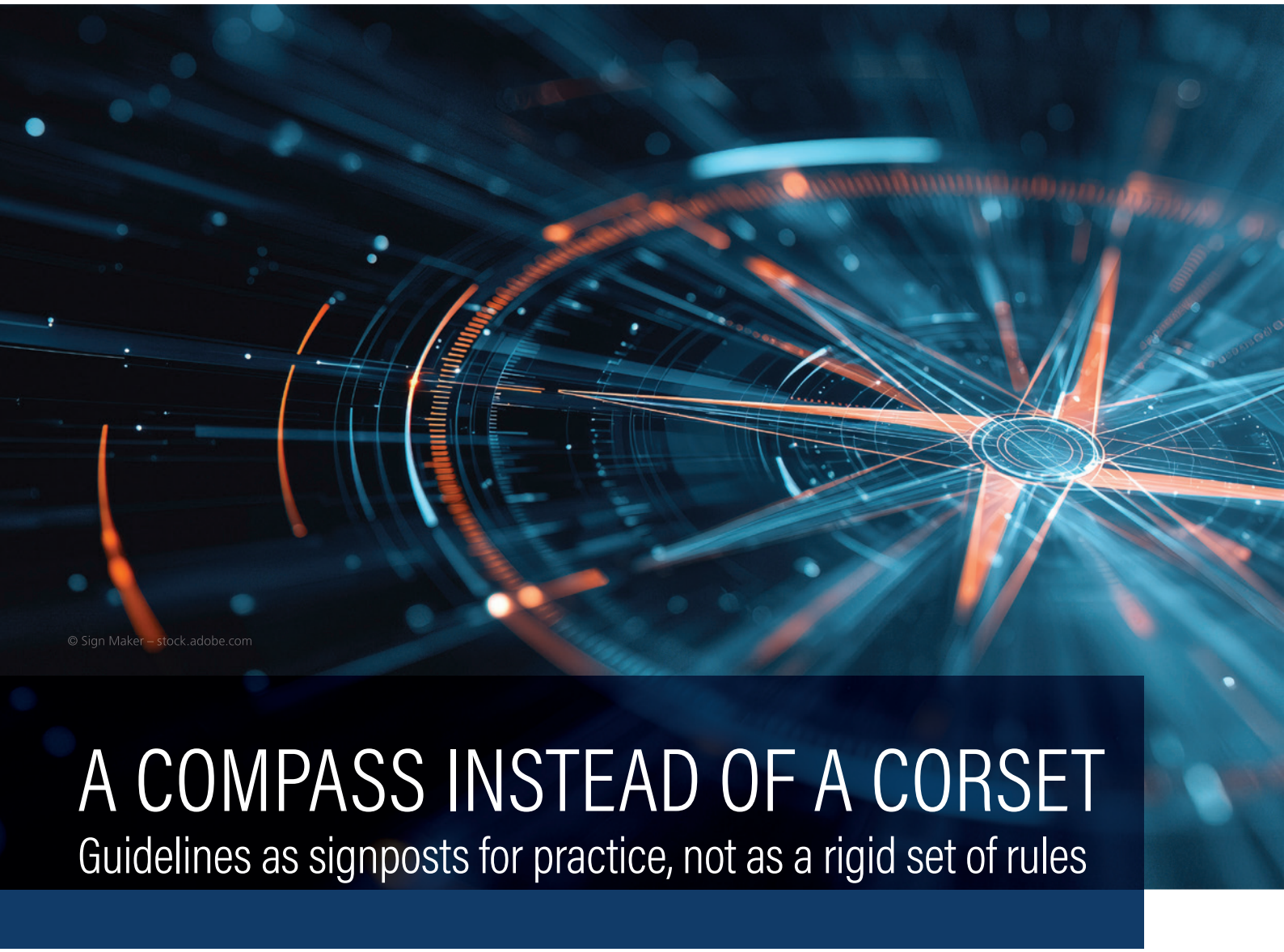
European Association of Dental Implantologists
Bundesverband der implantologisch tätigen Zahnärzte in Europa e.V.

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European Journal for Dental Implantologists



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A COMPASS INSTEAD OF A CORSET

Guidelines as signposts for practice, not as a rigid set of rules

EDI News | Overview: dental guidelines—expectations, reality and the limits | All about the international FDI congress in Prague | Curriculum Implantology of BDIZ EDI sets standards | **Case Studies** | Prosthetic rehabilitation within seven days—guided all-on-6 implant placement under analgosedation | From urgent care to comprehensive oral rehabilitation—interdisciplinary management of a patient with dental anxiety |

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A compass instead of a corset

Today, clinical guidelines are an integral part of modern dentistry. They offer guidance within an increasingly complex healthcare landscape, consolidate scientific findings, and establish a common foundation for diagnosis and treatment. Yet, as their significance grows, so too does the importance of the question: what can these guidelines achieve, and where do their limitations lie?

The answers to this are nuanced. Guidelines are neither laws nor rigid instructions for action; they are intended to provide orientation, not to replace decision-making. In this issue, Prof. Joachim E. Zöller points out that overinterpretation occurs when evidence-based recommendations are misconstrued as immutable rules. Particularly in dentistry, the individual patient must always be given greater consideration than any recommendation—no matter how carefully it may have been formulated.

At the same time, an examination of the evidence base for many clinical guidelines reveals that the level of scientific certainty is not always as high as one might wish. In the field of implantology some recommendations are based not solely on high-quality studies, but also on expert consensus or limited data. This can give rise to risks—ranging from over- or undertreatment to poor decision-making—if such recommendations are adopted without critical evaluation.

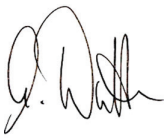
In the context of medical expert assessments, the role of clinical guidelines should not be overestimated. Prof. Johann Müller emphasises that the standard of care expected of a specialist and the individual clinical findings are the decisive factors when evaluating medical cases. While guidelines can support an assessment, they cannot replace a careful analysis of the specific case at hand. Furthermore, problems arise when outdated guidelines are cited or when contradictions between different recommendations are overlooked.

Why, then, has the BDIZ EDI been so deeply involved in the development of clinical guidelines for many years? The answer lies in the association's own self-conception. For President Christian Berger, contributing to these guidelines is a way to ensure quality and further the advancement of implantology. In this process, the BDIZ EDI incorporates the perspective of dentists who practise implantology into national guideline development, while simultaneously helping to translate scientific findings into practical applications for everyday clinical use.

The fact that scientific guidelines alone cannot address every question encountered in daily clinical practice is reflected in another of the association's initiatives: the development of practical guides. While formal guidelines often take a long time to produce and are updated only at infrequent intervals, these guides are designed to incorporate recent developments more rapidly and provide access to international expertise. They serve as a supplement to traditional guideline development, acting as a bridge between scientific evidence and the realities of everyday clinical care.

The discussion surrounding clinical guidelines will therefore continue. Greater transparency, a stronger evidence base, regular reviews, and the consistent consideration of potential conflicts of interest are among the demands put forward by our experts on the board.

One thing is certain: good clinical guidelines provide a sense of security. Yet they only reach their full value when understood for what they are intended to be: a scientifically sound compass for treatment—not a straitjacket that replaces clinical reasoning, experience, or the individuality of the patient. The "art" lies precisely in combining both.



