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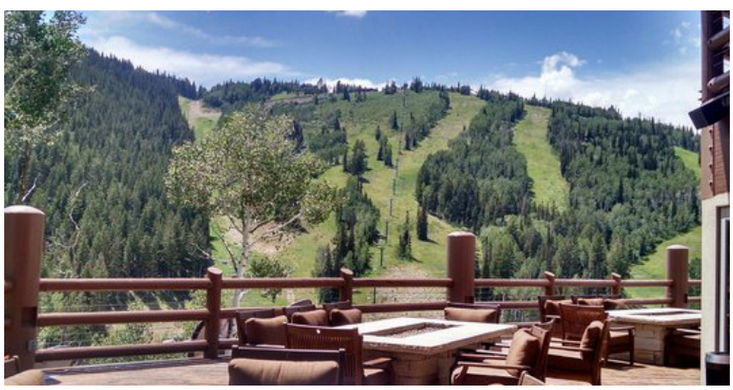

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PARK CITY, UTAH

Inside the Journal

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MESSAGE
FROM THE PRESIDENT

Dear Fellow Academy Members, Colleagues, and Friends

What a year, my fellow mini implant clinicians, what a year! Oh 2020, you have been completely unprecedented . All the new aspects of patient care: PPE, new office protocols, Covid 19 testing, contactless thermometers, patient wellness questionnaires, anti-aerosol techniques, the lack of leadership on almost every level from politicians to medical experts both near and far all the way to our very own ADA and all the work related to dentistry on the front lines during this pandemic. What A YEAR... as always with every new challenge lies the abundance of opportunities. Our Mini Dental Implant brotherhood and sisterhood carries us through these amazing challenges. I had the wonderful opportunity to speak with so many of you brilliant mini implant dentists, trouble shoot together, and bounce new implant concepts and ideas off each other I feel like it was absolutely time well spent, even during a government forced closure of all of our practices.

Now we are Back! I hope you have felt the same resurgence in your Mini Implant Dentistry as I have. The IAMDI Academy and I want to help. Powered by Mini Dental Implants, our great dental team, the top notch marketing programs and those unstoppable little pieces of titanium my practice and I hope yours is coming ROARING back! Tons of interested patients flocking in my door means mountains of accepted and treated mini implant dentistry and amazing daily and monthly numbers that will put us on pace not only to finish the year in survival mode but Really thriving GROWTH, not only hitting but surpassing our 2020 goals. These are things I never thought I would be saying in the dark days of April if this year. Look at us now, it's Q4 and we have collectively survived the worst of an immensely challenging year and the trends are up, up, Way UP. And Minis are that lifeline that got us through the year that none of us could have ever expected.

I wish you all only the best in Health, Wellness, and Successes on your journey to True Happiness with Minis and your dental practices.

JOE GILLESPIE, DDS
IAMDI President

MESSAGE
FROM THE EDITOR

Hello Friends

If anyone had told me on January 1, 2020 what was in store for the entire world in 2020, I would have been convinced they were still under the influence of the New Years Eve celebrations!

I last saw many of you at the Advanced Course in Buffalo in early March 2020. It was a great course and a great time catching up with our Implant "family". We "temped" course attendees ,used our hand sanitizer and listened to news of the ever increasing Covid-19 closures and restrictions around the nation while in Buffalo. I went home the following Monday to have our State Dental Association call for voluntary closure of all Michigan Dental Offices to everything except emergency and urgent care effective immediately. The following Monday, it became mandatory by executive order by our Governor.

I chose to stay open to Emergency and Urgent care and was busy extremely beyond my expectations . I'll have those stories to tell the Grandkids about being among the 3% of Dentists that stayed open during the pandemic.

So everything has changed , yet really very little has changed. Universal Precautions with minor modifications still protect Doctors, Staff and Patients, even in the Covid-19 era. The CDC and WHO have both stated that there has not been a single case of Covid transmission attributed to a Dental setting, and there is not a single cluster of Covid infections among Dental Personnel or Associated with a Dental Facility. Doctors, take a bow!

Minimally Invasive, Mini Dental Implant Treatments are still highly desired and are recognized for the value, comfort ,ease, function and quick completion they provide.

Many of our Doctors are now busier than ever since Dentistry has reopened.

So there just might be a "silver lining" in that dark cloud of 2020.

I will miss seeing you all at the Annual 2020 IAMDI Meeting in Park City, Utah. I'll be having my second 2020 hip replacement a few days prior. I will be there in spirit, and looking forward to seeing you all soon.

Wishing you all the very best!

ALAN F. ROBINSON, DDS
MAGD DICOI DIAMDI FAGD
President Emeritus of the IAMDI

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JOIN the Mini Dental Implant Centers of America Revolution

Shatkin F.I.R.S.T.® has thousands of dentists using out mini dental implant system, laboratory & patented procedures. A select few have choosen to set themselves apart.....don't be left behind

Mini Dental Implant Centers of America

Come to one of our upcoming Mini Dental Implant lectures to learn more about this unique opportunity or Call Tom Fitzpatrick at 716-839-2959, to learn more!

• BENEFITS FOR THE PATIENT •
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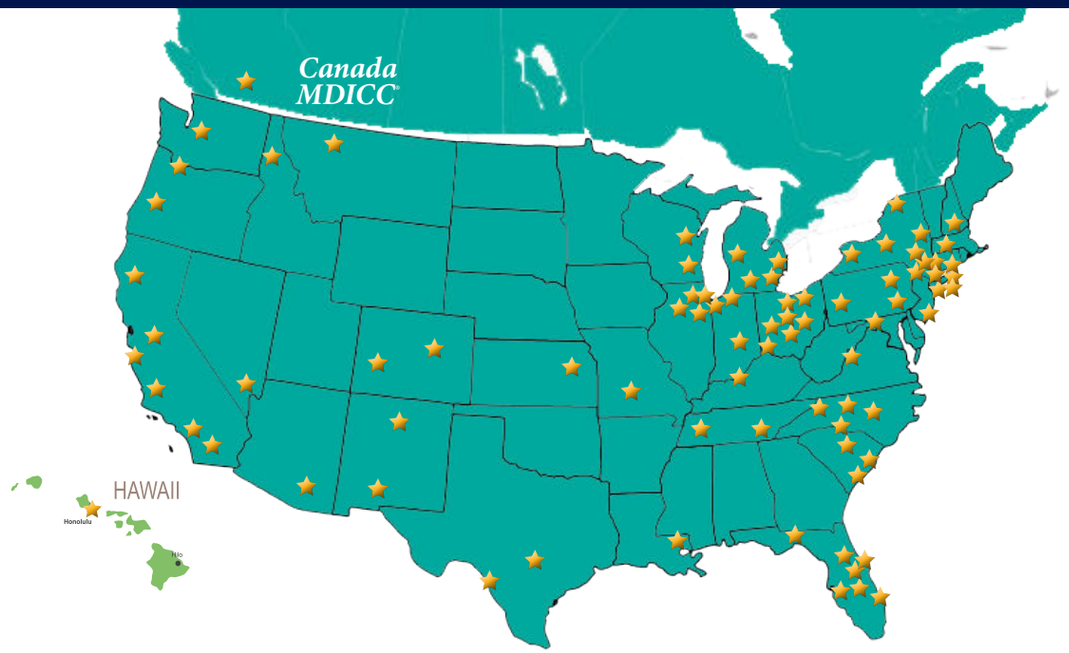

76 CENTERS & GROWING!

MINI DENTAL IMPLANT CENTERS OF AMERICA'S EXCLUSIVE TRADEMARK LICENSING AGREEMENT

This business opportunity will show you how to make your practice the premier dental implant practice in your community. After implementing this program, you will become more efficient with your time and find great rewards, both personally andprofessionally.

By joining our elite group, you will receive a five-year MDICA® Trademark License Agreement with geographic exclusivity in your area. We include the products, services and all marketing and sales material promoting your new "Mini Dental Implant Centers of America®".

This complete program includes our business system to help build your dream dental practice.

GUEST SPEAKER
ROBERT MILLER, DDS

Dr. Robert Miller

Offers Patients The Many Benefits Of Being A Board Certified Dentist

Why do dental patients from throughout the United States and Europe travel to Delray Beach to see Robert J. Miller, MA, DDS, DABOI, DICOI, FACD, at the Center for Advanced Aesthetic & Implant Dentistry? Why do many dentists ask Dr. Miller to perform their own treatment and refer challenging cases to him?

It's because Dr. Miller is a board certified clinician as well as a researcher and renowned lecturer. A pioneer in laser/surgical dentistry, he is known for his ability to handle very complicated cases, even for patients who have been told there is no hope, and to save failing implants (implant revision) with or without surgery.

"We have the experience and very advanced technology to diagnose multiple issues and help you achieve your goals," says Dr. Miller, who has been treating patients in Delray Beach for 37 years. "While we can correct multiple problems related to prior surgery, it is always much better to get the right treatment the first time."

A longtime proponent of dental and medical technology, Dr. Miller assisted in the design and development of the Biolase Waterlase Laser. In his practice, he uses five different lasers, a fully digital imaging system and a high-powered microscope. He also provides platelet therapy using the patient's own cells to accelerate the healing process.

Board Certified Specialist in Implant Surgery & Reconstruction
Pioneer in Laser Dentistry & Surgery Specialist in Revision of Failing Implants

A diplomate of the American Board of Oral Implantology and a fellow of the Academy of Osseointegration, Dr. Miller has been the chairman of the Department of Implant Dentistry at Palm Beach State College, teaching up to 30 dentists each season about why and when to use implant products, three-dimensional scanning, bone grafting, platelet therapy, reconstruction (prosthodontics) as well as other topics and surgical training.

GUEST SPEAKER
GORDON CHRISTENSEN, DDS

Dr. Gordon Christensen

Founder and Chief Executive Officer of Practical Clinical Courses (PCC), Chief Executive Officer of Clinicians Report Foundation (CR), and a Practicing Prosthodontist in Provo, Utah.

Gordon and Dr. Rella Christensen are co-founders of the non-profit CLINICIANS REPORT FOUNDATION (previously named CRA). Currently, Dr. Rella Christensen is the Director of the TRAC Research Division of the CR Foundation. Since 1976, they have conducted research in all areas of dentistry and published the findings to the profession in the well-known CRA Newsletter now called CLINICIANS REPORT.

Gordon's degrees include: DDS, University of Southern California; MSD, University of Washington; PhD, University of Denver; and two honorary doctorates.

Early in his career, Gordon helped initiate the University of Kentucky and University of Colorado dental schools and taught at the University of Washington.

