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International Academy of Mini Dental Implants • International Academy of Mini Dental Implants

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JOURNAL OF THE INTERNATIONAL ACADEMY OF MINI DENTAL IMPLANTS

L-PRF: CHANGING DENTISTRY TODAY AND FOR THE FUTURE

Matt Lasorsa, DMD

Andrea Smith, DDS

Alan Robinson, DDS

integrity | compassion | education | research | fellowship

JIAMDI IAMDI

Journal of the
International Academy
of Mini Dental Implants

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of Mini Dental Implants

ON THE COVER

L-PRF: CHANGING DENTISTRY TODAY AND FOR THE FUTURE

L-PRF™ is a 3-D autogenous combination of Platelet Rich Fibrin derived from the patient's blood. A simplified chairside procedure results in the production of a thin, compressed layer of platelet rich fibrin that is strong, pliable and suitable for suturing. This natural fibrin network is rich in platelets, growth factors and cytokines that are derived from the blood platelets and leukocytes.

The presence of these proteins have been reported to produce rapid healing, especially during the critical first seven days after placement. This network promotes more efficient cell migration and proliferation without chemical or bovine thrombin additives.

Clinically, Leukocyte-Platelet Rich Fibrin displays excellent working properties. This biomaterial is resilient, strong and pliable, making it easy to manipulate. It can be cut to size, and is supple enough to adapt to many anatomical areas. It is adhesive in nature and very receptive to suturing. In addition, there is ample working time since L-PRF™ is stable at room temperature for several hours.

Todd E. Shatkin, DDS, President Emeritus of the IAMDI

Todd E. Shatkin, DDS

Dear Fellow Academy Members, Colleagues and Friends,
It was an honor to be your Editor of this year's Journal of the International Academy of Mini Dental Implants. I would like to personally thank Dr. Robert Caseldine for blazing the trail with past issues and for his professional leadership as President over the last two years.
To Dr. Caseldine, his staff and the Editorial Board, we appreciate your service to the IAMDI.

This is an exciting time in Dentistry! With all of your help, Mini Dental Implants have revolutionized Dentistry, making an implant procedure less invasive, less painful with less healing time, less visits to the dentist, and more affordable than conventional implants. We can replace a missing teeth in as little as one visit and stabilize dentures in as little as an hour. WOW!!!

Dr Gordon Christensen, a diplomat and founding member of our Academy, stated on numerous occasions that every General Dentist should be offering mini dental implants in his or her practice.
My Father, the late Samuel Shatkin, Sr. DDS, MD (also a founding member of the Academy), told me 15 years ago that mini dental implants gave him a reason to keep working into his 70's. I was very fortunate to have practiced with him by my side for over 20 years. He helped dentists from all over the world gain a better appreciation for Mini Dental Implants. He prepared me to do what I do today, providing Doctors with the knowledge and skills needed to grow their practices while providing an affordable, fast solution to loose dentures and missing teeth.

In conclusion, I invite you to send me your interesting cases in a way (word document with photos) that we can share your experiences with your IAMDI family. Let's grow together and grow our membership.

David R. Powers, DDS President & Diplomat of the IAMDI

David Powers, DDS

Dear Fellow Academy Members, Colleagues and Friends,
I am honored to be the new President of the IAMDI. Being involved with mini dental implant dentistry and the academy has not only changed my life, but the lives of other dentists and their patients. The impact of our members in the dental community is truly powerful and I hope to continue to educate and inspire dentists from all over the world to embrace the mini dental implant use in main stream dentistry. The IAMDI promotes comradery amongst dentists to improve the quality of dentistry performed in dental practices across the world and will continue to strive for excellence.
I look forward to serving this outstanding organization.

GUEST SPEAKER

Integrity | Compassion | Education | Research | Fellowship

KEY NOTE SPEAKER

Samuel Shatkin Jr., M.D.

Certified by the American Board of Plastic Surgery
Aesthetic & General Plastic Surgery

Samuel Shatkin Jr., MD is a Board Certified Plastic Surgeon in Buffalo and Western New York, and performs all aspects of Aesthetic Plastic Surgery. He has presented his surgical and non-surgical techniques nationally and internationally and has won numerous awards in the field of Plastic Surgery and Advanced Skin Care including TopDoc Award in Western New York and is a finalist in the 2016 Buffalo/ Niagara Business Ethics Award. Dr. Shatkin is recipient of the prestigious 5-Star Diamond Award from the American Academy of Hospitality Sciences, with the distinction of being the only practicing Plastic Surgeon in the world with that honor. He has been in private practice since completing his Plastic Surgery Training in 1989. His major concentration is in the areas of Aesthetic surgical and non-surgical treatments, Advanced Skin Care and Anti-Aging Services. He is president of the Aesthetic Learning Academy, which trains health professionals in his aesthetic techniques and on the board of trustees and founder of the International Society of Aesthetic Medical Professionals. He is Medical Director of the Aesthetic Associates Centre for Plastic Surgery and Advanced Skin Care and medical director of Trés Auraé Spa and oversees services as a consultant. He holds a position as Assistant Professor of Surgery at the State University of New York at Buffalo. Dr. Shatkin resides in Williamsville, NY with his wife and three children.

Shatkin F.I.R.S.T.®

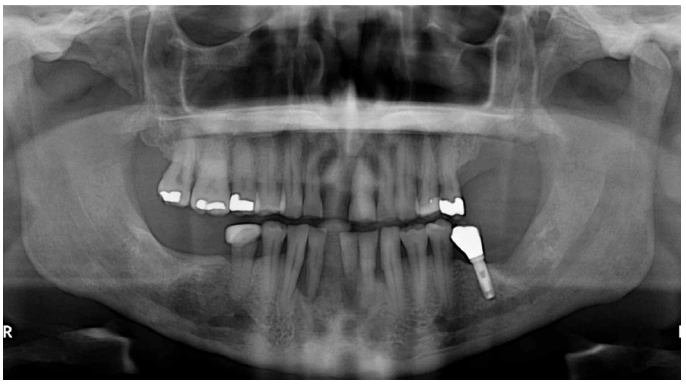
INTRASPIN™

SYSTEM

FDA Cleared

L-PRF™

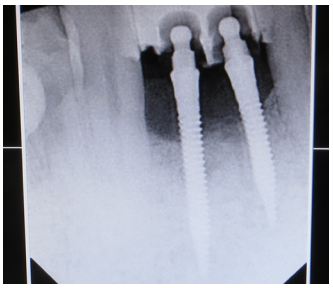
The IntraSpin™ System establishes a three-step protocol for drawing and centrifuging the patient's blood,removing the fi brin clot and processing it in the Xpression™ Fabrication Kit. A thin, compressed layer of Platelet Rich Fibrin or plugs for extraction sites can then be formed, using either the internal plate or the piston assembly.

