International Academy of Mini Dental Implants

NASHVILLE

2021

- Integrity
- Compassion
- Education
- Research
- Fellowship

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| www.iamdi.org |

MESSAGE
FROM THE OUTGOING PRESIDENT

Welcome Members, Diplomats, Fellows, Mastership holders, and colleagues of the only International Academy based on the study and development of Mini Dental Implant principles, techniques, and concepts. What a great and exciting time for us all. I cannot wait for what the future holds with this amazing procedure and life changing technique. Mini Dental Implants give us all the ability to help our patients and allow us to truly enjoy dentistry.

I want to begin with a special thank you to Dr. Todd Shatkin for his leadership, mentoring, and vision for the future of Mini Dental Implants. It started with your state of the art training center in Buffalo, NY and has been followed-up by your tireless efforts and vision including the first one-year residency based on an immersive Mini Dental Implant education, and your plans for a new Dental School with the same educational emphasis teaching basic curriculum with the addition of mini dental implant concepts.

The past two years of my tenure have flown by in a kind of slow motion of drastic change and the pandemics creation of new and different challenges seen by us all. One constant has remained that Mini Dental Implants help serve our patients needs and are commonly THE Solution to what the patient presents as their chief complaint. The affordable price-point, with our abundant financing options, makes this procedure recession and even pandemic proof, as has been evident through my communications of the experiences of all of our academy members.

We were able to stay in touch through technology via the eight webinars organized by the great team at Shatkin F.I.R.S.T.® The very first Continuing Education live course I returned to was a Mini Dental Implant course in Salt Lake City, Utah. Present was the dental "godfather" Gordon Christensen, who was giving his first lecture since the pandemic. I know that the protocols had changed but it was just so very nice to share the same space with all of you even if we were masked the whole time and observed the recommended 6 feet distancing. The second live course was our annual triumphant return to Las Vegas, Nevada and we were there an entire week before that great entertainment and convention city had really officially opened up again. It is this can do kind of attitude that reverberates out of Shatkin F.I.R.S.T® headquarters in Buffalo where there is always a way.

As we all look to the future and the new normal of patient care in an ever-changing pandemic landscape, I am full of hope. Mini Dental Implants provide my patient pool with the most time efficient, least visits to the office, and best price point available in modern dentistry. Seeing the joy and renewed confidence this simple procedure can create on a daily basis for every one of my patients fuels my fire and motivates me every day to teach, share and implement this small wonder into my clinic more than just daily but rather hourly. I know each of you are on that same path and I look forward to sharing that passion conversely every time we meet.

The Academy has the most members of any mini dental implant based doctors only study club on Facebook. We are welcoming two amazing clinicians into the highest leadership positions of our group. Mini Implant dynamo and President Elect Dr. Diana Rodriguez who represents the real world success story of building a practice focused on Minis, and the incoming new President of the academy filling my seat, Dr. Andrea Smith, the mini implant guru of the west. Both of these dynamic and amazing women, mothers, outstanding mini implant dentists, and friends will lead us all into the future in new and fascinating ways. I look forward to their insights, experience, and implant wisdom bringing an entirely fresh and new prospective as leaders of the academy in the coming years. I am honored to pass off the torch and cannot wait to see what the future holds in each of their very capable hands.

Thank you all for this distinguished honor as the first two-time non-sequentially serving president. I look forward to seeing you all at meetings all over the country, to your future mini implant successes, and to my President Emeritus (X2) status, Cheers and good luck to each of you.

Joe Gillespie, DDS
Academy Founder, Mastership & Diplomat of the IAMDI, President Emeritus (X2)

MESSAGE
FROM THE EDITOR

Hello Friends,

Welcome to another issue of your Journal of the International Academy of Mini Dental Implants. I've had an opportunity to talk with many of you at the Advanced Courses in Buffalo this year in March and June. It's great to get back to live seminars with old and new friends. 2021 has brought us several significant events in Mini Implantology including the Harvard Health Letter, a ringing endorsement of Mini Implant treatment from the chairman of the Restorative Department of the Harvard School of Dentistry. If you don't have it or have not seen it, contact Shatkin F.I.R.S.T® for a copy.

Thanks to all of those who have contributed to the 2021 Journal! The sharing of your knowledge and experiences helps others more than you will ever know. Plan now to add your article to the 2022 Journal.

I wish you all health, happiness, prosperity and contentment.

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

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MESSAGE from the INCOMING IAMDI PRESIDENT

ANDREA JOY SMITH, DDS

Advancing the Mini Dental Implant Paradigm

Solving patient problems is at the core of the important work that we as dentists have chosen to do. As members of the International Academy of Mini Dental Implants, IAMDI, we are the trailblazers of Mini Dental Implantology, creating the path and leading the way for our dental implant colleagues to follow, advancing the Mini Dental Implant Paradigm as a viable option for single tooth replacement, denture stabilization and full mouth reconstruction and leading the way for our colleagues who dare to think outside the dental implant box.

Advancing the Mini Dental Implant Paradigm is my chief mission as academy president. This mission, however, will take the collective effort of all of us to achieve.

The reality is that many of our colleagues and peers are not yet believers in the viability of the mini dental implant despite its over 20-year FDA approval for fixed single tooth and full mouth restorations.

As your President, I am suggesting actions that can be taken by all of us to advance this important and modern approach to treating edentulism.

All of us in attendance here at the academy meeting have already taken the first and most important step, which is to attend an IAMDI Academy meeting. Here we take advantage of consulting with like minded colleagues and learning from their experiences and sharing your own insights as well.

Further actions I recommend are as follows: Train as a life-long learner; Learn conventional implantology as a tool to educate patients and discuss pros and cons intellectually with colleagues; Join and become credentialed in other implant academies such as the AAID and ICOI; Advertise your mini dental implant services in the community; Join your local peer review committee; Maintain an easily accessible library of relevant articles to share with colleagues with questions.

I look forward to speaking with each one of you, this weekend to expound upon my views on the actions that we can take to further the Mini Dental Implant Paradigm.

As your President, I have set two goals, the first is to make sure you are all aware of and have access to the readily accessible set of articles and FDA approvals. You can find them at the International Academy of Mini Dental Implants website, IAMDI.org. Secondly, I plan to create a letter from the International Academy of Mini Dental Implants as a statement our solidarity and commitments to continuing to provide these viable options to patients and to support our colleagues.

GUEST SPEAKER

THIERRY GIORNO, DDS

Dr. Thierry Giorno

Founder of Biofunctional Materials

He will be presenting scientific research and clinical documentation pertaining to the latest advances in both micro and macro implant design.

Dr. Thierry Giorno, an AAID Associate Fellow, is a graduate of Nice University, School of Odontology where he received a Doctor of Dental Surgery degree. He completed his Post Graduate work in Implantology at Harvard School of Dental Medicine and the Maxi Course in Implantology at the Medical College of Georgia.

Dr. Giorno had an active private practice in Monte Carlo, Principality of Monaco and Nice, France specializing in implantology, and is the owner of Zantex (alternative to metals) related patents. He has lectured extensively on the subjects of biomechanics, implant science and implant clinical applications at the University of Nice, University of Lyon, University of Paris, and numerous scientific societies in France, Italy, Spain, Korea, Thailand, China, Brazil, the United States and other venues throughout the world.

JOIN the Mini Dental Implant Centers of America Revolution

Shatkin F.I.R.S.T.® has thousands of dentists using our 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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69 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 and professionally.

By joining our elite group, you will receive a five-year MDICA® Trademark License Agreement with geographic exclusivity in your area. This complete program includes our business system to help build your dream dental practice.

CASE STUDY
Disciplined Treatment Planning and Success with Mini Dental Implants

VANCOVER, WA
Mini Dental Implant Centers of America

DAVID KELLER, DDS, MBA

In this article I will describe a systematic thinking pattern that I employ every time I am faced with the prospect of replacing a tooth, giving particular emphasis to the selection of and placement of simple single or multiple small diameter or "mini" implants. I will then demonstrate its application with a clinical example. I am not attempting this article as a systematic review of the literature, nor as a definitive clinical guide for surgical implant placement. I remind all readers that tooth replacement in the least complicated of situations represents a complex dental environment. "What you were born with often represents the highest possible level of satisfaction for individuals." For those with the courage and training to jump into those situations that start with less than idea, I hope to empower clinicians with a predictable way of reducing complex dental needs into manageable clinical decisions.

Discipline is defined by dictionary.com as "[bringing] to a state of order and obedience by training and control. Even in the case of simple tooth replacement, learning how to identify and, to the extent possible, control the multiplicity of factors that resulted in that tooth loss and that influence its successful replacement can be overwhelming. To help bring order to that chaos, I have found the following five questions to be immensely helpful in creating a scaffolding upon which predictable results can be achieved.

QUESTION 1: WHO IS MY PATIENT?
How well do I understand them as an individual? Will they follow instructions for care, use, and maintenance for my prosthesis? In my experience, patients of record represent the most predictable of patients because I have had long standing relationships with them. In contrast, those for whom the procedure represents a single transaction carry the highest level of behavioral risk.

QUESTION 2: What financial, medical, behavioral limitations does my patient place on me?

I always seek to understand completely all limitations placed on me by my patients, discuss them thoroughly, and propose multiple solutions to their problems within the context of the limitations imposed by them. I also routinely offer alternative solutions outside of those limitations. For example, if a patient really wants a fixed-on-six roundhouse, and has stated that sinus grafting is not on the table, but it is needed to predictably achieve the desired fixed-on-six outcome, I will still discuss it.

I specifically document all limitations placed on my care, both those specified by the patient, and those implied by their limitations. For instance, if the patient smokes, I emphasis and document that smoking will adversely affect both the chance of success and the anticipated longevity of any treatment provided.

While financial conversations are routine, causing few difficulties, avoid these easy pitfalls:
- Be sure they know total costs, any discounts, and monthly payments
- Be sure they are aware of maintenance costs and intervals

When considering medical conditions, pay closest attention to conditions that are known to create or exacerbate parafunction, conditions that threaten maintenance, such as arthritis, dementia, OSA, auto immune disease, etc…, and conditions and medications that cause or exacerbate xerostomia.