Anita Wuttke
Editor-in-Chief



20th BDIZ EDI Europe Symposium in Tirana



BDIZ EDI board meets in Alsace



Prothetic rehabilitation within seven days

EDI News

08 Expectations, reality and the limits
Overview: dental guidelines

10 More bureaucracy, higher costs, little progress
Long-serving chamber consultant for practice management criticises new S2k clinical guideline

12 A "monstrous" conflict of interest
British Medical Journal (BMJ) Investigation

16 3 questions for Prof. Dr Joachim E. Zöller
Guideline topic: significance and evidence base

17 3 questions for Prof. Dr Johann Müller
Guideline topic: role and misinterpretation

18 3 questions for Christian Berger
Guideline topic: the role of the BDIZ EDI

20 Anniversary congress
20th BDIZ EDI Europe Symposium in Tirana, Albania

22 Management of acute periodontal conditions
European Federation of Periodontology (EFP) guideline

24 Setting a strategic course
BDIZ EDI board meets in Alsace

25 We want YOU!
BDIZ EDI and its multifaceted work

26 Insufficient bone volume—what can be done?
22nd Expert Symposium in Cologne: 6 and 7 February 2027

28 A curriculum that sets new standards
Launching in November in Cologne

30 Strong in terms of content
FDI World Dental Congress in Prague

32 Guiding principles for international standards
FDI Congress in Prague—political work

33 Growth of strategic importance
FDI membership trends

34 Focus on the code of ethics and digitalisation
European Regional Organisation (ERO) in Prague

36 Europe Ticker

38 Three rulings that dentists should be aware of
Key rulings by the European Court of Justice

Case Studies

40 Guided all-on-6 implant placement under analgosedation
Prosthetic rehabilitation within seven days

44 Interdisciplinary management of a patient with dental anxiety
From urgent care to comprehensive oral rehabilitation

Business & Events

49 From Vienna to Baku: a milestone year for the EFP
EuroPerio12

50 Meeting in Lisbon attracts delegates from across the globe
EAO Annual Congress 2026

52 From evidence to clinical implementation
Global consensus for clinical guidelines

54 Evidence-based learning. Anywhere, anytime.
Osteology Foundation

55 Beyond implants: OSSTEM expands its vision for modern dentistry
OSSTEM IMPLANT

News and Views

03 Editorial

06 Partner Organizations of BDIZ EDI

07 Scientific Board/Imprint

56 Product Reports/Product Studies/Product News

66 Calendar of Events/Publisher's Corner



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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)

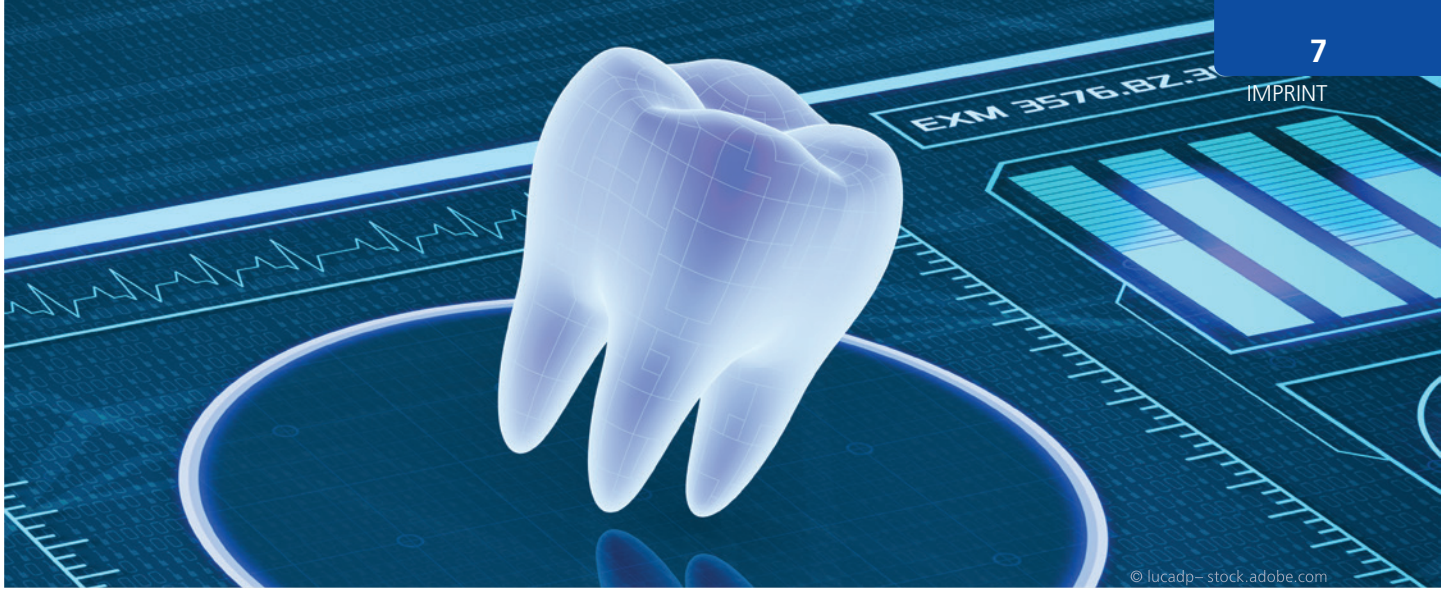
USSI EDI was founded in 2010 with the desire to enhance dentists' knowledge of dental implants, as well as to provide the highest quality of continuing education in dentistry. The most important aims of the organisation are to make postgraduate studies meeting the standards of the European Union available 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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Overview: dental guidelines

Expectations, reality and the limits

Dental guidelines are regarded as a key source of guidance for diagnosis and treatment. They are intended to consolidate scientific evidence, support clinical decision-making and improve the quality of care. However, in practice it is evident that, whilst guidelines are valuable, they are by no means free from problems. A critical assessment is necessary to realistically evaluate their benefits and avoid misinterpretations.

Guidelines are recommendations—not laws

The most important point, which is often overlooked in practice, is that guidelines are not legally binding. They are recommendations for action intended to reflect the current state of scientific knowledge.

Nevertheless, they are often treated as quasi-normative requirements in expert reports, insurance proceedings or legal disputes. This leads to two problems: on the one hand, guidelines are presented as mandatory, even though they expressly do not set binding standards (over-interpretation); and on the other hand, individual clinical decisions are retrospectively assessed against guideline criteria that were not mandatory at the time of treatment (lack of flexibility). In principle, whilst guidelines may provide guidance, they do not replace clinical judgement.

The evidence base is often less robust than claimed

Many dental guidelines—particularly in implantology, endodontics and periodontology—are based on heterogeneous studies, limited case numbers or data with limited validity. Typical problems include: a lack of randomised trials, short observation periods, industry-funded research and a lack of standardised definitions of success and failure. As a result, guidelines are often based on expert consensus rather than on sound evidence. Consensus is valuable—but it is no substitute for robust data. Guidelines are only as good as the evidence on which they are based.

Conflicts of interest—a structural risk?

Even though guideline groups have strict rules on the disclosure of conflicts of interest, the reality remains complex. Many experts are active in research, industry or continuing professional development. Implantology and digital dentistry are heavily influenced by commercial interests, and conflicts of interest can have subtle effects—for example, through the funding of studies or product preferences. This does not mean that guidelines have been "bought". But it does mean that a critical perspective remains necessary, as we will demonstrate in this issue using a case study from the UK.

Guidelines often lag behind clinical reality

Dentistry is evolving rapidly: digital workflows, new biomaterials, AI-assisted diagnostics, minimally invasive procedures. Guidelines, on the other hand, take a long time to develop, go through consensus-building processes, must meet AWMF standards and are generally only updated every three to five years. As a result, they are often out of date by the time they are published—or fail to adequately reflect new developments.

