CAPP’s Clinical Implantology Programme live surgical treatment performed in Ajman University

By Dental Tribune MEA / CAPPmea

CAPP-Tipton Dental Academy, British Academy of Dental Implantology (BADI) and the British Academy of Restorative Dentistry (BARD) have launched the Clinical Implantology Certificate and Diploma programme in Dubai, UAE. Group 1 started in January 2018. Group 2 will be starting on 17 October 2018. The same programme has been happening in the UK since 1992 and is now offered in Dubai.

Several weeks ago the delegates concluded Module 2 of the programme where they performed a live-patient treatment hands-on training. The hands-on part of the programme took place in Ajman University so the delegates had access to professionally equipped clinics. The course is ideal for dentists with little or no experience in placing implants and oral surgery but also for dentists who are looking to further enhance their clinical skills by placing implants in real-life situations. As delegates work towards placing implants under supervision, they will be able to practice these skills by treating patients, not only delivering results but knowing the reasons why the results were delivered.

The programme covers the key aspects of dental implantology to provide evidence-based, safe and predictable treatment of patients’ own cases. As a live patient course there is significant focus on patient selection, identifying suitable implant patients and how to create an optimum treatment plan using checklists and digital treatment planning tools. Delegates will grasp an in-depth knowledge of all the adjunct therapies and diagnostic tools to ensure that planning stages are comprehensive and thorough ensuring the patient journey is smooth and predictable.

This is the third programme that CAPP-Tipton Dental Academy and the British Academy of Restorative Dentistry (BARD) have started in Dubai, UAE. There are over 200 delegates already participating in the Restorative & Aesthetic Dentistry Diploma and Clinical Endodontics Diploma.

The Certificate consists of 3 modules which take place every 2 to 3 months. Each module is 4 days long. The course offers the participants a chance to obtain a Certificate in Clinical Implantology from the British Academy of Dental Implantology (BADI) and the British Academy of Restorative Dentistry (BARD).

After a successful completion of the Certificate course, the participants will have the chance to sign up for the Diploma course which will lead to Post-Graduate Diploma in Clinical Implantology from the British Academy of Dental Implantology (BADI) and the British Academy of Restorative Dentistry (BARD). The Diploma consists of additional 3 modules which take place every 2 to 3 months. Each module is 4 days long. The entire programme (Certificate and Diploma) is 14 months long, 6 modules totaling 24 days.

CAPP-Tipton Dental Academy offers 3 Diploma programmes in Dubai, UAE namely:
1. Restorative & Aesthetic Dentistry Certificate & Diploma
   www.cappmea.com/capptippton
2. Clinical Endodontics Certificate & Diploma
   www.cappmea.com/endo
3. Clinical Implantology Certificate & Diploma
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For more information visit the above mentioned websites or Call/Whatsapp +971528423659 or e-mail p.mollov@cappmea.com
Considerations for Long Term Success
Implants are Never Forever!

By Dr. Shankar Iyer, USA

This article will emphasize the importance of factors to consider before treatment planning for full arches with implants. It is not uncommon to make misleading promises when discussing implants as an option with unfounded claims of 98% success rates. Most of the survival rates are based on retrospective studies and not necessarily attributable to the original Branemark work published in 1981. Repeated citations of this article and the subsequent follow-up articles have made claims of a high percentage of success with implants. While this is partially true, the circumstances under which these implants survived has been incorrectly extrapolated to other clinical situations. The original Branemark research was done on edentulous arches with hybrid prostheses opposing either complete dentures or prosthesis of similar construction.

Patients are now wondering with these highly overstated survival rates, why their implants are failing and need maintenance within a short span. The answer lies in the lack of understanding of biomechanics. The contention that anything works has led to confusion in the field. The diametrically opposite views of short vs long implants, axial vs angled implants, graft vs graftless solutions, regular vs minis, delayed vs immediate, one piece vs two pieces, guided vs free hand placements and platform switching concepts have only caused anarchy in the discipline of implant dentistry. Potholes have gained popularity through corporate support and we see opinion leaders vociferously making unsubstantiated claims through limited clinical evidence. A novice finds it very difficult to get involved in implant dentistry because the education is being blessed by companies and not through universities or institutions.

After being involved in implants for over 20 years, I find it to be an humbling experience with cases that I treat or plan two decades ago returning to me for maintenance. Seeing these cases today, I wish I had this experience at that time so I could have served my patients better. Today it has taught me a lot in treatment planning. I am able to prognosticate the outcome and its management in the event of an untoward incident. The lessons in biomechanics have complemented the initial biological responses that can be predicted initially so that the survival of implant therapy is prolonged.

