Dhabi for 269.25 CME hours. The Eighth Annual Program was accredited for 252.75 CME hours.

The UAE Program is in its Eighth Year. A total of 5 modules and each Module is of 6 days with a didactic and Clinical Component with in depth review of surgical and prosthetic protocols based on scientific and evidence based practice. It is a non-commercial, non-sponsored course covering a wide spectrum of implant types and system. The Eighth Annual Program was accredited by the Health Authority of Abu Dhabi for 269.25 CME hours.

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The AAID Foundation also awards Research Grants to help members continue dental implant specific research work. Recently $62,000.00 was awarded to three researchers that brings the amount awarded by the Foundation to over $700,000.00 over the past few years since the inception of the Endowment Fund.

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registration:
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By AAID

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THE NINTH ANNUAL AMERICAN ACADEMY OF IMPLANT DENTISTRY MaxiCourses®- UAE 2016 – 2017 Starts August 30

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In Fulfillment of the Educational Requirement for the Examination for Associate Fellow Membership for the American Academy of Implant Dentistry.

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The Faculty are as follows.

Dr. Frank Lozada, USA
Fellow, American Academy of Implant Dentistry
FAI, Diplomate ABOI
Dr. Robert Schroering, USA
Director of the Graduate Program in Implant Dentistry
Assistant Director of the University Dental Hospital.
Dr. Robert Miller, USA
Member, Alabama Implant Study Group
Member, AADSM, American Academy of Periodontology
Dr. Irfan Kanchwala, India
Fellow, American Academy of Implant Dentistry
Diplomate AAID
Dr. Jaime Lozada, USA
Chair, AAID’s MaxiCourse Program
Fellow, American Academy of Implant Dentistry
Diplomate ABOI

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Introduction of Peri-Implantitis with the Picasso Diode Laser

A long-term follow-up after debridement and grafting

By Gregori M. Kurtzman, DDS, MAGD, Markus Wettl, DDS, Ron Kamines, DDS, Daniel D. Gober, DDS

The prevalence of peri-implant complications is rising significantly as implant treatment increases. Periodontal disease associated with implants can range from gingival inflammation in the absence of bone loss to significant bone loss and mobility of the fixture. The latter can occur when the disease process is not identified early in the process or a “watch and wait” attitude is taken.

Treatment has traditionally involved flap elevation and mechanical debridement with surgical hand instruments to remove any granulation tissue present on the implant threads. As a result of the limitations of surgical tools, removal of additional bone might be required to reach areas that are not visible. Success diminishes as more surface area is left untreant.

Diode lasers have several benefits related to peri-implantitis treatment. The small diameter of the flexible glass fiber allows easier and more complete access without the need to remove as much bone as when only surgical instruments are utilized. Additionally, the diode has the ability to sterilize the implant’s contaminated surface, eliminating any existing bacteria and keeping them from preventing healing after treatment. The added benefit of using a diode in these procedures is bioactivation of the mesenchymal stem cells in the surrounding bone and soft tissue, an important tool for regenerative therapy and tissue engineering to provide better healing.

Thus, the diode laser is a good adjunct in the treatment of peri-implantitis, improving the clinical results observed with more traditional methods.

Case Presentation

A 64-year-old male patient presented in June 2010 with a fistula draining on the buccal of the upper right canine. The fistula was located distal to the canine midline in close proximity to the gingival margin (Figure 1). A gutta-percha cone was inserted into the fistula to locate the orignment point of the draining infection and a radiograph was taken. It was determined that the fistula traced to the apical of the implant situated at site No. 6. Implants had been placed and restored for teeth Nos. 3 through 7 several years previ-

ously. The implant was identified as a Biomet Mark III RP (Nobel Biocare, www.nobelbiocare.com) at site Nos. 4 through 6, and a NobelReplace (Nobel Biocare) at site No. 7. A radiograph was taken to evaluate the un-

derlying osseous structure around the implant, which demonstrated radiolucency associated with the apical of implant No.6 and dental bone loss with thread exposure under the soft tissue on implant No.7. Clinically, no mobility was detected. The patient was informed of the gingival issues and the available options, including removal of the ailing implant, grafting the site, and placing and restoring a new implant after an appropriate healing period. The other option would be elevating a flap, cleaning out any granulation tissue, and treating the site with a diode laser and graft to replace any lost bone.

He was also informed that the latter option meant that the site would need to be evaluated once entered and there was a possibility that the implant would need to be explanted should it exhibit mobility following debridement. The patient chose peri-implantitis repair.

Properative antibiotics (O. garlic) were given orally 1 hour prior to the initiation of treat-

ment. A local anesthetic (Septo-

not, www.feldengam.com) 500 mg for pain to be taken twice daily for the initial 3 days post-surgically. The patient returned after 1 week for suture removal and indicated no significant postoperative discomfort. The site appeared to be healing normally and he was ap-

pointed for a follow-up check healing. At the next postoperative visit, the site appeared healed with a lack of inflammation and the patient was placed on periodontal recall alterna-

tive with his general dentist office.

At 3 years post peri-implantitis treatment, cone-beam computed tomography (CBCT) was used to evaluate the long-term status of the repaired area. The CBCT三维成像 at the right maxillary canine demon-

strated that the grafted buccal plate remained at the position completely covering the implant with no sign of further infection (Figure 6 and 7). A periapical radiograph confirmed osseous integration (Figure 8).

