

The Journal of ORAL CERAMIC IMPLANTOLOGY

January/February 2020



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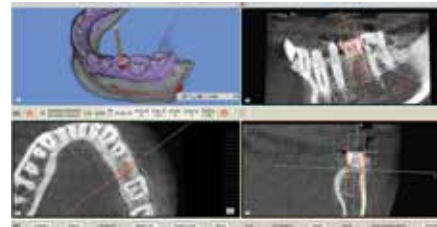
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THE JOURNAL OF
ORAL CERAMIC IMPLANTOLOGY
ZIRCONIA IMPLANTS

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Publisher Palmeri Publishing Inc.
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Canadian Office: 35-145 Royal Crest Court,
Markham, ON L3R 9Z4

Tel: 905.489.1970
Fax: 905.489.1971

Publication Dates: Spring Summer, Fall, Winter

Printed: In Canada Canadian Publications.
Mail Pr. Sale Agreement 9386690

Spectrum Implants: ISSN 2293-7897

Editor-in-Chief: Dr. Sammy Noubissi

Design & Layout: Samira Sedigh
samira@palmeripublishing.com

Spectrum Implants is published four times a year, and is distributed to dental practitioners across Canada and the United States. The journal is committed to better the knowledge of dental practitioners in the discipline of dental implantology.

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A case report: A path towards health through multi unit immediate implantation using the Swiss Biohealth All IN ONE concept

Dr. Corbin Popp, Dr. Ulrich Volz, Dr. Josephine Tietje,
Dr. Rebekka Hueber, Paul Kilanowski

Immediate implantation vs. late implantation

Today, implants are usually placed as late implants in healed extraction sockets three to six months after tooth removal. In order to shorten these long therapy and healing phases and to reduce the number of surgical interventions, immediate implant placement has been tested in addition to this procedure⁽¹⁾. The first trials of immediate implant placement with implants made of aluminum oxide (Tübingen immediate implant) were conducted by Prof. Dr. Wilfried Schulte at the University of Tübingen as early as 1978⁽²⁾.

According to the ITI Consensus Conference in 2009, a distinction is made between immediate implant placement (immediately after extraction), early implant placement (4 to 8 weeks), delayed implant placement (12 to 16 weeks) and late implant placement (6 months after extraction)⁽³⁾. Studies show a slightly higher survival rate for late implantation (4-6). Implants placed in fresh extraction sockets appear to have slightly higher loss rates than late implants^(4,7,8).

Immediate implant placement has advantages and disadvantages over the other procedure. It is particularly advantageous in the anterior region to preserve the soft and hard tissue profile after extraction of the tooth (9). Bone augmentation or the use of bone replacement materials is often not necessary (10, 11). Long waiting times for the patient are also avoided and the patient is promptly helped to achieve a better oral quality of life (12). Patients with a thin gingival type, lack of keratinized mucosa, a thin buccal bone wall and periodontal or periapical pathological findings are disadvantaged and at higher risk^(3,13).

Overall, it can be stated that immediate implants are now a proven procedure and show high survival rates⁽¹⁴⁻¹⁷⁾. The advantages of classic late implant placement are that the alveolus is completely healed in bone and the procedure can be planned with low risk. The implant can be placed in a primarily stable osseous position. The disadvantage is that vertical and

horizontal resorption can occur during the healing phase of the bone without loading^(18,19).

Zirconium dioxide implants

Zirconium dioxide implants (ZrO₂ implants) as an alternative to titanium implants are used more and more frequently. The ceramic implants made of aluminium oxide, which were introduced for the first time, could not establish themselves due to high fracture rates (20). However, through continuous development and introduction of ZrO₂ implants, ceramic implantology is increasingly establishing itself in the dental market.

The material ZrO₂ has many advantages. It is metal-free. The stable bonding of zirconium with oxygen as dioxide results in a material with high biocompatibility (21). The material is fully reacted and therefore shows a high resistance to corrosion⁽²²⁾. In the case of titanium, which is highly reactive as a metallic material, on the other hand, many studies show corrosion on the surface with release of titanium oxide particles. These trigger an inflammatory reaction in the surrounding tissue and can promote the development of periimplantitis⁽²³⁻²⁵⁾. This particle release is also caused by mechanical friction during insertion or by micro-movements of the titanium implant under load⁽²⁶⁾. In comparison, natural aging processes of ceramic implants do not appear to be associated with a loss of flexural or fatigue strength⁽²⁷⁾.

ZrO₂ shows a low elasticity, but the bending strength is above 1000 MPa. Thus, the rather brittle material has a high flexural strength⁽²⁸⁾.