Expert report: incorrect use

In the field of dental expert reports, a systematic problem frequently arises: clinical guidelines are interpreted as the standard of care, even though they are not. Another form of misuse involves citing specific passages from these guidelines in isolation—stripped of their context. Complex clinical situations are evaluated using oversimplified statements from the guidelines, causing the individual patient's circumstances to be overlooked in favour of a rigid "guideline-based" benchmark. This can lead to erroneous assessments and, in the worst-case scenario, to unjustified accusations of fault.

The strength of guidelines: structure, orientation, transparency

Despite all the criticism, clinical guidelines do offer distinct advantages: they provide structure in complex clinical areas and promote transparency in decision-making processes. They support professional development and quality assurance, and they help in communicating treatment options in a clear, comprehensible manner. Their value, therefore, lies in the guidance they provide.

Conclusion

Dental clinical guidelines are an important tool in modern dentistry. However, their application requires critical reflection, scientific competence, and clinical experience. Using them responsibly means knowing and understanding them, placing them in the proper context, and avoiding the mistake of overstating their significance. Only then can they fulfil their purpose: to support evidence-based, patient-centred, and professionally sound care—without restricting clinical freedom.

References

From S1 to S3

In Germany, medical and dental clinical guidelines are classified according to the AWMF system. The designations S1, S2k, S2e, and S3 represent different quality levels, which are distinguished by their methodology, evidence base, and consensus-building processes.

S1 guideline: expert consensus (lowest level)

An S1-level clinical guideline is developed when a group of experts reaches an informal agreement on recommendations.

Characteristics:
- no systematic literature review
- no formal consensus process
- no structured methodology
- recommendations are based primarily on experience

Validity: S1 is the weakest form of clinical guideline. It is useful when evidence is lacking—but it is not robust enough for legal or expert-opinion assessments.

Typical issue: in practice, S1 guidelines are often overinterpreted, even though they provide no guarantee of scientific evidence.

S2k guideline: consensus-based (intermediate level)

The S2k guideline is based on a structured consensus process, but without a systematic search for evidence.

Characteristics:
- formal consensus methods (e.g. Delphi, moderated voting)
- structured development process
- however: no systematic literature review

Validity: S2k is methodologically more rigorous than S1, but its recommendations are still primarily based on expert opinion rather than systematic evidence.

Typical issue: S2k guidelines are frequently presented as "scientific," even though an evidence base is lacking. In dentistry in particular, most guidelines are of the S2k type—due to a scarcity of robust studies.

S2e guideline: evidence-based (intermediate level)

S2e means systematic literature search, but no formal consensus process.

Characteristics:
- systematic evidence search
- structured assessment of the studies
- however: no formal consensus process among experts

Validity: S2e is scientifically more robust than S2k because its recommendations are based on evidence. However, without a consensus-building process, its level of acceptance may be lower.

Typical issue: S2e is rare because the combination of evidence-based work without consensus is organisationally difficult.

S3 guideline: evidence + consensus (highest level)

The S3 guideline represents the most methodologically robust form: it combines a systematic search for evidence with a formal consensus-building process.

Characteristics:
- systematic literature search
- assessment of evidence (GRADE, etc.)
- structured consensus-building
- transparent methodology
- multidisciplinary involvement

Validity: S3 is the gold standard. It is scientifically robust and methodologically sound—and therefore the most relevant type of guideline for clinical decision-making and expert assessments.

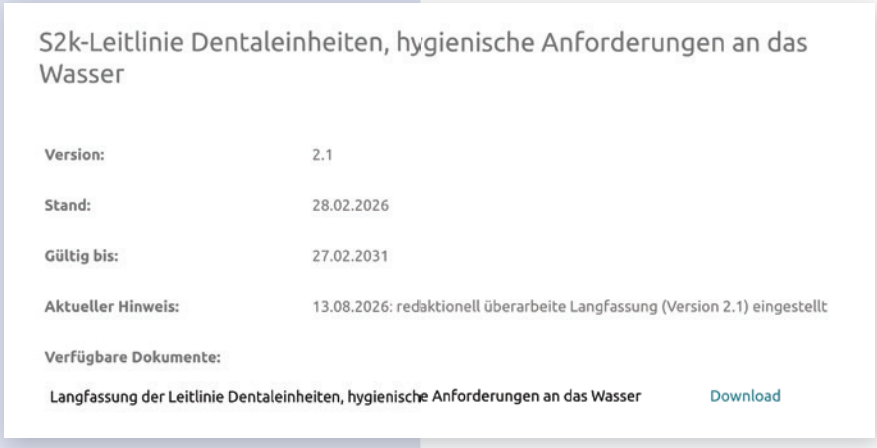
Typical issue: S3 guidelines are extremely time-consuming and expensive to develop. In dentistry, there are very few S3 guidelines.

What does this classification mean in practice?
- Most dental clinical guidelines are classified as S2k—meaning they are consensus-based rather than evidence-based.
- In expert reports, clinical guidelines are often exaggerated, even though they are not legally binding.
- S1 guidelines are not suitable for assessing potential treatment errors.
- S3 guidelines are rare—and often lack the specificity required for complex, individual cases.
- Clinical guidelines frequently reflect the reality of dental practice only after a time lag.

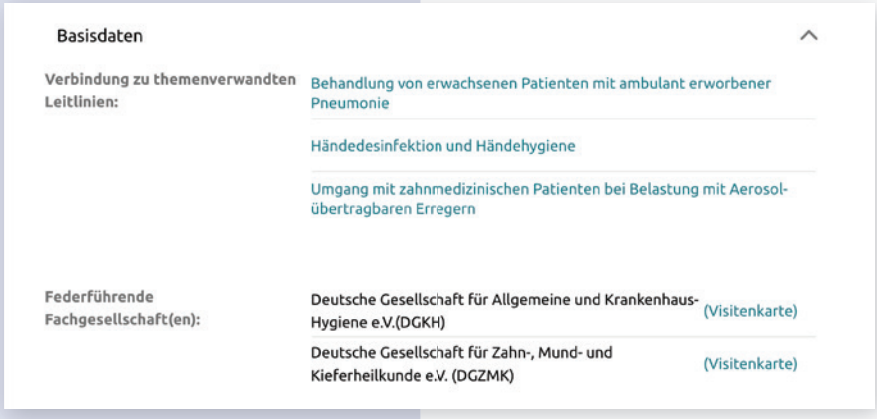
Long-serving chamber consultant for practice management criticises new S2k clinical guideline

More bureaucracy, higher costs, little progress

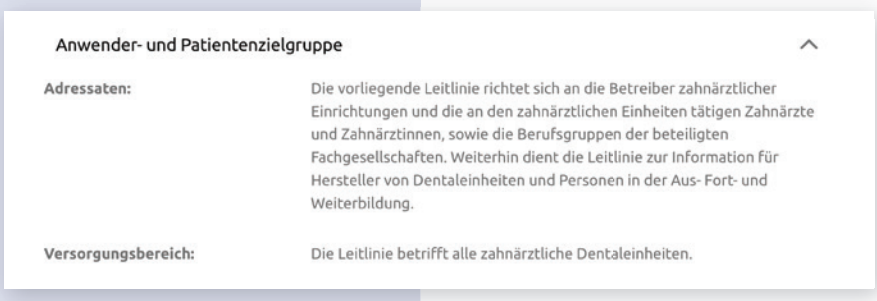
Drawing on the revised S2k guideline "Dental Units—Hygienic Requirements for Water," published in July 2026, we present an example of how a practice management consultant—who works closely with dental practices—assesses and critiques this revision. The individual in question is Dr Michael Rottner, who served as the consultant for practice management at the Dental Chamber from 2002 to 2022.


