm (Fig. 7). Peri-implant gaps were grafted with particulate dentine autograft and sealed with platelet-rich fibrin (PRF) membranes using the Poncho technique.¹⁴ After buccal and palatal tunnel preparation, the premolar extraction sockets and submerged left central incisor root were covered with PRF membranes, prepared according to the Choukroun method (A-PRF, mectron) after centrifugation at 1,300 rpm for 13 minutes.¹⁵ The right central incisor was covered with a connective tissue graft harvested from the palatal mucosa of the first quadrant. Covering membranes and the connective tissue graft were introduced into the buccal and palatal tunnel preparations and fixed with absorbable monofilament #5/0 suture thread (Serafast, Serag Wiessner; Fig. 8). The postoperative radiograph showed adequate root submersion of the central incisors, correct implant positioning in the lateral incisor sites and proper filling of both premolar extraction sockets (Fig. 9). The patient was provided with the fixed provisional bridge (Fig. 10) and prescribed amo-

xicillin (1 g three times a day for five days after surgical intervention). Postoperative healing was uneventful.

At the time of the second surgical intervention, three months after the first surgery, no obvious volume loss of the maxillary alveolar crest was noticed (Fig. 11). Second-stage surgery was performed in the left posterior maxilla with an open flap approach. After elevation of the mucoperiosteal flap, very good preservation of bone volume was observed, indicating successful ridge preservation by means of particulate dentine as the augmentation material (Fig. 12). Partial extraction therapy was performed for the right first molar. After decapitation, socket shield therapy of the mesiobuccal root and submersion of the distobuccal root was performed. After extraction of the palatal root, the implant site was prepared in the septum and the sinus membrane was concomitantly lifted by the use of an osseodensification protocol with Densah burs (Versah).¹⁵ After sinus grafting with Gen-Os (OsteoBio), a particulate collagenated corticocancellous bone mix of porcine origin, a BEGO Semados RSX implant with a length of 13.0 mm and a diameter of 4.5 mm was placed. Another BEGO Semados RSX implant with a length of 13.0 mm and a diameter of 4.1 mm was placed into the first premolar region. In order to evaluate the remodelling process after ridge preservation with the dentine autograft histologically, a histological sample was harvested with a trephine bur from the first premolar region during implant preparation. Histological analysis revealed new bone formation in close contact with dentine particles and no signs of inflammation or fibrous encapsulation of the autologous augmentation material (Fig. 13). Immunohistochemistry was done in order to evaluate osteoblast differentiation and bone formation. New bone formation was confirmed by osteoblasts, being marked by antibodies against Osterix (Anti-Sp7/Osterix antibody, ChIP grade, ab22552; Abcam). All implants healed uneventfully during a period of four months.

Prosthetic treatment

Definitive prosthetic treatment was performed after completion of implant healing with three CAD/CAM-fabricated monolithic zirconia bridges (DD cubeX², Dental Direkt). The bridges were screwed on to BEGO titanium base abutments (Figs. 14–16). Good fit of the prosthetic superstructures was displayed in the radiograph after placement (Fig. 17). The two-year fol-

low-up examination in July 2019 revealed excellent aesthetic and clinical soft-tissue conditions (Figs. 18–20). No radiographic bone loss had occurred at the implant sites (Fig. 21). Neither the submerged central incisors nor the distobuccal molar root displayed any signs of periapical inflammation, and the patient reported no complications. The patient's oral hygiene had improved significantly during the follow-up period.

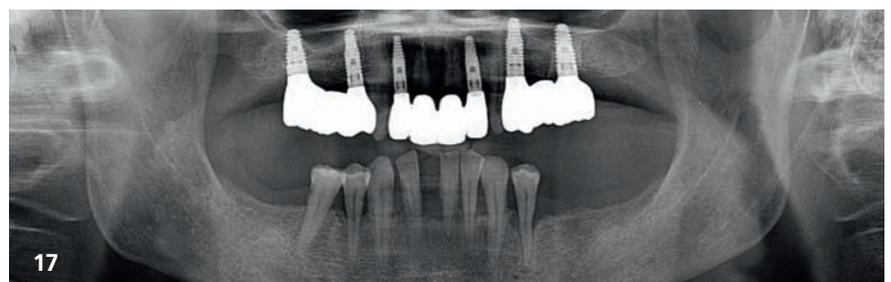


Fig. 14: Frontal aspect of the definitive prosthetic restorations, showing good aesthetic conditions with no signs of soft-tissue complications after insertion. **Fig. 15:** Right lateral aspect of the restorations. **Fig. 16:** Left lateral aspect of the restorations. **Fig. 17:** Final radiograph with definitive prosthetic superstructures in place.



Fig. 18: Frontal aspect of the restorations after the two-year follow-up period. **Fig. 19:** Right lateral aspect of the restorations after the two-year follow-up period. **Fig. 20:** Left lateral aspect of the restorations after the two-year follow-up period.

Discussion

The key objective of the present treatment approach was maintenance of maximal ridge volume for both aesthetic and functional reasons as described in a recently published technical report.¹⁶ A staged approach using a few teeth to support a provisional fixed restoration during the healing process was applied

for a number of reasons: (1) immediate implant placement after the extraction of hopeless teeth was contra-indicated in the premolar area owing to the poor periodontal state; (2) a fixed provisional prosthesis would enable soft-tissue conditioning during healing;¹⁷ and (3) surgical burden, postoperative morbidity and additional costs could be reduced for the patient through the application of par-

tial extraction therapy, an osseodensification protocol for bone expansion, compaction and crestal sinus elevation, and autologous dentine as augmentation material. Root submergence therapy of both central incisors was chosen in our patient case as the procedure of choice in order to avoid unfavourable buccal bone remodelling. Submerged root therapy is based on reports from the early 1940s that showed that fractured roots may be retained in the extraction socket without any pathological clinical symptoms if they are protected by epithelial gingival overgrowth.^{3,4} Since the alveolar bundle bone and periodontal ligament are preserved, submerged root therapy appears to be a promising technique for ridge preservation in conjunction with conventional prosthetic treatment. The presence of the periodontal ligament seems to preserve a higher amount of surrounding hard and soft tissue, compared with conventional socket preservation techniques.^{6,18} Reduction of root heights in order to maintain a sufficient soft-tissue thickness of 3 mm between submerged roots and the gingival margin and future pontic base, respectively, as well as dense primary closure of submerged roots with connective tissue grafts or fibrin membranes, seems to be a prerequisite for a rapid healing process and for successful submersion of root segments.^{19,20}

Hinze et al. demonstrated in a cohort study successful preservation of alveolar width and height by applying the socket shield technique in conjunction with immediate implant placement, producing no midfacial recession or increased probing depths.²¹ The main concerns with the socket shield technique still lie in the limited evidence, specifically the need for randomised controlled studies, in order to enable more evidence-based insights. Autogenous particulate dentine has gained attention as an alternative grafting material to autologous bone and bone substitutes. Despite the fact that dentine is an acellular matrix, bone and dentine are very similar in their biochemical structure, comprising mainly Type I collagen with growth factors like bone

morphogenetic protein (BMP-2) and fibroblast growth factors.^{22,23} The present histological and clinical findings after ridge preservation with autologous dentine are in line with the insights of clinical studies, including new bone formation, favourable wound healing and good dimensional stability.^{24,25} Clinical aspects in connection with re-entry in the left posterior maxilla showed very good ridge dimensions after three months. The present clinical and histological results confirm suitability of particulate dentine autograft as augmentation material for ridge preservation, retaining adequate dimensional stability and holding osteoinductive and osteoconductive capacity.

