European Association of Dental Implantologists
Bundesverband der implantologisch tätigen Zahnärzte in Europa e.V.

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EDI JOURNAL

European Journal for Dental Implantologists

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Quality is the biggest issue

Growing interest in the Europe-wide work of the BDIZ EDI testifies to the great importance that the affiliated associations attribute to the work of the European Committee and to the work of the European Consensus Conference under the auspices of BDIZ EDI.

In this issue, we showcase the BDIZ EDI work at European level and beyond. For example, the BDIZ EDI took part in the EDI of Macedonia and Albanian Implantology Association AIM congress in Skopje/North Macedonia for the first time. Two members of the Board—President Christian Berger and Board member Markus Tröltzsch (online) were lecturing at this congress, which dealt with modern aspects of oral implantology and surgery as well as facial aesthetics. The hospitality extended by President Dr Daniela Veleska-Stevkovska and Dr Fisnik Kasapi was overwhelming.

Recently, the EDI India—associated partner of BDIZ EDI—has launched an advanced training programme that has been prepared over a long period of time. Indian dentists can complete and achieve Fellowship status—similar to the curriculum in Germany and Europe—and the advanced Diplomate status. EDI India was founded by Dr Vikas Gowd from Hyderabad, who has been a regular and active participant in the European Consensus Conferences (EuCC) of the BDIZ EDI for many years and thus contributes to the practice guidelines.

Talking about guidelines: the quality guidelines of the BDIZ EDI can help professionals in evaluating their own work. This booklet—BDIZ EDI Quality Guideline for Implantology—has been established to support dental clinicians in evaluating their own treatment results by comparing them with evaluation categories ranging from A+ to C. But it's more than simply a rating. It's a guidance for assessing one's own work in all aspects. Since it is not easy for dentists to evaluate their own work objectively, nor for patients to correctly assess the outcome of their treatment, the BDIZ EDI is providing guidance to assist implant dentists in evaluating the quality of their treatment. The Quality Guideline is intended for self-evaluation and self-assessment, since only the clinicians themselves are familiar with their own work and know their patients, their expectations and problems. And only the clinicians themselves can reliably evaluate how the prevailing framework conditions—which will influence any dental and medical treatment, sometimes decisively so—have affected the treatment resulted in question, either positively or negatively. But patients, too, need reliable and comprehensible criteria to evaluate treatment results. The Quality Guideline does not intend to prescribe or introduce standardised treatment processes or office structures. The dentist's profession is a liberal profession, and it will continue to be up to dental practitioners themselves how they achieve the required quality. That's the message!

Quality in oral implantology is the most important aspect of the BDIZ EDI's European work—as is support of the free practice of the profession. For this reason, the editorial team regularly looks to Brussels and Strasbourg to examine and critically scrutinise the work of the European Commission, the European Parliament and other bodies.

You can read about them all in this issue.

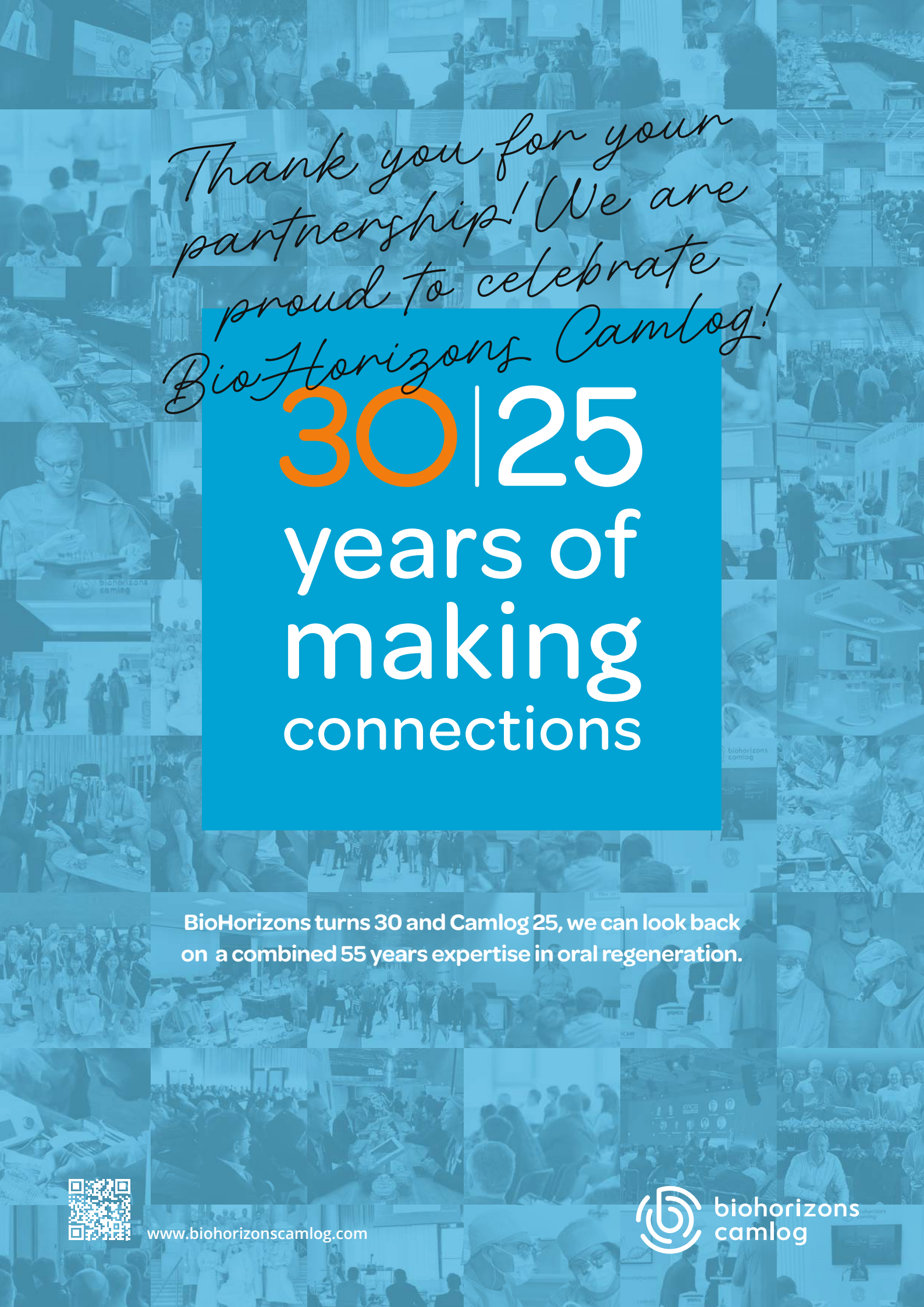
Best regards,

Anita Wuttke
Editor-in-Chief

Guidelines—recommendations for practitioners

Google and Alphabet v. the EU commsission

18th European Symposium of BDIZ EDI in Stockholm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Partner Organizations of BDIZ EDI

Association of Dental Implantology UK (ADI UK)

ADI UK, founded in 1987, is a registered charity committed to improving the standards of implant dentistry by providing continuing education and ensuring scientific research. It is a membership-focused organisation dedicated to providing the dental profession with continuing education, and the public with a greater understanding of the benefits of dental implant treatment. Membership of the ADI is open to the whole dental team and industry, and offers a wealth of benefits, education and support for anyone wishing to start out or develop further in the field of dental implantology.

Ogolnopolskie Stowarzyszenie Implantologii Stomatologicznej (OSIS EDI)

OSIS EDI, founded in 1992, is a university-based organisation of Polish scientific implantological associations that joined forces to form OSIS. The mission of OSIS EDI is to increase implant patients' comfort and quality of life by promoting the state-of-the-art and high standards of treatment among dental professionals. OSIS EDI offers a postgraduate education in dental implantology leading to receiving a Certificate of Skills (Certy kat Umiejetnosci OSIS), which over 130 dental implantologists have already been awarded.

Sociedad Espanola de Implantes (SEI)

SEI is the oldest society for oral implantology in Europe. The pioneer work started in 1959 with great expectations. The concept of the founding fathers had been a bold one at the time, although a preliminary form of implantology had existed both in Spain and Italy for some time. Today, what was started by those visionaries has become a centrepiece of dentistry in Spain. SEI is the society of reference for all those who practice implantology in Spain and has been throughout the 50 years, during which the practice has been promoted and defended whereas many other societies had jumped on the bandwagon. In 2009 SEI celebrated its 50th anniversary and the board is still emphasizing the importance of cooperating with other recognised and renowned professional societies and associations throughout Europe.

Sociedade Portuguesa de Cirurgia Oral (SPCO)

The SPCO's first international activity was the foundation—together with their counterparts in France, Italy, Spain and Germany—of the European Federation of Oral Surgery (EFOOS) in 1999. The Sociedade Portuguesa de Cirurgia Oral's primary objective is the promotion of medical knowledge in the field of oral surgery and the training of its members.

Udruženje Stomatologa Implantologa Srbije-EDI (USSI EDI)

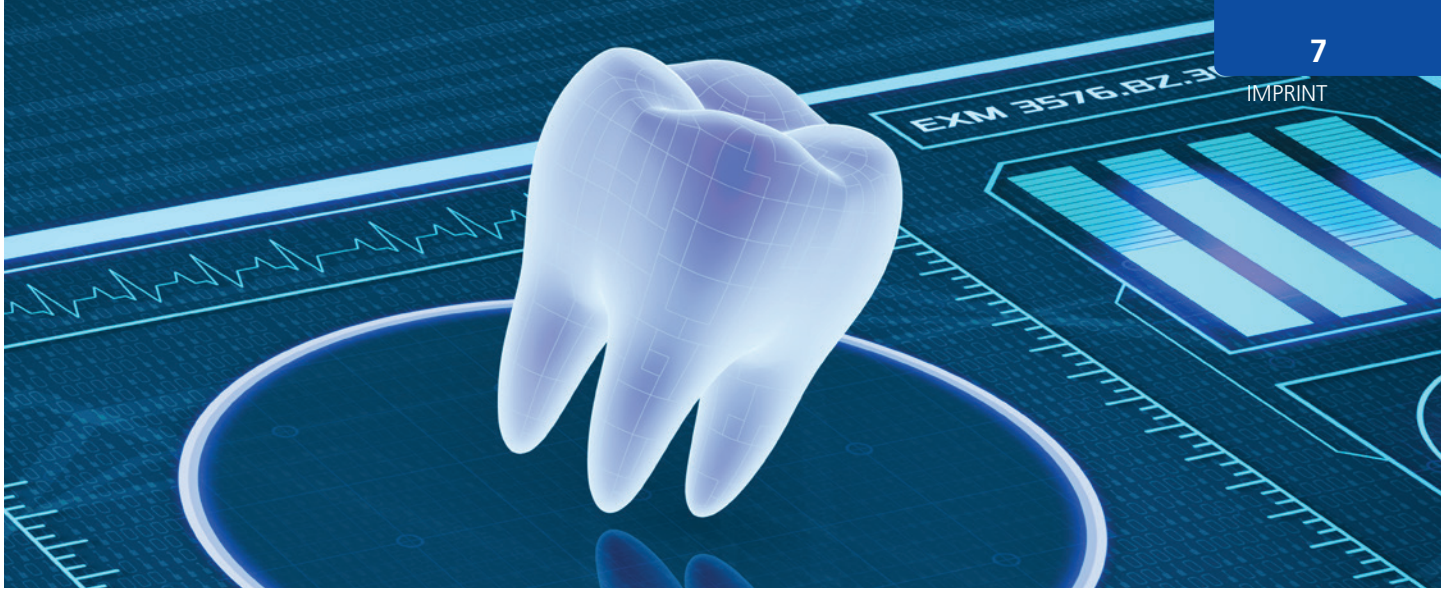
USSI EDI was founded in 2010 with the desire to enhance dentists' knowledge of dental implants, as well as to provide the highest quality of continuing education in dentistry. The most important aims of the organisation are to make postgraduate studies meeting the standards of the European Union available to dentists from Serbia and the region; to raise the level of education in the field of oral implantology; to develop forensic practice in implantology; and to cooperate with countries in the region striving to achieve similar goals.

EDI of Macedonia

The Association is Albanian Implantology Association of Macedonia—AIAM was founded in 2013 as a branch of Albanian Dental Society of Macedonia. The association was created to advance education in the field of dental implantology for the benefit of the population. The objectives of the association are:

– To promote the progress of education, research and development of dental implantology in Macedonia
– To encourage postgraduate education, study and research in dental implantology through:
  - Appointment of meetings, lectures, seminars and courses either individually or with others
  - Encouraging the publication of dental implantology articles!
  - To cooperate and make agreements with relevant, national, local, foreign and different institutions.

In 2017, AIAM & MAOS (Macedonian Association of Oral Surgeons) became EDI of Macedonia and signed a Cooperation Agreement with BDIZ EDI to cooperate in dental implantology!



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1–2 March 2025: Complications in implantology—why did it happen?

BDIZ EDI celebrates 20 years of the Expert Symposium

The Expert Symposium will be held in Cologne for the 20th time. For this anniversary symposium on Sunday, 2 March 2025, the BDIZ EDI is offering a modified concept that is particularly aimed at the next generation of implantologists.

In addition to the experts, the speakers' assistants will present cases and discuss them with the main speakers and the participants. The topic of complications in implantology will therefore be back on the agenda after 2019.

In 2025, the European Consensus Conference (EuCC) under the auspices of the BDIZ EDI will again discuss complications in implantology in the run-up to the 20th Expert Symposium. The then 14th Guideline, the EuCC consensus paper, summarised the 2024 results as follows:

"Dental implants are reliable treatment options for restoring patient function and aesthetics. Careful case selection is necessary by considering not only the oral findings alone. Due to the great variation of implant designs and surgical and prosthetic procedures proposed, the individual suggested parameter should be followed to avoid complications. All procedures should be performed by treatment providers with the requisite up-to-date expertise and training."

The day before, on Saturday 1 March 2025, delegates will be treated to new technological and scientific evidence in four workshops hosted by industry partners. New to the programme is a Presentation Award, which will be presented at the end of the one-day symposium.

The 20th Expert Symposium will be held under the proven scientific direction of Prof. Joachim E. Zöller. Zöller, Vice President of the BDIZ EDI, has also been the President of the "Grosse von 1823", Cologne's oldest carnival society, for many years. All participants are once again invited to the Great Sunday Session in Gürzenich Hall. For the second year in a row, the expert symposium will be held at the Pullman Hotel in Cologne's Helenenstraße.

The workshops will be held on Saturday between noon and 6 p.m. The latest information can be found on the BDIZ EDI website.

Take advantage of the early bird discount now!

The early bird discount is only valid until 1 December 2024. Register now for the Anniversary Symposium—it is more than worth it. Register online:

20th BDIZ EDI Expert Symposium
Pullman Hotel, Cologne
1 March 2025: Industry workshops
2 March 2025: Symposium

More information and registration:

Workshop day, Saturday 1 March 2025
Error prevention in the aesthetic zone versus complication management **Dr Amely Hartmann (Camlog)**
Digital implantology: Ways to achieve more speed, better quality, and greater predictability today **Dr Detlef Hildebrand (MegaGen)**
Immediate implantation in the esthetic zone: common failures and how to avoid them **Dr Adriano Azaripour (BEGO)**
Navigation in implantology **Dr Markus Tröltzsch (Nobel Biocare)**

Symposium day, Sunday 2 March 2025	
09:00 – 09:15	Welcome 20th Expert Symposium **Christian Berger and Prof. Joachim E. Zöller**
9:15 – 9:45	Major presentation Complications from a legal perspective **Prof. Thomas Ratajczak (Sindelfingen)**
10:00 – 10:45	Major presentation Deviations from 3D planning: always a complication? **Prof. Jörg Neugebauer (Landsberg am Lech)**
10:45 – 11:15	Coffee break Dental exhibition visit
11:15 – 11:30	Short presentation The learning curve in 3D-based implantology: Is everything really made easier? **Dr Paul Henn (Ölbrunn-Dörn), PhD student with Prof. Neugebauer**
11:30 – 11:45	Short presentation Complications in fully guided oral implantology **Nikolaus Ernst, assistant of Prof. Schlegel**
11:45 – 12:30	Major presentation Demographics—what is happening? **Dr Markus Tröltzsch (Ansbach)**
12:30 – 13:30	Lunch break Dental exhibition visit
13:30 – 13:45	Short presentation All-ceramics on implants—is stronger always better? **Dr Tobias Graf, assistant of Prof. Güth**
13:45 – 14:00	Short presentation Damage related to local anaesthesia **Ina Younan, assistant of Dr Hartmann**
14:00 – 14:45	Major presentation Avoiding complications in implant prosthetics **Prof. Jan Güth (Frankfurt am Main)**
14:45 – 15:15	Coffee break Dental exhibition visit
15:15 – 16:00	Major presentation Why neurophysiological changes get on your nerves **Dr Amely Hartmann (Filderstadt)**
16:00 – 16:15	Short presentation **TBA** **VFwZ award winner**
16:15 – 17:00	Major presentation Complications in augmentative implantology **Prof. Andreas Schlegel (Munich)**
17:00 – 17:30	Discussion, award ceremony **Christian Berger and Prof. Joachim E. Zöller**

20 years European Consensus Conference (EuCC) under the auspices of the BDIZ EDI

Guidelines—recommendations for practitioners

Every dental practice has to face new challenges every day, absorbing scientific and technical innovations, but also in terms of insurance issues and ever-changing guidelines and laws. Once a year, the European Consensus Conference (EuCC) of the BDIZ EDI provides practical recommendations on a major topic within oral implantology. The consensus paper is sent to the members as a printed guideline and is freely available online, in German and in English. All guidelines provide a comprehensive list of references on their topics.

The EuCC is an international body consisting of experts a specific topic. It seeks consensus after detailed discussion on the basis of a working paper prepared by the University of Cologne, with the proceedings being solidified into a guideline. The papers from previous years, some of which have been updated, are available for download on our website and address the following topics: Preventing, detecting and treating specific complications (2019); Update: Peri-implantitis (2020); Update: Ceramics in implant dentistry (2021); Update: Cologne ABC Risk Score (2022); Update: Short, angulated and reduced-diameter implants (2nd update) (2023); and the current guideline, Update: The digital workflow in oral implantology (2024). The following presentation includes the most frequently downloaded papers. You will find them online by following this QR code:

2019: Preventing, detecting and treating specific complications

The conclusions of the 14th EuCC (2019) were as follows (they are scheduled to be updated in 2025): "Dental implants are reliable treatment options for restoring patient function and aesthetics. Careful case selection is necessary by considering not only the oral findings alone. Due to the great variation of implant designs and surgical and prosthetic procedures proposed, the individual suggested parameter should be followed to avoid complications. All procedures should be performed by treatment providers with the requisite up-to-date expertise and training."

2020 Update: Peri-implantitis

When defining peri-implantitis, the 15th EuCC (2020) made a distinction between: (1) initial, reversible mucositis; (2) inflammatory, currently irreversible peri-implantitis; and (3) apical inflammation as a special manifestation following endodontic treatment and/or apical granuloma or burnt-bone syndrome (so-called retrograde peri-implantitis). As far as diagnosis, the EuCC recognised the inflammatory mediators in the sulcus fluid as a biomarker for peri-implantitis and found that this biomarker can be used to differentiate between early and late disease.

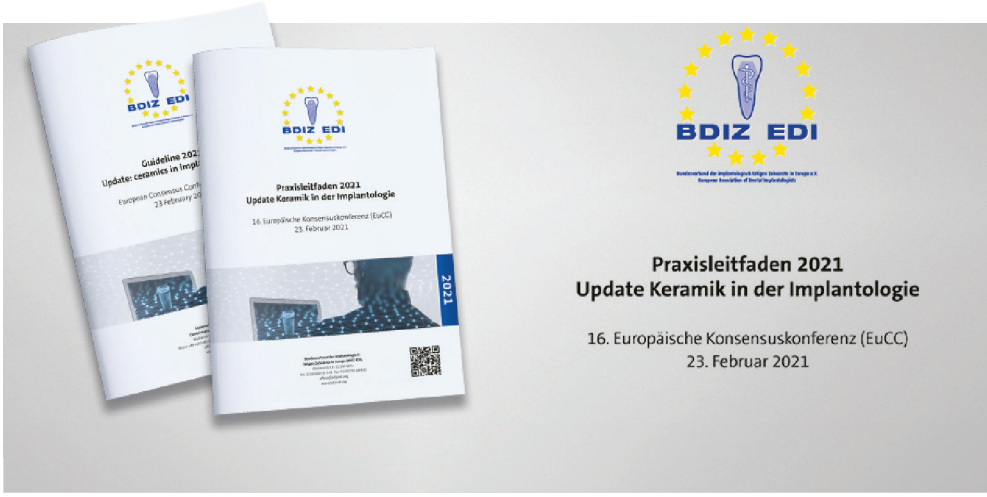
2021 Update: Ceramics in implant dentistry

The 16th EuCC (2021) found that commercially available titanium implants inserted according to the manufacturer's instructions achieved good osseointegration and soft-tissue biocompatibility as well as good clinical success, both from an immunological and a biological point of view.

It dispelled earlier concerns about one-piece ceramic implants. The risk of implant fracture is low for current commercially available implants. Overload damage during the early healing phase can be avoided by splinting or by eliminating functional loads on the temporary restoration.

For two-piece ceramic implants, the 16th EuCC stated that various abutment connection designs are available, some of which have a metal core. However, the concept of metal-free implant designs has been abandoned. The EuCC pointed out that abutment fixation requires a special protocol that follows the manufacturer's instructions, stating that "Scientific evidence for two-piece implants is rare".

Ceramic abutments scored higher than metal abutments in terms of aesthetics, especially in patients with a thin tissue phenotype.



The reduced biofilm adhesion compared to titanium, based on experimental studies, was emphasised, but the primary determinant of biofilm accumulation is the surface topography, not the choice of material.

According to the 16th EuCC, zirconia superstructures are now commonplace. For ceramically veneered frameworks as implant superstructures, the 16th EuCC called for an appropriate design and trained practitioners to avoid chipping.

They found was little medium- or long-term evidence for the use of monolithic zirconia.

2022 Update: Cologne ABC Risk Score

Using a simple ABC system, possibly and attractively visualised in four colours, clinicians are given the opportunity to assess the risk of their planned implant treatment, stated the 17th EuCC (2022) in its guideline. The four partial scores:

1. Medical history
2. Local findings
3. Surgical
4. Restorative

Each partial score including a summary rating, with the results—like the criteria—expressed in terms of the colours green, yellow and orange, corresponding to A, B and C (Always – Between – Complex).

- A = Always lowest = assessed risk, green
- B = Between = medium risk, yellow
- C = Complex = increased risk, orange

Red is reserved for cases where the risk assessment shows that treatment at issue may not be recommended (which is not the same as being contraindicated). The overall patient assessment according to the Cologne ABC Risk Score works as follows:

- If all four partial scores are green, the patient case as a whole is assessed as low-risk (A for Always).
- If at least two of the four partial scores are yellow, the patient case is assessed as medium-risk (B for Between)
- If all four partial scores are yellow, the patient case is assessed as high-risk (C for Complex). The same is true if at least two of the four partial scores are orange or yellow.

2023 Update: Short, angulated and reduced-diameter implants

Short implants

This second update has left the definition of "short" unchanged. As before, they have a designed intrabony length of ≤ 8 mm with a diameter of ≥ 3.75 mm.

They are used, among other things, to avoid bone grafting in the posterior jaw segments of partially edentulous patients, but also to support removable overdentures and as single or multiple tooth replacements in the anterior jaw. The 18th EuCC (2023) found that there was no longer any difference in success rates compared with standard implants with augmentation procedures. A new indication is that for immediate loading. There are now studies that support the use of

short implants with special treatment concepts in immediate-loading situations.

Angulated implants

There have also been new developments regarding angulated implants, which are becoming routine in splinted reconstructions of edentulous jaws. The 18th EuCC (2023) agreed that they increase primary stability for immediate loading procedures with longer implants, avoiding bone grafting. In most cases, these treatment concepts require four implants in the mandible and four to six implants in the maxilla. However, current observations have also revealed limitations. "Despite the positive clinical results, the scientific debate on the clinical relevance of the development of marginal bone levels around angulated implants is still ongoing", as Prof. Neugebauer summarised the consensus findings.

Reduced-diameter implants

The EuCC distinguishes between two general settings. Reduced-diameter implants—those with intraosseous diameters of < 3.5 mm—are indicated for use in jaws with reduced widths. EuCC refers to implants with diameters of < 2.7 mm as mini-implants. There is no change from the previous 2016 guideline.

2024 update: The digital workflow in oral implantology

The 19th EuCC (2024) examined the various digital procedures for diagnosis, surgical preparation, digital implant planning and prosthetic rehabilitation. Aspects covered included:

- Digital diagnosis
- Digital impression-taking and imaging
- CAD/CAM-assisted grafting techniques
- Digitally guided implant positioning
- Digital laboratory procedures
- Artificial intelligence (AI) in oral implantology

Conclusions of the 19th EuCC: Digital technologies in implant dentistry are improving, with good clinical results and better patient-related outcomes (PROMs). The specific parameters for each procedure must be considered by the clinician.

The guidelines are available for download in German and English from the BDIZ EDI website.

25th Curriculum Implantology now complete

Congratulations to the curriculum graduates!

The 25th Curriculum Implantology, jointly arranged by BDIZ EDI and the University of Cologne, was completed in August 2024 after the final exams. The participants had completed eight modules on oral implantology over a period of one year.

The successful graduates of the 25th Curriculum Implantology at the University of Cologne Professor Hans-Joachim Nickenig.

BDIZ EDI has been organising the Curriculum Implantology in cooperation with the University of Cologne for more than 25 years now. The "father" of the programme is Prof. Joachim E. Zöller, whom we introduce in the following interview.

Due to the immense demand, two groups were again formed for the 25th Curriculum in order to ensure learning success in small groups. The Curriculum leaders: Prof. Joachim E. Zöller, Prof. H.J. Nickenig and Prof. Matthias Kreppel.

The 25th Curriculum Implantology of the two cooperation partners, BDIZ EDI and the University of Cologne, is the latest chapter in a long success story. Since 2004, the year of the first curriculum, a total of 750 graduates have been trained in oral implantology. As Prof. Joachim E. Zöller said in 2004, "In addition to theoretical presentations, there are practical demonstrations and personal experience gained through practical exercises or the treatment of real patients", Zöller, now Vice

President of BDIZ EDI, was and continues to be responsible for the implementation of the curriculum and its objectives, and over the years, he has proven time and again that this is possible.

Eight modules—one curriculum

Today the curriculum consists of eight modules in two-day courses, which include observation and are supervised by experienced instructors. The overall aim is practical relevance.

To achieve this, the teaching modules and their content are constantly updated. After successful observation and supervision, participants can sit the exam for the formal professional focus on oral implantology if they can demonstrate the required practical experience.

No closed-shop policy

All modules can be taken individually. Modules completed with other providers can be credited with appropriate documentation. Prof. Hans-Joachim Nickenig, who modernised the Curriculum when he took over several years ago, is the contact person for all participants.

Instructors

The instructors are experienced implantologists who have presented their training units with videos and live patient demonstrations for many years. Each course includes practical sessions, most of which use realistic training models or human specimens rather than the usual plastic jaw replicas. "The training units are designed to highlight the interrelationships between the prosthetic and surgical aspects, even though the main topics focus on one or the other," said Zöller. "A limited number of participants—an aspect that is important to both BDIZ EDI and the university team—ensures a lively exchange of ideas between instructors and participants."

RED/AWU

Graduates of the 25th curriculum:	
Hemin Authman M.Sc.	Dr Hannah-Lea Koch
Yasmin Baneyaghili	Mira König
ZA Kawa Barakat	Roxana Kramer
Abdussalam Abdalla	Helena Samantha Krug
Abdussalam Bazuti	Karolina Marta Mastalerz
Charlotte Friederike Marianne Beckers	Javed Ur Rahman Matin
Juliane Elisabeth Berhardine Beenen	Katharina Maria Meindorfer
Dr Christian Bouché	Michael Menges
Claudia Brock	Dr Bahareh Norouzi Sedeh
Dr Christina Viktoria Elisabeth Commes	Dr Aaron Nühlen
Dr Michael Johannes Denzer	Georgios Papamargaritis
Schihab-Aldin Dib	Lucretia Pavlenco
Dr Franziska Dirks	Dr Robert Christian Johannes Ramroth
Dr Kim Yvonne Eckerth	Dr Cabar Reyhan
Fatih Ercan	Ali Shahrour
Lea Antonia Fontani	Henrik Sluka
Dr Moritz Franz	Carsten Sonnenburg
Dr Leon Goldschmidt	Kristoffer Strübing
Thalia Genet Hampl	Dr Philipp Turanli
Vera Hentgen	Jens Martin Vogel
Niole Hirt	Victoria Wächter
Mark Pascal Jäger	Serra Simone Weber
Jasper John	Alice Wegener
Karasmanes	Dr Lena Wepner
Alexandros Rodriguez	Jan Zander
Moayad Kashkoul	Dr Verena Zurmühl

Start of the 26th Curriculum Implantology

October marks the beginning of the 26th Curriculum Implantology. Due to the high demand, as in the previous two years, BDIZ EDI and the University of Cologne have set up a second group. The Cologne Curriculum is already fully booked. The Curriculum South started in Ansbach at the end of September.