S2k-Leitlinie Dentaleinheiten, hygienische Anforderungen an das Wasser

Version:	2.1
Stand:	28.02.2026
Gültig bis:	27.02.2031
Aktueller Hinweis:	13.08.2026: redaktionell überarbeite Langfassung (Version 2.1) eingestellt
Verfügbare Dokumente:	
Langfassung der Leitlinie Dentaleinheiten, hygienische Anforderungen an das Wasser	Download


Basisdaten

Verbindung zu themenverwandten Leitlinien:	Behandlung von erwachsenen Patienten mit ambulant erworbener Pneumonie
	Händedesinfektion und Händehygiene
	Umgang mit zahnmedizinischen Patienten bei Belastung mit Aerosol-übertragbaren Erregern
Federführende Fachgesellschaft(en):	Deutsche Gesellschaft für Allgemeine und Krankenhaus-Hygiene e.V.(DGKH) (Visitenkarte)
	Deutsche Gesellschaft für Zahn-, Mund- und Kieferheilkunde e.V. (DGZMK) (Visitenkarte)


Anwender- und Patientenzielgruppe

Adressaten:	Die vorliegende Leitlinie richtet sich an die Betreiber zahnärztlicher Einrichtungen und die an den zahnärztlichen Einheiten tätigen Zahnärzte und Zahnärztinnen, sowie die Berufsgruppen der beteiligten Fachgesellschaften. Weiterhin dient die Leitlinie zur Information für Hersteller von Dentaleinheiten und Personen in der Aus- Fort- und Weiterbildung.
Versorgungsbereich:	Die Leitlinie betrifft alle zahnärztliche Dentaleinheiten.

"To a large extent, the guideline follows the previous version, merely responding to legislative changes such as the revised 2023 Drinking Water Ordinance and the EU Medical Devices Regulation. It lacks any original new standards or innovative hygiene concepts. Consequently, the guideline remains reactive rather than future-oriented.

The recommendation to test for Pseudomonas species and viridans streptococci—in addition to the standard parameters for drinking water—is particularly contentious. While these supplementary indicator organisms may be sound from a hygienic perspective, they impose significantly higher costs on operators, including:

- additional laboratory analyses
- more extensive sampling
- an increased documentation burden
- potential remediation measures in the event of concerning findings.

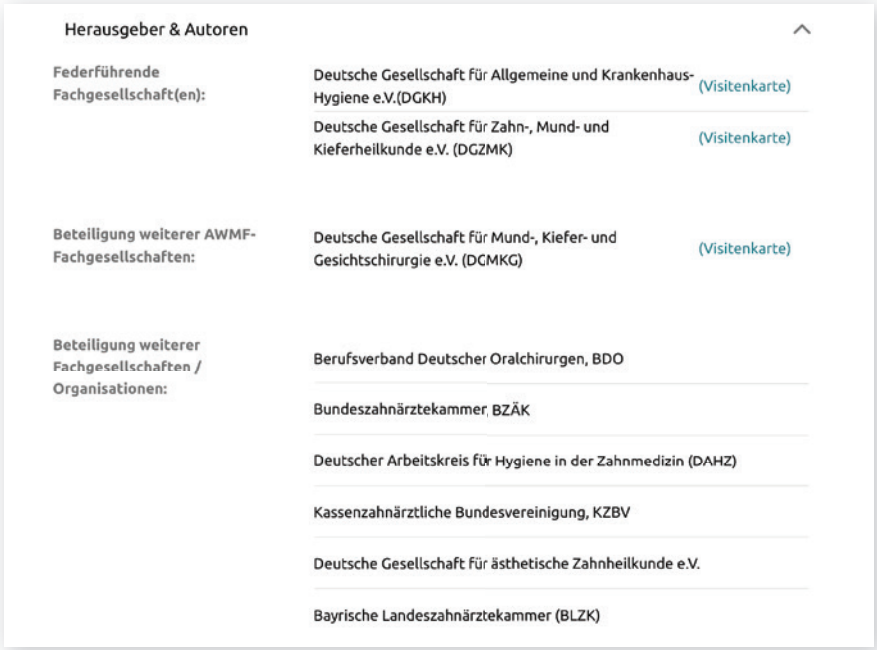
For many practices, this entails a noticeable additional financial burden—not least because the guideline fails to specify clear consequences or sets of measures to be taken upon the detection of these germs.

Although the authors of the guideline themselves emphasise that it is not legally binding, it is used in practice by public health departments, regulatory authorities, and hygiene inspectors as a benchmark. This creates a de facto obligation

that dental practices can hardly afford to ignore. The result: recommendations become requirements, and requirements become cost factors.

Smaller practices are hit particularly hard, as the guidelines mandate extensive flushing, testing, and documentation procedures that are difficult to manage in terms of both staffing and finances. In short: a greater burden with little benefit.

The new S2k guideline fails to deliver any genuine advancement in water hygiene for dental units. Instead, it increases the bureaucratic burden, raises the costs of microbiological testing, and remains conservative in its content.

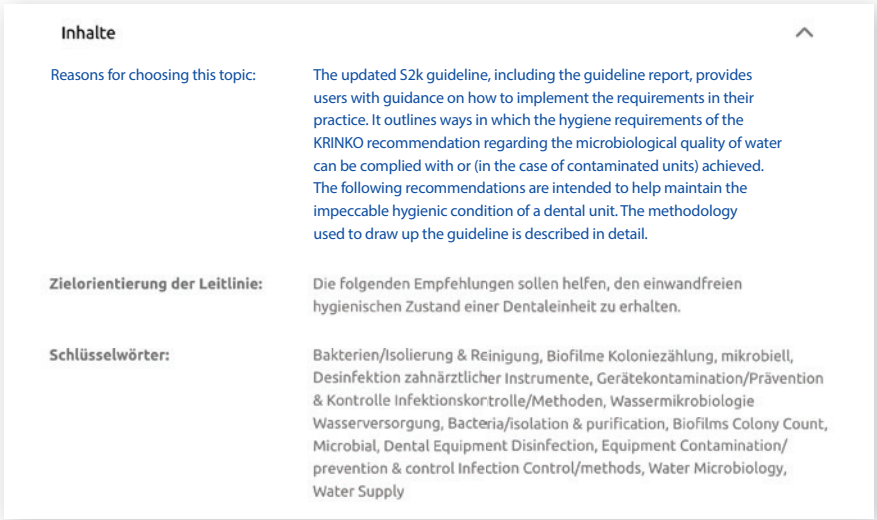


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Inhalte

Reasons for choosing this topic:	The updated S2k guideline, including the guideline report, provides users with guidance on how to implement the requirements in their practice. It outlines ways in which the hygiene requirements of the KRINKO recommendation regarding the microbiological quality of water can be complied with or (in the case of contaminated units) achieved. The following recommendations are intended to help maintain the impeccable hygienic condition of a dental unit. The methodology used to draw up the guideline is described in detail.
Zielorientierung der Leitlinie:	Die folgenden Empfehlungen sollen helfen, den einwandfreien hygienischen Zustand einer Dentaleinheit zu erhalten.
Schlüsselwörter:	Bakterien/Isolierung & Reinigung, Biofilme Koloniezählung, mikrobiell, Desinfektion zahnärztlicher Instrumente, Gerätekontamination/Prävention & Kontrolle Infektionskontrolle/Methoden, Wassermikrobiologie Wasserversorgung, Bacteria/isolation & purification, Biofilms Colony Count, Microbial, Dental Equipment Disinfection, Equipment Contamination/prevention & control Infection Control/methods, Water Microbiology, Water Supply

The dental profession requires practical, evidence-based, and economically viable hygiene concepts—not guidelines that primarily create additional burdens. The revised version of the guideline goes far beyond the requirements set out in 2014. Based on the theoretical assumption that back-suction could occur through handpieces and contra-angles during patient treatment—potentially leading to contamination of the dental unit—the guideline now mandates additional testing for the microorganisms *Streptococcus viridans* and *Pseudomonas aeruginosa*. It should be noted, however, that for many years, these handpieces, contra-angles, and motors have been equipped with anti-back-suction mechanisms. Furthermore, there have been no reported infections linked to their use. This is, therefore, a purely theoretical risk with absolutely no supporting evidence!"



