AAID MaxiCourses

By AAID

The American Academy of Implant Dentistry, founded in 1971, is the first professional organization in the world dedicated to Implant Dentistry. Its members include general dentists, Oral and Maxillofacial Surgeons, Prosthodontists, and others interested in the field of Implant Dentistry. The Academy conducts and expands the opportunities for dentists to obtain comprehensive, non-biased curriculum of quality education to prepare them for including implantology in their scope of practice. The recent launch of the MaxiCourse Japan after approval brings to 11 the number of MaxiCourses offered around the world. The First Annual AAID MaxiCourse in UAE was offered in 2009 in Abu Dhabi and to date 960 doctors—Consultants, Specialists and general dental practitioners have graduated from the Program. Currently the Program is in its Eighth Year. The Program consists 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 45.5 CME hours.

MaxiCourses are the preferred means for a doctor to obtain comprehensive foundation in Implant Dentistry says Dr. Rod Stewart, Chair of AAID’s MaxiCourse subcommittee of the Academy’s Education Oversight Committee during his recent visit to the UAE as one of the speakers of Module 5 of the MaxiCourse in Abu Dhabi. The Faculty of the Program, all credentialed by the American Board include Drs. Shankar Iyer (Co-Director), Jaime Lozada, Robert Miller, Alfred Duke Holts, Tatsuya Nakagihatani, William Locante, Natalie Wong, Stuart Otten Jones, Irfan Kanchwala, Mathew Kattadiyil, Frank Lamer, Robert Schoeiring, Amit Vohra, said Dr. Ninette Banday who is the CEO-Director of the Program in the UAE and also an instructor in the Program. These Top Speakers discuss a broad range of interesting topics that all experience levels can benefit with scientific support. The Program moves from the basics to the advanced level and so in Module 1 all participants review the Anatomy, basic surfacing skills, flap designs along with placing implants on artificial jaws. This prepares them for and sets the basis for the subsequent clinical sessions where the participants work under direct supervision of the instructors on patients. The Ninth batch scheduled to start from August 30th 2016 will allow the participants to place 10 implants as part of the Program. The participants therefore get an opportunity for discussion of actual problems and to find solutions which they can apply in their clinical practices. Adding the supervised Clinical sessions both surgical and restorative has further elevated the level of the Program. The expertise developed in turn benefits the patients the dentists serves.

The Program fulfills the educational requirements for the Examination for Associate Fellow Membership Examination for the American Academy of Implant Dentistry. In several parts of the world the Associate Fellowship or Fellowship of the AAID is an acknowledged credential that represents quality training in Implantology and skills in the Art and Science of Implant Dentistry. To obtain these credentials our participants have to take the AAID examinations which involves a written Examination—the Part 1 and an Oral/Clinical Examination which is clinically oriented, the Part 2. The Part 1 the written part can be taken at several Prometric Centers in Abu Dhabi and Al Ain and also in other centers in the Middle East Region. For the Part 2, previously participants had to travel to Chicago, but now since last two years they can take it in Dubai and the next Part 2 Examination is scheduled in May 2016. The Faculty are now working to start an advanced Bone grafting and a Soft tissue Management Course that is scheduled to start from August 2016 to further the clinical skills of the MaxiCourse alumni.

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.

The AAID is making every effort to make implant education more accessible and beneficial to the participants ensuring comprehensive training Programs in Implant Dentistry for the MaxiCourse Asia additional information can be obtained online at www.maxicoursesasia.com or by emailing Dr. Ninette Banday at dmrbanday@yahoo.com.

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Pre-Registration is Mandatory so it is a Limited Participation Program. For further information and registration details visit website: www.maxicoursesasia.com or e-mail Dr. Ninette Banday, Coordinator AAID-MaxiCourse UAE at dmrbanday@yahoo.com.
The treatment of peri-implantitis is a long-term follow-up after debridement and grafting.

**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 6). A Gutta-percha cone was inserted into the fistula to trace the origin 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 previously.

The implant was identified as a Biometron Mark III RP (Nobel Biocare, www.nobelbiocare.com) at site No. 4 through 6, and a NobelReplace (Nobel Biocare) at site No. 7. A radiograph was taken to evaluate the underlying osseous structure around the implant, which demonstrated radiolucency associated with the apical of implant No. 6 and rootal bone loss with thread exposure under the soft tissue on implant No. 7. Clinically, no mobility was noted.

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-implant repair.

Preoperative antibiotics (2 g amoxicillin) were given orally 1 hour prior to the initiation of treatment. Local anesthesia (Septo-nest, www. septodont.com) was administered for local infiltration on the buccal and palatal of the treatment area.