For more information, visit the BDIZ EDI website at www.bdizedi.org/curriculum.

“Full house” for the first of eight training modules in Ansbach, Franconia, Northern Bavaria

Successful premiere of Curriculum Implantology South

Twenty-eight young dentists from across Germany, including Bavaria, Baden-Württemberg, Hessia, Berlin and North Rhine-Westphalia started the first Curriculum Implantology South on 27 and 28 September 2024. The kick-off weekend with introduction and workshops was held in Ansbach, a regional administrative centre about 40 km (25 miles) west of Nürnberg. It was organised by BDIZ EDI and hosted by course director and local resident Dr Markus Tröltzsch, with the participation of eight renowned implant and material manufacturers as well as a billing service provider from Germany.

Oral implantology has become one of the most important areas of dentistry. BDIZ EDI offers dentists the opportunity to acquire the necessary knowledge in a structured way. The curriculum is suitable for beginners as well as for advanced practitioners who wish to actively pursue oral implantology or who wish to delve deeper into the discipline. From the basics to surgery, prosthetics and issues relating to demographics, medicine, biology and mechanics, the eight course modules cover the full spectrum of implantological knowledge.

History

The BDIZ EDI Curriculum Implantology has been an integral part of BDIZ EDI's postgraduate training programme for 25 years. The courses, which consist of eight modules and can be completed over a period of one year, have been held in cooperation with the University of Cologne under the direction of Prof. Joachim E. Zöller for the past 25 years.

New in the south

Due to the high demand, BDIZ EDI is now offering its first Curriculum in southern Germany, which has been developed on the basis of the successful Cologne Curriculum. It is taught by Prof. Joachim E. Zöller, Prof. Jörg Neugebauer and Dr Markus Tröltzsch; the latter is an oral and maxillofacial surgeon who works locally in a joint practice with his brother (and who is a BDIZ EDI board member).

Eight modules

Participants complete eight modules, which are divided into two-day face-to-face events in Ansbach and Munich and online modules. Renowned speakers—Prof. Daniel Edelhoff, Chair of Prosthodontics at Ludwig Maximilian University of Munich; Prof. Andreas Schlegel, expert consultant for the Bavarian Association of Statutory Health Insurance Dentists; and Dr Markus Tröltzsch—will lead the remaining live modules on prosthetic concepts, immediate implant placement and immediate loading, diagnostics and case planning, and augmentation and complex implant placement.

Thirty-four other eminent speakers will cover a wide range of surgical, medical, dental, chemical and physical aspects of oral implantology in online seminars that delegates can view on demand in preparation for the final event. Topics include, for example, biological and mechanical aspects, individual case planning and, of course, the use of different implant systems. The most important implant and material manufacturers from Germany and Europe are also "on board". In Module 1, the participants were already able to familiarise themselves with the different systems.

Vesna Heins from Bonn is a participant of the Curriculum Implantology.

Testimonial

At the first module at the "Hürner" hotel in Ansbach, participant Vesna Heins, an employed dentist from Bonn, confirmed the modern concept of a mixture of face-to-face and online events: "As a full-time working mother of two small children, it's super practical to know that when I'm on site, things are hands-on, and when it comes to theoretical learning, I can do it at home, just as I like and as it fits into my work-life balance!"

One of the more experienced attendees, with more than six years' experience in implant dentistry, particularly appreciated the variety of systems presented and the opportunity to work with them in small groups and at one's own pace.

As an industry representative, Markus Knabel of Camlog described the launch as a highly successful start and sees it as setting a new benchmark for continuing education.

Save the date!

Curriculum Implantology South 1 will conclude on the weekend of 23 and 24 May 2025 in Ansbach with the participants' final projects. Curriculum 2 will start in September 2025—again under the direction of Dr Markus Tröltzsch, who is highly satisfied with the response to the first Curriculum: "We at BDIZ EDI are thrilled with this successful start. The modern format—a blend of face-to-face and online learning, with an emphasis on hands-on workshops—has been very well received by our colleagues!"

AWU

Markus Tröltzsch at the opening of Curriculum Implantology in Ansbach.

High expectations among the participants.

Impressions from the start of the 1st Curriculum South in Ansbach

The first Curriculum South in Ansbach got off to a successful start: On 27 and 28 September, 28 participants had the opportunity to take part in hands-on workshops from eight leading implant and dental material manufacturers as well as a well-known billing service. This means that BDIZ EDI is now offering a comprehensive introductory course in implantology with a high practical component in the south of Germany. The practical basics acquired in the first module are intended to serve as a foundation for subsequent theoretical modules.

Attendee Ilke Aydin-Demirel was delighted: "As a beginner, I think it's really nice that I can [...] take part in practical workshops and learn a lot. The communication here is very intensive." The event was hosted by Dr Markus Tröltzsch. He was joined on site by BDIZ EDI President Christian Berger, who emphasised the equivalence of the two curricula, Cologne and South, in his speech.

The second on-site module, "Diagnostics and Surgical Techniques", will be presented on 8 and 9 November, again in Ansbach.

Intensive exchange between Christian Berger and Markus Tröltzsch.

Participants listening to the presentations.

Billing expert Anja Schulte-Frankenfeld enjoying coffee after her presentation.

Full concentration during the two days of module 1.

Media officer Anita Wuttke hands out the course materials.

Perfect start for all: participants, lecturers, sponsoring partners.

Organising and moderating: Markus and Matthias Tröltzsch.

Hands-on workshops in compact groups.

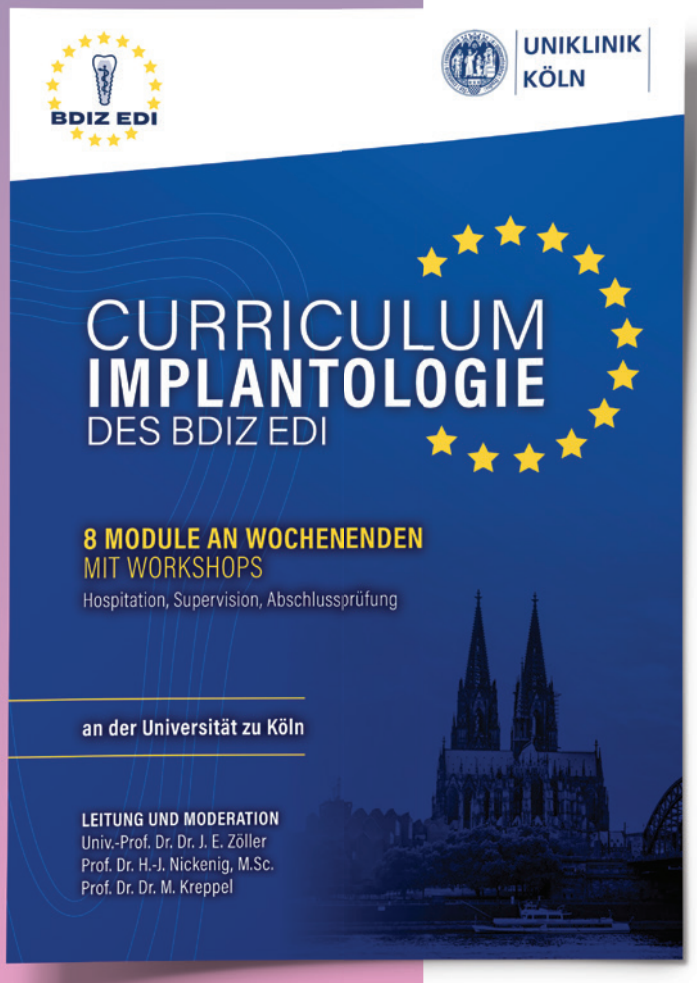
The Curriculum South mascot.

Speech of the President of the BDIZ EDI at the 2024 Annual Meeting in Dresden

Politics and policies

Dear colleagues:

Our Association was founded 35 years ago in response to the 1988 GOZ. Since then, we have gone down many different roads—even to the Federal Constitutional Court. As you probably know, six dentists (mainly members of our Board) have filed a complaint with the Berlin Administrative Court on the initiative of the BDIZ EDI and with the support of our legal advisor—thank you, Thomas Ratajczak, for your incredible preparatory work. The wheels are turning slowly as the Federal Ministry of Health makes the most of all the time available. But eventually—and we hope during Lauterbach's term of office—the Federal Ministry of Health will have to take a stand.



As early as 2022, we had decided to take legal action against the unequal treatment in the fee schedules and against the 65-year standstill in the GOZ point value. We deplore the fact that the legal requirements of Section 15 of the German Dentistry Act (ZHG) have not been complied with for decades by failing to adjust the dentists' fee schedule. The federal government seems to have no problem adjusting the veterinary fee schedule regularly to changing economic conditions, most recently on 1 October 2022.

Lawyers will also receive another fee increase. This unequal treatment violates the general principle of equality (Article 3 [1] of the German Basic Law) and the freedom of dentists to exercise their profession (Article 12 [1] of the German Basic Law).

Continuing professional development

The BDIZ EDI is also picking up speed in the area of training. Prof. Joachim E. Zöller will tell you more about this in a moment. But perhaps a brief mention of the Curriculum Implantology in Cologne is in order. The 25th Curriculum will soon be completed, and we already have a long list of prospects for the 26th Curriculum.

The Curriculum is a success story, with almost 1,000 participants having successfully completed the course to date. More than 80 per cent of them remain members of BDIZ EDI. More about this and our latest project—Curriculum South, starting at the end of September—from Prof. Zöller.

Communication

In order to save money and resources, we regularly keep our members informed through our BDIZ EDI newsletter. Subscribers regularly receive news about current developments and, of course, about upcoming virtual and face-to-face events. 2,300 members are currently subscribed to the newsletter. If you do not yet receive it, please contact our office.

Consensus Conferences

The BDIZ EDI not only participates in the Consensus Conferences on implantology, but also in the guideline conferences of DG Paro, DGI and DGZMK, in order to contribute the broad professional competence of its oral implantologists.

Today we held our 34th Conference of Experts on Implantology on behalf of the Consensus Conference. I would like to take this opportunity to thank our partner, the State Dental Association of Saxony, and in particular its President Dr Thomas Breyer and his staff, as well as the Saxony State Association of Statutory Health Insurance Dentists (KZV), on whose premises we are meeting.

Europe

In May 2024, the BDIZ EDI actively participated in the four-chamber meeting of the Dental Chambers of the Czech Republic, Saxony, Bavaria and Austria in Český Krumlov. More to come soon in *EDI Journal*. The European Symposium was held in Split, Croatia this year and showed that we can organise nice and small symposia with high-quality presentations and renowned speakers. Looking ahead to 2025, we are planning to be in Stockholm, Sweden on 20 June.

This year we are celebrating the 35th anniversary of BDIZ EDI. We have invited the founding members to join us here in Dresden. I would like to extend a very warm welcome to Werner Hotz, who is one of the founding members. I am personally delighted that you are here with us today. Unfortunately, we learned in April that another founding member had passed away: Dr Hans-Joachim Foet. We will remember him with affection and respect.

Looking ahead

The 20th Expert Symposium will take place at the beginning of March next year, followed by IDS 2025. It is important for us to be there to present our work to a wider audience. Participation is a must for us to "stay in the game" and to present ourselves and our partner associations as the international point of contact for all issues relating to oral implantology, dental billing and health care law.

Publications, web, social media

I would also like to remind you of our website and our newsletter, which we publish to keep you up to date with the latest news and information on our webinars. Take advantage of being the first to know! Subscribe to the newsletter via our website if you have not already done so. You will receive valuable

information on current events, helpful templates to download and, of course, lots of useful information on billing and legal issues.

Make sure you use the members' area on our website. This is the only way to access recorded webinars, download important forms or checklists, and search the case-law database.

We are now on almost every social media platform: Facebook, Instagram, X and YouTube—we would love for you to follow us there!

The Board

Once again, our Board members have worked with great passion and commitment to provide you with valuable information and our recommendations. I would like to thank Joachim E. Zöller, Jörg Neugebauer, Detlef Hildebrand, Stefan Liepe, Wolfgang Neumann, Freimut Vizethum, Renate Tischer, Nathalie Khasin and, since 2021, Markus Tröltzsch, who is not only an internationally sought-after speaker but also brings a lot of fresh ideas to our association.

Thank you so much for your great contributions!

Thank you also to all those who work in our committees, and last but not least our auditors.

Membership

As of 29 June 2024, we had a total of 2,288 members. It is becoming clear that we still have many first-generation members who have been working in their practices for more than 20 or even 30 years, but there are also members who are gradually retiring from their practices. However, most of them nevertheless choose to remain (non-paying) members—which makes us very happy. This reflects clearly and favourably on the Association and its work.

On the other hand, we also need new blood to remain strong in the face of internal and external challenges and to be able to respond to new laws, regulations and ordinances. I would like to appeal to you to help us stay strong. Talk to the young people in your practice, show them what we can do. After all, this is what we have proven not least in these challenging times. Thank you very much for coming to Dresden today.

Finally, I would like to thank the staff of BDIZ EDI: Brigitte Nötzel in Cologne, Helga Karanikas in Munich and Marion Kerstin Salhoff, who is responsible for the billing hotline. And I would like to thank Anita Wuttke for her many years of commitment to the media work of the Association. She is also responsible for European affairs and is Editor-in-Chief of our journals *BDIZ EDI konkret* and *EDI Journal*.

Thank you to everyone who has come here today and to all the members who have supported the Board with their feedback.

Thank you for your interest and your attention.

Christian Berger
President

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1 Ratka C. et al. JCM. 2019;8(9):1397. **2** Bosshardt DD. et al. Clin Oral Invest. 2022;26(4):3735–3746. **3** Zipprich H. et al. Clin Oral Invest. 2022;26(6):4549–4558. **4** Schlee. et al. JCM. 2019;8(11):1909. **5** Schlee M. et al. JCM. 2021;10(16):3475. **6** Data on file, GalvoSurge AG.

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BDIZ EDI and its multifaceted work

We want YOU!

AT IDS 2025 BDIZ EDI is relaunching its "We want you" information campaign. The aim is to interest young dentists from Germany and Europe in oral implantology and in the work of BDIZ EDI.

With the "We want you" campaign, the association wants to draw attention to the many different support services it offers for all dental practices, even beyond implantology, including continuing education for newcomers to the profession and seasoned practitioners alike.

BDIZ EDI is an active Europe-wide association that in 2002 went beyond the borders of Germany to forge collaborations, support partner associations and make its voice heard in EU politics. Of course, health policy interventions are also initiated at the federal level. BDIZ EDI is the only association to have presented its own draft law on combating corruption in the health sector. It is currently working intensively on the Medical Device Regulation (MDR) and its many problems.

With its information offensive, BDIZ EDI is highlighting its work in the field of continuing education:

- "Meet the Experts" allows newcomers to get in touch with experienced implantologists and top lecturers.
- An absolute must for anyone interested in implantology is the Curriculum Implantology, which is run in cooperation with the University of Cologne and recently started in the south of Germany. This eight-module course teaches the key building blocks of implant dentistry to small groups of participants. The curriculum takes place at the University of Cologne. It runs for one year and is designed to be affordable for newcomers to the profession. Some partner associations have adopted, and adapted, the modules for their countries: Greece, Serbia, Poland and India.
- Each year, the BDIZ EDI Expert Symposium provides an update on a current issue in implant dentistry, and the associated European Consensus Conference (EuCC) provides guidance for practitioners.
- The Europe Symposium of BDIZ EDI provides an opportunity to look beyond the local dental fence and to appreciate the work of European colleagues and exchange ideas. This year's Europe Symposium took place in Split/Croatia. Next will be in Stockholm.

A wide field

The full scope of BDIZ EDI's work is illustrated by the "BDIZ EDI informs" webinar series, which the association has been organising since the start of the COVID-19 pandemic in 2020. The continuing-education webinars feature top-notch presenters and cover dental topics (not just implantology!) as well as legal issues. The webinars are particularly suitable for strategic practice orientation for current and future practice owners. BDIZ EDI webinars are aimed at dentists and all members of the dental team. Participation is free of charge for members. On average, BDIZ EDI webinars are attended by between 150 and 400 participants. Members can view the recorded webinars in the seminar archive after the live broadcast.

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Bundesverband der implantologisch tätigen Zahnärzte in Europa e.V.

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Collaboration of BDIZ EDI with EDI India on postgraduate education

Ample opportunities for advanced training

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In 2021, the BDIZ EDI and the associated partner EDI India entered into a Memorandum of Understanding with the affiliated School of Dental Implants (SDI) in Hyderabad, India to jointly develop postgraduate training for Indian dentists in the discipline of oral implantology. In this interview, Dr Vikas Gowd, Director of the SDI, provides information on the objectives and opportunities for postgraduate training in oral implantology for dentists interested in implantology.

In Europe, oral implantology is still not a part of dentistry at the universities. How about India?

The situation in India is similar to that in Europe. Implantology is generally introduced in a basic form at the undergraduate level, but is more extensively covered in postgraduate programmes and through specialised courses or certifications. Many dental colleges in India offer Master of Dental Surgery (MDS) programmes with a focus on prosthodontics, periodontics or oral surgery, which include advanced training in implantology. In addition, there are various short and long-term courses specifically focused on implantology for practicing dentists who wish to specialise further in this area. So, while implantology may not be uniformly integrated into undergraduate programmes in both Europe and India, there are ample opportunities for advanced training in this area through postgraduate education and specialised courses.

Programme structure

Fellowship programme: This is an entry-level certification that offers a comprehensive understanding of dental implantology, including foundational theories, clinical practices, and patient management. It typically includes hands-on training, live patient demonstrations, with cases on patients and case discussions with an exam of submission of 10 implant cases.

Diplomate programme: This is a more advanced level, usually pursued after completing the Fellowship or directly for someone who already has finished basic implantology and looking to enhance their skills. It focuses on complex implant cases, advanced surgical techniques, and problem-solving in implantology. The Diplomate programme often requires participants to present documented cases and pass a rigorous examination.

Collaboration with EDI: The collaboration with the European Association of Dental Implantologists ensures that the curriculum is aligned with international standards. Participants benefit from the latest research, techniques, and best practices from Europe.

The programme often includes guest lectures or workshops led by European experts, providing participants with a global perspective on dental implantology.

Accreditation and certification: Upon successful completion, participants receive certification recognised by both the School of Dental Implants and the European Association of Dental Implantologists. This certification can enhance the professional credentials of participants, making them more competitive in the field of dental implantology.

This programme is ideal for dental professionals in India and other regions who wish to achieve international standards in their implantology practice. It combines theoretical knowledge with practical skills, ensuring that participants are well-prepared to handle a wide range of implant cases.

Dr Vikas Gowd

What is the Fellowship and Diplomate programme in collaboration with the European Association of Dental Implantologists all about?

The Fellowship and Diplomate programme is a collaboration between Indian dental professionals and the European Association of Dental Implantologists (EDI) to provide advanced training in implantology. This partnership ensures that the programme follows international standards and incorporates the latest European research, techniques and best practices. Through this collaboration, participants will benefit from a curriculum in line with global trends and have access to workshops and lectures by European experts. On successful completion of the course, participants will receive certification recognised by both the School of Dental Implants and the European Association of Dental Implantologists. This certification can enhance participants' professional credentials and make them more competitive in the field of dental implantology. This programme is ideal for dental professionals in India and other regions who wish to achieve international standards in their implantology practice.

Could you please explain the difference between both programmes?

The Fellowship programme teaches basic implant dentistry skills suitable for beginners, including patient assessment, treatment planning and basic techniques. It usually lasts several months and participants receive a Fellowship certificate. In contrast, the Diplomate programme is an advanced certification aimed at those with Fellowship or equivalent experience and focuses on complex cases and advanced topics. The Diplomate programme takes longer to complete and participants receive a Diplomate certificate, which demonstrates a higher level of expertise.

Interview was conducted by Editor-in-Chief Anita Wuttke

MIF

A dentist for 50 years: BDIZ EDI board member Dr Renate Tischer

High power in Bad Salzungen

After the German reunification, Dr Renate Tischer was one of the first dentists in the east of Germany to not only set up her own practice in Bad Salzungen, but also to study oral implantology, a new and promising dental discipline, and integrate it into her practice.

In East Germany, in the former GDR, there were no dental practices as we know them today. Tischer worked at the university in traumatology, operating on facial injuries. As soon as the Iron Curtain fell, she set up her own dental practice and brought her knowledge of oral implantology, still in its infancy in the early 1990s, into her own practice. This is how she met the "founding father" of BDIZ EDI, Professor (h.c.) Egon Brinkmann (†), and she was not afraid to travel to Sweden to study with the "founding father" of implantology, Per-Ingmar Brånemark (†).

Tischer has been an active member of the BDIZ—now BDIZ EDI—board since 2001. At that time, BDIZ also addressed the formal Focus of Professional Activities: Oral Implantology ("Tätigkeitsschwerpunkt"), whose existence was successfully defended by BDIZ EDI before the Federal Constitutional Court in 2001 against fierce opposition from the dental associations at the time. In today's dental disciplines, a Focus of Professional Activities is a certification that requires a high level of skill. It must be reapplied for every five years. At that time, the Dental Association attempted to revoke Tischer's Focus certification. Together with the then chairperson of BDIZ, she fought a legal battle against the Dental Association and won.

In 2003, she successfully passed the EDA examination and became a European Specialist in Oral Implantology (EDA). She has been a member of the BDIZ EDI and EDA examination committees for many years and is responsible for assessing the cases of candidates for the specialist title.

In the early days of BDIZ, she had set up and supervised the association's study group in the German state of Thuringia. Today, she works with her daughter Kristin-Theres in their joint practice, continues to contribute her broad experience to BDIZ EDI—and proves that she is a power woman—now more than ever.

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EU commission objectives and personnel, 2024 to 2029

Prosperity, security and democracy

Ahead of the European Parliament's conference of political group leaders, EU commission president Ursula von der Leyen outlined the goals of the new commission and presented her proposed vice-presidents and commissioners. Before the commissioners can take office, the EU parliament will scrutinise the personnel table in detail until November.

The EU commission president also presented her key priorities for the next five years. They revolve around prosperity, security and democracy against the backdrop of the EU's competitiveness in the digital and ecological transformation currently underway. "We have dissipated the former rigid stovepipes of responsibility. This was one of the main recommendations of the Draghi report."

Six priorities

Von der Leyen outlined six points: "Strengthening our tech sovereignty, security and democracy. Building a competitive, decarbonised and circular economy, with a fair transition for all. Designing a bold industrial strategy with innovation and investment at its heart. Boosting European cohesion and regions. Supporting people, skills and our social model. Ensuring Europe can assert its interests and lead in the world. And this is reflected in the titles of the six executive vice-presidents."

The new structure of the EU commission stipulates that each commissioner has an equal responsibility to deliver on the commission's priorities. For von der Leyen, that means that all commissioners must work together. She explained that there will be no additional level of vice presidents. In von der Leyen's first commission, a number of executive vice-presidents led groups of vice presidents and junior commissioners.

While the two-tier vice-presidencies will be abolished, the president will continue to make the executive vice-presidents responsible for a group of commissioners in a specific policy area. Nevertheless, von der Leyen succeeded in doubling the number of commission vice-presidents in her new college.

The commission president also sees a good balance in her work in terms of gender, thematic focus and geography. The proposed college includes 11 women, representing a share of 40 per cent. In recent weeks, following the first nominations from the member states, von der Leyen had attempted to increase the share of women among the EU commissioners. It is against this background that she wants her nomination of the six executive vice-presidents to be understood: "Four women, two men. Three from member states that joined before the fall of the Iron Curtain. And three from member states that joined after Europe was reunited. From the Baltics, the Nordics and Eastern Europe. Ministers and prime ministers. Different backgrounds. But all with one common goal—and that is to make Europe stronger."

Executive vice-presidents

Von der Leyen surprised everyone with her decision to nominate Roxana Mînzatu from Romania and Henna Virkkunen from Finland as vice-presidents. This meant that three incumbents were given less important positions. Two of them are considered veterans of the commission: Maroš Šefčovič of Slovakia and Valdis Dombrovskis of Lithuania. Dubravka Šuica of Croatia was also demoted.

Teresa Ribera (Spain, Socialists and Democrats—S&D) will be Executive Vice-President of a Clean, Just and Competitive Transition. Currently Minister for Ecological Change, Ribera will now also be responsible for competition policy. She will lead the work to keep Europe on track to meet the targets set out in the European Green Deal. The aim is to decarbonise and industrialise the economy at the same time.

Henna Virkkunen (Finland, European People's Party—EPP) will be Vice-President for Tech-Sovereignty, Security and Democracy. She will also be in charge of digital and frontier technologies, as well as aspects of internal and external security, the foundations of democracy and the rule of law.

Stéphane Séjourné (France, Renew Europe) will be Executive Vice-President for Prosperity and Industrial Strategy. He will also be responsible for the Industry, SMEs and Single Market portfolios and will be tasked with helping to create the conditions for European businesses to thrive, from investment and innovation to economic stability and trade, to economic security.

Kaja Kallas (Estonia, Renew) will be High Representative and Vice-President. She will have to be the bridge between European domestic and foreign policies. Sie will also have to ensure that "the EU commission remains a geopolitical commission".

Roxana Mînzatu (Romania, EPP) will be the Executive Vice-President for People, Skills and Preparedness. She will be responsible for skills, education and culture, quality jobs and social rights at a tome of demographic challenges.

Raffaele Fitto (Italy, European Conservatives and Reformers—ECR) will be the Executive Vice-President for Cohesion and Reforms. His nomination is not without controversy in the EU parliament. He is called upon to help modernise Europe and strengthen cohesion and growth policies.

Commissioners nominated

Maroš Šefčovič (Slovakia, S&D) will have two portfolios. He will be the Commissioner for Trade and Economic Security, which also includes customs policy. He will also be responsible for interinstitutional relations and transparency. In his second role, he will report directly to von der Leyen.

Valdis Dombrovskis (Latvia, EPP) will also have a dual role. He will be the Commissioner for Economy and Productivity and the Commissioner for Implementation and Simplification. He, too, will report directly to von der Leyen in his second role.

Dubravka Šuica (Croatia, EPP) will be the Commissioner for the Mediterranean. She will work closely with Kaja Kallas and many other commissioners to develop our shared interests with the region.

Olivér Varhelyi (Hungary, Patriots for Europe) has been nominated as Commissioner for Health and Animal Welfare. He will be responsible for building the European Health Union and continuing the fight against cancer and promoting preventive health.

Wopke Hoekstra (Netherlands, EPP) will be the Commissioner for Climate, Net Zero and Clean Growth. He will continue to work on the implementation of climate targets and adaptation, climate diplomacy and decarbonisation. He will also be in charge of taxation.

Andrius Kubilius (Lithuania, EPP) will be the Commissioner for Defence and Space. He will work on developing the European Defence Union and boosting the EU's investment and industrial capacity in this area.

Marta Kos (Slovenia, Renew) is slated to become the Commissioner for Enlargement, including the EU's Eastern Neighbourhood. She will work to support Ukraine, continuing the work on reconstruction, and help candidate countries to prepare for accession.

Jozef Síkela (Czech Republic, The Greens/European Free Alliance) will be the Commissioner for International Partnerships. He will lead the work on the Global Gateway and ensure the development of mutually beneficial partnerships that invest in a shared future.

Costas Kadis (Cyprus, EPP) will be the Commissioner for Fisheries and Oceans. His mission will be to help build a resilient, competitive and sustainable sector and present the first European Oceans Pact.

Maria Luís Albuquerque (Portugal, EPP) will be the Commissioner for Financial Services and the Savings and Investment Union. Her task will be to strengthen and complete the Capital Markets Union and to ensure that private investment drives productivity and innovation even more than it does today.

Hadja Lahbib (Belgium, Renew) will be the Commissioner for Preparedness and Crisis Management. This is another new portfolio dealing with resilience, preparedness and civil protection. She will be responsible for leading the efforts of the EU Commission's efforts in crisis management and humanitarian aid.

Magnus Brunner (Austria, EPP) will be the Commissioner for Internal Affairs and Migration. He will also focus on the implementation of the Pact on Asylum and Migration, but also on strengthening the borders and developing a new internal security strategy.

