Dental Tribune Middle East & Africa Edition | February 2015

By Dental Tribune MEA

DOHA, Qatar: Dental Tribune MEA visited the 3rd Qatar Dental International Conference on 11 – 12 December 2014. We find out more from the President of Qatar Dental Association – Dr. Mohammed Al-Darwish on the developments in Qatar.

Dental Tribune MEA: How do you reflect back the time since Qatar Dental Society was established in 2007?

Dr. Mohammed Sultan Al-Darwish: Before 2006, we dreamed to have an organization covering all dentists in Qatar under one umbrella. We dreamed to have a dental conference in the country. We dreamed to have a dental society similar to our neighboring countries. There was a group of 20 dentists held a small meeting and after a 5 hours discussion on all of the challenges, the decision was to establish a dental society in the country. Now, after 6 years we reach some of the targets we had set ourselves.

As President of the Qatar Dental Society, how have you seen dentistry develop in Qatar during your current term as leader of the QDS?

When I started my term as the first president of Qatar Dental Society, the number of dentists in Qatar were 657. Now in 2014 we reached 1228 dentists. We organized the first, second and third Qatar International Dental Conference. Also, more than 12 small dental symposiums, workshops and seminars have been organized.

In 2009 you organized the First Qatar International Conference, in 2011 you organized the second. How important is it for the Qatar Dental Society to have annual conferences? What has improved since last conferences?

On December 15 - 14, 2000, we organized the first Qatar Dental International Conference. It was part of Qatar Health Medical Conference with 15 lectures and small exhibition area (6 booths). On 12 - 15 April, 2012, we organized the second Qatar Dental International Conference & the 8th Gulf Dental Association conference. The scientific program of that conference had 19 lectures and 2 workshops. The exhibition area consisted of about 19 booths. On 11 – 12 December, 2014, we organized the 3rd Qatar Dental International Conference. The conference has grown over the years and the scientific program included 26 lectures with 8 workshops. The exhibition area consisted of 20 booths. More than 12 Deans of dental schools attended this conference. As I mentioned during the opening ceremony of this conference, the supreme council of health in Qatar decided that a dentist must have 40 CME each year to renew the license and 15 CME out of 40 must be local. At this point we are looking forward to make the conference annually.

Are there plans for a Dental University to open up in Qatar any time soon?

Yes, there is a plan to open a dental school in Qatar, and now we are in the preparatory stages of making this happen.

Are the number of dentists in Qatar increasing? There are a small number of Dental Technicians, how do you go about increasing these numbers?

Yes, the number of dentists in the country are increasing as I mentioned before. As you know we have North Atlantic College – Qatar, and in this college we have a dental assistance program and this year we started a dental hygienist program. Regarding the dental technicians, we have plans to coordinate with other dental institutes to recruit dental technicians in Qatar.

How can dentists in Qatar stay up to date with the latest in dentistry?

By organizing the conferences, seminars, workshops and symposiums we keep our dentists updated with the new dental technology. Also, all government sectors, such as Hamad Medical Corporation, Primary Health Care Corporation, Aspetar, Qatar Petroleum, Dental Services in the Army and others always send the dentists to international conferences and workshops that are organized in other countries.

Has Digital Dentistry had a strong influence in Qatar?

Yes, Digital Dentistry has a strong influence in Qatar. Majority of dentists in Qatar have started to use CAD/CAM and dental laser in their clinics. What advice do you have for the young generation of dentists in Qatar?

Work hard, continue your study with an advanced program and master degree, involve yourself in dental researches and do not forget to attend dental conferences and workshops to keep yourself updated with the new dental technology.

Is there anything else you would like to share with the readers?

Qatar Dental Society would like to thank Dental Tribune MEA/Dr. Mohammed Sultan Al-Darwish for participating in the 3rd Qatar Dental International Conference. 

