# 2025 IAMDI.ORG

# International Academy of Mini Dental Implants



## AUGUST 1 AND 2, 2025
## ORLANDO, FL

### CASE STUDIES
RONALD PETROSKY, DDS
RANDY STAPLES, DDS
QUINCY THOMPSON, DDS

### 2025 LECTURERS
TODD E. SHATKIN, DDS
THOMAS BAGGETT, DDS
JAMES THARP, DDS

### KEYNOTE SPEAKER
ROBERT J. MILLER, DDS

### INTERNATIONAL SPEAKER
MARIO ERNESTO LEON ZAMUDIO, DDS

# Founding Member Letter to the Membership

## International Academy of Mini Dental Implants (IAMDI)

## Todd E. Shatkin DDS

***Dear Colleagues and Members,***

Over 20 years ago, my father, Samuel Shatkin Sr., DDS, MD and I were one of four founding fathers of the International Academy of Mini Dental Implants. It is with great pride and enthusiasm that I address you at this pivotal moment in the evolution of implant dentistry.

First and foremost, I would like to extend our deepest gratitude to **Dr. Diana Rodriguez** for her outstanding leadership during her tenure as President over the past two years. Her vision, dedication, and tireless efforts have helped guide our Academy through a period of growth, innovation, and increasing clinical acceptance. Her contributions will have a lasting impact on both our organization and the greater dental community.

We are now witnessing what many of us have long believed: the **Mini/Mono One-Piece Dental Implant**—especially the **Shatkin One-Piece Implant**—is rapidly gaining traction as the new standard of care in dental implantology. Its minimally invasive nature, cost-effectiveness, and remarkable clinical success rates have made it a transformative solution for patients and providers alike.

During a recent Shatkin F.I.R.S.T. Advanced Course, world-renowned dental educator **Dr. Gordon Christensen** remarked that the One-Piece Dental Implant is outperforming the traditional two-piece systems, particularly in its resilience against peri-implantitis. This validation from one of our profession's most respected voices further cements what many of us have seen in our own practices.

As we look to the future, we are committed to furthering education, research, and global awareness surrounding Mini/Mono Implantology. The momentum is undeniable, and I am excited to communicate with the next generation of implant dentists, including my son Dr. Jared Shatkin. I hope to keep working along with our other young colleagues to carry this innovation forward with integrity, evidence, and patient-centered care.

Thank you for your continued support, commitment, and belief in our mission. Together, we are shaping the future of implant dentistry.

***With respect and appreciation,***

**Todd E. Shatkin DDS**
*Founding Member & Treasurer*
International Academy of Mini Dental Implants

# From the Desk of
# Thomas Baggett, DDS
# President & Diplomate

***Dear Colleagues and Friends,***

It is with great honor and heartfelt gratitude that I step into the role of President of the International Academy of Mini Dental Implants (IAMDI). I want to first extend my deepest appreciation to Dr. Diana Rodriguez for her outstanding leadership during her term. Her vision and commitment have strengthened our academy and have positioned us for continued growth and innovation.

As we look ahead, I am excited to help lead IAMDI into its next chapter — one rooted in clinical excellence, education, and global collaboration. Mini dental implants are no longer an alternative option; they are rapidly becoming the standard of care. With advancements in techniques, materials, and long-term outcomes, we are witnessing a transformation in the way we restore smiles and change lives.

My goals as president are simple yet ambitious:

- *To expand access to high-quality training for dentists worldwide*
- *To strengthen our research and case documentation efforts*
- *To elevate public awareness and acceptance of mini dental implants as a safe, minimally invasive, and cost-effective solution*

Together, we will continue to raise the standard for what is possible in implant dentistry. I encourage each of you to stay engaged, share your experiences, and support one another in our mission to serve patients with compassion, integrity, and innovation.

Thank you for your trust and continued support. I look forward to what we will accomplish—together.

*Warm regards,*
**Thomas Baggett, DDS**
President, International Academy of Mini Dental Implants

# Outgoing President's Letter

## Diana Rodriguez, DMD

***Dear Esteemed Members,***

As I conclude my two-year term as President of the International Academy of Mini Dental Implants, I want to express my deepest gratitude for the honor and privilege of serving this incredible community.

Together, we've navigated a time of growth, innovation, and global collaboration in the field of mini dental implants. It has been inspiring to witness the passion and professionalism each of you brings to advancing minimally invasive care for patients around the world. From our scientific sessions and hands-on training programs to the exchange of ideas through our global network, the IAMDI continues to set the standard for excellence in implant dentistry.

To our Advanced Members, thank you for your commitment to continued education and leadership within the Academy. Your dedication not only strengthens our organization but also elevates the reputation and reach of mini dental implants worldwide.

As I step down, I do so with full confidence in our incoming leadership and the exciting future that lies ahead. The Academy is in excellent hands, and I look forward to continuing my support as a lifelong member and colleague.

Thank you again for your trust, support, and friendship. It has been an extraordinary journey, and I am proud of all we have accomplished together.

***With appreciation and respect,***

**Diana Rodriguez, DMD**
*Outgoing President*
International Academy of Mini Dental Implants (IAMDI)

# KEYNOTE SPEAKER

## ROBERT J. MILLER, DDS

When you love what you do, as does Robert J. Miller, MA, DDS, FACD, DABOI, there is no such thing as work or retirement. “I am very fortunate that my dedication to this area of medicine has been acknowledged by other doctors, researchers and professional organizations, ” says Dr. Miller. Dr. Miller is Chairman of the Department of Oral Implantology at Palm Beach State College research division, where each year dentists are taught current technology and techniques. He graduated from NYU College of Dentistry and completed his hospital residency at Flushing Hospital Medical Center. He holds a B.S. in Biology and an MA in Biology with a Thesis in Endocrinology. He has served as president of the South Palm Beach County and Atlantic Coast District Dental Associations. His work has been recognized by his colleagues and Dr. Miller has been invited to lecture by The American Academy of Implant Dentistry, The Academy of Osseointegration and other organizations throughout the United States, Europe and the Middle East. “I love speaking as much as I do practicing dentistry,” he says. “Lecturing lets me share my discoveries and also learn from colleagues about new technological procedures for patients’ betterment, comfort and success. For his patients’ benefit, Dr. Miller offers Implant Surgery and Implant Reconstruction, General and Cosmetic dentistry and revision for failed implant cases as well as a variety of corrective cases. To provide multiple services successfully, Dr. Miller works with the most cutting-edge technology using 3D digital scanning, digital X-rays, surgical microscopes, five different lasers and growth factor technology. He takes advantage of the best dental products for bone growth, platelet therapy, periodontal disease and implant surgery for long-term success. Dr. Miller’s experience enables him to handle multiple types of cases to “get patients back into function and good health.” This includes working with patients who’ve been told there is no hope. “Many complicated cases have been referred to my office,” he shares. In addition, Dr. Miller has created techniques to save failing implants. “We’re developing new procedures, not just doing them.” His practice participates in clinical trials and publishes their findings in journals. Dr. Miller’s goal is to provide the highest level of care to his patients by including them in their oral health treatment plan decisions. He then designs a treatment plan to meet their dental objectives. “The doctor’s role is to create a plan with the best chance for success,” he says.

# INTERNATIONAL SPEAKER

## DR. MARIO ERNESTO LEÓN ZAMUDIO

Dr. Mario Ernesto León Zamudio earned his degree from the prestigious National Autonomous University of Mexico (UNAM) in 1972, with advanced training in occlusion. In addition to being a dentist, he is also a dental laboratory technician, giving him a comprehensive understanding of both the clinical and technical aspects of dentistry.

With over five decades of experience in the dental field, Dr. León has placed and restored more than 15,000 implants over the past 35 years, including performing all related laboratory procedures. He is widely regarded as a pioneer of implant dentistry in Latin America.

Dr. León maintains a private practice and serves as a consultant for several international companies, contributing to the development and refinement of implant-related products and techniques. He is a member of the American Dental Association (ADA), the Asociación Dental Mexicana, the Academy of Osseointegration, and the International Congress of Oral Implantologists (ICOI). His expertise has made him a respected thought leader and international lecturer in implant dentistry.

He has also played a key role in establishing various implantology training programs across Mexico and is dedicated to inspiring and educating future generations of dental professionals.

# PARK CITY, UTAH 2024



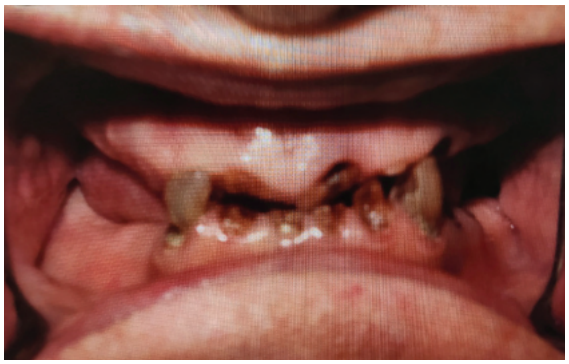
# CASE STUDY

## OVERCOMING MANDIBULAR TORI USING FULL ARCH ROUNDHOUSE BRIDGE IN FULL MOUTH REHABILITATION

QUINCY THOMPSON, DMD

Dr. Quincy Thompson grew up in the rainy northwest of Washington State. He earned his Bachelor's in Exercise Science from Brigham Young University-Idaho. He attended Roseman University of Health Sciences and earned his Doctor of Medicine in Dentistry.

He is a member of the American Dental Association, Tennessee Dental Association, 7th District Dental Association, the Academy of General Dentistry and the International Academy of Sleep. Dr. Thompson loves traveling and spending time with his wife and two daughters. He enjoys volunteering in the community and abroad. He had the opportunity to visit Ecuador during a dental mission trip, and looks forward to many more mission trips. He also had the privilege of serving as a Scoutmaster for a Boy Scout troop for 4 years.



### Introduction

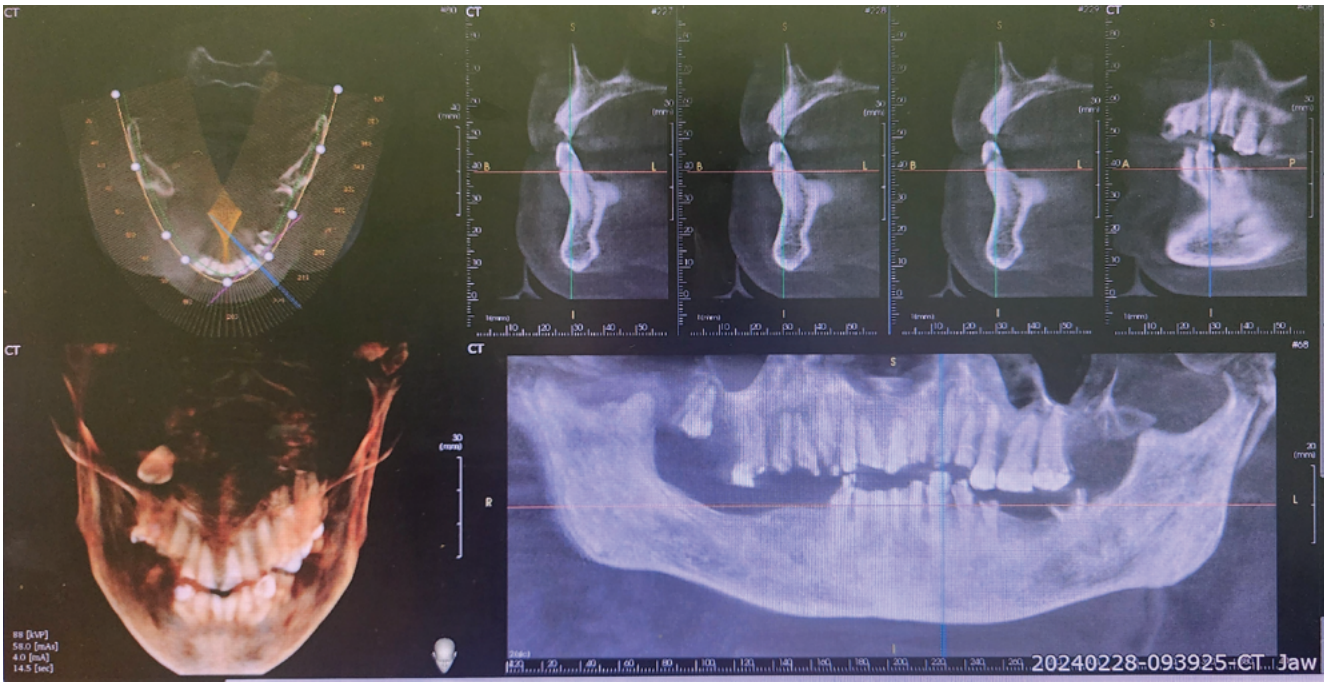
69 yr old Female presents to office with broken teeth and pain on max posterior teeth.

**CC:** Wants to be able to eat and smile again

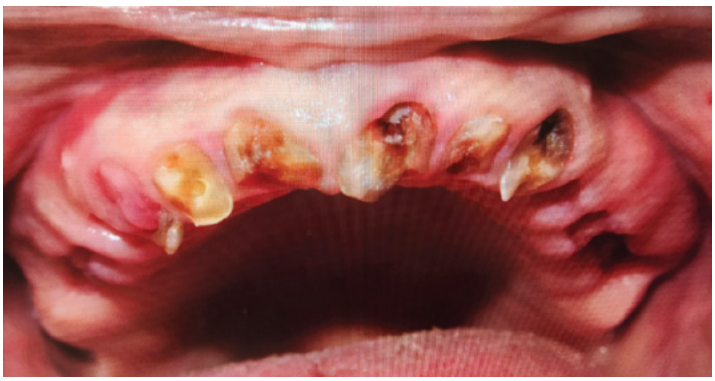
**Med Hx:** former smoker (quit 2 yrs ago), Type II diabetes, high blood pressure, high cholesterol, COPD, kidney disorder, depression

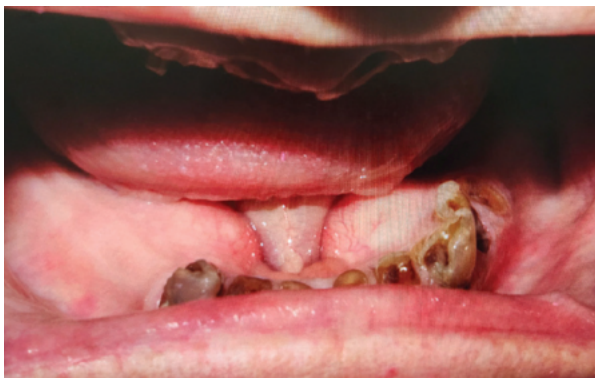
**Med list:** pantoprazole, zolpidem tartrate, celexa, Ozempic, amitriptyline, allopurinol, amlodipine, irbesartan, metroprolol, buspirone

Pre-op CBCT




Photos after ext of max posterior





**Treatment Plan:**

**Phase 1:**

1. Impressions for wax rims
2. Wax rims to make immediate temp max denture and mand roundhouse bridge
3. Ext max posterior teeth with socket grafting (Osteogen)
4. Ext mand teeth with socket grafting (Osteogen) and immediate implant placement for temp roundhouse bridge
5. Ext max anterior teeth with socket grafting (Osteogen) and temp max denture
6. Heal 3 months

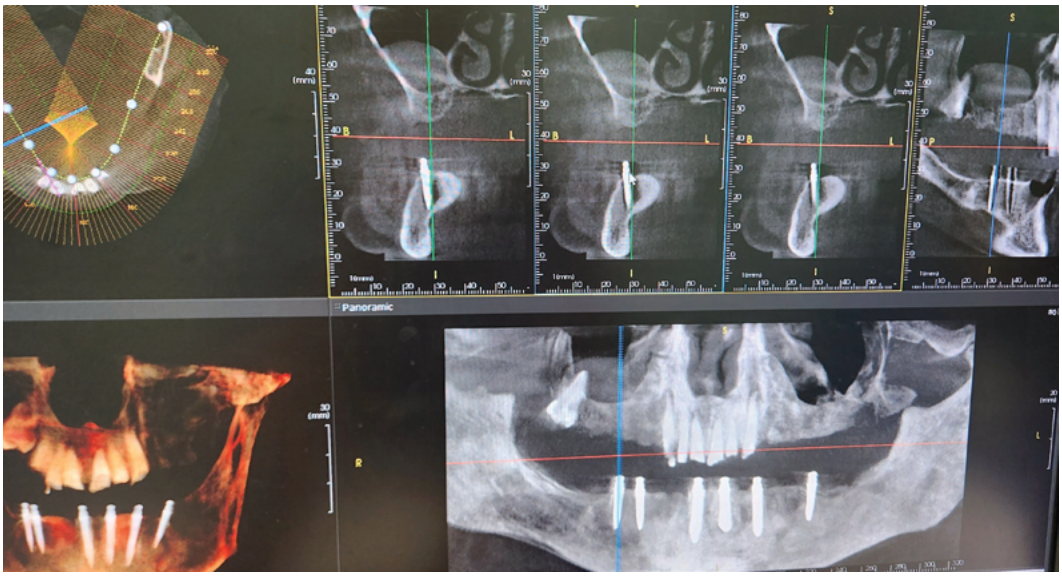
**Phase 2:**

1. Place additional implants on mand
2. Place implants on max
3. Heal 1 month
4. Impressions for new wax rims
5. Wax rims
6. Wax try in for final max overdenture and mand zirconia roundhouse bridge
7. Delivery of final restorations