BEHAVIORAL FLAGS OF GREAT IMPORTANCE:
Patients with high caries rates, high plaque indexes, smokers, diabetics, and patients with unrealistic expectations

QUESTION 3:
How well will each of the following treatment options solve the patient's chief complaint, both short and long term?
1. Do nothing
2. Removable prostheses
3. Traditional fixed prostheses
4. Conventional implants
a. Implant v. tissue supported
b. Patient v. doctor removable
c. Resin v. zirconium
5. Small diameter implants
a. Implant v. tissue supported
b. Patient v. doctor removable
c. Resin v. zirconium

QUESTION 4: As best as possible, predict overall oral health and specific health for key teeth at 1 yr, 3 yrs, and 5 yrs.

QUESTION 5: Would I offer this procedure and/or prosthesis to my own family members who I will see routinely for the rest of my life?

Rigorously answering all five questions on every patient every time prepares clinicians to accept those patients and cases for which they will have a high probability of success. If any of the five questions reveal complexities that exceed the clinician's ability or desire to treat and maintain, referral is a wonderful option for all parties.

CASE EXAMPLE
"Jim" (real name not used) is a 77year old patient in my practice who has been coming to me for over a decade. In August 2018, he presented to my office with #7 fractured off at the gumline for two weeks and asked me, "what can I do?"

QUESTION 1:
Jim has been a patient of record for over a decade. He has no history of missing appointments, has completed 2 rounds of SRPs in my office over the past decade, and receives PMR therapy 2-3 times/year for generalized mild periodontal disease. He has a moderate to high dental IQ, and has been very compliant with accepting recommendations for treatment in our office. I consider him to be a compliant and dependable patient.

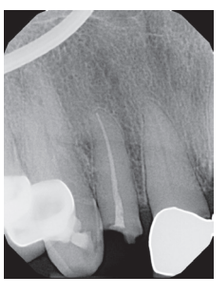
QUESTION 2:
Jim immediately eliminated doing nothing and removable prostheses from discussion. Jim is also a smoker and we discussed how smoking both lowers the chance of successful integration of any implants placed and the longevity of any prostheses attached to either teeth or implants. Other than smoking, Jim did not have any medical contraindications and I did not identify any behavior modifiers to his treatment plan.

QUESTION 3:
We discussed the advantages, disadvantages, risks, and alternatives to the following treatments:
1. A bridge from 6-8
2. Extraction of 7 and a cantilever from 6 or 8.
3. Extraction, grafting, and placement of either a conventional or small diameter implant #7 immediately
4. Extraction; no grafting; delayed placement of a conventional or small diameter implant #7.

After discussing all options, Jim elected option #3: extraction, grafting, and placement of a small diameter implant #7. His primary rationale was his aversion to having a bridge placed that could affect his capacity for home care.

QUESTION 4:
I reviewed his risk factors: mild periodontal disease and smoking, and the risks associated with extraction, grafting, and concomitant placement of an implant. I predicted that his case had a high probability of both short (<1yr) and long (>5yr) success.

QUESTION 5:
I absolutely would have done the same procedure on a friend or family member.
Clinical documentation:

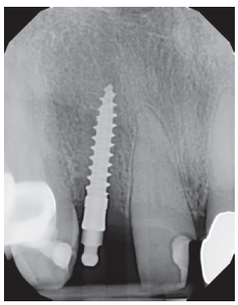


Radiograph of how patient presented in AUG 2018.
Decay on #8 M was noted and treatment options discussed.
Patient elected to have the crown replaced.

Tooth #7 was removed atraumatically. 2 vials of whole blood were removed and L-PRF clots were formed following a standard Intraspin protocol.

A single Intralock MDL 2.5 x 15.0mm implant was placed in the palatal bone of the extraction socket. The socket was packed with L-PRF, no membrane, and secondary closure was achieved with 1 x 4.0 Intrasorb suture. Patient was give 2.0g amoxicillin stat and was sent home with a bisacryl provisional, attached to implant #7 via a conventional healing cap.

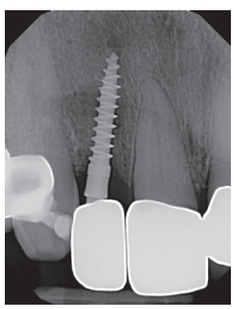
At 8 weeks, #8 was removed and refined for a full coverage zirconium crown. Note the excellent soft and hard tissue response to the L-PRF grafting.



Radiograph #8 weeks

Photo at 8 weeks

Full zirconium crowns were fabricated and inserted via standard cementation technique. Final radiograph is the crown try-in/adjustment photo.



Try-in/adjustment radiograph
prior to cementation

Try-in/adjustment photo
prior to cementation

Patient was very satisfied with the result, a result made more predictable for me by following a disciplined routine in diagnosing and treatment planning adequate patient care.

Dr. Keller practices comprehensive dentistry in Vancouver, WA.
He is married Rachel Dyer, and they have six amazing children.

CASE STUDY
BOTOX™ TO THE RESCUE
ANDREA JOY SMITH, DDS

SACRAMENTO, CA
Mini Dental Implant Centers of America

Modern Dentistry: A Patient Focused Approach to Treating Traditional Dental Problems in Innovative ways. This article will focus on the treatment of Temporal Mandibular Disease (TMD), Gingival Recession and protection of teeth and dental restorations with use of neurotoxins.

Many clinicians are aware that Botox™ and other neurotoxin brands are used in medicine to treat patients who suffer from migraines, but did you know that the therapeutic use of Botox™ in dentistry can treat traditional dental problems directly and indirectly to have a positive impact on the oral health of patients.

Successful pain management of patients who suffer from Temporal Mandibular Disease (TMD) has eluded the dental community since the discovery that the complex Temporal Mandibular Joint (TMJ), was the primary source of orofacial pain, not involving an actual tooth. Orofacial pain is that pain that emanates from the oral cavity, jaw or face. This pain, not only effects the movement of the TMJ itself, but effects the muscles of the head and neck that control the movement of the joint. Botox to the rescue! Botox paralyses muscles commensurate with the dosage administered intramuscularly. It reduces the patient's ability to contract the muscle excessively and thus reduces parafunction. Parafunction of the muscles of mastication, is the use of these muscles in ways that are not related to the normal function of eating, chewing and talking. The pain associated with these habits is eliminated as well.

The Muscles of Mastication; the Masseter, the Medial Pterygoid and the Temporalis are the three main muscles treated with neurotoxins to directly eliminate the parafunctional habits of bruxism (teeth grinding) and clenching. The traditional treatment for bruxism is the use of night guards to be worn while sleeping to prevent the unconscious grinding of the teeth. These parafunctional habits can lead to fractured teeth, broken restorations and gum recession

That leads me to the indirect benefits of Botox™ on the dentition. Have you heard the saying "long of tooth"? It refers to teeth that are longer than normal due to gum recession. Gum recession is the pulling away of the gum tissue from the neck of the tooth exposing the root, thereby creating the appearance of a longer tooth. The primary cause is teeth grinding and clenching. Gum recession can now be treated in a innovative manner that does not involve scalpels and sutures. The new technique is called The Chao Pinhole Surgical Technique™. Once the procedure is completed, Botox™ can be used to prevent the root cause of the problem, grinding, and clenching of teeth. Of course, good oral hygiene and proper brushing technique are vital as well.

Finally, the administration of Botox™ to the muscles of mastication can protect the dentition from tooth or dental restoration fracture, and excessive tooth wear.

The use of Botox™ in this context is innovative modern dentistry.

CASE STUDY
"NONE-ON-3" A CASE STUDY TO RESCUE AN "ALL-ON-4" CONVENTIONAL CASE WITH MINI DENTAL IMPLANTS

ANDREA JOY SMITH, DDS

PURPOSE: The purpose of this case is to demonstrate the versatility of mini dental implants. In this case the addition of mini dental implants recued this two-year post Conventional implant placement full upper denture case. After wearing a full upper denture for over 20 years, this patient sought conventional "ALL-on-4" dental implant treatment and was expecting a fixed appliance a year and a half ago. However, she presented wearing an upper denture that was not supported by the conventional implants that had been placed. There were four implants initially placed, however, one of the four implants failed twice. Hence the "None-on-3" conundrum. After two implants and two bone grafts the patient had was frustrated, she wanted to realize her goal of an upper fixed appliance.

FINDINGS:
73-year-old female,
Medical History: Unremarkable
Drug Allergy: Pen VK
DENTAL HISTORY: Upper Edentulism, Complete Upper Denture, "All-on-4" Implant treatment started 2 years ago. Three of the four dental implants present with healing caps. a complete upper denture. Lower Partial Denture present.
Chief Complaint: Patient doesn't want to wear a denture and would like a fixed option. She states that she started treatment with the hope of having a fixed upper restoration She is feeling very frustrated with "All-ON-4" process and the failed implant. She was hoping to have mini dental implants placed so that she could realize her dream.

RECORDS TAKEN:
Pre-op CT
PAs of remaining lower teeth
Two Upper Impressions, one with and one without the current denture
Lower opposing impression
Bite registration.
Obtain Conventional implant Information/Order Lab analog and Impression coping prior to Mini Implant Surgery.
The CT revealed that there were bone graft tenting screws left in the upper left anterior.

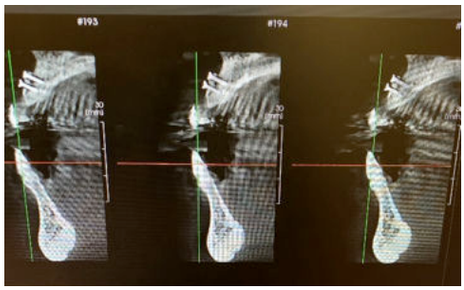


Figure 1: Pre-op CT Tenting Screws

Figure 2: Maxillary Arch Pre-op

TREATMENT PLAN:
Add Mini Dental implants upper arch to support upper fixed restoration, Place abutments on the existing conventional implants to use them to support the final zirconia restoration as well.
At the records visit, prior to the placement of implants, the Impressions taken were used to fabricate an open trench (troughed out to allow space for implants) Resin Round house to be placed at the implant surgery. The lab used the model of the original denture to establish bite and size of arch.