Studies prove many positive effects of ZrO₂ in soft tissue behavior. For example, a high affinity for soft tissue and low affinity for plaque was shown^(29,30). Another important factor is the ivory color of ZrO₂. It proves to be very advantageous and provides excellent esthetic results.

The survival and success rate of ZrO₂ implants is now equal to that of titanium implants^(30,31). Prospective

long-term studies show survival rates for one-piece ceramic implants of over 95%⁽³²⁻³⁴⁾.

Case presentation

PRESURGICAL CONSIDERATIONS:

This 57-year old female patient was referred to our clinic (SWISS BIOHEALTH CLINIC) in Kreuzlingen Switzerland, after presenting to Dr. Corbin Popp, Denver, CO, USA. She had a long history of dental therapy and several dental and systemic symptoms including temporomandibular joint disorders (TMD), bite misalignment/disharmony after orthognathic surgery, multiple symptomatic titanium implants, and severe health issues. Years ago, she had a double jaw/ bimaxillary surgery performed, that was supported with a fixed orthodontic treatment afterwards. The orthodontic devices had been removed one year prior to her introduction to the clinic, but the titanium plates from the orthognathic surgery remained in place. Since her first bimaxillary surgery, she had been suffering from chronic pain in her head and jaw, skin rashes, skin sores and a continual, intense feeling of pressure in her head.

A MELISA test revealed a sensitivity to Titanium and in addition her chronic facial skin reaction gave cause for concern that there was a metal allergy. At this point the patient was then referred to SWISS BIOHEALTH CLINIC, Kreuzlingen Switzerland, to treat her missing teeth and remove the metal of the bimaxillary surgery.

Prior to treatment at the SWISS BIOHEALTH CLINIC, TMD treatment with bMAGO (bioesthetic Maxillary Anterior guidance Orthotic) to reach stable condyle position (SCP) and dissolvment of TMD symptoms was performed by Dr. Popp.

At the start of surgical treatment her vitamin D3 level was at 91,2ng/l and her LDL at 1,4 g/l. In order to guarantee optimal bone metabolism, patients at the SWISS BIOHEALTH CLINIC are given a vitamin D level of at least 70 ng/ml. Studies have shown that an LDL value of less than 1.2 g/L has a positive effect on the healing rate of implants.

The intraoral and x-ray investigation (Figure 1-2) showed the placement of numerous metallic plates, five titanium implants, several tooth fragments and leftovers, insufficient metallic crowns and dental restorations. The vitality test of tooth 14 was negative and the tooth displayed a large cyst.

Surgical treatment

Following the concept of the SWISS BIOHEALTH CLINIC and the request of the patient, all metals were removed (metallic plates and titanium implants) and her missing teeth were replaced with metal-free, zirconia implants (SDS Swiss Dental Solutions).

The surgery was performed over two consecutive days.

Day 1: Under sedation of the patient, oral surgeon Dr. Josephine Tietje removed ten metallic osteosynthesis plates and forty-two screws. The access was chosen to follow the old scars in the vestibulum, partially removing and correcting the course and the thick scar tissue. In order not to restrict the blood supply to the gum tissue, minimally invasive incisions were made. Due to the long period of time that the osteosynthesis plates were in place, bone had already grown over them. (Figure 3). The plates were carefully uncovered using piezo-surgery and fine hand instruments (Figure 4). All wounds were disinfected with ozone,



Figure 1: Panoramic x-ray (from 3D scan) 11/2018



Figure 2: Intraoral situation at time of first introduction to our clinic

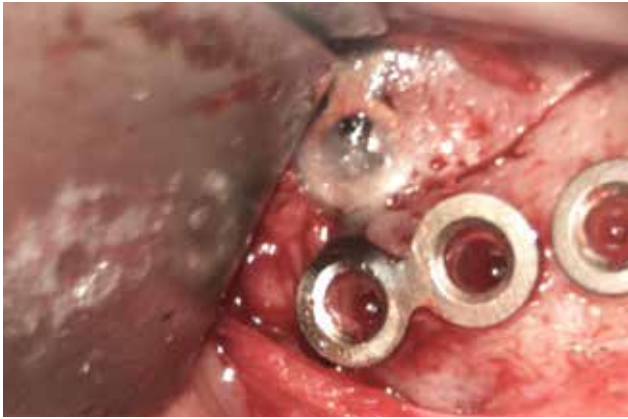


Figure 3: Intraoperative display of the metallic plates



Figure 4: Display of the removed metal



Figure 5: Implant placement of the upper jaw



Figure 6: Implant placement of the lower jaw

A-PRF membranes (Mectron *Æ*, Dr. Joseph Choukroun) were applied to support the healing and the incisions were closed with Atramat (mednaht *Æ*) suture material. At this point of time, the sedation was ended and the surgery was continued with the patient awake.