Currently, he is an Adjunct Professor at the University of Utah, School of Dentistry. Gordon has presented thousands of hours of continuing education globally, made hundreds of educational videos used throughout the world, and published widely.

Gordon and Rella's sons are dentists. William is a Prosthodontist, and Michael is a General Dentist. Their daughter, Carlene, is an Administrator in a biomedical company.

CASE STUDY

FIX On SIX® – A Mini Dental Implant Alternative to the All-on-4® Less Invasive, Less Time, Less Costly, and Less Discomfort

Todd Ellis Shatkin, D.D.S. –
Private dental practice Buffalo, NY, Owner Shatkin F.I.R.S.T., LLC
Alysa Brooke Sadkin –Dental student, University of Pittsburg Dental School

INTRODUCTION:

Aesthetic dentistry has evolved throughout the past few decades, specifically in the field of Implantology. Patients are preferring endosseous procedures over dentures and other removable prosthetics in order to increase stability, increase comfort and decrease pain.[1] Conventional implants require several procedures, multiple appointments and upwards of a year until completion, although some newer techniques promote a faster completion time. The All-on-4® technique is an immediate conventional implant procedure, in which four large diameter implants, two in the anterior and two in the posterior, are inserted at a forty five degree angle in order to take advantage of the available bone and reducing the need for bone augmentation and/or sinus lift.[2] According to the Nobel Biocare All-on-4® treatment concept manual, a minimum of 5 mm in bone width and 8 mm in bone height is necessary to begin the procedure.[3] Though the All-on-4® technique claims to eliminate the need for bone augmentations and sinus lifts, these procedures cannot always be eliminated if the bone quantity does not meet the requirements due to the large diameter of a conventional implant.1-2,4 While the All-on-4® technique offers acceptable support with four implants, the endosseous procedure is still invasive and time consuming compared to the immediate and early loading procedures used with mini dental implants. The All-on-4® often requires a minimum of four to six months before the final restoration is fully completed.[4] In addition, if one of the 4 implants fails to integrate or fails following placement of the restoration, the entire restorative procedure must be restarted, additional surgery performed and the restoration remade. Considering the average fee for All-on-4® is in the range of $30,000 - $40,000 per dental arch, this technique is not affordable to the vast majority of dental patients.

Immediate and early loading endosseous procedures with mini dental implants are more desirable to patients in many instances because of the speed of completion, the affordable fee, the less invasive procedure and the reduced post-operative discomfort.4 The small size of the mini dental implants (available in several lengths and diameters) eliminates the need for bone augmentation and/or sinus lifts. This is due to the fact that the mini dental implant can be angled into available bone rather than augmenting the bone.4 The Shatkin F.I.R.S.T®Technique (Fabricated Implant Restoration and Surgical Technique) (Patent USPTO #7,108,511 B; September 2006), developed by Dr. Todd E. Shatkin DDS, provides for the mini dental implant(s) to be placed and the restoration(s) cemented in one patient visit.8 Dr. Shatkin's most recent innovation, FIX On SIX®, offers a combination of the Shatkin F.I.R.S.T.® Technique using 6 - 8 or 10 mini dental implants with a 12 unit fixed detachable zirconia full arch restoration with O-ring implant housings. The restoration is only removed at recall cleanings as the dentist is able to snap off the FIX On SIX® restoration. The hygienist will then completely clean the implants, the restoration and the surrounding tissue and easily reinsert the restoration without patient discomfort. This FIX On SIX® procedure is completed in a fraction of the patient's and the dentist's time as required by the All-on-4® technique. The success rates of the immediate loading mini dental implant endosseous procedures are competitive with the All-on-4® technique. If one of the mini dental implants were to fail with a FIX On SIX® restoration, the failed mini implant can be easily replaced with a new mini implant and O-ring housing, placed in the same or different location. In addition, the FIX On SIX® restorations are considerably more affordable than the All-on-4®, costing approximately a third to half of the cost. Consequently the FIX On SIX® restorations are more desirable to the patient due to their affordability, greater comfort, reduced treatment time and the less invasive nature of the procedure.

Fixed partial dentures are commonly supported by mini dental implants to provide a natural, aesthetic appearance for the patient. In recent years, Zirconium Dioxide (zirconia) frameworks have been used in dentistry for fixed restorations.[5] The introduction of zirconia has allowed for the production of metal free prosthetics, by means of Computer-Aided-Design/Computer-Aided-Manufacturing (CAD/CAM) technology. The result is improved aesthetics with increased success and reliability.[6] There is also evidence that zirconia attracts less plaque accumulation preventing gingival problems.[7] The architecture of these zirconia-based prosthetics enable superior strength and chewing resistance on the posterior teeth relative to other ceramics.[8-9] Due to its favorable chemical composition

and mechanical properties, clinicians have been eager to use zirconia in implant-supported restorations after its continued success in tooth-supported restorations.[10]
The following Case Study presents a clinical report of mini dental implants with the FIX On SIX® Technique. The use of 6 – 8 or 10 mini dental implants allows for the functional and aesthetically pleasing zirconia fixed prosthesis to be supported. Using CBCT technology, a zirconia prosthetic restoration was created and fixed over Shatkin F.I.R.S.T. (by Intra-Lock) mini dental implants using O-ring housings processed into the zirconia framework.

CASE STUDY:
A 56 year old male patient with an upper denture presented himself at a consult on 5/13/2016. He had come to me from our TV marketing campaign. At the consult our new patient had a CT scan (using our Shatkin F.I.R.S.T. CBCT machine for pre op and postop scans), treatment plan and impressions taken for a FIX ON SIX® detachable-removable bridge. To minimize the discomfort and to eliminate the existing issues with his old denture, a zirconia bridge was prescribed and designed to fit on the mini dental implants that would be placed. Zirconia was chosen as the fabrication material due to its strength and durability and resistance to plaque. A treatment plan for placing 10 IntraLock MDL's in the Maxillary arch using the Shatkin F.I.R.S.T.® Technique for mini dental implant placement was chosen. He was asked to return in 2 weeks for his procedure and placement of a temporary bridge.

6-22-17 The patient returns, signs the consent form and was administered Topical (2 carps of septo w/epi). A CT guided stent from Shatkin F.I.R.S.T. Lab was used and a Thompson marking pen was used to mark the position of the 10 implants using the CT guided stent. The Implants used were 9 Intra-Lock mini dental implants on the upper maxillary arch, size 25mm/15mm at #3,4,5,6,9,10,11,12,13 and one 25mm/11mm for #8. I used the CT guided stent through-out the procedure, removing it between final placement of each implant, using my patented F.I.R.S.T Technique (Fabricated Implant Restoration and Surgical Technique) (patent USPTO #7,108,511 B; September 2006). When finished placing all 10 implants using my Shatkin F.I.R.S.T. procedure I placed the housings and used A1 Luxatemp to create the Temporary Bridge. Patient liked the Temporary. Impressions were taken and sent to the Shatkin F.I.R.S.T. Lab. Two prescriptions (penicillin 500mg, Norco 51325) were sent to the patient's pharmacy and an appointment for two weeks was made for the delivery of the permanent "Fix on Six®" detachable removable bridge.
7-7-16 Patient returns, I removed the temporary and placed the "Fix on Six®" detachable -removable roundhouse restoration. The Fix on Six® restoration looked good, patient was happy. I provided the patient with a Shatkin Water Flosser and Sonicare toothbrush which I provide to all of my mini implant patients for hygiene. It has been a very successful tool in keeping tissue clean and free from food particles between checkups, when I remove the "Fix on Six®".

CONCLUSION:
This article presents an alternative to All-on-4® which is less expensive, less painful, less invasive, with faster results utilizing a superior dental material. FIX On SIX® offers patients a beautiful zirconia restoration which is removable by the dentist but provides the patients with the feel and aesthetics of a fixed prosthesis. Creating a fixed prosthesis which is able to withstand the occlusal forces applied, provide cosmetic appeal and patient satisfaction is an enduring task for all dentists.11 Today in dentistry, zirconia has traditionally been used in fixed partial dentures as tooth supported restorations.[9-10] With most cases that use zirconia as a fixed restoration, high success rates have been recorded, most above 95%.9 Zirconia's ability to increase the durability of a prosthesis by up to 30-40% has made it a good candidate for use in hybrid fixed cases.[11] The use of CT technology increases zirconia's stability in conjunction with decreasing failure rates of these restorations, due to the industrial processing.

In this case study, the patient was dissatisfied with his upper denture because of cracks in the acrylic along the palate, the dentures were not comfortable to wear and food would trap under the dentures. By designing a fixed zirconia bridge (FIX On SIX®) instead of acrylic dentures or a hybrid acrylic fixed bridge, the patient will no longer have these negative experiences. The use of zirconia instead of acrylic increases durability of the prosthesis while also offering the comfort of fixed restoration and healthier surrounding gingival tissues

*All-On-4® is a registered patent owned by Nobel Biocare® developed together with Paulo Malo, DDS, PhD, at MALO CLINIC.
** Fix-On-Six® is a registered trademark owned by Shatkin F.I.R.S.T. developed by Todd Ellis Shatkin, DDS.
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FIX on SIX® – A Mini Dental Implant Alternative to the All-on-4®
Less Invasive, Less Time, Less Costly, and Less Discomfort

Todd Ellis Shatkin, D.D.S. – Private dental practice Buffalo, NY, Owner Shatkin F.I.R.S.T., LLC
Alysa Brooke Sadkin –Dental student, University of Pittsburg Dental School

Figure 2. Dental model made using the impression taken at the consult appointment.

Figure 3. The tissue was marked using a Thompson marking pen through the surgical guide stent to get a visual for placement of the mini implants.

Figure 4. Holding the CT guided stent still in preparation of placing mini implants.

Figure 5. Using the Shatkin F.I.R.S.T. Pilot Drill Guide and 20:1 MDL Contra Angle Driver to make Pilot hole.

Figure 6. Placing mini dental implant through the CT guided stent with 20:1 handpiece.

Figure 7. Fully seating the mini dental implant after removing the surgical guide stent.

Figure 8. After placing the first 5 mini dental implants, the clinician checks for proper alignment.

Figure 9. The 10 mini dental implants were placed in the maxilla. Notice the bottom of the square is level with the gingiva, and the ball and square are above tissue.

Figure 10. Placing all 10 micro metal housings on the mini dental implants.

Figure 11. Final restoration before placement of o-rings.

Figure 12. Fixed on 10 final restorations with o-rings placed in restoration.

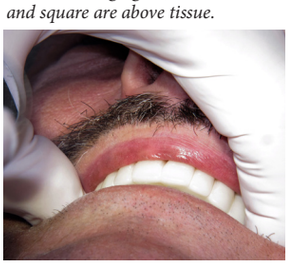

Figure 13. Verification of final zirconia restoration fit.