At the surgery visit nine (9) Mini Dental Implants were added to this case. There were no implants placed in the upper left anterior region where the previous bone graft and tenting screws were present. The conventional Implant parts (Impression coping & lab analogs) were ordered prior to surgery visit. During the surgery visit the conventional implant impression copings were used to have custom abutments fabricated by the lab. The resin Roundhouse was cemented

into place with temporary cement with shims covering the mini dental implants and the conventional implant healing caps were in place.

Figure 3:
Implant Model

The model, Figure 3, was prepared by the lab to start fabrication of the Upper Zirconia Roundhouse. A try-in was fabricated from the implant model.

Figure 4: Maxillary Arch Post Implant Placement (reverse Image)

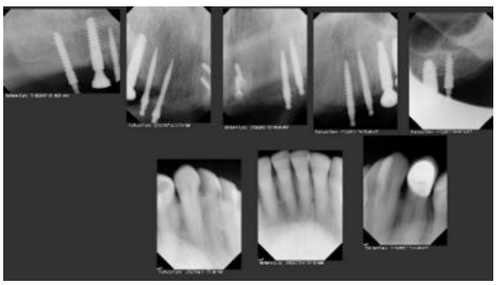


Figure 5: FMX Post Mini Implant placement

The FMX, Figure 2, was taken after Mini Dental Implant placement. A Post-Op CT was taken as well (not Shown).
The pre-maxilla was very deficient therefore, Mini Dental Implants were not added to the upper left anterior. There were ample mini dental implants placed with a favorable A-P spread, to support the restoration without placing implants in that location.
A Zirconia Round-house was the final restoration planned to complete the case. Final Impressions were taken on the day of mini-dental Implant placement. After Placing the mini-dental implants the prefabricated resin round house was cemented. The resin round house was fabricated from the initial study models. Before the Zirconia Round-house is fabricated a Round-House try-in to verify esthetics and occlusion was fabricated for try-in at next visit.

Figure 6: Final Zirconia Bridge

DISCUSSION

In the age of Dental Implantology, patients are often deterred from treatment due to the cost. However, there is a large subset of the population who can indeed afford to have dental implant treatment. This patient invested the over $25,000 required to have a fixed ALL-ON-4, upper restoration two years before coming to my office for treatment. Yet, she still has a removable upper denture because one of the implants failed, twice. Simply adding mini dental implants transformed her from being a removable denture wearer to a fixed restoration wearer, something she was looking forward to two years ago when she started “ALL-ON-4” treatment. She did not expect to have “None-On-3” for two years. The mini dental implant procedure was life changing for her. She asked, “why didn’t the dentist just place the mini-implants”. I did not have a good answer for her. However, I believe there are one of three reasons mini dental implant treatment was not offered. One, the had never heard of mini-dental implants and thus did not know it was an option. Two, the amount of money and time invested by the dentist in learning conventional implantology prevented the dentist from exploring other options. Lastly, the dentist has not embraced the minimally invasive mini dental implant technology. Whatever, the reason, this patient was not well served by waiting for the bone graft and eventually the new implant to be successful.

This patient had more than four conventional implants placed. There were two on the upper left side (that served as one implant) , however, they were placed too close together for the proper A-P spread to support a fixed appliance. The fifth Implant failed twice and the tenting screws from the graft were never removed.

CONCLUSION:

This case is a perfect example of the versatility of the mini-dental implant. It can solve problems that are otherwise very difficult. The more than twenty-year track record and FDA approval of mini-dental implants for fixed and removable restorations is should not be overlooked or ignored. In a perfect world this technology would be embraced and used to help patients everywhere.

As the mini-dental implant trail-blazers the members of The International Academy of Mini-Dental Implant Academy are, we should dedicate ourselves to advancing the mini-dental implant paradigm.

Figure 7: Complete case on Model

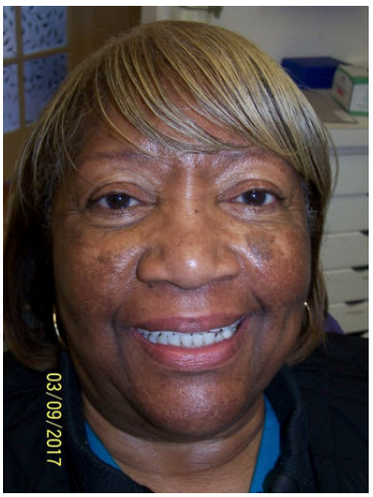


Figure 8: Before with Upper Complete Denture

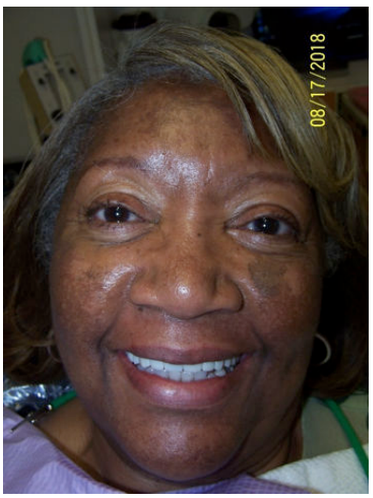


Figure 9: After Upper Zirconia RoundHouse

CASE STUDY

INTRODUCING GREAT ON EIGHT

THE FIVE APPOINTMENT FIXED DETACHABLE FULL ARCH ZIRCONIUM BRIDGE ON MINI DENTAL IMPLANTS COMPLETED IN JUST OVER 8 WEEKS

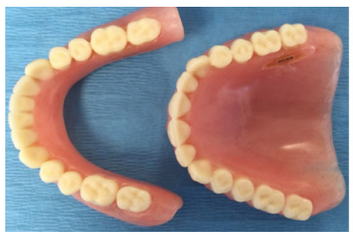
JOSEPH GILLESPIE, DDS

MT. PLEASANT, SC
Mini Dental Implant Centers of America

The idea for Great on Eight™ developed as a constant evolution of form, function, support, and esthetic to create the best available solution to replace a full arch of missing teeth on a foundation of immediate one piece mini dental implants. This solution explicitly targets a full spectrum of patients from suffering edentulous patients who cannot tolerate traditional floating dentures to patients who simply cannot afford other nationally advertised full arch solutions on four implants. A leader and innovator in mini dental implants, my mentor, Dr. Todd Shatkin serves as the inspiration for this concept with his Fix on Six technique. (1) The Goal of this article is to show the five appointment steps through the eight-week treatment duration to complete full mouth implant rehabilitation. This case represents the culmination of almost 2 decades of mini dental implant experience, constantly evolving dental restorative materials that allow the full arch span zirconium bridge, and the penultimate work of passionate open minded mini implant dentists, lab technicians, and our patients in search of the best treatment. The case study shown here is the least invasive, most patient friendly, strongest restoration, involving the quickest entire mouth treatment, and stands at the most affordable price point for full mouth rehabilitation. The Great on Eight™ utilizes cemented ceramic 10 unit brides on 8 or more mini dental implants for restorations on both upper and lower arches. The patient presents as a twenty plus year fully edentulous male in his mid-sixties with no health contraindications responding to our marketing for a permanent cemented implant solution for his loose denture struggles.

The present incarnation of the Great on Eight™ evolved around multiple one-piece mini dental implants supporting upper and lower full arch removable dentures.(2,3) In time the proof of concept for Great on Eight™ developed with the clinical successes showing resounding results of cemented single unit crowns on mini dental implants (4), then multiple unit bridges on one piece minis and eventually entire quadrant dentistry. These multiple crown quadrant bridges extended up to half of the arch restoration with fixed solutions that successfully cemented directly to mini implants. (5,6) For the purposes of this case study the patient presented as a dissatisfied full arch denture wearer searching for a better full mouth implant solution.
The patient's available bony ridge presented here,

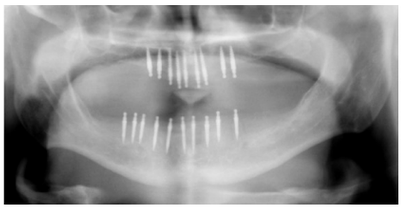
edentulous for over two decades, with a slow but constant decrease in fit, retention, comfort, and function of his complete dentures. Bone loss of his ridges in height and volume over time are the issues causing his struggles. He even opted to have new dentures made that were still unsatisfactory. The patient's limited bone volume in width and height disallowed root form two-piece dental implants in this patient without extensive bone grafting which he denied.(7) His first appointment with us is a free consult and Panorex to determine that the patient is a Great on Eight™ candidate and with a CBCT and financing set up the 2nd appointment is made for implant placement surgery.
Enter the Modern Great on Eight™, a full arch appliance with ten to fourteen unit Zirconium bridge supported by a minimum of eight one piece mini dental implants but as many as twelve or more implants can be utilized when required by poor available bone height, width, and density. We allow the patient freedom from the daily labors and limitations of their floating dentures



even if their bony ridge has atrophied to minimal available bony widths

The Placement of the implants follow established Mini dental implant insertion techniques from removable overdentures (8) with the only exception of the additional implants from 6 on the upper and 4 on the lower to 8 or more inserted on both arches.

Implant insertion occurs here on the patients second appointment. A full arch of Eight mini implants should be positioned staying anterior to the sinus in the posterior maxilla and superior to the IAN in the mandible paying special attention to the foramen and vital anatomy at the lower second bicuspid location in the mandible.



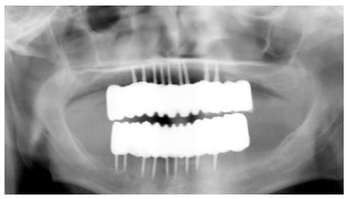
See how overall Anatomic Parallelism is created with the free hand implant insertion that will aid the draw of the restoration over the implants. The patients existing denture is soft relined to the implants after impressions are made for the Great on Eight™ acrylic mock up. Three weeks later for appointment #3 the Mock up is tried in and approved by the patient to fabricate the duplication in zirconium
The established mini implant O-Ball abutment and O-Ring housing interface to a multiple of 8 or more retains the Zirconium Bridge.(9,10,11)

Multiple titanium housings retain the nitrile rubber doughnut shaped O-rings that are placed and picked up from the implant abutment with a composite resin cement inside the gingival aspect of the bridge. A composite resin cement is placed into the restoration and seated over the implant, shim, and housing. Completing appointment #4 the cementation visit involves allowing the cement to cure the arch of teeth. The Great on Eight™ can be retrieved and excess cement can be removed and the appliance can be polished and seated back on the implants retaining the appliance in the mouth.