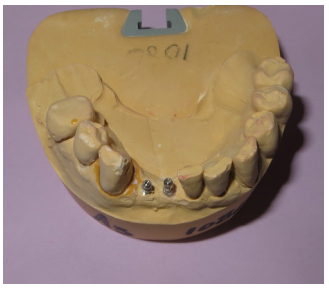


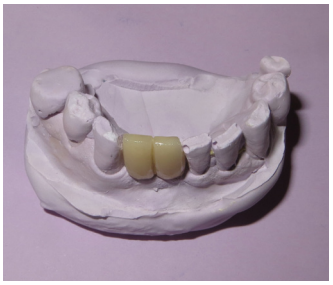
Mini Dental Implant Center Orlando

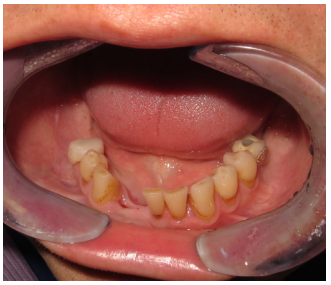
Matt Lasorsa, DMD

This patient presented with a missing tooth #25 and a non restorable #26. Originally he just wanted a flipper, then changed his mind to 2 mini dental implants with some L-PRF grafting. The extraction site was curetted out, rinsed with peridex and saline, then bleeding holes created with a surgical handpiece. Blood was drawn and spun in Intra-lock's Intraspin to create L-PRF. A 2.0x15mm implant was placed in the area of #25, and a 2.0x18mm was placed in the area of #26, both with 60nCm of torque. L-PRF was placed in and around the exposed threads in the defect, then saturated with serum. PGA sutures used to close the wound covered with an L-PRF membrane. The implants were then temporized with healing caps and bonded with composite.

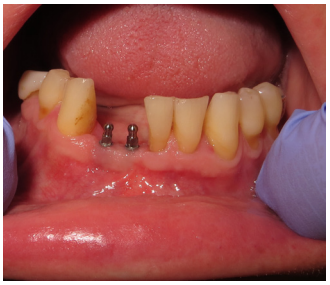


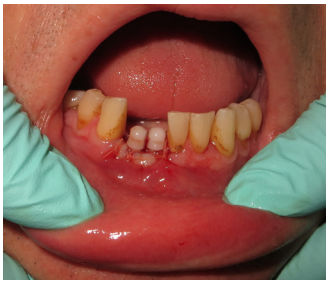




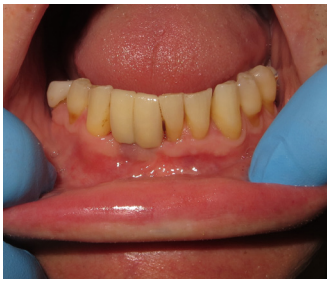


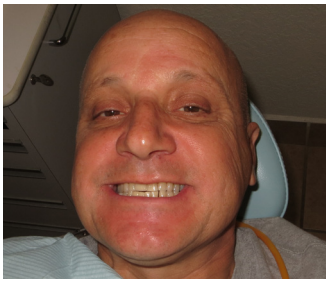
After 2 weeks the sutures were removed, and the area was healing well.





After 3 months the temp was removed for a final impression. An xray was taken at the 3 month interval to evaluate the regeneration of bone. As shown on the xray, the defect has filled in and the bone has grown vertically and horizontally around the threads of the implants. This regrowth is credited to the increased healing with L-PRF and the Ossean surface of the implants. The regeneration of bone will continue to be monitored over the next year.





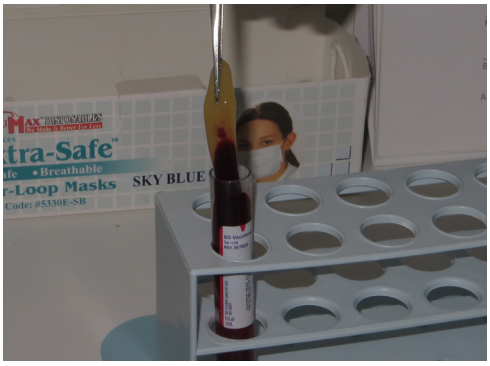
The final crowns were cemented a few weeks later to a very happy patient.

L-PRF TECHNIQUE

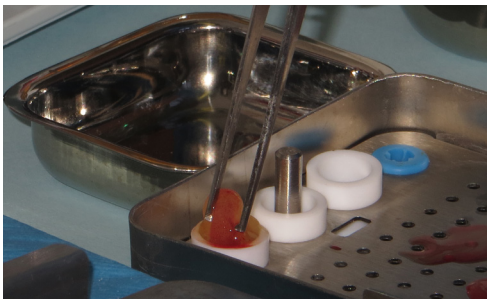
Matt Lasorsa, DMD

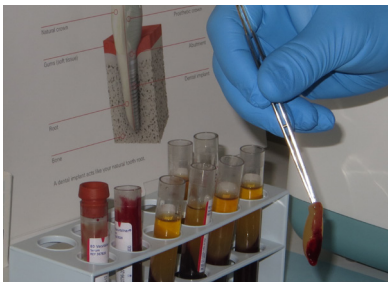
Blood draw for 8 tubes of blood

After the spin is complete, there are 3 layers in the tube: The top layer is the PPP(platelet poor plasma). The second layer is the L-PRF clot, this is what we want. The bottom layer is concentrated erythrocytes, which we don't want.

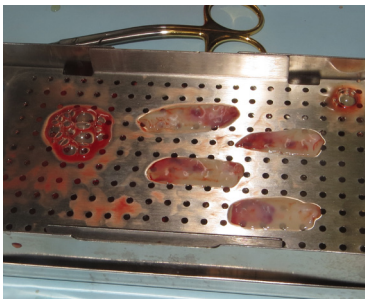
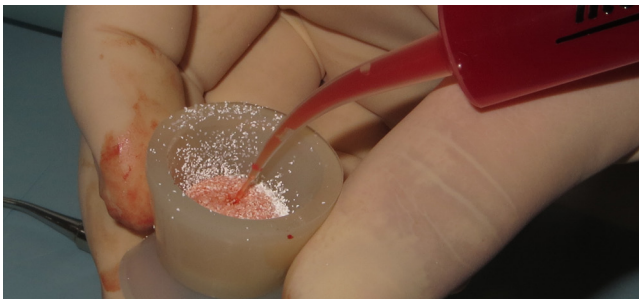
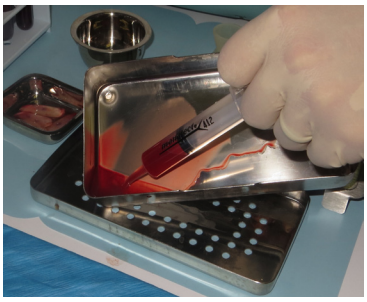
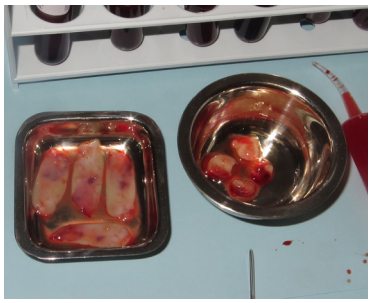


The L-PRF layer is engaged with cotton pliers, and the erythrocytes are scraped off with a spatula