About ...



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is a doctor of both general medicine and dental medicine and holds a specialisation in oral surgery, periodontics and implantology. She is currently based in Rijeka in Croatia, where she practises, teaches and mentors. Since 2010, she has been head of the department of oral surgery at Rident dental clinics in Croatia. She also teaches as an assistant professor at the Department of Oral Medicine and Periodontology of the Faculty of Dental Medicine at the University of Rijeka.

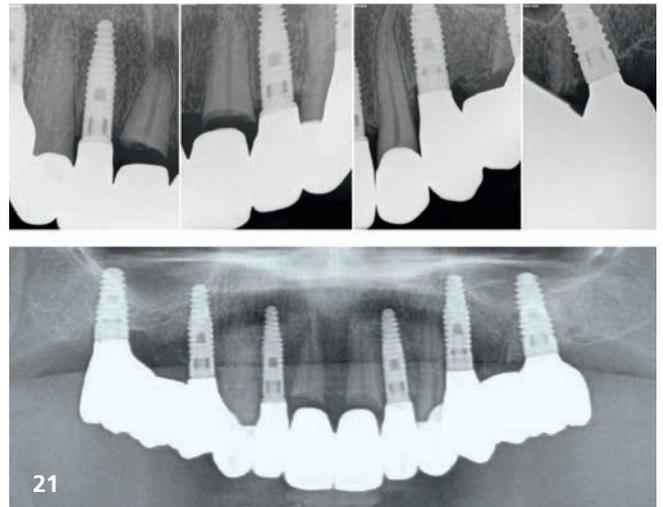


Fig.21: Radiographic control after the two-year follow-up period, showing no visible bone loss at the implant sites and no signs of periapical inflammation at submerged roots.

In our present case, implant site preparation of the molar septum after partial extraction of the right maxillary first molar, as well as the simultaneous trans-crestal sinus elevation, could be performed by using the osseodensification protocol with Densah burs.²⁶ Osseodensification has been shown to increase bone mineral density and bone to implant contact and to enhance primary implant stability, compared with standard drilling.^{27,28} Nonetheless, this technique should be used with caution, because of a limited number of long-term studies.^{29,12} The main concerns with the socket shield technique still lie in the technique sensitivity of this method and the need for randomised controlled studies in order to enable evidence-based insights and transfer of this technique into routine dental practice.³⁰ However, the present case report encourages the application of different preservation procedures as alternative clinical methods for successful ridge preservation. Corresponding patient cases are intended for presentation in future publications.

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Literature



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The modified coronally or laterally displaced tunnel for the treatment of singular and multiple recessions

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The predictable coverage of recessions often poses a particular challenge to the practitioner. With the development of tunneling techniques, results can be achieved today that were unthinkable a few years ago. In the following, clinical cases are used to demonstrate the surgical technique and the results of MCAT and LVT in the treatment of singular and multiple recessions in the mandible and maxilla.

Exposure of the root surface due to a gingival margin retreating apically to the cemento-enamel junction (CEJ) is defined as a gingival recession. It may be isolated or generalized, occurring in both older and younger individuals with good but also with suboptimal oral hygiene. Several factors may favour the development of gingival recession, such as the presence of bony dehiscences covered by a thin and fragile gingiva or marginally attached labial or buccal frenula. These may prevent successful and atraumatic plaque control, making it difficult to perform oral hygiene and promoting the development of gingivitis or root caries and the progression of bone/attachment loss.

They can also impair the aesthetic appearance or cause cervical hypersensitivity. Other factors commonly associated with gingival recession include orthodontic therapy, as well as oral jewellery such as lip or tongue piercings.

Primary indications for gingival recession therapy are a need to improve oral hygiene and aesthetics and, in some patients, to treat cervical hypersensitivity.

Predictable coverage of singular and multiple recessions can be a significant challenge for the practitioner. However, different variants of the tunnel technique have now been developed so that results

can be achieved that would have been unthinkable a few years ago.

Modified coronally advanced tunnels (MCAT) and laterally closed tunnels (LCT)

Variants of the tunnel technique include the modified coronally advanced tunnel (MCAT) and the laterally closed tunnel (LCT). In both approaches, a mucoperiosteal flap is prepared, the tunnel flap is displaced coronally or laterally without tension, and the graft or soft-tissue substitute is covered (Sculean, 2018; Sculean and Allen, 2018; Sculean et al., 2014, 2016, 2017).

Surgical technique and results

This article presents, based on clinical cases, the surgical technique and results of MCAT and LCT in the treatment of singular and multiple recessions in the mandible and maxilla (Figs. 1 to 3). In both these procedures, minor scaling of the exposed root surfaces to remove any biofilm is followed by intrasulcular incisions in the recession area. The buccal soft tissue (i.e., the gingiva and the mobile mucosa) is detached using special tunnelling instruments and mobilized beyond the mucogingival margin (mucoperiosteal preparation). The papillae are

undermined and mobilized, and a so-called tunnel flap is formed (Figs. 4 to 8).

To mobilize the tunnel flap in a tension-free manner up to or even coronal to the CEJ or laterally to the recession, adherent frenula are detached from the inside of the flap using a mini-scalpel or sharp curette.

In the case of deep recessions, biological materials such as enamel matrix proteins or hyaluronic acid can be applied to root surfaces to support periodontal wound healing and regeneration (Fig. 9) (Sculean and Allen, 2018; Sculean et al., 2014, 2016; Guldener et al., 2020; Lanzrein et al., 2020). For maximum stabilization, a subepithelial connective-tissue graft or a soft-tissue substitute is then introduced into the tunnel using single interrupted or mattress sutures and secured to the CEJ of the respective teeth with sling sutures (Figs. 10 to 12). Finally, the tunnel flap is repositioned coronally or laterally and secured above the teeth or the previously splinted contact points using sling sutures (Figs. 13 to 15).