The Great on Eight™ is implant retained and tissue supported but is deemed a fixed detachable bridge. The patients fifth appointment includes a follow up of the cemented appliance with bite adjustments and home care instructions. For the experience of the patient the appliance is fixed and should be cleaned twice a day with regular home care tooth brush and tooth paste as well as use of a water pik to irrigate clean the interface between artificial zirconium and the patients periodontal tissue. A small amount of mouthwash placed into the water pik reservoir is recommended for the oral irrigation, but the patient does not remove this appliance creating the fixed prosthesis aspect of the Great on Eight™. However the appliance is removable as necessary during the two initial follow up visits after delivery where balanced occlusion is achieved by adjusting the bite and any other esthetic concerns are addressed with Ceramic burs and polishers. Finals

In Conclusion this case was two months in duration. From Initial consultation visit #1 and surgical Implant placement with impressions and a retrofitted denture to complete visit #2. Visit #3 was a visual inspection of an acrylic prosthetic design a mere three weeks later and approval of the Resin Mock-up Great on Eight™ and with the patients smile approval appointment #4 delivery, was set. An additional 3 weeks passed for the fabrication of the final restorations for visit #4. On this visit the final esthetic was approved at try in and cemented in place, cleaned adjusted, polished. The patient was able to immediate enjoy function and esthetics. Final appointment #5 occurs within one week of delivery to fine tune occlusion, function, and overall esthetics. The patient will go on 6 month routine hygiene as the Great on Eight™ experience is brief, enjoyable with one surgical intervention, and decades of enjoyment returning to function most like the patients own natural teeth.

In a mere two months of care over five treatment visits the Great on Eight™ returns the patient to near limitless function with Implant retained Zirconium ceramic bridges with the highest of strength and custom esthetic at an remarkably affordable pricepoint. See the post operative panorex of the results of the retained upper and lower final restoration, the modern Great on Eight™



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CASE STUDY #1
ANOTHER VIEW: SERVICE AFTER THE SALE
ALAN ROBINSON, DDS

CLINTON TOWNSHIP, MI
Mini Dental Implant Centers of America

Alan F. Robinson, DDS, MAGD, DICOI, DIAMDI
The Lakeside Center for Implant Dentistry PC

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As Implant Practices grow, particularly Mini Implant practices, a very successful strategy has been to limit practice services to implant placement and restoration only and have the implant patient seek continuing non implant care including regular Implant maintenance care elsewhere. The simplicity and profitability of that strategy has been proven by a good number of practitioners. There are several negatives to that strategy that arise however, can have significant consequences, and must be considered.

The marketing that is required to develop an all implant practice inevitably yields a great deal of non directly implant related dental treatment. In my practice this seems to run at approximately 30% of the treatment needs of those new patients presenting for "implants" because of the marketing program. There are also situations where the new patients have significant dental needs and relatively large treatment plans, but can't (or won't) do implant treatment at that time. For many of those treatment plans, the implant treatment could be an option at a later date. Serving these patients represents not only the income to the practice from the conventional dentistry needs, but also then in-house implant treatment that can arise later.

Upon completion of an implant course of treatment, first rate continuing care is a must. Fixed full mouth cemented roundhouse restorations, for example, require regular prophylaxis for optimal results and health. These restorations are not yet commonplace enough that all Hygienists or Dentists are expert in that periodic routine care and evaluation. Same goes for Mini Implant retained single and multiple fixed crown and bridge restorations. In fact, because of their unfamiliarity, they are likely to "poor mouth" or deride the quality and appropriateness of the treatment. This is true even when the treatment is 100% successful and the patient is completely satisfied. Having your patients back to provide expert and what is really specialty follow up care is excellence in care and deserves a premium fee. That being said, do not expect many Insurance carriers to pay that premium. In fact, the ADA eliminated the Implant Maintenance Code D6080 from the CDT billing codes in the 2021 CDT Code Listing. One must wonder if the people making this decision understand anything about the nature of this care and the business of Dentistry. Implant providers do always have the option of structuring a separate Implant practice such that they are not required to be bound by reimbursement policies of Insurance Companies that prohibit fair payment for services. A superior service warrants a premium fee. Thanks

Having a continuing relationship with a patient often brings additional income and referrals to the practice providing maintenance services in part because of that continued relationship, contact and care. Often an Implant retained denture or partial denture patient will ask about "upgrading" to a fixed treatment option. Also many that have lost and replaced teeth have other teeth which must later be extracted and replaced. Who better to advise than their trusted Office providing their continuing care?
We include o-ring replacement at no additional cost to our patients that present for regular Implant Maintenance visit (prophylaxis and examination) adding value to our enhanced maintenance fees.

A possible blueprint is to maintain an affiliated but separate Dental Practice within your Office. We see the continual economic "beat down" by constant reductions and coverages by insurers, despite ever increasing costly governmental and industry requirements for proper treatment as well as ever rising labor, site and supply costs. Further, providing excellence in all care is costly and deserves a premium fee. Even in your General Dentistry practice, you should consider structuring so that you set treatment fees, not an Insurance Actuary in an office thousands of miles away. It can be done, and many have done so with stunning success and profitability. Consultants will tell you that most practices that discontinue participation status see an increase in revenue, not a decrease. These practices trade less profitable business for more profitable business.
So consider your practices' path forward as it grows rapidly once you are meeting your patients Dental, Implant, Continuing care and Reconstructive needs. Your investment in education, equipment and excellence in care stands out in your community as does your experience. That combination deserves superior compensation for the Doctor and Staff.

CASE STUDY #2
THE ABBREVIATED ARCH: A TREATMENT STRATEGY FOR LIMITED BONE

ALAN ROBINSON, DDS

CLINTON TOWNSHIP, MI
Mini Dental Implant Centers of America

When a patient presents a fixed restoration to restore missing posterior dentition or missing full arch , often full anatomical restoration is not possible due to inadequate posterior bone height and or quality due to enlarged maxillary sinus spaces, generalized or localized bone loss due to trauma, injudicious extraction technique or a atomic deformity. Even in this instance, in the majority of cases, fixed crown and bridge, implant retained restoration with small diameter, mini implants is possible, even routine, back to the first or second bicuspid area in the maxilla as well as the mandible, anterior to the mental foramen. Restoring back to the first molar can prove to be impossible at worst, and risky at best in terms of long term implant success and or other complications in these cases. I would propose a strategy to fully restore these cases using the areas suitable for highly successful placement to still get molar and bicuspid occlusion by eliminating one bicuspid per quadrant, exactly the same occlusal pattern we would see in a 4 bicuspid extraction orthodontics case in natural dentition.

In the maxilla the implants are placed anterior to the Mesial wall of the of the maxillary sinus. Distal most implant(s) can also be mesially inclined (the abutment is distalized) to follow the incline of the anterior wall of the sinus which adds strength due to the buttressing effect of the cortical bone of sinus and increases the A/P spread, the measurement of the distance between the anterior most implant and the posterior most implant. Increasing the A/P spread increases the theoretic maximum distal cantilever possible, which is 50% of the A/P spread . That is purely an engineering calculation. From a practical standpoint however, keeping that cantilever as small as possible makes your restoration stronger, more reliable and much less likely to fail. For the mandible, the implants are placed anterior the mental foramen , the distal most implants are angled mesially (which distalizes the abutment). This pattern mimics positioning in the conventional implant “all on four” technique. Using this strategy , I have found that my usual cantilever is about half a molar width, which is managed by controlling tooth size and anatomy. The strategy and reasons for why it needs to be employed are explained to the patient in the planning stage so they know what to expect and why their restoration differs from usual anatomy with one less tooth per quadrant. We use a global, all in one fee for our “roundhouse” cases and am occasionally asked if it’s cheaper because there are less teeth than a usually designed case. Our answer is no, but we are also not charging additional for the increased difficulty either. In restoring a single quadrant, for example, charges are per tooth, as usual.

A comment about cantilever and the 50% of AP spread calculation. My bias is that cantilever anything is an inherently potentially weak design. When recognized and properly designed for by keeping the actual cantilever to the absolute minimum and being certain there is more than adequate interocclusal space for an abundance of material, despite what the calculation would allow, you can be very confident in the reliability of your restoration.

Mini Implants have allowed for many innovations that allow Mini Implantologists to offer solutions never before possible. We can add one more to that growing list!

CASE STUDY
IMPOSSIBLE CASE #1
JAMES THARP, DDS

FRANKFORT, IL
Mini Dental Implant Centers of America

PATIENT'S CHIEF COMPLAINT

Patient presenting complaint is a 66 year old female presented with an adequate upper denture and a severely atrophic mandible with a single mini implant remaining in the area of tooth #23. She had been edentulous for more than 20 years. There were at least two other mini implants that had been lost and the existing implant had periimplantitis and bone loss around it. She emphatically insisted that she wanted more implants especially in the posterior mandible and a new denture. After consultation we decided that we would make a fixed detachable porcelain / zirconium mandible denture supported by eight more minis with two being in the posterior. She was advised that there was a considerable risk involved including paranesthesia of one or both of her mandibular nerves leading to numb lip and or weakening of her mandible to the point of fracture. She and I were willing to take the risk.

DISCUSSION

The case was planned on the Trianan software and we were able to plan for adding six additional implants in between the mental foramen and two implants in the area of #17 and #32. It was thought that we could keep the implant in the area of #23 if it was cleaned and turned in to the mandible under anesthesia. The implants to be used would be Shatkin F.I.R.S.T Intralock 2.0x11mm in the anterior and 2.0x10mm in the posterior- see photos. An essential part of planning a case like this is to trace the path of the mandibular nerve into the CBCT and to try virtual implants into the three-dimensional jaw in the radiograph. We have had good success in gaining keratinized tissues/attached gingiva when placing in an area with only loose gingiva. These restorations are designed to not be removed by the patient. For the first year we see them every 3 months to remove and clean and check the implants and after the first year every 6 months. Different types of bone grafting were discussed with the patient and she and I decided that she would rather try with out.