Figure 15. Final CBCT and panoramic radiograph.

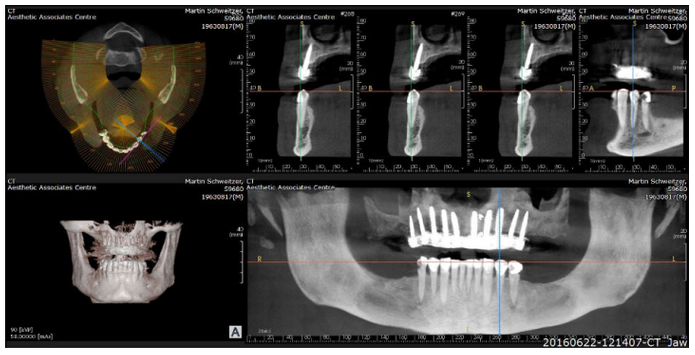

Figure 1. CBCT scan from consult.

CASE STUDY
QUESTIONABLE DATA, BAD SCIENCE & FUZZY MATH

ALAN F. ROBINSON, DDS, MAGD, DICOI, DIAMDI

EDITOR'S BLOG

CLINTON TOWNSHIP, MI
Mini Dental Implant Centers of America

SCIENCE IS SCIENCE. MATH IS MATH.

The numbers regarding Covid-19 are derived from recording data daily from around the US and the World. By analyzing that information, our political leaders ,doctors, and public health officials are making life and death decisions for us all. Decisions that determine how we can safely educate our children and college students, and how we can get us all back to work so that we can support our selves and families and serve our neighbors with goods and services they need to live.

Science has rules for gathering data so that other scientists can come behind a researcher and repeat and verify their results.This is called the Scientific Method.

The Covid-19 numbers we hear reported daily are not comparable because there isn't a defined way to count who is and who isn't a Covid-19 death case. At times and in some areas, every death was counted as a Covid death which tended to inflate the number of deaths truly due to Covid-19 and in the Confirmed Cases count , a suspected Covid case counted as a confirmed case and as you might suspect, the more tests given the higher numbers of cases that will be found. The people who had cases with mild or no symptoms were never counted for the most part, because they recovered at home and most not tested. So while it's good to know positive tested cases, it's not a reliable figure to use to compare different locations due to different levels of testing mostly.

To address this,to make a reliable comparison and evaluation of different social policies, events and occurrence rates we need to change our method of calculation slightly. We are counting our mortality rates by deviding deaths by confirmed cases. Confirmed cases are influenced by all of the factors we discussed earlier. Since they're not consistent and ever changing, our ratios and rates tell us really nothing. This makes it impossible to compare data from city to city, state to state and country to country.

So let's apply the Scientific Method and get some solid information .

We will have to accept some data undefined, such as death figures by location, as there is no way to replace that data consistently.

If we use population as our denominator, we can reliably compare the severity of the disease from place to place in terms of occurrence resulting in death. The effectiveness of treatments is reflected in this calculation of rate as is the effectiveness of the measures taken and propagation events that occurred. Those effects are all reflected in the death rates compared location to location.

So let's examine how death rates compare in different areas. As of 7/19/2020

Michigan has 6000 deaths(undefined), population of 10M death rate of .060%. [8/10 6526 .0653%].

New York State has 32445 deaths(undefined), population of 20.7M for a death rate of .157%. New Jersey deaths were 15699 deaths (undefined) population 8.94M for a rate of .176%. Georgia deaths 3173 population 10.68M rate .0297%. Florida deaths ,4805, population of 20.6M ,for a rate of .0233%.

Texas deaths 3865 , population 29.9M , rate is .017%. Illinois deaths 7295, population 12.66M, rate .0576%. California 7595 deaths, 39.94M population, rate of .0190%.

Washington State deaths 1444, population 7.8M, rate .0185%.

US deaths, 140,000 , population 331M rate of .0423%.

Italy deaths 35045, population 60.31M , rate .058%.

Spain deaths 28420, population 47.43M rate of .0599%.

Denmark deaths 611, population 5.83M rate .0105%

Sweden 5619 deaths, population of 10.34M ,rate of .0543%. [8/10/20 5766 .0558%]

Germany deaths 9163, population 82.91M, rate of .011%.

Global deaths 603,697, population 7.8 B , rate .0773%

STATE	RATE
Michigan	.060%
New York	.157%
New Jersey	.176%
Georgia	.0297%
Florida	.0233%
Texas	.017%
Illinois	.0576%
California	.0190%
Washington	.0185%

COUNTRIES	RATE
United States	.0423%
Italy	.058%
Spain	.0599%
Denmark	.0105%
Sweden	.0543%
Germany	.011%
GLOBAL	**.00773%**

In examining rates, it's interesting to note that death rates in Italy and Spain which were the horrifying scenes of death , coffins laid out in local Cathedrals and in refrigerated trucks as there was no where else to hold the deceased that we witnessed before Covid-19 cases started with any appreciable velocity in the US . Yet the rates in Italy and Spain are equal to rates recorded in Michigan and Illinois and exceeded in New York State by a factor of 2.5 and New Jersey by a factor of 3. Washington State, where the pandemic really started in the US had an death rate less than 1/3 that of Michigan and Illinois. Sweden protected its vulnerable with quarantine, but took no closing actions on businesses and had a death rate comparable to Michigan and Illinois.

With meaningful data, we can analyze what measures were taken for prevention, contrast health care methods and conditions, analyze patient population demographics to help evolve our response nationwide.

It appears that the results of the various quarantines in different States in throttling back occurrence rates has been at least partially negated by recent protests and riots in which no distancing or PPE was practiced by many. Also , spring break travel to Mexico by many college age young people also had an occurrence increasing effect.

The end of risk for everyone from the Covid-19 pandemic will come when we have an effective vaccine or we achieve herd immunity, which occurs at exposure levels of 50-80%. Dr Faucci of the US CDC has stated that a vaccine, when one is available for use, is likely to be 70- 75% effective. He has also This jives with what has been observed in the effectiveness of other flu vaccines at other times, but on average flu vaccines are 50-60% effective according to studies conducted by the Mayo Clinic.

Many Pandemic experts believe that the best way to achieve herd immunity is to vigorously protect our vulnerable; the older and the medically compromised , but let the others of the population return to their normal routines , taking reasonable precautions. The huge majority of young healthy people have mild or no symptoms when infected, but achieve antibody levels that protect them. There is a worry that there is a carrier state, where an asymptotic person spreads the virus for an undetermined time. This could be just an asymptomatic patient during their infection time. This is being studied, but it's not known at this time. Experts also question how long post infection immunity will last . That raises the question of how long vaccination derived immunity might last.

A statistical look at how the protect the vulnerable, then return to normal with reasonable precautions method is available because that's exactly what Sweden did. And as a comparison, neighboring Denmark did precautions similar to the US .

Sweden had a death rate (.0543%) similar to Michigan (.060%) Illinois (.0576%) and Italy (.058%) while never closing the economy down.

Remember, the reason for and goal of the quarantine was to keep our Medical resources from being overloaded and being unable to treat and save as many infected as possible. The overflow facilities built around the country were used very little and in some cases not at all. That is at least partially testament to the success of controlling the rate of spread in that first wave of infection and the great success American health care had in treating and containing the Covid-19 outbreak here in the United States.

This success in managing the opening act in the long process seems to have led some politicians to believe they have controlled the virus and by their efforts the danger averted if we would just follow the restrictions they have laid out. Truth is that as long as infections are raging anywhere in the world, we are at risk for a resurgence of infections to anyone without immunity, whether by recovery after exposure, or by vaccination. The level of travel seen in Countries and the World almost guarantees continuation of spread, as long as significant levels of infection exist anywhere. Other flu vaccines suggest only partial coverage of populations vaccinated.

The only true end to risk of continued infections and resulting pandemic is herd immunity, through exposure and or vaccine. Anything short of or other than that has no scientific basis in effectiveness.

CASE STUDY

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 55-74. 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.

CLINTON TOWNSHIP, MI
Mini Dental Implant Centers of America

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The Lakeside Center for Implant Dentistry PC

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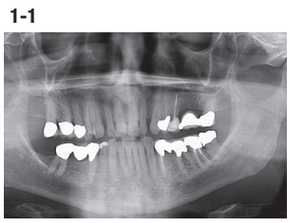
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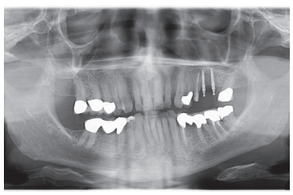
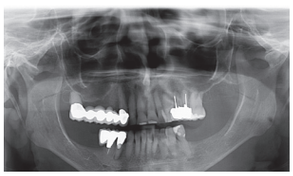

1-8

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, and 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.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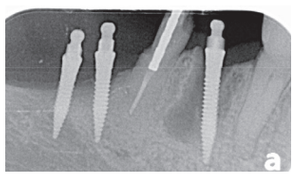
2-2


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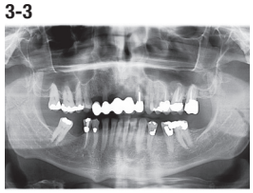
2-7


2-8

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.


3-1


3-2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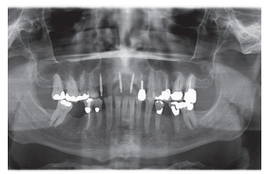
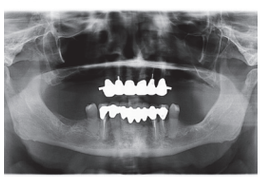

3-10

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.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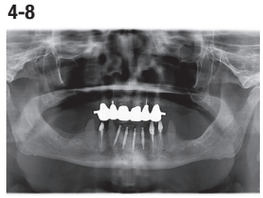
4-8

Dennis (69) (Fig 4-1 through 4-8) 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.

Chew on, "Boomer Nation"!