The titanium implants in the lower jaw (region 18, 19, 28) were removed using piezo-surgery and the “Implant Removal Kit” (Neobiotech *Æ*). In addition, a root fragment was removed in region of tooth 20. Five ceramic SDS-implants were placed in the lower jaw (region 18, 19, 20, 28, 30). The implants were immediately restored chairside with fixed temporaries made from Luxatemp (DMG *Æ*) and cemented with Durelon (3MTm *Æ*).

Day 2: On the second day of surgery, Dr. Ulrich Volz, specialist and pioneer of ceramic implantology, removed the titanium implants in the upper jaw (region 7 and 8). Since the previous implant positioning was not optimal prosthetically and surgically, bone grafting had to be performed to fill the former drill holes. Bone chips were collected and mixed with the solution of A-PRF in order to generate sticky bone that forms a flexible bone graft. Connective tissue was collected from the maxillary tubal area and placed in the front region to



Figure 7: Intraoral situation after placement of all temporaries



Figure 8: Postoperative panoramic x-ray

enhance the aesthetic result. Tooth 14 was extracted, the cyst thoroughly cleaned with hand instruments and six ceramic SDS-implants were placed (regions 3, 7, 8, 11, 13 and 14).

The aggressive dynamic thread design of the SDS ceramic implant proved to be very useful in this case, as it allows individual positioning, allowing the anterior implants to be placed independently of the previous drilling. To place a long and stable implant in region 14, an internal sinus floor elevation was performed and the implant gained the necessary stability by anchoring in the sinus floor. Figures 5-8 show the situation after completion of the surgery.

Immediately after completion of the operation, the patient felt relieved from her persistent head pressure. Slight swelling developed, but it decreased continuously after the third day after the operation.

Prosthetic treatment

Temporary prosthetic restoration immediately after surgery:

In addition to the removal of the metal implants and their prosthetic parts, all remaining conservable teeth that had good vitality (teeth 2, 4, 12, 21, 29, 31) were consistently treated prior to surgery by replacing inadequate fillings and caries. After finishing the surgical intervention, chair-side long-term temporary restorations were made in blocks, connecting all neighboring teeth and one-piece implants with good primary stability (temporaries ##2-4, 7-8, 11-13, 18-21, 28-31). Luxatemp (DMG) was used as temporary material. The temporaries were fixed on natural teeth with highly biocompatible adhesive. Flow composite (Saremco) and Durelon (3M) were used simultaneously as cement on the ceramic implants. In addition, the temporaries on the teeth 7 and 8 were connected adhesively to the neighboring teeth.

The occlusion was adapted to the habitual bite, which was prepared beforehand by means of appliance therapy (see above). All occlusal and articulating contacts of the temporaries were removed in order to exclude harmful forces during the healing phase. The patient was advised to only chew on very soft food for eight weeks after surgery.

Post surgical considerations

Two months after the surgery at the SWISS BIOHEALTH CLINIC a new full time bMAGO (Eclipse, Dentsply Sirona) was applied to resolve reoccurring TMJ symptoms, balance occlusion, reach SCP and simulate the targeted Vertical Distance of Occlusion (VDO).

Final fixed prosthetic restoration with ceramic

After a healing phase of five months, all implants showed good osseointegration, shown by a positive percussion test

and good periost values (all between -4 and -6.5 indicating optimal integration). Thus, final prosthetic treatment for fixed prosthetics could be started, which was performed by Dr. Corbin Popp (Denver, CO, USA).

The functional and aesthetic rehabilitation presented several challenges that had to be addressed. The reduced anterior ridge in the upper anterior region, the large discrepancy in the patients upper and lower arches, achieving a balanced bite with proper anterior or group function guidance to protect her new implants, and to provide comfort to her TMJ as simulated in her well-adjusted bMAGO. The final challenge was matching her existing natural teeth to the new implant ceramic crowns considering the amount of reduction needed on otherwise healthy teeth.

Final restoration

An initial anterior wax up was completed by Andre's Dental Studio (Dana Point, CA) prior to the restorative treatment. Original temporaries were removed and the preparations were revised on the implants and natural teeth. The implant shoulder of all implants of Swiss Dental Solutions can be prepared with a diamond bur to adapt the preparation margin to gingival level.