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3rd Qatar Dental International Conference
11 – 12 December 2014, Doha, Qatar

Regional Dental Associations, Societies and Universities attending the Event

By Dental Tribune MEA

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Date of preparation: June 2014. Ref: CHSAU/CHPLD/0008/14b
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Ref: CH-SAUC/CHPLD/0008/14c
Modern implants from a different angle

By Safa Tahmasebi DDS, MS (USA) Prosthodontist; Costa Nicopolouds BDS, FFD (SA) Oral & Maxillofacial Surgeon

Background

With the success of dental implants in the profession of dentistry has moved into applying innovative ideas that have decreased treatment time and amplified the quality of patient’s lives. While integrating into modern dentistry, implant treatment has shifted direction from being surgically driven to prosthetically driven. Amongst other developments in improving all aspect of implant dentistry, angled implants were first introduced in the early 1990’s and since then there has been ample research into cases to assess and support their success. (Figure 1)

Implants were originally tilted in a bodily fashion to bypass certain anatomical structures that otherwise hindered clinicians from placing them in areas such as maxillary sinuses, inferior alveolar nerve canal, the mental foramen, mandibular lingual canals and maxillary buccal canals. Procedures such as nerve repositioning, various grafting procedures, distraction osteogenesis, ridge splitting and many more not only lengthened treatment time, but also increased patient morbidity during implant rehabilitation cases. In addition to bypassing the anatomical limitations, the tilting of posterior implants in a distal manner results in an increase in the implant-abutment interface, thereby allowing better load distribution, and reducing the cantilever forces. A tilted implant became an effective and safe alternative to major augmentation procedures such as maxillary sinus grafting procedures and ridge augmentation procedures.

Initially there were negative speculations regarding the hard and soft tissue response around tilted implants as opposed to axially straight implants. However various in vitro and in vivo studies have proven no apparent long-term detrimental effects between angled and straight implants. Kerekanos et al in 2000 followed up forty-seven consecutive patients with tilted implants for forty months and showed no significant difference between tilted and non-tilted implants. A comparative 3D finite element stress analysis conducted by Cases et al in 2008 showed no indication that angled implants create stress-induced problems compared to straight implants. A meta-analysis performed by Mercier et al in 2012 evaluated the outcomes of upright and tilted implants supporting full arch rehabilitation, and found that immediate rehabilitation of edentulous maxillae, after at least 1 year of treatment. No significant mean difference between tilted and upright implants was found with regards to bone loss. Rosén et al in 2013 retrospectively evaluated the surgical effect of tilted implants in the severely resorbed edentulous maxillae as opposed to bone grafting and conventional prosthodontics to restore the posterior maxilla. In a ten-year study with tilted implants patients stated that the alternative to the more demanding grafting techniques.

Angled abutments

Furthermore while angled implants improved load distribution, reduced augmentation procedures, lessened cost, treatment time and eliminated cantilevers in many cases they did necessitate the use of angled abutments to achieve a parallel path for the draw of the final prosthesis. Custom or prefabricated abutments were necessary to redirect the screw access holes in a common path of insertion to aid in the fabrication and installation of the final prosthesis. In addition these abutments were also used to redirect the screw access hole in the lingual direction to aid with esthetics of the final restoration. In cases of severe angulation the patient is limited to the use of cemented restorations with the use of custom made abutments. (Figure 2)

Although these abutments are widely used today, they do present certain disadvantages that warrant mention. Firstly the connecting surfaces of custom made abutments may have casting imperfections that can attract bacteria and bio film accumulation. Secondly if used in cement retained restorations, they promote the use of cements that can cause untreated peri-implantitis and peri-implant mucositis. Thirdly, thinning of the custom abutment decreases the abutment and prosthesis integration allowing the implants to fracture at the final restoration under severe load. Fourthly, the use of abutments takes up interocclusal vertical prosthetic space often needed for the restoration. Finally in certain cases one may not be able to redirect the screw access whole lingually and masially to fabricate a screw retained restoration even with the use of prefabricated 17° and 50° angled abutments. (Figure 3)