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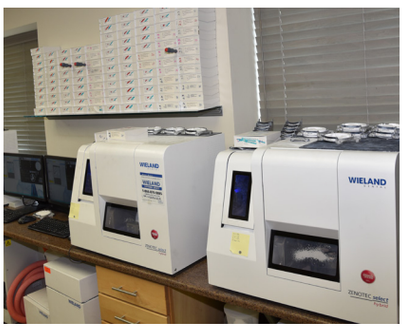

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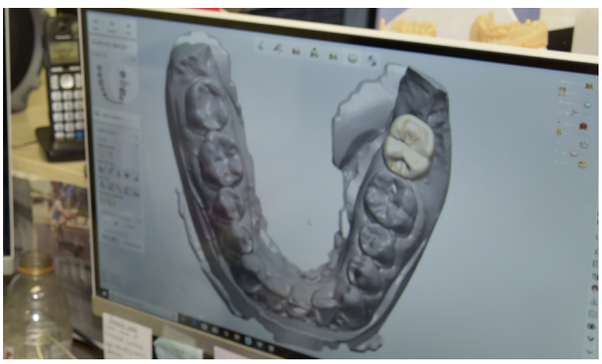

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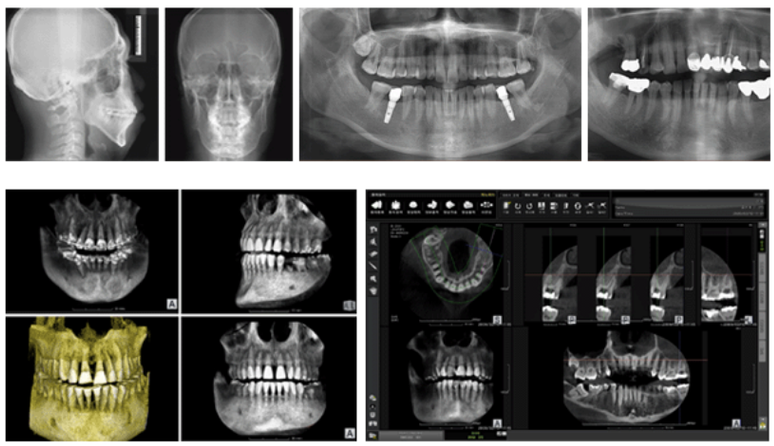

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JOE GILLESPIE, DDS

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Buffalo, NY.....**JANUARY 15 & 16**
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Buffalo, NY.....**APRIL 15 & 16**
Buffalo, NY.....**MAY 20 & 21**
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Buffalo, NY... (WORLD SYMPOSIUM & IAMDI) **SEPTEMBER 23, 24 & 25**
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Chicago, IL (VIRTUAL ONLY) ..... February 25, 26 & 27
CDS Mid-WInter Dental Show

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UOP Alumni Meeting

Salt Lake City, UT ..... April 8 & 9
Utah Dental Association

Buffalo, NY..... September 23, 24 & 25
World Symposium on Mini Dental Implants &
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Annual Meeting

Las Vegas, NV Mandalay Bay .....October 14,15 & 16
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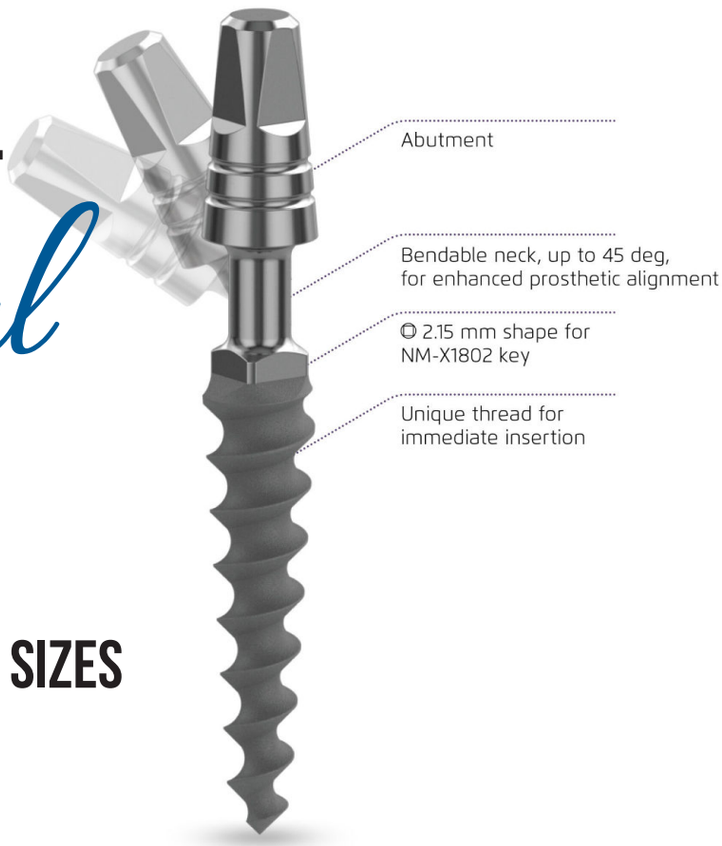

10 MONO IMPLANTS - AVAILABLE SIZES

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3.3 - 10, 11, 13, 16 MM LENGTH
3.7 - 10, 11, 13, 16 MM LENGTH
4.2 - 10, 11, 13, 16, 18 MM LENGTH
5.0 - 10, 11, MM LENGTH

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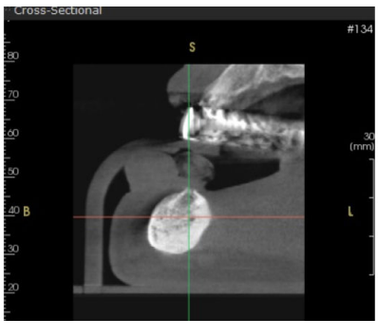
CASE STUDY
IMMEDIATE IMPLANT RETAINED LOWER DENTURE
JAMES THARP, DDS,

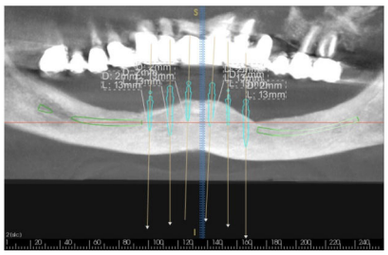
FRANKFORT, IL
Mini Dental Implant Centers of America

A 78 year young female presented with a very resorbed mandible and no lower teeth.



Her maxillary teeth were mostly present with porcelain to metal crowns and bridge restorations from #2 all the way around to #14. These showed signs of decay and periodontal problems. She said she was leaving the country in a few weeks and wanted to have a lower denture done with implants before she left. She said that she would be getting her upper teeth restored when she got to her home country in Europe. She had been using an old partial denture on her lower that had been added to and was severely worn.

After agreeing to a fee and treatment plan the case was planned on the Triana Genoray software for placing of six 2.0x13mm Intralock MDL implants.



The denture for this case would be a Shatkin First temporary denture to be relined with Flexacryl Hard Reline methyl methacrylate. A preliminary impression was taken using a Massad denture impression tray and Aquasil impression material.

Two carpules of Septocain 1:100,000 epinephrine were used for local anesthesia. It was placed at the buccal and lingual and on the ridge at the implant sites.

After marking the implant sites with a Thompson marking stick it was decided that five implants would fit better than 6. The 1.2mm osteotomy sites were free hand drilled to about 80% of the 13mm length or about 10mm. On drilling the osteotomy, the bone felt very firm, like a type one bone. This was confirmed by the CBCT reading of over 2000 Hounsfield units.

The placement of the first implant stopped less than halfway in on the 30 NCM setting on the AEU-7000 Shatkin First implant drill. With type one bone this hard, it has been my experience that drilling wider to 1.5 mm and deeper to 90% with the osteotomy has a higher success rate than forcing the implant in at 60NCM. This is probably because the slightly larger hole gives the body more chance to grow new bone and blood supply with less pressure on the bone implant interface. The other 4 osteotomies were then drilled to 1.5 mm wide and all 5 implants were placed with torque valves of 30 NCM. All five implants "tapped" solid and had no mobility.

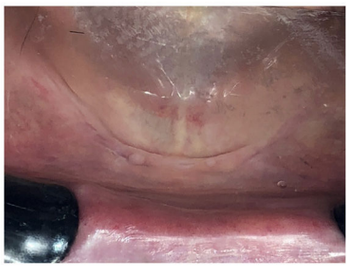
Vinyl shims were place on all the implants and the "O" ring housings were placed on top of them. The "B" sized denture had been previously trimmed and shaped with a scissors and a commercial heat gun on a model that had been poured with rigid Aquasil.

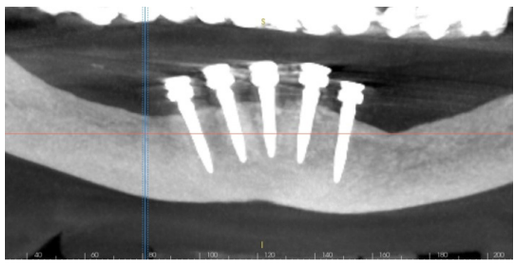
By pouring a model with a rigid impression material you get a model that not only sets quickly but is easily trimmed with a strait scalpel and is less likely to abrade when fitting the "boil and Bite denture. The housings were picked up using the Flexacryl reline material directly in the mouth. Any methacrylate direct reline is technique dependent. The key is to keep a sample of the acrylic between your fingers and when it gets hard and hot take out the denture. Small voids in the reline were filled using the Shatkin First reline material with a small tip. The denture was then reinserted making sure to keep the vinyl shims on the implants while the reline material set.. After this had set the denture was removed and polished. Make sure to remove the vinyl shims before dismissing the patient. The denture was checked with LeeMark Pressure Disclosing Paste applied with a toothbrush to form fine lines. Any disruption in these lines should be trimmed and polished. This one step almost always assures no sore spots. The occlusion was checked for high spots, even contacts and lateral prematurities. The patient was instructed not to take out the denture overnight and given prescriptions for antibiotic and pain. At the 24 hour and one-week check there were no sore spots and the implants "tapped" soundly.

Six months later the patient was contacted in Europe and reported no soreness and that all the implants were solid and not hurting.

CONCLUSION

This service was what the patient wanted. It was done quickly and easily with good results. She felt that she got what she paid for and was happy with the result, being able to eat without pain and not having her teeth loose.





CASE STUDY
TREATING PERI-IMPLANTITIS WITH MINI DENTAL IMPLANTS

MATTHEW J LASORSA, DMD, PA, DIAMDI

CITRUS HILLS, FL
Mini Dental Implant Centers of America

Peri-Implantitis is nothing new or rare in implant dentistry. In fact, 47% of bone level implants (2 piece implants) will develop some form of peri-implantitis. Although there is no absolute cure for peri-implantitis(except for taking the implant(s) out) there are several ways of treating and managing the condition. Peri-implantitis develops sometime after placement. The cause, timetable, degree of inflammation, and bone loss is quite variable, and the etiology is still somewhat unknown. The good news is small diameter implants have a much lower rate of peri-implantitis than their larger diameter cousins. The rate of peri-implantitis around mini dental implants is about 7% vs the 47% reported on conventional implants.