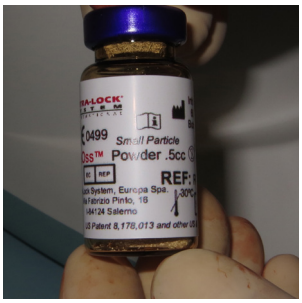




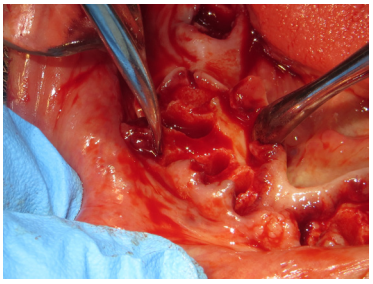
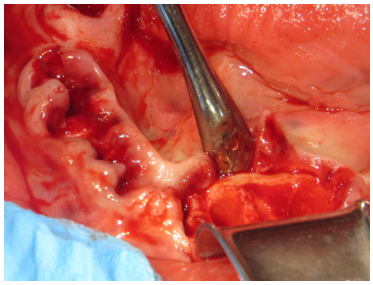
All clots are removed and placed on the expression kit to be pressed flat to create membranes or placed in a cylinder to create a plug.

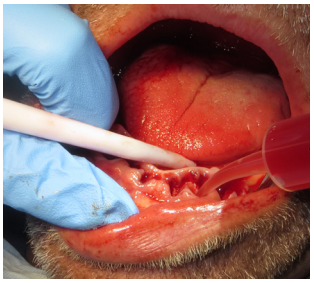
5 minutes for the clots to express. The membranes and plugs are removed and ready for use. Serum is collected in the bottom of the expression kit. This serum from the L-PRF clots contains some PRP(platelet rich plasma).

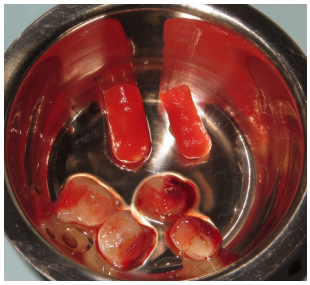
A vial of ReOss powder is hydrated with serum and minced bits of PRF to make a putty.

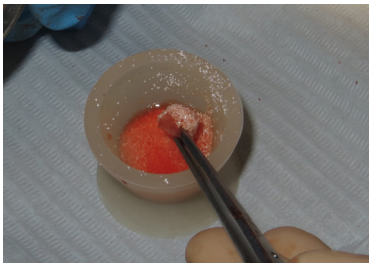
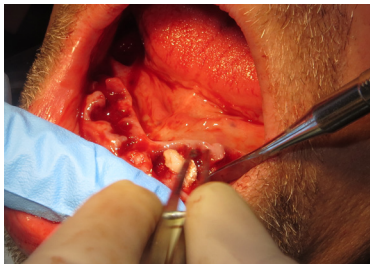
After all extractions, all pathology is removed and bleeding points made with a surgical handpiece. Bleeding points are necessary to allow the migration of new cells into the graft site.



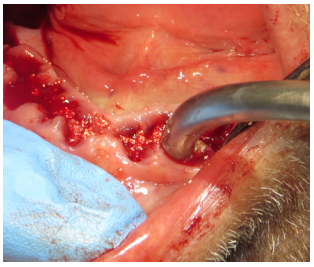
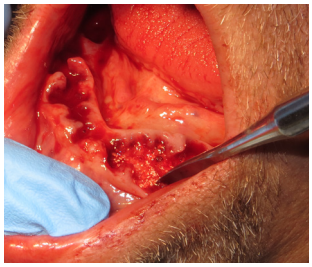
The graft sites are saturated with serum to introduce growth factors

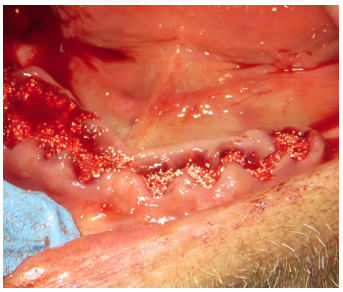
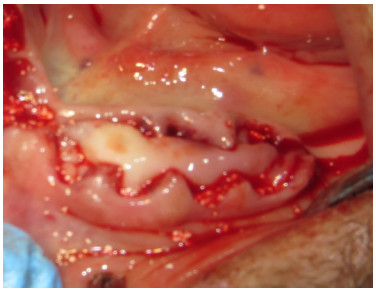
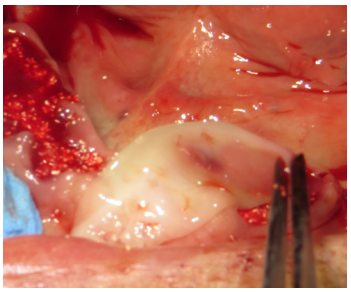
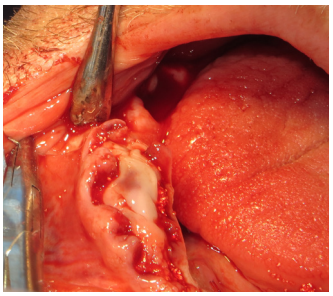


A collection of L-PRF plugs and saturated collagen plugs. Keep them hydrated with serum

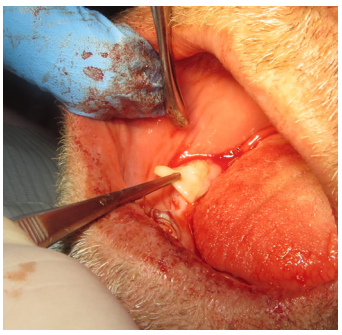
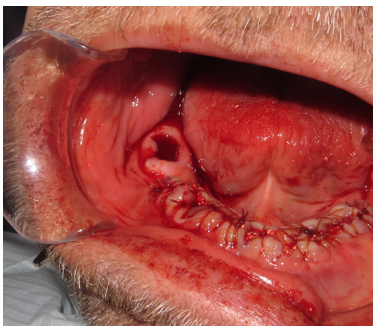



The putty mixture of L-PRF pieces, ReOss bone powder, and serum are packed into the extraction sites.