Co-Axis Implant

Fortunately the above disadvantages can be eliminated by the use of Co-Axis Implants (Southern Implants Irvine, California) introduced eleven years ago for their ease of use and ability to redirect the 3-D position of the desired installation of the implant within the bony housing. The angulation correction allows for the placement and emergence of the implant with the bony housing and hence allowing for a minimum of 2mm of buccal bone that will ensure the stability and firmness of the gingival position in the esthetic area. (Figure 4)

Anterior Maxilla

Implants in the esthetic area has been a popular topic in the recent years due to the catastrophic failures associated with implants in the esthetic region. The difficulty that arises with implants in the esthetic area is related to anatomic limitations and the higher resorative properties of the buccal plate. The anatomic limitation is the common buccal concavity associated with the pre maxillary region. The anatomic limitations of the anterior maxilla often require either an angled implant or adjunctive grafting procedures. The use of Co-Axis implants allows the operator to place an implant within the extraction socket of an anterior maxillary tooth without pressure on the buccal plate and simultaneously avoiding buccal plate perforations. The placement of an implant close to the buccal plate will lead to implant thread failure after initial healing, not to mention the inevitable use of custom made abutments and cemented restoration to correct the severe facial angulations. Consequently by avoiding the use of angled or customized abutments the inflammatory response due the micro gap / cement that may ultimately lead to crestal bone loss over time is eliminated. Lastly, facial inclination of an implant makes the facial surface of the connecting abutment thinner than usual and hence avoiding to fractures and prosthetic complications. The Co-Axis angle correction allows for implant placement in the available bone and hence the screw axis hole emerges from the palatal direction allowing the implants to be centralized within the alveolar bony. This angular correction allows for the placement of the implant within the bony housing and hence allowing for a minimum of 2mm of buccal bone that will ensure the stability and firmness of the gingival position in the esthetic area. (Figure 5)

Deciding on the Angle

This tapered body implant is available in 12°, 24° and 36° degree built in angle , ranging in 4, 5, 6 mm diameter and 8.5mm to 18mm in length. It is currently available in the external hex, Tri-nex and internal octagon connections. In extreme cases for even higher angle correction, the Co-Axis implant can be combined with a 17° or even the 50° angled abutment. With various angulations available one can make a decision of the angulation needed by the use of angled direction indicators that may be used to orientate and assess the 3-D position of the desired access hole within the surgical guide (Figure 6). The angled direction indicator is inserted into the osteotomy and the prosthetic axis is checked regarding the access hole position for screw retention as well as for parallelism with other implant fixtures. When the orientation is confirmed the mesial or distal rotation of the implant allows for the correct and easy internal inclination of the implant. The use of the Co-Axis Implants facilitates the avoidance of anatomical limitations, shortening of cantilevers, and enables the use of screw retained restoration without the need of angled abutments. The use of angled abutments is hence not necessary since Co-Axis Implants correct the inclination within the body of the implant.

Implant Tribune
firmed, then the site is enlarged to appropriate implant diameter & length and the implant with the appropriate built in angulation is inserted (Figure 7). The angle correction of the implant is therefore at a sub-crestal level and prosthetic space is not utilized by angulated abutments.

Conclusion

Today more clinicians are advocating the use of angled implants. This leads to less grafting procedures that not only minimizes the overall treatment time, but also reduces the cost and diminishes the patient’s morbidity associated with grafting procedures. Co-Axis implants also allow early or immediate loading protocols that would otherwise not be possible with conventional implants. Therefore, the use of native bone, the avoidance of expensive angulated abutments, decreased patient morbidity, reduced cost, benefits of immediate loading, likelihood of bone retained restorations, and elimination of long cantilevers are all advantages of using Co-Axis implants.

References


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Dr. Safa Tahmasebi D.D.S, MS
Cert. Prosthodontist (USA)
Dr. Safa Tahmasebi Completed his Bachelors degree in Biology and a minor in Biochemistry at Saint John’s University. Queens New York in 2004 with a full scholarship based on academic performance. In 2005 he joined State University of New York at Buffalo School of Dental Medicine where he attained his Doctor of Dental Surgery and qualified as a Dentist in 2008. He joined the Albert Einstein Medical hospital of Montefiore in Bronx New York where he completed one-year hospital dentistry fellowship. In 2013 he completed three and half year full time training in prosthodontics and surgical training with a masters degree in prosthodontics at the West Virginia University School of dentistry. During this time He was an adjunct clinical instructor to the undergraduate programs at the WVU University. In 2015 he joined the SameDay Dental Implants Bränemark Osseointegration Center (BOC) Dubai as a full time prosthodontist specializing in full mouth rehabilitation, immediate loading and Smile reconstruction.