Some of the causes of peri-implantitis are as follows:

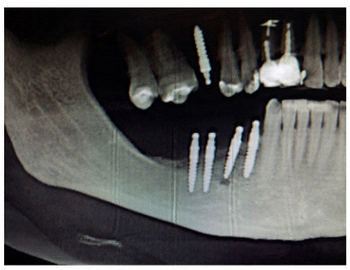
-periodontitis
-poor oral hygiene
-heavy occlusal forces
-poor quality bone
-not enough buccal bone
-lack of keratinized tissue around implants
-shallow vestibule
-muscle pull on mucosal tissue
-excess cement
-implant out of position causing more stress
-worn out O-rings or soft liner
-patient lost other teeth now putting extra stress on implants
-not wearing nightguard or dentures at night
-changes in medical history
-wrong grafting material
-poor implant choice
-heavy drinking/smoking
-micromovement at abutment to implant junction on a 2 piece implant
-foreign body reaction

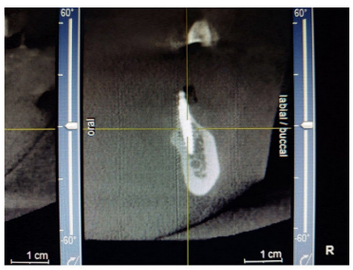
It has been suggested that due to the narrow diameter of mini dental implants they are generally surrounded by more bone and keratinized tissue than conventional implants, therefore having a much

lower rate of peri-implantitis. Another contributing factor is that mini dental implants are one piece and are not subject to the micromovement of the abutment to implant junction.
Below are some treatments for peri-implantitis:
-Debridement
-Specialized titanium brushes for the slow speed handpiece
-Irrigation with Peridex
-Treatment with Betadine
-Very frequent hygiene visits
-Laser decontamination of the implant surface
-Reduce occlusal load
-Prep and polish exposed threads. This may not be a good idea in some cases as it can cause a foreign body reaction
-Flap and check for excess cement on implant crowns
-Flap, debride, graft, and PRF
-Soft tissue graft
-Don't use plastic scalers, they do no good at all
-NEVER use an electrosurgery unit around implants! If you still have one throw it away.

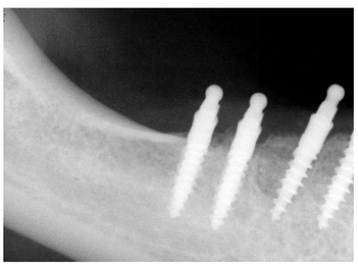
Currently there is limited success with all peri-implantitis treatment. The goal is to manage the situation so that the patient is comfortable and the implants last as long as possible.

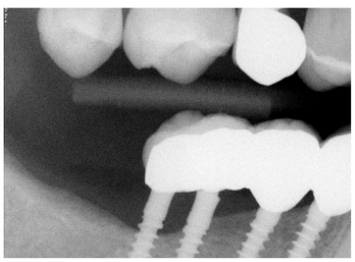
This patient had 4 minis placed to restore teeth 28-30 with a splinted bridge. The post-op CT scan shows good placement in the center of the mandible and all implants torqued between 30-60 N-cm.



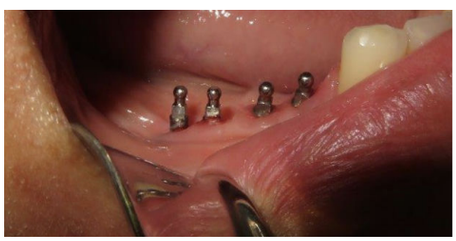


About a year after restoring the implants the patient started to complain of sensitivity under the bridge. There was some crestal bone loss radiographically around the distal implant of #30.



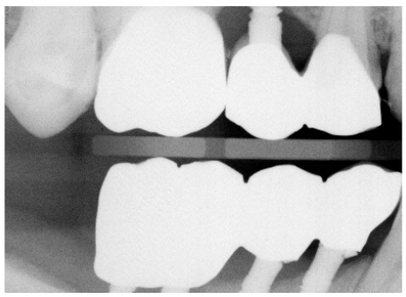


The cause was believed to be from heavy occlusion since the patient did not have any posterior occlusion on her left side. The bridge was removed and the implants were temporized. There was indeed some crestal bone loss around the distal implant of #30.



There was keratinized tissue present, there was also some inflammation and exposed threads. Since the tissue was relatively healthy, it was decided to prep and polish the exposed threads then remake the splinted bridge with a lesser occlusal load on #30.

The remake of the bridge also utilized cemented abutments to create a better emergence profile.



A new bridge was delivered and the patient had a night-guard fabricated. The new bridge is stable, no peri-implantitis noted, and the patient is comfortable with the bridge in function. The bone loss is still present, but it has not progressed so it seems the peri-implantitis has been arrested.

In summary peri-implantitis is common in long term implant dentistry and should be recognized and managed. There are several factors that can contribute to this condition and sometimes the cause is unknown. There are also several ways to treat it, and it must be understood by the patient and the doctor that there is limited success on all peri-implantitis treatments, the goal is to manage the condition for the long term.

It's in the details...

ossean® SURFACE

- ***Optimal Differential Profilometry***
- ***Calcium Phosphate - "Beyond Nano Size"***
- ***Thick Oxide Layer***
- ***Hydrophilic Surface Increases Wettability***
- ***Site-Specific Surface Modification***

Changing the Nature of Healing

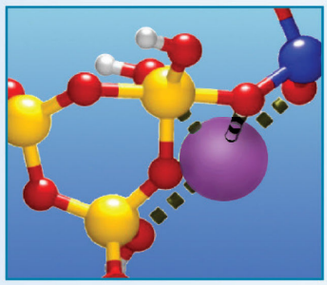
Numerous scientific papers have been published on OSSEAN®. They report the remarkable performance of this surface compared to others, particularly immediately after implant placement and during the initial phase of healing. The very nature of the healing chain has been reported to be changed and shortened*.

Compressing the Healing Process

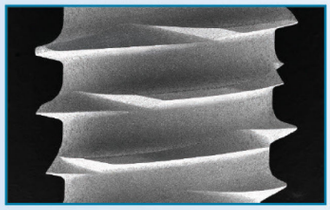
The most critical phase of implant treatment occurs from the moment an implant is surgically placed, through the first weeks of initial healing. It is in this period when most complications and/or adverse effects occur. This juncture also sets the stage for ongoing and long-term future implant success. Naturally, the importance of shortening this time by compressing the healing process is crucial*.

Documented "in-vivo" Study

Furthermore, this early accelerated healing process has been documented in "in-vivo" in a bone histological, gene expression, and nanomechanical study. The OSSEAN® surface was shown to play a critical role at the DNA level by favorably enhancing osteoblasts formation and accelerating the mineralization on the newly formed bone*.

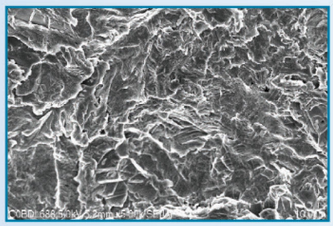


Calcium Phosphate in Molecular Fusion

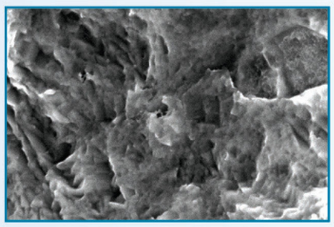


Robotic Micro-Blasting Preserves Cutting Edge Geometry

Multi-Process Cleaning Keeps Surface Free from Contaminants



Cellular Level - Enhanced Osteoblast Attachment



Molecular Level - Improved Fibrin Attachment

Thick Oxide Layer

Hydrophilic Surface

$595 Dentists
$395 Staff

Matt Lasorsa, DMD

Join Matt Lasorsa and learn about the L-PRF. L-PRF is a fibrin matrix, prepared using the patient's own blood. Surgical and implant sites filled with L-PRF reveal considerably faster healing times and improved gum and bone healing. L-PRF is similar to the procedures that are used to assist professional athletes heal quicker from sports injuries.

Mark your Calenders!

2021 L-PRF COURSE

March 13th • June 12th
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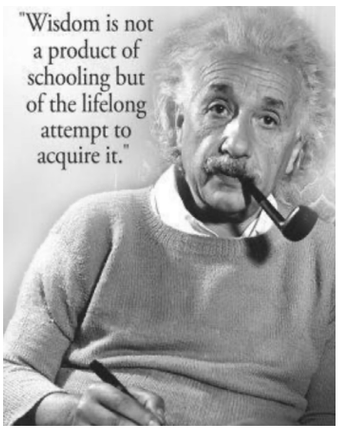
at THE SHATKIN FIRST TRAINING CENTER in BUFFALO, NEW YORK
VISIT SHATKINFIRST.com

CASE STUDY
THE TOOTH-IMPLANT SUPPORTED PROSTHESIS (TISP)...HISTORICALLY, A VIABLE & VALUABLE OPTION

RONALD P. PETROSKY, DDS, MAGD,DICOI



While sharing some of my thoughts on this controversial and misunderstood topic of TISP... I will do so coming, from what I would describe myself as ,a conservative, minimally invasive dentist ,seeking to preserve as much of my patients healthy natural dentition as possible,with the minimal amount of treatment necessary. Clearly, there are clinical situations when all teeth have come to the 'end of the line' and must no doubt be extracted. However, there too,are times when some teeth are strong enough to save and serve as abutments as part of a fixed bridge. That's where multiple prosthetic options comes into play...

In contrast,I have from time to time, witnessed what I perceive to be an over-the-top ,radical removal of strong healthy teeth (like the Rock of Gilbraltor) long before their time...often taking a huge piece of alveolar ankylosed bone with it !!! That's a real tragedy and over-treatment IMHO...all in the name of some perceived new-age ideal methodology for replacing missing teeth! Teeth with a strong & healthy periodontium, especially those canines and first molars, should be saved if at all possible as abutments for a fixed restoration TISP restoration.

The late Dr. Carl Misch said in his textbook Dental Implant Prosthetics, 2005 that:
"An axiom of traditional prosthodontics is to provide a FIXED PROSTHESIS wherever possible." "However,when insufficient implant support is available, the NATURAL TEETH may be considered as potential abutments."
"SPLINTING natural teeth is the usual method to reduce mobility."