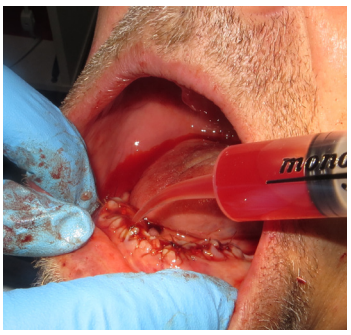
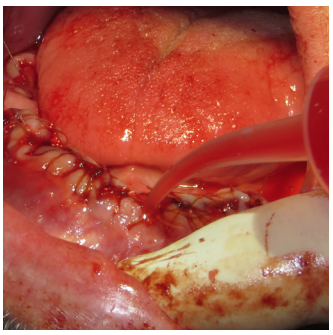



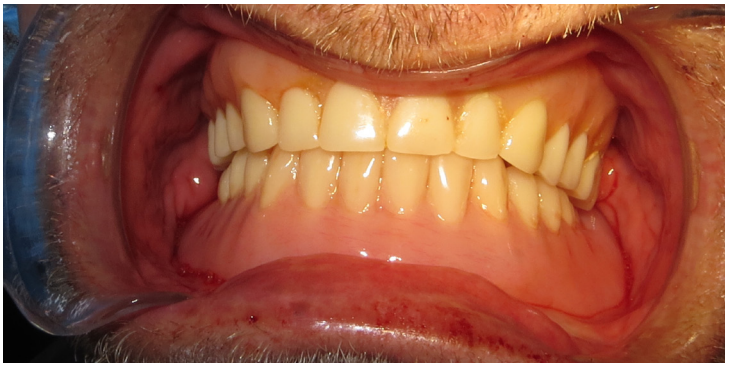
The graft sites are covered with L-PRF membranes tucked into the buccal and lingual tissue

Everything is sutured into place to prevent graft leakage and immobility

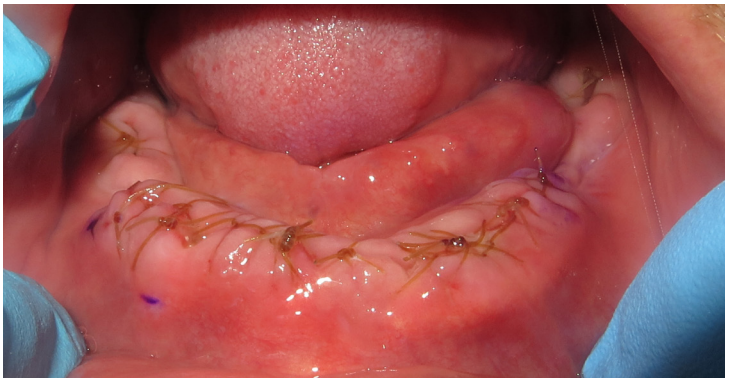
Once the suturing is complete, the surgical area is saturated with serum again



The immediate lower denture is fitted into place.

Post op instructions for the patient are :

1. Antibiotic coverage for one week
2. No rinsing for 72 hours, after 72 hours, gently rinse with warm salt water
3. No carbonated beverages for one week
4. No toothpaste for one week (instruct them to use mouthwash on their toothbrush instead of toothpaste for the first week)



Patient is seen for post op 5 days later. Incredible healing and very little adjustments on his denture. Suture removal is 8-14 days after the day of surgery. Full bone maturation is in 4 months from the day of surgery.

Rebuilding the "Boomer Nation"
Building Bridges for the Future

The United States is now seeing the "Boomer Nation" entering the retirement years. The post-World War II "Boomers" born 1946-1965 are now aged 51-70. This group experienced tooth loss at a greater rate than what is common today but many have replaced those missing teeth with Fixed Crown and Bridge Restorations. As Abutment Tooth Conditions deteriorate over many years due to recurrent carries, periodontal disease, tooth fracture or trauma, many patients are now facing the loss of multiple teeth and/or pontics. For placement of Conventional Dental Implants, because of the remodeling of bone in edentulous areas over years, the long term edentulous areas would require extensive, often multiple bone grafting procedures for placement of conventional implants including block grafts, ridge splitting, appositional grafts, buccal grafts, bone tenting and sinus lifts which have significant cost, time inconvenience and discomfort negatives. If extensive bone grafting is even possible, these procedures add 6-12 months to treatment times before conventional implants can be placed. Due to smaller diameter, which allows precise placement in existing bone, Mini Implants are a versatile, quicker, easier and much less costly alternative to restore these failing Crown and Bridge restorations.

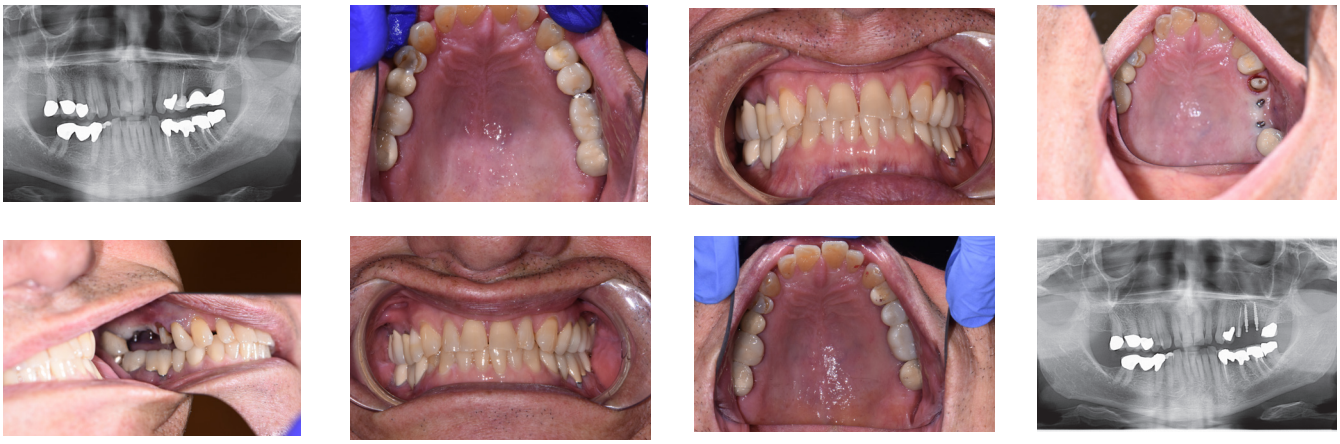
Each case is a "Snowflake," unique in treatment planning considerations. At times, the Abutment teeth are suitable in strength and condition as single tooth restorations, but are now unsuitable as an anchor for a long span Fixed Bridge. In other situations, the Abutment tooth requires extraction and replacement. We will illustrate both scenarios in various combinations in the following 4 cases.

Alan F. Robinson DDS, PC
General Dentistry Practice
The Lakeside Center of Implant Dentistry
Mini Dental Implant Practice

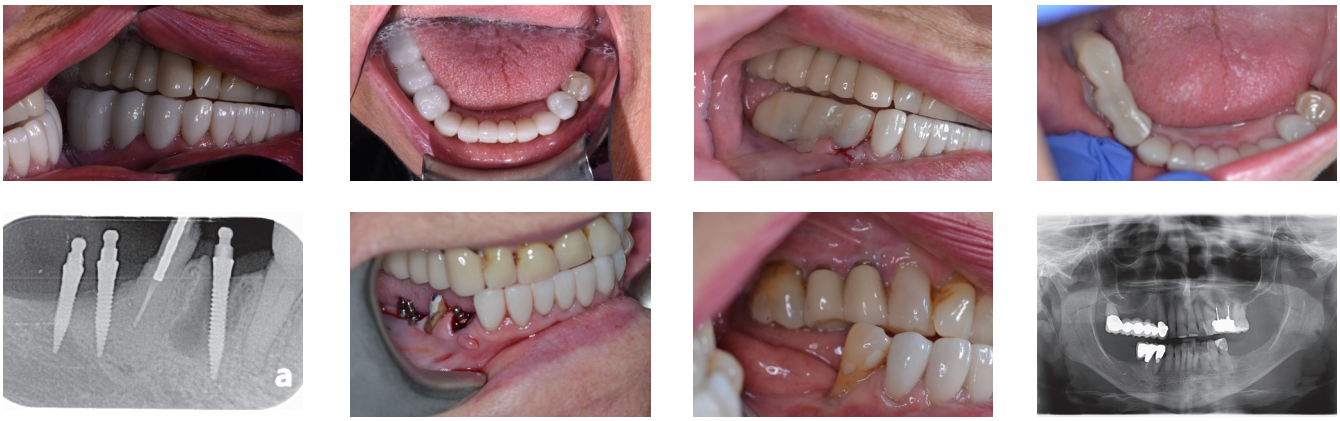
Alan F. Robinson, DDS, FAGD, FIAMDI, FICOI, MIAMDI, MICOI, DICOI