Jessika Roswall (Sweden, EPP) will be the Commissioner for Environment, Water Resilience and a Competitive Circular Economy. She will be responsible for protecting the environment and recognising that a sustainable economy cannot function without an intact environment. She will also lead the work on water resilience.

Piotr Serafin (Poland, EPP) will be the Commissioner for Budget, Anti-Fraud and Public Administration. He will report directly to von der Leyen and focus on preparing the next long-term budget.

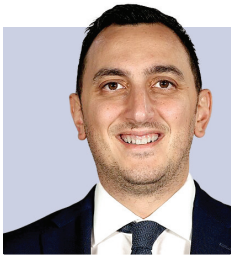
Dan Jørgensen (Denmark, S&D) will be the Commissioner for Energy and Housing. His work should help to bring down energy prices. He will look at investment in clean energy and will be the first housing commissioner to look at all aspects: from energy efficiency to investment and construction.

Ekaterina Zaharieva (Bulgaria, EPP) will be Commissioner for Research and Innovation. Research and innovation, science and technology must be placed at the heart of the EU's economy. She will help ensure that the EU invests more and focuses its spending on strategic priorities and on breakthrough innovations.

Michael McGrath (Ireland, Renew) will be Commissioner for Democracy, Justice and the Rule of Law. He will be responsible for taking forward the European Democracy Shield. He will also lead the work on the rule of law, the fight against corruption and consumer protection.

Apostolos Tzitzikostas (Greece, EPP) will be Commissioner for Sustainable Transport and Tourism. He will be responsible for the mobility of goods and people. These are essential sectors for competitiveness but also for the transition, for connecting people and driving local economies.

Christophe Hansen (Luxembourg, EPP) will be the Commissioner for Agriculture and Food. His task will be to give life to the report and recommendations of the Strategic Dialogue. Based on the Strategic Dialogue, he will develop a Vision for Agriculture and Food in the first 100 days of his mandate.



Glenn Micallef (Malta, EPP) will be Commissioner for Intergenerational Fairness, Culture, Youth and Sport. He will be responsible for striking the right balance in our society.

Following the presentation of the candidates nominated by the President of the European Commission, the EU parliament will examine the proposals in a confirmation hearing—but only once all national confirmations have been received. The appointment of Marta Kos has not yet been finalised. She was the second choice after von der Leyen persuaded Ljubljana to replace the original candidate, Tomaz Vesel, with a woman, causing tension between the Slovenian government and opposition. Her official confirmation by Slovenia had not yet been received at the time of going to press.

AWU

Sources: EU Commission; Euractiv

World Dental Congress in Istanbul

Eight policy statements adopted

The World Dental Federation (FDI) met in Istanbul, 9–14 September 2024. The meeting resulted in eight adopted policy statements, including on artificial intelligence in dentistry, oral health for patients with special needs, non-communicable diseases and reducing sugar consumption. Prof. Falk Schwendicke from Germany was elected to a second term of office on the FDI Science Committee.

At the 2024 FDI World Dental Congress in Istanbul, FDI held its parliament meetings and took key decisions during the General Assembly.

The General Assembly (GA) is the supreme legislative and governing body of FDI. The GA gathers once a year and sets FDI policies, the strategic plan, missions and aims, and monitors progress on their achievement.

Additionally, the GA approves the annual budget, establishes the annual subscription of the Regular Members, receives and takes necessary action on reports of the Council, and elects Regular, Associate, Affiliate and Supporting Members, Committee and Council members, as well as the Speaker of the GA.

This year, in Istanbul, the voting members of the GA took the following decisions:

Membership applications

Accepted Lebanese Dental Association—Tripoli application for regular membership

Accepted Société Congolaise des odontologues, stomatologues et chirurgiens maxillofaciaux application for regular membership

Election results:

newly appointed officers

- Dr Mauricio Montero (Colegio de Cirujanos Dentistas de Costa Rica)
- Dr Sophie Dartevelle (French Dental Association)
- Dr William Cheung (Hong Kong Dental Association)
- Prof. Elham Kateeb (Palestinian Dental Association)
- Prof. SM Balaji (Dental Association of Seychelles)
- Dr Anna Lella (Polish Chamber of Physicians and Dentists and Polish Dental Society)
- Asst Prof. Duygu Ilhan (Turkish Dental Association)

Speaker

- Dr Stephen Liew (Australian Dental Association)

Membership Liaison and Support Committee

- Dr Irene Marron-Tarrazzi (American Dental Association)

Dental Practice Committee
- Dr Doniphan Hammer (French Dental Association)
- Dr Hiroyuki Hirano (Japan Dental Association)

Education Committee
- Prof. Jun Tsuruta (Japan Dental Association)
- Dr Antonio Estrada Valenzuela (Asociación Dental Mexicana Federación Nacional de Colegios de Cirujanos Dentistas, A.C.)
- Dr Antonio Roma Torres (Portuguese Dental Association)
- Prof. Tianmin Xu (Chinese Stomatological Association)

Science Committee
- Prof. Falk Schwendicke (German Dental Association [BZÄK])
- Dr Wendy Thompson (British Dental Association)
- Prof. Kıvanç Bektaş Kayhan (Turkish Dental Association)

Public Health Committee
- Dr Louisa Nokukhanya Makwakwa (South African Dental Association)
- Prof. Youn-Hee Choi (Korean Dental Association)
- Assoc. Prof. Simona Dianišková (Slovak Chamber of Dentists)
- Prof. Islam Tarek Abbas Hassan (Egyptian Dental Association)
- Prof. Chun-hung Chu (Hong Kong Dental Association)

New policy statements

FDI policy statements, which detail FDI's position on issues of interest within the oral health community, are put together through consultation, discussion, and consensus among leading dental experts from around the world. This year, the GA adopted eight policy statements:

- Artificial intelligence in dentistry
- Reduction of sugar consumption
- Early childhood caries
- Oral health and non-communicable diseases
- Special care dentistry
- Ethics in dentistry
- Dental laboratory technician
- Lasers in dentistry

The newly adopted policy statements will be available for consultation on the FDI website soon and will be published in the *International Dental Journal*.

Source: FDI; German Dental Association 19 September 2024

World Oral Health Day campaign

FDI has unveiled its 2025 "A happy mouth is… a happy mind" World Oral Health Day (WOHD) campaign The campaign was officially launched during FDI's World Dental Congress, in Istanbul, on 12 September. 2025 This marks the second year of the 2024–2026 campaign, "A happy mouth is…", which aims to inspire lasting and positive change by educating people on the crucial role a healthy mouth plays in our lives.

With this concise yet impactful tagline, FDI hopes to simplify oral health and make it accessible explaining the benefits upfront in a plain-speaking way without relying on additional explanation.

From the mouth–body connection to the mouth–mind connection

Each year of the three-year campaign focuses on a specific theme that aligns with global health developments, particularly following the adoption of WHO's Oral Health Resolution in 2021.

In 2024, the theme was "A happy mouth is… a happy body", highlighting the strong connection between oral health and general health.

In 2025, the focus will shift to the mouth–mind connection, with the tagline "A happy mouth is… a happy mind."

This campaign aims to raise awareness of how poor oral health can negatively impact quality of life, highlighting the importance of a healthy mouth for mental well-being.

The campaign will emphasise for example how maintaining a healthy mouth can contribute to overall happiness because your mouth, body, and mind are all interconnected, and caring for your teeth and gums can significantly improve your overall well-being. In fact, a healthy mouth can boost your positivity, self-esteem, and confidence, ultimately enhancing your quality of life. On the other hand, poor oral health can make it difficult to socialise, limit your food choices, and lead to stress and anxiety—all of which are essential for a happy mind.

Last year, Toothie, FDI's beloved beaver mascot, starred in an engaging movie-themed campaign. For 2025, Toothie returns in a new campaign set to the rhythm of a beat, with music playing a significant role in campaign activities. The goal? To make everyone smile—inside and out! This new creative approach is designed to captivate diverse audiences and continue the campaign's broad-reaching impact, encouraging people to prioritise their oral health and join in celebrating World Oral Health Day.

At the end of your campaigns, you may even get the chance to win a WOHD Award, like our champions from this year's campaign. Read more here: www.worldoralhealthday.org/world-oral-health-day-awards

Europe Ticker +++

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France discusses new law

Violence against doctors to be included in the criminal code

France is moving towards stricter penalties for violence against healthcare staff. A new law, currently under discussion in the Senate, aims to include both physical and verbal assaults in the criminal code. The legislation, part of a broader initiative to improve safety for healthcare workers, focuses on three key articles.

Article 1 proposes harsher sentences for physical attacks on healthcare professionals. Assaults resulting in incapacity to work for more than eight days will be punishable by up to five years' imprisonment and a fine of €75,000. Lesser attacks that do not lead to incapacity will incur a penalty of up to three years in prison and a fine of €45,000. Additionally, the theft of medical equipment from healthcare facilities will carry a maximum sentence of five years and a €75,000 fine.

Article 2 extends the criminal offense of insult to all healthcare employees, including those in freelance roles. Insults will be subject to fines of up to €7,500.

Article 3 grants employers the right, with the employee's consent, to act as a joint plaintiff in cases of violence or threats against their staff and to file a criminal complaint.

On average, around 65 healthcare professionals in France, including many working in dental practices, experience verbal or physical abuse at work each day.

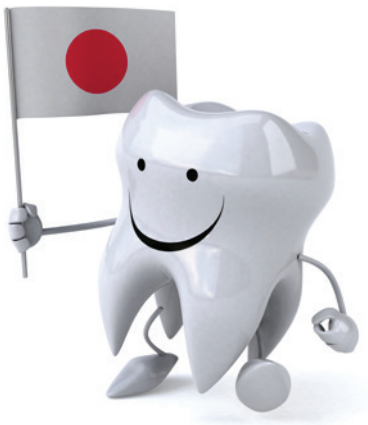
Source: zm 14/2024, Germany

Medication under test in Japan

Growing new teeth

A groundbreaking drug developed in Japan aims to regrow missing teeth, offering an alternative to conventional prosthetics. Following successful animal trials, the medication is now undergoing human testing, reports Swiss radio SRF. According to Prof. Michael Bornstein, Head of Research at the Institute of Dentistry at the Basel University Centre for Dentistry (UZB), the drug works by stimulating the body to produce new teeth endogenously. "The goal is to restore missing teeth within the patient's own body, rather than using prosthetics," explains Bornstein.

The mechanism relies on specific cellular messengers that transmit signals, leading to tooth growth. Researchers at Kyoto University have discovered that the protein USAG-1 inhibits tooth development. By blocking this protein, they believe it is possible to stimulate the growth of new teeth.



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The drug is particularly intended for children suffering from tooth agenesis. In such cases, the medication can directly influence and stimulate the formation of the tooth structure. However, Bornstein notes that its effectiveness diminishes significantly in patients over the age of 40: "At that age, the natural predisposition for tooth growth is largely absent, and other approaches, such as stem cell implantation, are necessary." Nonetheless, researchers continue to explore natural methods as alternatives to traditional dental implants.

Source: SRF (Swiss radio), 4 June 2024

Wir verlegen dental – Und das konstant seit drei Jahrzehnten.

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EPP in the EU Parliament

ENVI Committee to be split up

The EU Parliament's Committee on Environment and Health (ENVI), which was remarkably busy in the last legislative period, should be split up. Following the EU elections, the Parliament's largest political group, the European People's Party, wants to change the structure to accommodate the growing number of laws passing through the Environment and Health Committee.

Although the matter is not "100 % fixed", the EPP sees a "growing consensus among the leaders of the different groups" and expects a decision soon. The split would entail a Health and Food Safety Committee separate from ENVI, which would remain in charge of environmental and climate legislation. Other political groups are reportedly not yet confident the split will materialise.

Source: euractiv, 2 July 2024

Breast cancer patients with bone metastases

Osteonecrosis of the jaw now frequent and occurring later during cancer treatment

Osteonecrosis of the jaw (ONJ) is a significant complication in the treatment of bone metastases using antiresorptive therapies such as bisphosphonates and denosumab. A recent study found that 8.8 % of women with breast cancer undergoing these treatments develop ONJ—a figure notably higher than previously reported in international literature. The study, led by Dr Christine Brunner from the Medical University of Innsbruck and published in the *Journal of Clinical Oncology*, revealed that ONJ occurred more frequently in patients treated with denosumab compared to bisphosphonates. This marks the first comprehensive long-term survey of ONJ in breast cancer patients with bone metastases.

The researchers examined 639 women receiving monthly antiresorptive therapy: 292 were treated with denosumab, 255 with bisphosphonates, and 92 sequentially with both drugs. ONJ was observed in 56 women (8.8 %): 11.6 % of those treated with denosumab, 2.8 % with bisphosphonates, and 16.3 % of those who received both drugs. The study also highlighted treatment duration as a key risk factor. Among patients who developed ONJ, the median time to onset was 4.6 years for denosumab, 5.1 years for bisphosphonates, and 8.4 years for those treated with both therapies sequentially.

These findings emphasise the importance of dental pre-treatment and regular check-ups for patients with advanced breast cancer before and during antiresorptive therapy. In addition, they should have regular dental check-ups to ensure optimal dental care and to recognise the first signs and symptoms of jaw necrosis at an early stage.

Source: Medscape 12 September 2024; Journal of Clinical Oncology

2024 OSSTEM EUROPE MEETING

LONDON

22. - 23. November 2024

Mukesh Soni | Session 1: Clinical procedures for favorable immediate implant placement & loading

22. Nov.
09:30 - 11:00

N. Saynor
Time of implant positioning: How to reach predictable results

L. Muzzi
Timing of implant positioning: Do Immediate implants work?

V. Rutkunas
Improving implant prosthodontics through the total fit workflow

Ieva Gendviliene | Session 2: Role of bone regeneration in enhancing successful osseointegration

22. Nov.
11:30 - 13:00

D. Chong
GBR in Implant Dentistry: Essential or Optional?

A. Ashraf
The craft of decision making before, during and after ridge augmentation surgeries

S. Meloni
Vertical and horizontal prosthetic and aesthetic Computer Guided Bone Regeneration.

Árpád Joób-Fancsaly | Session 3: Soft tissue stability for optimal esthetic outcomes

22. Nov.
14:00 - 15:30

P. Windisch
Implant site soft tissue management prior to augmentation & implant placement.

A. Sculean
Management of soft tissue complications after implant placement. Etiology & treatment.

D. Božić
Xenogenous collagenous soft tissue matrices for soft tissue augmentation around implants.

Matthias Kaupe | Session 4: Discover the Benefits of a Digital Workflow for Treating Fully Edentulous Patients

22. Nov.
16:00 - 17:30

N. Oberai
Full-arch dentistry with a focus on analog techniques

A. Ricci
How to restore a terminal dentition: from esthetic diagnosis to follow-ups

E. Clozza
FP1 Full-arch Implant Restorations with Photogrammetry

Kyoungwon Kim | Session 5: Gain tips and techniques for the management of implant complications

23. Nov.
09:00 - 10:30

C. Barclay
Implant disease

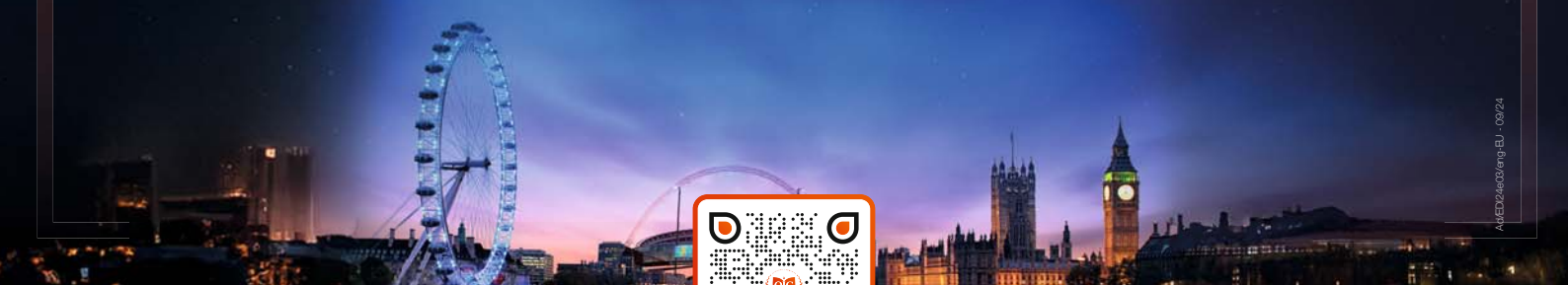
F. Barrak
Is there a place for bioactive glass in implant dentistry today?

M. Tallarico
Re-treatment of failed implants: from prevention to advanced hard and soft tissue management

David Chong | Session 6: Live Surgery - Full arch implant placement in the maxilla with 4 implants and immediate loading on the same day

23. Nov.
11:30 - 13:00

A. Ali
Live Surgery



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AM/ED/24d03/eng-EU - 09/24

Judgement in case C-48/22P Google and Alphabet v. the EU commission

ECJ confirms Google fine

The European Court of Justice (ECJ) has confirmed the fine of €2.4 billion imposed on Google for abusing its dominant position by favouring its own price comparison service. At the same time, the ECJ rejected the appeals of Google and Alphabet.

Background

In 2017, the EU commission imposed a €2.4 billion fine on Google for abusing its dominant position in several national markets for online search services by favouring its own price comparison service over those of its competitors. As the General Court of the European Union essentially upheld this decision, Google and Alphabet appealed to the Court of Justice. The ECJ dismissed the appeal, thereby confirming the judgement of the General Court.

The case

In its decision dated 27 June 2017, the commission found that Google had prioritised the results of its own price comparison service over those of competing price comparison services on its general search results page in 13 European Economic Area countries Google presented the search results of its own price comparison service at the top and highlighted them in "boxes" with attractive images and text information. The search results of competing price comparison services, on the other hand, only appeared in a subordinate position in the form of blue links and could therefore—unlike the results of Google's own price comparison service—be downgraded by the ranking algorithms on Google's general search results pages.

The commission found that Google had abused its dominant position in the markets for general online search services and for special product search services and therefore imposed a fine of

€2,424,495,000, for which Alphabet, as Google's sole shareholder, is jointly and severally liable for €523,518,000.

EU commission's decision challenged

Google and Alphabet challenged the commission's decision before the General Court of the European Union. In its judgement of 10 November 2021, the Court essentially dismissed the action and, in particular, upheld the fine.

However, the Court did not consider it proven that Google's conduct had even potentially anti-competitive effects on the market for general search services. It therefore annulled the decision to the extent that the commission had also found an infringement of the prohibition of abuse of a dominant position in relation to that market.

Google and Alphabet subsequently lodged an appeal with the ECJ, seeking to have the judgement of the General Court set aside in so far as it dismissed their action and to have the commission's decision annulled.

ECJ: Abusive exploitation

In its judgement of 10 September 2024, the ECJ dismissed the appeal, upholding the judgement of the General Court. The Court pointed out that EU law does not sanction the existence per se of a dominant position, but only the abusive exploitation thereof.

Specifically, the law sanctions any conduct of undertakings in a dominant position that has the effect of hindering competition on merits and is thus likely to cause direct harm to other undertakings or consumers. Such conduct includes any practice which, on a market where the degree of competition is already weakened precisely because of the presence of one or more undertakings in a dominant position, hinders the maintenance or development of competition through the use of means other than those governing normal competition between undertakings.

The Court added that it could not be regarded as a general rule that a dominant undertaking which treats its own products or services more favourably than those of its competitors engages in conduct which departs from competition on the merits, irrespective of the circumstances of the case. In the present case, however, the General Court had rightly found that, in view of the characteristics of the market and the specific circumstances of the case, Google's conduct was discriminatory and did not reflect competition on merits.

Note

Appeals on points of law only may be brought before the Court of Justice against judgements and orders of the General Court. In principle, an appeal does not have suspensory effect. If the appeal is admissible and well founded, the Court of Justice will set aside the judgement of the General Court. Where the state of the proceedings so permits, the Court of Justice may itself decide the case. Otherwise, it refers the case back to the General Court, which is bound by the decision given by the Court of Justice on the appeal.

Source: ECJ press release of 10 September 2024

The judgement

Judgement of the European Court of Justice in case C-48/22 P | Google and Alphabet v. commission (Google Shopping)

BDIZ EDI Quality Guideline for Implantology

Recommendations for practitioners and patients

BDIZ EDI President Christian Berger explains in this interview why the association created the Quality Guideline for Implantology. Berger was instrumental in revising the Quality Guideline, which was first published in 2002 and is regularly updated—the latest update is from 2019. It is intended as a set of recommendations for practitioners and patients.

BDIZ EDI President Christian Berger talks about the revised Quality Guideline for Implantology.

What are the benefits of the BDIZ EDI Quality Guideline for Implantology?

Our Quality Guideline has the status of a recommendation and serves as a tool for self-evaluation and self-assessment. Only dental professionals know their own work and their patients, with all their expectations and problems. Only treatment providers themselves can reliably assess how the prevailing conditions—which influence every medical treatment, sometimes decisively—have positively or negatively influenced the respective treatment result. BDIZ EDI would like to emphasise the fact that the criteria are based on evidence from dental science. They can therefore claim validity even in the current political and scientific environment, where scientific evidence is unfortunately often disregarded when it comes to defining what constitutes fair remuneration. In 2000, the Quality Guideline was a first attempt to highlight the issue of quality in oral implantology in Germany. The Quality Guideline has been continuously modified and updated and will continue to be updated as necessary.

What about its implementation in practice?

First things first: The Quality Guideline is not intended to prescribe or introduce standardised treatment procedures or practice structures. Dentistry is a liberal profession, and it will continue to be up to dentists to decide how to achieve the required quality, because it is their responsibility to achieve it. The Quality Guideline sets out a list of six quality criteria for implant procedures: medical history, examination, treatment planning, patient education, concomitant prevention—as well as implant surgery and implant prosthetics themselves. These quality criteria are assessed on the basis of five evaluation criteria: What is the indication for the proposed treatment? What are the treatment goals? What are the risk factors that affect the treatment goals? Are there standards related to the treatment measures? What are the indicators of treatment outcome? This evaluation assigns the treatment result one of the following categories:

- A+ Excellent result with no reservations whatsoever
- A Good result, appropriate to aspire to in normal cases
- B Deficient, potentially harmful
- C Unacceptable, alternatives required

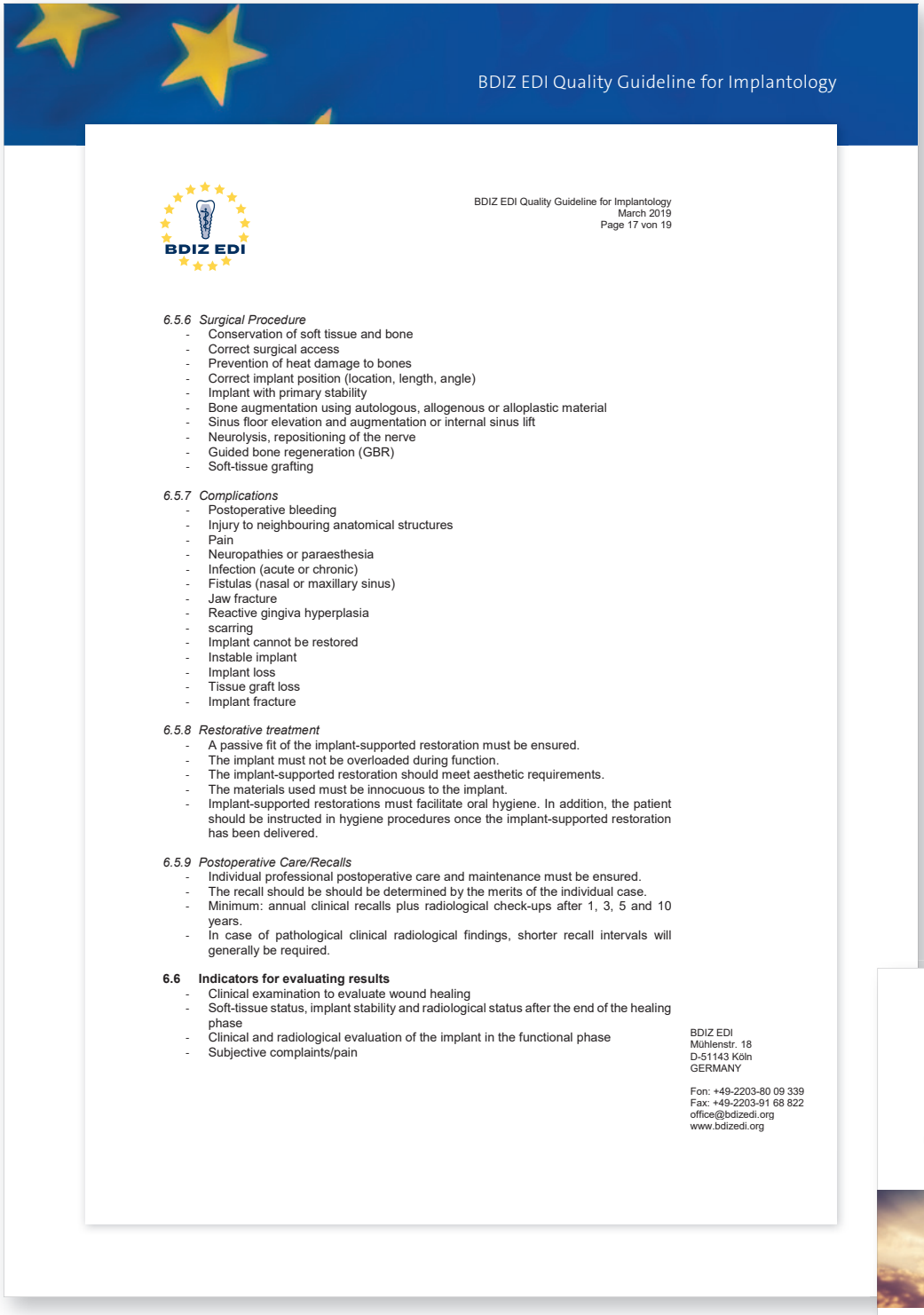
The Quality Guideline provides a step-by-step procedure for applying these quality and evaluation criteria, culminating in a list of criteria and of the categories A+ to C.

What is the aim of the BDIZ EDI Quality Guideline for Implantology?

Promoting quality in implant treatment has been the main objective of BDIZ EDI for 30 years now. It was no coincidence that in 2001 we received recognition from the German Federal Constitutional Court for a formal specialisation, or professional focus, on oral implantology for dentists. Our Quality and Registration (Q&R) Committee tests products and materials. We continue to develop our own biotope of implantological experts. We emphasise the importance of well-trained professionals who regularly participate in continuing education (CE) activities. And we publish annual guidelines on current implantological issues complete with recommendations for clinicians. Of course, we know that assessing the quality of dental outcomes is not an easy task, not least because quality issues are controversial even among many experts in the field. Our aim is to provide implant dentists—and, where possible, their patients—with a suitably calibrated yardstick by which they can assess the results achieved for themselves and for their patients.

Thank you very much for your comments.

The interview was conducted by Anita Wuttke, Editor-in-Chief.



Bibliographical note

BDIZ Quality Guideline for Implantology. Updated March 2019. 17 A4 pages and cover.
With a description of six quality criteria and five evaluation criteria and an overview of categories A+ to C.

English version available for download from https://bdizedi.org/en/quality-guidelines.

Impressions from Skopje

"The profession first" was the motto of the 3rd Congress for Oral Surgery and Implantology of the Albanian Association of Implantology (AIAM) and EDI of Macedonia, partner association of BDIZ EDI since 2017.

At the invitation of Dr Fisnik Kasapi, President of EDI Macedonia, and Dr Daniela Veleska-Stevkovska, President of the Oral Surgery Association, President Christian Berger attended the two-day congress in Skopje as a speaker and representative of BDIZ EDI. His presentation was on the "Digital workflow in oral implantology based on prosthetic concepts". BDIZ EDI board member Dr Markus Tröltzsch was also present as a speaker and gave a presentation on "Precision meets innovation—digital support in aesthetic implantology and oral surgery". His presentation was streamed in for the attendees. Dr Erion Çerekja from Albania was the third speaker at the European Consensus Conference (EuCC) under the auspices of BDIZ EDI. He spoke on "Key points of implant surgery in the aesthetic field".

AWU

Dr Daniela Veleska-Stevkovska was the host for the first day.

Good vibes at the EDI of Macedonia booth. (From left to right) Christian Berger, Dr Erion Çerekja, Dr Fisnik Kasapi and two members of the board of EDI of Macedonia.

A certificate for the presenter: Christian Berger and Dr Veleska-Stevkovska.

Dr Markus Tröltzsch held his presentation remotely.

Christian Berger spoke about the digital workflow.

Dentists from Albania, Macedonia and Turkey attended the congress.

Philipp I of Macedonia, father of Alexander the Great.