Dr Michael Rottner
Chamber Consultant for Practice 2002–2022, Regensburg

About the guideline

The S2k guideline "Dental Units—Hygienic Requirements for Water" (register no. 075-002, dated 28 February 2026) is valid until 27 February 2031, and can be viewed here.



***British Medical Journal (BMJ)* Investigation**

A "monstrous" conflict of interest

A historical case involving more than £50m shows what's at stake in the debate around transparency of doctor–industry relations.

A British cardiologist and former president of the European Society of Cardiology (ESC) has been judged by the ESC to have committed severe misconduct after a Danish TV documentary reported that he had been involved in drawing up guidelines for the use of the heart drug ivabradine (Corlanor, Procoralan) while profiting from lucrative contracts with the drug's maker.[1]

Between 2006 and 2015, Kim Fox, emeritus professor of clinical cardiology at the National Heart and Lung Institute, Imperial College London, and his wife Karen Summers, a former drug industry executive, received more than £50m as co-directors of the UK based contract research organisation Heart Research. This company was involved in running at least three clinical trials of ivabradine, made by French drug company Servier, that were published in the same period.

Most of the money Fox and Summers received came in the form of dividends and distributions paid to them as sole shareholders of Heart Research. The bulk of it—more than £33m, the equivalent of £47m today—came as a distribution of retained capital and profits on liquidation of the company in 2015.

Ivabradine, a sinus node inhibitor, works by slowing the heart rate and was first approved by the European Medicines Agency for treating stable angina in 2005. In 2006, when Fox became president of the ESC, he chaired an ESC taskforce that published a guideline recommending ivabradine as an alternative treatment for angina in patients who



couldn't tolerate beta blockers.[2] At the time, Heart Research was already involved in the Servier funded "Beautiful" trial of ivabradine for coronary artery disease with left ventricular systolic dysfunction.[3] The ESC guideline stated that its authors were asked to disclose conflicts of interest, but the document did not publicly identify what Fox had disclosed, just indicated that forms were available on "written request to the ESC president".

When Fox's term as ESC president concluded in 2008, he remained on the board for a further two years as the society's past president. Although ivabradine had failed to meet the primary endpoint in Beautiful—of significant reduction in cardiovascular death or hospital admission for heart attack or heart failure—he described it publicly as the "gold standard for any anti-anginal, anti-ischaemic drug".[4]

Talking to *The BMJ*, Irène Frachon, a pulmonologist in Brest, France, who took on Servier over another of its drugs (benfluorex sold under the brand name Mediator) in a highly publicised case, described the sums involved in the Fox case as "monstrous". She said that it should have been obvious to Fox that, given his ties to the company, he should have recused himself from the guideline taskforce. "It stinks!" said John Martin, professor of cardiovascular science at University College London and a former vice president of the ESC. Rita Redberg, a cardiologist at the University of California, San Francisco, and former editor-in-chief of *JAMA Internal Medicine*, told *The BMJ* that she felt sad on learning about the case: "It totally goes against the grain of the profession."

Fox declined an interview request but sent a statement and agreed to answer *The BMJ*'s written questions. He "strongly denied" ESC's conclusion of severe misconduct. He wrote that he "did not breach any [ESC] rules and regulations applicable at the time," adding that "ESC was aware of his relevant interests, which were declared, transparent, and public, and the ESC had no apparent concerns at the time".

Persistent doubts have been expressed about the safety and efficacy of ivabradine, although it remains an approved treatment for both angina and heart failure in Europe and for heart failure in the US. After the 2014 "Signify" trial—which also involved Heart Research—showed an increased risk of heart attack and cardiovascular death in a significant subset of patients, the European Medicines Agency reviewed the drug and issued warnings on its use in treating angina.[5,6]

After the Danish documentary aired in September 2024, the ESC commissioned an internal review of its guidelines pertaining to ivabradine, including the 2006 guideline that Fox chaired. The review, seen by *The BMJ*, concluded that the recommendations were "appropriate" and reported "no evidence to suggest a bias towards ivabradine".

But many cardiologists now consider ivabradine a third line treatment at best.[7] The independent French medical journal *Prescrire* advises doctors not to use it. Aroon Hingorani, a specialist in clinical pharmacology at University College London who previously directed UCL's Institute of Cardiovascular Science, reviewed the evidence for *The BMJ*. He concluded that the harms outweighed the benefits:

"I can't really see any place for it, either in angina or in heart failure," he said.

An eye watering sum

Many—and, in some contexts, most—clinicians have some form of financial link to drug companies. Such relationships are baked into the fabric of industry sponsored clinical trials, but the Fox case is striking for the eye watering sums involved and his eminence: as well as presiding over a globally influential medical association, he reportedly served as cardiologist to the late British monarch, Queen Elizabeth II. And the revelations come at a time when some groups in Europe are pushing for reforms that would end voluntary declaration of conflicts of interest and enshrine greater transparency in law.

The Danish documentary originally aired on Denmark's TV 2 channel.[1] It was rebroadcast in Switzerland last year, but it hasn't yet been televised in the English speaking world. Although questions had been asked for years about the ESC's relationship with industry, both by its members and outside observers,[8,9] it took a Danish exposé to trigger an internal investigation of Fox's case.

There is no suggestion that Fox or his wife broke any laws, but the ESC told *The BMJ* that, in March 2025, the ESC ethics committee found that he "had failed to meet his ethical obligations and considered his behaviour as a severe misconduct". Asked precisely what those obligations were, an ESC spokesperson responded that the committee had found that Fox "failed to recuse himself in the presence of a significant conflict of interest".

After being presented with the committee's findings early last year, Fox resigned from the ESC, placing himself out-

side the reach of disciplinary action. Nevertheless, the society stated that Fox was ineligible to rejoin and could not be invited as faculty to any ESC event—"the highest level of exclusion under ESC rules". In May 2025, the board stripped him of the gold medal—the society's highest honour—that he had been awarded as outgoing ESC president, and his name is no longer in the ESC's website listing of past presidents.[10]

The ESC did not publicise its actions, but journalists who inquired were sent a statement about the case. The statement claims that the procedures by which the society draws up clinical guidelines are robust and says, "This process is entirely independent of industry influence."

Under ESC rules in place in 2006, Fox was required to submit a paper based declaration of his interests to the society, but he would not have been obliged to mention the size of any payments, and his declarations would not have been made public. An ESC spokesperson said that the society no longer archived declarations made before 2011—when the process went online—and Fox did not provide his to *The BMJ* when requested.

The BMJ reviewed publications co-authored by Fox in the decade from 2005 and found that most of them disclosed his relationship with Servier. But as journals do not routinely ask authors to report the magnitude of their financial ties to industry, the scale of his was obscured.