Fellow, Academy of General Dentistry
Fellow, International Academy of Mini Dental Implants
Fellow, International Congress of Oral Implantologists
Master, International Academy of Mini Dental Implants
Master, International Congress of Oral Implantologists
Diplomat, International Congress of Oral Implantologists

- Henry Ford Hospital Consulting Staff
- Manuscript Reviewer – Journal of the Academy of General Dentistry



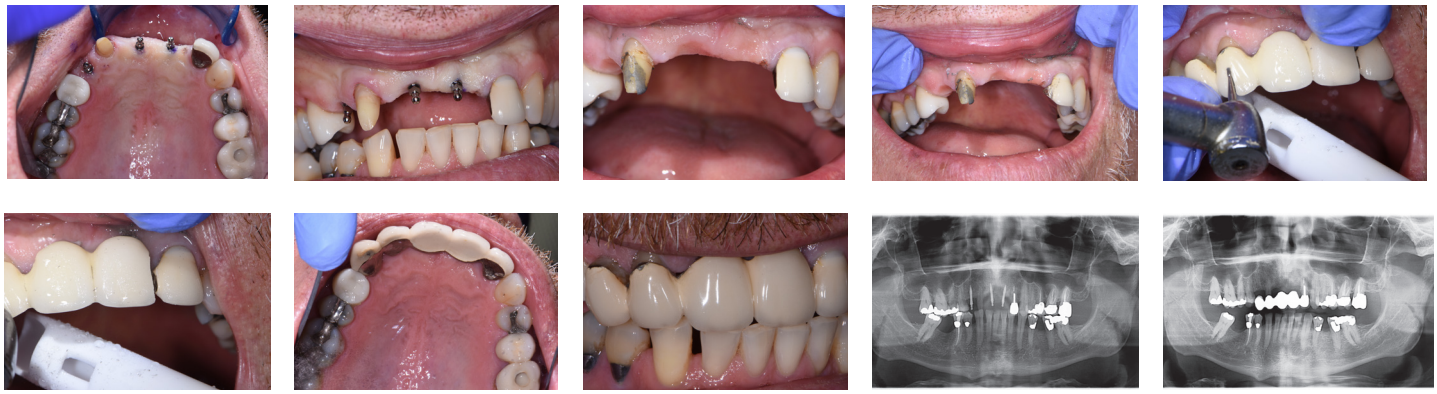
Brian (71) (Fig 1-1 through 1-8) presented with Fixed Bridge #13-15(#14 pontic) which was debonded on #13 due to failure of the cement bond, but still cemented to #15. #13 is Endodentically treated and posted and appears restorable but the existing abutment crown has poor marginal fit, but as we know, an endodontically treated abutment for a Fixed Bridge has a much higher failure rate than non-Endodontically treated abutments. The Treatment plan was to section the bridge at the mesial of #15, maintaining as a single crown for now, with the possibility of later replacement. Placement of 2 2.5 x 13 Intra lock MDL Implants in #14 edentulous area and a new Porcelain Crown on Tooth #13 were the remaining treatment plans. The permanent restoration was placed 3 weeks later.



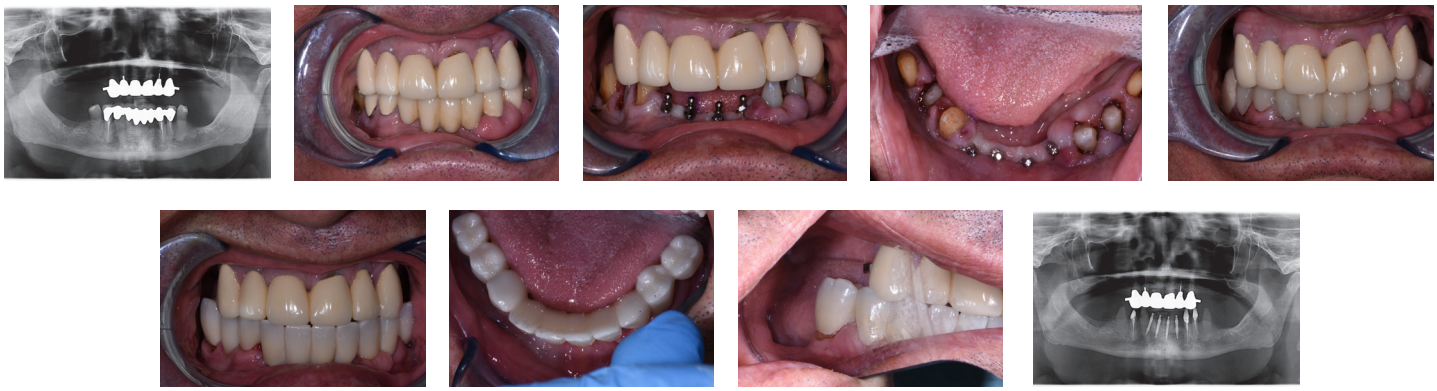
Connie (81) (Fig 2-1 through 2-8) presented with a Cantilever Bridge #28 to 30 (30 Cantilever Pontic) which was loose and failing due to loss periodontal attachment on Tooth #28. Tooth #29 is sound. The treatment plan was to atraumatically Extract Tooth #28, Immediately Place Implant #28 (2.0 x 13 MDL Intra lock), Socket graft (Intra lock Re Oss Putty), Socket Closure with 3-0 PGA Suture, Place 2-2.0 X 11 Intra lock MDL in #30 area and Temporize for 9 weeks with a Composite Resin Temporary Bridge (to allow for soft tissue healing) bonded on to Implant abutments. At 9 Weeks post extraction, the Temporary was carefully cut away, the Implants evaluated and Impressed, and another Temporary bonded in place. The permanent restoration was placed 3 weeks later.

CASE STUDIES

Integrity | Compassion | Education | Research | Fellowship



Jeff (61) (Fig 3-1 through 3-10) presented with Cantilever Bridge #6 to #10 with Abutments #7 and 10. The Cement was unbonded on #7, but intact on #10. The Treatment Plan was to section mesial to #10 to preserve #10 as a single crown, place 3 2.5 x 13 Intra lock MDL Implants in positions #6,8 and 9, re-prepare #7 and place a combination Implant\Tooth Borne Splint #6-9. The area was temporized with a locked on composite Temporary and Permanent splint placed 3 weeks later.