New Luxatemp temporaries were fabricated chairside from the new waxed-up model and the lower anterior teeth were slightly enlarged chairside to ensure a balanced contact at a specific VDO for optimal restorations. After a few weeks the patient was very satisfied with the it.

A ceramic abutment on ceramic implant 16 was cemented, resulting in the same shape and functionality as a one-piece ceramic SDS implant.

We then replaced the posterior temporaries chairside based off the wax up at this same VDO. Afterwards new records at this VDO were taken for the next set of temporary anterior restorations.

A revised wax up with minor adjustments was performed by Andre's Dental Lab; Dana Point, CA. New laboratory-fabricated temporaries made of IPS e.max (lithium disilicate) were fabricated and placed to restore the bite and function and achieve appealing aesthetics. This was the final set of temporaries on the upper anterior implants and crowns to help determine proper shading of the implants 7 and 8 implants and the natural tooth crowns and 10 natural tooth crowns. The lower anterior teeth 22 - 27 and the upper right canine tooth no. 6 were restored with a direct composite injection molding technique RSVP based on the final wax-up.

In favor of a minimally invasive approach, no ceramic inlays or onlays were used at that time to preserve the tooth structure, as the history of devitalization of the patients teeth after restorative work is known.



Fig. 9



Fig. 10



Fig. 11



Fig. 12

After placing the temporary anterior crowns (IPS e.max), the final posterior crowns made of layered zirconium dioxide (region 3, 13, 14, 18, 28-31) were cemented and direct composite restorations were placed on the natural teeth (region 6, 2, 4, 12, 22-27) using the same techniques as described above. In the following restorative phase, the patient demonstrated her satisfaction with the function and esthetics of the anterior region, so that the IPS e.max temporary restorations on the SDS implants and natural teeth were replaced by layered ceramic zirconia crowns, except for implant 11, which remained in place due to satisfactory shading in IPS e.max Adjacent implants received connected crowns according to the SDS protocol and were cemented with Ketac Cem (3M). The connected crowns have several advantages without significant downsides. Since ceramic implants are highly osseointegrated and immobile, no individual crowning is necessary as with natural teeth, which have an individual movement within the natural alveolus. The bonded crowns result in higher stability, friction and less problematic areas in terms of periodontal hygiene.

Bite registration happened in centric relation after appliance therapy (bMAGO) to ensure SCP (Stable Condylar Position) per OBI (Orthognathic Bioesthetics International) bioesthetic therapy.

Occlusal and functional contacts were adjusted to axial loading forces and in a way to ensure maximum longevity and function. Implants were adjusted in slight infra-occlusion (~10µm) in soft occlusion



Fig. 13

Figures 9 – 13: Showing the final restoration



Figure 14: Panoramic x-ray after final prosthetic treatment

restorations with ceramic inlays or onlays and a veneer on tooth 6 in the future. She is very happy and feels much better.



Conclusion

In a written testimonial to the Swiss Biohealth Clinic the patient states after the procedures: "(...) Prior to my procedures I was losing energy, had trouble thinking straight, and couldn't relax; my coordination was poor and getting worse with time. Additionally, my eyes were sensitive to light, my ears were sensitive to sound, and my skin was very sensitive to touch. I was also emotionally sensitive and very anxious. I constantly felt like I had a metal rod running between my ears. If exposed to too much Wi-Fi, smart meters, smart-phones, or anything with EMFs, all my symptoms would get much worse. The "metal rod" would seem to get larger in diameter and throb, radiating throughout my entire head. After my first day of surgery I could feel the pressure in my head reduce and my body already start to relax for the first time in a very long time. The "metal rod" feeling in my head was gone by that night. About one or two days after my procedures, I noticed that my heart was no longer racing and I had my balance and coordination back when I wake up in the morning. (...) I am feeling much calmer and can relax, my energy is returning, I am sleeping much better and longer, my ears and eyes are losing their sensitivity. (...) At Swiss BioHealth I was very well taken care of. Every person at the clinic was very kind and competent. They all have a good understanding of what their patients are experiencing, and are there to help. I have no doubt going to Swiss BioHealth to have the metal in my mouth removed, non-reactive implants placed and cavitations cleaned out was the best decision for my health. I am so grateful to my dentists in the United States for being the kind of dentists who look deeply into the health of their patients'

mouth. (...) I am also very grateful to Dr. Volz for all the time and effort it must have taken to develop non-reactive implants as well as the careful attention to detail regarding pre- and post-surgical treatments to aid in healing. You are all amazing – Thank You So Much!" - J.H., Casper, WY, USA