Let’s Share What We Know

Take part in one of our upcoming seminars.

Orthodontic Seminars – by Dr Fabien Depardieu
- Restorative/Orthodontic Interface: Working together to get the best results for our patients
- Orthodontics in 2015: What’s new
- Facial Aesthetics
- Orthognathic surgery

Oral surgery seminars – by Dr David Roze
- Immediate implant into a fresh socket
- Oral surgery in the dental clinic: Review and results
- Implant crown restoration

Dr. Costa Nicolopoulos DDS, FFD (SA)
MFDS
Oral & Maxillofacial Surgeon
Dr. Costa DDS qualified as a dentist in 1984 receiving his dental degree cum laude from the University of Witwatersrand, Johannesburg, South Africa. He graduated top of his class with rank order No.1 and received numerous awards including the Gold Medal of the Dental Association of South Africa for the most outstanding graduate. In 1986 he completed his 4 year full time postgraduate Maxillo-Facial & Oral Surgery training at University of Witwatersrand, South Africa and was awarded FFD (SA) MFDS. Since 1999 he is in full time specialist Maxillo-Facial & Oral Surgery practice private practice concentrating on immediate loading of dental implants. To date he has placed over 50,000 dental implants. He has also presented as a key lecturer at numerous international implant congresses.

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Figure 6. 12° direction indicator within a surgical guide
Figure 7. Direction indicators left to right (0°, 12°, 24° and 36°)

Figure 8. The use of 12°, 24° and 36° implants in a fixed maxillary immediate loading rehabilitation

Coming up soon:
- Orthodontic Seminars – by Dr Fabien Depardieu
- Oral surgery seminars – by Dr David Roze
- Immediate implant into a fresh socket
Sinus lift with simultaneous implant placement

Piezosurgery offers the patient a gentle treatment with less complications and time saving benefits.

By Dr. Peter Hentschel

Oral rehabilitation has been paid notice for a long time to regain masticatory function and for aesthetic reasons. Implant placement in the maxilla is often limited due to missing height of the alveolar process, this can be solved by external Sinus Graft (Bone 1990). The alveolar crest can be built up to 8-15 mm by Sinus Elevation. The function of the sinus is not touched by the reduced volume, the success rate is between 85 to 90 % after 15 years. The lower success rate often comes along with an intra-operative perforation of the Schneiderian membrane (Incidence 25-40%), failures are based on the in some circumstances following complications. In opposite of app 25 % perforations with bone milling devices the use of piezoeurgical surgical devices can lead to perforation rates of 5%. At external elevation and sinus augmentation a second surgical procedure can be avoided by simultaneous implantation in case of 5 mm bone height. During the Elevation of Schneiderian Membrane with sandwich technique autologous bone and bone substitute materials are used (Kamikawa et al. 2000). To resist the respiratory pressure non-resorbable bone substitute material (eg. Compactbone B, bovine Bone) or the cranial bone lid are placed next to sinus membrane.

The during the procedure gained autologous bone can be placed alone or in combination with a bone graft material (eg. Compact Bone S, biphasic Calciumphosphate) around the placed implant. Sinus Elevation with simultaneous implant placement is indicated with up to 97.0% survival rate in after years (Frelag et al. 2000). Guided Bone Regeneration (GBR) as state of the art method for bone grafting uses in most cases bioresorbable Membranes. Resorbable membranes offer several advantages beside the easy handling, as no need for a second surgical procedure for removal or minimization of complications, e.g. soft-tissue dehiscences.

Directed by the cranial bone lid design sharp edges can be avoided which reduces the risk of perforation.