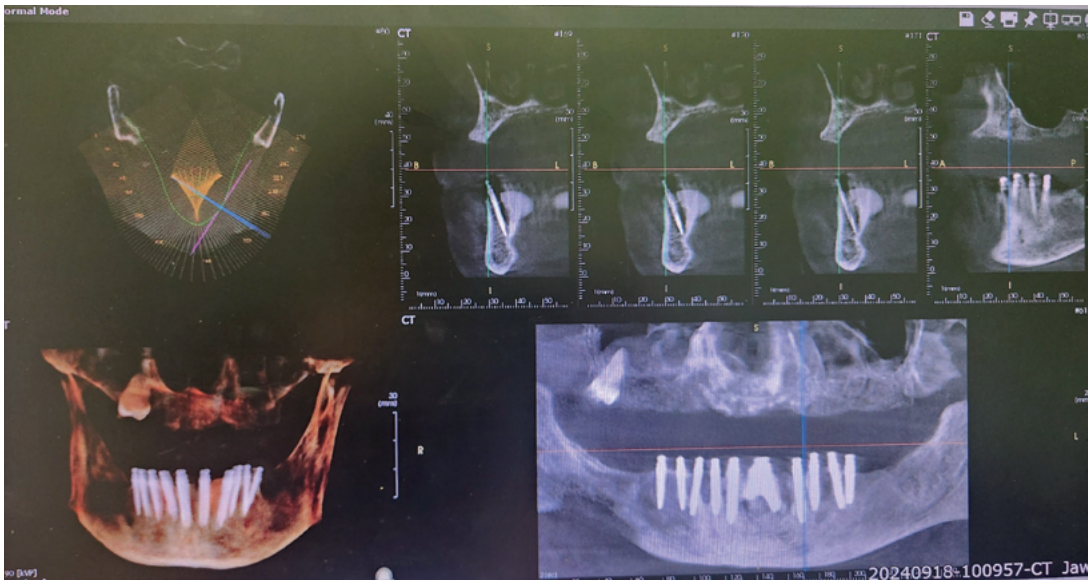
**Follow plan:**

6 month follow-up and o-ring change if needed, then 6-12 month follow ups as needed to change o-rings

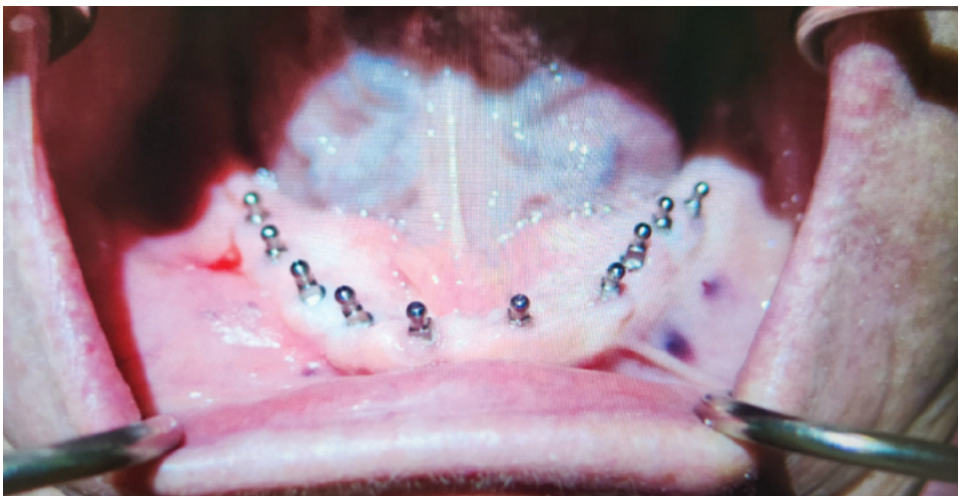
CBCT after Ext of mand teeth with immediate implant placement - 3 2.0x13 minis and 3 2.0x18 minis



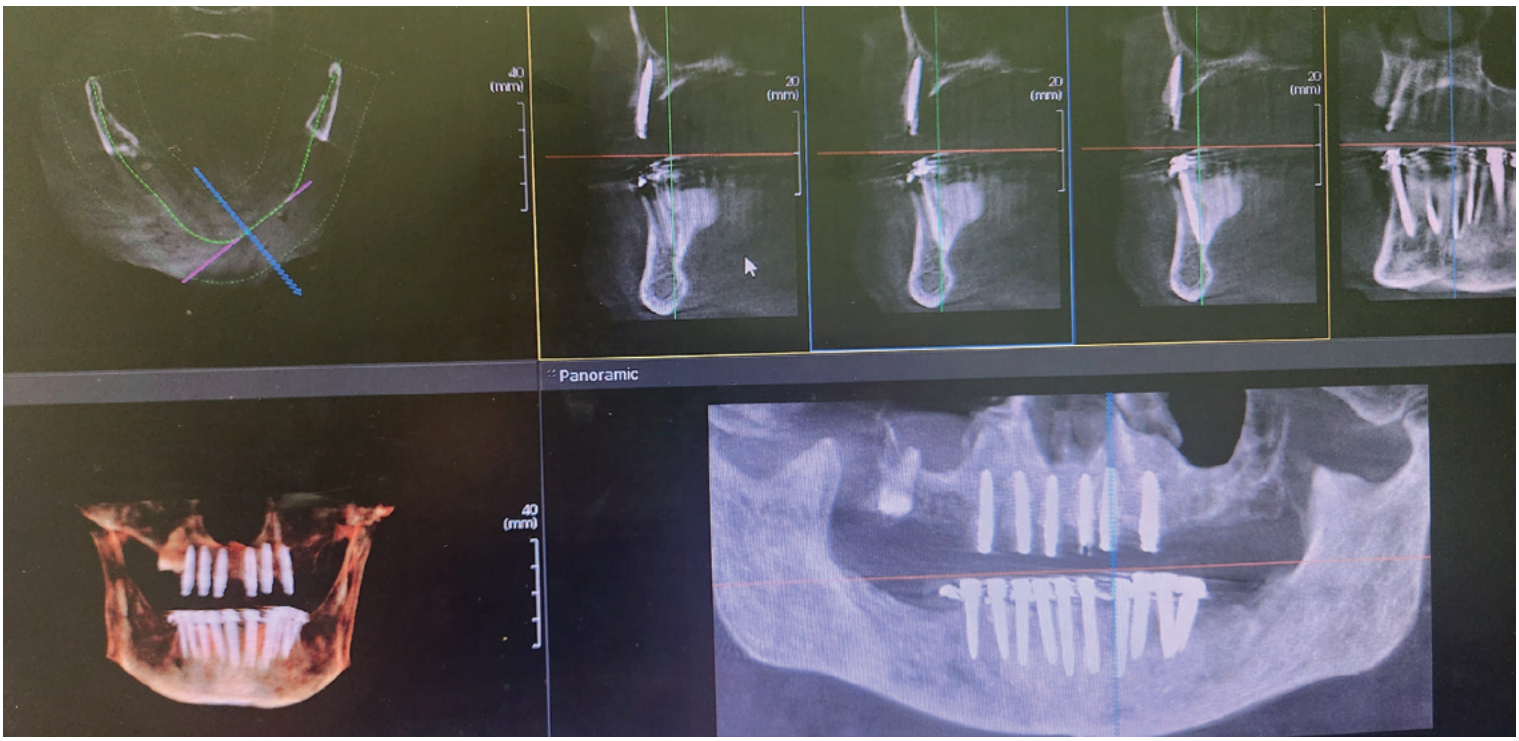

CBCT after additional placement of 4 2.0x15 minis



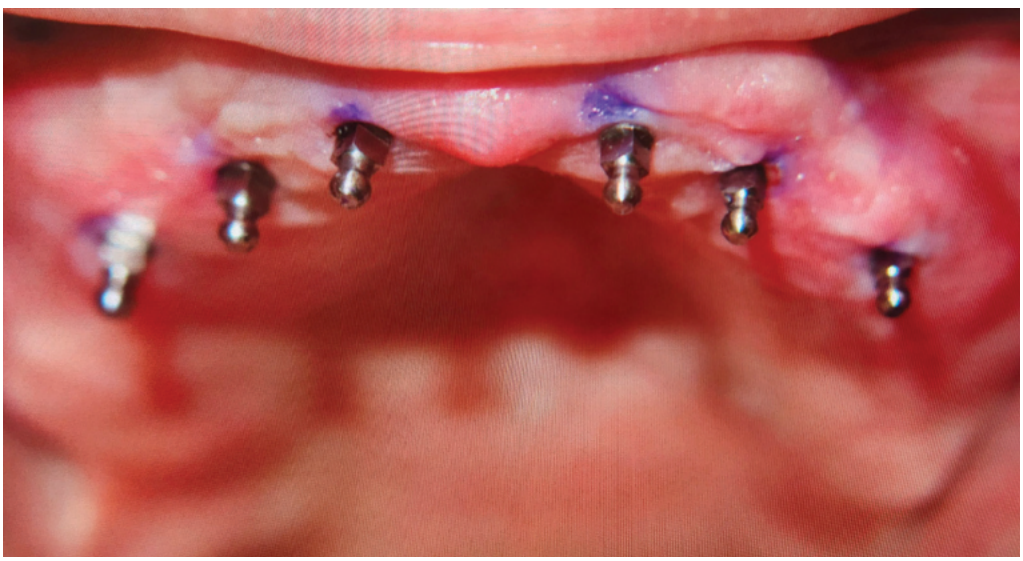
IO photo after additional placement of 4 2.0x15 minis



CBCT after placement of max implants - 6 2.0x15 minis




IO photo after additional placement of 4 2.0x15 minis

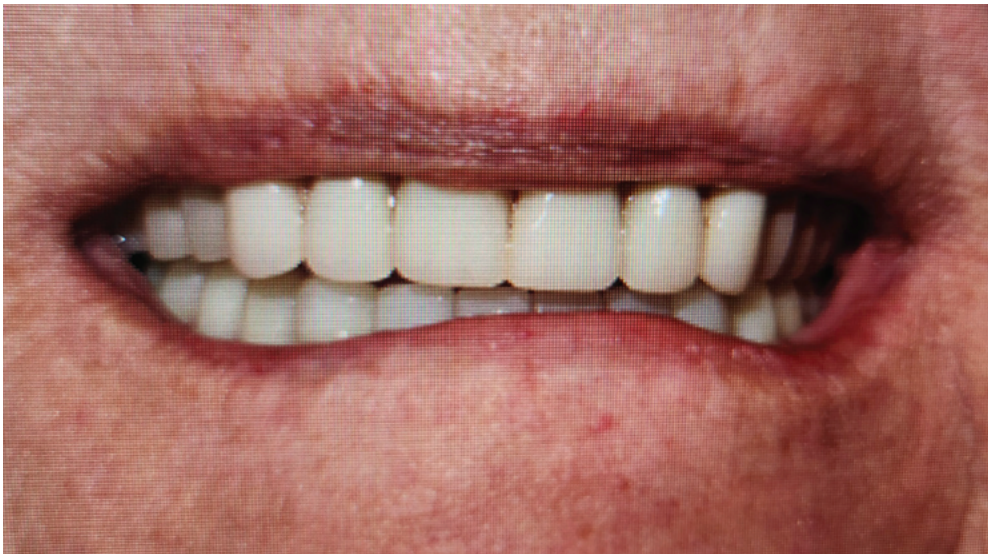


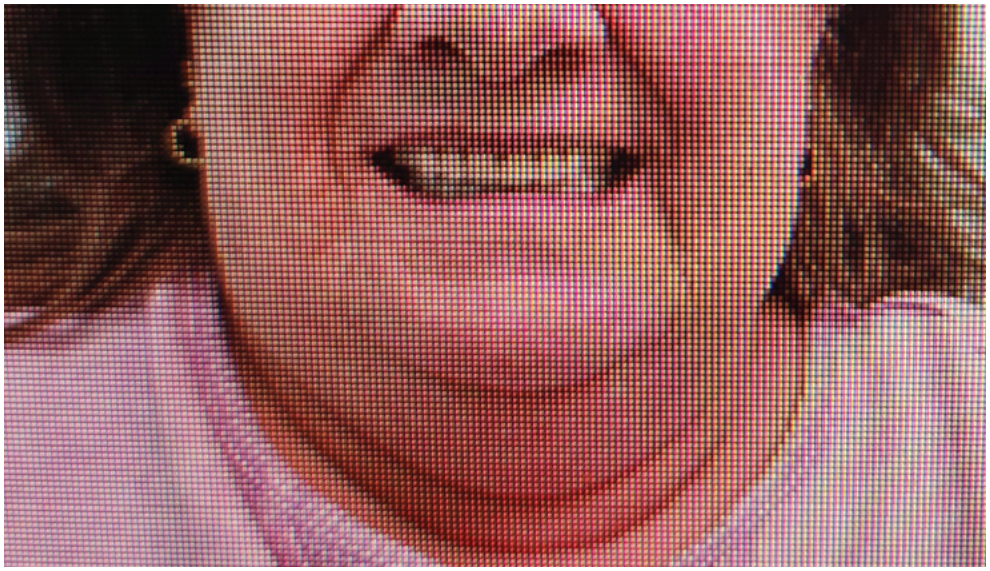
**Complications & Challenges**
Limited VDO, made it difficult to make max overdenture with enough thickness for housings but thin enough for pt tolerance. Pt did not want to have mand tori removed, thus requiring a lower roundhouse option. This proved to help with the limited VDO and doing a max roundhouse bridge would have been easier if pt finances would have permitted.

**Pt Thoughts & Conclusion**
Pt was very grateful and excited that she could go out with family and friends and enjoy smiling and eating again. She loves telling her friends about the procedure and how it changed her life.

It was a very successful case with 100% implant integration healing despite the complicated medical history of the pt. Mini dental implants where the best choice for this case. It enabled the pt to afford treatment, allowed treatment to be done quickly, and allowed treatment to be completed faster than possible verses using root form implants

Photos of final max overdenture and mand roundhouse zirconia bridge





# CASE STUDY

## YOU CAN AFFORD TO SMILE AGAIN

RANDALL STAPLES, DDS

Just before lunch I walked into an exam room, sat down and said to this young man " Hello, I'm Dr. Staples. What can I do for you?" He quickly fired back, " I came here today to see if I can afford to smile again!"

He explained that he had fractured his two front teeth off to the gum line eight years earlier at work. He had been wearing a flipper to replace his missing teeth. After years of dealing with several removable appliances he wanted something that looked, felt and functioned more like natural teeth.

After visiting a periodontist's office earlier that week, a treatment plan was presented to him requiring buccal plate and ridge bone grafts, two conventional root form implants, abutments and crowns and at least three full thickness flap surgeries with an estimated minimum treatment time of one year ( if the bone grafting was successful) and cost in excess of $9000. (The abutments and crowns would have to be placed by another dentist because the periodontist did not do crown and bridge.

After dinner that night after the implant consult, he and his wife sat down to look at their budget and plan a way for him to have these dental procedures.
He told his wife " I want to see if we can figure out a way so I can afford to smile again!"

She said " That's interesting that you just said that. I saw a billboard in town today that said that very phrase. 'YOU CAN AFFORD TO SMILE AGAIN! See Dr Randy Staples at the Mini Dental Implant Centers of America in Jackson.' Go see him before you make a decision."

Then he looked me in the eye and said " Well, here I am. What can you do for me?'

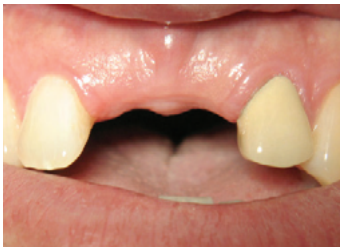
After a quick oral exam and review of his medical history we took a panoramic X-ray. I examined the film then turned to him, placed a model in his hands of what I had in store for him and gave him my treatment plan.

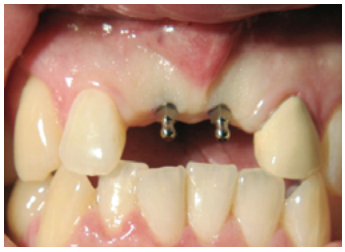
Two mini implant retained crowns at a cost of less $4000 with cash. Two appointments, no surgical flaps, no bone grafts, and a possible two to three week finish date.

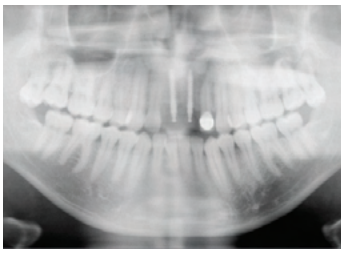
He actually reached into his back pocket and took out his checkbook while asking if we could start right now? You can guess what my response was! After taking his check we started!

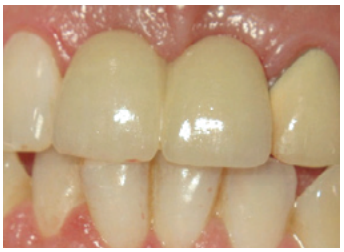
It was the lunch hour and I had some time so in less than twenty minutes we placed two mini implants and took impressions for his crowns. I made a modification to his flipper and sent him on his way.