Some of our sacred & ethical duties as a health care provider to the patients we are blessed & entrusted to serve is:
1. First Do No Harm (Hippocratic Oath)
2. Treat the patient as if they were a member of your family
3. Don't overtreat

Our esteemed colleague,
Dr.Christensen ,touched upon this alarming concern way back in his 2005 JADA article :
The advantages of minimally invasive dentistry
OBSERVATIONS GORDON J. CHRISTENSEN, DDS, MSD, PhD
JADA, Vol. 136 www.ada.org/goto/jada November 2005

"In my opinion, during the past several years, there has been an obvious trend in dentistry toward COMPLEX TECHNIQUES and accomplishing MORE TREATMENT THAN REQUIRED. The trend has been mentioned to me many times by colleagues as I have traveled around the world. Recently, I had the opportunity to speak at the annual meeting of the World Congress of Minimally Invasive Dentistry. It was refreshing to be with a group of fellow practitioners who were attempting to provide OPTIMUM services for patients with the MINIMUM amount of treatment. "

With that said,it is my experience that ...
'One Prosthetic Option Does Not Fit All'
just like
'One Implant Diameter Does Not Fit All'!
Given that no two people are alike, the well rounded contemporary implantologist of this 21st century should provide state of the art ,minimally invasive protocols such as: • oral surgery procedures,
•surgical implant placement techniques & a variety of prosthetic options all within the minimum amount of treatment.

More specifically:
1. MINIMALLY INVASIVE ORAL SURGERY...
is often necessary before any implants can be placed.
in my experience should include:
• the Physics Forceps and
• the Piezotome Cube to simplify those previous difficult surgical extractions of fragile teeth, for LESS TRAUMA,LESS DRAMA and immediate implant placement.
Lots of YouTube videos are available that show how this advanced technology will make your life as a dentist so much easier...as well as the patient. A real win-win experience worth every penny! The combination of Piezotome Cube & the Physics Forceps are truly PARADIGM SHIFTS of mega proportions IMHO! It's minimally invasive oral surgery ,particularly of those fragile ,decayed root canaled, ankylosed,broken down teeth to the gum line.
The days of using high speed surgical bur in a bloody surgical field to remove bone are over!

It's summed up well in the article : Bone augmentation procedures in implant dentistry. Review article Chiapasco M, et al. Int J Oral Maxillofac Implants. 2009

"Every surgical procedure presents advantages and disadvantages. PRIORITY should be given to those procedures which are SIMPLER and LESS INVASIVE, involve LESS RISK of COMPLICATIONS ,and reach their goals within the SHORTEST time frame". Chiapasco M, et al.
Int J Oral Maxillofac Implants. 2009

2. MINIMALLY INVASIVE IMPLANTS...
IMHO, should allow for less flaps,grafts, & osteotome .This is the case in my experience...if we utilize a VARIETY of IMPLANT SIZES such as the :
• IntraLock MDL's (2.0-2.5) ,
• IntraLock MILOS (3.0,3.75),
• NorisMedical MONO (3.0-5.0)... with DIAMETERS ranging from 2.0-5.0mm,& LENGTHS ranging from 10.0-18.0mm.
All are solid one piece titanium alloy that implants have aggressive thread designs to easily thread through & engage bone densities from D1-D4 for that very important initial primary stability of 35Ncm.

Dr. Dennis Flanagan, who has many years of experience, impressive credentials,and authored excellent AAID journal implant articles stated: IMPLANT-SUPPORTED FIXED PROSTHETIC TREATMENT USING VERY SMALL-DIAMETER IMPLANTS: A CASE REPORT 2006 Journal of Oral Implantology 34 Vol. XXXII

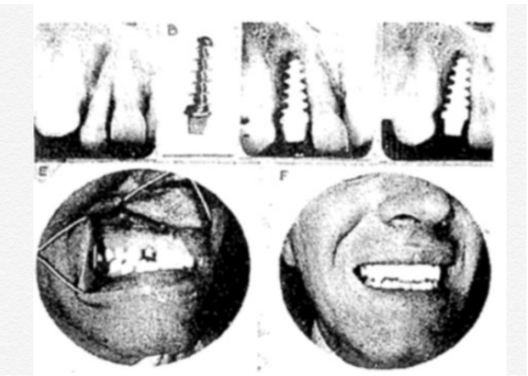
"An up-to-date and pervasive knowledge of the ARRAY of implant SIZES and SHAPES is an ASSET for treatment. Implant diameters are available from 1.8 to 8 mm. Many implantologists believe that a SMALLER-diameter implant is MORE DESIRABLE than a LARGER one for REASONS of BLOOD SUPPLY ,that is, LARGER-diameter implants may IMPEDE the blood supply to bone surrounding the implant. Additionally, if an UNFORESEEN bone density or site inadequacy is encountered during the osteotomy of a small-diameter implant, the use of a slightly larger-diameter implant that is able to attain better initial stability remains an option, if there is adequate space. Consequently, it may be BETTER to have a BIAS TOWARD a smaller-diameter implant rather than one with a larger diameter."

Therefore, MORE implant SIZES options...
allow for MORE implant PROSTHETIC options.

3. MINIMALLY INVASIVE PROSTHETIC OPTIONS
It should be evident that we need available...
MORE THAN ONE IMPLANT OPTION
to offer our trusting patients as choices in solving the wide variety of partial & full edentulous dental dilemmas that come our way...addressing their anatomic,medical, and financial limitations.
However, I often get the impression when I examine those who have been to some national branded implant centers, that the 'All on Four' procedure fits all.
No natural tooth left behind mentality!!

If I'm wrong...my apologies! For example,just look at the Glidewell Labs implant promotions we get in the mail ... they are all 'All on 4' over & over ,unless I'm missing something! Please show me their TISP tooth-implant supported brochure ... I've yet to receive one!!!
From my observations...
the TISP appears to have been an overlooked and taboo to talk about in some Implants circles!
However,an internet search of the available ClinicalStudies and corresponding opinion articles still reveal that the TISP ...
has been, still is, & will continue to be a viable, conservative, more economical prosthetic option.
Historically TISP has been utilized as far back as the 1940-50's with such trailblazing implant pioneers as
Dr. Manlio Formiggini
Dr. Leonard Linkow, Dr.Raphael Chercheve, Dr. Gustave Dahl, and Dr. Albert Strock to name a few.

1938-1955



Mid-1940's

The prototype for some of the most successful "screw type" endosseous implants in the past was devised in the mid-1940s by the Italian Manlio S. Formiggini. In recognition of his contribution, he was sometimes referred to as the "father of modern European Implantology," a well deserved title, although it was actually the Strock Brothers, form Boston, in 193 8, who inserted the first endosseous screw type implants into the bone for individual tooth replacements, as well as pushing some of them through the apex of a loosened tooth where a large opening in the bone was made so the implant could then be pushed downward or upward through the entire root and into a portion of the bone to lengthen the root to crown ratio.

Formiggini's early implant was fashioned of an inert metal wire, usually of stainless steel or tantalum, bent back upon itself to form a series of spirals. The two ends of the wire were soldered together. Formiggini's design allowed tissues to grow into and around the spirals of the implant.

Fig. 35:

The prototype for some of the most successful 'screw type" endosseous implants in the past was devised in the mid-1940s by the Italian Manlio S. Formiggini. In recognition of his contribution, he was sometimes referred to as the "father of modern European Implantology," a well deserved title, although t was actually the Strock Brothers, form Boston, in 193 3, who inserted the first endosseous screw type mplants into the bone for individual tooth eplacements, as well as pushing some of them

Although the TISP has seemingly fallen out of favor with some implant providers given all the implant advancements over the last 70 years...
the REALITY is that the TISP still remains a VALUABLE & VIABLE OPTION to offer our patients even now and in the foreseeable future...for those who wish to replace & restore their missing teeth to optimum form & function with minimally invasiveness,more economical & less treatment in mind.

IN CONCLUSION...

it should be recognized ,that there are several 'schools of thought' relative to the implant surgical and prosthetic approach,given the wide variety of experience ,and continued education programs .
With that said...we recognize that no two patients are alike anatomically, medically,or economically.
Therefore,with their many variables and factors to be contended with for each patient presenting ...being able to also offer the TISP tooth-implant supported prosthetic is a win-win for the doctor and patient.

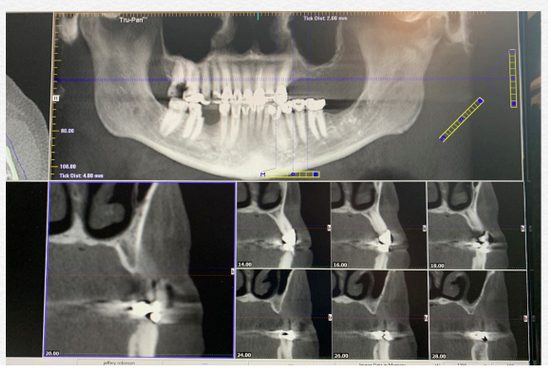
CLINICAL CASES:

CASE # 1 : 49 YEAR OLD MALE
One such ethical dilemma presented itself this week whereby: A 49 year old male patient came in for an upper & lower arch dental implant consultation ...believing all his teeth were too far gone to be saved as per another recent implant consultation.
Patients do want to trust us to inform them of all their options and make recommendations in their best interest.
Patients with multiple missing teeth seek our professional advice for the various options and alternatives available for replacing them,the
benefits & risks,the time duration,along with the corresponding cost.

He recently had his suspicions confirmed after visiting a New Jersey ClearChoice Center in which they would for $48,000:
• remove all upper &lower teeth
• insert All on Four upper & lower
• all in one day !!!!!
I informed his this absolutely COULD be done...
but in my many years of experience,this positively SHOULD NOT be bone. Maybe somewhere in the future...but not necessary now! After my evaluation, I informed him that...
given the fact that you have :
•strong bony structure,
•strong & long rock solid roots (those teeth ain't coming out easy & you'll lose a lot of bone with it)
•relatively healthy gums
•many years to live God willing (his mother who came with him is 80 & has most of her teeth with crowns that have lasted a long time)
•otherwise good physical health he could save & restore most of his teeth .

I offered, what I believe is, a realistic hope for far more non-radical,conservative,less invasive procedure of:
•removing only #2 & #30 and
•using routine crown & bridge work ,
•some UL-posterior & LR-posterior Implants to restore his oral health to something far more natural and comfortable than All on Four...and for a lot less (about $24,00)!