After release of the sinus membrane (Fig. 4) the implant tunnel was prepared (Fig. 5) and the Implant (SL Implant; Dentegris, Germany) placed (Fig. 6). Simultaneously the surrounded space was covered with a rehydrated Collagen Membrane (Bone Protect Membrane; Dentegris, Germany) as protections of the Schneiderian membrane (Fig. 7). Autologous bone was mixed with Compact Bone B and placed in the sinus for stabilization (Fig. 8).

After control of primary stability particulate materials was filled laterally and covered with pericard membrane according to GBR standards (Fig. 9). The flap was readapted and closed, controlled by X-ray shows axial positioning and augmentation of sinus maxillaris (Fig. 10).

Reentry after five months was accompanied by full ceramic crown and results in aesthetic and harmonic rehabilitation (Fig. 11).

To ensure the barrier and to stabilize the particulated bonengrafting material a pericardium membrane with a resorbtion time of 16-24 weeks is used (Bone Protect Membrane; Dentegris, Germany). The pericardium membrane offers very good handling properties in combination with a prolonged barrier function.

Case Study

The patient (36 y,f.) was showing an alveo loco lost tooth in 15 (Fig. 2), Patient's request was aesthetic and masticatory rehabilitation which was suggested by one-stage external elevation.

Based on diagnostic planning piezoeurgical window preparation in 15 (Fig.5) was performed after local anesthesia and periotomal flap. By choosing a round-oval lid design sharp edges can be avoided which reduces the risk of perforation.

For filling of horizontal-cranial space and stabilization of bone lid a bovine bone graft is used (Compact Bone B; Dentegris, Germany). Bovine bone has been used in dental surgery for decades and is well known for stable and reliable results.

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*** Exclusively distributed by Henry Schein Middle East ***
A big scientific date. A historical event. An international agora.

By Medicon

A new, progressive, engaging and exclusive Congress, which represents the whole world of dentistry. This Congress will be open to debate with the big citizens audience on prevention topics and health care, especially the dental care, which aims at recommending practical solutions and at opening up new horizons for the general qualifications of all professionals for an efficient, precise and motivated assistance.

The involvement of both the Italian and the International press shows an unusual interest for all the issues related to the dentistry throughout the world. With great satisfaction the organizers announce the exceptional participation of Scientific Associations, Universities, Hospitals, No-Profit Organizations that will allow not only a discussion, a comparison, a moment of experience but also will broaden the horizons for an evolving, growing and improving world.

As President of ANDI Rome I must attribute this success to a great team work with the same purpose and to an incisive efficiency which make me proud and very satisfied. The involvement of ANDI Lazio, ANDI Naples and ANDI Campania underlines and highlights a desire of unity, collaboration, foresight which will be able to positively affect the future work of everybody in order to promote the “excellence” in the world of dentistry.

On June 18-19-20, 2015 a big event on a scientific debate will be celebrated in Rome between the Mediterranean and Middle East countries, and we hope it will become the starting point for a collaboration for a better future for all of us.

I wish you a great job and see you in Rome!

Sabrina Santaniello
President of Scientific Committee
Gabriele Edoardo Pecora

With great satisfaction we announce the participation of numerous lecturers coming from many worldwide countries and the city of Rome will be a meeting point for networking and sharing, a new project which looks at the future of the dental world.

In particular, in the “International Multidisciplinary Program” every country joining the Congress will be represented by a speaker.

A major knowledge is necessary, as well as a greater integration, a concrete sharing of cultural projects, of operational protocols and of stimulus for research.

This Congress in Rome wants to represent the start time of a collaborative project involving the countries of Middle East and Mediterranean!

Gabriele Edoardo Pecora
President of the Congress

Roberto Pistilli
The large participation of Universities, Hospitals and Professional Freelancers has allowed the programming of a Congress that we cannot define that ambitious. With the support of the most important Scientific Societies, we will have a Prestigious Faculty with speakers of international renown who, with your presence, will make this event the “Main Event 2015”.

As President, I extend a warm invitation to participate for living all together an unforgettable experience.

Roberto Pistilli