TREATMENT

At the second appointment we placed eight implants using just Septocaine local anesthetic and Nitrous oxide and oxygen sedation. No guide was used. We adapted her old denture using o-ring housings and Shatkin F.I.R.S.T.® reline material. She returned for her 24 hour and one week post op visits. At these appointments sore spots were relieved and occlusion was adjusted. The implant in the area of #17 was place through non-attached gingiva and had to keratinize before it was felt that we could get a good impression. The patient was checked every 2 weeks and after 6 weeks impressions were taken and sent to Shatkin F.I.R.S.T.® lab for computer milled plastic try in.

This was tried in with o-ring housings in place and adjustments were made to the occlusion and the intaglio surface. These were sent back and the plastic try in was scanned and duplicated in zirconium porcelain. The o-ring housings were then picked up using Shatkin F.I.R.S.T.® resin cement and the patient was checked at 24 hours and 1 week.

CONCLUSION

The patient was checked at 3 months and is very happy with the results. She is using a water flosser to keep the tissue healthy and says she can eat anything. On removal of the appliance the tissue looked healthy with no inflammation or bleeding and all of the implants tapped solid with no mobility. She had no numbness or pain.

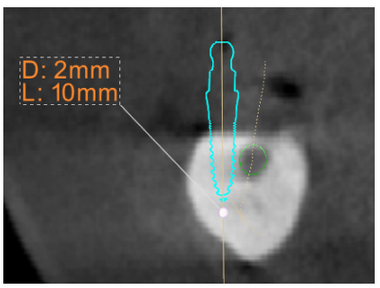
Lower before

Lower After

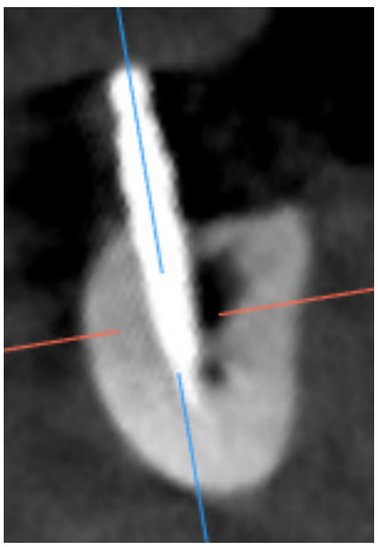
Old Lower

New Lower Intaglio Surface

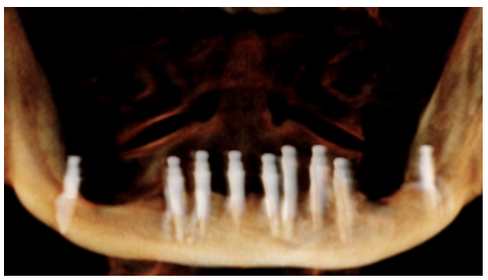
New Lower Porcelain Zirconium



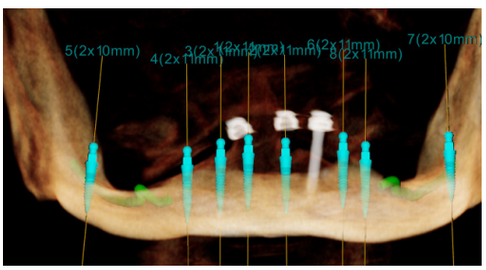
Planning #32



Post Op #32



Post Op Lower CBCT



Panning Lower CBCT

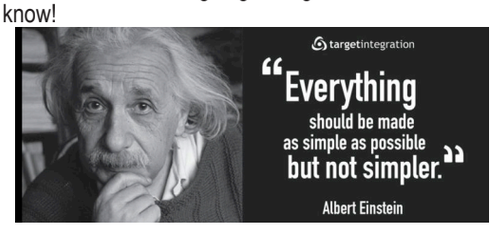
CASE STUDY....
A MINIMALLY INVASIVE IMMEDIATE PLACEMENT IMPLANT PROTOCOL FOR FIXED PROSTHETICS...RONALD PETROSKY, DDS

The State of The Art & Science ...of replacing missing teeth utilizing dental implants in this 21st Century … has dramatically changed & improved since my dental school days of yesteryear…with many simpler technological advancements and techniques of the treatment process. It's truly an amazing time to be an Implant dentist utilizing the advanced minimally invasive & innovative protocol… long advocated with monthly continuing education at Shatkin F.I.R.S.T.® in Buffalo,NY. With that said…to have a thriving & successful contemporary implant practice in 2021 & beyond…it is certainly advantageous and convenient for the doctor and patient to provide the complete (A-Z) implant treatment plan presented….**"ALL UNDER ONE ROOF"!**

We need to acquire, implement & document the necessary everyday clinical skills, credentials ,& advanced continued education that builds our confidence to perform everyday Implantology…through joining such organizations as:
The International Academy of Mini Dental Implants
The American Academy of Implant Dentistry
The International Congress of Oral Implantologist
The Academy of General Dentistry
There's a whole lot more to learn beyond dental school…and truth is, we really NEVER stop learning! Learning is a Lifelong Journey….Not a Destination! Remember too…That the only constant thing in this world is change! What we did years ago…may be obsolete today!

SO ESSENTIALLY… THE IMPLANTOLOGIST OF TODAY SHOULD BE ABLE TO:
1. **EXTRACT** all hopeless teeth in your office using advanced atraumatic methods.
2. **PLACE** all the implants … at raumatically making…The implants fit the Patient NOT The Patient Fit the Implant' with less need for grafting.
3. **RESTORE** all the implants …using advanced digital impression techniques for more accurate fit & less adjustments.
   All in ONE PLACE without referrals…is the preferred option by many patients. By providing such everyday immediate placement/ load procedures you'll: have satisfied patients • be in demand (doing what most places don't) • be very satisfied professionally • be able to endure happily & indefinitely your lifelong chosen career • be much more profitable…with each passing year getting better & better!

WHAT'S BETTER THAN HAVING YOUR MISSING TOOTH BACK SAME DAY?? Therefore, going forward into the future…my philosophy is, IMHO, work less as the years go by ,travel more…but NEVER retire because I believe, work keeps you young, mentally sharp & with a purpose in life a reason for living, making a contribution to society! Look at Warren Buffet at 91 & still going strong. When God wants you…He'll let you know!



SOUNDS LIKE THE 'KISS' FORMULA, LET'S …
KEEP IT SUPER SIMPLE
So here are my … Implant Success Essentials

STEP 1: ORAL SURGERY
Obviously… We can't place that implant…Until you get that tooth out first! So,First things First…There often comes a time when we live long enough… that that some teeth are too far gone to save…& have to come out . It's those ankylosed difficult extractions, those old fragile root canal teeth,which can easily be far more challenging than placing implants…are most definitely simplified with the technological design advantages of utilizing what I would call: 'The Fab 4 MUST HAVE' in your surgical armamentarium:

a) The Piezotome Cube by Acteon (available at ShatkinF.I.R.S.T.®) to loosen up & sever the PDL atraumatically with no burs,no bleeding…utilizing ultrasonic fine blades with minimal bleeding. I use it for all extractions. Every office doing extractions needs The Cube…you just not know it yet!

b) The PHYSICS FORCEPS by GoldenDent to using the age old Principles of Leverage to loosen up teeth .

c) The PROXIMATORS by Karl Schumacher.

AFTER initially using The Piezotome Cube to sever the PDL…
go back in with the Proximators to elevate & work loose from any angle those broken root tips Day After Day… they truly work like a charm !
Wish I had them years ago!!

d) Socket Preservation Essentials available at Shatkin F.I.R.S.T.®

The INTRASPIN by IntraLock

Osteogen Plug

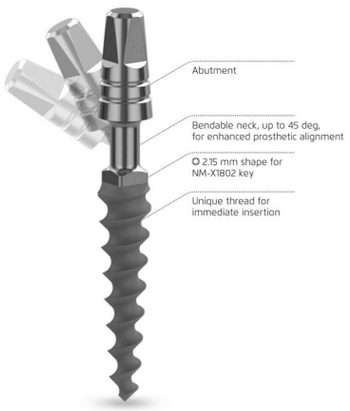
The OsteoGen® Bone Grafting Plug is the easiest and most affordable way to clinically deliver bone graft for ridge maintenance and socket preservation. The idea is simple - we take a collagen plug and fill it with our … OsteoGen® non-ceramic bone graft crystals to create the OsteoGen® Bone Grafting Plug. The result is a bone graft combined with a collagen plug for ease of clinical delivery – all at the introductory special price of only $50 per extraction without the need for a membrane

Hemostyp

DESCRIPTION:
Topical Hemostatic Dressing 0.75" x 0.75", 4 Ply 20/Pk.
A sterile, woven, pH neutral soluble hemostatic gauze that is .. derived from cellulose and is easy to apply.
Upon contact with blood, it quickly…
• transforms into a clear viscous gel,
• which fills wound voids,
• seals capillary ends,
• activates the clotting system and
• thereby helps to stop bleeding.
Once bleeding has ceased and coagulation has occurred, HemoStyp can be rinsed away with water and dissolves into glucose and saline. Hypoallergenic

STEP 2: IMPLANT PLACEMENT
I like the MonoBendable Implant, as available at ShatkinF.I.R.S.T.®, for its minimally invasive, compressive & tapered design: The MONO is … NOT an old style conventional cylindrical two-stage implant, with a much more invasive, multi-drilling protocol, with more cancellous bone needing to be removed, more prone to crestal bone loss, screw loosening & fracture! That Was Then…This is Now!

FROM SINGLE TOOTH REPLACEMENTS TO... ROUNDHOUSE CROSS ARCH STABILIZATION FIXED RESTORATIONS my personal 'Implants of Choice' preference are the: MONO Bendable One Piece Implants with diameters 3.3, 3.75, 4.2 & 5.0 ...given at least 1mm of bone buccal & lingually plus the diameter of the implant.



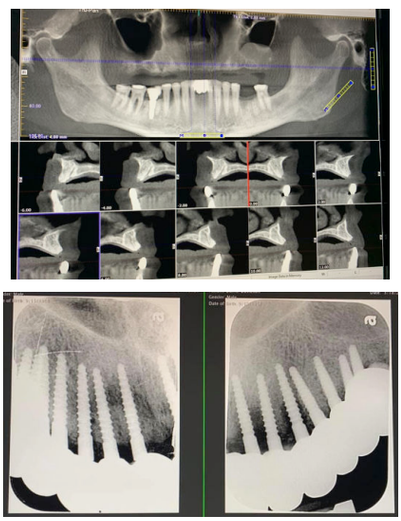
Bendable Illustration

For ridge width GREATER than >5mm: I like…The MonoBendable's (with a 4mm long/1.8 diameter neck)… especially for Maxillary Anterior where bending the abutment is almost a routine..