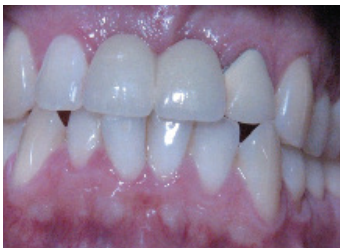
Two weeks later we seated his two unit bridge from FIRST Lab and he was one happy camper!











**PRODUCTS USED IN PROCEDURES**

1. **2.0 x 15mm Intra-Lock MDL® mini dental implant (2)**
2. **Aseptico 7000 Surgical Handpiece**
3. **Disposable pilot drill 1.2mm diameter**
4. **Contra angle driver**
5. **Shatkin F.I.R.S.T.® Self-Cure resin cement**

# Shatkin F.I.R.S.T.®

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# CASE STUDY

## THE STAGED APPROACH VS. SAME DAY ALL ON 4(X) FOR FULL ARCH IMPLANT RESTORATION

RONALD P. PETROSKY, DDS, MAGD, DICOI, IAMDI DIPLOMATE

***"You LEARN the most from things you ENJOY DOING so much, that you don't even notice time passing. I am often so engrossed in my work that I forget to eat lunch."***

-Albert Einstein's

Wise advice to his son Albert on November 4, 1915. Einstein passed away on April 18,1955, aged 76.

So true Uncle Albert, it's like... 'time flies when your having fun' (wish it was the other way around)...it's like the old adage that says...'love what you do & do what you love!'...and we certainly love placing Mini and Mono implants! Amen to that.

With that said, I have to say personally, after placing literally thousands of the One Piece Mini & Mono Implants with that tapered, aggressive thread, One Piece design...that they have been a real 'Dream Come True'...a definite 'Game Changer' as compared to years gone by. We have been truly blessed and really love what we do!

'Gotta love how OPIs are much less invasive, less cost, less time, less parts and pieces, less healing, less grafting, and therefore, a far more simplified implant surgical and prosthetic protocol for doctor and patient than any 2-piece system can offer. I find this especially true when doing full arch roundhouse restorations on One Piece Implants.

Mono and Monobendable One Piece implants are so versatile and practical, especially for the GP, in that they that they can be used to treat single, multiple, and full arch restorations. They are so routine that we could place them 'at a moments notice' so to speak!

Placing and restoring Mono implants can easily be a routine and everyday procedure and protocol readily educated, learned, and implemented at:

- ShatkinFIRST in Buffalo, NY - a 20+ year leader in One Piece Implants
- Dr. Gordon Christensen, Provo, Utah
- The Resnik implant Institute , Orlando,Florida

Not a big learning curve, but most definitely very specific Do's &'Don'ts!!! You really should attend multiple implant meetings over the years to advance and update your knowledge and skills as everything is constantly changing. Learning is a never ending process, life long process.

Even Albert Einstein once said...

***"Once you stop learning...you start dying"***

Learn from the experience from those who have 'blazed the trail' and are successfully placing One Piece Implants.

The FDA 510(k) indications for use states: *"Noris Medical Dental Implants System is intended to replace missing tooth/teeth in either jaw for supporting prosthetic devices that may aid in restoration of the patient's chewing function. The procedure can be accomplished in a one-stage or two-stage surgical operation. All implants are appropriate for immediate loading when good primary stability is achieved and with appropriate occlusal loading."*

It's an absolute total joy to comfortably, relatively speaking, transition our patients out of their old, failing dentition and into a new found fixed cemented roundhouse prostheses that feels secure and functions like natural teeth...that some patients often say are better than what their natural teeth ever were! I tell my patients that it's like having your 'high school teeth' back all over again! It's LIFE CHANGER with their self confidence restored all over again. 'You can be you again!'... unlocking their true personality. Ain't nothing better, IMHO!

***In my experience...*** A FIXED cemented prostheses for most patients is so much more natural and comfortable with far fewer post operative adjustments than anything REMOVABLE. Studies do show that the implant prosthetic success rate and patient satisfaction is higher for FIXED than for removable! Ask yourself... 'What would you want in your own mouth?' No way would we want anything removable!

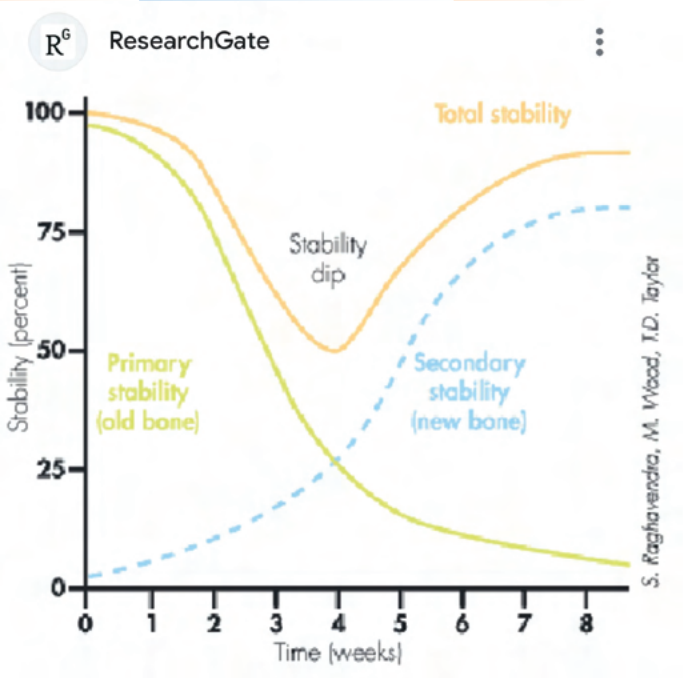
2023 Dentists' Preference toward Fixed Versus Removable Implant Prosthesis on Edentulous Jaws to Improve Quality of Life Sanjog Agarwal, et al. Journal of long-term effects of medical implants 33 (1), 2023

"Patients with implant supported FIXEDC dental prosthesis had a BETTER QUALITY of LIFE better compared with patients with implant supported overdentures."

2015 A systematic review and meta-analysis of removable and fixed implant-supported prostheses in edentulous jaws: post-loading implant loss Jaana-Sophia Kern X, Thomas Kern, Stefan Wolfart, Nicole Heussen Clinical Oral Implants Research / Volume 27, Issue 2/ p. 174-195, 2015

Corresponding implant loss rates per 100 implant years were SIGNIFICANTLY HIGHER in the MAXILLA (0.42 [95% CI 0.33; 0.53] vs. 0.22 [95% CI 0.17; 0.27]; P = 0.0001).

Implant loss rates for FIXED restorations were SIGNIFICANTLY LOWER compared to removable restorations (0.23 [95% CI 0.18; 0.29] vs. 0.35 (95% CI 0.28; 0.44); P = 0.0148). Four implants and a fixed restoration in the mandible resulted in significantly higher implant.





Open Access Article

**Factors Influencing Primary and Secondary Implant Stability—A Retrospective Cohort Study with 582 Implants in 272 Patients**

by Andreas Vollmer [1,†], Babak Saravi [2,*,†], Gernot Lang [2], Nicolai Adolphs [1], Derek Hazard [3], Verena Giers [1] and Peter Stoll [1]

*Appl. Sci.* **2020**, *10*(22), 8084; https://doi.org/10.3390/app10228084

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(This article belongs to the Special Issue New Trends in Implant-Prosthetic Therapy)

**Primary stability includes the mechanical attachment of an implant in the surrounding bone at the insertion, whereas secondary implant stability is the tissue response to the implant and subsequent bone remodeling processes.**

https://www.mdpi.com › ...

Factors Influencing Primary and Secondary Implant Stability—A Retrospective Cohort ...

Generally speaking, there are two (2) surgical/prosthetic approaches to choose from when replacing a failing dentition with full arch implant restorations, namely
- the 'All on 4(X)' same day approach or
- the gradual Staged Approach .

That choice between the two approaches is personal doctor preference & judgment... relative to the individual years of clinical skills,experience & training, as well as the patients physical,anatomical ,and psychological challenges, Essential...Choose what Best works for doctor and patient.

**Complications issues with the Maxillary Hybrid All on 4 involve:**

**BONE REDUCTION**
- All on 4 requires extreme bone reduction!
- 11-15 mm of bone removal per jaw(½ inch)
- 22-30 mm both jaws (1 inch)
- ANGLED IMPLANTS AND ABUTMENTS
- SOFT TISSUE ISSUES
- CLEANSIBILITY
- SPEECH ISSUES
- TOOTH BREAKAGE
- DENTURE BREAKAGE
- MULTIPLE PARTS & PIECES

There are numerous complaints about those placing the All on 4 on the web, validating all,the complications and dissatisfaction that can occur! So, I'm sticking with the fixed cemented Zirconium Roundhouse as a far more natural and simplified prosthesis.

When doing the gradual STAGED APPROACH for a full arch restoration, I will:
- save the strongest teeth for last,
- work on one quadrant per visit
- replacing the premolars & incisors initially
- prepping the canines and/ or molars as temporary abutments for a time while the implants fully integrate.

Patients are generally quite happy knowing they have something fixed... and not removable.

Then, after extracting the last natural teeth such as the canines and/ or molars...I'll then place a full arch PMMA provisional roundhouse restoration to establish aesthetics and occlusion as well as patient approval.

Patients do appreciate the staged approach as it typically is well tolerated and NOT overwhelming.

**Advantages of the Staged Approach to Full Arch Implant Restoration**

A staged approach to dental implant supported restorations involves breaking down the treatment into multiple phases, often separated by healing periods or appointments.

This contrasts with the same-day approach, common with All on 4(x) which aims complete the restoration in a single visit.

**Here are the key advantages of a Staged Approach:**

1. Enhanced Healing and Reduced Risk of Complications:
   - Allows for thorough infection control:When EXTRACTIONS are necessary, a staged approach allows time for any existing infections to resolve completely before implant placement. This minimizes the risk of peri-implantitis (infection around the implant), which can lead to implant failure.
   - Facilitates optimal healing and tissue development: Allowing extraction sites and surgical areas to heal naturally before further steps promotes better soft tissue and bone development, which is crucial for long-term implant stability and aesthetics. This can result in enhanced keratinized tissue development around implants, leading to a better seal, improved aesthetics, and easier hygiene maintenance.

2. Improved Aesthetic Outcomes:
   - Greater control over planning and customization: By allowing for healing and assessment between stages, dental professionals gain a better understanding of the underlying bone and soft tissue structure. This translates to more precise implant placement and better planning of the final prosthetic, leading to a more predictable and natural-looking aesthetic result.

- Opportunity for adjustments: The staged approach allows for adjustments to be made during the process, ensuring the final restoration meets the patient's aesthetic goals.

3. Patient Comfort and Flexibility:
   - Shorter, more manageable appointments: Separating procedures into multiple visits reduces the duration and intensity of each appointment, potentially minimizing anxiety and discomfort for the patient.
   - Allows for financial flexibility: Phasing treatment can make it more affordable for patients by breaking down the overall cost into smaller, mandageable increments. This can reduce the need for external financing and its associated costs.
   - Opportunity to reassess treatment goals: The healing period between stages provides an opportunity for patients to evaluate their initial results and make informed decisions about future treatment, including the potential to delay or forgo certain procedures.

4. Enhanced Treatment Planning and Control:
   - Systematic and methodical approach:A staged approach allows for a comprehensive evaluation and diagnosis of the patient's overall oral health, addressing biological and functional issues systematically.
   - Assessment of patient response: It provides the dental team with an opportunity to assess how the patient responds to occlusal and aesthetic changes throughout the process.
   - Predictable and stable outcomes: By carefully planning and executing each stage, the dentist can establish and maintain occlusal stability, leading to predictable and long-lasting results.

**In Conclusion:**
While same-day restorations offer convenience and immediate gratification, a staged approach often provides a more favorable pathway, especially for complex cases or when prioritizing long-term health and optimal aesthetic outcomes. It allows for better healing, reduced risks, enhanced control over the final result, and greater patient comfort and flexibility.

**My 4 Staged Approach Example**

Immediate Placement Approach to Restoring a MONO Implant Full Arch Roundhouse Restoration

**• A Progressive Placement & Loading Approach •**

Since this often involves IMMEDIATE PLACEMENT In my experience, I believe...extracting ALL teeth (8 or more) in ONE VISIT...is TOO MUCH (anesthesia, time, trauma,etc) for patient and doctor, IMHO!

Since I prefer to have implants out of occlusion for up to at least a month I like to remove teeth in stages retaining the strongest teeth that are in occlusion for last, like maybe saving the canines and first motors or whatever has the strongest occlusion for the patient...thus helping to keep the newly placed implants out of occlusion and therefore, having a greater chance to integrate while too, the patient has some area to still eat & function.

I inform the patient that their and mouth is under construction and that they need to have a soft diet to avoid the implant area as much as possible .during the integration process. On any area where I place implants, I ask the patient to NOT chew there for 6-8 weeks...a critical period for that secondary stability &'integration. All temporaries are out of occlusion for that time period.

Incidentally, I am a fan of immediate placement for the One Piece Implants, but NOT immediate loading. What's the rush! Keeping the patience out of something removable and they'll be happy.

Therefore, my patients and I prefer...

**The 4 Stage Progressive Placement & Loading Approach**

So, with the GOAL of placing at least 8-12 One Piece MONOS for stability and retention of a 12 Unit Full Arch Restoration, in my experience...a generalized sequence often goes like the following:

**VISIT 1: UR POSTERIOR**

- Extract #3-5 & place two to four regular MONOS (non bendable) with wider neck
- Add your graft of choice for any socket voids more than 1 mm or so
- Make sure abutments are out of occlusion
- Instruct patient to only chew on other side
- Don't brush, rinse, waterpik surgical site
- Leave It Alone & It Will Leave You Alone...it will heal all by itself
- Splint all implants with Luxatemp flow-like material to splint & protect from any lateral forces (no cement /use shims if you wish)
- Trim off with bur in subsequent visits
- Patient should be on antibiotics
- Simple DUAL ACTION ADVIL for discomfort
- StellaLife Kit (rinse, spray, and gel) day or so later (StellaLife.com)

Note: The ultimate GOAL is a 12-unit all implant (8-12) supported restoration.
- If any 2nd or 3rd molars are present and are in occlusion leave them in place UNTIL all Implants integrated, as they
  - help with eating while under construction and
  - help with vertical dimension and occlusion of final prosthesis

**VISIT 2: UL Posterior**
- A week or two later after UR doing well
- Extract # 12-14 & place two or three regular Mono implants
- Add any graft for any socket voids more than 1 mm
- Make sure abutments are Out of occlusion
- Instruct patient to only chew on other side

- Don't brush, waterpik surgical site
- Leave It Alone & It Will Leave You Alone...it will heal all by itself
- Splint all implants with Luxatemp like material to protect from any lateral forces. Trim off with bur in subsequent visits
- Patient should be on antibiotics
- Simple DUAL ACTION ADVIL for discomfort
- StellaLife Kit day or so later

**VISIT 3: UR Anterior**

A week or two later after UR and UL are doing well...then EXTRACT #3-1" and place one or two MonoBendable Implants. Make a temporary out of occlusion #3-8 chairside.