Avoiding complications

Mucoperiosteal preparation minimizes the risk of flap perforation or flap necrosis, a complication that may occur particularly at sites with extremely thin soft tissue. Avoid-



Abb. 1: Isolated RT2 recession in the mandibular anterior region, preoperative view. – **Abb. 2:** Multiple adjacent RT1 mandibular recessions, preoperative view. – **Abb. 3:** Multiple adjacent RT1 maxillary recessions, preoperative view. – **Abb. 4:** Tunnelled mesial papilla on tooth 31 (case shown in Fig. 1). – **Abb. 5:** Tunnelled distal papilla on tooth 31 (case shown in Fig. 1). – **Abb. 6:** Tunnelled mesial papilla on tooth 33 (case shown in Fig. 2). – **Abb. 7:** Tunnelled distal papilla on tooth 33 (case shown in Fig. 2). – **Abb. 8:** The fully mobilized tunnel flap can be advanced mesially or distally above the recession on tooth 31 without tension (case shown in Figs. 1, 4 and 5). – **Abb. 9:** Application of hyaluronic acid to promote wound healing (case shown in Figs. 2, 6 and 7).

ing vertical and papillary incisions ensures an adequate blood supply to the muco-periosteal flap. Tension-free coronal or lateral advancement of the tunnel allows complete or partial coverage of the soft-tissue grafts, improving their vascularization and chance of survival.

The laterally closed tunnel (LCT)

The LCT is a variant of MCAT and is primarily indicated for the treatment of deep, isolated RT1 and RT2 recessions in the mandible, where coronal displacement of

a flap is particularly difficult due to traction forces exerted by the labial ligaments and muscles (Sculean and Allen, 2018). The LCT is prepared in the same way as a MCAT, except that the wound edges are closed laterally using single interrupted sutures or double-loop sutures to cover the graft and recession (Figs. 4, 5 and 8).

For singular and multiple Miller class I, II and III recessions (current designation: RT1 and RT2 recessions), MCAT and LCT combined with a subepithelial connective-tissue graft result in a mean root coverage of 83% to 96% (Figs. 16 to 18). Recent

results have shown stable outcomes over a period of five to ten years (Fig. 18).

It has also been shown that MCAT delivers excellent results in the treatment of gingival recessions on teeth restored with crowns. The treatment yielded a mean root coverage of 92.62% one year after treatment (Sculean et al., 2017).

Surgical technique and results

In conclusion, both MCAT and LCT ensure good vascularization of the coronally or laterally advanced flap and the



Abb. 10: The graft was introduced into the tunnel and attached to tooth 31 above the recession using sling sutures (case shown in Figs. 1, 4, 5 and 8). – **Abb. 11:** A sufficiently long and wide subepithelial connective-tissue graft supports the papillae and reinforces the buccal soft tissue (case shown in Figs. 2, 6, 7 and 9). – **Abb. 12:** The graft was introduced into the tunnel and secured above the recessions on teeth 32, 33 and 44 using sling sutures (case shown in Figs. 2, 6, 7, 9 and 11). – **Abb. 13:** Tension-free lateral closure of the recession and graft on tooth 31 (case shown in Figs. 1, 4, 5, 8 and 10). – **Abb. 14:** Tension-free coverage of the recessions and graft on teeth 32, 33 and 44 using sling sutures (case shown in Figs. 2, 6, 7, 9, 11 and 12) – **Abb. 15:** Tension-free coverage of the recessions and graft on teeth 13, 14 and 15 using sling sutures (case shown in Fig. 3). – **Abb. 16:** One year after treatment, good root coverage and optimal shade and thickness were evident (cf. the preoperative situation in Fig. 1). – **Abb. 17:** Clinical outcome one year after treatment of the recessions shown in Fig. 2. Excellent root coverage and a natural shade and thickness was achieved. – **Abb. 18:** Clinical outcome five years after treatment of the recessions shown in Fig. 3. Stable and complete long-term root coverage with a natural shade was achieved.

underlying graft, improving wound healing and the clinical outcome. Eliminating vertical incisions improves the blood flow to the surgical area for scarless healing and optimal aesthetic results. Notwithstanding the absence of vertical relief incisions, MCAT can result in complete and tension-free mobilization of the flap and complete coverage of the recessions. Long-term stability is best ensured by providing a subepithelial connective-tissue graft or a collagen-

based soft-tissue substitute to reinforce the flap and to protect the underlying blood coagulum (Cosgarea et al., 2020; Sculean, 2018).

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Giornate Veronesi

Implantology and modern dentistry in May 2022

Implantology and modern dentistry are on the agenda on 20 and 21 May 2022 in Valpolicella/Italy. Under the Italian sun, so to speak, the Giornate Veronesi, after a time of corona-related restrictions, will offer top-class scientific lectures, seminars, table clinics, a live tutorial and a great social program.

All good things come in threes. Due to the event being hindered because of the corona pandemic in 2020 and 2021, this year, on 20 and 21 May 2022, the educational event Giornate Veronesi will be brought back to life with its special Italian flair. Dentists as well as their teams are invited to the congress resort Villa Quaranta Tommasi Wine Hotel & Spa in Valpolicella/Italy. The scientific program remains mostly identical to the previously planned version from last year. In addition to the main topic implantology, there will be general dentistry programs as well as programs for dental assistants. The event is therefore also ideally suited as a team training event. Except for one lecture, which will be held in English, the congress language will be German.

The congress will start on Friday morning with a team workshop. The surgical tutorials will begin at noon, followed by the table clinics. On Saturday the scientific lectures will take place in two parallel podiums. Thus, the program structure provides maximum flexibility for your individual schedules. The scientific director of the congress is Prof Mauro Marinicola/ Italy.

In addition, the Giornate Veronesi offer an unusually large amount of space for speaker discussions and collegial exchange. Alongside the technical program, the get-together on Friday and the dinner party with wine and music on Saturday evening provide ample opportunity for this.

Additionally, while at the Giornate Veronesi, there will still be enough time, apart from the scientific events, to exchange opinions with all the speakers and of course for collegial interactions; on Friday the Get-Together and Saturday evening the dinner party with wine and music.

As the event will take place at the famous Tommasi family vineyard, it stands to reason for the congress participants to use the given opportunity of a wine seminar on Thursday evening and become "experts" in this field.



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OSSTEM ON DEMAND

AIC Europe continues its free video-on-demand lecture programme in 2022

Osstem OnDemand keeps dental community up-to-date

AIC Europe (Advanced Dental Implant Research and Education Center Europe) has recently announced the speaker line-up for Osstem OnDemand, its video-on-demand lecture programme, for this year. Eight lectures by renowned European speakers are scheduled throughout the year, and the first lecture was released in February.

For the last two years, online learning has been proven an effective and reliable source of education in conditions of uncertainty. AIC Europe has therefore decided to continue providing new online content this year via Osstem OnDemand to ensure that the dental community can remain up-to-date in its knowledge no matter what the circumstances, reflecting the continued need for this type of educational opportunity in addition to face-to-face training.

Osstem OnDemand was first introduced in mid-2020 when the pandemic was harshly impacting the world and has ever since been providing content on various topics related to dental implantology, including sinus lift, treatment in narrow ridges, guided bone regeneration, and aesthetic and digital dentistry. More than 40 lectures by dental professionals from Europe and abroad have been already shared in the community and new content is coming up.