Dennis (69) (Fig 4-1 through 4-9) presented with a Fixed Bridge #21 to #28 (pontics 23,24,25,26) which was loose on Abutments 21 and 22. The Treatment Plan was to remove the existing Bridge, repost #21 and 22, Place 4 2.0 x 13 Intra lock MDL implants in #23,24, 25 and 26 positions and place a combination Implant (Tooth borne Splint #20 to #29. (Note: a Cone Beam confirms Implant #26 position is not encroaching #27). The permanent restoration was placed 3 weeks later.

Mini Dental Implants provide unique treatment possibilities in Simple and Complex situations. Many situations ideal for Mini Implants placement have no suitable Conventional Implant based alternative, whatsoever. These situations are common to every Dental Practice, and these treatments represent a Win-Win for Doctor and Patient.

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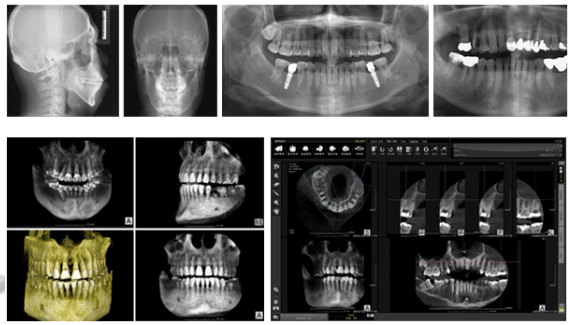

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	$1,607.09	*$1,368.33*	*$1,276.64*
Rate:	*4.49%*	*4.49%*	*4.49%*

2016 Section 179

Example Calculation

Equipment Purchases:	*$84,900*
2016 Section 179 Deduction	*$84,900*
CASH SAVINGS:	*$22,750*
$84,900 X 35% TAX BRACKET	
Equipment cost after Tax:	*$62,150*
ASSUMING A 35% TAX BRACKET	

Andrea Smith, DDS

A case Study of a severely medically Compromised patient receiving Mini Dental Implant

Purpose:

The purpose of this case study is to demonstrate that due to the minimal invasive nature of mini dental implants a person who is severely medically compromised can receive mini dental implant treatment for full mouth reconstruction.

Findings:

The subject is a 76-year-old female
Invalid: bedridden all day
Unable to walk, wheel chair mobile
Medical History: Dementia which worsens at night, but has clarity of thought during the day
Heart Disease: Wears a cardiac life vest due to history of cardiac arrest
Anxiety/Depression
Dental Anxiety
Chronic pain: legs, joints

Medications:

Plavix 75mg 1x/day
Lorazepam 1mg 1x/day
Oxycodone 1mg 1x/day
Aspirin 81mg 1x/day
Hydrocortisone 10mg 2x/day
Zyprexa 1omg 1x/day
Acetaminophen 500mg 3x/day
Effexor 75mg 4-6x/day
Doxepin 50mg 2x/day

Dental History:

Maxillary teeth: Multiple dental restorations, failing root canals and crown and bridge work in need of extensive treatment, see figure 1 & 2.
Edentulous mandible: Lower complete denture made several years ago, she has never worn the denture, it does not fit. Severely resorbed mandible, see figure 3.

Chief Complaint: Her husband says she does not want to eat anymore because of her teeth. He blends her food and she basically drinks her nutrition. This makes for a poor quality of life for the patient and her husband who is her primary caregiver. Her husband simply wants her to enjoy food again. He himself had trouble eating for years until he completed full mouth mini dental implant treatment and received fixed Zirconia roundhouse bridges. He felt the procedure was so simple and noninvasive for him, he believed she can receive this type of conservative implant treatment. We have discussed treatment for his wife over the last year, however the real emergency occurred when she broke a front tooth.

Treatment Plan:

Mandibular Implant supported Resin Roundhouse supported by 6 to 8 Mini Dental Implants
Maxillary Full Mouth extraction (staged)
Maxillary Implant Supported Resin Roundhouse supported by 6 to 8 Mini Dental Implants.
Due to the patient's health and the effort required to come into the office, each visit needed to be very efficient and as much work completed as possible.

Visit #1

CT scan
FMX
Diagnostic Photography
Upper/Lower PVS Impressions
Tooth #7 Extraction/Implant/Temp
Mild Sedation/ pulse oximetry monitored
Four (4) Mini Dental Implants to support existing denture, modify denture by cutting off all posterior teeth and cementing the anterior segment to the mini dental implants
Impression for lower resin roundhouse
Maxillary opposing Impression

Visit #2

Remove mandibular cemented denture segment
Place 3 additional Implants
Retrofit lab made resin roundhouse to accommodate additional Implants
Cement Lower Resin Roundhouse
Mild Sedation/pulse oximetry monitored
Impressions for immediate Maxillary resin roundhouse

Visit #3

Mild Sedation pulse oximetry monitored
Tooth #9 extraction & Implant tooth #9
Bite Registration for Upper Resin roundhouse

Visit #4

Mild Sedation pulse oximetry monitored
Extract the remaining teeth
Place additional Implants
Retrofit Prefabricated Upper resin roundhouse