I am a firm believer of long term data and I fear the rapid evolution of products and techniques that claim to be faster and easier. If only I could train my patients osteoblasts to work harder and faster so their bones can heal rapidly, all of the problems can be eliminated and failures can be a thing of the past. The life cycles of cells have been a constant over a million years. We are told that implants are approved for immediate load and the cells can adhere to inanimate objects through unique surfaces. My understanding of cell biology may be limited but it is common knowledge that behavior of cells cannot be changed because the mitotic cycle for the DNA takes the programmed time period for turn over. Only in disease this rapid uncontrolled proliferation takes place. If this rule is upset then we look at metaplastic or anaplastic changes according to the turnover rate. Claims made by certain companies that, bone heals faster with their implants is unquestionable. Bone levels are magically maintained with their unique surface modification is also far from the truth. I have used over 16 different implant systems in my practice over the years and in my training programs and I have found that the osteoblasts are notoriously unbiased. There is bone loss with every system and modifying the surface or creating morphological shifts does not predictably deter bone loss.

In the courses I teach, I recommend waiting for a period of three years after any new feature or biological product is introduced into implant dentistry. There is no room for latest or newest in clinical practice. If a company is constantly introducing new product lines and changing their designs, there is only one conclusion – They are having trouble and hence they have to change. A robust system that works seldom needs modifications for getting predictable results. Aspirin can never be dubbed for its efficacy, being so old and dated. The original Branemark external hex (now made out of type 4 Titanium but designed in 1965) is still very functional and out of type 4 Titanium but designed in 1965) is still very functional and in 1996 is still very functional and a work horse for hybrid prosthesis. The surfaces have improved much but its basic design and biomechanical considerations will be valid for another 50 years. Premature adoption of technology or materials is fraught with shortcomings and unknown consequences. Classical examples of potential catastrophic failures include the TPS coatings, HA surface modifications, sintered surfaces, flawed surgeries, guided surgeries, immediate loading, costly BMPs and the list goes on.

The message is very simple – one cradles before they walk and you must learn to walk before you can run. The same is true for implant dentistry. The novice today has a wide choice – you can become a complete arch implant specialist with 4 implants and guided surgery over a weekend or spend 4 years learning the basics and judiciously treatment plan cases with customized solutions. Half of the participants of our Maxicourses that we run in the U.S. and overseas have practitioners who have placed hundreds of implants and got their training through corporate education. One does not become a musician by buying a piano or a musical instrument, nor can you become a pilot by buying a plane. Training in implant dentistry has become a fad. Most courses are offered through companies and the company’s sole interest is to sell their systems. There is a whole world of treatment plan that is out there before the system can be utilized. Let’s not place the cart before the horse. The void is very apparent the time is now for implementing judicious treatment plans. Let’s serve our patients with what they need and not what we want them to have.

Iyer’s Top 10 Guidelines for Predictable Implantology

1. Diagnose the problem first and don’t treat because you have a tool that you can use.

2. Measure the disease and provide the therapy, don’t sell concepts. Leave what’s new and latest to the risk takers, stick with proven and tried systems.

3. Implants are the last resort in treatment planning – exhaust all conservative modalities.

4. Implants should replace missing teeth not replace teeth.

5. Expensive implants don’t mean success rates are better, cheaper does not mean everything works – you get what you pay for. There is no substitute for evidence based practice.

7. Consider every implant as a failing.
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entity and the trick is to do the best you can to maintain it as long as you can.

8. Select the system that does not change its product line every year.

9. There are no short cuts or faster ways to get success in life and implants are no different.

10. The success rates of implants are inversely proportional to the number of years you practice implants.

Case Report

This case report will provide a rationale for a sound sequential treatment plan in the management of long-term failure of dental implants.

Two patients were referred to my practice for rehabilitation of failing implants. The patients were referred by their current restorative dentists for a second opinion regarding the failing implants. After a consultation, it was decided that the implants were salvageable. Treatment plan for each patient was based on the long-term considerations. One of the reasons for not using them now is not because they fail, but because in the long term, the success rate of implants is not because they fail, but because in the long term, the success rate of implants is lower than expected. One of the reasons for not using them now is not because they fail, but because in the long term, the success rate of implants is lower than expected.

A 58-year-old male patient presented for the management of failing implants in the maxillary anterior sextant. The patient had undergone a full arch reconstruction with screw-retained prosthesis approximately 10 years ago. The patient reported having some symptoms of sinusitis and complained of pain in the area of interest. The implant prosthesis was unstable and the patient was referred for treatment. After a comprehensive examination, it was decided that the implants were salvageable. Treatment plan was to perform subperiosteal implants and use the existing Framework for fabrication.

The implant prosthesis was removed and the implant sites were prepared for subperiosteal implants. The subperiosteal implants were placed and the Framework was fabricated and the tissues were sectioned and removed piecemeal. The patient was referred for rehabilitation and the Framework was inserted. The Framework was indexed and the positions of the abutments were checked for passivity and accuracy. The Framework was processed and inserted. The patient's vertical was maintained. The post op radiograph reveals a stable outcome. The anterior cantilevered crowns provide for optimal esthetics in the extremely resorbed anterior maxilla. The post operative outcome provided an aesthetic and functional rehabilitation of the failing implant FPD. The provision of pontics enhanced the outcome in the esthetic zone and in this case it favored the design due to the atrophy that precluded implant placement in the premaxilla. The case has been in function for over 5 years and the patient has been on re-examination every 4 months.

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Module 4  November 1st – 6th       2018
Module 5  January 24th – 29th     2019

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