For 2022, new lectures will be released every third Tuesday of each month through AIC Europe's online platform (www.aic-europe.eu). If you register as a member, you will receive a newsletter whenever new content is released.



For more information

www.aic-europe.eu

www.osstem.eu

OSSTEM-HIOSSEN MEETING IN EUROPE



ROME

Auditorium del Massimo
28-29 / October



OSSTEM-IMPLANT AIC EUROPE

AIC Europe

The Osstem-Hiossen Meeting 2022: The symposium returns to Europe

AIC Europe (Advanced Dental Implant Research and Education Center Europe) has confirmed that its symposium will be held in Rome (Italy) as scheduled on 28 and 29 October. The two-day event will consist of lectures by more than 20 renowned speakers from Europe and abroad, as well as a live surgery, a round-table discussion and an oral competition. The organisers expect more than 700 participants.

After a long break, the Osstem-Hiossen Meeting in Europe is finally returning. The last European symposium was held back in 2019, right before the pandemic hit the whole world, and dentists from more than 30 countries, not only from Europe but also from the Middle East, Africa and the Americas, gathered in Prague (Czech Republic). This year, the symposium invites you to the city of seven hills and the cradle of the Western Christian culture and civilisation, Rome.

Event highlights, including speakers from around the globe

Special guest speaker Dr David Chong from the US will give the symposium's grand opening address, which will be followed by presentations by top speakers from the host country, including Dr Francesco Mintrone and Dr Silvio Meloni. Prof Bilal al-Nawas from Germany, Dr Darko

Božić from Croatia and Waldo Zarco Nosti from Spain will also enrich the symposium with their academic and technical expertise.

The last session of the first day will be dedicated to the round-table discussion, during which three dentists representing Asia (Dr Hyunjoon Jung), Europe (Prof Marco Tallarico) and the US (Dr David Chong) will present different approaches to the rehabilitation of the upper jaw with terminal dentition.

A live surgery—the highlight of the symposium—will be performed on the second day as a collaboration between two dentists, Dr Hyunjoon Jung from South Korea and Dr Roberto Scrascia from Italy.

As a part of the symposium, an oral competition and a poster zone will also be organised. The call for submissions will open in April, and dentists and students will be able to submit their abstracts under three topics, digital, pros-

thesis and surgery. Submitted abstracts will be reviewed by the committee, and those accepted will be invited to present in the oral competition and poster zone.

For entertainment and networking among participants, a gala dinner offering Italian cuisine and unique cultural performances is scheduled for the Friday night.

The whole symposium will be live-streamed via Osstem's global broadcasting system, DenAll TV, and other related channels.



For more information

www.aic-europe.eu

www.osstem-europe-meeting.com

W&H will simplify clinical work

The full range of oral surgery applications

For the first time, W&H can cover the entire workflow for minimally invasive oral surgery with a modular solution. With a new add-on for Implantmed Plus, the Piezomed module, the company is breaking new ground: implantology and piezo surgery are now combined in a single device. This will simplify clinical work and open up new prospects for treatment. Andreas Brandstätter, Strategic Product Manager for Oral Surgery and Implantology, was impressed with the new standard for the market. We spoke to him about the product's positioning and benefits for users.

What makes the new Piezomed module from W&H a genuine breakthrough in oral surgery?

At W&H, we want to push boundaries and think outside the box with our users. We definitely achieved this in the development of our Piezomed module. It is easy and cost-effective to fit onto the Implantmed Plus. The result is a modular system that combines implantology and piezo surgery in one device for the first time, simplifying workflows. For me, this marks a genuine breakthrough in oral surgery that meets our users' requirements.

How important is the new Piezomed module in modern oral surgery?

It is a component that was missing on the market until now. The new Piezomed module complements our product range and combines implantology and piezo surgery in one device for the first time. This, coupled with the implant stability measurement and documentation features, makes us the first manufacturer to cover the entire surgical workflow. Oral surgeons can now discover a new world of treatment possibilities.

How does W&H's surgical portfolio differ from that of competitors?

We have the complete range of oral surgery. All products and features are fully tailored to the user's workflow: Implantmed Plus ensures efficient, safe implantology work, while the Piezomed module gives oral surgeons all the benefits of W&H piezo technology. Our surgical contra-angle handpieces allow procedures to be performed with unrivalled precision, while the wireless foot control ensures greater comfort and freedom of movement. The Osstell Beacon for measuring implant stability provides certainty in assessing the correct loading time for an implant. Comprehensive documentation guarantees full traceability. That means we are offering a unique modular system with perfectly dovetailed components, guar-

anteeing maximum efficiency and reliability in everyday clinical practice.

What market strategy are you pursuing with the new Piezomed module?

We want to embed piezo surgery as the new oral surgery standard in dental practice and establish it as a fixed element of surgical workflows. The aim is for our new modular system to become THE synonym for oral surgery & implantology in the future.

What are the strengths of W&H piezo technology?

First and foremost, it is easy and intuitive to use. Another technical highlight is the patented automatic instrument detection. This automatically sets the right power class when the instrument is inserted and reduces the risk of instrument overload. In addition, with more than 30 different instruments and saws,





1 | The new Piezomed module: an important component that was previously missing on the market.

2 | Andreas Brandstätter, Strategic Product Manager for Oral Surgery and Implantology.

3 | The new modular system from W&H simplifies the surgical workflow.

our product range covers a broad spectrum of tasks. The specially developed saw-cutting geometry ensures outstanding cutting performance. For example, bone block removals can be carried out with little bone loss, which is ideal for ensuring procedures are minimally invasive. And, we use a special spray design to cool the treatment site perfectly.

What advantages does the new W&H modular system have in store for users?

We are offering two versions of our Piezomed module: Piezomed Plus and Piezomed Classic. Whether it's for general dental scenarios, for example assisting with tooth extractions, or for intensive use, both versions are designed to simplify processes in dental practice.

Another benefit is the standardised operation. What's more, only irrigation tubing and a saline solution are required, which enables optimised handling. In addition, users always have the right device (implantology motor/piezosurgical instrument) to hand in a compact and space-saving form, whatever the application.

What is your personal highlight of the new product innovation?

With our new modular system, we are pushing the boundaries of oral surgery. The way of working is changing and becoming simpler, helping modern dentistry to progress.

In addition, we are offering our customers an attractive solution in terms of price. Even as early as the product development stage, we kept an eye on the manufacturing costs and deliberately avoided using multiple components. For example, only one display, touch screen and coolant pump are used for a surgical application. We are delighted we can pass on this manufacturing cost reduction to our customers—a classic win-win situation.

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Barbara Sobzak on the Straumann Group SmileAward

A great union of dentists

Everyday thousands of dental professionals across the globe use Straumann products to give patients the confidence to smile again—to laugh freely with friends, to eat the foods they love. Our mission is to change people's lives by giving smiles back. But while Straumann produces dental implants and everything related to them, it's not the implants that change lives...it's you, the dental professional, who does.



What attracted you to participate in the SmileAward 2021?