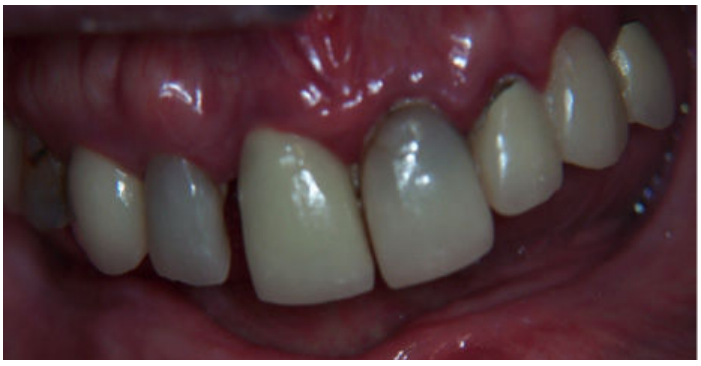


Figure 1: Pre-op Photo Maxillary teeth

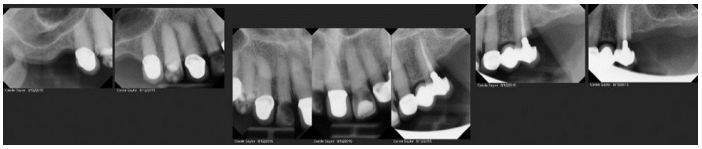


Figure 2: FMX Maxillary Teeth

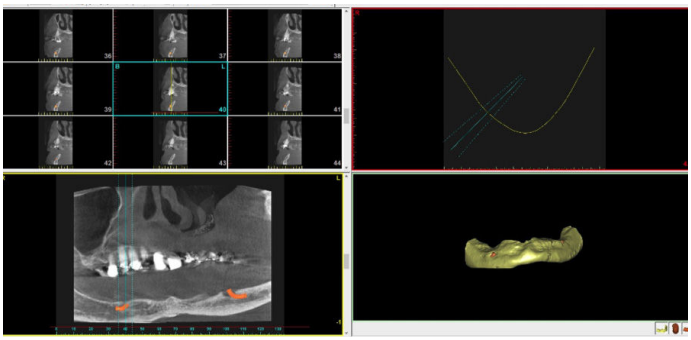


Figure 3 CT Scan/Resorbed Mandible

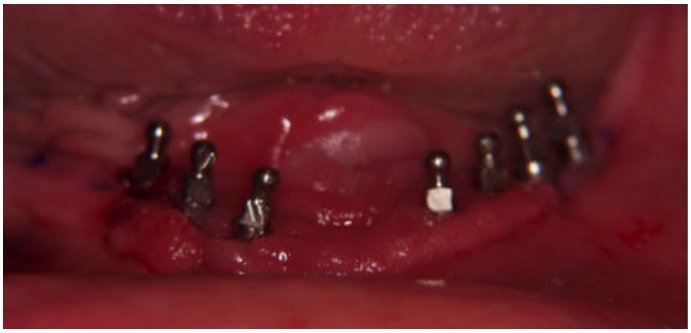


Figure 4: Seven Mini Dental Implants in place

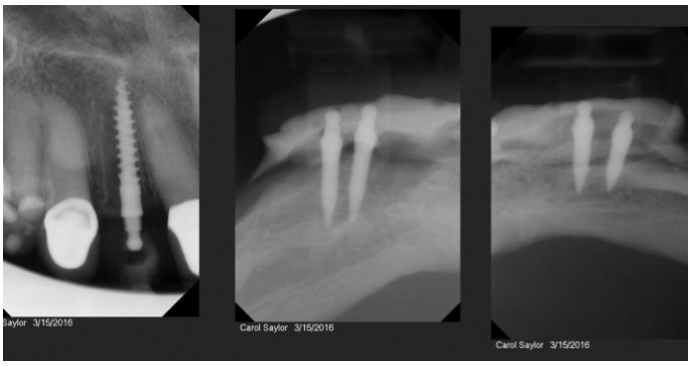
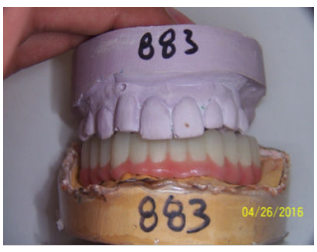


Figure 5 Initial Implant placement @ visit #1



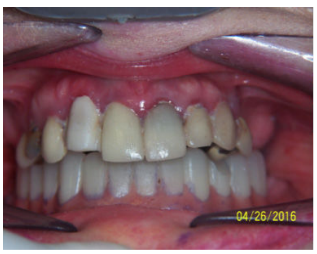


Figure 6 Lower Resin Roundhouse on model and in place in the mouth

Discussion:

The ability to eat is something many of us take for granted. Medically compromised patients who have a poor dentition, are often unable to perform this basic function without help or extremely modified eating, such as eating pureed foods or foods softened by using a blender. This makes for a quality of life that is severely hampered for the person who is ill as well as the family members they live with. In the case of this subject, her husband says that she did not want to eat because it was just too difficult to eat with a denture that did not fit and upper teeth that were brittle and painful. Poor nutrition is something that medically compromised patient can ill afford. Proper nutrition is vital to the maintenance of their remaining quality of health.

Mini Dental Implants in a case like this is truly life changing. Teeth that are stable and free of pain makes eating more enjoyable, immediately and without the need for major oral surgery. The minimal invasive nature of mini dental implant placement means less surgery time, fewer risks of complications during surgery, and less healing and recovery time. Invasive surgery even with healthy patients have inherent risks and even more so with patients with chronic medical conditions. Any procedure that can be done with less potential for complications is a must for patients with medical problems. Convention implant oral surgery would involve multiple surgical visits, extended surgery time, a longer healing period. The patient would require extensive bone augmentation, see CT scan, figure 3. Further the time from bone grafting and conventional implant placement to fixed restorations could be as long as one year. For the severely medically compromised patient this is not an option. Because of her complicated medical history she would not be a candidate for conventional implants. Seven Mini dental implants were placed, figure 4, and were sufficient to retain the lower resin roundhouse restoring the lower arch.

Having a healthy dentition has social implications as well. When the subject broke tooth #7 and appeared to have a missing front tooth, her husband classified this as an emergency. Despite her health conditions and fragile state her husband arranged for her to be brought her to the office almost immediately.

Even though, it is very difficult to get to the office, arrangements must be made well in advance with Paratransit, a medical transportation service, it was necessary for that front tooth to be fixed even if no other treatment could be performed that day. That was Visit #1, see figure 5. She subsequently fractured tooth #9 and again he called to schedule an emergency appointment. That was Visit #2. The patient was experiencing no oral pain due to the broken tooth, it was "cosmetic pain."

The completion of the upper prosthesis will be staged. There are already two maxillary implants in place as a result of two teeth fracturing off at the gum line before officially starting the restoration of the upper. All that remains is the extraction of six additional teeth and place four implants and cement the Upper resin roundhouse. The lower has been restored with a lower resin roundhouse restoration, see figure 6.

Conclusion:

Mini dental implants are a viable option to treat elderly and medically compromised patients in need of full mouth reconstruction, but are not healthy enough to undergo conventional implant treatment. The amount of bone remaining, in many cases, is not sufficient to accommodate conventional implant treatment without significant bone grafting procedures. Conventional implant and bone grafting techniques are contra-indicated in this case due the patient's poor health. Mini Dental Implant placement is a single implant surgical procedure which reduces surgery time, reduces healing time and provides for immediate loading.

References:

1.Shatkin, TE, Petrotto, CA, Mini Dental Implants: A retrospective study0f 5640 implants placed over a 12-year period Compendium Contin Educ Dent. 2012; 3:2-9

2.Shatkin First Dental Lab, Resin Roundhouse, Zirconia Roundhouse, Shatkin First Intralock Implants 2500 Kensington Ave. Amhurst, NY 142326

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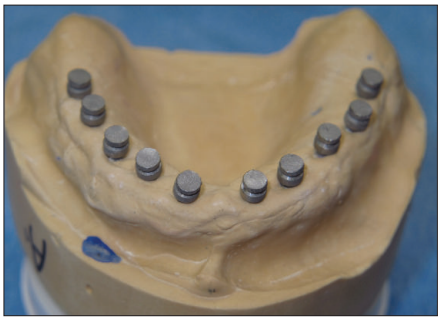

Figure 1. Fabricating the FIX*on*SIX poured model with housings in place.

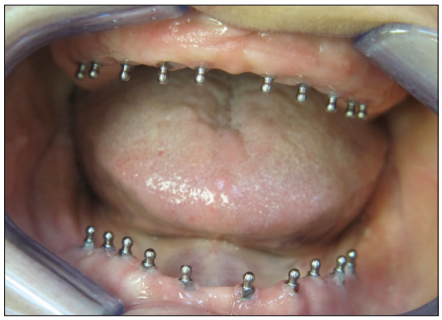

Figure 2. Ten upper and 10 lower Shatkin F.I.R.S.T. Mini Dental Implants.