The organising team and the speakers relaxing over dinner after work.

Save the Date—June 2025

18th European Symposium of BDIZ EDI—up north

The 2025 BDIZ EDI European Symposium will be held in Stockholm. For the first time, Scandinavia—more specifically Sweden's capital Stockholm—will be the destination for the one-day BDIZ EDI Symposium, which promotes the exchange of ideas between implant dentists in Europe.

Speakers will be coming from all over Europe—including, of course, members of the BDIZ EDI Board. The Symposium will be held in English. Topics will include implant surgery and implant prosthetics.

Stockholm—then and now

Stockholm is probably named after the protective wooden poles (stock) that lined the sound of Lake Mälaren leading up to the islet (holme) which is today the central island called Stadsholmen or, more commonly, Gamla Stan. Its history of settlement dates back to the 11th century. Stockholm has been the royal residence since 1643.

Water covers about 30 per cent of the city's area. The city still draws its drinking water from Lake Mälaren; the high quality of the water makes it possible to fish for salmon right in the city centre. The city is spread over 14 islands connected by 53 bridges. Much of the city is wooded.

The site of present-day Stockholm was first mentioned by the Icelandic poet and saga writer Snorri Sturluson (1179–1241) in his Ynglinga saga, where he describes a barrier of poles across today's Norrström waterway, which he called Stokksunda. Excavations in the late 1970s uncovered the remains of water poles from the 11th century, which support this statement. Snorri also mentions a fortification tower from the 12th century, which is said to have been located where the royal castle has stood since 1580.

A letter of protection for Fogdö Monastery, issued in July 1252, is the oldest surviving document in which Stockholm is mentioned. The Erik Chronicle (Erikskrönikan), written between 1320 and 1335, states that the founder of Stockholm, the regent Birger Jarl, wanted to build a fortress around 1250 to protect Lake Mälaren from pirate raids.

In the 15th century, its strategic and economic importance made Stockholm an important factor in the conflicts between the Danish kings of the Kalmar Union and the Swedish national independence movement. With the arrival of Gustav Vasa in 1523 and the establishment of a strong royal power, Stockholm became an important royal residence. The royal court also began to shape the cityscape, which had previously been dominated by merchants—often German—and craftsmen.

Sweden rose to become a great power in the 17th century. This was reflected in the development of Stockholm—between 1610 and 1680 the population increased sixfold. In 1713 and 1714, Stockholm was ravaged by the plague. After the end of the Great Northern War and the resulting loss of Swedish territory in 1721, the city began to stagnate and continued to do so throughout the early 19th century. Norrköping became the largest manufacturing city and Gothenburg, with its favourable location on the Kattegat, a straight opening to the Skagerrak and the North

Sea, became Sweden's most important export port. It was not until the second half of the century that Stockholm once again took on a leading role in the country's economic development. A number of important industrial companies were established here, with the result that Stockholm developed into an important centre for trade and services, as well as a transport hub.

Places of interest

Stockholm's cityscape and architecture are shaped by its unique location on the shores of Lake Mälaren, a freshwater lake that runs from west to east; a ridge of glacial moraine that runs from north to south; and the central island in the middle of the river. The city has many small parks, including Tegnérlunden, which is mentioned in Astrid Lindgren's work. The old town (Gamla Stan) on the city island (Stadsholmen) still has the medieval street network with the streets that cross the island from north to south (Österlånggatan and Västerlånggatan) and narrow alleyways sloping down to the water—which have become longer and longer over the centuries as the land has slowly risen following the disappearance of the heavy Ice Age glaciers, a process that continues to this day.

Why the European Symposium?

Every day we face new and continuing practical challenges. Undoubtedly, innovations in implant dentistry come from scientific advances and are translated into products developed by the dental industry. The demand from practicing dentists for new products and procedures and improved treatment options has culminated in the remarkable variety of new applications we see on the market today—new approaches to bone grafting, new capabilities in laser technology, chairside CAD/CAM and new materials of all kinds.

Given that we have already achieved very high standards and high success rates in implant therapy, it is not easy to strive for even better results and shorter treatment times. Nature sets limits. This makes it all the more important for implantologists to continue their education to stay abreast of the latest scientific and technical innovations and materials for the benefit of their patients and their practices. Education and training must keep pace with developments.

BDIZ EDI has therefore always considered the exchange of ideas as part of its professional focus. For the 18th time, BDIZ EDI will be organising its European Symposium in 2025—and for the first time in Scandinavia. Demosthenes (384–322 BCE) already knew that "small opportunities are often the beginning of great enterprises." This quote is characteristic of the BEDIZ EDI's European Symposia. Humble beginnings and spurious opportunities have been consolidated into a comprehensive approach that allows communities of dentists to transcend national borders and to intensify the exchange of ideas within Europe. The 18th European Symposium in Stockholm is a good example of this. It will once again demonstrate how implant dentists from all over Europe can benefit from each other's experience.

Christian Berger
President, BDIZ EDI

Certification as an EDA Expert in Implantology

Qualification for experienced implantologists

For many years, BDIZ EDI has been catering to experienced and well-versed oral implantologists by offering the certification exam for EDA Expert in Implantology. Jointly with the European Dental Association (EDA), BDIZ EDI regularly invites interested dentists to take the certification exam, which we would like to present in this article.

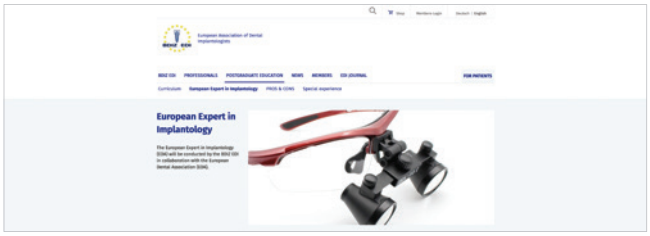
That quality is of paramount importance to BDIZ EDI is no secret. BDIZ EDI has demonstrated this in many different areas—legal and accounting, materials testing, postgraduate education, the annual guidelines of the European Consensus Conference (EuCC) on current implantological issues and finally the qualification of court experts. BDIZ EDI also supports dental education with its Curriculum Implantology that introduces aspiring dentists and young implantologists to this dental specialty in eight well-organised modules.

Admission requirements for the certification exam

Certification as Expert in Implantology requires very good to excellent skills and knowledge. Candidates must meet the following admission requirements:

- 250 EDA-recognised continuing education/training hours in various sub-disciplines of implantology
- Submission of ten documented, independently performed implantological treatment cases
- At least five years of professional activity, primarily in the field of implantology.

Specific experience and primary activity in the field of implantology must be documented by at least 400 implants inserted and



150 implants restored within the past five years. Candidates who already obtained qualifications in oral implantology (e.g. from other professional societies) may submit the appropriate credentials with their application for certification as EDA Expert in Implantology.

The exam

Candidates meeting all the requirements will be admitted to the examination. The examination board of BDIZ EDI and EDA consists of recognised specialists. The exam has a theoretical and a practical part, both of which must be completed successfully. The procedure is as follows: the theoretical part of the exam will start with a discussion of the documented cases. In addition, candidates are expected to answer questions related to oral implantology and closely associated fields. The theoretical examination usually takes no longer than 60 minutes; it may be administered to candidates in groups. The practical part of the examination covers one or more recognised, state-of-the-art treatment method or methods and/or treatment plans covering some aspect of oral implantology. Candidates will be informed of the respective topic two weeks before the exam date. Candidates are responsible for providing the required materials and instruments on the day of the exam. The examination as a whole is subject to a fee to cover the cost incurred by the examination board.

New EDA Experts in Implantology are nominated by the president or vice president of the EDA certification committee.

AWU

More information...

To register for the next certification exam, please go to www.bdizedi.org and select English > Professionals > Expert or write to the BDIZ EDI office in Cologne at office@bdizedi.org.

Applicant's address:

Full name: .....

Full address: .....

.....

.....

E-mail: ..... Date: .....

Forward by mail or fax to:

European Association of Dental Implantologists (BDIZ EDI)
Lipowskystr. 12
81373 Munich
Germany

office@bdizedi.org
Fax: +49 89 72069889

Certification exam: EDA Expert in Implantology
Application for accreditation

I hereby apply for the EDA Expert in Implantology certification exam (EDA = European Dental Association).
I am qualified for this exam as defined below:
Member of BDIZ EDI ☐ yes ☐ no
Member of the following Societies/Associations: .....
I am: ☐ a dental clinician ☐ an oral surgeon ☐ a maxillofacial surgeon
I meet the training requirement of 250 hours of postgraduate education. ☐ yes ☐ no

Education and experience:

Surgery:

Inserted implants:	☐ less than 400	☐ more than 400
Sinus lift:	☐ yes	☐ no
Close to nerve:	☐ yes	☐ no
Advanced atrophy of the jaw:	☐ yes	☐ no
Soft-tissue augmentation:	☐ yes	☐ no
Bone augmentation:	☐ yes	☐ no

Prosthodontics:
Implant-supported restorations: ☐ less than 150 ☐ 150 or more
During the exam, I will be able to present documentation for 10 treatment cases. ☐ yes ☐ no

I understand that the examination board will review my qualifications and vote to accept or reject my application. Furthermore, I declare that all images I present are my own and that the implants have been inserted and prosthetically restored by me.

....
Applicant's signature Date

Having successfully passed the exam and paid the requisite fee, I will be certified as EDA Expert in Implantology.

Stackable guides for the immediate restoration of dental implants

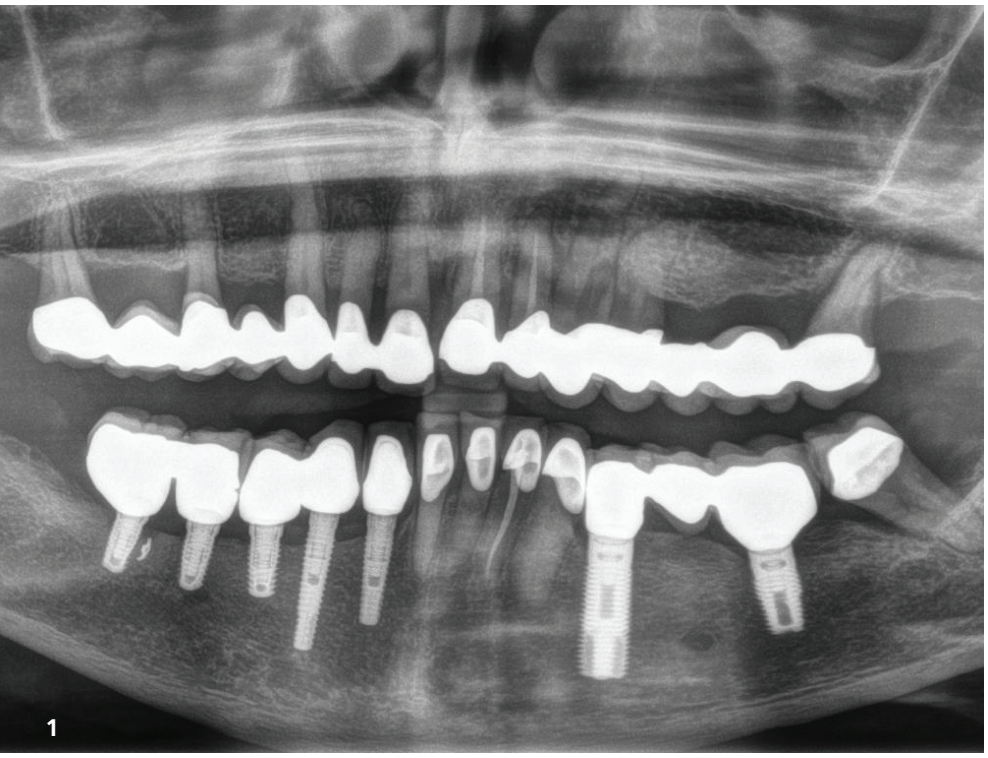
Benefits of the digital process chain

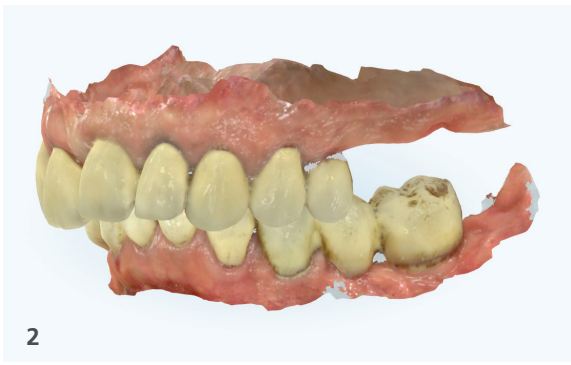
Dr Steffen Kistler, Prof. Jörg Neugebauer, Siegfried Weis, Dr Frank Kistler, Germany

Stackable guides—multi-part surgical guides—translate the benefits of the digital process chain into efficiency and reproducibility when inserting implants, even in complex situations such as immediate implant placement and immediate restoration.

Guided implant placement combined with 3D diagnostics and the superimposition of intra-oral scan data has made significant advances over the past few decades.[4,8] While in the early days of using surgical guides, the aim was to achieve better implant positions for the subsequent prosthetic restoration, in recent years more minimally invasive surgical techniques have been developed and the dental procedures for immediate restorations have been optimised.[5,16] One innovative method that is becoming increasingly important is the use of stackable guides (multi-part surgical guides) for immediate restorations. They ensure that implants can be placed in a guided manner and that the prepared prosthetic restoration can be accurately fixed using reference points.[6] Thanks to the multi-part approach, the surgical guides remain securely in place during the immediate restoration—something that is not always possible after tooth extraction, as extractions invariably change the clinical situation.[1] This technique offers many advantages in terms of precision, efficiency and patient comfort.

Preoperative diagnostics





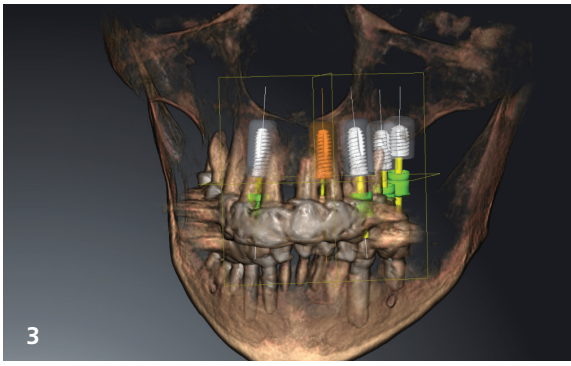


Fig. 1: Initial diagnosis using panoramic radiograph (Orthophos, Dentsply Sirona). Loosened bridge 21–27. **Fig. 2:** Intra-oral scan (iTero, Align Technology) after removal of tooth 27. **Fig. 3:** CBCT with initial implant planning (SICAT 2.3, SICAT).

What is a stackable guide?

A stackable guide is a specially fabricated, multi-part guide that is created for guided implant placement based on a three-dimensional radiological data set, a digital scan of the jaw and a digital reconstruction of the intended prosthetic restoration. The individual parts of the guide are stacked on top of each other, hence the term "stackable guide".[6] Each part of the guide has a specific function at various stages of the procedure.

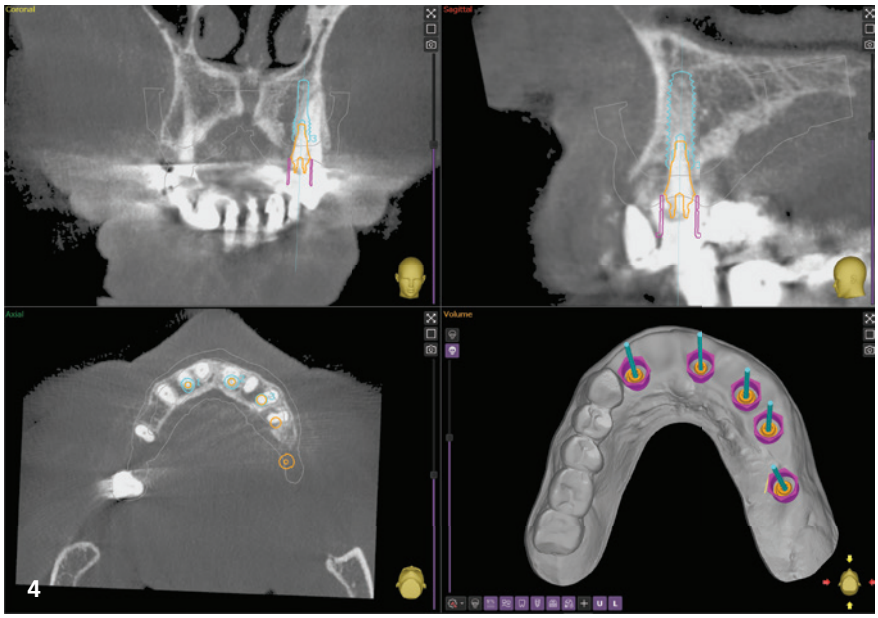
How to use stackable guides

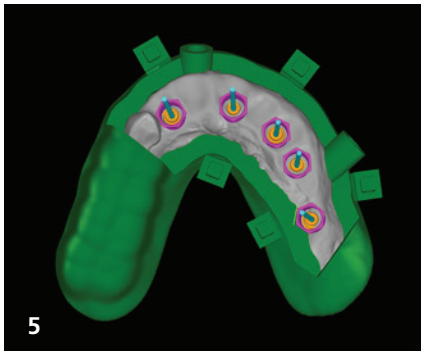
Due to the complexity of designing stackable guides, thorough preliminary implant planning is essential. This process requires a detailed analysis of both the available bone structure and the desired prosthetic outcome. Once the anatomical and prosthetic requirements for immediate restoration are met, the radiological data is exported in DICOM format. Simultaneously, the intra-oral scan and prosthetic design generated by the CAD/CAM system are exported in STL format for direct import into the implant planning software.

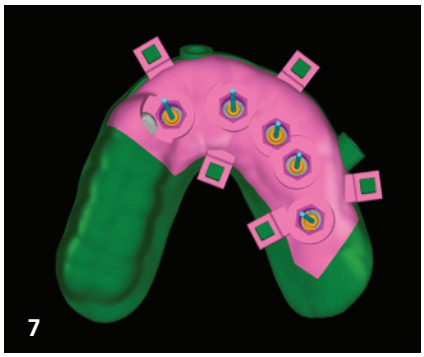
In addition to the precise implant positioning based on anatomical and prosthetic criteria, the basal guide design is determined. This guide is then attached to the alveolar ridge with fixation screws, known as anchor pins.[7,13]

- The basal guide is designed to prevent interference or collisions with instruments during tooth extraction. The basal guide is equipped with at least three pegs, which ensure proper alignment and positioning of subsequent guides in the stackable system. For precise positioning of the basal guide, an additional guide is created to rest on the teeth scheduled for extraction.
- This positioning guide provides the basis for accurate placement of subsequent guides and helps secure the temporary restoration.
- The static drilling guide, which defines the exact positions of the drill sleeves, is designed based on the implant plan.

Planning and design of the stackable guide







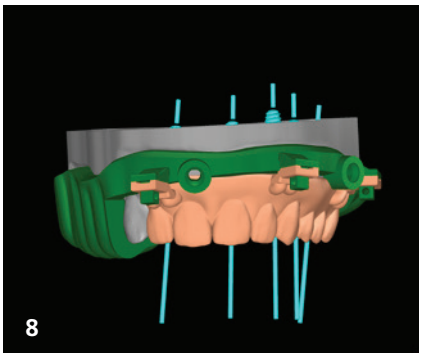
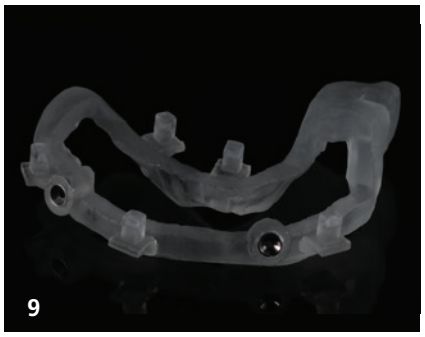
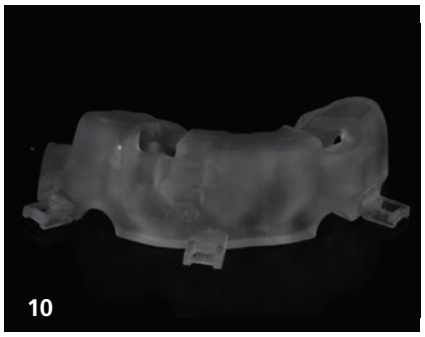


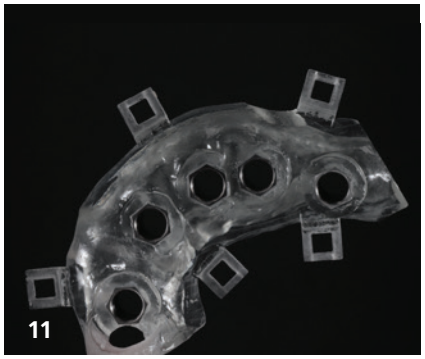
Fig. 4: Definitive implant planning following the decision to use a stackable guide. **Fig. 5:** Design of the basal guide after defining implant positions (ImplaStation, ProDigiDent). **Fig. 6:** Design of the positioning guide for the basal template. **Fig. 7:** Design of the drilling guide holding the primary sleeves. **Fig. 8:** Design of the temporary restoration with fixation on the basal template.

The positions of the fixation screws must be carefully checked to ensure that they do not interfere with the planned implant positions. In the final design step, the STL data set is overlaid onto the prosthetic restoration design, and the guiding elements are added to complete the guide structure. The stackable guide thus consists of three parts and an immediate temporary restoration. The four corresponding data

Fabrication of the stackable guide







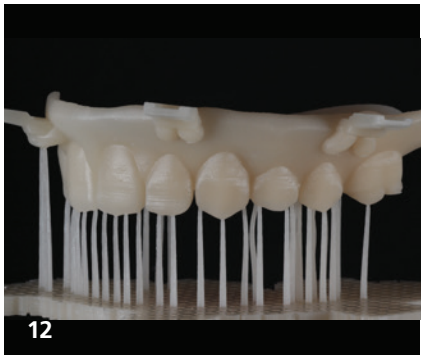


Fig. 9: Basal guide milled from PMMA with drill sleeves for fixation pins (SKY pro guide, bredent medical). **Fig. 10:** Positioning guide with openings for position control on the teeth scheduled to be extracted. **Fig. 11:** Drilling guide with primary sleeves (SKY pro guide, bredent medical) for the selected implant system. **Fig. 12:** 3D-printed temporary restoration before removal of the supporting structures.

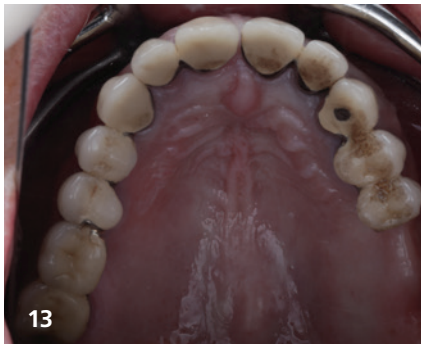
sets are exported from the planning program as STL data and can be printed or milled, depending on the material selected.

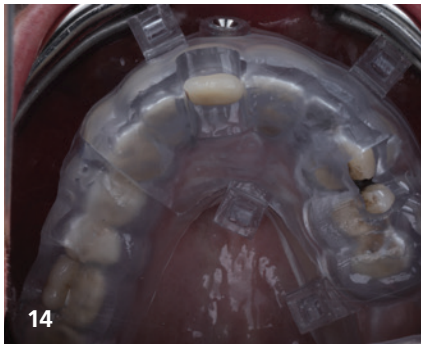
Strict adherence to the specified sequence of application of the stackable guides is crucial for successful implementation.[7] As tooth extraction is often necessary, only the basal and intermediate guides can be tried in first. If the positioning guide can be placed accurately, the basal guide can be secured in place with the anchor pins.

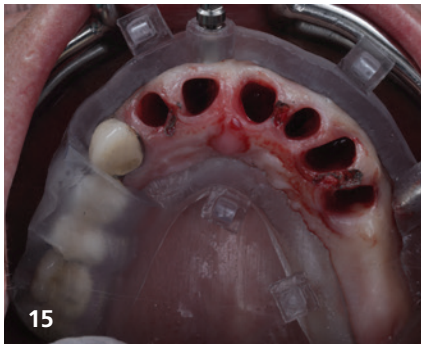
When the positioning guide has been removed, any teeth or existing restorations scheduled for extraction can be addressed. Next, the static navigation guide is inserted, and the implant beds are prepared using the appropriate implant system instrumentation.

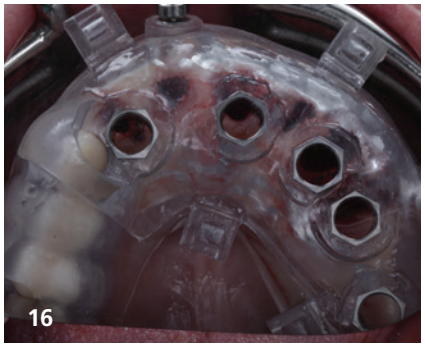
Once the implants are accurately positioned, the navigation guide is removed, and the abutments are placed to accommodate the prepared prosthetic restoration. The temporary restoration is placed on the basal template, and the titanium cylinders are cemented to secure the restoration.

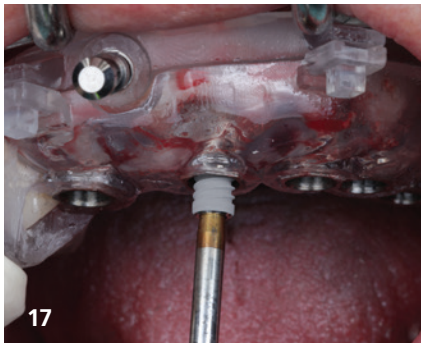
Clinical application











Finally, the anchor pins of the basal splint are removed, and the retaining screws of the titanium cylinders are loosened so that the temporary restoration can be finalised. Once osseointegration is complete, the final prosthetic restoration can be fabricated and placed.

Advantages of stackable guides

Stackable guides provide a precise, guided approach to implant placement, ensuring that implants are positioned with close attention to prosthetic requirements.[4] This precision reduces the risk of implant misplacement and complications, particularly during the final prosthetic restoration, by ensuring that the implants are correctly aligned from the outset.[11, 12]

Early loading of the implants promotes intensive and early bone remodelling, significantly improving the quality of osseointegration.[10] By placing the implants according to prosthetic requirements, abutments can be accurately preselected, simplifying intraoperative logistics and reducing the need for later adjustments. This allows optimal use of the one-abutment-one-time concept, which contributes to long-term stable bone levels by minimising repeated interventions at the implant site.[15]

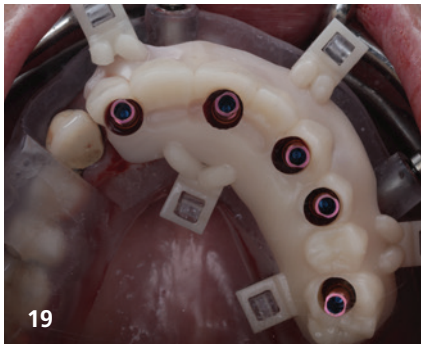
Moreover, by predetermining implant positions through meticulous guide planning, the overall surgery time is significantly reduced, as no intraoperative adjustments are required.[14] This efficiency is particularly beneficial for the placement of temporary restorations, which, without stackable guides, would depend on rough anatomical landmarks and typically yield less accurate results.