I was invited to take part in the competition by Dr. Fabio Cozzolino, the cofounder of Zerodonto. But already I was thinking about this contest for two reasons. First reason was that I wanted to show to a bigger number of doctors my treatment protocol—the Sobczak Concept in combination with Straumann Pro Arch. The second reason: I wanted to take part in a worldwide competition for doctors. That allows to feel more united and see how colleagues are managing their patients. I had this amazing feeling during the competition that from one side you want to win, but from the other you also have your favorites and you keep your fingers crossed for them.

How did you find out about the contest?

I became aware of it on social media: Facebook and Instagram.

What did you like most about the contest?

I liked that great union of doctors. Eventually we started to write to one another to exchange our appreciation of someone

else's work and videos. How much we were touched by particular patient's story. That competition reminds us that beside the craftsmanship of our job we do it for particular people, our patients. Most of the social media dental content is about showing the outcome of the procedures. This is about the state of art and emotions. That makes this contest so special and so involving.

„I liked that great union of doctors. Eventually we started to write to one another to exchange our appreciation of someone else's work and videos.“

What did you obtain beyond the prize? Visibility maybe? And how did it impact communication with your peers/patients?

In my case I believe that I obtained some more visibility. My patients were proud of my achievement and so was my team at the clinics. As always I was happy that Straumann team is so open and understanding that I managed to change my prize to the prize when I can do a pro bono case and change life of a particular person. I will be happy to share that case soon. But beside that I just had great time and really enjoyed the contest.

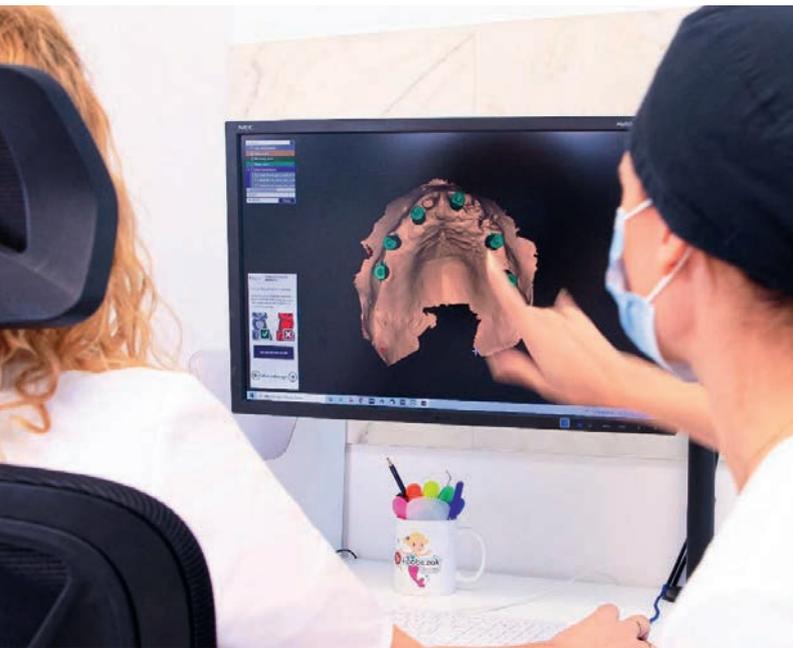
How does it feel now to be part of the jury?

I am honored to be a part of the jury. This is so important and I take it very seriously because I know exactly how to be a participant of SmileAward. I am very much looking forward to great adventure of seeing inspiring cases from all over the world.

„Working as an implantologist is all about giving our patients the best treatment.“

Where do you see the link between the purposes of both the contest and your profession?

Working as an implantologist is all about giving our patients the best treatment. So besides everyday planning and perform-



ing surgeries I love to take part in courses and symposiums. That is very much needed inspiration to my work. This contest is like being both inspired and motivated by our colleagues’.

„My patient cannot imagine going back to times when she couldn’t freely eat and smile.“

What was the impact the contest had on the live of your patient—how did it change his or her life?

My patient was very proud to be a part of this contest. Now she is very happy after the surgery. She says that she divides her life in two; before Sobczak Concept with Straumann Pro Arch and after. She cannot imagine going back to times when she couldn’t freely eat and smile.

About ...

Barbara Sobczak

Graduated from Warsaw Medical University in 2007 and Goethe University in Frankfurt/Main in 2017. ITI Fellow, ITI Study Club Mazovia Director, Medical Consultant for Straumann in Poland. Center of Excellence for Education in Oral Implantology. Owner of clinics in Poland: Dr Sobczak Klinika Radosc, Dr Sobczak Klinika Babice and Dr Sobczak Junior Wilanow.

About ...

SmileAward

Show us how YOU are changing the lives of your fully edentulous patients and how dentistry can give back confidence and improve the overall well-being of individuals. Please create and submit your best patient story, together with the clinical procedure and the patient's testimonial by April 20th, 2022. All cases fulfilling the criteria will be submitted for public voting. A jury composed of world-renowned thought leaders in the field of dentistry will select the final winners who will be awarded their prizes during the EuroPerio 10 (June 15–18, 2022). Participate now and don't miss the opportunity to showcase the way you are impacting your patients' lives every day.

About ...

the Straumann Group

Since our foundation many decades ago, we’ve been inspired to make people’s lives better. Our entrepreneurial spirit and commitment to scientific excellence, has made us a global market leader in esthetic dentistry. We’ve transformed millions of lives. And we’ll transform millions more. Patients and professionals all over the world confirm that improved oral health increases self-confidence. It restores people’s self-esteem and unlocks their life potential. We are proud to be able to make a fundamental difference. Because what we do, goes way beyond simply restoring a smile.

Barbara Sobczak
2021 winner
video:



Interview with Dr Markus Tröltzsch on greenviu

Sustainability is not achievable by dental practices working on their own

When it comes to sustainability in the dental practice and to “green dentistry”, initial steps have been taken by various groups and associations to address the topic. Dr Markus Tröltzsch takes a different approach. Together with his brother and another partner, he founded greenviu GmbH. In this interview he explains his motives, goals and hopes.



Exactly what is greenviu, Dr Tröltzsch?

The question can be answered in two ways, emphasizing two distinct aspects: as far as its corporate standing, it is a classic limited liability company (LLC; “GmbH” in German) that offers a service, namely, to simplify tasks and to empower medical businesses embarking on the path to sustainability.

But the more exciting aspect is the principle underlying greenviu. It is an LLC of medical institutions—which includes physicians, dentists, physiotherapists, pharmacists, anyone who is active in the medical field—who have the declared goal to make

the practice of medicine beneficial for both humankind and for nature. In short: practicing medicine as sustainably as possible.

The greenviu platform gives medical professionals access to relevant areas of knowledge and practice processes, and to relevant products that actually are more sustainable, as far as can be ascertained—advising them how to work more sustainably themselves. But the platform is also about serious possibilities to compensate for those aspects of medicine that simply cannot be made more sustainable because, after all, we put the safety of our patients first. This part of our impact we should be able to compensate for by connecting with reputable projects that help us do so. Greenviu is part of the United Nations Climate Initiative and through it has access to the UN climate offset projects, and this in turn ensures that the platform is an integral part of a larger context.