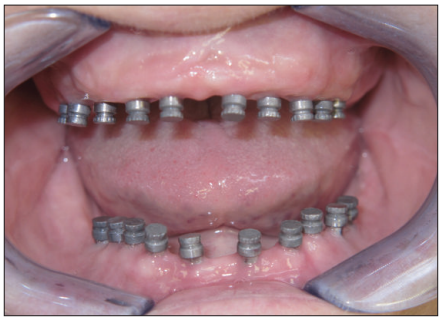

Figure 3. Housings in place prior to pickup in fixed restoration.

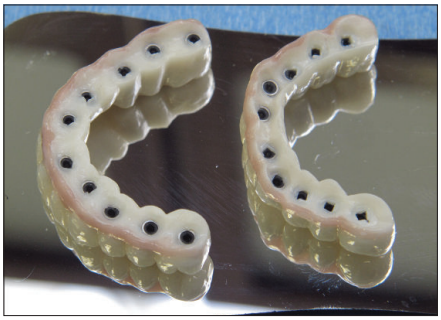

Figure 4. Final zirconia roundhouse bridge with layered porcelain and housings in place.

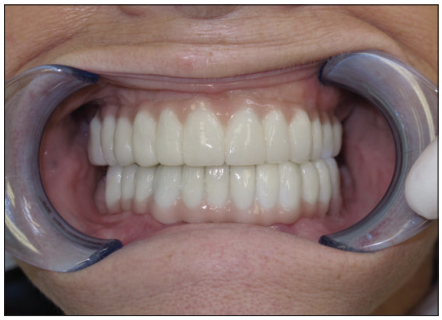

Figure 5. Final retracted view.

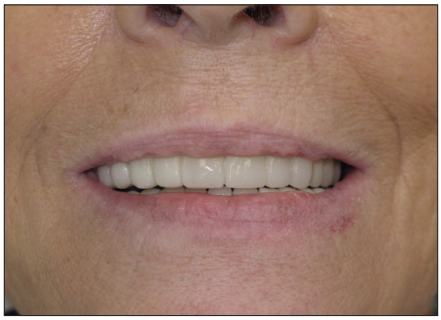

Figure 6. Final restoration: "You have changed my life, Dr. Shatkin!"

Todd E. Shatkin, DDS

When I learn from new patients how unhappy they are with their loose dentures, I offer a very viable solution called FIX*on*SIX. This is a fixed detachable mini dental implant zirconia bridge that allows these patients to throw their dentures away and be delighted that they no longer have to agonize from wearing loose dentures. Typically, 6, 8, or 10 mini dental implants are placed by the general dentist in the minimally invasive procedure that results in placement of a temporary restoration and then the final in as little as 2 weeks. The mini dental implant housings in the zirconia bridge secure the bridge to the mini dental implants. These housings act the same way as "shock absorbers" in this implant-retained bridge. The FIX*on*SIX is detachable by the general dentist at the recall appointment and can be used in the mandibular and maxillary arches. The FIX*on*SIX average lab fee, including the lab components and case planning, is $2,450. The mini dental implant cost, depending on 6 to 10 utilized, is approximately $600 to $1,000. The average FIX*on*SIX patient fee in the United States is $12,500 to $15,000. Combine this affordable patient fee with the noninvasive mini implant procedure with high patient case acceptance, and this will lead to a significant growth in a general dental practice's annual earnings.

You may know of the other fixed detachable solutions available to you and your valued patients. These require an invasive surgical procedure for placement of 4 to 8 large-diameter implants and the subsequent healing time prior to the final restoration. The average lab fees for conventional implant roundhouse bridgework are $6,000 to $7,000, with approximately $2,000 to $3,000 for the large-diameter implants. The usual, customary patient fee is $35,000 to $50,000. With this substantial patient cost, case acceptance is low, and the opportunities to significantly build a practice's earnings are missed.

I have personally placed more than 13,000 mini dental implants during the past 15 years with amazing results. The new FIX*on*SIX option gives us another wonderful option to eliminate dentures and increase practice revenue. It's done this for me, and it can do it for you!

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16 CE Credits, Meeting Cost $1,295

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Mini Dental Implant 2 Day Course in Las Vegas

Febuary 10-11, 2017
Las Vegas, NV
16 CE Credits, Meeting Cost $1,295

Dr. Shatkin's Two Day Mini Dental Implant Training Course in Las Vegas includes Mini Dental Implant Treatment Planning, Case Selection Placement Procedure, Single and Multiple Unit Fixed Restorations in Less Than One Hour using Dr. Shatkin's F.I.R.S.T. technique®, Marketing Mini Implants in your practice, Case Presentations and Helpful Tips from guest speakers of the faculty of the International Academy of Mini Dental Implants.

Mini Dental Implant 2 Day Course in Disney, Orlando

August 4-5, 2017
Orlando, Florida
16 CE Credits, Meeting Cost $1,295

Dr. Shatkin's Two Day Mini Dental Implant Training at the Disney Yacht and Beach Club includes Mini Dental Implant Treatment Planning, Case Selection Placement Procedure, Single and Multiple Unit Fixed Restorations in Less Than One Hour using Dr. Shatkin's F.I.R.S.T. technique®, Marketing Mini Implants in your practice, Case Presentations and Helpful Tips from guest speakers of the faculty of the International Academy of Mini Dental Implants.

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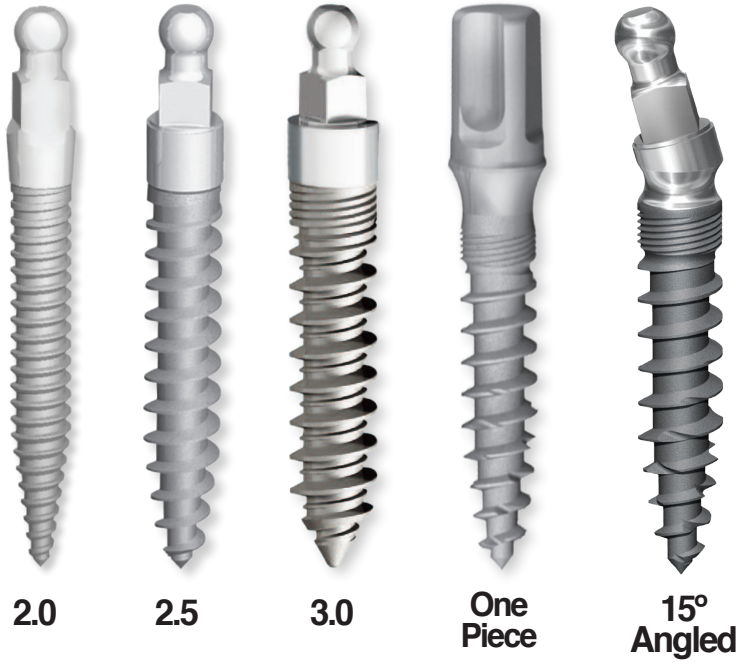

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