- Same instructions as Visit 1

**VISIT 3: UR Anterior**

- EXTRACT # 6-8 and place two or three MonoBendable Implants
- Bend with surgical screw driver
- Make a 6 unit temporary #3-8 chairside with #6-8 out of occlusion
- Eat UL anterior only

**VISIT 4: UL Anterior**

- Extract # 9-11 and place two or three MonoBendable implants
- Bend with surgical screw driver
- Make a 12 Unit PMMA temporary #3-14 chairside or have fabricated at lab

**VISIT 5: Four (4) WEEKS**

- Establish after last extractions to make a PMMA prototype what final prosthesis may look like

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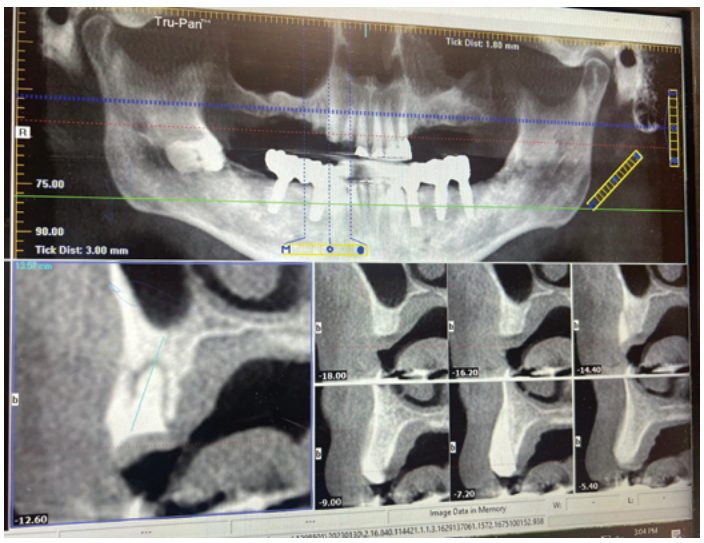
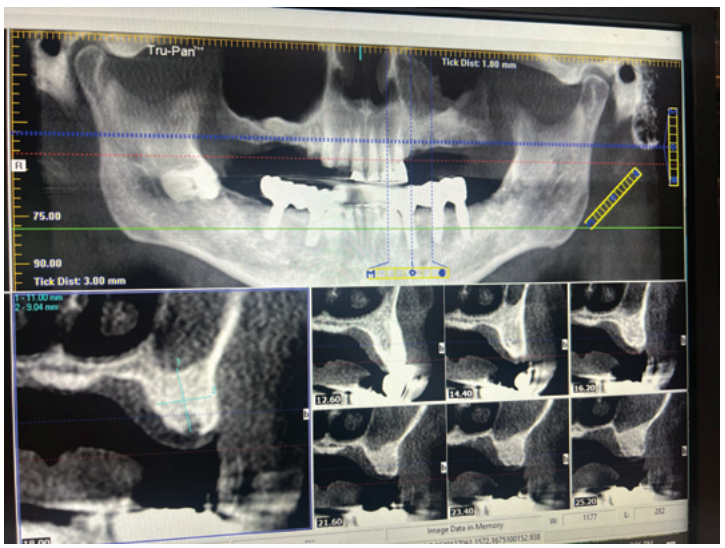
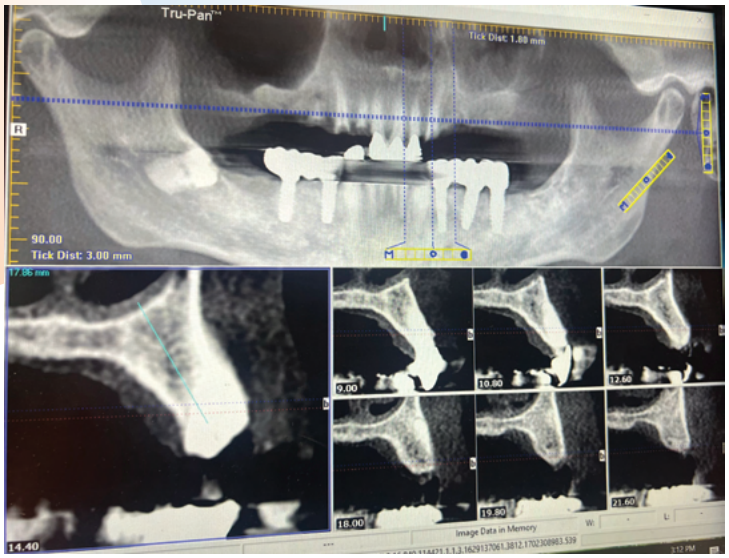
# Clinical Case # 1

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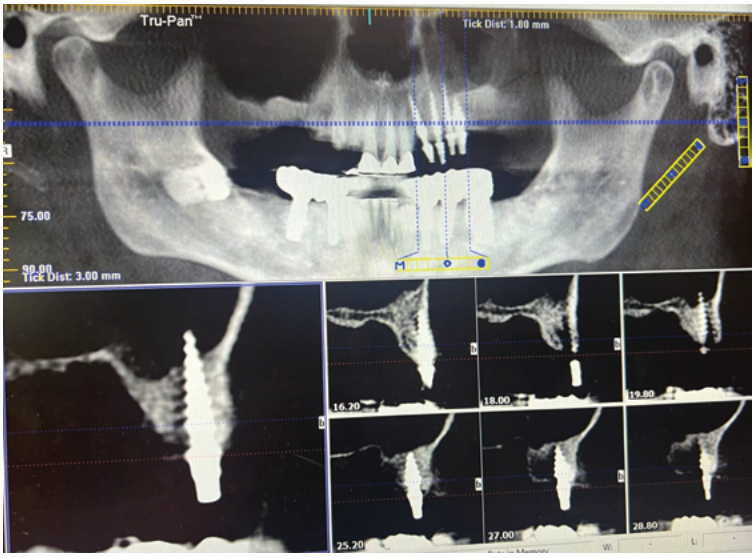
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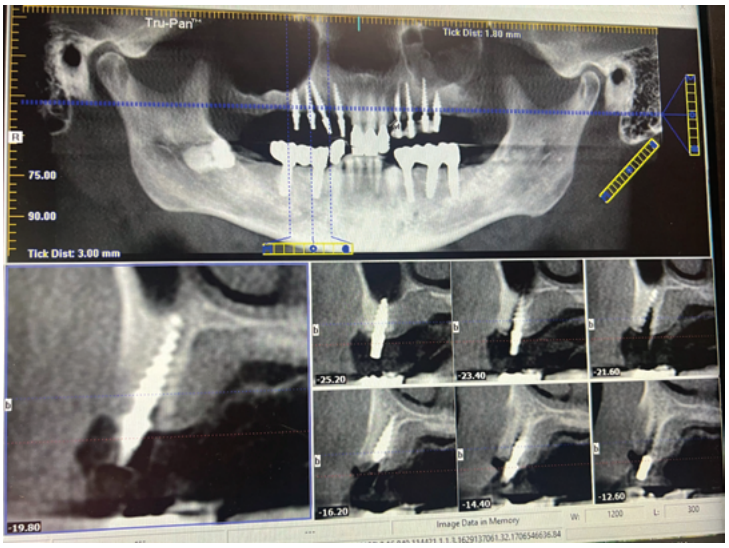
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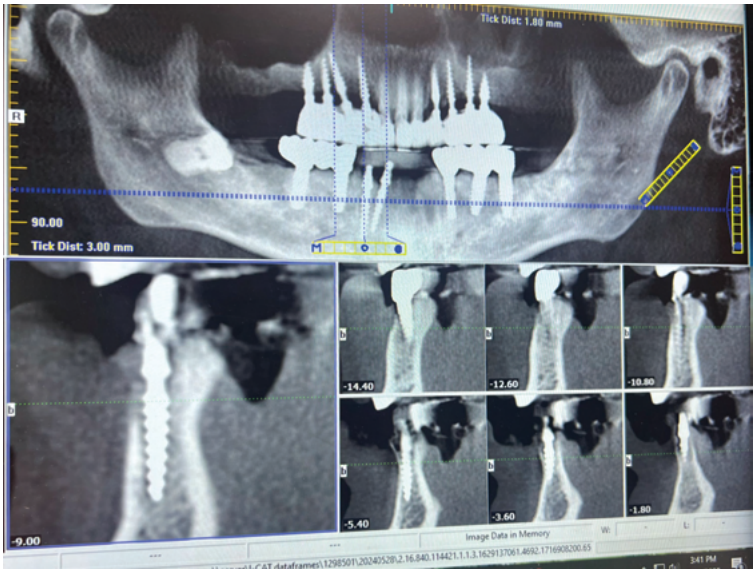
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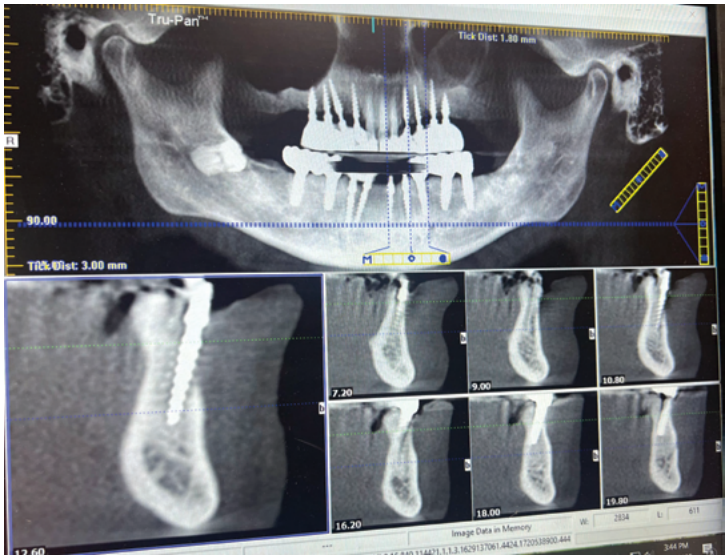
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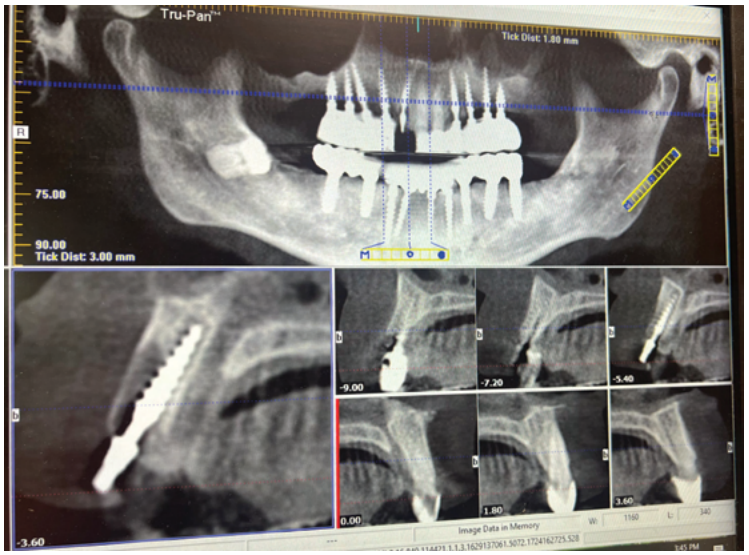
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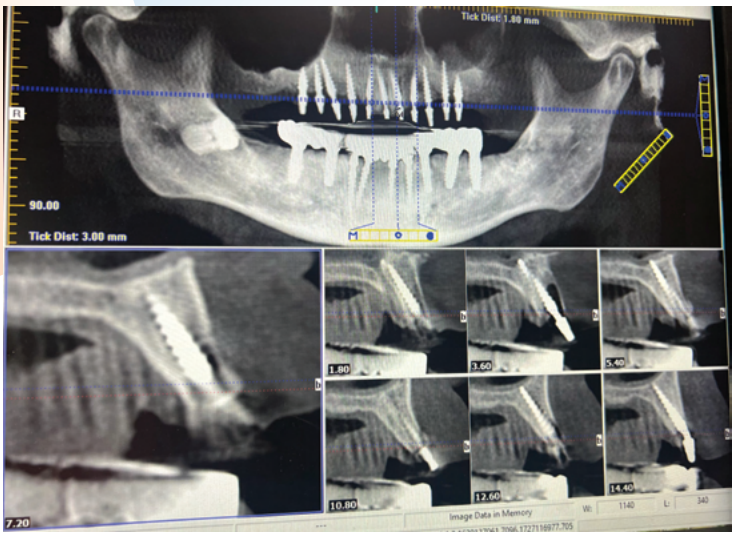
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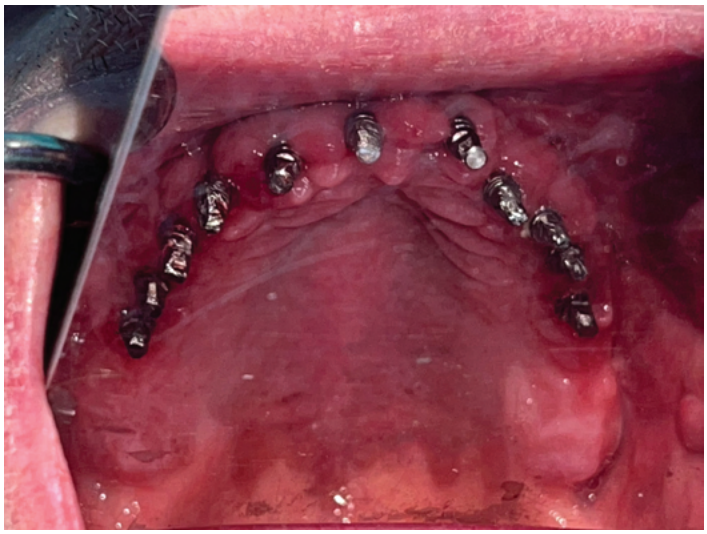

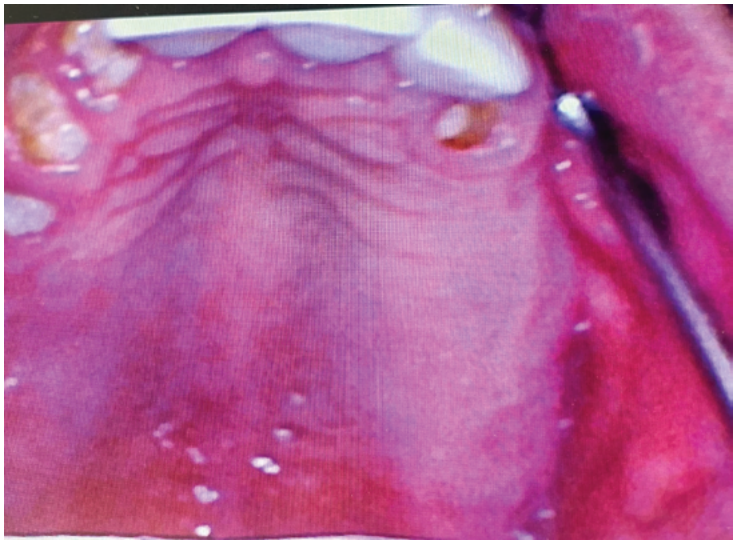

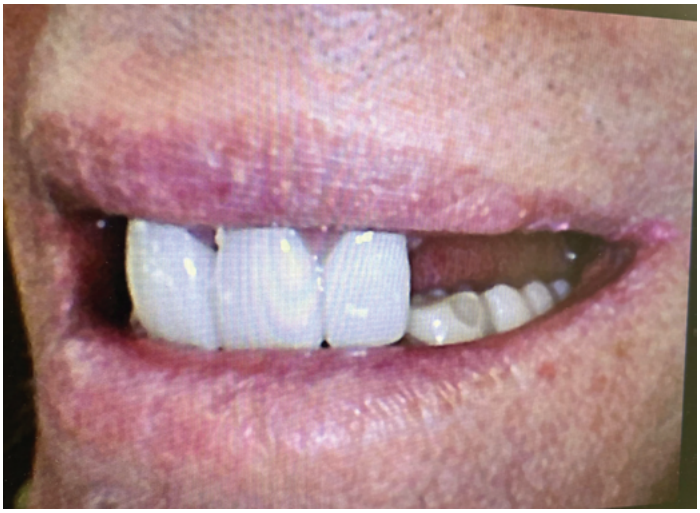

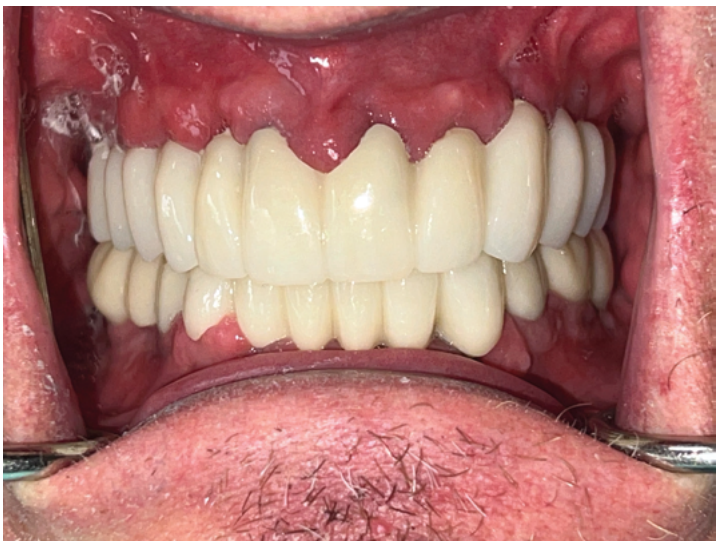

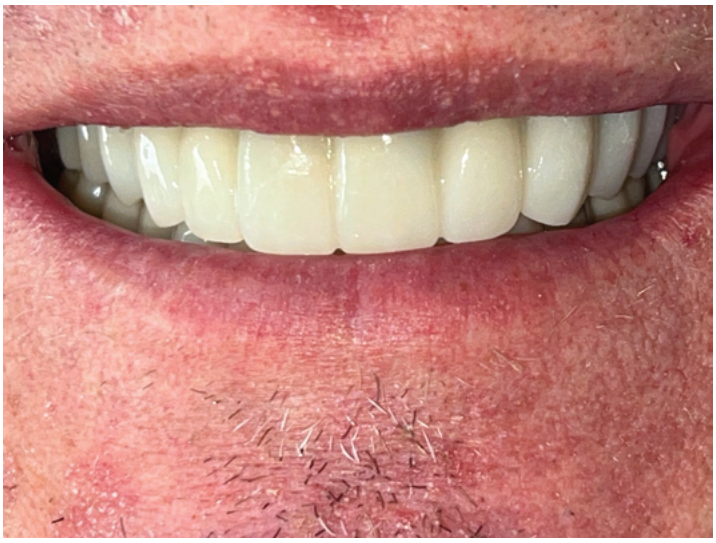


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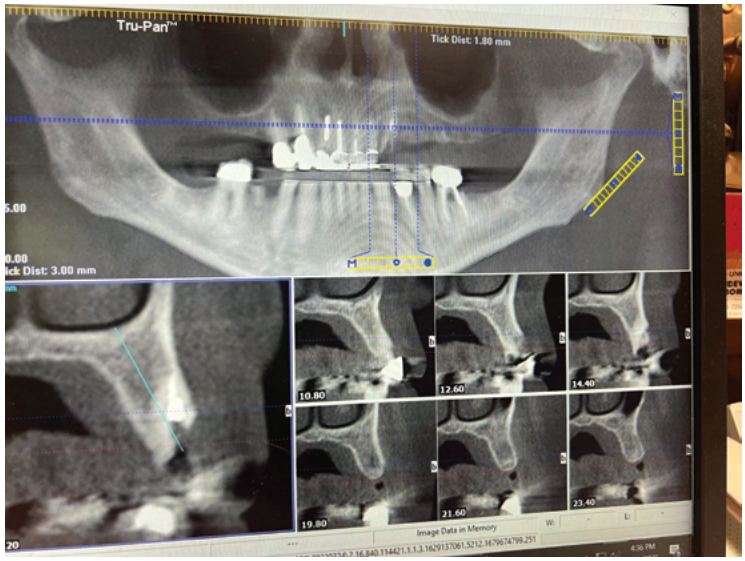