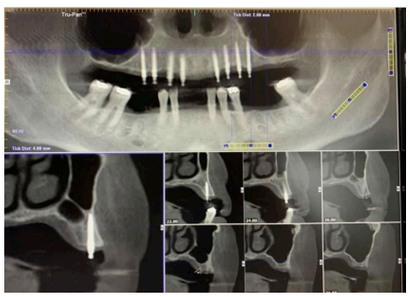
The MONO's (non bendable with the 3mm long / 2.0, 2.5, 2.8 diameter neck) …are good for the posterior where usually not have to bend neck and the implant length needs to be shorter due to anatomic landmarks of IAN and max sinus. So…a thicker & shorter neck may be better strength wise.

For ridge widths LESS than <5mm ... p
• a small diameter implant (INTRALOCK 2.0, 2.5) may be used or
• the ridge can be widened using the OSSEODENSIFICATION technique.

NON-REMOVABLE CEMENTED ZIRCONIA ROUNDHOUSE ON 12



GREAT ON 8 SEMI-REMOVABLE BY DOCTOR ONLY



The Bottom Line is that the MonoBendable Implant
CAN BE COUNTED ON to be placed with...
* relative simplicity & reliability
* a minimally invasive approach
* easily bendable (that changes everything)
* prepable if necessary
• excellent self-tapping tapered thread design
• immediate same day placement following extraction
* immediate primary stability
* immediate (very light) loading

Those placing the MONO's now ...really love them after a very short learning curve... and those hesitating will love them too & then wonder ... Why the heck did I wait so long ?? What was I thinking???

Lastly & Most Importantly, the MonoBendable Implant is a Viable & Reliable Alternative Solution to those implant doctors who prefer
NO SCREWS - NO TWO STAGE
for replacing missing teeth with fixed applications.

STEP 3: PROSTHETIC IMPRESSIONS (GO DIGITAL !)

The CEREC Primescan

The 3Shape Trios

Having recently "discovered" the many advantages of
DIGITAL IMPRESSIONS.
My PVS impression taking days are 95% over!
Obviously,the fit & accuracy of the FINAL RESTORATION …
is only as good as the accuracy of the FINAL IMPRESSION!

The Digital Impressions … using the CEREC Primescan, the 3Shape Trios, or something similar… has proved to a Game Changer for me & deliver
• more accurate restorations with
• less, if any adjustment, in
• less time
• less cost
• more patient / doctor eaze & comfort

I would highly recommend taking a close look at utilizing the Digital Impressions Technology for the PROSTHETIC PHASE of the implant restorative process…you'll be so glad you did!

Digital impressions have huge advantages over traditional impressions. by Terri Lively of Dental Products Report.

They have a HIGHER CLINICAL SUCCESS RATE when compared to traditional impressions. Digital workflows INCREASE EFFICIENCY by streamlining the production of restorations and REDUCING the need for REMAKES . Digital scans never degrade, can be reused, are easily stored with your digital patient files, indefinitely, and sometimes are accessible anywhere you have an internet connection. Furthermore, digital impressions create a BETTER PATIENT EXPERIENCE by eliminating the sa need to bite into a tray of impression material, sometimes more than once and over the course of three appointments.

* Reduced possibility of impression-taking errors and elimination of material inaccuracies for fewer restoration mistakes
* Patients tend to appreciate the new technology and state-of-the-art dental care, so they become more engaged in, and better informed about, the treatment process because they can see their impressions on-screen chairside.
* The scan of the teeth being restored, as well as the opposing teeth and bite, can be completed in just three to five minutes.
* The digital impression can be stored electronically indefinitely, which saves space, contributes to efficient recordkeeping, and supports a paper-free environment.
* Green dentistry and eco-friendly aspects include eliminating the need for disposable plastic trays and impression materials, which otherwise would be polluting landfill space; digital data is eliminated with the "delete" button.

With traditional dental impressions…there is SIGNIFICANT ROOM for **ERROR IMPRESSIONS CAN HAVE :**
• voids or defects • air bubbles or distortions
The implant abutments … are smaller than natural teeth…& therefore can be problematic if you prep them & can't use impression analogs!!! This is NOT a PROBLEM with a Digital Impression. The fit & accuracy over the PVS impression in definitely better with usually NO ADJUSTMENT. Some popular Digital Scanners are the CEREC Primescan 3Shape-Trios and iTero

STEP 4: PROSTHETIC DESIGN
Full Cross Arch Stabilization provides for a far more stable restoration long term…able to withstand those lateral forces biomechanically.

Clinical Advantages and Limitations of Monolithic Zirconia Restorations Full Arch Implant Supported Reconstruction: *Clinical Study | Open Access Volume 2015 |Article ID 392496 | https://doi.org/10.1155/2015/392496 Joao Carames, Loana Tovar Suinaga, Yung Cheng Paul Yu, Alejandro Pérez, Mary Kang, International Journal of Dentistry, vol. 2015, Article ID 392496, 7 pages, 2015.*

ABSTRACT PURPOSE.
The purpose of this retrospective case series is to evaluate the clinical advantages and limitations of monolithic zirconia restorations for full arch implant supported restorations and report the rate of complications up to 2 years after insertion.

CONCLUSIONS.
Monolithic zirconia CAD-/CAM-milled framework restorations are a treatment option for full arch restorations over implants, showing a...96% success rate In the present study. Some of the benefits are accuracy, reduced veneering porcelain, and minimal occlusal adjustments. The outcome of the present study showed…
• high success in function,
• aesthetics,
• phonetics, and
• high patient satisfaction.

Long-term outcomes for cross-arch stabilizing bridges in periodontal maintenance patients--a retrospective study
Oystein Fardal et al. 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.

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. I prefer the full arch, cross stabilization of the 12-unit Zirconia-Roundhouse Restoration having had predictable success.

STEP 5: MARKETING
a) 30 Second TV Commercials
my two different 30 second commercials target whatever seniors watch works well for me. Patients are impressed with a TV presence .

b) Monthly Mailers
Like the ClipperMagazine & ShoreSavings with a variety of other coupons reach over 50 thousand plus households per month also works well.

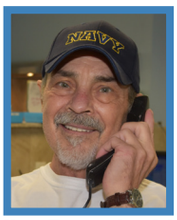
TUCKERTON, NJ
Mini Dental Implant
Centers of America

SHATKIN F.I.R.S.T.® LABORATORY

*THE ONLY MINI DENTAL IMPLANT LABORATORY PROVIDING **FREE** CASE CONSULTATIONS!*

Valdemar Blaszak
Operations

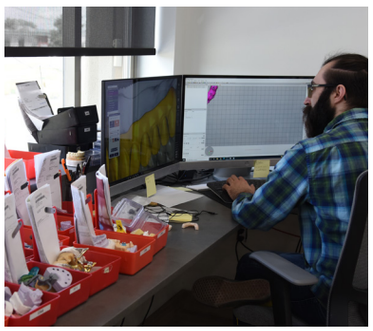
Kevin Summerville
Crown & Bridge Department

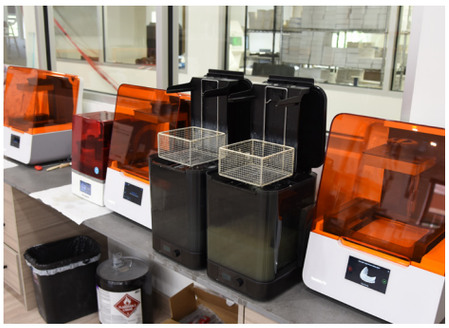


Jim Brzezinski
Removable Department

Our specialized ceramic laboratory provides you with a team of professional technicians headed by Valdemar Blaszak. Mr. Blaszak's technical staff carries an average of 20 years of technical expertise in dental prosthetics. All Porcelain fused to Zirconia, the NEW Zantex or Porcelain fused IPS e.max Crowns, Bridges, Veneers and FIRSTEMPS™ are all offered from our unique facility. In addition, Jim Brzezinski heads up our denture laboratory with over 40 years experience to provide you with superior implant dentures.

THE WORLD'S MOST INNOVATIVE MINI DENTAL IMPLANT LABORATORY





AUTOMATED MACHINERY FOR FASTER TURNAROUND TIME

Our products are fabricated in the United States using all FDA approved and registered materials.

In addition to the excellent customer support and convenient shipping expected of such a laboratory, Shatkin F.I.R.S.T., LLC includes a variety of value-added services

Shatkin F.I.R.S.T.® TRU-LOK
O-Cap Master Kit

10 Shatkin F.I.R.S.T. Yellow Caps (Standard Retention)
10 Shatkin F.I.R.S.T. Pink Caps (Strong Retention)
10 Shatkin F.I.R.S.T. Clear Caps (Extra-Strong Retention)
30 Shatkin F.I.R.S.T. Stainless Steel Caps
30 Shatkin F.I.R.S.T. Block Out Shims
1 Shatkin F.I.R.S.T. Insertion & Removal Tool for O-Caps

Shatkin F.I.R.S.T.® O-RINGS

STANDARD RETENTION	STRONG RETENTION	EXTRA STRONG RETENTION
70 Durometer	80 Durometer	90 Durometer
SF-MOR10	SF-TSMOR10	SF-TESMOR10
10 PACK O-RINGS	10 PACK O-RINGS	10 PACK O-RINGS

Shatkin F.I.R.S.T.® TRU LOK™ ABUTMENTS

NO CEMENT TRY IT!