Fox rejected the ethics committee's findings. He told *The BMJ* that he had always declared any conflicts of interest and that he had resigned from the ESC because "he was not prepared to be judged on the basis of rules and regulations described in 2024 retrospectively for activities in 2006 to 2008".

An ESC spokesperson admitted to *The BMJ* that its declarations process was relatively lax in the early 2000s and said that it had been substantially strengthened since. But former ESC vice president Martin said that his attempts to inject more transparency to the process were rejected by the board that included Fox. Martin recalled speaking at a board meeting in 2006, when Fox was president elect, about the need to publicise conflicts of interest, and his proposal being met "with a cool response".

The impact of conflicts of interest on clinicians' objectivity was already well documented in the early 2000s,[11] and under the ethical conduct policies of both the ESC and the UK's General Medical Council, Fox—then a practising clinician—would have been expected to put patients' interests first and to avoid either exposing himself to, or being perceived as exposing himself to, undue influence.[12] "We know that even small sums of money influence behaviour," said Redberg.

Servier told *The BMJ* that it "strictly complies" with transparency guidelines established by the European Federation of Pharmaceutical Industries and Associations, a trade body. In a statement sent to TV 2 in 2024, a Servier spokesperson wrote: "As a cardiologist and leading expert in the field, Kim Fox was paid by Servier to advise on the clinical development of ivabradine and its indications, and to provide feedback on study results, all of which constitute routine practice in scientific collaborations." They did not disclose the amount paid.

The ESC's most recent past president, Franz Weidinger, declined to be interviewed by TV 2, as did the past president who immediately followed Fox, Roberto Ferrari, although the then chair of the clinical practice guidelines committee, Eva Prescott, defended the guidelines process in the documentary. In April 2026, the current president, Thomas Lüscher, agreed to speak to *The BMJ* .

Lüscher, who once worked alongside Fox at London's Royal Brompton Hospital, expressed his shock at the case, but added, "There were always rumours." Fox's ownership of a contract research organisation was not itself a problem, he went on. "The problem was that he was at the same time secretary, then president elect, then president, and even worse, he talked at [industry sponsored] satellite symposia as the president, at our congress. Today this is unthinkable."

Under current ESC rules, an annual income of €10,000 or more from industry related activities renders a person ineligible for a guidelines taskforce.[13] The cap, which includes payments made to spouses and partners, was introduced in 2022. Since 2026, the board's annual industry related activities have been published on the ESC website, although no amounts are given.

Asked if the ESC had followed up on TV 2's allegation that Fox's case wasn't unique, Lüscher said that, as a volunteer run organisation, it lacked the resources to conduct the necessary investigations.

Imperial College London, whose website still hosts Fox's biography and publications, declined to comment on the case, but a spokesperson pointed out that "emeritus professor" was an honorary title that carried no remuneration and that its current conflict of interest policy was introduced in 2011. Lüscher said that he had informed Imperial's leadership of the situation.

The case remains unreported in most of Europe and beyond, even though the ESC's guidelines are influential worldwide. Benoy Shah had not heard of it by March of this year. A cardiologist at Southampton General Hospital in the UK, he and two of his students reported in 2021 that at least 80% of the authors of four key ESC guidelines had a relevant financial conflict of interest.[14] Shah says that the study was inspired by a session he attended at the 2012 ESC congress, where fleetingly shown conflict of interest slides gave him an impression of an unhealthy proximity between presenters of updated guidelines and drug companies whose products featured in those guidelines. "I remember walking out of that session, halfway through, and thinking that this is all just a farce," he said.

Calls for reform

The Fox story also spotlights the questions of whether payment transparency should be voluntary or mandatory and who should be responsible for it. In the US and France, so-called sunshine acts


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require industry to publicly report the exact monetary sums paid to hospitals and healthcare providers.[15, 16] In the UK, a review led by Julia Cumberlege recommended a similar mandatory scheme, but the review's lead researcher, Sonia Macleod of the University of Oxford, said that the government had so far resisted enacting this.[17] "The current impetus in the innovation strategy is not to do anything that they perceive may be damaging to growth," she said. "The life sciences and the pharmaceutical industries are a key element of [the government's] growth strategy." The resistance seems to extend into the community of healthcare professionals, too.

Piotr Ozieranski, a sociologist at the University of Bath who has studied the impact of sunshine acts, told *The BMJ* that, although they didn't seem to have changed doctor behaviour or led to those with conflicts being excluded from decision making, they had enabled greater scrutiny of industry ties by journalists and transparency watchdogs and had knock-on effects on professional bodies.[18–20] Since at least 2021, the American Heart Association and American College of Cardiology—which develop clinical guidelines jointly—have required members of the committees who write those guidelines to disclose the financial value of their relationships with industry. Under their current rules, disclosed payments are reported as "modest" or "significant" depending on which side of a $10,000 threshold they fall.

Some professional societies have taken to publishing authors' financial relationships, reporting dollar amounts in bands.[21] "On balance," said Ozieranski, "industry self-regulation performs worse than disclosure mandated by sunshine acts."[22, 23]

Redberg said that Fox's case "could be the tip of the iceberg". "There's a lot of potential for these kinds of very unsavoury and unprofessional relationships."

European cardiologists, meanwhile, are ruing the damage to their credibility, now that years of rumour and suspicion have been found to have substance. For Martin, the ESC has not done enough to restore public trust, and the recent revelations risk damaging the doctor–patient relationship while also leaving the volunteers who run the society feeling betrayed. He urged action. "The ESC board might be seen as tacitly complicit unless there is a thorough public investigation," he said. "Many questions remain."

Competing interests: I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

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Guideline topic: significance and evidence base

3 questions for Prof. Dr Joachim E. Zöller



Prof. Zöller, how would you define the importance of dental guidelines in day-to-day clinical practice—and where does over-interpretation begin?

Dental guidelines are intended to provide guidance for clinical decision-making. They are designed to ensure that the latest, evidence-based recommendations for diagnosis and treatment are followed.

Over-interpretation occurs when guidelines are viewed as immutable rules rather than evidence-based recommendations. This is because, in many cases, greater consideration needs to be given to individual patient factors than to rigid guidelines.

How do you assess the evidence base for many dental guidelines—particularly in implantology?

The level of evidence for many clinical practice guidelines is not very high, as, for example, prospective, randomised trials are very difficult to conduct. Consequently, whilst there are good RCTs and systematic reviews on specific topics in implantology (e. g. implant materials, surfaces), many guidelines are based on expert opinions, case series or studies with limited sample sizes.

What risks arise when guidelines are primarily consensus-based rather than evidence-based?

If guidelines are primarily consensus-based, there is a risk that they will have low scientific validity, as decisions are then often based solely on expert opinion rather than the best available data. This reduced reliability of the recommendations means that they may lead to overtreatment (e. g. unnecessary procedures), undertreatment or even incorrect treatment.

Final question for you: what reforms would be needed to make the guidelines more robust and relevant to practice?

Firstly, the evaluation procedures should be strictly standardised; all decision-making processes and data sources should be disclosed. This should allow for regular external reviews to take place. Participants would not only have to declare any conflicts of interest but would also be barred from taking part in the process.

Following the drafting of each guideline, consideration should be given to whether additional studies on clinical relevance and cost-effectiveness might be appropriate. Whilst these cannot, of course, form part of a scientific guideline, they may, under certain circumstances, provide important guidance for clinical practice.

Guideline topic: role and misinterpretation

3 questions for Prof. Dr Johann Müller



What role should guidelines play in expert assessments—and what role should they explicitly not play?