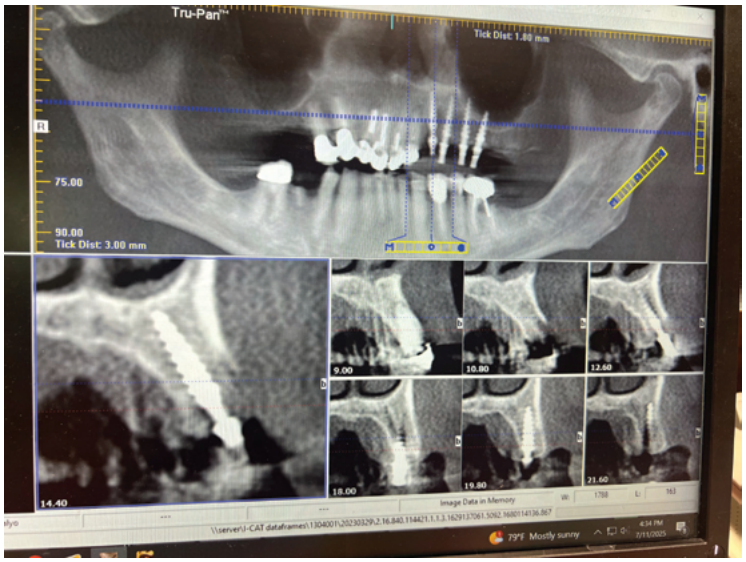


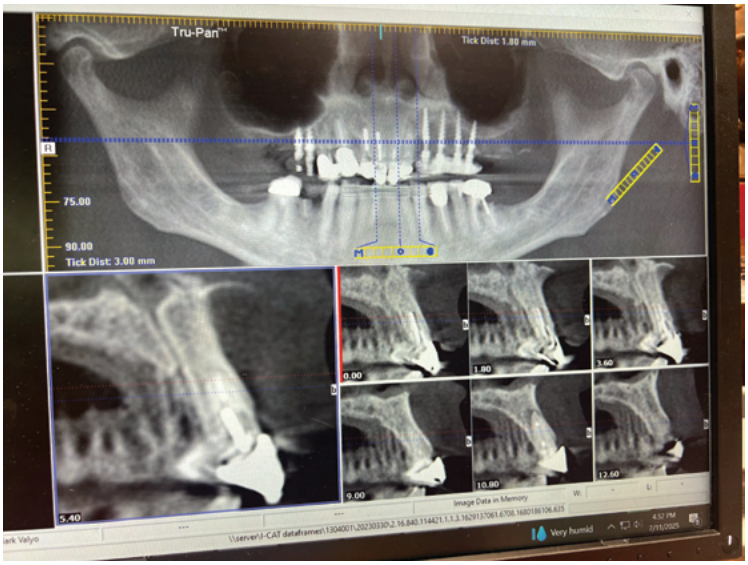


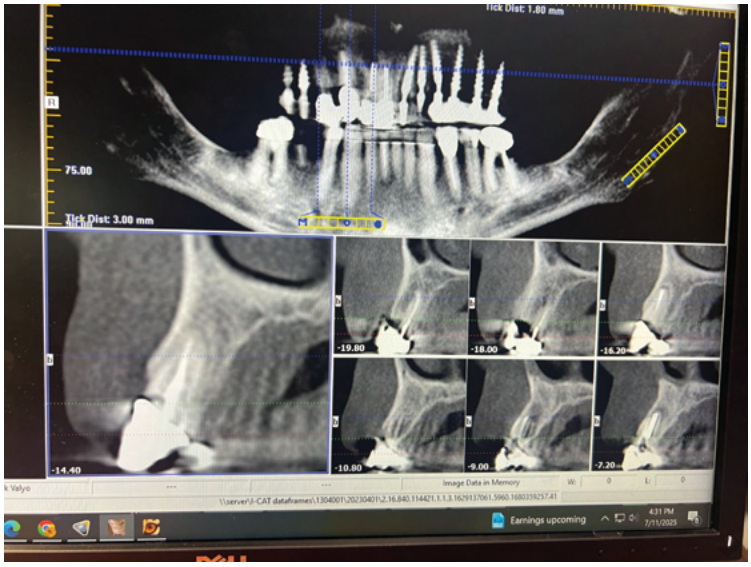

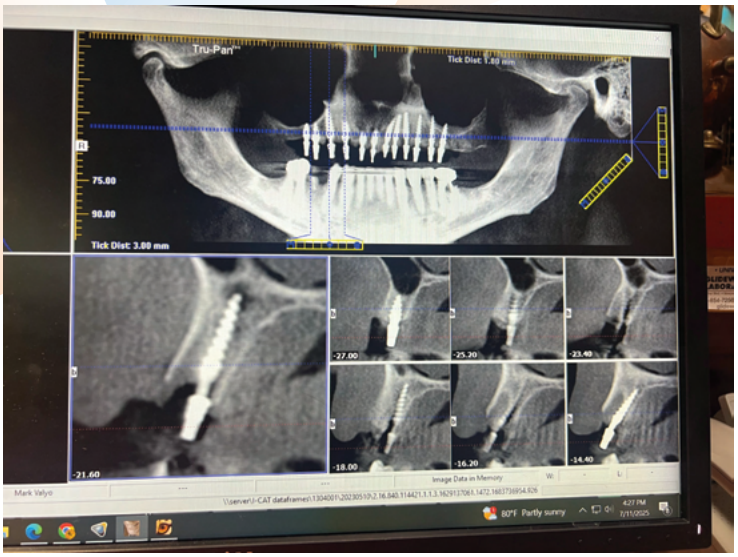
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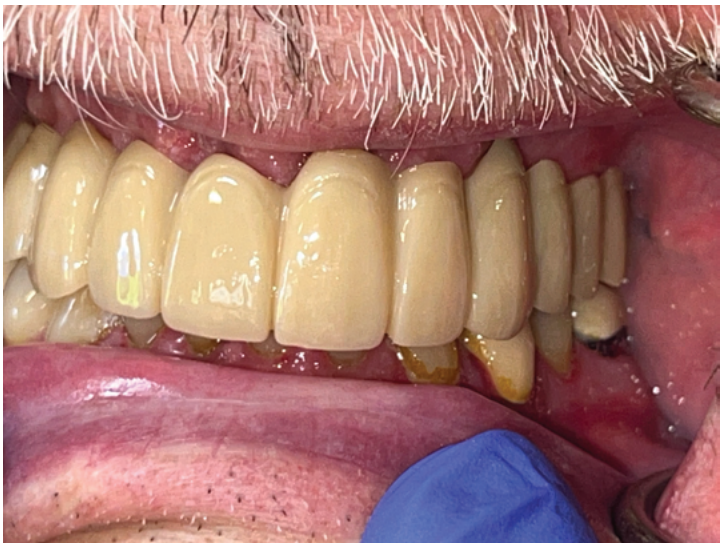

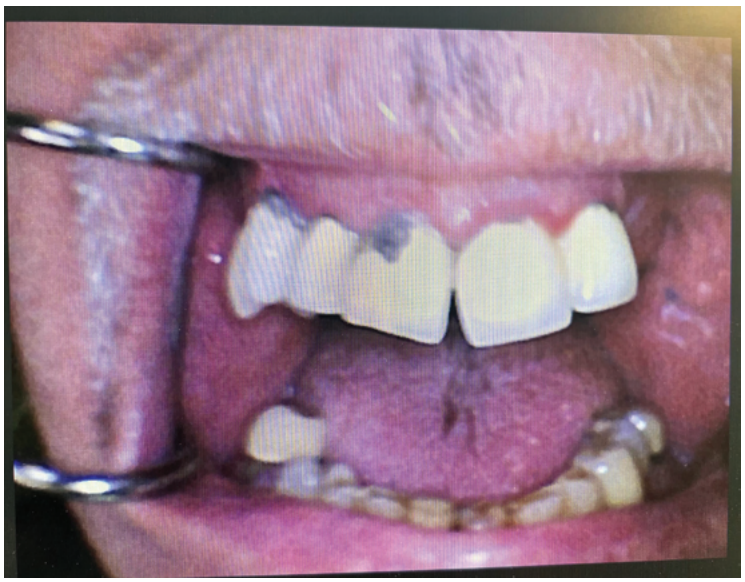

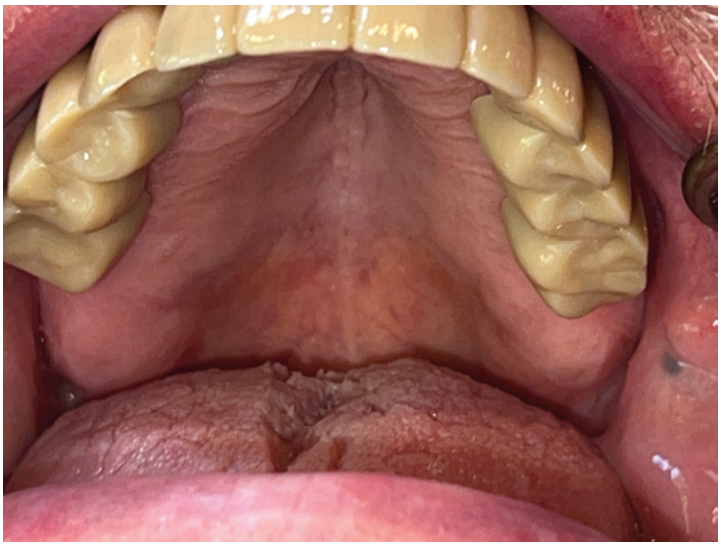

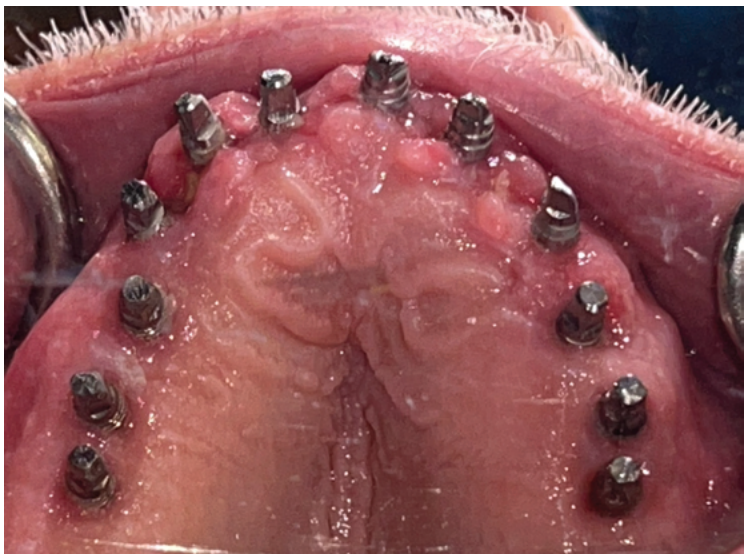

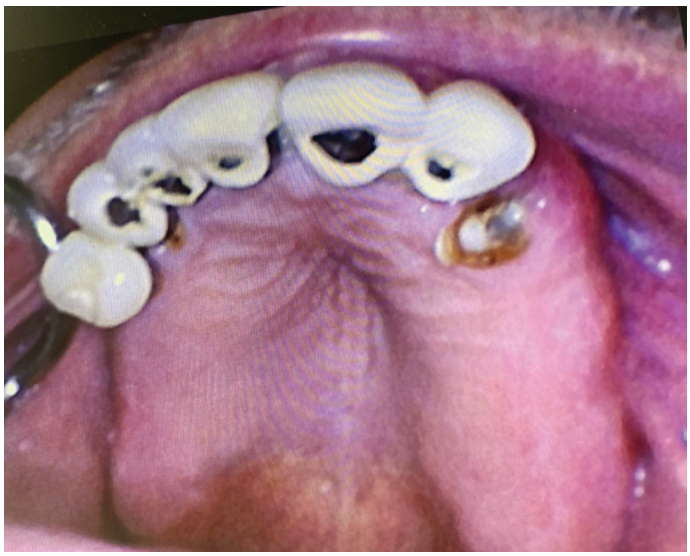

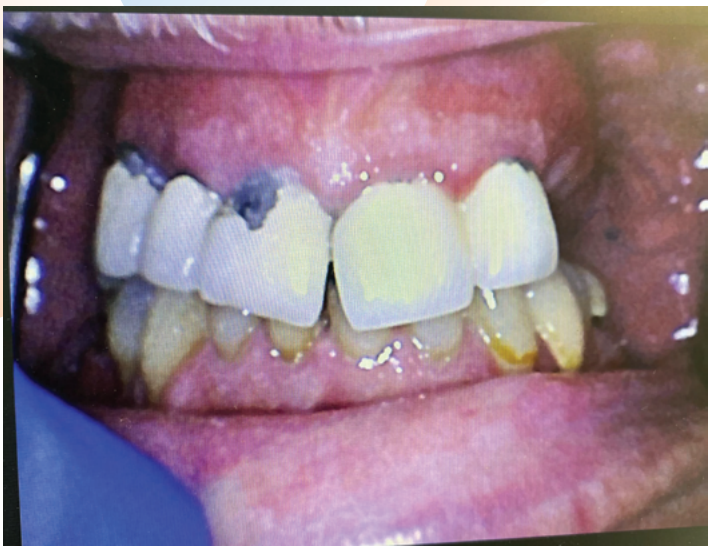

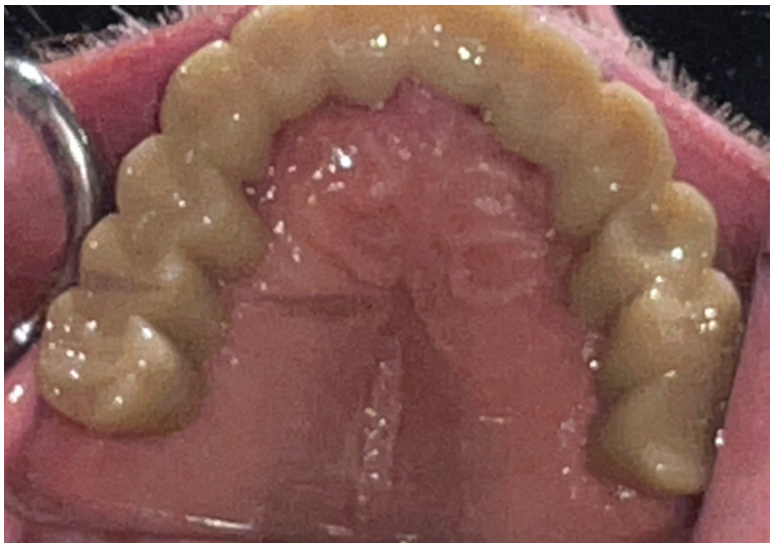

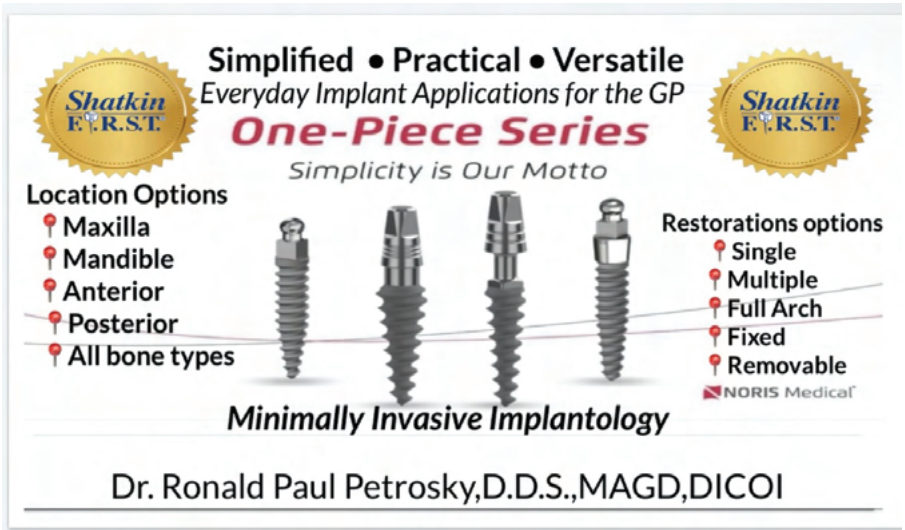


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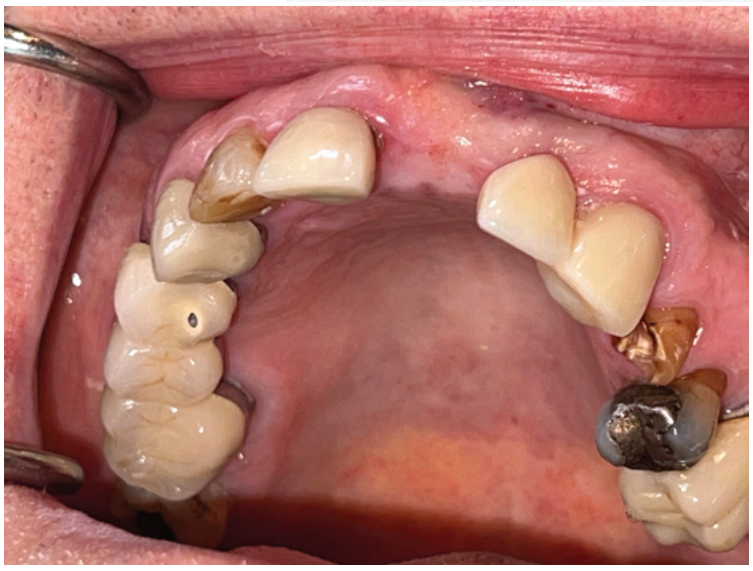