Sounds professional. Who is behind this?

It started with us—my brother and me—trying follow a path to sustainability in our own practice. We soon realized that if we were to be serious about this, we could not go it alone. This is not about just doing things a little better, it is about making the practice sustainable using a scientifically based approach, from process management to the products used, and all that without compromising the safety, practicality, success rate and efficiency of our processes. And, of course, the process should remain affordable. We understood that we really had to put our efforts in a larger context. That is why we created the LLC.

By now, many well-known personalities from the worlds of medicine and dentistry are behind this endeavour. On the web you can see some of them presented; Professor Schlegel, for example, is one of them. The goal of these supporters is to jointly bring the project forward. Increasingly, industry circles are also signalling an interest.

Why not go non-profit?

Important question. In the end, non-profit means that the overall structure must resemble that of a club or association,

and of course that no money can be made. We made a conscious decision to make money from this project so that we have funds available to invest in the further development of sustainable medicine.

For example, our research funding scheme will take off this year. We are making a dedicated effort to strengthen scientific efforts, and for the financial support to come from a company would seem more appropriate to the purpose. In this way, it is possible to work through collaborative schemes. This provides an incentive for other profit-oriented companies to take an interest in promoting the idea of sustainability.

Overall, as a “non-non-profit”, you are much more flexible in your structure, and you can make significantly better use of the money flow you generate. Of course, non-profits also earn money, and they spend it on association structures or the like. In the context of non-non-profits, the process can be made much more transparent.

Who may participate and in what form—as a member, as a shareholder?

A prerequisite for membership is that you must work in the field of medicine. Members sign up for an annual membership. Right now, the majority of our members are physicians and dentists, but of course pharmacists, osteopaths, medical journalists—medical professionals in the broadest sense—can also be members. We are targeting anyone who keeps medical and dental operations running. For now, membership is by invitation only so that we can manage our growth somewhat. In the longer term, however, membership will be freely accessible. I am not sure we can get there this year. As a next step, we will approach various professional societies and give their members the opportunity to participate.

Whither the journey?

The idea is to provide opportunities for developing standards to move sustainable medicine forward at a serious scientific level. The moment everyone plays their own little game and implements their own little rules, (a) we lose all structure; (b) we lose all credibility; and (c) we will not get the whole industry moving in the same direction.

The problem is that if I did this in my own practice, I would not have much credibility, because there are just way too many definitions floating about. Which, by the way, is another reason why we did not implement this on our own. With greenvui, we are creating a standardized approach that can work for medicine as a whole, and we will also use it to try and establish a uniform system across many countries. Patients should know that when they frequent a greenvui practice, they support a practice where sustainability is a priority—but not at the expense of their safety, and not at the expense of the success of the treatments practiced there, but in harmony with the overall sustainability goals. At the moment, we have members in 22 countries. So we are slowly evolving.

Does this put you in competition with those associations that have discovered “green dentistry” as one of their topics?

Not at all. I think it is great that there we have come to an understanding at different levels of how much we need sustainability in medicine and in dentistry. And it makes sense to think in different directions. The problem with the various activities, however, is often that it is basically once again the dental or medical practice all by itself that is supposed to implement everything. We think that that is a problem, because going it alone—from identifying sustainable products to process management—is actually pretty costly, and it gets us back into that trap where there is no comparability, no uniform standard. Any and all activities in this direction are highly welcome and worthy of support, and wherever opportunities present themselves, we would also like to move forward together. After all, the idea behind greenvui is that much of the work of becoming sustainable is done by greenvui on behalf of the practices.

What are the benefits of the activities for the individual member? The greenvui poster—is that powerful advertising?

First of all, each member receives a certificate of membership. All members compensate a mandatory 10 tons of CO₂ per year via a project within the scope of their membership. This is a fixed part of the membership, and it cannot be “deselected”; or in other words, each member is already taking a step on the path to serious sustainability.

Members get access to sustainable products in addition to all the process guidelines for their practices. These products are not randomly thrown together but have been selected by us in a lengthy process, and the products are at least as good as or better than those we use by default in the practice. Members get these products at a lower price than they would otherwise receive by suppliers, as a membership benefit. This is a financial incentive.

We also offer social media and PR support to members. Our members-only area offers content that can be used for the various news channels. The content has been prepared by us but can of course also be customized to point out to patients that the practice is taking the path to sustainability.

Thank you very much, Dr Tröltzsch, for your comments.

This interview was conducted by Anita Wuttke, Editor-in-Chief.



Dentaurum

The new fixing screw— development for the digital workflow



Fig. 2: tiologic® TWINFIT titanium scan abutments.

Improvements always start in the detail. True to this motto, the innovators at Dentaurum Implants have developed the fixation screw. It allows the new titanium scan abutments to be inserted safely and precisely. This ensures that the abutment is correctly inserted, even in areas that are difficult to view—without additional X-rays.

The new fixing screw has a shortened thread and can therefore only grip if the scan abutment is correctly lodged in the implant. If there are even the slightest deviations, the thread will not find a grip and the dentist will immediately notice that readjustment is necessary.

Perfect placed insertion is ensured even under poor visibility or with raised gingiva. Deviations in the digital impression will be minimized. The new fixing screw is also anodized in red to make it easier to perceive. Dentaurum Implants is actively committed to environmental protection. Besides the certification according to DIN EN ISO 14001 and EMAS, the reduction of disposables is an integral part of the concept.

With the new HLD coating, it has been possible to make the scan assemblies and scan caps completely scannable without powder or spray. After using, the articles can be sterilized in the thermal disinfectant. With the titanium material, the abutments are robust and resistentially stable, making them more durable and environmentally friendly.



Fig. 1: The new fixing screw.

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The new whiteSKY Alveo Line from bredent

Optimal care for every case



In 2021, the whiteSKY implant system from bredent received an improved design. Now it has been complemented by a new line: the Alveo Line. This means more treatment options for the implanter and an optimal restoration for every case.

The whiteSKY implant system from bredent is one of the best documented zirconium implant systems in the world. In addition to numerous studies proving its good osseointegration and longevity, the system has also proven itself in practice: The survival rate of whiteSKY is on par with implants made of titanium.

The system has been comprehensively improved as recently as 2021. Now, in addition to the Tissue Line, there is another line: the Alveo Line. The implanter now has the choice: should space be left for the soft tissue or should the extraction socket be filled?

Tissue and Alveo Line: What are the differences?

The whiteSKY Tissue Line is a narrow implant that is offering plenty of space for hard and soft tissue. The slightly waist like shape in the sulcus area of the whiteSKY Tissue Line allows very attractive esthetics, especially in the area of the transition from gingiva to implant crown. The whiteSKY Alveo Line fills the extraction socket during immediate implant placement. At the same time, it is giving the practitioner the opportunity to indi-

vidualize the implant accordingly to the requirements of the clinical case.