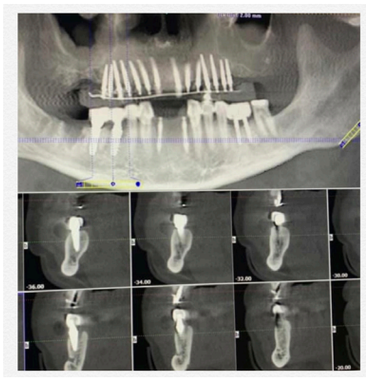
Prognosis would be excellent if he agreed to •
• better dietary habits (no soda) ,
• better home care utilizing the Waterpik,&
• semi-annual maintenance visits.
The son and mother were pleased with my 'Clear Alternative Choice to All on Four'... so much so ,that the mom plans to cancel her approved loan application with the other office,and the refinance her home to pay for sons treatment..
The 49 year old patient:

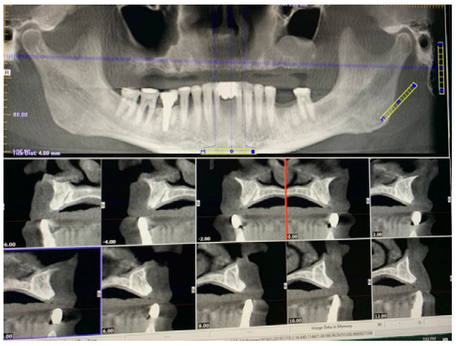


A case of over-treatment shared by Dr. Christensen

CASE #2: PATIENT DD, MARCH 2020
After a frustrating year of wearing a full upper denture with lots of Fixodent following extraction of all his upper teeth, and simultaneously suffering from continued lower periodontal issues even after multiple treatments by a periodontist ,this patient did much internet research and had several consultations by various specialist concerning all his replacement options with the help of using using dental implants ...including the All on 4 option.
Ultimately, DD chose an:

•upper (ISP) Implant Supported Prosthesis with 14 MDI Implants and a ZirconiaRoundhouse rigid resin cemented fixed bridge. A biomechanical advantage of much greater support and surface area than four standard size implants.
•lower (TISP) saving several natural teeth that were periodontally healthy as abutments,along with both smaller and larger diameter implants as abutments for another Zirconia Roundhouse rigid resin cemented fixed bridge.

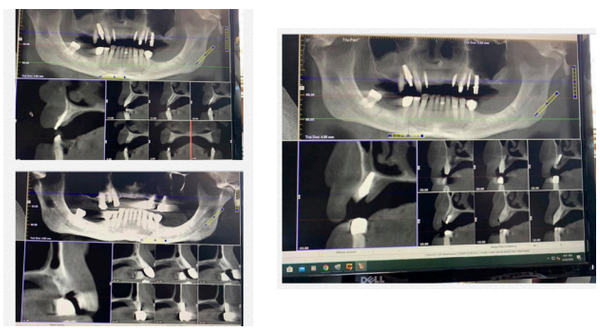




CASE #3: MH 2014

A 50 year young highly educated lady presented in early 2014 with mobility/ discomfort #15 and #11-14 Bridge due t ortho root resorption in her youth. Patient declined all Implant Supported Bridge (more extractions,more implants ,more cost)and preferred a mo conservative & economical Tooth-Implar Supported Fixed Bridge with two 2.9mm mini implants cemented to two natural teeth.
One treatment plan of an IDEAL all impla prosthesis all the time in the REAL WOR does not fit all!
Almost 4 years later...all is well with the bite & it's all ahead full!
Thank God for Mini Dental Implants!

CASE #4: WJ. 2020



One MAIN GOAL of an implant-restorative dentist should be to help patients with missing teeth achieve their needs and desires of optimum dental health, function, and comfort.

This particular 79+ year old former patient of ours ...returned to us after a 5 years abscence...had since lost his upper fixed bridgework which he loved, and had his missing teeth restored with a removable upper partial denture .

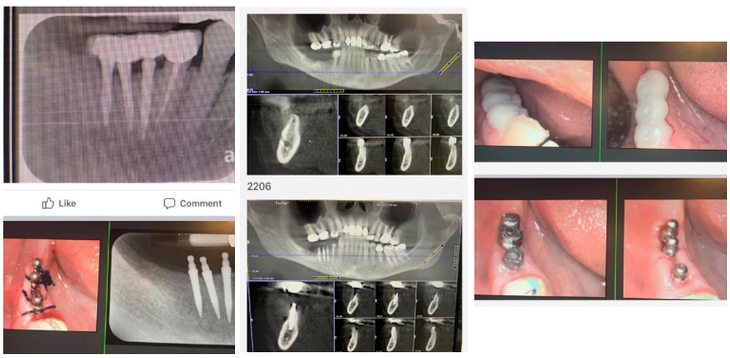
When he requested something more permanent & fixed... he was told it's NOT an option to add more implants WITHOUT extensive & expensive grafting due to atrophic deficient boney ridges. With that grim forecast and one year of frustration,.. he sought other opinions.

After one year of frustration with discomfort and difficulty eating...it was time to seek other opinions.

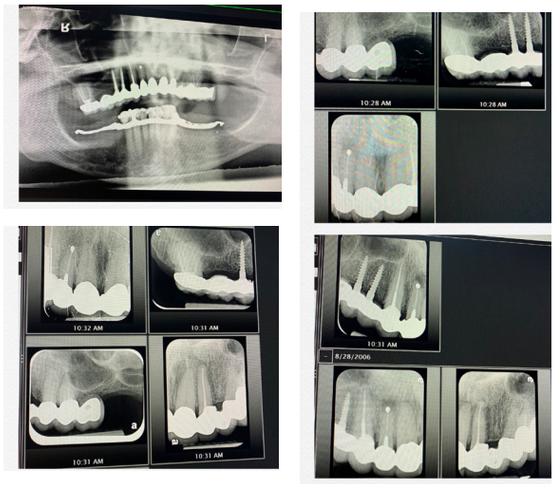
There is a School of Dental Implant Philosophy in our profession that believes connecting natural teeth to implant is contraindicated... and they are entitled to their own opinions. However, the real world experience and facts are that small diameter implants combined to strong periodontally healthy teeth forming a fixed tooth- implant supported restoration... does just fine!

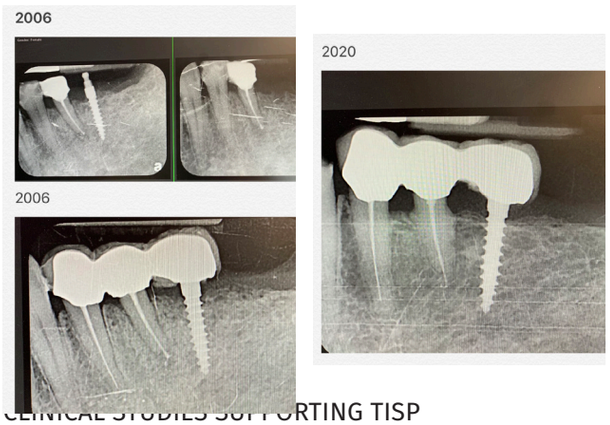
So, thanks to the increased VERSATILITY of small diameter implants in fixed restorative cases of patients with atrophic ridges as advocated for many years at ShatkinFirst in Buffalo ... we routinely can, from single tooth to full cross-arch restorations,treat many cases like this more conservatively and compassionately by not subjecting our patients to unnecessary extraction of relatively healthy teeth. In this case,the patient was pleasantly surprised that we simply were able to add four more implants and deliver a provisional fixed #3-14 cross-arch stabilized tooth-implant supported restoration...all in one visit!
The patient was delighted...and this is IMHO,is minimally invasive dentistry at it's best...making the once seemingly IMPOSSIBLE a reality!

CASE #5 SR 2009-PRESENT



CASE #6: DC, 2006-PRESENT
This 40 year old female was informed at a previous office all her upper teeth needed to be removed and a full denture made. Such was not her only option as we utilized a cross-arch stabilizing fixed bridge supplemented with two small diameter implants. The has been happy ever since!





CLINICAL STUDIES SUPPORTING TISP
1 Article :Should Implants Be Connected to Natural Teeth? by Dr. Gordon Christensen
Dentaltown Archives December 2018 Provo, Utah

Fig. 5: A hopeless, discouraged cleft palate patient who had two conventional-diameter implants fail that were planned for removable prosthesis retention. She wanted a fixed prosthesis. The image on the right shows two small-diameter implants at the day of placement in the healed bone. There is almost no bone in the anterior area.
Fig. 6: The nine-unit porcelain-fused-to-metal fixed prosthesis has now served for 12 years supported and retained by both teeth and implants.
She has been a very faithful patient with her oral hygiene and has avoided chewing hard foods in the anterior portion of her mouth.

Both you and I find occasions when patients have CLINICAL SITUATIONS where it seems LOGICAL and FEASIBLE to attach implants to natural teeth.

My strong conclusion ...
after years of observing thousands of dental implants in service is: There is NOTHING like a NATURAL TEETH .
KEEP THEM IF AT ALL POSSIBLE.

There are times ... when a simple connection of a natural tooth to an implant eliminates the extra procedures and costs explained above.

Need for more support for a cemented fixed prosthesis.
There are times ... when there is not enough bone for an implant without grafting, as shown in Fig. 4. In this case, we solved the dilemma by connecting the remaining natural tooth to an implant. There are many times ...
when there are not enough natural teeth to support a fixed prosthesis.
Often, patients cannot afford such treatment. Minimizing the number of implants is an option, but it may require connecting the implant to a natural tooth there are times when a simple connection of a natural tooth to an implant eliminates the extra procedures and costs explained above.

We used small-diameter implants in the healed areas where the conventional-diameter implants had failed, and we seated a fixed prosthesis over both teeth and implants.
There also are numerous other legitimate reasons to connect teeth to implants, including accidents and mobile but healthy teeth.
SUMMARY
The FALSE ASSUMPTIONS that ...IMPLANTS should NOT be ATTACHED to NATURAL TEETH has permeated the profession for several years. It is NOW OBVIOUS from both CLINICAL OBSERVATION and CONTROLLED RESEARCH that this procedure, done correctly, is VIABLE.

#2 Article:
Connecting Teeth to Implants:
A Critical Review of the Literature and Presentation of Practical Guidelines 2009
Literature Review
New York,New York

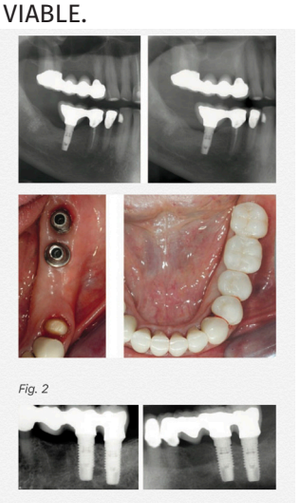


Fig. 2

Gary Greenstein, DDS, MS;1John Cavallaro, DDS;2 Richard Smith, DDS;3and Dennis Tarnow, DDS4
SCompendium September 2009—Volume 30, Number 7

Abstract
Historically ,CONNECTING a TOOTH to an IMPLANT to function as an abutment to replace a missing tooth WAS DISCOURAGED.