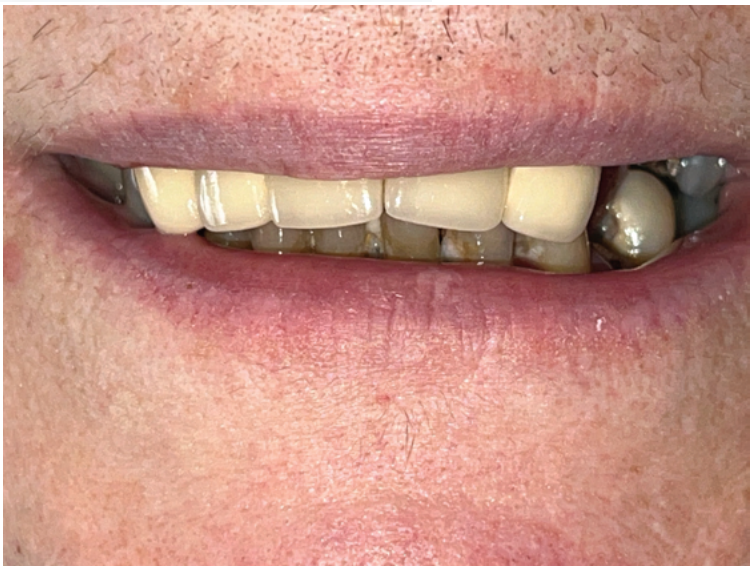

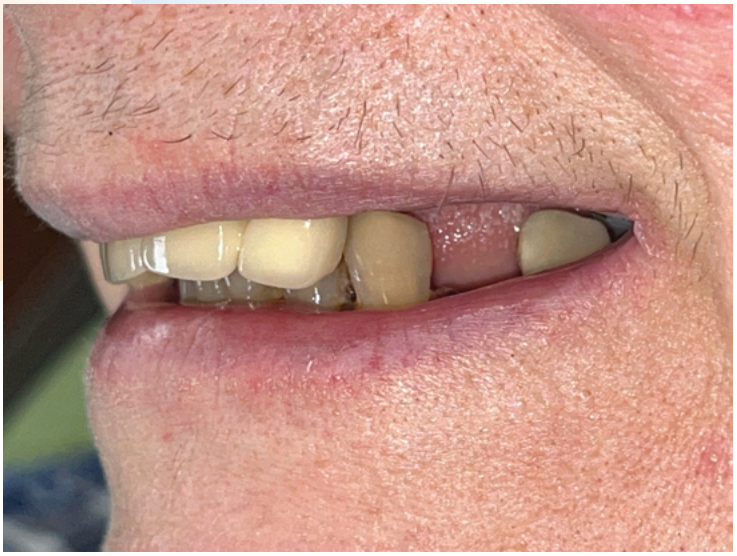

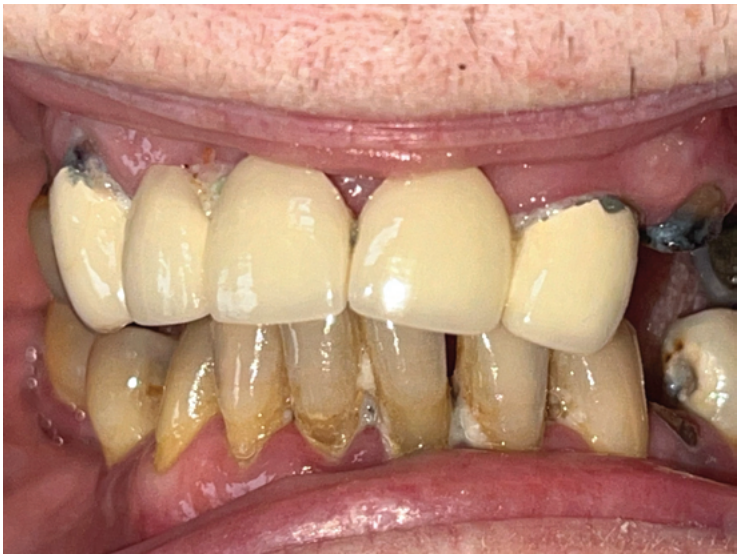

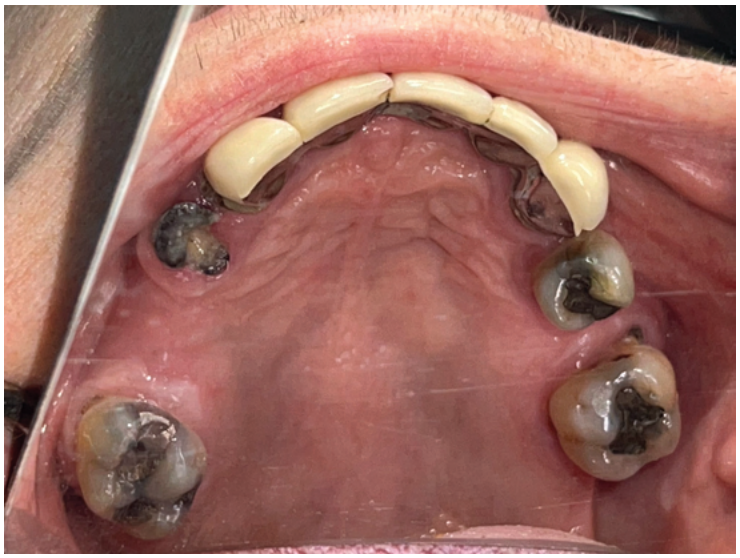

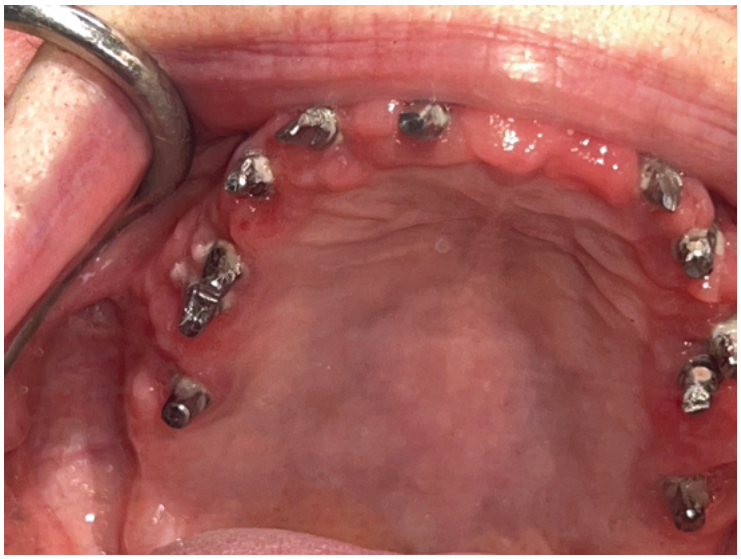

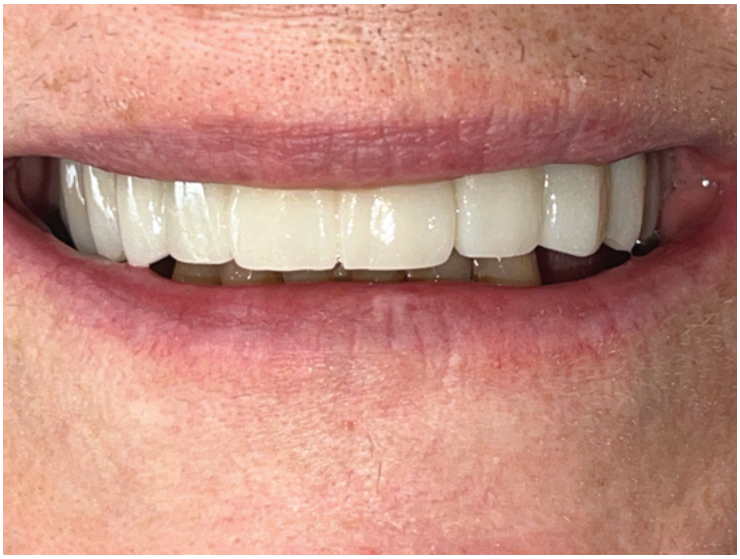

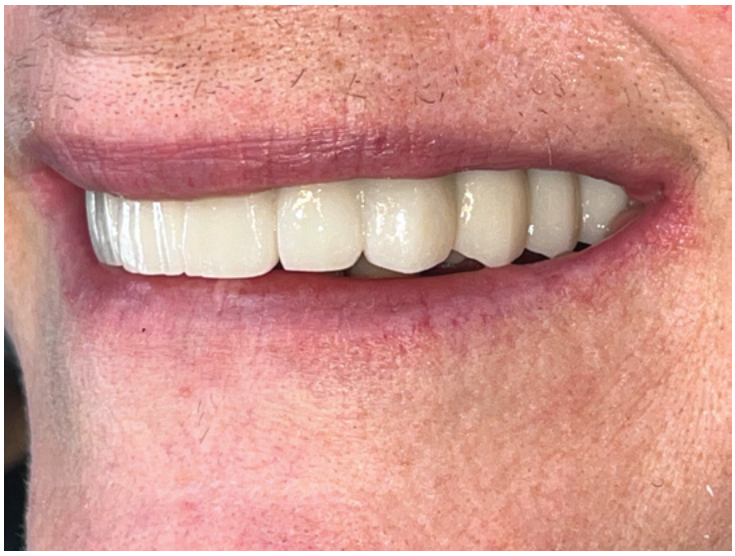

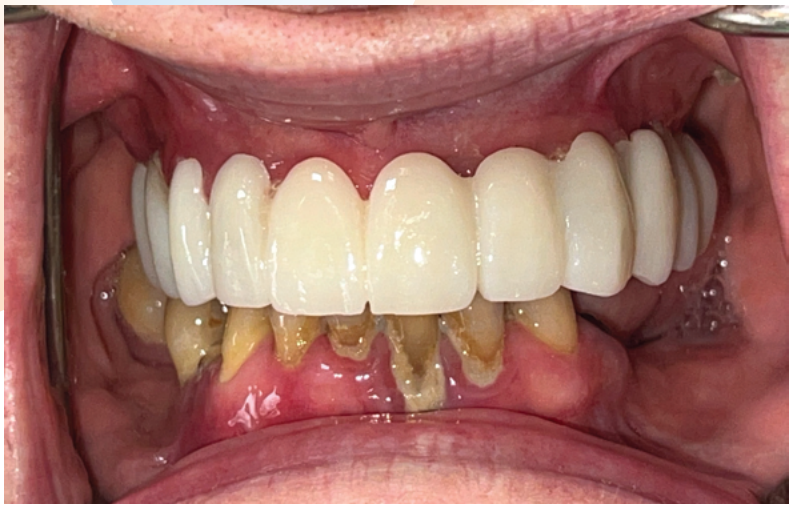

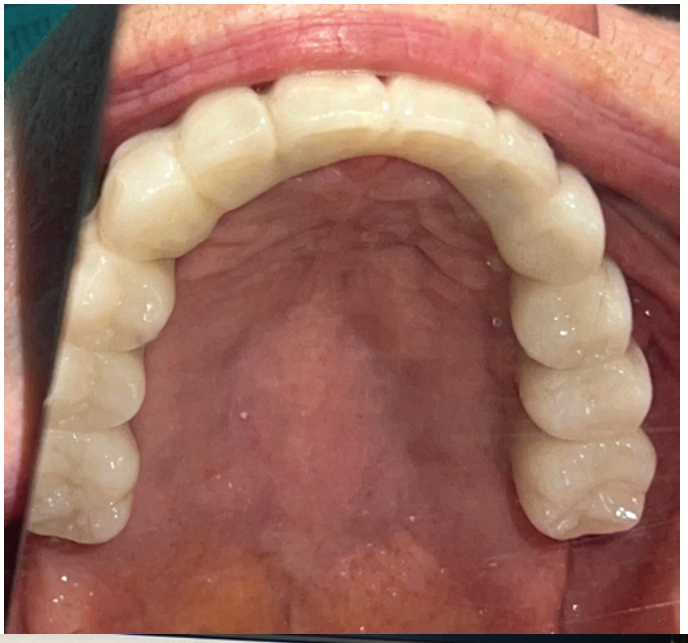

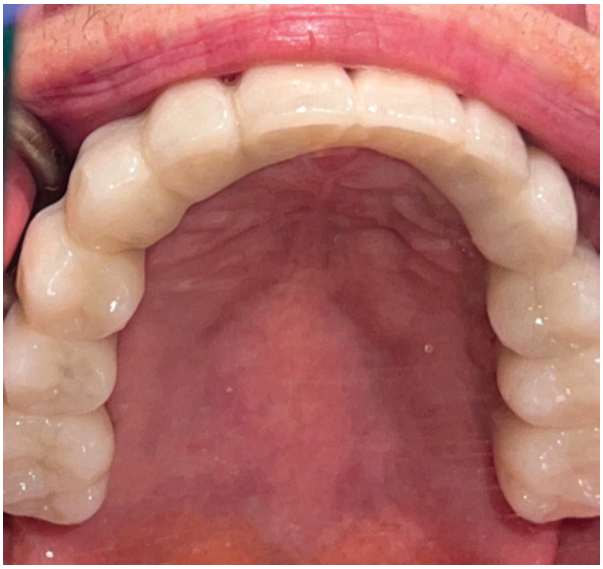

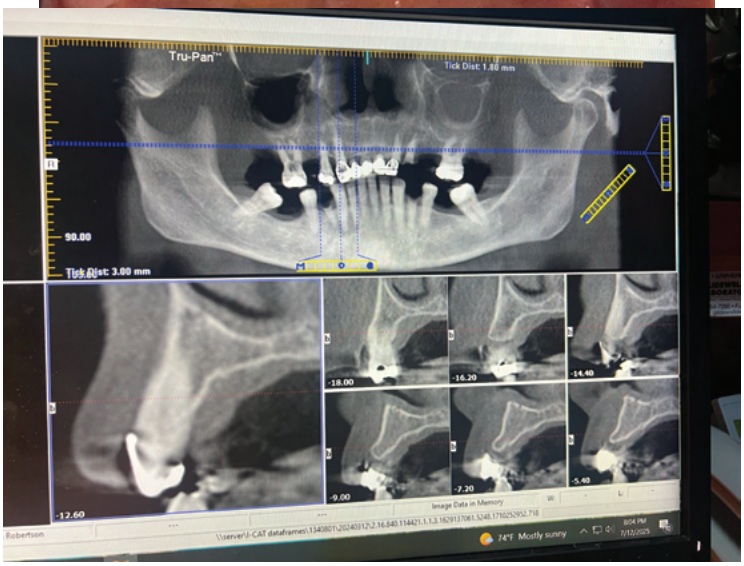
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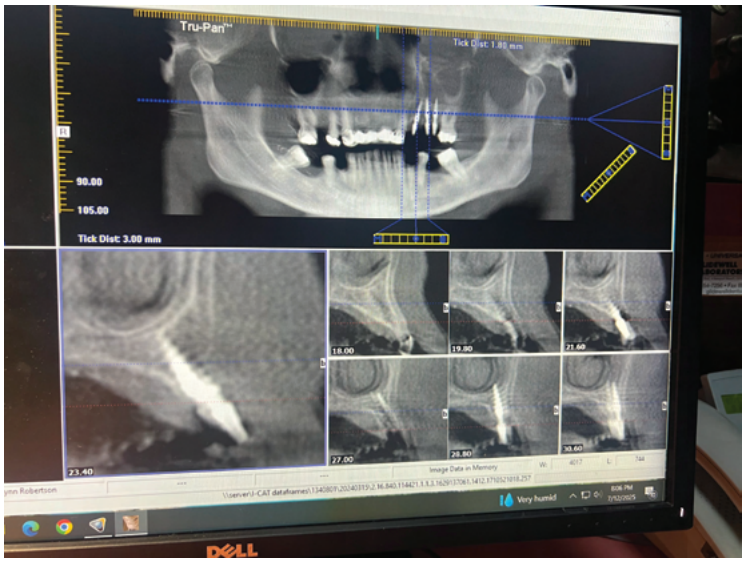
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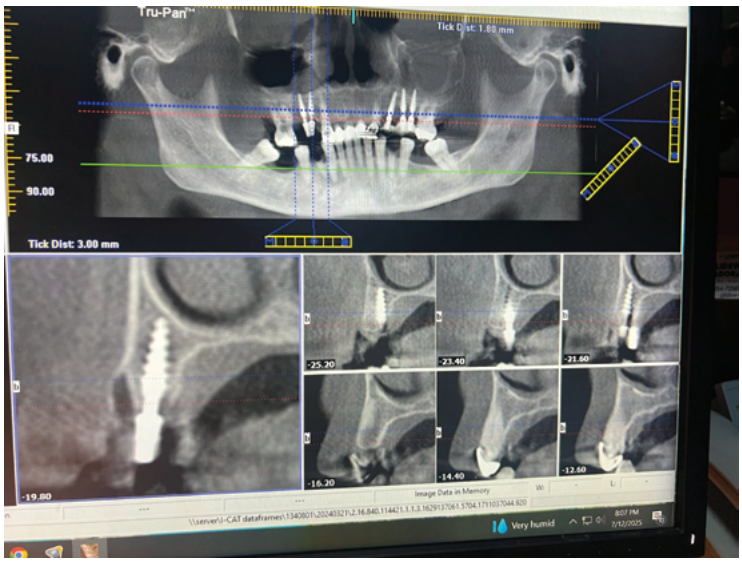
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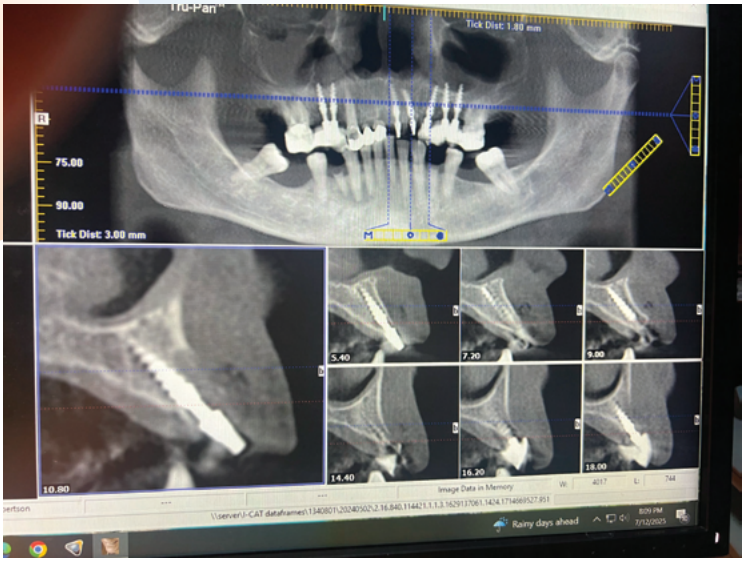
-12.60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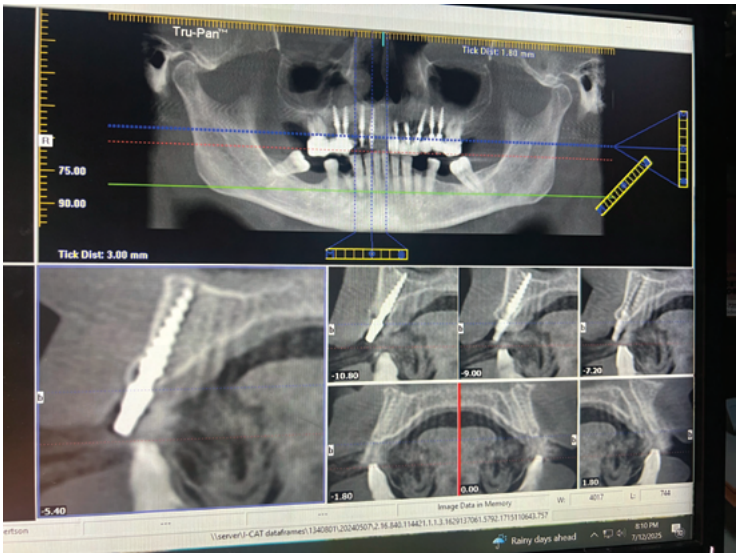
Rainy days ahead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Rainy days ahead

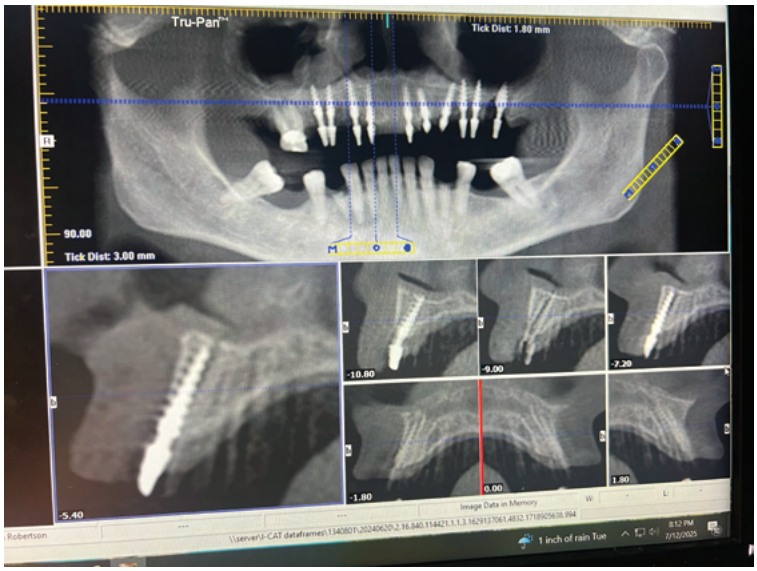
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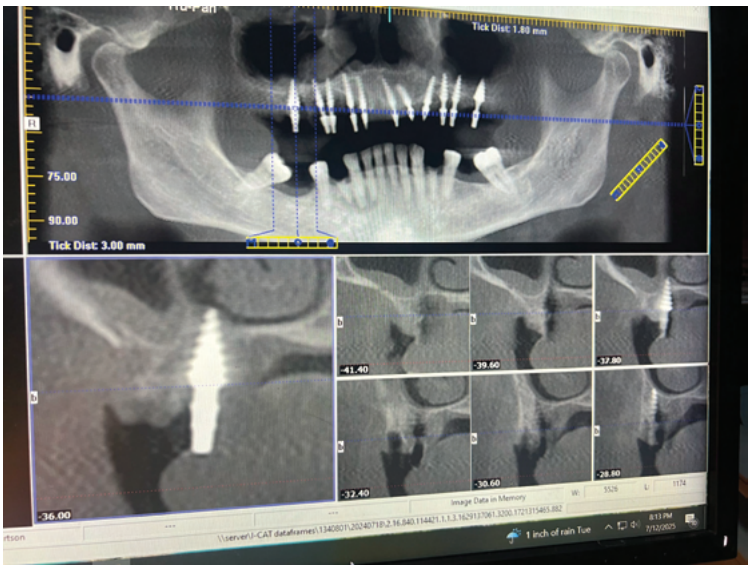
Image Data in Memory
1 inch of rain Tue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-36.00
-32.40
-30.60
-28.80
Image Data in Memory
1 inch of rain Tue

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# CASE STUDY

## COMBINATION IMPLANT TREATMENT ROUNDHOUSE BRIDGE IN FLARED MAXILLA BONE FOR FULL MOUTH REHABILITATION

QUINCY THOMPSON, DMD

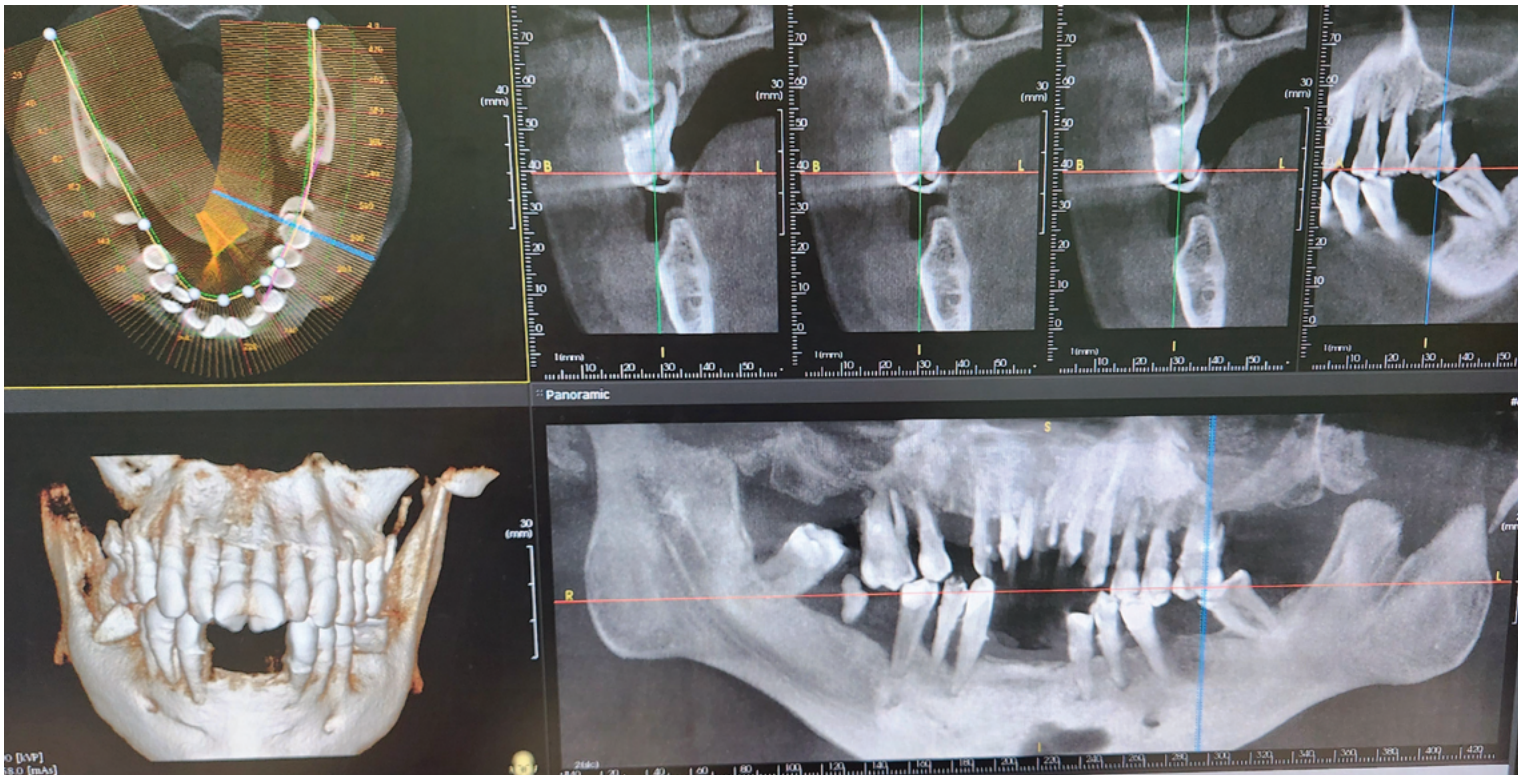