Where are the similarities?

Whether Alveo or Tissue Line—both shapes are offering optimal conditions for soft tissue attachment due to their sulcus surface. The whiteSKY implants are made of hipped zirconia and come as an one-piece. These two product characteristics give them very high mechanical stability. Thanks to the improved thread design and a bone quality-oriented surgical protocol, high primary stability is achieved across every treatment case. This makes both lines of whiteSKY implants ideal for immediate restoration. Studies have shown that immediate implant placement improves bone-to-implant contact by more than 50 per cent.

Would you like to learn more about whiteSKY implants?

Go to the product website at <https://bit.ly/3w8BQqK>.

Contact address

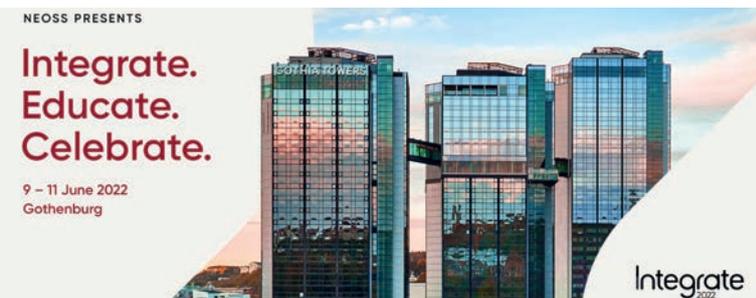
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Neoss

Three-day conference to celebrate 20 years of Intelligent Simplicity



This summer, Neoss is celebrating 20 years of Intelligent Simplicity and is inviting the dental community from around the globe to attend an exceptional scientific programme. Happening in Gothenburg, Sweden, the home of modern implantology and Prof. Per-Ingvar Brånemark, from 9 to 11 June. This three-day conference chaired by Prof. Christer Dahlin, will invite renowned speakers to

the stage to discuss topics and techniques such as prosthetic simplicity without compromise, simplicity in practice, managing risk factors, digital flexibility for you and your patient, and accurate simplicity in intra-oral scanning. Included, will be various break-out sessions for the whole dental team. The programme lectures and break-out sessions will showcase how you can bring efficient workflows into your daily practice. And that's not all! Each day, scheduled around the conference will be social activities and excursions which will delight all, from the more energetic morning running, boat trips and exciting dinners, to the more relaxed sunrise yoga and health and wellbeing sessions. All to celebrate the valued community Neoss has created over its 20 years of innovation.

Contact address

Neoss Ltd., UK

www.neossintegrate.com

Argon Medical

A combination of main healing aspects and desirable aesthetics

The successful K3Pro implant line from Argon Medical has been enlarged last year by an additional innovation, namely The Compress Implant. The dire need of discerning implantologists to provide their patients with stable provisionals immediately after implantological operations, requires an implant with exceptionally high primary stability—especially in the case of soft bone. For immediate implantations, however, it is often necessary that self-tapping thread flanks secure the implant with the alveolar wall. Also and of much importance is a generous free space for healing through blood coagulation. The new Compress Implants fulfil both aspects mentioned above without neglecting the classic virtues of optimisation for sub-crestal insertion for outstanding aesthetics. Furthermore, the anti-bacterial seal, as well as the micromovement-free connection for sustained tissue preservation is also given in this well-rounded idea of the Stable Tissue Concept. The compressive and progressive self-tapping thread for easy and precise insertion in soft bone has a plateau design and offers added

primary stability for immediate loading. The implant diameter is measured according to the width of the thread flank, whereas the implant body remains similarly slim. Therefore, the choice of diameter regulates the degree of primary stability.



Contact address

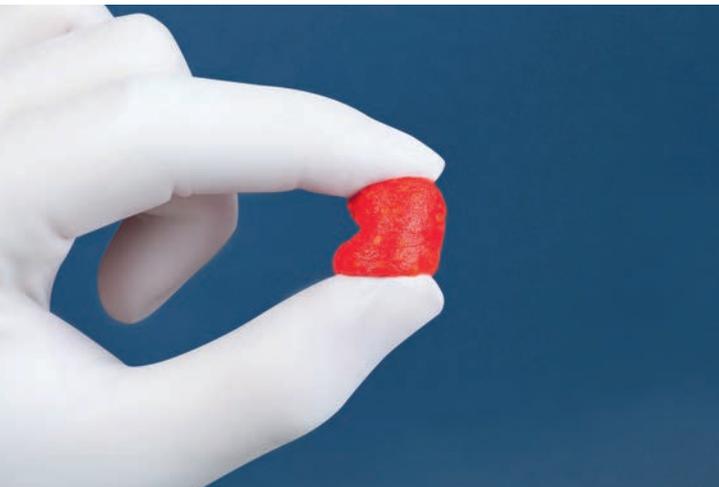
Argon Medical, Germany

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www.argon-medical.com

curasan

Maximum flexibility with CERASORB® Foam



CERASORB® Foam is a multiporous composite material for bone augmentation consisting of collagen and resorbable bioceramics. The use of phase-pure β -tricalcium phosphate with regular interconnecting porosity and primary particle size results in the degradation of the biomaterial simultaneous to bone formation. The shapeable variant of the CERASORB® Foam with low density allows plastic deformation and can be individually adapted to the defect. CERASORB® Foam is miscible with blood and I/A-PRF at a ratio of 1:1, producing an ideal kneadable mass for filling bone defects. The multiporosity of the granules embedded in the collagen helps bone to grow in faster. Blood components and body fluids can permeate the bone regeneration material unhindered and rapidly to accelerate osseous integration, vascularisation, and resorption. Due to the specific composition of CERASORB® Foam, a high degree of volume stability is achieved even after degradation of the more rapidly resorbable collagen, while high radiographic density is maintained. In addition to the round granule form, which has only interconnecting micropores, CERASORB® Foam consists of polygonally broken β -tricalcium phosphate with micro-, meso- and macropores with a pore size up to 500 μm .

Contact address

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www.curasan.de

Next-generation Implant System with
an internal design by enhancing
strength and convenience!

KS System—The key solution for strong implant



The KS (Key Solution) implant system provides durable stability for patients and easy access and manipulation for dentists. The KS implant has an internal hexagon connection and 15° Morse taper, which provides larger angular compensation compared with its forerunner. Its internal hexagon connection ensures high structural stability against external loads. The use of this system reduces chair time thanks to its strong structure, simple platform, and easy prosthetic application.

Enduring the forces and stress dispersion are strongly enhanced compared with existing products. The wall thickness of the connection is increased, owing to the 15° Morse taper angle. The KS implant has been proven to be stronger and to maximise fracture resistance.

Thanks to the system's single platform, prosthetic planning is simpler than ever. It reduces the steps and the chair time by not having to identify specifications regardless of the platform to select the prosthesis. Moreover, its effects on reduction of prosthesis fastening error due to the abutment compatibility with all diameters of implants enable stock control by reducing inventory burden.