The "NEW" Shatkin F.I.R.S.T.® Tru-Lok™ Snap on and prepable Abutments will revolutionize the way you cement crowns and bridges and on Shatkin O-Ball Mini Dental Implants. The patent pending Tru-Lok™ Abutment allows the dentist the ability to retrieve these restorations without any damage to the Shatkin O-Ball Implant and without having to cut off the restoration

Shatkin F.I.R.S.T.® Patient Education Models

ZANTEX
Fix on Six or Roundhouse Model 6-12 Implants

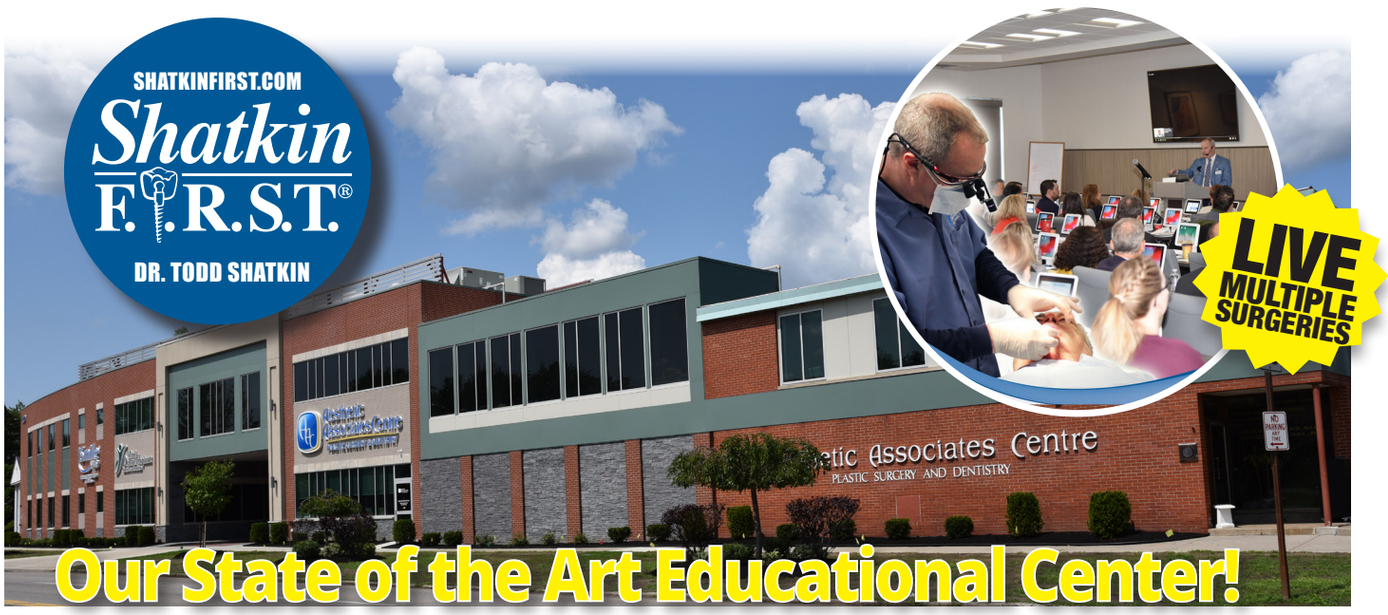
ZANTEX
Metal Free Suprastructure

Zirconia Roundhouse Model 10-12 Mini Implants

*Lower Denture Model *Upper & Crown & Bridge Models also Available*

Fixed on Six Zirconia Model 6-12 Mini Implants

Hybrid Denture Model 6-10 Mini Implants



TODD E. SHATKIN, DDS

The Mini Dental Implant Techniques taught in our courses can be easily mastered and are quite rewarding to the patient and the dentist. Many previous course attendees have enjoyed a renewed enthusiasm for dentistry, improved patient lives and have significantly built their practice earnings

JOE GILLESPIE, DDS

2022 TRAINING COURSE SCHEDULE

EARN UP to 18 CE CREDITS

Buffalo, NY..... **FEBRUARY 4 & 5**
Buffalo, NY..... (ADVANCED) **MARCH 10 & 11 & 12**
Buffalo, NY..... **APRIL 7 & 8**
Buffalo, NY..... **MAY 12 & 13**
Buffalo, NY..... (ADVANCED) **JUNE 9, 10 & 11**
Orlando, FL DISNEY..... **AUGUST 5 & 6**
Buffalo, NY..... **SEPTEMBER 16 & 17**
Buffalo, NY..... **OCTOBER 28 & 29**
Buffalo, NY..... (ADVANCED) **NOVEMBER 17, 18 & 19**
Orlando, FL..... (L-PRF ONE DAY COURSE) **DECEMBER 3**

ADD ON to our TWO DAY TRAINING COURSES
EARN UP to 9 CE CREDITS

Buffalo, NY..... **March 12**
Buffalo, NY..... **June 11**
Buffalo, NY..... **November 19**

ADD ON - Problem Solving with Matt Lasorsa, DMD

Dr. Matt Lasorsa

2022 MEETING SCHEDULE

BOSTON, MA..... January 27-29
Yankee Show

Chicago Mid Winter ..... February 24-26

ORLANDO, FL ..... June 27-26
Florida Dental Association - FDC

SALT LAKE CITY, UT ..... March 31-April 1
Utah Dental Association - UDA
"LIVE SURGERY"

HOUSTON, TX ..... October 13-17
American Dental Society

Course Prices:

Two Day Course Dentists $995/Staff $495
DISNEY Orlando, FL Dentists $1,295 / Staff $695

FDA CLEARED for implants & prosthetics

The American Academy of Hospitality Sciences Star Diamond Award

PACE ACADEMY OF GENERAL DENTISTRY PROGRAM APPROVAL FOR CONTINUING EDUCATION

Introducing the New

MONO DENTAL IMPLANT

Starter Special

$1,590

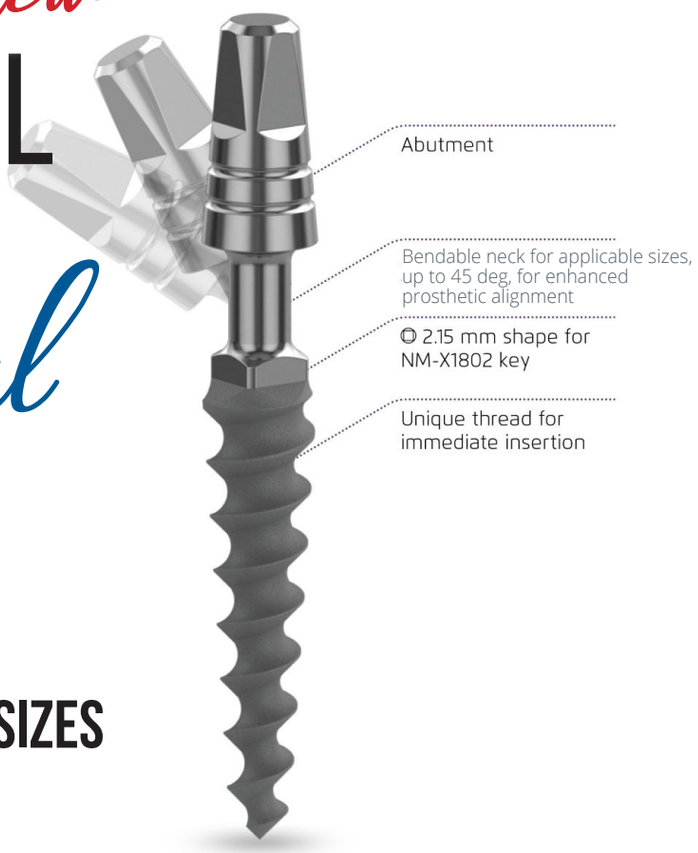


Illustration of Bendable Implant

10 MONO IMPLANTS - AVAILABLE SIZES

3.0 - 10, 11, 13, 16 MM LENGTH
3.3 - 10, 11, 13, 16 MM LENGTH
3.7 - 8, 10, 11, 13, 16 MM LENGTH
4.2 - 8, 10, 11, 13, 16 MM LENGTH
5.0 - 8, 10, 11 MM LENGTH

& RECEIVE
OVER $500 FREE INSTRUMENTATION

1 - DRILL EXTENDER
1 - D32
1 - MONO FINGER HEX DRIVER
1 - MONO RATCHET DRIVER
1 - MONO CONTRA ANGLE DRIVER
1 - MONO HEX RATCHET WRENCH
1 - D2515, 1 - D2015 & 1 - D1515
1 - MONO SURGICAL KIT

* MONO HEALING CAPS, IMPRESSION COPINGS & ANALOGS AVAILABLE

CASE STUDY
CHANGE OF PLANS!
RANDALL STAPLES, DDS

JACKSON, TN
Mini Dental Implant Centers of America

Clayton, a 38 year old male, presented to our office for his consultation requesting "could we please use mini dental implants to give me back my smile and my ability to chew again and not hurt!"

He confessed that his mouth was a "wreck" as a result of years and years of neglect based on a genuine fear and phobia of dentists. Clayton only sat in a dental chair when his pain forced him to.

After watching my infomercial week after week for over 6 months he mastered up the courage to call our office to begin his quest for a new smile before pain attacked once again.

After a clinical exam, review of his medical history, and referencing a CBCT we discussed his options for treatment. His choice was to restore his dentition with maxillary and mandibular implant retained dentures. Taking into consideration his reluctance to involve both arches at once, we suggested then opted to restore the lower arch first before beginning the upper.

Referencing the illustrations and Xrays will demonstrate the sequence of treatment.

Interestingly enough, Clayton became an extremely calm and cooperative patient. After just a few visits, the soothing nature of my staff helped him to overcome his dental phobia and to realize that our intentions were to make sure he experienced minimal discomfort.

You will notice in the illustrations that just before delivering his final lower denture, Clayton decided that he wanted to upgrade his treatment to upper and lower cemented roundhouses bridges

He asked if he was a candidate? You can see for yourself my answer to that question!