Stackable guides also eliminate the need for bite position corrections, as the temporary restoration is incorporated without deviations, improving patient comfort and accuracy. This reduces the burden on both the patient and the dental professional by eliminating the need for time-consuming dental adjustments at the end of the procedure. As a result, an ideal aesthetic and functional outcome can be achieved immediately after surgery.[16]

Disadvantages and challenges

While stackable guides offer numerous advantages, it's crucial to acknowledge the associated disadvantages, particularly the considerable time, expertise, and resources required for planning and production. Creating these guides involves using specialised software, and one should

Fig. 13: Initial situation with a non-salvageable restoration 12-25. **Fig. 14:** Placing the positioning guide with the basal template. **Fig. 15:** Basal guide with fixation pins in place after tooth extraction. **Fig. 16:** Secured drilling guide for guided implant placement (SKY pro guide, bredent medical). **Fig. 17:** Guided implant placement using the drilling guide (copaSKY, bredent medical). **Fig. 18:** Abutments with titanium cylinders to hold the temporary restoration. **Fig. 19:** Precisely positioned temporary restoration before bonding the titanium cylinders. **Fig. 20:** Temporary restoration cemented in place with the basal guide. **Fig. 21:** Finished temporary restoration at the end of the procedure, following removal of the basal guide. **Figs. 22a & b:** Radiographic control showing subcrestally placed implants with the bridge abutments (copaSKY, bredent medical). **Fig. 23:** Checking the restoration on the first postoperative day, showing minor soft-tissue swelling.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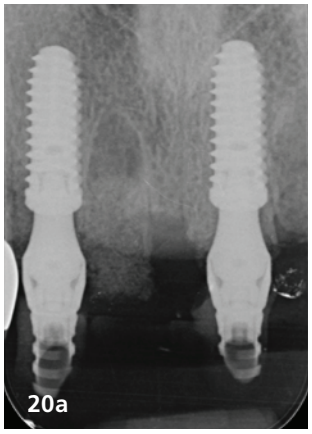
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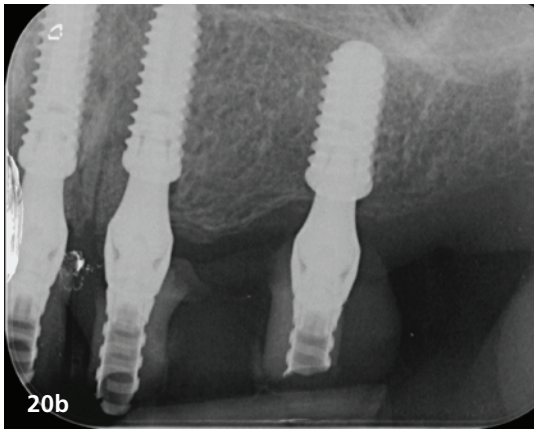
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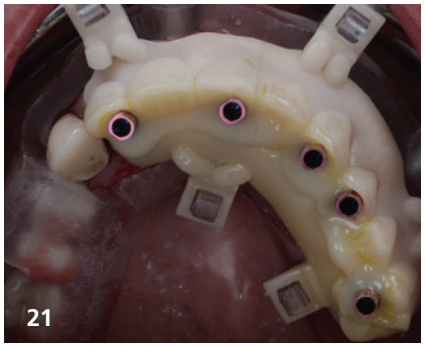
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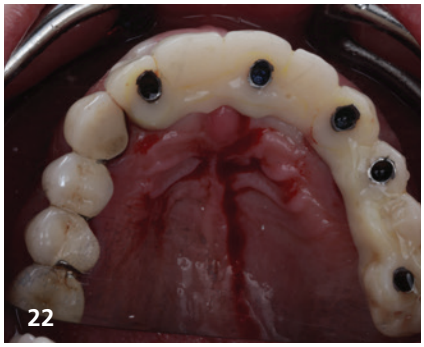
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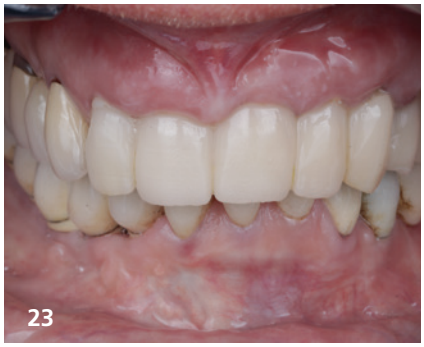
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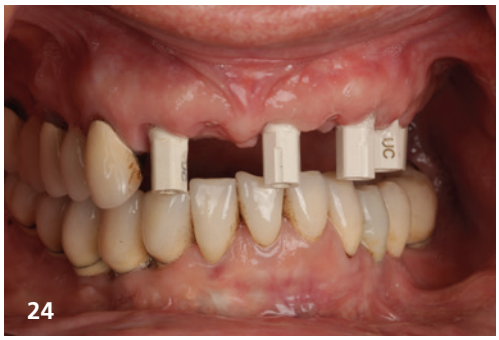
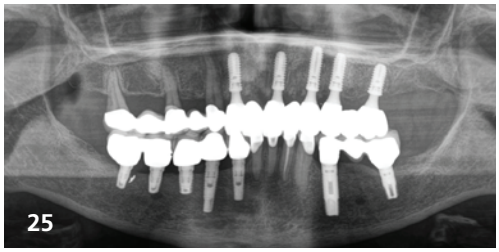
Definitive prosthesis





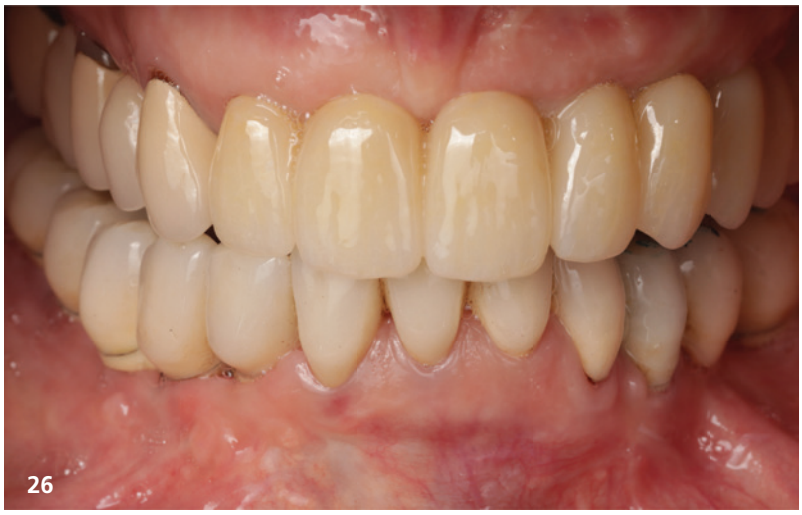


Fig. 24: Preparation of the final intra-oral scan with scan bodies at abutment level. **Figs. 25:** Radiographic control of the mock-up during the prosthetic phase. **Fig. 26:** Definitive restoration. Analogous shaping of the soft tissue and bridge pontics.

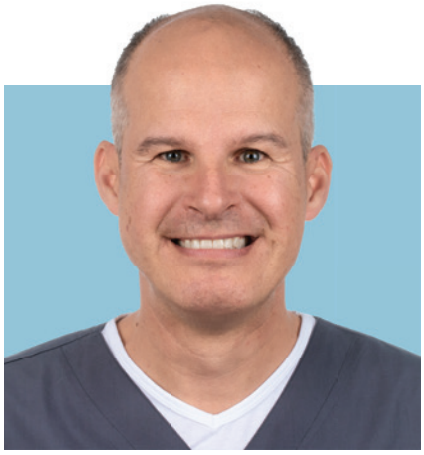
not underestimate the learning curve associated with mastering such tools.[9]

In practices without the necessary in-house expertise, these tasks can be outsourced to specialised laboratories. Harnessing the benefits of stackable guides requires strict adherence to a specified procedural sequence. Deviations from the sequence could limit the effectiveness of the guides. In terms of material selection and guide connections, magnets or metal basal templates are recommended over plastic pins.[2,3]

However, intraoperatively, magnets have shown limited fixation strength, which increases the risk of subsequent templates becoming loose during surgery. While metal basal guides offer superior stability, their fabrication is complex and resource-intensive. In most cases, a carefully produced 3D-printed basal template offers sufficient stability for the procedure.

Conclusion

Stackable guides represent a significant innovation in immediate implant placement with immediate restoration. They provide significant advantages in terms of precision, efficiency, and patient comfort, though they also come with challenges, particularly regarding costs and technological demands. The integration of stackable guides into the first 3D planning programs has simplified their application and reduced the planning effort. However, the learning curve associated with their use should not be overlooked. With proper preparation, stackable guides significantly reduce treatment time, particularly for fitting the temporary restoration in full-arch immediate restorations, making this protocol increasingly favoured.



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References

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12-months follow-up—case series

Oral rehabilitation with two-piece ceramic implants

Alice Maria de Oliveira Silva, Vittorio Moraschini, Rafael Seabra Louro, Amanda dos Santos Bussinger Porto, Daniel Moraes Telles, Mayla Kezy Silva Teixeira, Eduardo Veras Lourenço, Alexandre Marques Paes da Silva, Brazil

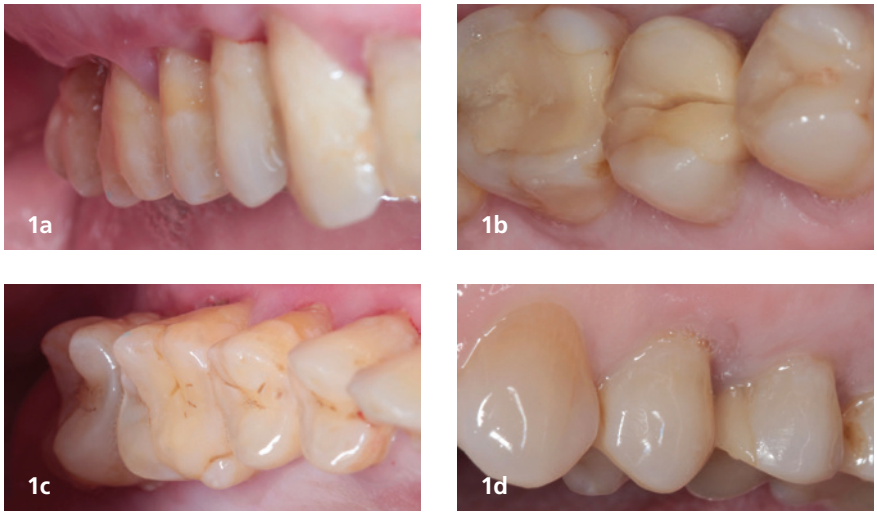
This case series aimed to describe the clinical and radiographic performance of four two-piece ceramic implants placed in two patients in posterior sites of the upper jaw.

Cone beam computed tomography (CBCT) was used in both cases for surgical planning, and periapical radiographs were used during the implant follow-up period. The implants were placed in fresh (immediate) sockets, immediately positioned, and the gaps in the sockets were filled with a bone substitute. Three months after surgery, the temporary prostheses were removed and three lithium disilicate crowns and one milled monolithic zirconia crown were made by impression with addition silicone. Both patients were followed for at least 12 months, during which clinical and radiographic success was observed with respect to osseointegration, stability at the marginal bone level, and peri-implant health of all implants.

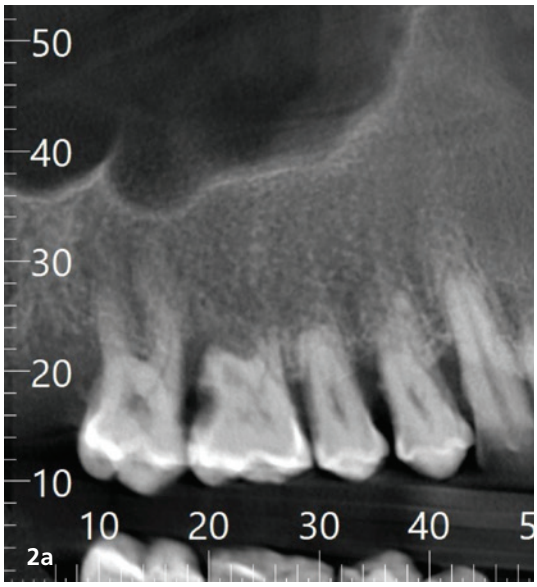
Introduction

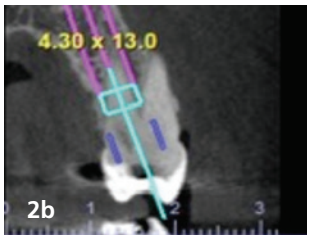
Metal-free restorative solutions, especially zirconia implants, have received increasing attention in implant dentistry due to their superior easthetic and biocompatible properties compared to traditional titanium implants.[1,2] Although titanium has been widely and successfully used, its disadvantages include possible allergic reactions and sensitivities in some patients.[3] Due to their white colour, zirconia implants integrate better with the gingival tissue and natural dentition, especially in aesthetically sensitive areas with grayish discolouration that may be visible, especially in cases of patients with thin gingival phenotype.[4] In response to these limitations, zirconia implants, a high-strength ceramic, have emerged as an attractive alternative for the rehabilitation of not only anterior and posterior teeth. Recent studies indicate that zirconia offers excellent mechanical strength and chemical stability, in addition to being highly biocompatible due to its low affinity with bacterial plaque, reducing the risk of inflammation and, consequently, favouring the maintenance of peri-implant health over time.[5,6]

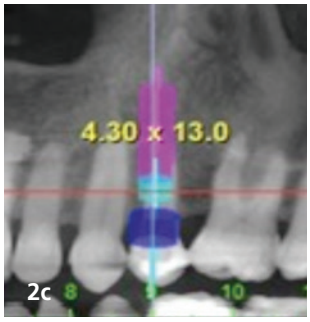
From a clinical point of view, zirconia implants demonstrate success rates comparable to titanium implants, with promising results in terms of osseointegration.[7,8] However, the literature still points to the need for long-term studies, especially regarding the resistance of ceramic implants under conditions of extreme functional loads and their performance in complex rehabilitations. In this sense, the objective of the present study was to observe the clinical and radiographic performance of two-piece ceramic implants in posterior areas of the upper jaw after a follow-up period of 12 months.



Figs. 1a–d: Initial clinical situation of patient 1—Upper right premolars and first molar (a & b). Initial clinical situation of patient 2—Left second premolar (c & d).







Figs. 2a–c: Initial tomographic images.

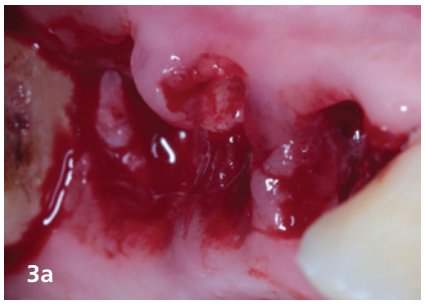
Case reports

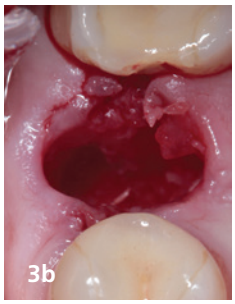
In March 2023, two patients presented to the private clinical trial center Sobre-Implantes in Rio de Janeiro, Brazil, seeking oral rehabilitation with single dental implants—immediate or delayed, with or without immediate loading. One patient required removal of the upper right premolars and first molar due to root resorption of the same (Figs. 1a & b), and the other patient had a fractured left second premolar (Figs. 1c & d). Comprehensive planning and diagnosis were facilitated by performing cone beam computed tomography (CBCT) scans (Figs. 2a–c) and using periapical radiographs during the immediate post-operative period and subsequent follow-ups to assess marginal bone stability. All patients in this case series were non-smokers in good general health, or had controlled systemic conditions. Despite effective bacterial plaque control, all patients underwent supragingival scaling and root planning.

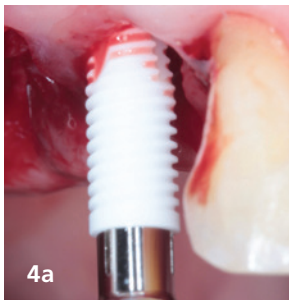
Surgical procedure

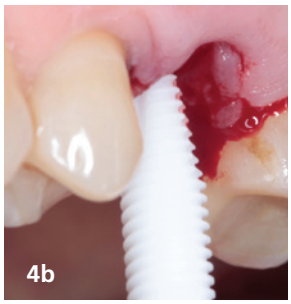
All patients received identical surgical procedures, starting with antibiotic prophylaxis: four 500 mg tablets of Amoxicillin administered one hour prior to surgery. They rinsed their mouths with 0.12 % chlorhexidine for 30 seconds before receiving local anaesthesia with Articaine 4 % (1:100,000).

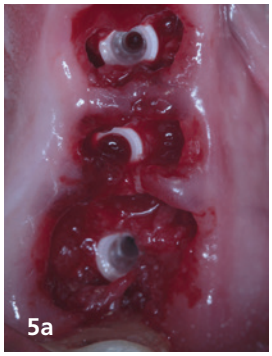
The implants were placed in fresh sockets. Tooth extractions were performed using a minimally invasive surgical approach with delicate periotomes to sever the periodontal ligament, allowing for complete tooth removal without raising a flap (Figs. 3a & b). Post-extraction, each socket was meticulously examined to eliminate any inflammatory lesions of endodontic or periodontal origin, followed by abundant saline irrigation. After appropriate bur instrumentation, each ceramic implant was inserted into its respective socket using a contra-angle adjusted to 30 rpm and

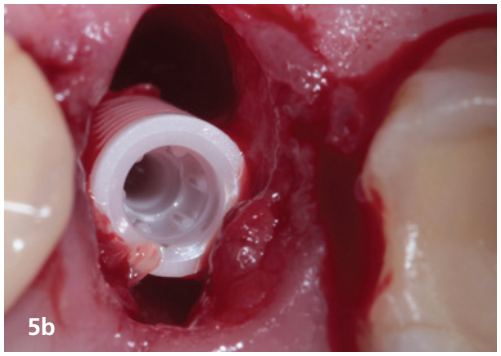


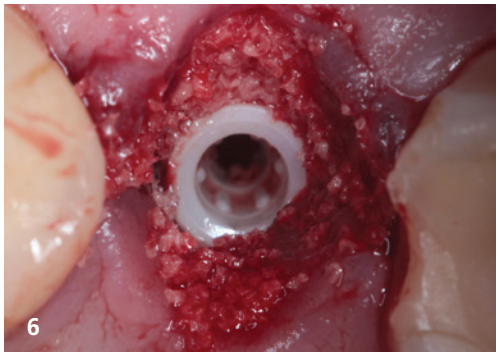




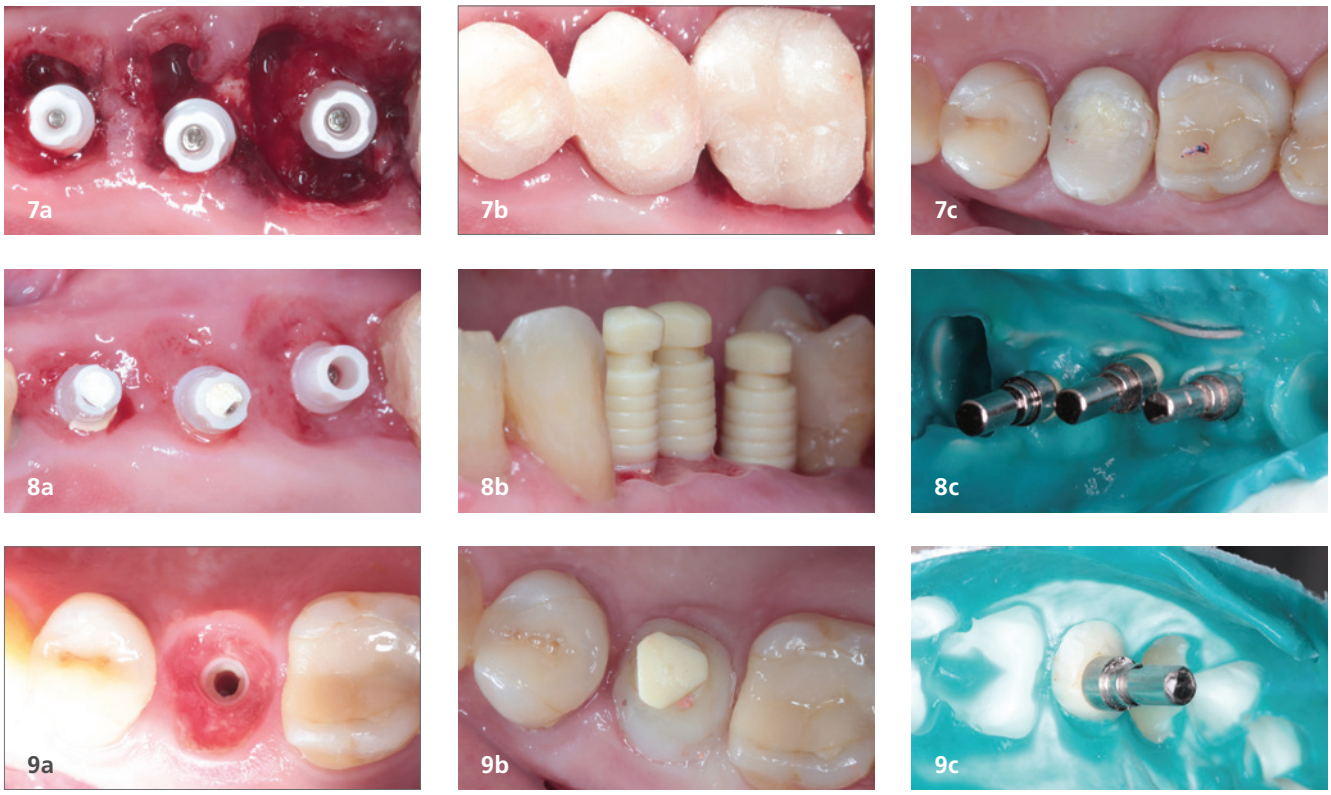








Figs. 3a & b: Preservation of fresh sockets after atraumatic tooth extraction. **Figs. 4a & b:** Implant placement. **Figs. 5a & b:** Occlusal view of fresh sockets. **Fig. 6:** Implant and bone substitute.



Figs. 7a & b: Occlusal view of the three zirconia Implants with the CR abutment and provisional crowns, respectively. **Fig. 7c:** Occlusal view of the temporary crown in the second premolar area. **Figs. 8a–c:** Conventional workflow with closed tray technique with the aid of addition silicone for molding premolars and first molar. **Figs. 9a–c:** Conventional workflow with closed tray technique with the aid of addition silicone and flow resin (emergence profile) for molding the second premolar area.

35 Ncm (Figs. 4a–5b). Gaps were filled with bone substitute material (maxresorb® 0.5–1.0 mm, 0.5 cc, Straumann®; Fig. 6).

Immediate provisional restoration

In this case series, immediate provisional restorations were performed using cemented zirconia retention pillars (CR Zi Pillar®). At the time of surgery, provisional crowns made of self-curing acrylic resin were installed (Figs. 7a–c).

Prosthetic procedure

Three months post-implant placement, the patients returned for definitive prosthetic work. All implants showed no complications during the healing period. Conventional impressions were taken using addition silicone with a regular body and mass, employing the closed tray technique (Figs. 8a–c). Notably, in one case, the gingival emergence profile was carefully replicated using light-cured flow resin (Master Flow, Biodinâmica; Figs. 9a–c). Three Lithium disilicate crowns (e.max®, Ivoclar Vivadent) and one milled monolithic zirconia crown were fabricated (Figs. 10a & b) and cemented to the prosthetic abutments using adhesive cement (Dual RelyX™ U200, 3M; Figs. 11a & b).

Follow-up

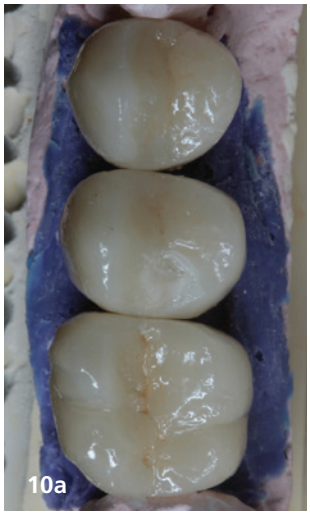
An X-ray was taken after cementation of the definitive crowns, revealing stable marginal bone levels compared to the immediate postoperative X-ray. Patients were followed up periodically for 14 months, with no reported complications in either clinical or radiographic examinations (Figs. 12a & b).

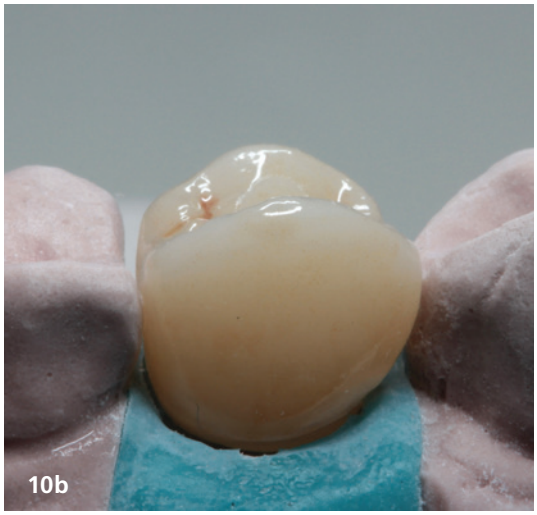
Results

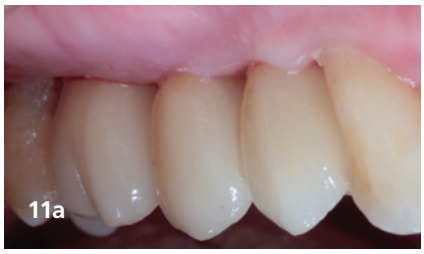
This case series involved four ceramic implants placed in two healthy individuals in March 2023, monitored over a 12-month period. One patient was a healthy 40-year-old man who received three implants, while the other was a 55-year-old healthy woman who received one implant. All implants had a diameter of 4.3 mm and a length of 13 mm. The insertion torque for the implants ranged from 35–40 Ncm, enabling immediate provisional placement. After 12 months of follow-up, both soft- and hard-tissue stability was observed, with no bone loss detected in any of the implants included in the study.

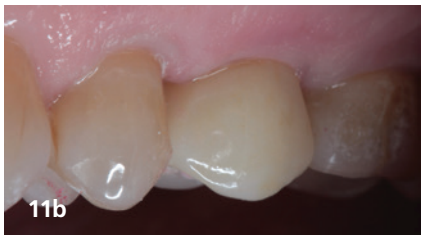
Discussion

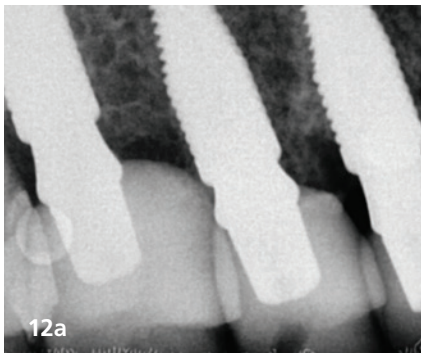
This case series aimed to evaluate the performance of four implants of a two-piece ceramic implant system (Zi ceramic implant®, Neodent) placed in the posterior region of two patients. After at least 12 months of follow-up, no technical or biological complications were observed in any of the cases, demonstrating clini-











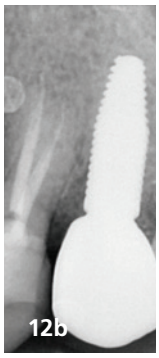


Fig. 10a: Definitive crowns in lithium disilicate. **Fig. 10b:** Definitive crown in monolithic zirconia. **Figs. 11a & b:** Clinical appearance after 12 months of follow-up. **Figs. 12a & b:** 12-month follow-up periapical radiograph.

cal and radiographic success of implant osseointegration and satisfactory preservation of the shape of soft and hard tissues, in agreement with the findings of other studies that used the same implant system and were followed for the same 12-month period.[8,10] Previous studies performed in animals have demonstrated that osseointegration of zirconia implants is reliable and safe under different loading conditions.[11,12] As previously described in this case series, all four implants achieved successful osseointegration during the 12-month follow-up.

There are previous studies showing that zirconia surfaces have a lower affinity for biofilm formation when compared to titanium surfaces.[13] In the present study, it was possible to observe peri-implant tissues free of inflammatory processes and with a healthy appearance (Figs. 12a & b). A prospective clinical study that used the same implant system used in this case series demonstrated that after at least 12 months of follow-up, they did not present any type of peri-implant disease, indicating healthy peri-implant soft tissues.[8] In this same research, as well as in our case series and a prospective clinical study, the authors observed that marginal bone levels were stable over the observed time.[8,10,14] The two patients reported here received ceramic implants in the posterior maxilla and no complications such as implant or abutment fracture were observed. This fact reinforces the findings of other studies that stated that yttria-stabilised zirconia (YTZP) implants are the material of choice for the manufacture of ceramic implants, not only due to their aesthetic and biological advantages, but also because they are resistant to corrosion, wear and especially to masticatory forces.[15] It is worth mentioning that the present series of cases had a follow-up period of 12 months, which is still short, however, during this entire period there were no clinical or biological complications, with emphasis on the maintenance of the bone level around the implants.

Conclusion

Given the limitations of this case series, the two-piece zirconia implant system used is a safe and reliable alternative in the oral rehabilitation of posterior teeth after 12 months of follow-up. Further studies should be performed to confirm our findings and the cases presented here will continue to be monitored.