Discussion

Managing peri-implantitis can be a challenge. In this case illustrated, bone loss may be progressing for an extended period of time before the clinician becomes aware of it. Treatment requires a surgical approach to remove any granulation tissue that has replaced bone overlying the im-

plant to achieve any success.

The benefits of the Picasso diode laser is the fiber can be extended into hard-to-reach areas around the im-

plant to achieve better sterilization and debridement without the need to remove additional bone for access, which would be necessary if only de-

brideent with surgical hand instru-

ments was utilized.

Traditional methods have re-

ported mixed results in removing all of the granulomatous tissue from the exposed implant threads without altering or gouging the implant’s surface or coating. A pulsed Er:YAG las

er has also been reported to cause implant surface alterations.

Scanning electron microscope analysis has demonstrated no dam-

Figure 1. Fistula present at the distal of the maxi-

lary right canine in close proximity to the gingival margin.

Figure 2. Initial radiographic presentation demonstrating a large radiculolytic around the apical half of the implant at site No. 6. Figure 3: Following a full-thickness flap and removal of the granulomatous tissue with the Picasso diode laser, a lack of buccal bone is noted down the entire length to the apical. Figure 4: Osseous graft material was placed into the defect that had been cleaned with the Picasso diode laser and built out to the proper contour for the buccal plate.

Figure 5. Periapical radiograph taken post-surgically demonstrating defect filled with the osseous graft material.

Figure 6 & 7: CBCT of a cross section (6.) and coronal slice (7.) of site No. 6 taken 5 years after peri-implantitis treatment demonstrating maintenance of the buccal plate and no return of the initial periodontal problem.

Figure 8: Periapical radiograph at 5-year follow-up.
Multidisciplinary approach

age or alteration of titanium surfaces from a diode laser, regardless of the power setting. No visible difference between lased and non-lased titanium surfaces after irradiation has been reported, ensuring that the result yields the best surface guided tissue regeneration compared to either mechanical debridement or a Er:YAG laser.

Success in peri-implantitis treatment is strongly linked to the ability to eliminate the bacteria in the site that could hamper regeneration. This becomes more critical with implants that have been surface treated. Treated implant surfaces exhibit macro roughness that are

Figure 2. Pre-op occlusion

Figure 3. Pre-op full upper dental arch with missing teeth and bone defect

Figure 7. Full thickness flap elevation, and thin ridge

Figure 8. Complete exposure of the site after vertical releasing incision

Figure 9. Hydrolic sinus lift using normal saline through the osteotomy

Figure 10. Bone harvesting from the external oblique ridge

Figure 11. Blood extraction for PRF membrane preparation

Figure 12. PRF membrane

Figure 13. Sinus floor elevation using PRF

Figure 14. Implant Placement and the narrow ridge

Figure 15. Buccal view of the implant site showing bone dehiscence

Figure 16. Augmenting the site

Figure 17. Fully augmented site

Figure 18. Correction of the buccal defect

Figure 19. Ti mesh use to protect the bone augmented site

Figure 20. Ti mesh stabilize by cover flat screw

Figure 21. Buccal view of Ti mesh

Figure 22. Ti mesh covered by PRF membrane

Figure 23. Tension free closure and PTFE suture

Figure 24. Healed site

Figure 1. Pre-op

Figure 4. Pre-op x-ray showing short bone height

Figure 5. Occlusal view showing buccal defect

Figure 6. Buccal view during orthodontic treatment

Figure 12. PRF membrane

Figure 13. Sinus floor elevation using PRF

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Conclusions

The key to successful peri-implantitis treatment is early identification to limit bone loss from inflammation and infection. The diode laser is a powerful adjunct to treating peri-implantitis, allowing better access to eliminate more granulation tissue than when only mechanical means are utilized. This case demonstrates that the protocol can provide long-term predictable results showing 5-year maintenance of the grafted area and an absence of inflammation over that time.

Acknowledgement

Treatment for the case presented was performed by Dr. Markus Weitz. The full list of references is available from the publisher.

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Figure 24. Surgical dissection and Ti mesh removal

Figure 25. Customize screw retained temp. crown

Figure 26. Temp. crown placed and 2 stabilization sutures

Figure 27. Adjustment the contact of the temp. crown and orthodontically reducing the mesio-distal dimension

Figure 28. Gingival healing around the temp. crown after adjustment of the mesio-distal dimension

Figure 29. Temp. crown occlusal view of the healed site

Figure 30. Implant site after soft tissue conditioning

Figure 31. Buccal view of the healed site after soft tissue conditioning

Figure 32. Duplicating the gingival tissue site

Figure 33. Gingival sulcus duplicated

Figure 34. Impression post

Figure 35. Impression post with sulcus shape

Figure 36. Impression post

Figure 37. Buccal view of the healed site after soft tissue conditioning

Figure 38. Pre-op full arch view

Figure 39. Post-op full arch view

Figure 40. Buccal view with the final screw retain crown

Figure 41. Occlusial view of screw final crown

Figure 42. Final frontal view after orthodontic and restorative correction

Figure 43. Final occlusal view post-op

Figure 44. Final occlusal view post-op before insertion of the final crown showing correction of the buccal defect

Figure 45. Frontal pre-op photo

Figure 46. Frontal post-op photo

Figure 47. Final view with the smile line after cementation of 4 units veneers

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