The All in One Concept done at the Swiss Biohealth Clinic and the excellent final prosthetic restoration (in this case done by Dr. Corbin Popp, Denver CO, USA) not only rehabilitates the patients functionally and aesthetically in an optimal way and in the shortest possible time, but also restores their quality of life and health. ■

The Authors



Dr. Karl Ulrich Volz is founder and former President of the ISM[®] International Society of Metal-Free Implantology, and founder of the dental clinics Bodensee Zahnklinik and Tagesklinik Konstanz. In 2001, he developed the first market-ready ceramic implant and was also the one who developed all of SDS Swiss Dental Solutions' implant designs for a wide range of indications. He went on to become the dentist to install the most ceramic implants in the world. Thanks to this pioneering achievement, he is arguably the most experienced and well-known biological dentist in Europe, and has developed unique treatment methods and surgery concepts which only became possible through the concurrent use of biological and immunological enhancement and accompaniment protocols. His treatment successes, publications, and interna-tional talks have sparked a new trend in dentistry and led to the fact that a large percentage of his patients are themselves dentists, doctors, and non-medical practitioners. He currently leads the biological dentistry department in the SWISS BIOHEALTH CLINIC in Kreuzlingen, Switzerland.



DR. Corbin Popp was raised by a dentist in Lincoln, Nebraska where he attended the University of Nebraska and accepted the prestigious Fulbright Scholarship to Germany for a year of study. Returning to dental school –only after taking 10 years to peruse a professional dance and Broadway career, Corbin was Top of the Class, and the Resident of The Year from the Arizona School of Dentistry and Oral Health and CU Anschutz GPR. Dr. Popp is a strong advocate of the Swiss Biohealth Concept and ceramic implantology. Dr. Popp currently is practicing at Bidentist Denver.



Dr. Josephine Tietje, born in Hamburg, Germany, in 1991, has studied dentistry at the University of Muenster, achieving the best state examinations of her semester and has successfully specialized in oral surgery. She has treated patients in a renowned private practice, a large maxillofacial practice and the central oral- and maxillofacial clinic in Bremen. Since the beginning of 2018, Dr. Josephine Tietje has placed several hundred ceramic implants at the Swiss Biohealth Clinic. She is responsible for all surgical procedures – be it bone grafting, implant placement, sinus floor elevation, cavitation treatment or complex wisdom tooth and metal removal.



Paul Kilanowski, DMD. Since the beginning of his dentistry studies at university, Paul Kilanowski underwent additional education and training in Implantology. Later, he continuously took part in numerous trainings, among them a one year implantological curriculum (DGO). Soon he will obtain his doctorate (Dr. med. dent.) at the Clinic of Oral and Maxillofacial Surgery of the FAU Erlangen–Nurnberg. Since 2017, Paul Kilanowski is trained in ceramic Implantology and biological dentistry by Dr. Volz personally at the SWISS BIOHEALTH CLINIC. He practices and continues learning this technique ever since. His focus is the head–neck area, the bite and the related detoxification. His therapeutical special field within biological dentistry covers total prosthetic rehabilitation regarding biological principles, the bite adjustment and aesthetic dentistry.



Dr. Rebekka Hueber, born in Germany, has completed her studies in dentistry at Ludwig–Maximilians–University in Munich with surgical top marks. Shortly thereafter, she obtained her doctorate in the surgical clinic, Klinikum rechts der Isar, at the Technical University in Munich. With great passion she completed the four–year specialization in well–known oral surgery practices in Munich and Rosenheim, Germany. She was also involved in dental aid in Peru, South America. Most recently, she successfully led the surgical department of a well–renowned private dental clinic as a specialist in oral surgery and implantology in Germany and implemented the concept of the Swiss Biohealth Clinic as a side department there. With great enthusiasm and experience in the field of medicine, she devotes herself to biological dentistry and has already been able to deepen her knowledge through numerous advanced training courses. She has completed the educational program of the specialization of the SDS Curriculum and is trained in ceramic implantology, the use of PRF and iPRF, Neural therapy and recovery of heavy metal, prosthetics on SDS implants and the Swiss Biohealth Concept. Since beginning of 2019 she is an Oral surgeon in Dr. Volz Swiss Biohealth Clinic and scientific researcher, as well as member in the Swiss Biohealth Academy in Kreuzlingen. She has completed the educational program of the SDS Curriculum “Ceramic Implants and Biological Dentistry” and other programs of biological dentistry.

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