References

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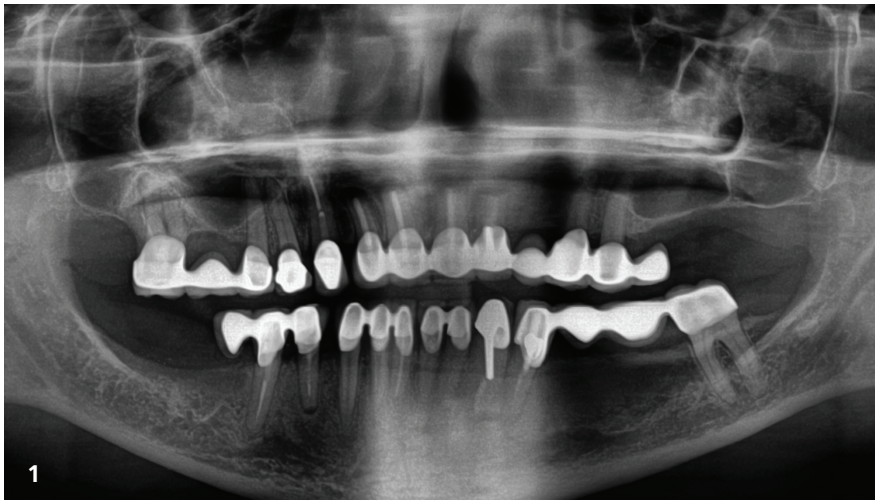
Simultaneous implant placement and vertical bone augmentation

Use of the hangar technique for maxillary vertical bone defects

Dr Frank Zastrow, Germany

The most effective conservative treatment for a severely compromised dentition is to preserve as many natural teeth as possible. However, if this goal can only be achieved at great expense and with an uncertain prognosis, many patients today tend to opt for extraction of the remaining teeth and implant treatment of the resulting edentulous jaw. A conservative approach can then be taken, with only the minimum number of implants placed (in line with the relevant clinical literature)—four in the mandible and four to six in the maxilla.



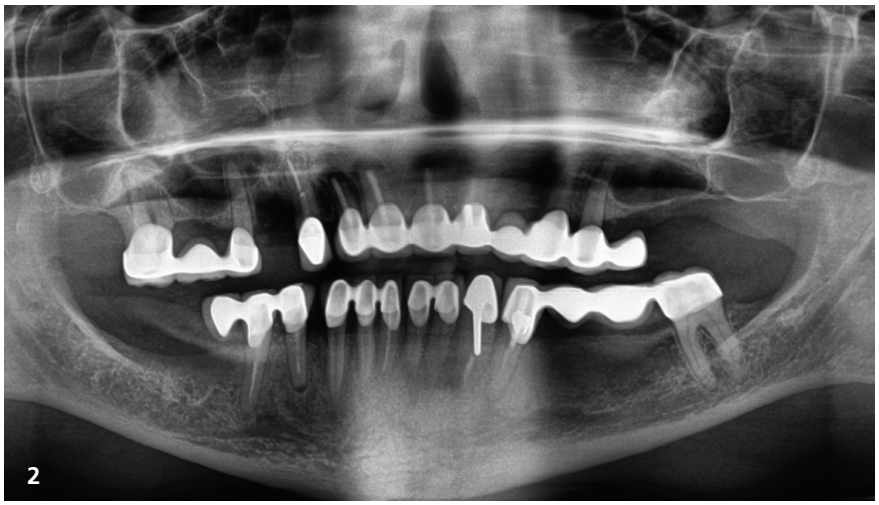


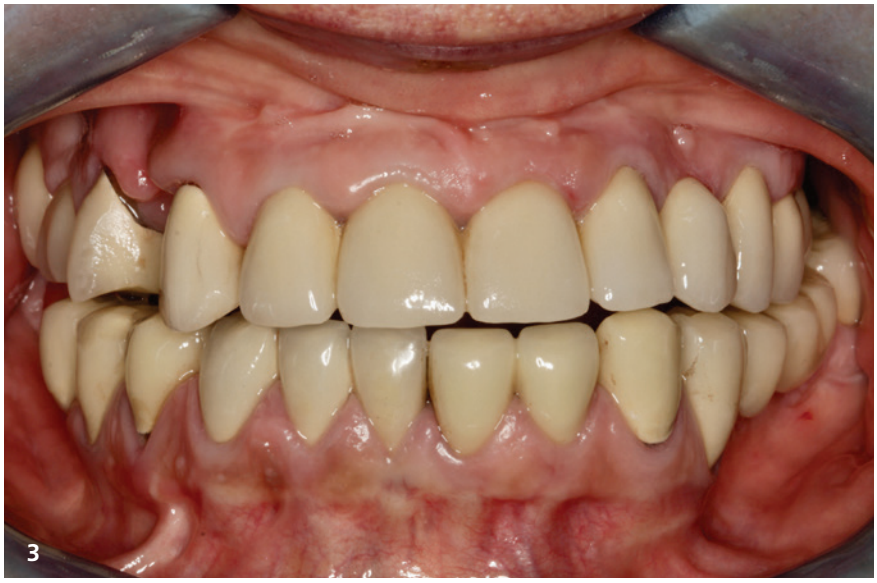
Fig. 1: Initial radiograph before extraction of the pathologically altered tooth 14. **Fig. 2:** Initial radiograph after extraction of tooth 14.

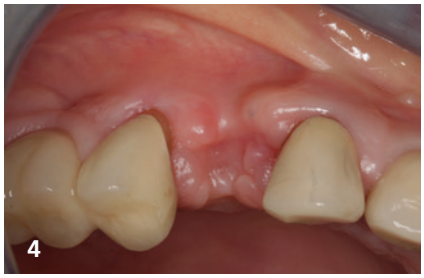
A 61-year-old woman presented with a hopeless tooth 14. The treatment plan was to provide an adequate implant-prosthetic restoration following the removal of tooth 14. In this case, vertical bone augmentation was necessary. The augmentation was performed using the hangar technique and strictly autologous bone shells. The bone shells were harvested from the mandibular retromolar region using the semilunar technique (SLT) and the Easy Bone Collector. The hangar technique allows implants to be placed directly through the occlusally fixed bone shell at the same time as vertical bone augmentation. The concept is named after the aircraft hangar, which is characterised by extraordinary stability and the typical rounded ceiling.

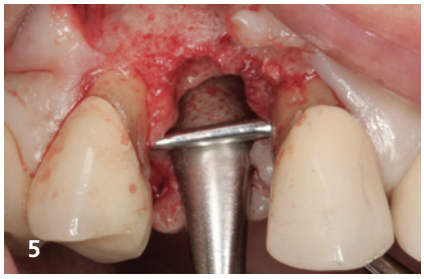
Introduction

Following tooth extraction and the loss of the so-called bundle bone, pronounced bone atrophy may occur.[1–3] The reconstruction of these bone defects forms the basis for the permanent restoration of healthy tissue conditions and a prosthetic restoration.

To create a sufficiently dimensioned new implant site, it may be possible to reconstruct bone defects with autologous







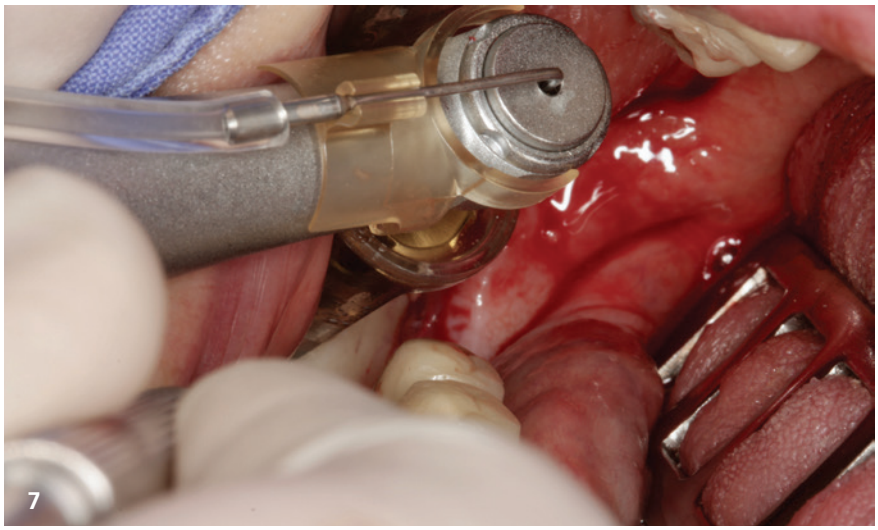


Fig. 3: Intra-oral baseline situation. **Fig. 4:** Intra-oral view of site 14. **Fig. 5:** Reflecting a flab exposes the lateral and vertical bone deficit at site 14. **Fig. 6:** The Easy Bone Collector is a bespoke instrument comprising a trephine drill, internal cooling, ceramic bearings and integrated soft-tissue protection, which facilitates the removal of bone shells. **Fig. 7:** The semilunar technique, when employed in conjunction with the Easy Bone Collector, allows for the harvesting of multiple intracortical bone shells from the retromolar region.

bone blocks, bone substitute material or a combination of the two.[4,5] In the present case, the bone augmentation was purely autologous. To make the bone harvesting process as minimally invasive as possible, it was carried out using the Easy Bone Collector and the semilunar technique, which eliminates the need to split the shells. In this type of bone harvesting, the shells are rounded, which may be advantageous in terms of exposure risk. The handling of these rounded bone shells and the reconstruction of the bone defect otherwise followed the instructions for the shell technique according to Prof. Khoury.[6,7]

A special feature of this case was that vertical bone augmentation and implant placement took place simultaneously. This was made possible using the hangar technique.

The shell shape in the hangar technique differs from that of the shells obtained using the split bone block technique (SBBT). This is due to the fact that the curvatures of the shells are a result of the trephine used during harvesting. This method of harvesting is also known as the semilunar technique, and it is made possible by using the Easy Bone Collector (EBC).

It is recommended that the surgical protocol for the hangar technique be followed as closely as possible. This involves piercing the occlusal shell after fixation with osteosynthesis screws using a trephine drill—preferably with the same di-

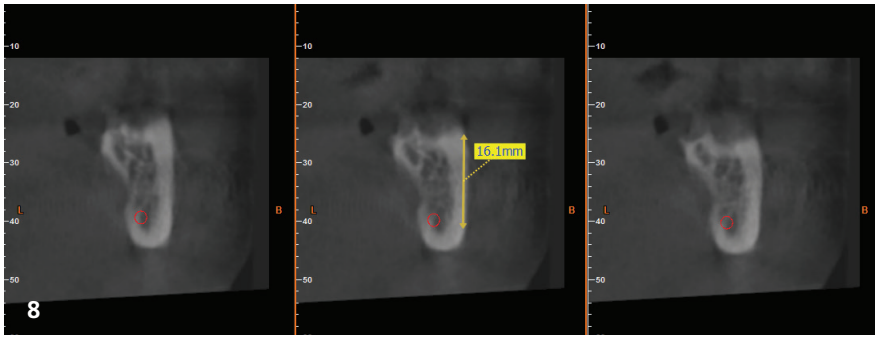


Fig. 8: The digital CBCT scan demonstrates adequate clearance from the inferior alveolar nerve, thereby enabling an estimation of the maximum permissible length of the bone shell. In this instance, the regular-size Easy Bone Collector was employed, resulting in the generation of a bone shell measuring 15 mm in length and 7 mm in width.

ameter as the implant—so that the implant can then be inserted through this trephination opening after the lacunae have been filled with autologous particles.

The semilunar technique is still relatively new, although the shell technique itself has accumulated almost 30 years of clinical experience. It is therefore possible to draw on a substantial body of evidence in support of the shell technique.

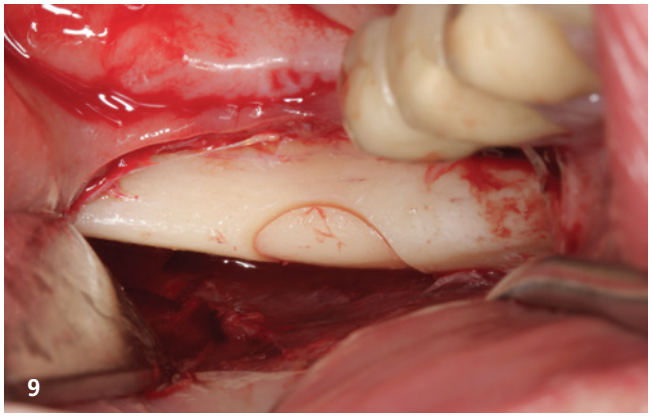
In the so-called split bone block technique (according to Prof. Khoury)[6,7], an autologous bone block is harvested from the retromolar region and sectioned. The resulting shells are secured to the alveolar ridge to create a new implant site.

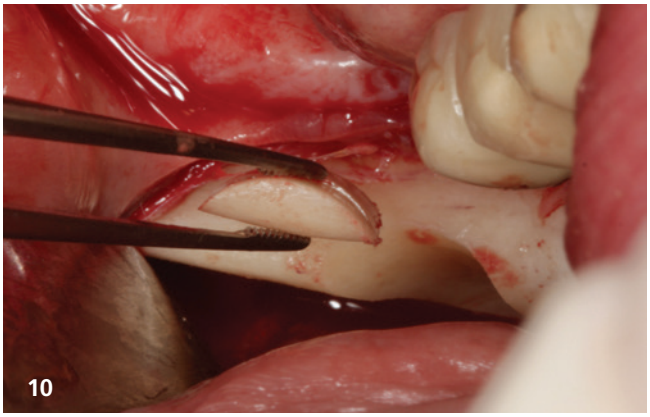
The case

The objective of the planned treatment was to achieve an adequate reconstruction of the hard and soft tissue as well as the prosthetic restoration by means of an implant-supported crown.

The bone defect was to be reconstructed by placing a previously harvested bone shell at a specific distance according to Prof. Khoury's shell technique and securing it in place with small osteosynthesis screws.

It would be advisable to aim for a ridge width of at least 7 mm to be able to insert an implant of sufficient dimensions in the premolar region.





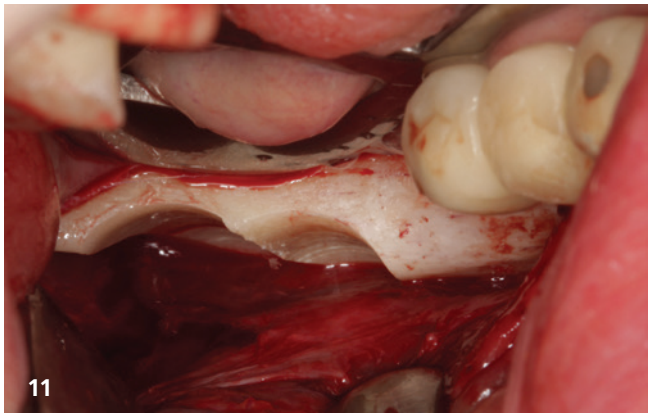


Fig. 9: Characteristic semilunar or crescent shape of the bone shells to be harvested. This shape has given the semilunar technique its name. **Fig. 10:** The semilunar bone shells have a thickness of only 2.1 mm, which makes further splitting unnecessary. The natural curvature of the shells may serve to further reduce the already minimal risk of exposure when autologous bone grafts are employed. **Fig. 11:** It is possible to harvest multiple semilunar shells side by side. **Fig. 12:** Due to the individual convexity of the alveolar ridge around the external oblique line, the bone shell can be positioned within the chamber of the Easy Bone Collector. However, the openings on the side of the trephine facilitate the harvesting process.

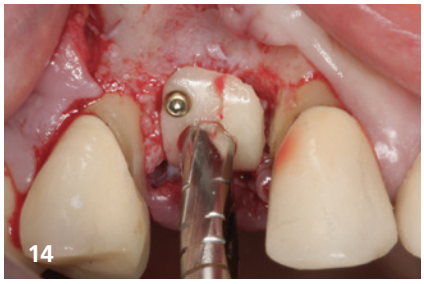
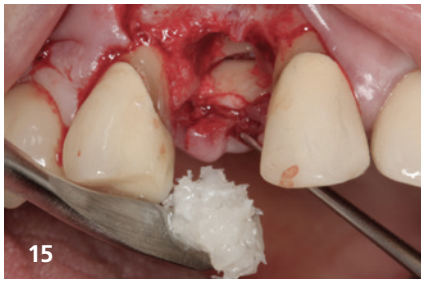
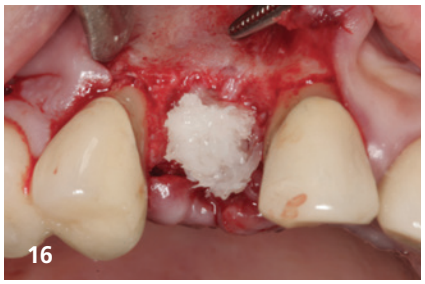
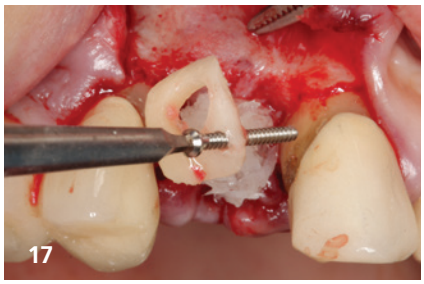
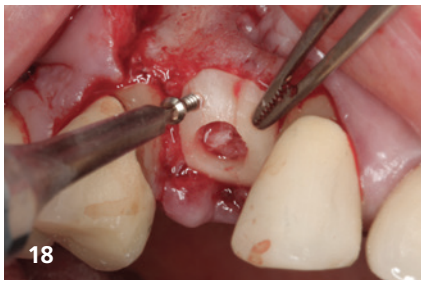
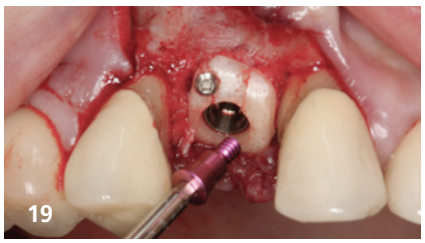








Fig. 13: After bone removal, the bone shells are further thinned with the Safescraper device. **Fig. 14:** The bone shell is secured in place with the rounded side facing upwards, using osteosynthesis screws. The shell is perforated with a trephine bur with a diameter matching the implant to be inserted. **Fig. 15:** The lacunae are filled with autologous bone chips. **Fig. 16:** Autologous bone chips are positioned within the defect. **Fig. 17:** The occlusal bone shell is repositioned. **Fig. 18:** Care must be taken to ensure stable fixation of the occlusal bone shell. **Fig. 19:** The implant is inserted subcrestally, and the cover screw is connected.

One of the benefits of the autologous bone augmentation method is that it does not require over-augmentation, as the risk of resorption is extremely low.

The existing cavity was then filled with particulated bone chips obtained from thinning the bone shells in accordance with the principles of biological autologous bone augmentation. This method differs from compact cortical blocks in that it increases the surface area of the bone, which in turn allows for a larger contact surface for the supplying vessels, thus facilitating faster nourishment and revascularisation of the augmented bone.

Restorative treatment

After taking an open impression, a master model was created in the laboratory and a cobalt-chrome bridge framework was fabricated using the CAD/CAM process. Once the framework had been fabricated, it was finished with veneering ceramic.

The crown was attached to the implant in a secure manner to prevent the onset of peri-implantitis caused by luting cement. The final clinical photograph showed no evidence of soft-tissue irritation in the peri-implant area; the peri-implant mucosa cuff appeared sufficiently keratinised.

Discussion

In the present case, thanks to the hangar technique, the implant could be inserted at the same time as the reconstruction of the vertical defect. The hangar technique allows implants to be placed directly through the occlusally fixed bone shell at the same time as vertical bone augmentation.

At the 8th European Consensus Conference of BDIZ EDI (2013), the indications for GBR and autologous bone were clearly defined. BDIZ EDI had discussed the state of the art in oral bone augmentation with experts from seven countries and devel-

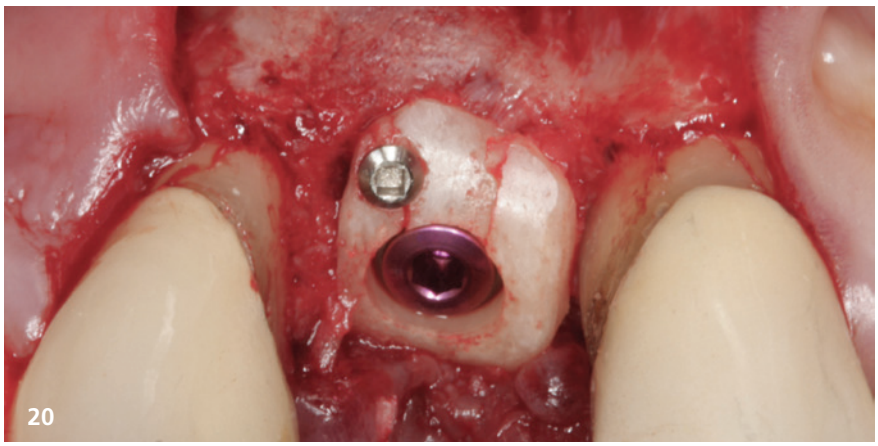
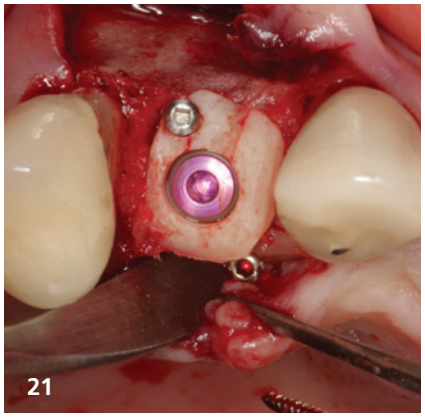
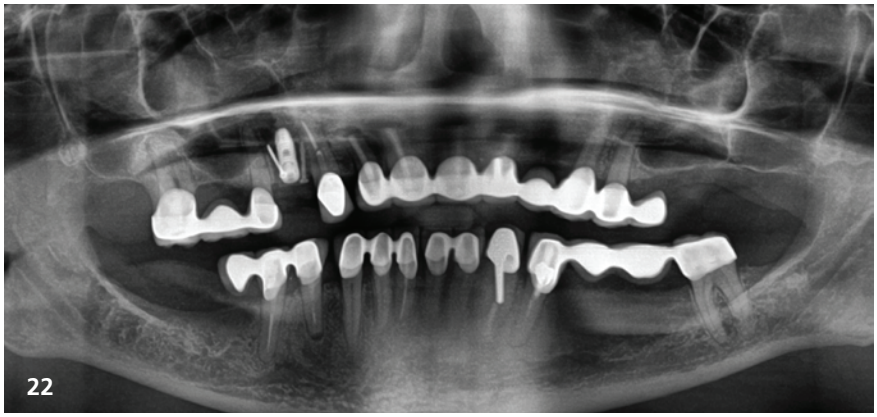
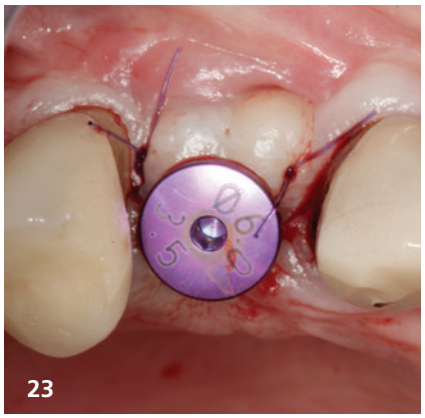


Fig. 20: In this case, only a single occlusal screw was used.







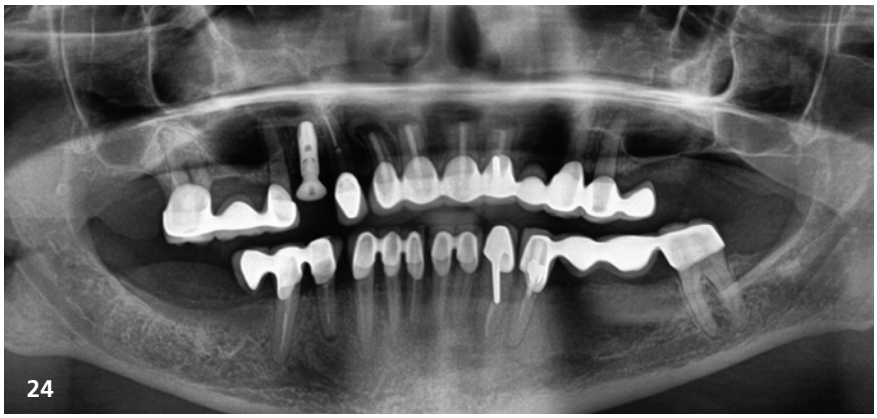


Fig. 21: Occlusal aspect of the hangar technique. **Fig. 22:** The postoperative panoramic radiograph depicts the augmented area in the upper right quadrant. Simultaneous insertion of the implant was made possible by the application of the hangar technique. **Fig. 23:** Reentry via a simple split incision, followed by the insertion of the healing abutment. **Fig. 24:** Final panoramic radiograph with the healing abutment inserted.

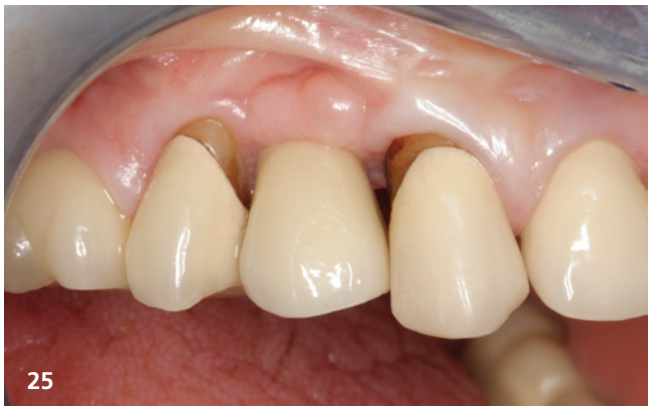
oped the Cologne Classification of Alveolar Ridge Defects (CCARD).

Previous defect classifications (Cawood and Howell, 1983; Seibert et al., 1988) failed to provide comprehensive coverage of hard-tissue defect situations and largely ignored the defect environment.

It is evident that the number of walls delimiting the defect and their relationship to the overall jaw structure greatly influence the success of post-augmentation procedures. Reconstructed defects still surrounded by bone walls are easier to stabilise (Khoury, Antoun et al., 2007) than extensive defects without bony delimitation (Araújo, Sonohara et al., 2002). This has a direct effect on post-augmentation success rates.

The consensus paper recommends that when using bone substitutes, autologous bone should be added wherever possible to improve the osteogenic potency of the augmentation material.

Augmenting medium-size and larger defects with bone substitutes and membranes results in significantly higher infection and exposure rates than autologous



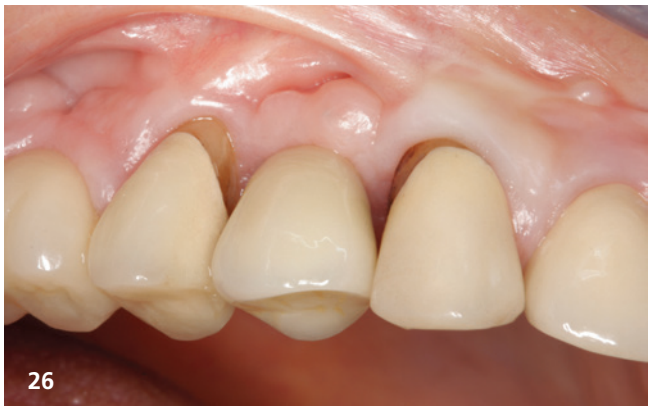


Fig. 25: Delivery of the final restoration. **Fig. 26:** Occlusal aspect of the final restoration.

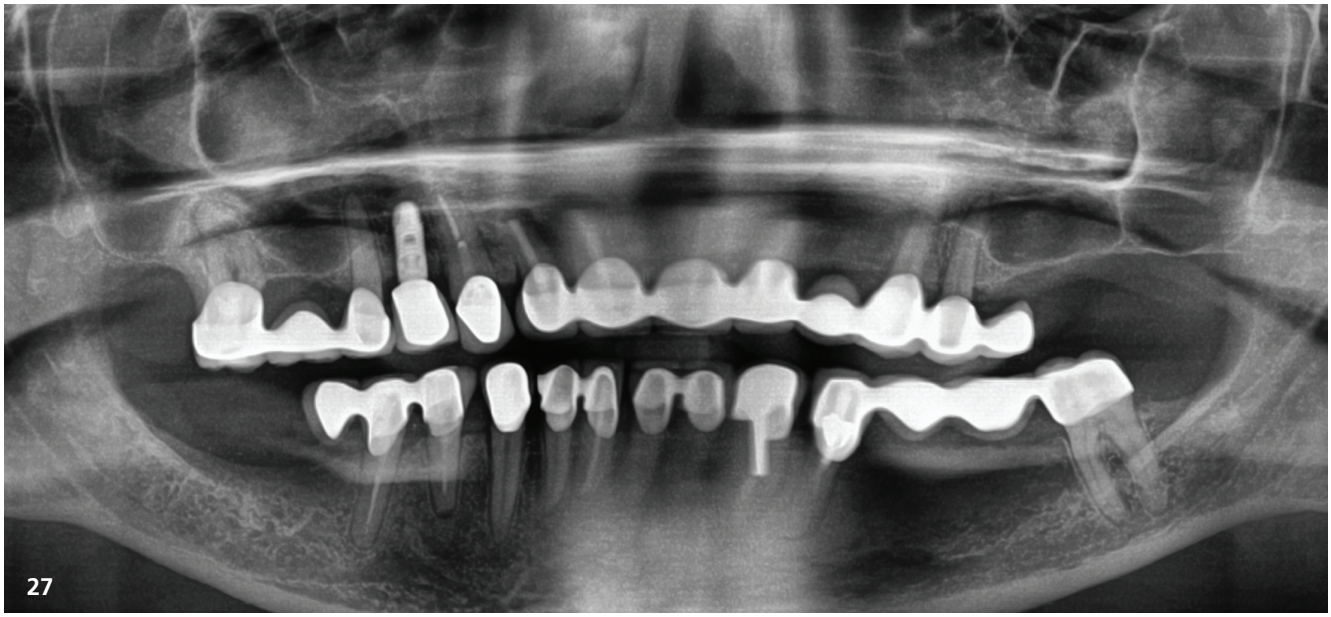


Fig. 27: Final radiograph with the final restoration in place.

bone-block augmentation (Chiapasco, Abati et al., 1999).