A horizontal incision was made from the distal of the first molar to the gingival margin to limit postoperative discomfort. The site appeared to be healing normally and he was appointed for a follow-up to check healing at the next periodontal recall appointment in 1 week for suture removal and a radiograph was taken twice daily for the initial 3 days post-surgically. The patient returned after 1 week for further removal and indicated no significant postopera-
tive discomfort. The site appeared to be healing normally and he was appointed for a follow-up to check healing at the next periodontal recall appointment in 1 week for suture removal and a radiograph was taken twice daily for the initial 3 days post-surgically. The patient returned after 1 week for further removal and indicated no significant postoperative discomfort. The site appeared to be healing normally and he was appointed for a follow-up to check healing at the next periodontal recall appointment in 1 week for suture removal and a radiograph was taken twice daily for the initial 3 days post-surgically. The patient returned after 1 week for further removal and indicated no significant postoperative discomfort.

**Diagnosis**

Managing peri-implantitis can be a challenge. As this case illustrates, 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 the impacted and infected tissue that has replaced bone overlaying the implant to achieve any success.

The benefit of the Picasso diode laser is the fiber can be extended into hard-to-reach areas around the implant to achieve better sterilization and debridement without the need to remove additional bone for access, which would be necessary if only debridement with surgical hand instruments was utilized.

Traditional methods have reported mixed results in removing all of the granulation tissue from the exposed implant threads without altering or gouging the implant’s surface or coating. A pulsed Er:YAG laser has also been reported to cause implant surface alteration.

Scanning electron microscope analysis has demonstrated no dam-

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**References**

1. The added benefit of using a diode in these procedures is biostimulation 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.

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

3. A hand instrument was utilized to remove any gross granulation tissue adherent to the bone and expose the implant threads (Figure 5).

4. An activated 300-µm diode tip on the Picasso laser (JADE Lasers, www.jadelasers.com) set at 10 W in continuous mode was used to remove any residual granulation tissue on the exposed threads at the defect and sterilize the defect area. The diode’s fiber tip was placed into physical contact with the implant surface to remove any residual granulation tissue and sterilize the area of any bacteria that contributed to the peri-implantitis, leaving clean threads.

5. Following debridement and sterilization, bone voids in the osseous walls were created.

6. Geistlich Bio-Oss® (Geistlich Pharma, www.geistlich-pharma.com, a bovine biocompatible porous bone mineral substitute, was packed into the defect around the implant and allowed to absorb blood from the surrounding tissue to form a coagulated mass.

7. The bone graft was built out buccally to create a new buccal plate covering the entire implant below the crestal bone line (Figure 6). A piece of resorbable membrane (Resorix® Plus, OralPharma, Inc, www.orapharma.com) was trimmed to overlay the osseous graft and end on native bone and was placed over the graft under the flaps that were repositioned and secured with nine interrupted sutures using 5-0 Prolene to achieve primary closure. A radiograph was taken to document the bone fill of the osseous graft (Figure 7). Hemostasis was confirmed and the patient dismissed. A prescription for a Z-Pak (Z-Pak, Pfizer, www.pfizer.com) was given with the instructions to use as directed until finished. Additionally, a prescription was given for Dolobid® (Merck & Co, Inc, www.merck.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 appointed for a follow-up to check healing at the next periodontal recall appointment with his general dentist office.

8. 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 cross-sectional image at the right maxillary canine demonstrated that the grafted buccal plate remained at the position completely covering the implant with no sign of further infection (Figure 5 and 7). A periapical radiograph confirmed osseointegration (Figure 8).

9. Discussion

Managing peri-implantitis can be a challenge. As this case illustrates, 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 the impacted and infected tissue that has replaced bone overlaying the implant to achieve any success.

The benefit of the Picasso diode laser is the fiber can be extended into hard-to-reach areas around the implant to achieve better sterilization and debridement without the need to remove additional bone for access, which would be necessary if only debridement with surgical hand instruments was utilized.

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**Figure 1.** Fistula present at the distal of the maxillary right canine in close proximity to the gingival margin.

**Figure 2.** Initial radiographic presentation demonstrating a large radiolucency around the apical half of the implant at site No. 6. Following a full-thickness flap and removal of the granulation 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.** Peninsular 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.
Multidisciplinary approach

**Figure 1. Pre-op**

**Figure 2. Pre-op occlusion**

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

**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 7. Full thickness flap elevation, and thin ridge**

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

**Figure 9. Hydraulic 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**

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**Age or alteration of titanium surfaces from a diode laser, regardless of the power setting.** No visible difference between laser and non-lasered titanium surfaces after irradiation has been reported, ensuring that the result yields the best surface guided tissue regeneration compared to other 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 advantageous for initial integration, but also will harbor bacteria when peri-implantitis has occurred. Removal of bacteria in these micro irregularities is difficult by mechanical means. The diode laser has the ability to decontaminate the exposed surface and threads without any negative effects.

**Conclusion**

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 performed by Dr. Markus Weitz.

**References**

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