The KS abutment holding system makes abutment seating easier. The KS implant and superstructure stay connected even before tightening the screw. The abutment does not fall out even when the implant is held upside down and shaken. The KS implant is the only implant system on the market providing single-handed use, giving the dentist easy access and the most convenient implementation. It also prevents the seated superstructure from being pushed up by the gingiva or the misconnection of the superstructure during flapless surgery.

The surface is coated with BA substance, a super-hydrophilic coating that boosts osseointegration by increasing blood adhesion. BA substance is 100% bio-absorbable and provides excellent healing efficacy which increases the success rate in bad bones as well. The rapid formation of woven bone by attracting blood to the titanium surface has contributed to improving the initial stability of implants. Therefore, the BA surface treatment shows excellent osteointegration without any concerns, and increases the implant's ability for bone formation and remodeling to enhance all the good effects.

Curaden

Rinsing against SARS-CoV-2— one mouthwash reduces infection risk

In a study that is the first of its kind, researchers from Claude Bernard Lyon I University in France have shown that Curaprox's Perio plus regenerate mouthwash reduces the risk of transmitting SARS-CoV-2. A single rinse with the mouthwash lowers the viral load in the mouth by 71%, aiding the immune system in controlling the start of infection.

An important breakthrough

The Curaprox Perio plus mouthwash protects against viral infections and has protective and regenerative properties, thanks to the hyaluronic acid it contains. The result is an oral mucosa that is in optimal health and minimally susceptible to viral infection. Rinsing and gargling with Perio plus regenerate is an excellent barrier measure against the spread of SARS-CoV-2. The discovery has interesting implications for fighting the COVID-19 pandemic, as well as for future antiviral preventive measures. Be it for personal or clinical use, antiviral mouthwashes could play an important role in reducing the general risk of contamination.

The study, titled "Use of an antiviral mouthwash as a barrier measure in the SARS-CoV-2 transmission in adults with asymptomatic to mild COVID-19: A multi-centre, randomized, double-blind controlled trial", was published in the October 2021 issue of *Clinical Microbiology and Infection*.

Contact address

Curaden, Switzerland

www.perioplus.com



Straumann

Iconic Tissue Level meets Immediacy

The science of tissue-level implants has been taken to the next level. Straumann® has built on and perfected its well established Straumann® TL system.

The Straumann® TLX system combines a neck design mimicking the natural anatomy and respecting the biological distance in all dimensions with latest innovative endosteal design, optimised for primary stability. The new system is designed to significantly reduce the risk of inflammation and bone resorption as the implant-abutment interface is moved away from the bone. The Straumann® TLX system has been developed for optimal primary stability and immediate protocols in all bone types and lets you increase efficiency with a one-stage, straightforward workflow. It forms the perfect complement to the Straumann® BLX system for bone-level implants. Both systems use one common drill set and TorcFit™ connection for maximum compatibility with minimum investment.

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(European Association of Dental Implantologists)

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Practicing implantology since:

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Continuing education Courses:

.....

Fellowship status / diplomate status in implantology

Yes No Organisation

Entry in BDIZ EDI Directory: Yes No

(For information on BDIZ EDI Directory of Implant Dentists see overleaf)

The annual membership fee for:

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(up to 5 years after graduation) 172,50 Euro

Second membership / family member 172,50 Euro

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(Companies etc.)

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Membership cards will be sent upon receipt of the annual subscription fee.

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	Event	Location	Date	Details/Registration
5/2022	Mectron Spring Meeting 2022	Venice Italy	6–7 May 2022	www.springmeeting2022.com
	17 th Expert Symposium of BDIZ EDI	Cologne Germany	7 May 2022	www.bdizedi.org/17-experten-symposium
	WID International Dental Exhibition of Vienna	Vienna Austria	20–21 May	www.wid.dental/en/
	Giornate Veronesi	Valpolicella Italy	20–21 May	www.giornate-veronesi.info
	Association of Dental Implantology ADI Team Congress 2022	Manchester UK	26–28 May 2022	www.adi.org.uk/congress22
	15 th European Symposium	Karlsbad Czech Republic	27–28 May 2022	www.pupp.cz
6/2022	EuroPerio 10	Copenhagen Denmark	15–18 June 2022	www.efp.org/about-europerio

EDI Journal—Information for authors

EDI Journal—the interdisciplinary journal for prosthetic dental implantology is aimed at dentists and technicians interested in prosthetics implantology. All contributions submitted should be focused on this aspect in content and form. Suggested contributions may include:

- Original scientific research
- Case studies
- Product studies
- Overviews

Manuscript submission

Submissions should be made in digital form. Original articles will be considered for publication only on the condition that they have not been published elsewhere in part or in whole and are not simultaneously under consideration elsewhere.

Manuscripts

Pages should be numbered consecutively, starting with the cover page. The cover page should include the title of the manuscript and the name and degree for all authors. Also included should be the full postal address, telephone number, and e-mail address of the contact author.

Manuscripts can be organized in a manner that best fits the specific goals of the article, but should always include an introductory section, the body of the article and a conclusion.

Illustrations and tables

Each article should contain a minimum of 20 and a maximum of 50 pictures, except in unusual circumstances. Our publishing house attaches great importance to high quality illustrations. All illustrations should be numbered, have a caption and be mentioned in the text.

The photos should have a size of 10x15 cm, the image or graphic files must have a resolution of 300 dpi. Tiff, eps and jpg file formats are suitable. Radiographs, charts, graphs, and drawn figures are also accepted.

Captions should be brief one or two-line descriptions of each illustration, typed on a separate page following the references. Captions must be numbered in the same numerical order as the illustrations. Tables should be typed on a separate page and numbered consecutively, according to citation in the text. The title of the table and its caption must be on the same page as the table itself.

References

Each article should contain a minimum of 10 and a maximum of 30 references, except in unusual circumstances. Citations in the body of the text should be made in numerical order. The reference list should be typed on a separate sheet and should provide complete bibliographical information in the format exemplified below:

[1] Albrektsson, T.: A multicenter report on osseointegrated oral implants. *J Prosthet Dent* 1988; 60, 75–82.

[2] Hildebrand, H. F., Veron, Chr., Martin, P.: Nickel, chromium, cobalt dental alloys and allergic reactions: an overview. *Biomaterials* 10, 545–548 (1989).

Review Process

Manuscripts will be reviewed by three members of the editorial board. Authors are not informed of the identity of the reviewers and reviewers are not provided with the identity of the author. The review cycle will be completed within 60 days. Publication is expected within nine months.

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[1] Semper-Hogg, W, Kraft, S, Stiller, S et al. Analytical and experimental position stability of the abutment in different dental implant systems with a conical implant-abutment connection Clin Oral Invest (2013) 17: 1017

[2] Semper Hogg W, Zulauf K, Mehrhof J, Nelson K. The influence of torque tightening on the position stability of the abutment in conical implant-abutment connections. Int J Prosthodont 2015;28:538-41

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