Onlay (vertical augmentation) grafts with osteoconductive bone substitutes outside the defect contours should be limited to minor augmentation heights of less than 4 mm, even in combination with autologous bone (Canullo, Trisi et al., 2006).

Medium-size and large defects (over 8 mm) must be reconstructed vertically outside the defect contours. The CCARD clearly states that autologous bone should be used in all cases.

Another recent (2019) study examined the ten-year follow-up after vertical bone augmentation in the maxilla in 142 patients. The results showed an average bone gain of 7.6 mm in height and 8.3 mm in width, and an average amount of bone resorption of only 0.63 mm after ten years (Khoury, 2019). The results make it clear that when using purely autologous bone, stable long-term results can be expected even in the supreme discipline of vertical reconstruction.

The author is convinced that there is no need to supplement this successful method, which has been established for years, by introducing xenogeneic substitute materials and membranes. This would jeopardise the result by increasing the risk of rejection and exposure.

The protocol presented here allows vertical bone defects to be safely reconstructed using purely autologous bone and restored with a screw-retained, fixed implant-supported prosthetic restoration with long-term aesthetic and functional results.

Dr Frank Zastrow

References

Join team bone

Dr Frank Zastrow is a specialist dentist for oral surgery, the owner of a private dental practice in southern Germany, the author of various specialist books and the founder of the "My Implant Business" education platform.

Find out more about his Masterclass Education and get access to the Easy Bone Collector at **www.myimplantbusiness.com/ebc**.

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Successful treatment of peri-implantitis with GalvoSurge® dental implant cleaning system

Impact of advanced surgical techniques on tissue health

Dr Algirdas Puišys, Lithuania

In this case report, we present a successful management of peri-implantitis using an alternative biofilm removal approach in combination with guided bone regeneration (GBR) in a posterior implant, as described by Renvert and Giovannoli.[1] This treatment not only resolved clinical symptoms but also regenerated lost peri-implant bone, resulting in a favourable long-term prognosis.

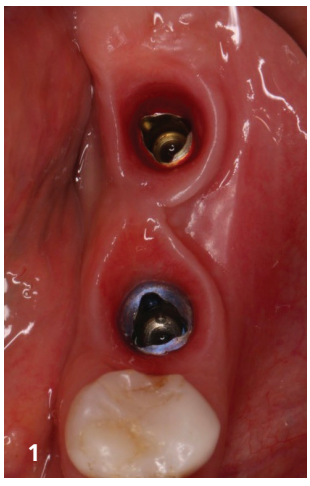
Peri-implant diseases, especially peri-implantitis, have become a significant and prevalent complication in implant dentistry.[1] With the increasing number of dental implant procedures, the incidence of peri-implantitis is also on the rise. This condition is characterised by inflammation and progressive bone loss surrounding dental implants, which can lead to potential implant failure and serious oral health issues.[2]

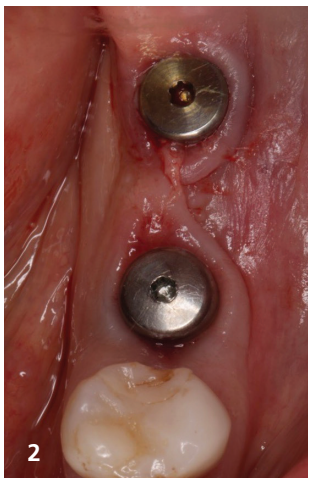
The primary trigger for peri-implantitis is the accumulation of bacterial biofilms on implant surfaces, leading to inflammation and subsequent alveolar bone loss. Traditional therapies, including non-surgical mechanical debridement, antimicrobial agents, and surgical interventions, have been utilised to arrest or reverse the progression of peri-implantitis; however, these conventional methods often have limitations.[3] GalvoSurge® offers an alternative biofilm removal approach for peri-implantitis. This dental implant cleaning system employs an innovative electrolytic cleaning method that promotes aseptic conditions and facilitates tissue regeneration around dental implants.[4]

Initial situation

A 66-year-old female patient, classified as ASA I and a non-smoker with no documented medication history or allergies, presented to our clinic in 2020 with complaints of pain and food impaction associated with one of her posterior dental implants. The patient reported maintaining regular follow-up appointments with her general dentist and had not previously undergone any peri-implant therapeutic interventions.

Upon conducting a comprehensive clinical and radiographic examination, dental implant #37 was diagnosed with peri-implantitis, in accordance with the diagnostic criteria established at the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions.[6] This diagnosis was substantiated by clinical indicators including bleeding on probing, increased probing depths, and significant circumferential peri-implant bone loss surrounding the affected implant.





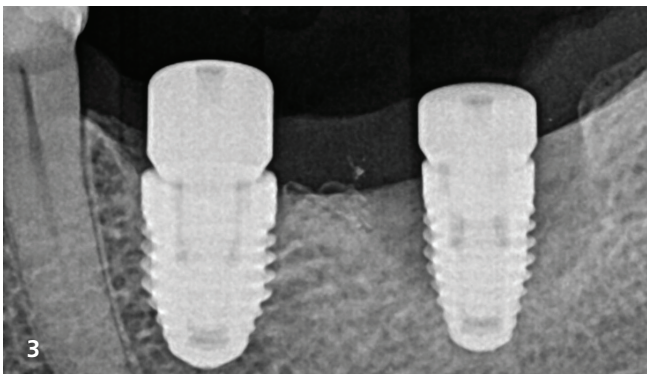


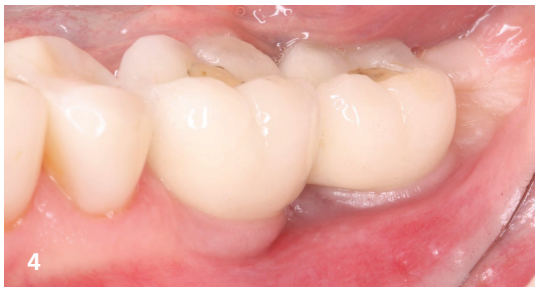
Fig. 1: Conservative treatment approach with prosthesis removed. **Fig. 2:** Healing abutments positioned for tissue adaptation. **Fig. 3:** Radiograph of implants placed in positions #36 and #37.

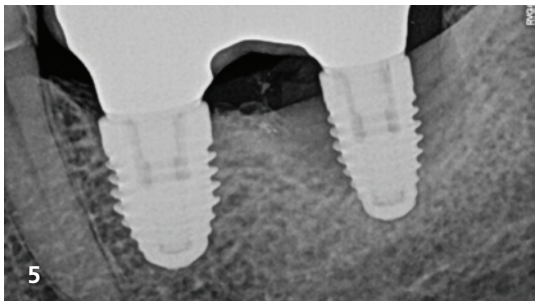
Treatment planning

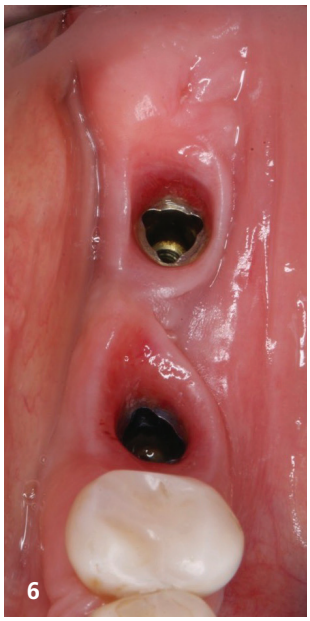
Following a detailed discussion of the potential treatment options with the patient, alongside a thorough assessment of associated risks and contraindications, we decided to initiate a non-surgical intervention to mitigate inflammation, subsequently followed by a surgical procedure incorporating guided bone regeneration (GBR) using GalvoSurge®. This innovative technology has shown substantial efficacy in the removal of bacterial biofilm from dental implants compromised by peri-implantitis, thereby facilitating a meticulous decontamination of the exposed implant surface and preparing it for re-osseointegration.

The initial phase involved conservative treatment, wherein the prosthetic restoration was removed, and healing abutments were placed (Figs. 1 & 2). Non-surgical mechanical debridement was performed utilising standard ultrasonic instruments and an air flow device. This was supplemented by irrigation with chlorhexidine 0.12% and metronidazole at a concentration of 5 mg/ml, followed by the application of a local antibiotic solution enriched with hyaluronic acid. Post-procedural radiographs were obtained for implants located in positions #36 and #37 after the healing abutments were screwed in place (Fig. 3).

After several weeks, the prosthetic restoration was reattached, and the patient was enrolled into a maintenance programme featuring regular follow-up appointments. During each visit, the patient exhibited good compliance, with no indications of plaque accumulation, bleeding on probing, or signs of inflammation. Consequently, a comprehensive evaluation of all clinical parameters was conducted, and it was deemed appropriate to proceed with the surgical phase of treatment.







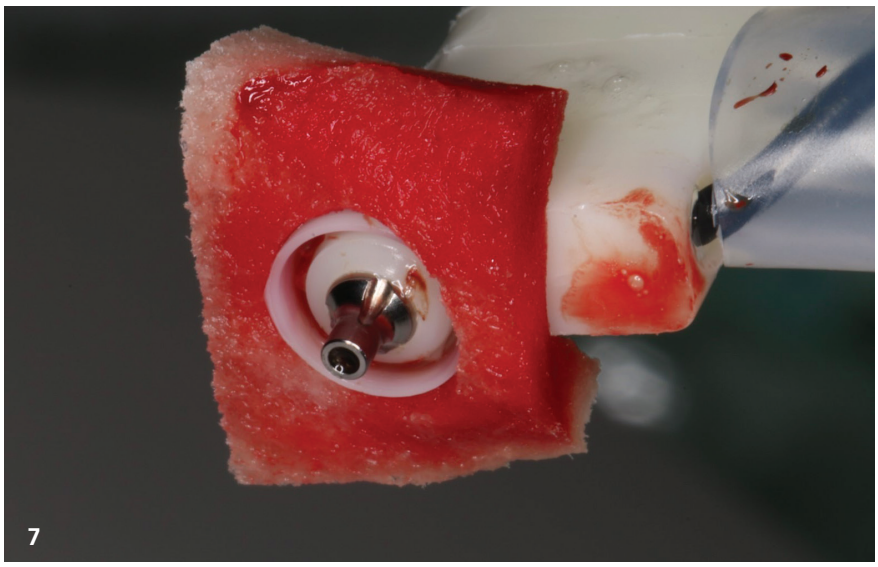
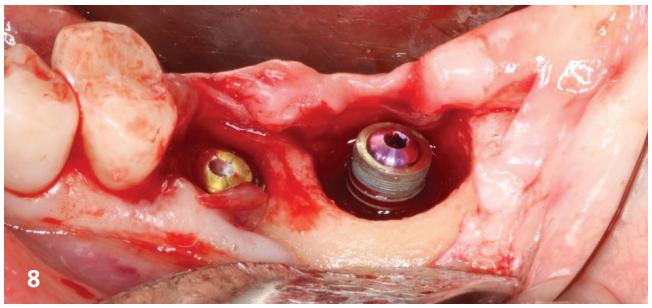


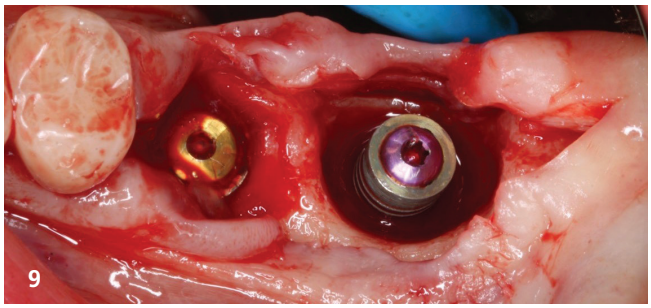
Fig. 4: Clinical reevaluation prior to surgical intervention. **Fig. 5:** Preoperative radiograph conducted before surgery. **Fig. 6:** Fixed prosthesis removed to facilitate access to the surgical site. **Fig. 7:** GalvoSurge® spray head equipped with a sponge to maintain maximum contact of the cleaning solution with the implant surface.

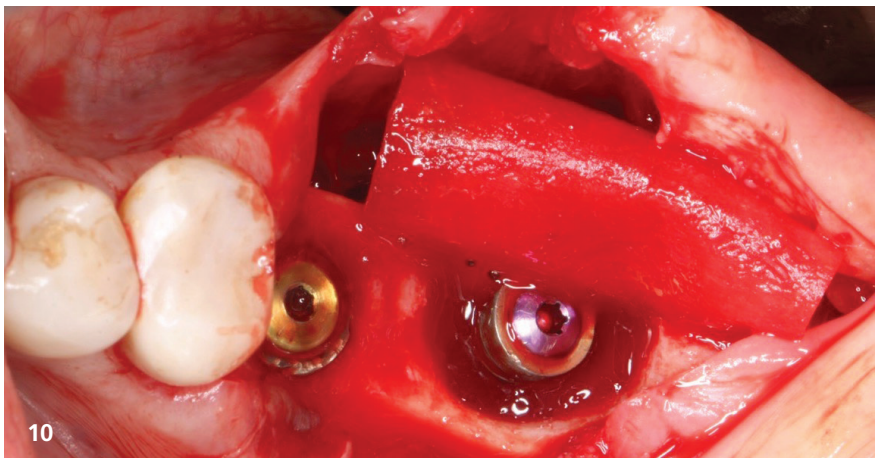
Surgical procedure

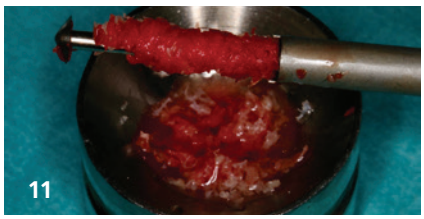
Prior to surgery, a comprehensive re-evaluation was conducted (Figs. 4 & 5). The fixed prosthesis was first removed (Fig. 6), after which the patient rinsed with a 0.12 % Chlorhexidine gluconate solution, and local anaesthesia was administered using 2 % lidocaine with 1:100,000 epinephrine. A full-thickness mucoperiosteal flap was then elevated through an intrasulcular and crestal incision. The bone defect was subsequently assessed and classified as a Class I infra-bony defect based on the modified classification system described by Renvert and Giovannoli.[5] This classification, indicating the presence of all four bony walls, deemed the defect suitable for guided bone regeneration (GBR), aiming to restore both functional and aesthetic outcomes.

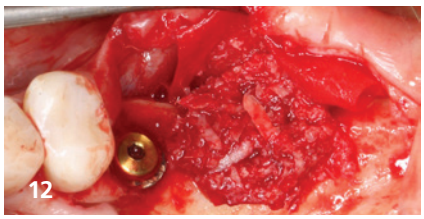
After the removal of the closure caps, the implants underwent a thorough cleaning and disinfection process using 0.12 % Chlorhexidine (CHX) solution and the GalvoSurge® device, with non-metallic suction applied throughout. The patient was advised about the potential for a salty taste from the cleaning solution, as well as the likelihood of increased liquid flow

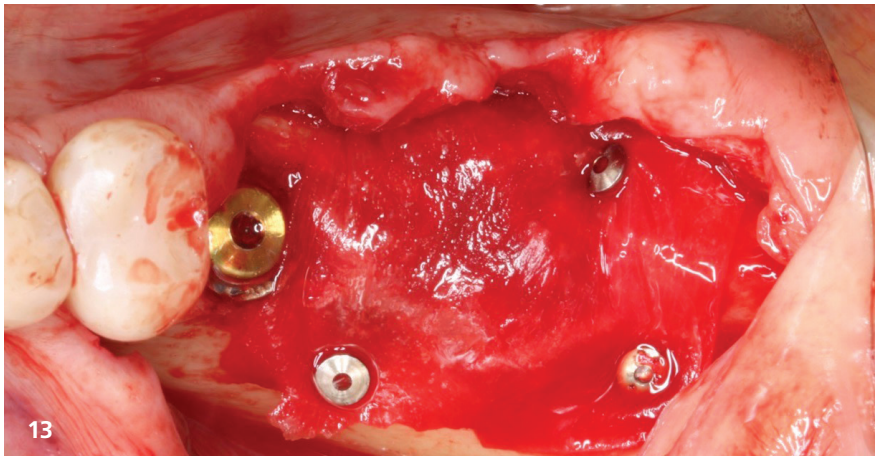


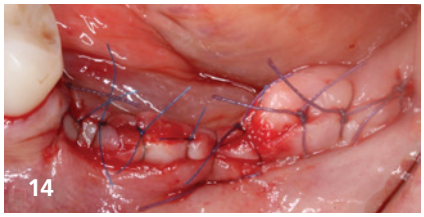


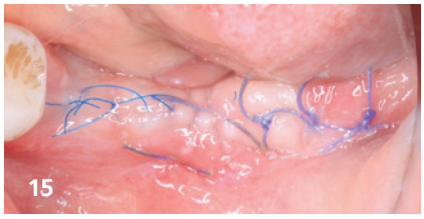


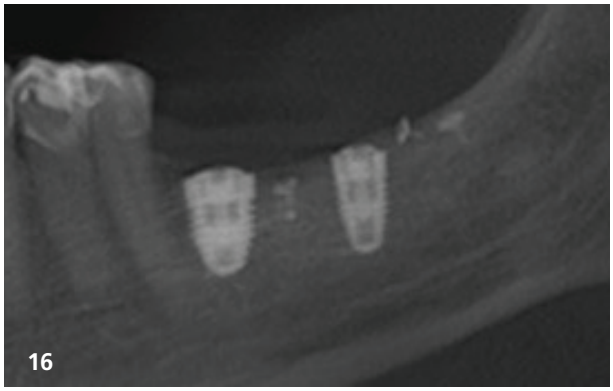












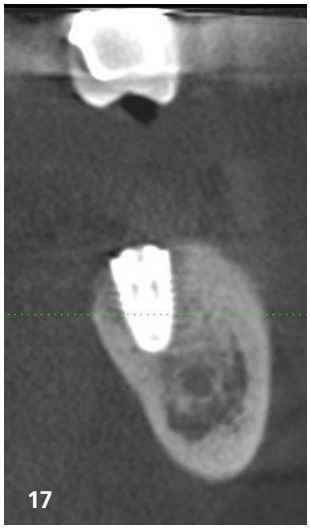


Fig. 8: Implant surface after electrolytic cleaning with GalvoSurge®, showing a clean and decontaminated surface. **Fig. 9:** Closure caps reinserted to protect the implant site. **Fig. 10:** Straumann® Membrane Flex positioned and secured with fixation pins. **Fig. 11:** Autogenous bone chips collected and mixed with botiss maxgraft® granules for grafting. **Fig. 12:** PRF combined with bone chip granules for application to the defect site. **Fig. 13:** Straumann® Membrane Flex secured with pins, providing soft tissue-support and containment of the graft material. **Fig. 14:** Suturing completed with 4/0 Vicryl and 6/0 Prolene for wound closure. **Fig. 15:** Clinical view ten days postoperatively, prior to suture removal. **Fig. 16:** Six-month follow-up demonstrating optimal bone levels surrounding the implants. **Fig. 17:** Control tomo-graphy taken after six months of healing.

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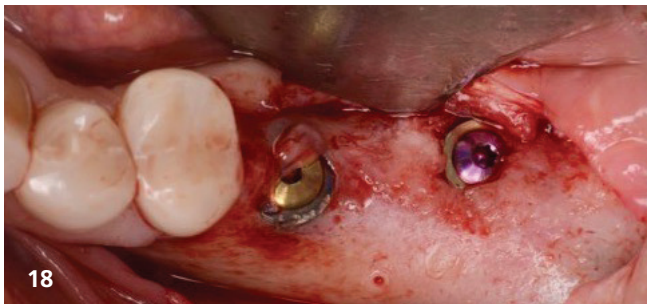

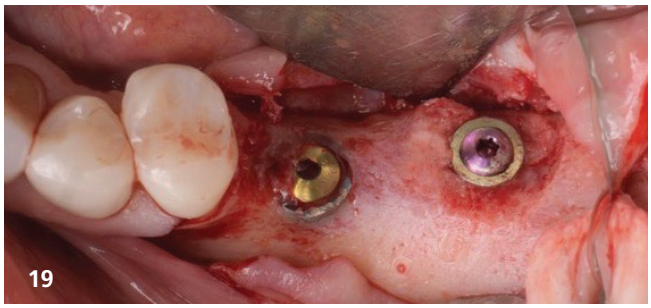

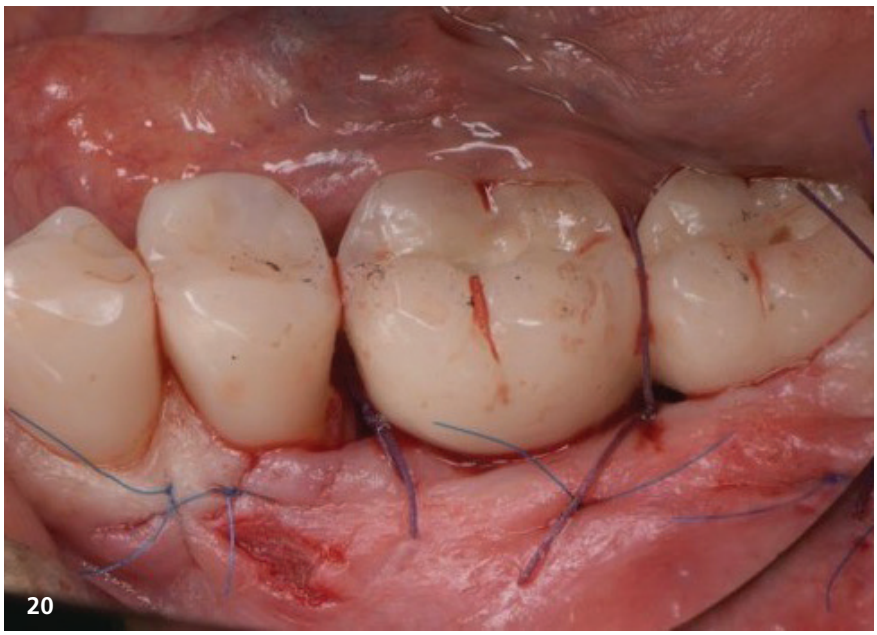

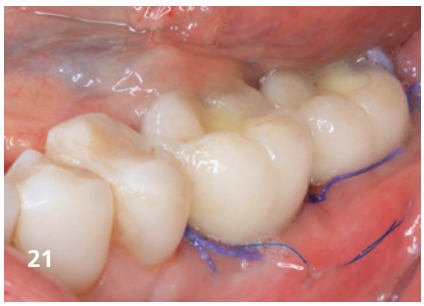

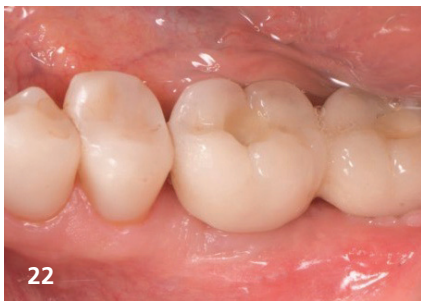

Fig. 18: Flap elevated to access and remove residual excess bone from the healing abutment. **Fig. 19:** Clinical situation following removal of excess bone around the healing abutment. **Fig. 20:** Prosthesis reattached to its designated position post-treatment. **Fig. 21:** Follow-up visit ten days post-procedure, with the clinical situation evaluated. **Fig. 22:** Clinical evaluation at the 2021 follow-up, showing maintained tissue health.

into the oral cavity during the procedure. The solution would be promptly suctioned to minimise discomfort.

The electrolytic cleaning process began by placing the spray head over the implant and inserting the Implant connector into its interior. Once the device was activated, gentle pressure was applied to the spray head to ensure optimal contact. The sponge component on the spray head was designed to maximise the retention of the cleaning solution around the implant surface during the entire procedure, enhancing cleaning efficiency and effectiveness (Fig. 7).

The presence of hydrogen bubbles during the cleaning confirmed the effective application of the GalvoSurge® system. Over the two-minute cleaning duration, these bubbles formed beneath the biofilm, lifting it from the implant surface and facilitating a thorough decontamination of the implant.

Upon completing the cleaning, the area surrounding the implant, as well as beneath the flap, was rinsed with sterile saline to remove any remaining coagulum or solution residues. Once the implant surface was verified as clean, the closure caps were reinserted (Figs. 8 & 9), marking the beginning of the guided bone regeneration (GBR) procedure. The GBR process involved securing a Straumann® Membrane Flex over the site with fixation pins (Fig. 10). Autogenous bone chips were collected and mixed with botiss maxgraft® granules (Fig. 11). This bone graft mixture was then mixed with PRF and applied to the defect (Fig. 12). To support the soft tissue and ensure graft containment, the Straumann® Membrane Flex was pinned in place over the graft (Fig. 13).

Suturing was performed using 4/0 Vicryl and 6/0 Prolene sutures to promote optimal tissue adaptation. Additionally, postoperative oral hygiene instructions were provided to the patient (Fig. 14). Ten days later, the patient returned for suture removal and wound evaluation. The healing process was uneventful, and the wound showed a satisfactory progression (Fig. 15).

After a six-month healing period, a follow-up tomography was performed, revealing optimal bone levels around the implants (Figs. 16 & 17). A flap was then elevated to access and remove any residual excess bone from the healing abutment area (Figs. 18 & 19). Closure of the incision was achieved using 4/0 Vicryl and 6/0 Prolene sutures to ensure a se-

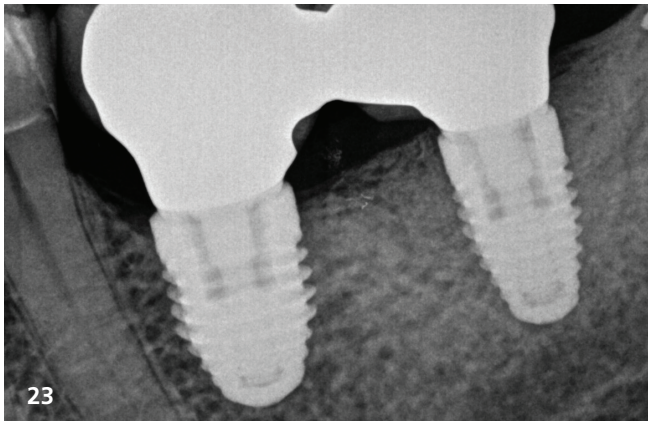

Fig. 23: Radiographic assessment at the 2021 follow-up visit, with no complications noted.

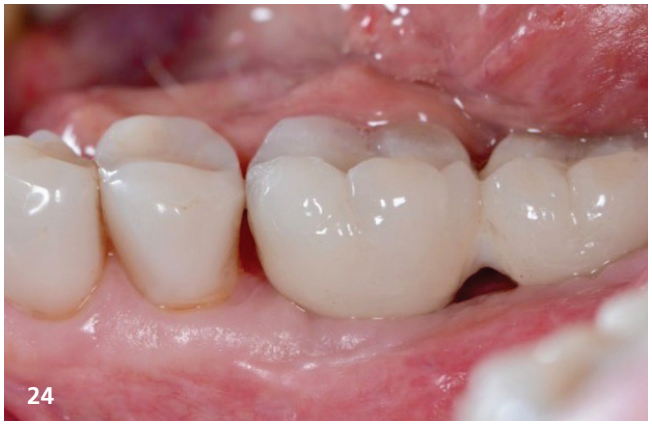

Fig. 24: Clinical stability and favourable outcome observed at the 2022 follow-up.