It was believed differences in mobility patterns of a tooth and an implant would result in the prosthesis being cantilevered off the implant, thereby stressing the implant.

CONCLUSION
Despite the fact that the potential mobility between a tooth and an implant are different and the precise etiology of tooth intrusion is unknown...IT IS REASONABLE to RIGIDLY CONNECT a TOOTH to an IMPLANT.

This is particularly true ...
•if the ANATOMY DICTATES that placement of an additional implant(s) is contraindicated or
•if there are ECONOMIC CONCERNS.

This deduction is based on almost every study that addressed this issue and found the SURVIVAL RATES were SIMILAR when TISPs and ISPs were compared.
The literature supports the idea that...
a RIGID CONNECTION rigid between a TOOTH and an IMPLANT usually PRECLUDES INTRUSION of teeth.
The following guidelines can help prevent ntrusion of teeth (items 1 to 9) and enhance patient care when contemplating fabricating a TISP.
1. Select healthy teeth—periodontally stable and in dense bone.
2. Rigidly connect the tooth and implant (no stress breakers), employ large solder joints to enhance rigidity (Figure 3), or use one-piece castings.
3. Avoid telescopic crowns (no copings) (Figure 4A and Figure 4B).
4. Provide retention form with minimal taper of axial walls on abutment teeth. Enhance resistance form with boxes and retention grooves if the clinical crown is not long (Figure 5).
5. Parallel the implant abutment to the preparation of the tooth and use a rigid connection.
6. Use permanent cementation (no screw retention or temporary cementation).
7. The bridge span should be short. Preferably, place one pontic between two abutments. However, with additional tooth or implant support or cross-arch stabilization, additional pontics can be used.
8. Occlusal forces should be meticulously directed to the

opposing arch (Figure 6).
9. In general, do not use TISPs in patients with parafunctional habits. If they are treated with TISPs, overengineer the case by maximizing the number of implants and splinting.
10. Cantilever extensions should be used cautiously; however, they may be employed when tooth or implant support is adequate, eg, cantilever-implant-implant-pontic-tooth-tooth (Figure 7).
11. TISPs in patients with uncontrolled caries should be avoided; ISPs are preferred (Figure 8).
12. Pulpless teeth with extensive missing coronal tooth structure or root canal anatomy that is inadequate to predictably retain a core or post and core should not be used in TISP.

#3 Article: Connecting Teeth and Implants: Yes, No, Maybe? By Frank Spear on May 7, 2018 |

IN CONCLUSION...
it would be safe to say that the MOST PREDICTABLE and LEAST RISKY restoration would leave the TEETH and IMPLANTS FREE STANDING,
but ...EXPERIENCE and the LITERATURE make it CLEAR that IMPLANTS CAN BE SAFELY CONNECTED to NATURAL TEETH as long as consideration is given to the challenges of implant overload, and preventing intrusion of the natural teeth. 12, 13

4 Article: Combined Implant and Tooth Support: An Up-to-Date Comprehensive Overview 2017
Amman,Jordan Mahmoud K. Al-Omiri, Maher Al-Masri, [...], and Edward Lynch 1School of Dentistry, University of Jordan, Amman, Jordan Int J Dent. 2017; 2017: 6024565.

CONCLUSIONS
The SUBJECT of CONNECTING TEETH to implants is controversial. The following conclusions and recommendations are suggested:

The first-line therapy seems to be using free standing implants for supporting fixed dental prostheses whenever possible. The most up-to-date publications show a higher need for maintenance and repair when teeth and implants were connected in comparison to free standing implant support. However, the literature presents three main schools of thoughts in this regard; one school advocates nonrigid tooth and implant connection; another prefers rigid connection, while the third recommends that implants and teeth should not be connected.
Joining teeth and implants during the rehabilitation of partial edentulism is indicated to provide clinicians with more treatment options where proprioception and bone volume are maintained and distal cantilevers and free end saddles are eliminated. Whenever suitable and justified, such treatment option becomes a VALUED ALTERNATIVE especially if it makes the treatment LESS COMPLEX ,OF LESS COST, and MORE ACCEPTABLE for the PATIENT.
This treatment paradigm is associated with some risks and complications including loss of osseointegration, periapical tooth infection, tooth intrusion, ceramic fracture, prostheses decementation, and screw loosening. In order to improve treatment success rate, it is better to avoid using short implants, poor bone quality, and endodontically treated teeth when this treatment paradigm is considered. Also, using rigid connection and permanent cementation are associated with less tooth intrusion and less complications. Further research is still required on many aspects of this treatment paradigm. No conclusive studies are available to show the best number of implants and teeth to be connected using this treatment option. In addition, no conclusive evidence is available to show the best prosthesis span length that can be supported via connecting teeth and implants. Also, studies on patient and clinician satisfaction with such treatment paradigm are not available.

#5 Article: Tooth-Implant Connection A Critical Review 2013 Puducherry, India N Aparna, S Rajesh
Department of Prosthodontics, Mahatma Gandhi Postgraduate Institute of Dental Sciences, Puducherry, India
2013 Volume 3. Issue 2 Page 142-147

CONCLUSION:
Thus tooth-implant connection has its own advantages, disadvantages, risks and complications, but what JUSTIFIES ITS APPLICATION is the RISK-BENEFIT EVALUATION with a special attention on PATIENT REQUIREMENTS.

Thus many longitudinal studies are necessary before this method is declared as the treatment of choice.
#6 Article: Long-term outcomes for cross-arch stabilizing bridges in periodontal maintenance patients--a retrospective study:2010 Norway

Oystein Fardal ,Gerald Linden University of Osio, Norway
J Clin Periodontol. 2010 Mar.

ABSTRACT
Background: Cross-arch bridges ...are used to stabilize teeth for patients with reduced periodontal support. Little is known about technical or biological complications, whether teeth and implants can be combined in this type of bridge and the long-term effects on tooth loss.

MATERIALS AND METHODS:
All patients treated in a specialist periodontal practice who received cross-arch stabilizing bridgework and were subsequently maintained for at least 7 years were included in the study. The patients were selected from all patients who underwent initial periodontal therapy after 1986 in a Norwegian periodontal practice.
The bridges were assessed for biological and technical complications. Bridges retained by teeth or by a combination of teeth and implants were included in the study.

RESULTS:
Ninety-four rigid fixed bridges (77 teeth supported, 17 teeth and implant supported) in 80 patients (46 females, 34 males) were observed for an average of 10 years (range 7-22 years). In four patients, a bridge became loose and had to be re-cemented, and in one case the metal framework of a bridge fractured and the bridge had to be remade. In total, eight abutment teeth were lost from five patients but no implant abutments were lost. Overall, a higher rate of tooth loss was observed for patients provided with stabilizing bridges compared with control maintenance patients not treated with bridgework ($p<0.0001$); however, the rates in both groups were very low.

CONCLUSION
Cross-arch stabilizing bridges ...
constructed for periodontal patients as part of their periodontal maintenance therapy had few complications and were associated with low rates of abutment tooth loss. Combining teeth and implants did NOT affect the performance of these bridges.

#7 Article: Should We Extract Teeth to Avoid Tooth-Implant Combinations? 2008 Sweden T Lindh. J Oral Rehabil. Jan 2008 Sweden Umeå University, Faculty of Medicine/ Odontology, Department of Periodontology, Umeå, Sweden. lindh@odont.umu.se
ABSTRACT
The controversy over combining teeth and implants for support of fixed partial dentures still remains after almost three decades of debate. The aim of this review was to evaluate what support that could be found in the literature for extracting teeth in favour of implants, and to elucidate whether tooth-implant prostheses were inferior to solely implant supported constructions in terms of survival and complications.
The methods for gathering relevant information entailed electronic searches on PubMed using relevant key words, as well as complementary manual searches in the retrieved publications. The results showed that there was no support for extracting teeth in favour of placing implants. On the contrary, the healthy tooth had a survival that was lifelong, which is yet to be shown for the dental implant. Also the use of teeth as abutments in combination with dental implants for support of fixed dental prostheses could be endorsed in certain situations with solid albeit limited scientific support.In a wider sense, such prostheses could be used as a reliable therapy in all regions of the jaws. However the status of the abutment teeth in terms of periodontal support, pulpal status and risk for carious lesions and biomechanical complications should always be considered in relation to the long-term prognosis of the prosthesis.
The conclusion was ...
• that teeth should NOT be extracted in favour of placing dental implants without a specific indication, and
• that tooth-implant supported prostheses SHOULD BE CONSIDERED as a VIABLE PROSTHETIC OPTION.
#8 Article:
Tooth-implant Connection: A Literature Review
Safoura Ghodsi, Sasan 2012 Iran World J Dent 2012;3(2):213-219

CONCLUSION
Although the BEST OPTION in partially edentulous patients appears to be complete implant-supported prosthesis, there are specific conditions in which the dentist should select between connecting the implant to the tooth in a fixed partial denture or using a removable denture, extraction of remaining teeth, or accept the related risks of other treatment options.
Based on literature reviewed, using implant-tooth splinting can be reliable treatment option in properly selected patients; there is no scientific support for extraction of the teeth to avoid connecting them to the implant.
Like every other dental practice, this territory requires proper patient selection and complete attention to all the details for success.
This method has its own advantages, disadvantages, risks and complications, but what justifies its application is risks- benefit evaluation with attention to patient requirements. However, due to limitations of available literature with regard to sample sizes, duration of studies, disparity of study groups and incoherent study situations, it is extremely difficult to compare the available literature and obtain absolute CONCLUSION.
These same features make more longitudinal studies necessary before this method can be recommended as the first choice of treatment. Yet, in specific situations, it can be a viable alternative method with an acceptable success rate.

CLINICAL SIGNIFICANCE
According to available studies, this literature review SUPPORTS tooth-implant connection technique where indicated, with complete attention to prudent guidelines.

QUICK TECHNIQUE

FIX*on*SIX From Shatkin F.I.R.S.T. Provides a Simple, Cost-Effective, Well-Received Alternative to Conventional Implants

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.

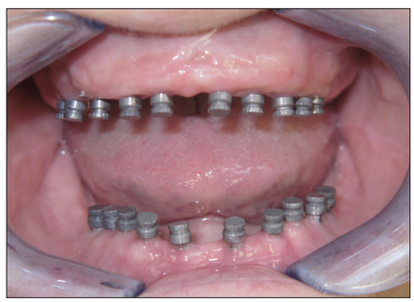


Figure 3. Housings in place prior to pickup in fixed restoration.

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 non-invasive 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!

For additional information, contact Shatkin F.I.R.S.T., LLC, at **(888) 474-2854** or visit the website ***shatkinfirst.com***.

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