Dr. Quincy Thompson grew up in the rainy northwest of Washington State. He earned his Bachelor's in Exercise Science from Brigham Young University-Idaho. He attended Roseman University of Health Sciences and earned his Doctor of Medicine in Dentistry.

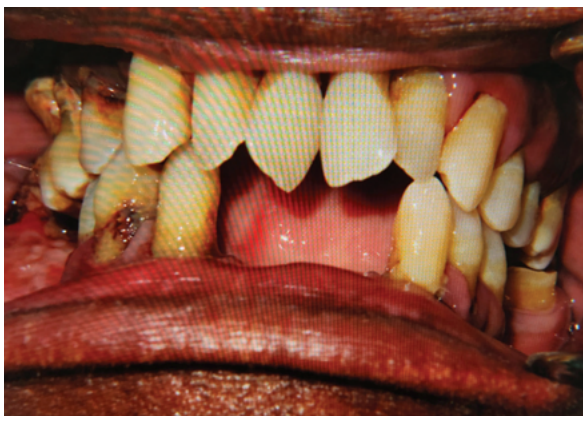
He is a member of the American Dental Association, Tennessee Dental Association, 7th District Dental Association, the Academy of General Dentistry and the International Academy of Sleep. Dr. Thompson loves traveling and spending time with his wife and

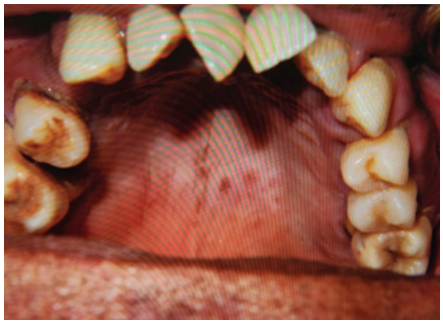
### Introduction

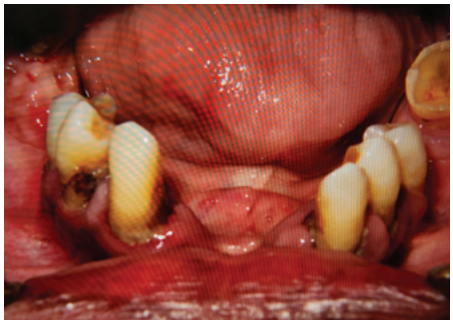
58 yr old Male presents to office with loose and missing teeth and severe periodontal disease.
**CC:** Can't eat food he wants to because of loose teeth. Has been told he needs all of his teeth extracted and dentures.
**Med Hx:** Periodontal disease, heart disease
**Med list:** daily aspirin

Pre-op CBCT and IO photos







**Treatment Plan:**

**Phase 1:**

1. Impressions for immediate temp max roundhouse bridge and mand denture
2. Ext of all teeth with socket grafting (Osteogen), implant placement and immediate temp max roundhouse bridge and mand denture
3. Heal 3-4 months

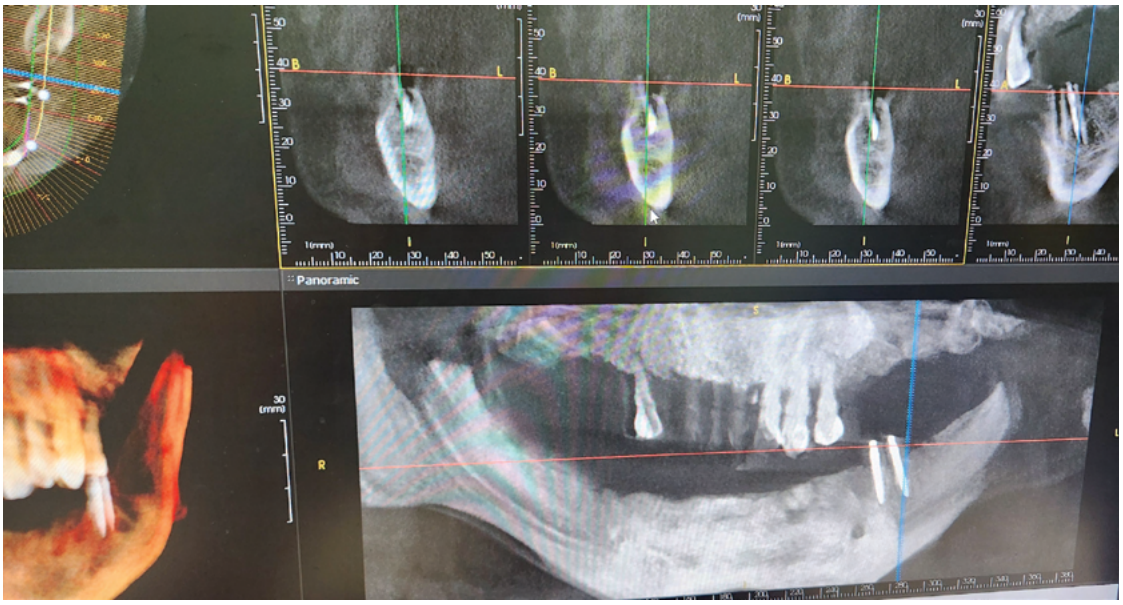
**Phase 2:**

1. Place additional implants on max and mand
2. Heal 1 month
3. Impressions for new wax rims
4. Wax rims
5. Wax try in for final max overdenture and mand zirconia roundhouse bridge
6. Delivery of final restorations