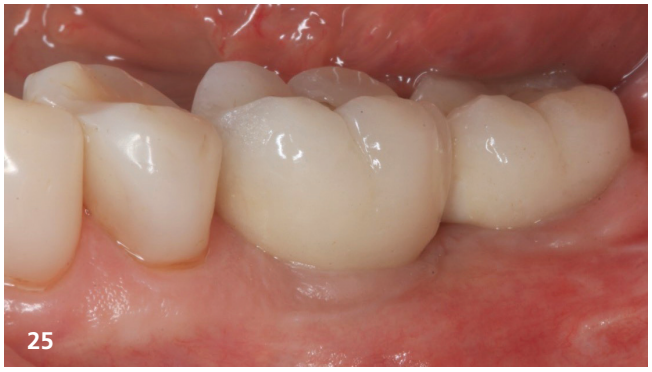

Fig. 25: Follow-up visit in 2023 indicating continued stability and no biological complications observed.

cure and effective wound closure. The prosthetic component was then carefully reattached and secured in its designated position (Fig. 20).

Ten days later, the patient returned for a follow-up assessment, during which a thorough evaluation of the treatment site was conducted. At this visit, the sutures were carefully removed, and a radiograph was taken to assess the ongoing healing and integration at the treatment site. The patient expressed satisfaction with the results, indicating a successful and favourable response to the procedure (Fig. 21).

Treatment outcomes

During follow-up visits in 2021 (Figs. 22 & 23), 2022 (Fig. 24), and 2023 (Fig. 25), no biological or radiographic complications were found. These evaluations confirmed excellent health in both hard and soft tissues, showcasing the effectiveness of the surgical approach. The GalvoSurge® system and guided bone regeneration (GBR) significantly contributed to these outcomes, emphasising the importance of these advanced techniques in achieving optimal patient results and long-term stability.

Author's testimonial

For years, I struggled to achieve effective bone regeneration in peri-implantitis defects and thought it was impossible. However, my perspective changed after incorporating GalvoSurge® into my treatment protocol. I realised that surface disinfection is crucial, and it significantly enhances biofilm control. Additionally, adopting conservative treatment methods, addressing influencing factors, and utilising the GBR protocol for vertical bone augmentation are essential considerations for success.

References

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Implant suprastructure restoration using CoCr CAM blanks

Stable, customised, precise—Enhancing aesthetic and functional outcomes

Prof. Maurizio Grande, Italy

Originality and individuality play a role in product development at Camlog. To meet requirements for compatibility, CoCr blanks are designed with abutment connections compatible with various implant systems, including those with Internal Hex connections.

These CoCr alloy CAM blanks enable the production of custom-milled precisely fitting non-precious metal (NPM) abutments using in-house milling machines. Based on intra-oral or model scans, both the abutment shape and the crown emergence profile can be designed and subsequently fabricated to meet individual patient requirements. In double-crown technology, CoCr offers improved sliding properties between the primary and secondary components compared to titanium.

Cobalt-chromium (CoCr) is a material widely used in dentistry due to its material properties such as high strength, durability, biocompatibility and corrosion resistance, and is not limited to model casting prostheses. With the introduction of digital technologies, the major disadvantages previously associated with the casting technique required for CoCr, such as cumulative distortion, porosity, high labour and production costs, which made finishing restorations difficult due to the material's structural hardness[3], have become a thing of the past. Digital processes now allow for the production of large frameworks with greater precision and accuracy of fit, eliminating most of the disadvantages thanks to subtractive and additive manufacturing technologies.

A thorough understanding of the design of dental prostheses, their effective-

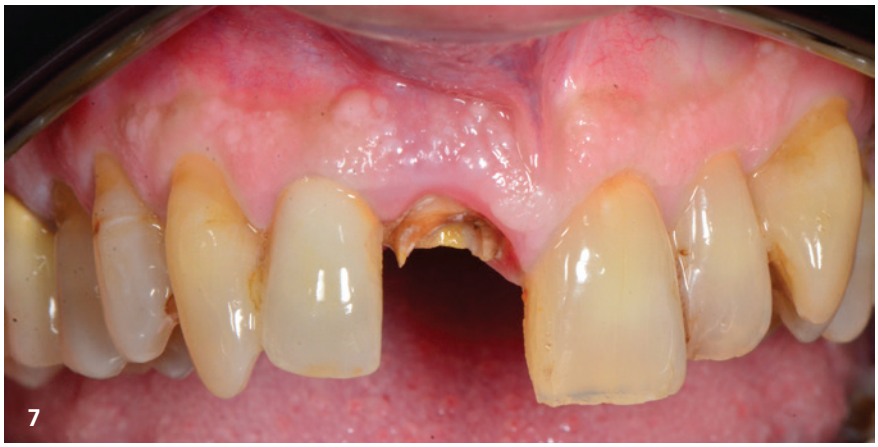
Fig. 1: Immediate implant placement with subsequent temporary immediate restoration. **Fig. 2:** X-ray control image of the immediate implant placement. **Fig. 3:** Mature peri-implant tissue before definitive restoration. **Fig. 4:** Definitive restoration. **Fig. 5:** X-ray of the abutment and the bonded zirconia crown with a hole to allow access to the screw of the CoCr abutment. **Fig. 6:** Follow-up nine months after implantation.

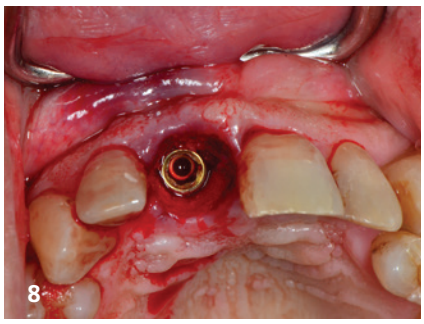
ness, and potential weaknesses is essential for restoring masticatory function. CoCr alloy is particularly advantageous when it comes to aesthetically demanding removable dentures using telescopic restorations. Compared to double-crown techniques with gold alloys, which are now scarcely affordable, or electroformed secondary copings requiring reinforcement with tertiary structures. CoCr allows for the wall thicknesses of both primary and secondary components to be minimised without compromising stability. In general, CoCr alloy is easier to polish than titanium. CoCr CAM blanks are suitable for the production of digitally designed abutments with anatomical emergence profiles for crowns and bridges, as well as telescopic abutments for removable, implant-supported prostheses as strategic pillars.

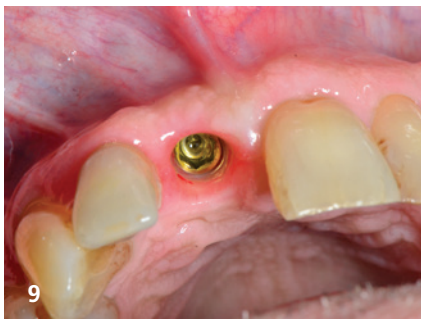
The following two case reports explain the advantages of CoCr abutments in restorative and implant superstructure applications. These reports highlight the excellent workability of CoCr, which allows for a smooth, polished surface finish and the precise milling of thin walls. Due to these properties, CoCr abutments are ideally suited for demanding clinical applications and contribute to the stability and long-term durability of implant restorations.

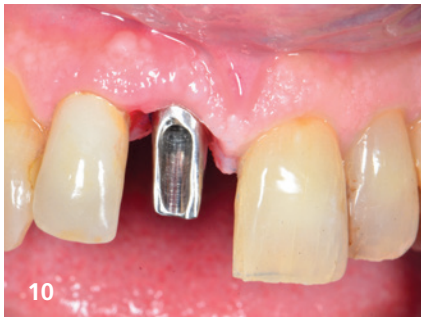
Case 1

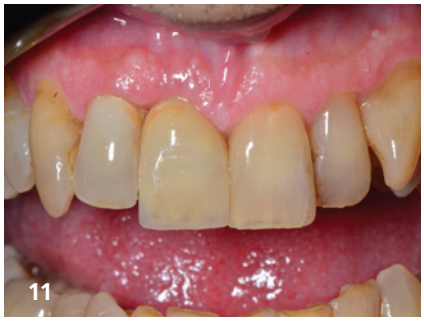
A 42-year-old male, non-smoker with excellent oral hygiene, received a dental implant at position #24. The inserted implant was a BioHorizons TLXP, Ø 4.6 mm x

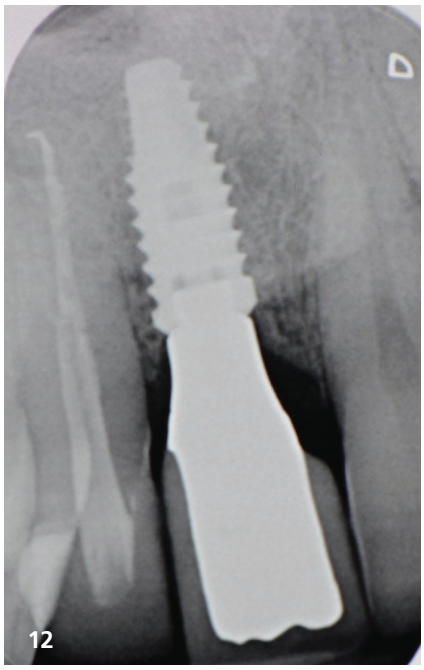












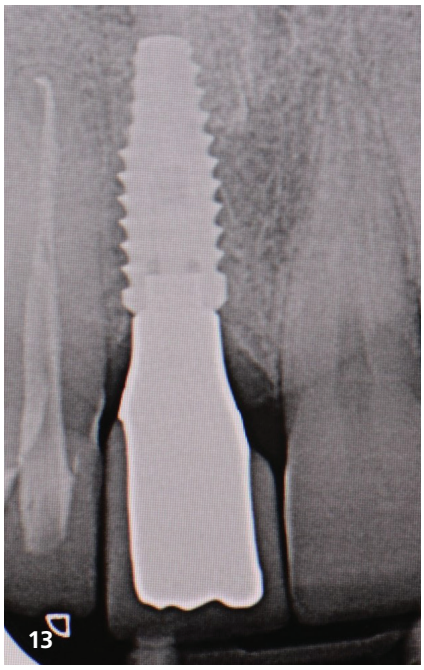


Fig. 7: Patient presented with a broken tooth crown. **Fig. 8:** An immediate implant was inserted after the root removal. **Fig. 9:** Situation after the healing period and complete osseointegration, at the time of the final anterior restoration. **Fig. 10:** Insertion of a digitally customised CoCr abutment. **Fig. 11:** Two and a half months after insertion, the gums are perfectly adapted and completely free of inflammation. **Figs. 12 & 13:** Less crestal bone loss was recognised during the nine-month observation period; the bone at the implant shoulder is in close contact with the abutment.

L 12 mm. The implant was immediately loaded on the day of surgery with a temporary restoration.

Five months post-op, a screw-retained zirconia crown was fabricated on a milled CoCr abutment, utilising a fully digital workflow and original CAM blanks from BioHorizons Camlog.

At a follow-up examination conducted two months later, the gingival tissue demonstrated ideal adaptation, with no signs of inflammation and a favourable marginal bone response. No crestal bone loss was observed during the nine-month observation period. Additionally, a reduction in probing depth was noted three months after the placement of the CoCr abutment and zirconia crown (Figs. 1–6).

Case 2

A 62-year-old male patient, non-smoker with a very good oral hygiene, presented with a dental implant at #11. The selected implant was a BioHorizons TLXP with dimensions Ø 4.6 mm x L 10.5 mm. The surgical procedure took place on 31 July 2023 and included the tooth extraction followed by the immediate placement of the implant.

To promote optimal osseointegration while allowing for immediate functional and aesthetic results, a temporary crown was affixed on the same day of the surgery. This approach facilitated immediate loading, providing the patient with an interim restoration during the healing phase.

At the six-month mark, after sufficient healing and integration of the implant, the final restoration was completed. A custom-milled CoCr abutment was fabricated using a fully digital workflow, ensuring precision and an excellent fit. This abutment supported a cemented zirconia crown, chosen for its durability and aesthetic qualities, thereby achieving a natural and long-lasting outcome for the patient (Figs. 7–13).

Conclusion

From a dental technician's perspective, CoCr abutments offer significant advantages due to their high workability. This material allows for the creation of a smooth, polished surface finish and the precise milling of thin walls, which is essential for many clinical applications. These characteristics make CoCr abutments ideal for achieving a refined fit and finish, enhancing both functional and aesthetic outcomes.

Clinically, hard tissue often remains in close contact with CoCr abutments, with no observable signs of crestal bone loss or marginal bone resorption. The soft tissue surrounding these abutments typically appears healthy, with no inflammation or other adverse reactions. Minimal probing depths have been recorded, and a reduction in probing depth was noted between the initial and three-month follow-up examinations. This suggests maturation of the peri-implant soft tissue, which is adapting well to the CoCr abutment.

CoCr abutments also demonstrate excellent biocompatibility, and current observations indicate that they are well-suited for clinical use. Nevertheless, while these preliminary findings are promising, extended studies and a longer observation period are necessary to confirm the long-term performance and stability of CoCr abutments.

About…

Prof. Maurizio Grande graduated in dentistry and honed his expertise in aesthetic prosthetics. He holds a postgraduate degree in prosthetics and prosthetic materials and has specialised in implant prosthetics. Over the years, he has collaborated on numerous clinical and research projects related to implant surgery. As an accomplished author, he has published extensively in national and international journals and is a sought-after speaker at various conferences and courses.

In 2004, he received the jury prize for the best original research in the dental materials section at the 11th National Congress of the College of Dentistry Teachers. Four years later, in 2008, an international jury awarded him the 1st Prize for the Esthetic Dental Care Award. Since 2012, he has been a member of the Chicago Dental Society and serves on the Editorial Board of the *International Journal of Experimental Dental Science*.

From 2016 to 2018, he was a professor at the University of Camerino. In 2018, he founded and became the president of the scientific association AGISI. Since 1996, he has been working as a freelance dentist in Rome.

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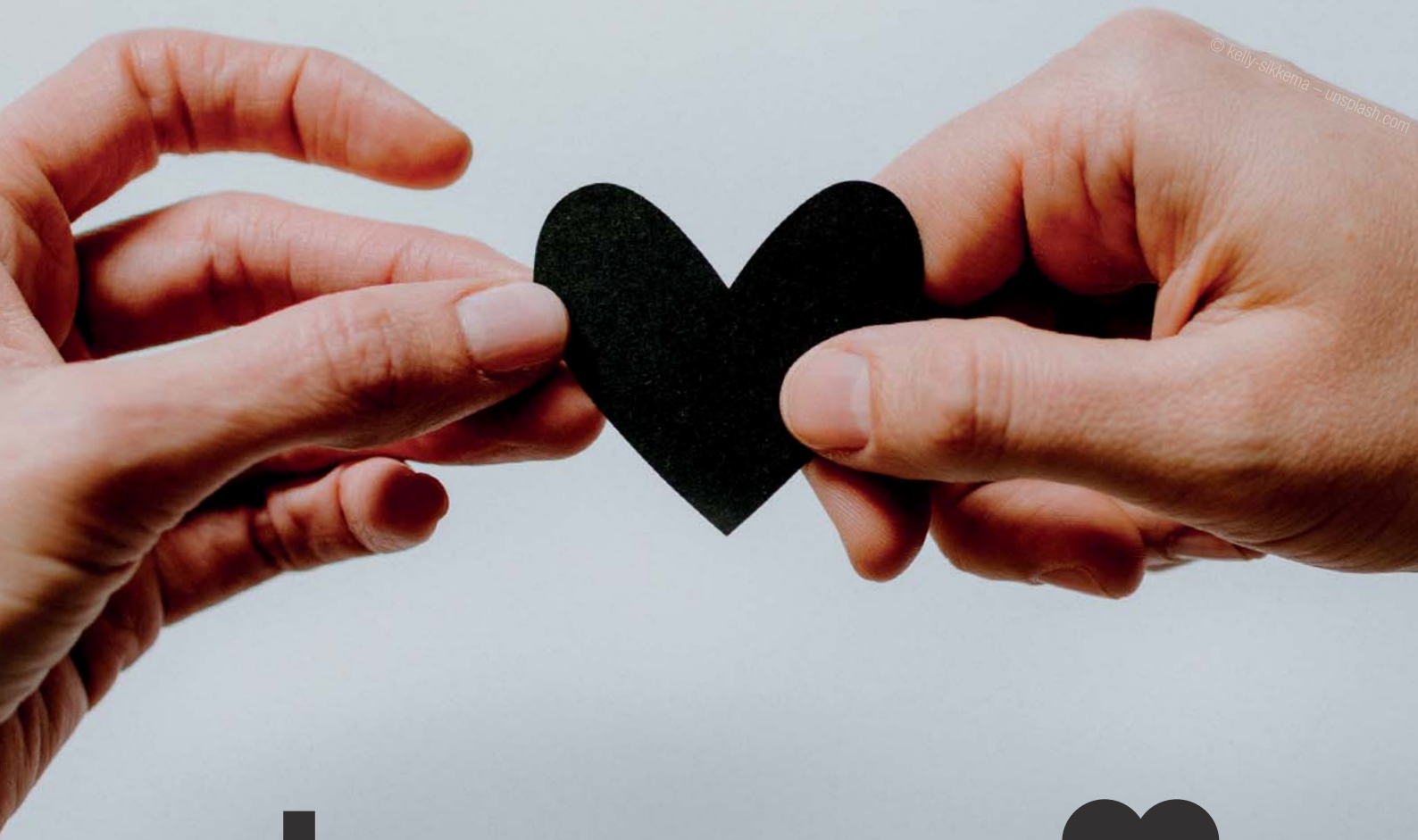

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OSSTEM IMPLANT at EAO Milan & London's Wembley Stadium

Experience the future of dental implantology

OSSTEM IMPLANT was proud to participate in the 2024 EAO Congress in Milan as a diamond sponsor, demonstrating ongoing commitment to innovation and excellence in implant dentistry. The event was held from 24 to 26 October where the company has showcased its latest advancements.

On 24 October the opening day of the conference, OSSTEM IMPLANT supported the "My First Implant" programme, organised by the EAO Junior Committee. This initiative combined theoretical lectures with hands-on training, giving young professionals a valuable opportunity to gain experience in implant procedures.

At the congress, OSSTEM hosted an industry forum on 25 October from 12:30 to 13:30 in Room Garda, where a distinguished panel of experts presented on key topics in implant dentistry. Chaired by renowned Italian moderator Marco Esposito, the forum featured leading specialists such as Darko Božić from Croatia, and Leonardo Muzzi and Fulvio Gatti from Italy. The session focused on the latest advancements in osseointegration and how they contribute to modern, patient-centered outcomes.

On 26 October OSSTEM also presented a hands-on workshop led by Marco Tallarico from 9:00 to 11:30 in Amber 4. Participants experienced modern surgical templates for complete-arch implant-supported restorations using the OneGuide system. The workshop covered advanced workflows, including implant placement, immediate loading, and achieving aesthetic results in narrow spaces, providing practical experience in complex cases.

Throughout the event, participants explored and engaged with OSSTEM's implants, digital solutions, and bone materials first-hand in hands-on demonstrations, gaining direct experience with OSSTEM products. Plus, a range of gifts were offered to visitors.

Following the presence at the EAO Congress, OSSTEM will continue its educational efforts with the OSSTEM Europe Meeting, taking place at London's Wembley Stadium on 22 and 23 November 2024. This event will bring together leading clinicians from across Europe to share insights on contemporary trends in dental implants.

The OSSTEM Europe Meeting will cover a variety of interesting topics, including:

- Session 1: Clinical procedures for favourable immediate implant placement and loading
- Session 2: The role of bone regeneration in enhancing successful osseointegration
- Session 3: Soft-tissue stability for optimal aesthetic outcomes
- Session 4: The benefits of digital workflows in the treatment of edentulous patients
- Session 5: Techniques and tips for managing implant complications
- Session 6: A live surgery demonstration

OSSTEM continues to be a leader in dental implant technology, offering cutting-edge solutions to enhance clinical outcomes. Don't miss the opportunity to learn from the experts and gain invaluable hands-on experience at the OSSTEM Europe Meeting in London. Through these upcoming events OSSTEM reaffirms its commitment to fostering collaboration and knowledge exchange within the dental community.

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ADI Masterclass on Soft Tissue Regeneration

A collaboration…

The Osteology Foundation and the British Association of Dental Implantology (ADI) share a common interest in spreading knowledge about oral tissue regeneration. As a result, they are jointly organising a Masterclass on "Soft Tissue Regeneration" on 23 November 2024 in London.

Following the success of the previous event, Osteology Executive Board Member and event chairman Nikolaos Donos has once again invited some of the world's leading specialists to contribute to this year's edition. Participants in this one-day masterclass can look forward to gaining concentrated knowledge from experts such as Ronald Jung, Frank Schwarz, Anton Sculean, France Lambert, Rino Burkhardt, Francesco Cairo, Stefan Bienz, Nikolaos Tatarakis, and Jeniffer Perussolo.

This Masterclass is a unique opportunity for dental professionals to deepen their understanding of soft-tissue regeneration through direct engagement with world-renowned experts. Whether you're looking to enhance your clinical skills or stay updated on the latest research in the field, this event promises invaluable insight and practical knowledge.

Places are limited, so early registration is recommended. For more information and to secure your place, visit our website. Don't miss your chance to be part of a powerful learning experience in the heart of London.

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Patient-customised concepts

"Implantology 4.0" in Düsseldorf this November

On 8 and 9 November 2024, the 53rd International Annual Congress of the German Association of Dental Implantology (DGZI) will be held in Düsseldorf, centered on the theme "Implantology 4.0—on the way to patient-specific concepts." This congress promises to be an enlightening event, guiding the future of dental implantology, fostering insightful discussions, and unveiling innovative approaches through the dynamic interaction between participants, speakers, and the industry.

For decades, dental practitioners have relied on standardised, evidence-based implantological treatments applicable to all patients. However, recent studies indicate a pressing need to reassess this one-size-fits-all methodology. What ensures success in one patient might not yield the same result in another. Hence, the focus is shifting towards patient-individualised concepts.

At the forefront of this transformation, the congress will showcase the latest scientific and practical findings. Renowned speakers will engage with participants to explore the full spectrum of dental implantology, fostering a collaborative environment where future advancements can take root. Traditionally, the congress kicks off with a forward-looking perspective, featuring presentations from the emerging generation of DGZI professionals who will share their current research and projects in a dedicated forum.

This year's DGZI Annual Congress will also include two in-depth tutorials: one on digital impressions in implantology and the other on immediate implantation and immediate loading. These sessions are designed to provide practical insights and hands-on experience. Additionally, the ever-popular table clinics return, offering participants the chance to discuss specialised topics with distinguished experts, thereby expanding their knowledge beyond their usual practice.

Complementing the scientific sessions, a separate congress for implantological assistants will take place, ensuring that the entire practice team benefits from comprehensive training and education.

Set against the backdrop of Düsseldorf, a city renowned for its vibrant culture and dynamic atmosphere, the congress offers more than just professional development. It promises an enriching and holistic experience that combines cutting-edge knowledge with the charm of one of Germany's most fascinating cities. The DGZI Annual Congress is a must-attend event for anyone involved in dental implantology, offering unparalleled opportunities for learning, networking, and professional growth.

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Geistlich receives MDR approval for entire product portfolio

The entire Geistlich product portfolio has been successfully certified according to MDR—well before the official transition period. The pioneer in medical regeneration thus confirms its claim to meet the highest quality and safety standards.

As one of the first companies in its field, the regeneration specialist Geistlich has successfully completed the approval process for its entire product portfolio in accordance with the new Medical Device Regulation (MDR) of the European Union (EU) 2017/745. Geistlich thus meets the highest European standards of quality, safety and performance for medical devices.

Strong scientific evidence

For MDR certification, clinical and preclinical evidence as well as safety and performance data were thoroughly reviewed. Since the project to achieve certification started in 2017, Geistlich has submitted more than 2,200 documents with almost 40,000 pages and had its quality management system audited according to MDR. The entire process required several years of collaboration between teams from different departments and shows how challenging it is to obtain MDR approval even for established products. „Without the solid scientific basis of our products and our high quality standards, MDR certification would not have been possible so quickly," says Diego Gabathuler, CEO of Geistlich.

Safe and effective solutions

The early MDR certification of all Geistlich products, even before the official deadline in 2027, underlines the company's strong commitment to the highest quality and safety standards. The certification is both proof and an incentive to continue to provide safe and effective solutions for patients and healthcare professionals, and to continue to advance the field of medical regeneration.

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High primary stability and aesthetic appearance

The whiteSKY implant system from bredent is among the best-documented zirconia implant systems worldwide. It has not only demonstrated excellent osseointegration and longevity in numerous studies but has also proven its efficacy in practice. In fact, the longevity of whiteSKY implants is comparable to that of titanium implants. The whiteSKY implant system offers two different implant types: the whiteSKY Tissue Line and the whiteSKY Alveo Line. The narrow whiteSKY Tissue Line implant provides sufficient space for both the hard and soft tissue and ensures an aesthetically pleasing appearance with its slightly tapered shape in the sulcus area, transitioning from the gingiva to the implant crown. The whiteSKY Alveo Line, on the other hand, is ideal for immediate loading as it fills the extraction socket. At the same time, it provides the treating doctor with the possibility to individualise the implant according to the specific requirements of the clinical case.

Optimal conditions for soft-tissue attachment and high mechanical stability

Both the Alveo and Tissue Line implants of the whiteSKY system offer optimal conditions for soft-tissue attachment due to their specially designed sulcus surface. The whiteSKY implants are made of hardened zirconia and are one-piece, which gives them particularly high mechanical stability. Thanks to the improved thread design and bone-quality-oriented surgical protocol, the whiteSKY implants achieve high primary stability, making them ideal for immediate loading. Studies have shown that immediate implant placement can improve the bone–implant contact by more than 50 per cent.

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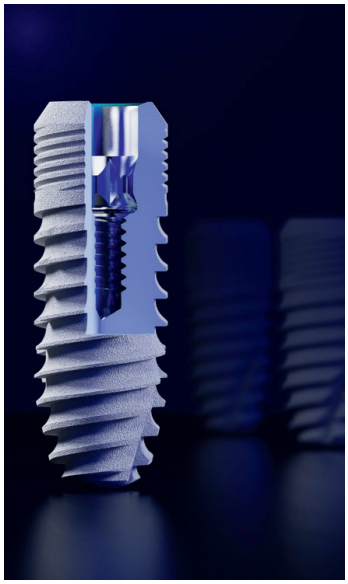

NucleOSS Europe

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The DC-BONE-LEVEL implant features modern and aesthetic design details and offers a safe and comfortable surgical experience for the dentist and patient. A wide range of prosthetic abutment options helps to give patients a radiant smile. In addition, the implant gives patients self-confidence through its intelligent and strong design. With extensive abutment options, a convenient application kit and a registered clean surface, the DC-BONE-LEVEL implant is more than outstanding. The groundbreaking aspect of the DC-BONE-LEVEL implant is that it balances quality and price. The implant has been carefully developed to increase comfort for clinicians and patients with its aesthetic design and high strength. SLH is a new dental implant system with the aim of giving patients back their bright smile and stands for "Smart Design, Leading System, Healthy Solution". By developing the highest level of biointegrity and excellent surface cleanliness, it is possible to create the highest possible standard for the user. Many years of research and development have resulted in a new implant system that enables the practitioner to achieve the best possible results.

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11/2024	OSSTEM Europe Meeting 2024	London UK	22–23 November 2024	www.osstem.de/events
	ADF Congress 2024	Paris France	27–30 November 2024	https://www.adfcongres.com/fr/
	DGI-Kongress/Implant Expo	Dresden Germany	28–30 November 2024	https://www.dgi-kongress.de/

EDI Journal – Information for authors

EDI Journal – the interdisciplinary journal for prosthetic dental implantology is aimed at dentists and technicians interested in prosthetics implantology. All contributions submitted should be focused on this aspect in content and form. Suggested contributions may include:

- Original scientific research
- Case studies
- Product studies
- Overviews

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Submissions should be made in digital form. Original articles will be considered for publication only on the condition that they have not been published elsewhere in part or in whole and are not simultaneously under consideration elsewhere.

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Illustrations and tables
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Each article should contain a minimum of 10 and a maximum of 30 references, except in unusual circumstances. Citations in the body of the text should be made in numerical order. The reference list should be typed on a separate sheet and should provide complete bibliographical information in the format exemplified below:
[1] Albrektsson, T.: A multicenter report on osseointegrated oral implants. J Prosthet Dent 1988; 60, 75–82.
[2] Hildebrand, H. F., Veron, Chr., Martin, P.: Nickel, chromium, cobalt dental alloys and allergic reactions: an overview. Biomaterials 10, 545–548 (1989).

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(For information on BDIZ EDI Directory of Implant Dentists see overleaf)

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