Medical reports must be based exclusively on specialist medical standards and the individual clinical findings. If these findings are supported by current guidelines following assessment, the guidelines may also be cited, either on their own or in addition. Relying solely on guidelines would fail to do justice to the individual clinical picture. This is usually more complex than a (single) aspect addressed in a guideline.

Where do you see the most common misinterpretations of guidelines in expert reports or insurance claims procedures?

The most common mistake is to rely (solely) on a guideline without taking a nuanced view of the entire diagnostic and therapeutic process. It is not uncommon for guidelines to be cited that were no longer valid, or had not yet come into force, at the time of treatment. Furthermore, guidelines often contradict one another; this is sometimes not sufficiently acknowledged or explained.

How do you ensure that guidelines do not override the individual clinical context?

Guidelines almost always focus on only one aspect of a complex individual case. As already explained, a detailed assessment of the individual findings by the expert—and frequently also an evaluation of the diagnostic and therapeutic measures taken by the treating and follow-up practitioners, and thus of the entire course of treatment—is crucial. By adopting a standardised and systematic approach to the preparation of the expert report—where necessary, following further consultation or enquiry with the court—it is highly likely that an appropriate assessment will be made in accordance with specialist medical standards.

Final question: what reforms would be needed to make the guidelines more robust and relevant to practice?

Above all, the membership of a guideline group should be restricted to an "expertocracy", and the AWMF's option to delegate voting rights should be abolished. This would most likely raise the standard of clinical and scientific rigour and reduce unnecessary and undesirable sources of influence.

Guideline topic: the role of the BDIZ EDI

3 questions for Christian Berger



How does the BDIZ EDI justify its active involvement in the development of guidelines at the AWMF: what evidence is available to support this, and what are the arguments in favour of a professional association specialising in implantology contributing to this process?

The AWMF guidelines are systematically developed tools to assist doctors and dentists in making decisions in specific situations. They are based on the latest scientific findings and tried-and-tested clinical practices and are designed to ensure greater safety in medicine and dentistry, whilst also taking economic considerations into account. The level of evidence in dentistry and medicine cannot be as high as in mathematics: it would, after all, be ethically unacceptable to deny half of the patients who, for example, need a new hip joint, this operation (randomised!) simply in order to generate more evidence through a "control group". As far as dentistry and implant treatments are concerned, the AWMF also calls on relevant dental scientific societies and professional associations, such as the BDIZ EDI, to cooperate. The BDIZ EDI naturally complies with this request.

The BDIZ EDI first drew up a quality guideline on implantology in 2002 and last updated it in 2019. What role does the BDIZ EDI's quality guideline play in implantology practice?

Describing the quality of implant treatment in a realistic manner has been, and remains, the BDIZ EDI's primary objective for the past 40 years; precisely because the success rates of implant treatments are usually significantly higher than in almost any other medical speciality. However, assessing the quality of dental services is no easy task and is not the same in every case, as each patient differs from the "norm". Our quality guideline is a recommendation and provides dentists specialising in implantology—and, where possible, their patients—with a benchmark that enables both to assess the work carried out. It therefore serves as a tool for self-assessment and self-evaluation. After all, only the treating dentist is familiar with the initial circumstances and the work performed, and knows their patients, including their wishes and problems. Only the dentist and their patient can assess how these contextual factors—which are, in some cases, of crucial importance for any medical procedure—have influenced the treatment outcome in question, whether positively or negatively. The criteria set out are based on the standards of dental science. This quality guideline, published in 2002, was the first attempt to define quality in implantology in Germany; it has been revised several times, further developed in 2019, and will need to be updated in the future as well.

The quality guide provides a list of six quality criteria for implantology procedures: medical history, examination, planning, patient information, prevention during treatment as well as implant surgery and prosthetics. These quality criteria are assessed and reviewed using five evaluation criteria: indication for the planned procedures, the aim of the procedures, risk factors affecting the aim, standards for the procedures to be carried out, and indicators for assessing the results. The quality guideline takes the reader step by step through these quality and assessment criteria and, at the end, provides an overview of the result categorised as A+ to C:

A+	for an outstanding result, no limitations of any kind
A	good, the result one would normally aim for
B	poor, potentially harmful
C	unsatisfactory, alternatives required

Why does the BDIZ EDI publish additional practice-oriented guides, even though formal guidelines already exist, and what specific benefits are these guides intended to bring to your colleagues?

The AWMF guidelines are drawn up in Germany; they take considerably longer than 12 months to produce and must be updated every four to five years. The European guidelines published by the BDIZ EDI address a specific topic each year that may—or may not—have already been covered in an AWMF guideline years ago. We develop these guidelines in collaboration with our European partner organisations and experts worldwide much more quickly, concisely and with a closer focus—both on research and on day-to-day practice—than would be possible with a national guideline. Nevertheless, the treating dentist receives important information that extends beyond national borders and can rely on it to provide their patients with the most up-to-date and best possible care.

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20th BDIZ EDI Europe Symposium in Tirana, Albania

Anniversary congress

Last year, Athens demonstrated just how powerful a European dialogue can be. Now all eyes are on Albania: the BDIZ EDI is hosting the 20th Europe Symposium—an anniversary event which will take place in Tirana on 23 and 24 April 2027 and will once again bring the European implantology community together.

A symposium marking a new beginning

Tirana, a city brimming with dynamism, youthful energy and cultural diversity, provides the ideal setting for this anniversary. In recent years, the Albanian capital has developed into a vibrant hub in South-Eastern Europe—modern, open and curious. It is precisely this atmosphere that the BDIZ EDI wishes to harness to further strengthen European cooperation in implantology.

Academic depth and European perspectives

The programme for the 20th European Symposium will once again address the topics shaping implantology in Europe:

- Digital workflows and AI-assisted diagnostics
- Hard- and soft-tissue management in everyday clinical practice
- Long-term stability of implants
- European regulatory developments and professional policy challenges
- Strategies for sustainable, evidence-based implant treatment

Renowned speakers from across Europe will present the latest research findings, discuss clinical decision-making processes and provide fresh insights for daily practice. The international mix of speakers and participants once again makes the symposium a forum where the transfer of knowledge and collegial exchange take centre stage.

Thinking about Europe—shaping implantology

The BDIZ EDI has always viewed the Europe Symposium as a platform that goes beyond the purely scientific. In Tirana, too, the European ideal is evident: common standards, shared responsibility, and joint development. This anniversary edition aims to emphasise this ethos even more strongly—with sessions focusing on European professional policy and discussions highlighting the role of implantology in the context of modern, patient-centred dentistry.

Atmosphere, dialogue, interaction

Between the academic sessions, the symposium provides an opportunity for personal discussions, forging new contacts and establishing international collaborations. Tirana, with its vibrant culinary scene, its youthful cultural scene and its warm hospitality, provides a special setting for this. Participants can look forward to an event that combines professional excellence with an inspiring atmosphere.

Invitation to Tirana

With its 20th European Symposium, the BDIZ EDI is setting an example: for quality, for European cooperation and for the future of implantology. Tirana will become the meeting place for a community that is advancing oral medicine with passion and a sense of responsibility.

The BDIZ EDI looks forward to welcoming its members, partners and colleagues working in the field of implantology to Albania on 23 and 24 April 2027—for an anniversary event that keeps the European spirit alive and showcases implantology in all its diversity.