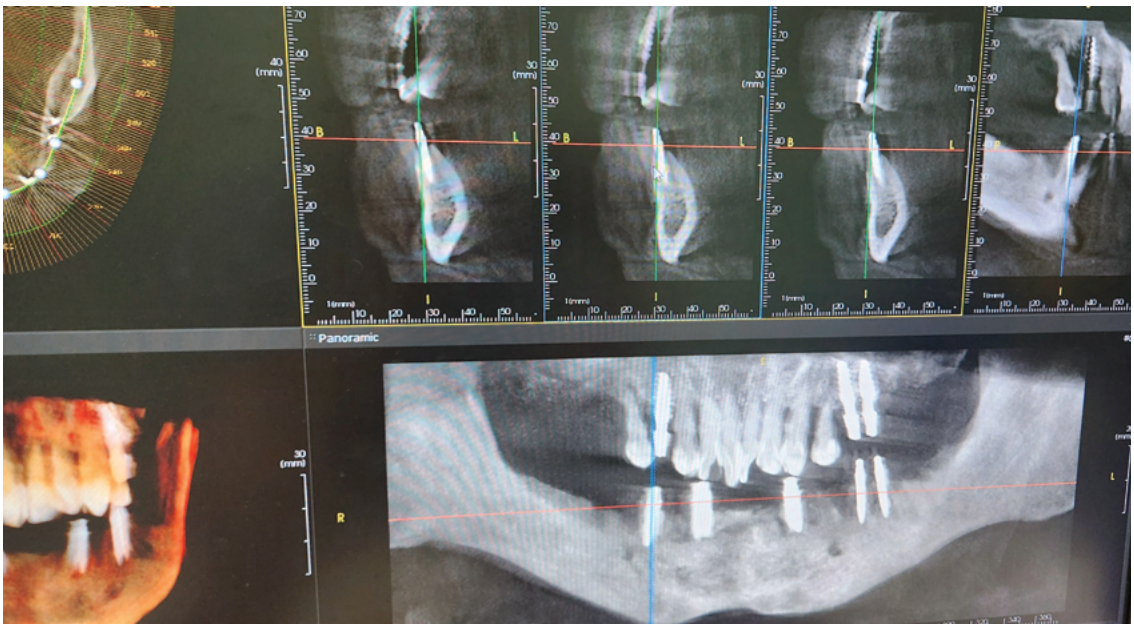
**Follow plan:**

6 month follow-up and o-ring change if needed, then 6-12 month follow ups as needed to change o-rings

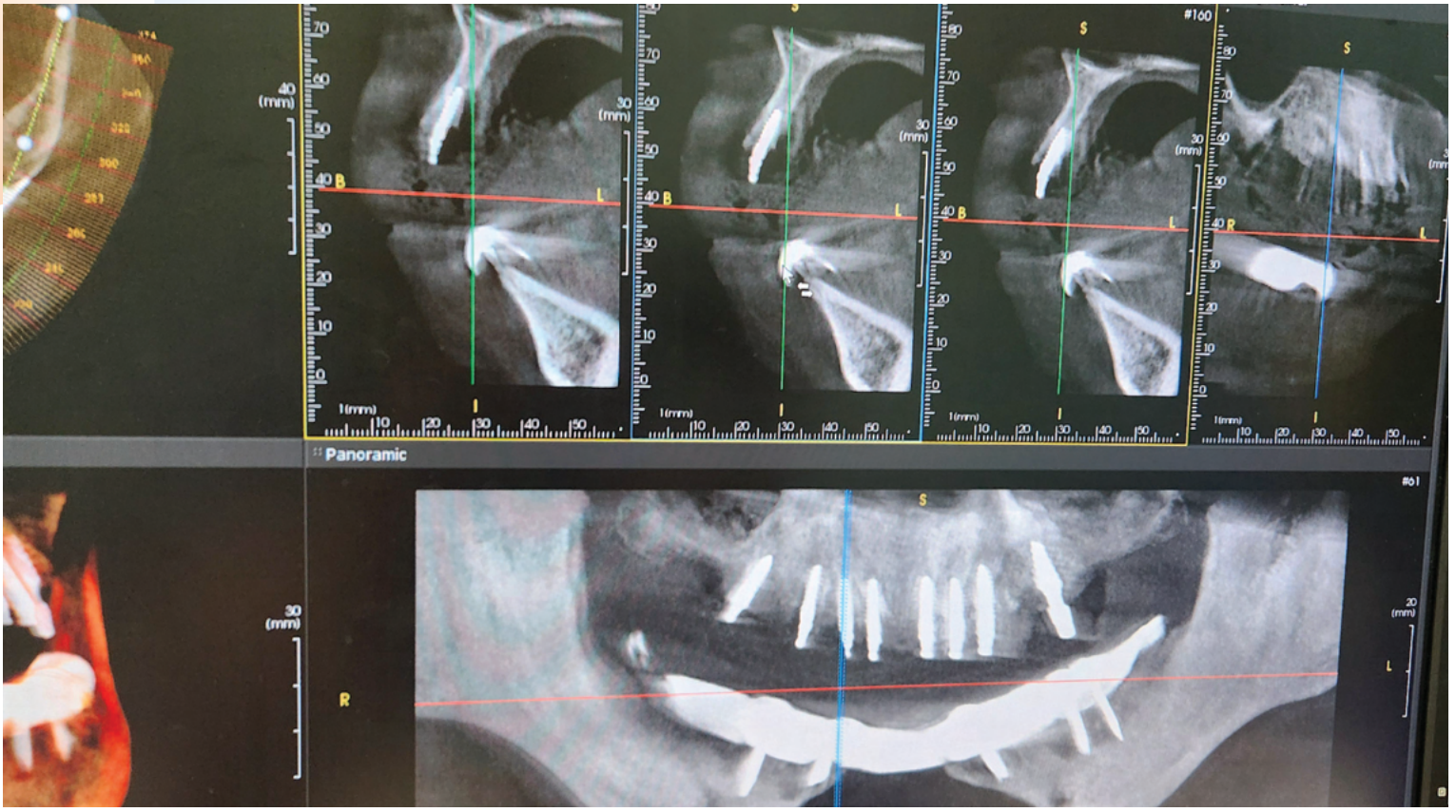
CBCT of Ext of max posterior teeth, Ext of mand teeth, and placement of 2 2.0x13 mini implant



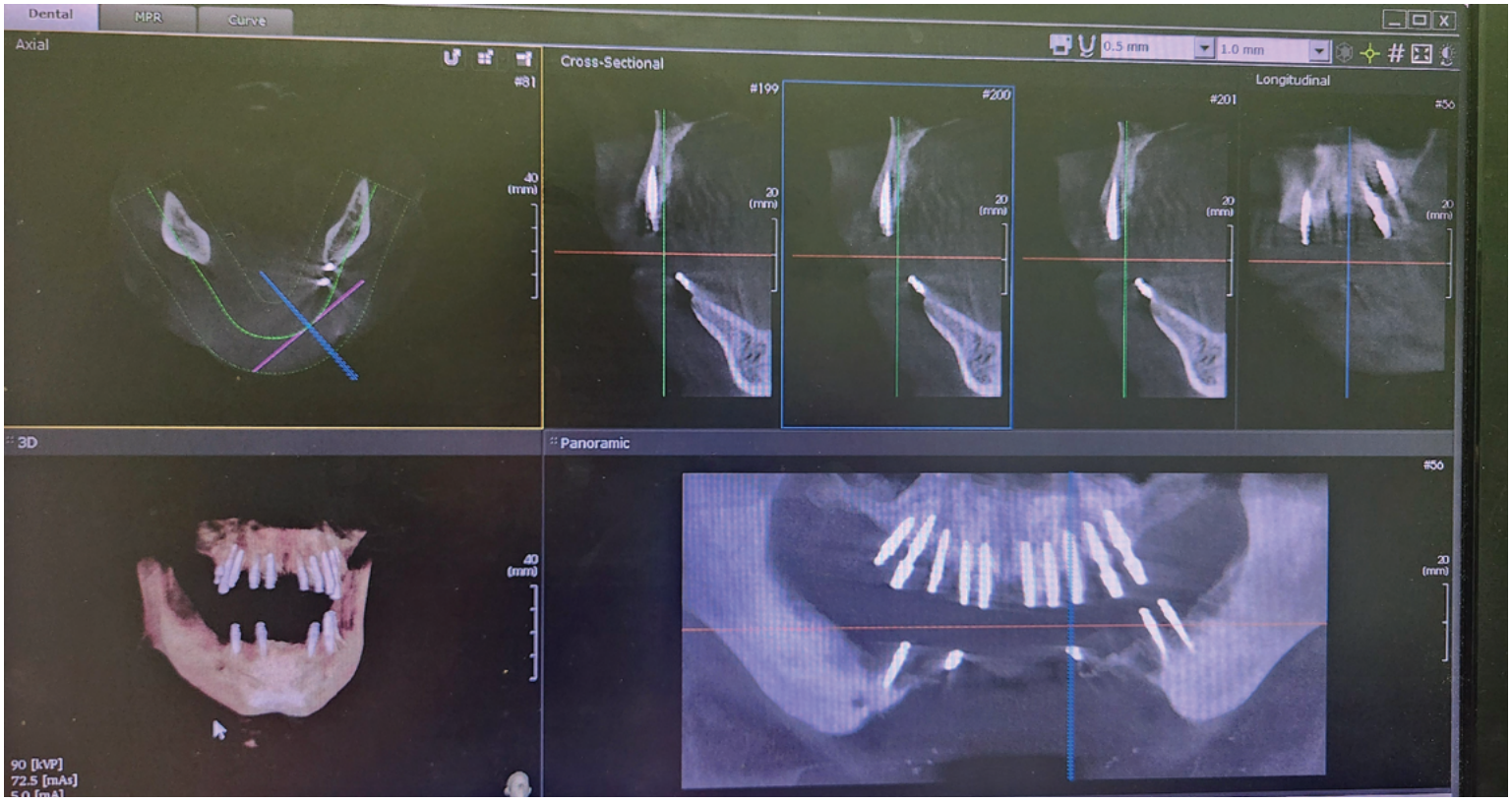

CBCT after 2nd surgery with placement of 2 3.75x11.5 and 1 4.2x10 monos implants in the max and 3 2.0x13 mini implants in the mand



CBCT after 3rd surgery with placement of 6 2.5x13 angled mini implants and 1 3.0x11.5 milo implant.
(2 of the monos from previous surgery did not integrate and where removed).




CBCT after 4th surgery with placement of 2 3.3x10 mono implants

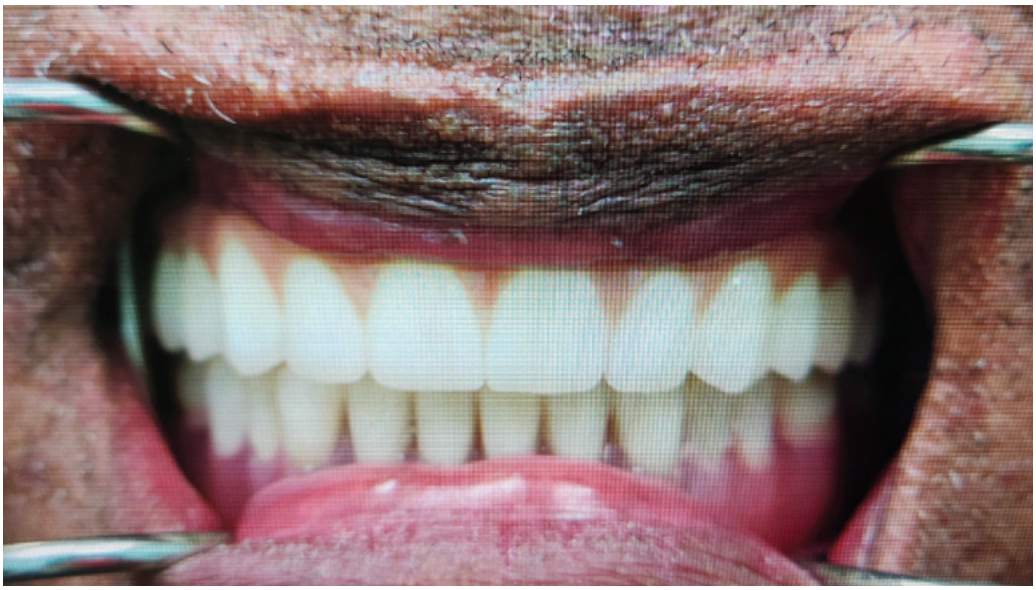


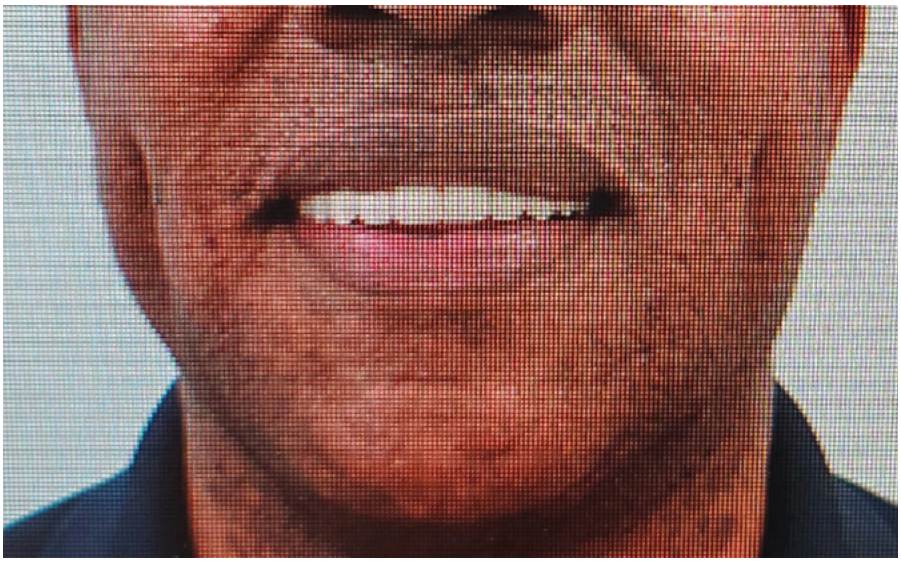
**Complications & Challenges**
Pt did not want to have max denture during healing time, thus requiring a temp roundhouse option. Pt also has a very angled max ridge, overdenture was not recommended.

Due to excessive bleeding at time of first surgery while Ext of mand teeth treatment plan had to be adjusted for multiple surgeries to manage bleeding. At first surgery only posterior max teeth and all mand teeth where Ext with placement of 2 mini implants on lower. Attempted to place 3 mono implants in max with placement of additional implants on mand. Only one of the mono implants integrated due to the large amount of periodontal infection in adjacent teeth and bone.

**Pt Thoughts & Conclusion**
Pt was very happy with the results of the appearance and that he was able to eat anything he wanted to again. The case was very successful, however it took longer than the pt wanted due to letting the pt dictate the speed of treatment. The case could have been completed faster if all teeth were Ext prior to any implant placement to allow healing and removal of the periodontal infection. Mini and Mono implants made this possible with immediate Ext and implant placement, would not have been possible with root form implants.

Final photos of final max zirconia roundhouse bridge and mand overdenture





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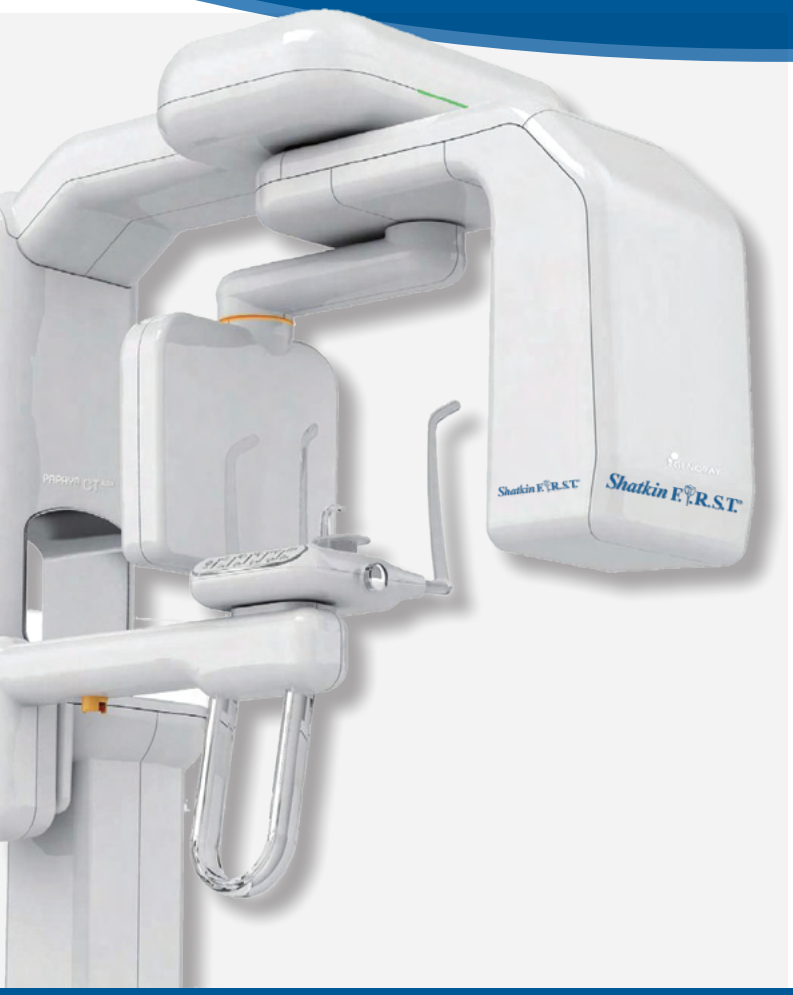


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