PRODUCTS USED IN THE PROCEDURES:

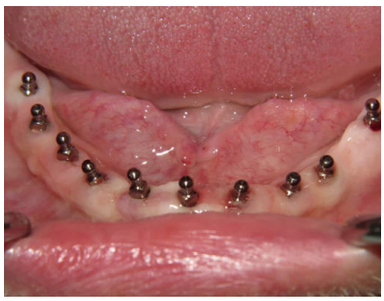
1. **Intra-Lock MDL mini implants of various diameters & lengths**
2. **Aseptico 7000 Surgical Handpiece**
3. **Disposable 1.2 mm pilot drills, Contra angle drivers, torque wrench.**
4. **Shatkin F.I.R.S.T.® plastic healing caps**
5. **Shatkin F.I.R.S.T.® Pink Implant Attachment & Reline Material**
6. **Shatkin F.I.R.S.T.® Self Cure Crown & Bridge Resin Cement**
7. **Shatkin F.I.R.S.T.® O-Ring Housings**
8. **Shatkin F.I.R.S.T.® Genoray Papaya 3D CBCT Imaging System**
9. **Shatkin F.I.R.S.T.® Porcelain Fused Zirconia Roundhouse Bridges**

INITIAL PANORAL X-RAY

4 MONTH POST OP
EXTRACTIONS BOTH ARCHES

4 MONTHS POST OP CENTRIC
OCCLUSION BITE

POST OP MANDIBULAR EXTRACTIONS,
IMPLANT PLACEMENTS,
SEAT PROVISIONAL DENTURE



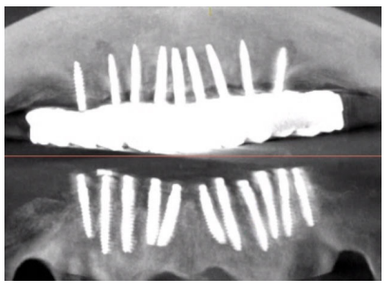
CHANGE IN TREATMENT PLAN...
UPGRADED TO MAXILLARY &
MANDIBULAR CEMENTED ROUNDHOUSES...
PLACEMENT ADDITIONAL IMPLANTS

CBCT LOWER IMPLANTS

SEATED LOWER ROUNDHOUSE

EXTRACTIONS MAXILLARY TEETH,
IMMEDIATE PLACEMENT IMPLANTS

SEATED PROVISIONAL MAXILLARY ROUND-
HOUSE RESIN BRIDGE



CBCT MAXILLARY & MANDIBULAR IMPLANTS

MAXILLARY CEMENTED ROUNDHOUSE

FINISHED CASE

CASE STUDY
REPLACING CONGENITALLY MISSING LATERALS WITH MINI DENTAL IMPLANTS

MATTHEW J LASORSA, DMD, PA, DIAMDI

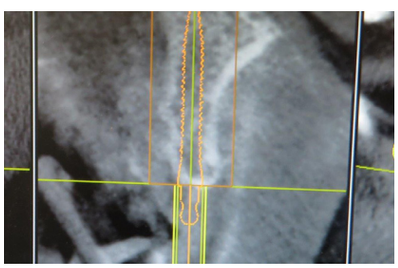
CITRUS HILLS, FL
Mini Dental Implant Centers of America

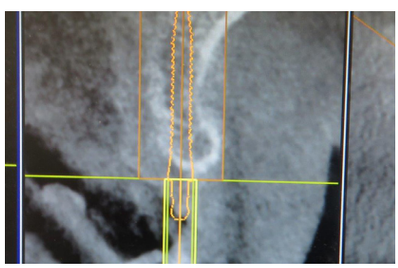
SLIDE 1 & 2

This patient presented for congenitally missing teeth #s 7 and 10.

SLIDE 3 & 4

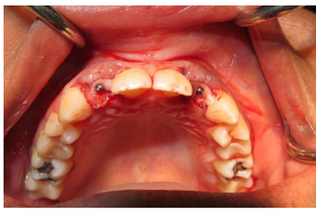
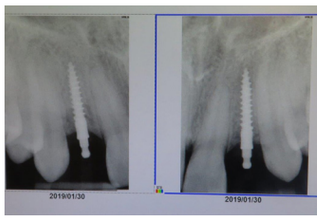
As you can see on the treatment planning software, the areas of bone in the #7,10 are atrophied and our choices of implants are limited. Even with mini dental implants care has to be taken that the implants are well within bone and that there's no fracture of the buccal plate on placement. Fractures of the buccal plate can lead to peri-implantitis, dehiscence and failure. The other concern is that the trajectory of a one piece implant can be placed in bone while still maintaining the correct angle and have enough occlusal clearance for restorability.

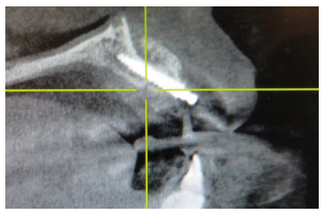
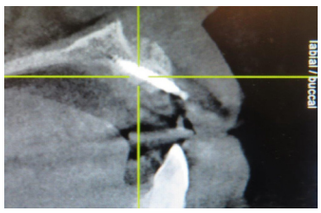




SLIDES 5, 6, 7, 8, 9

It was decided to treat these edentulous spaces with ball and square Intra-Lock 2.5x15 mini dental implants. A small incision was made at each site to rotate more keratinized tissue towards the facial. This also allowed some soft tissue release on the facial aspect to bulk up the area with a combination of freeze dried bone and L-PRF. Both implants were placed with a torque value of 35NCM. PRF membranes were placed over the heads of the implants and covered the incisions. Temporaries were created with healing caps and composite. These temporaries were contoured to train the tissue to recreate dental papillae.

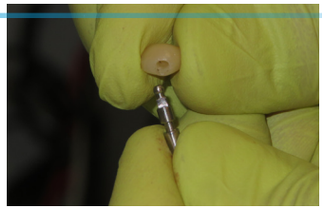
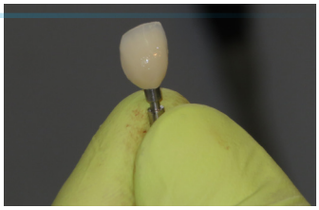




SLIDES 10, 11, 12, 13

After 3 months the implants are well integrated, the facial bone grafting is mature, and the soft tissue has recontoured around the temporaries. A direct impression was taken of the implants and precision fit crowns were created out of emax. When seating precision fit crowns care must be taken to extrude excess cement on an analog before seating them in the mouth.



SLIDES 14, 15, 16

Post op xrays and photos were taken to confirm the seating and the aesthetics for a very happy patient.



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

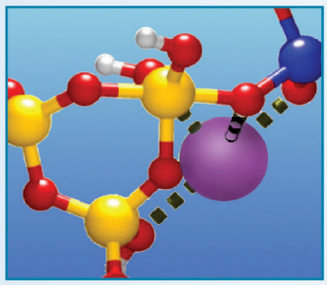
Numerous scientific papers have been published on OSSEAN®. They report the remarkable performance of this surface compared to others, particularly immediately after implant placement and during the initial phase of healing. The very nature of the healing chain has been reported to be changed and shortened*.

Compressing the Healing Process

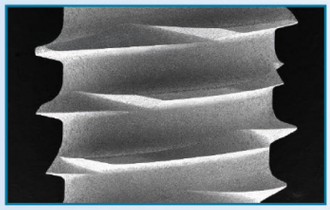
The most critical phase of implant treatment occurs from the moment an implant is surgically placed, through the first weeks of initial healing. It is in this period when most complications and/or adverse effects occur. This juncture also sets the stage for ongoing and long-term future implant success.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

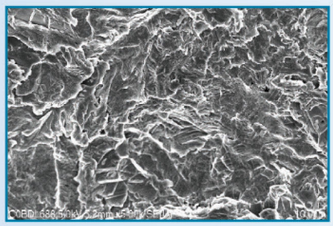


Calcium Phosphate in Molecular Fusion

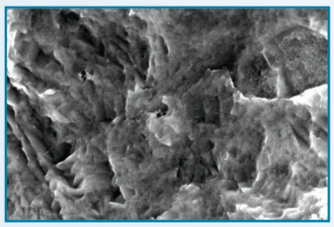


Robotic Micro-Blasting Preserves Cutting Edge Geometry

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 Calendar!

2021 L-PRF COURSE

December 3rd

in Orlando, Florida

REGISTER @ www.ShatkinFIRST.com

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.

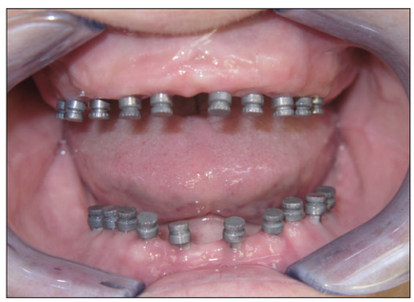


Figure 3. Housings in place prior to pickup in fixed restoration.

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

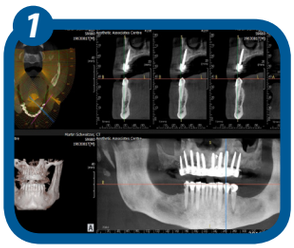
When I learn from new patients how unhappy they are with their loose dentures, I offer a very viable solution called FIX*on*SIX. This is a fixed detachable mini dental implant zirconia bridge that allows these patients to throw their dentures away and be delighted that they no longer have to agonize 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 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!

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

Shatkin F.I.R.S.T.®
Fix on Six® Procedural Guide



1 Edentulous impression in office and CBCT stent to lab dual/scan

2 Lab sends to the Doctor the CT stent, implants, drills & custom tray bite rim

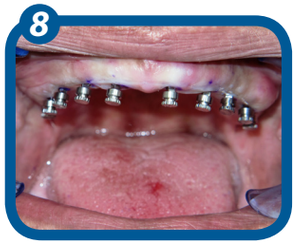
3 Doctor places implants then takes impression in bite rim and sends to lab

4 Doctor grinds out existing denture and places PVS impression material as temporary liner to implants.

5 Lab makes PMMA try-in and sends back to office.

6 Office inserts try-in to check: occlusion, midline, canting, shape, and design of teeth. Dentist may modify try-in at this time.

7 Once try-in is accepted, the office sents to lab for final bridge to be fabricated.



8 Place final restoration over housing and pick-up housing using Shatkin F.I.R.S.T.® resin cement.

*Dr. Shatkin recommends taking a Shatkin F.I.R.S.T.® Mini-Dental Implant training course before performing these procedures.

ENROLL & SUBMIT

Academy Membership Enrollment

- **Log on to www.iamdi.org**

  You can find the online enrollment from under the dentist page, just click on the membership page to find the online application form.

Journal Submittals

- **Mark Ahrens**
  Director of Marketing
  Send to mahrens@shatkinfirst.com
  1-888-4-SHATKIN

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Dedicated to Advancing Excellence in the Science & Art of Mini Implant Prosthetics Around the World!

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