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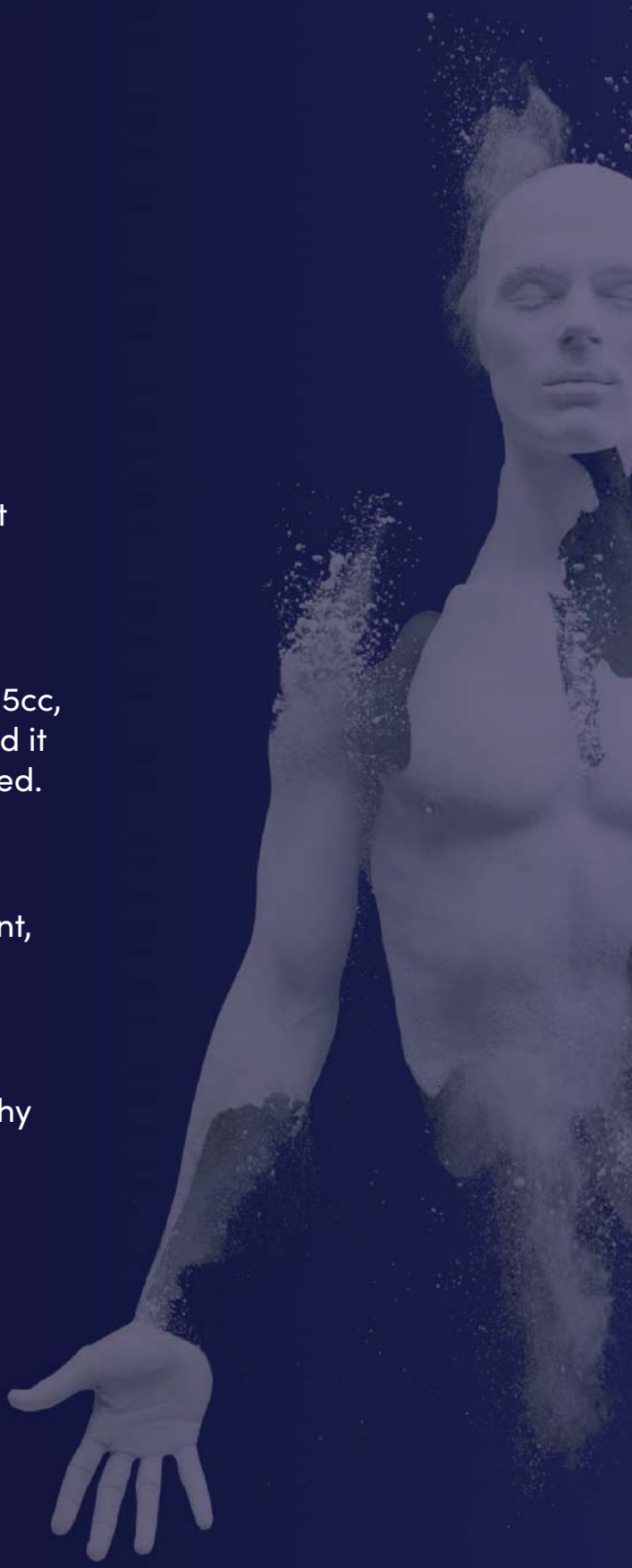
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European Federation of Periodontology (EFP) guideline

Management of acute periodontal conditions

The EFP has published a new guideline offering clinicians a structured approach to the diagnosis and management of acute periodontal conditions, where timely treatment is crucial to control pain, infection and rapid tissue destruction.

The EFP S2k level clinical practice guideline, published in the *Journal of Clinical Periodontology*, addresses three conditions defined within the 2018 classification of periodontal and peri-implant diseases and conditions: necrotising periodontal diseases, periodontal abscesses and endodontic-periodontal lesions.

Unlike many chronic forms of periodontal diseases, acute periodontal conditions are characterised by rapid onset and may involve pain symptoms ranging from discomfort to intense pain, and are characterised by rapid onset, rapid destruction of periodontal tissues, and risk of progression, extension and/or dissemination. Patients presenting with these conditions therefore require prompt diagnosis and immediately implemented appropriate treatment.

The new guideline provides clinicians with a clear framework organised around three successive steps:

1. Confirm the diagnosis, using the case definitions established by the 2018 classification.
2. Control the acute condition, including pain and active tissue destruction, through appropriate initial treatment.
3. Provide subsequent treatment, to manage underlying pre-existing conditions, reduce the risk of recurrence and control potential sequelae of the acute episode.

The guideline was developed following a rigorous process that included two commissioned systematic reviews which assessed the available evidence, to help in formulating specific recommendations, followed by a structured consensus process involving experts in the field and a broad range of stakeholders. In some areas scientific evidence was limited, so recommendations combine the best available evidence with structured expert consensus, leading to a guideline at S2k level.

"Acute periodontal conditions have a rapid onset and are usually painful, but the most important features are rapid tissue destruction and risk of progression and dissemination, which can even make them life-threatening (e. g., necrotising periodontal diseases in children with severe and chronic compromise of the immune system), so clinicians need clear guidance to help them make appropriate decisions without delay," said Professor David Herrera, first author of the publication. "This guideline brings together the available evidence and expert consensus in a practical stepwise approach, from accurate diagnosis and control of the acute episode, through to management of the underlying pre-existing condition and prevention of recurrence."

The guideline is an outcome of the 21st European Workshop on Periodontogy, held in November 2025, which focused on clinical guidelines for gingival diseases and acute periodontal conditions. It builds on the EFP programme of evidence-based clinical practice guidelines which already includes recommendations for the treatment of periodontitis in stages I–III (Sanz et al. 2020), and in stage IV (Herrera et al. 2022), as well as the prevention and treatment of peri-implant diseases (Herrera et al. 2023).

EFP President Mia Rakić said: "Providing dental professionals with robust, practical guidance that can be applied in everyday clinical care is a fundamental part of the EFP mission. With this new guideline, we address conditions that require rapid and well-informed clinical decisions, helping us deliver timely, consistent and effective care for our patients."

ABSTRACT

Background

The European Federation of Periodontology (EFP) has developed Clinical Practice Guidelines (CPGs) for the treatment of periodontitis and for the management of peri-implant diseases. In accordance with the 2018 classification, acute periodontal conditions are characterised by rapid-onset pain or discomfort, tissue destruction and infection. Therefore, the development of a CPG to guide patients and clinicians in their management is justified.

Aim

To develop an S2k-level CPG for the management of acute periodontal conditions, necrotising periodontal diseases, periodontal abscesses and acute manifestations of endodontic–periodontal lesions.

Methods

This S2k-level CPG was developed by the EFP, following methodological guidance from the Association of Scientific Medical Societies in Germany and the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) process. A rigorous and transparent process included synthesis of relevant research in two commissioned systematic reviews, evaluation of the quality and strength of evidence, formulation of specific recommendations and a structured consensus process involving leading experts and a broad base of stakeholders. Recommendations were based on the best available evidence, combined with structured expert consensus, particularly in areas where direct evidence remains scarce.

Results

The S2k-level CPG for the management of acute periodontal conditions presents a structured approach, grouping the recommendations in three successive steps: (1) confirming diagnosis, following the case definitions of the 2018 classification; (2) initial treatment, to control the acute condition including pain and active tissue destruction; and (3) subsequent treatments, to manage the pre-existing conditions and prevent the risk of disease recurrence and/or control the potential sequelae.

Conclusion

The present S2k-level CPG informs clinical practice, health systems, policymakers and, indirectly, the public on the available and most effective interventions in the management of acute periodontal conditions.

Source: https://doi.org/10.1111/jcpe.70166Digital Object Identifier (DOI), first published 9 September 2026





BDIZ EDI board meets in Alsace

Setting a strategic course

The board of the BDIZ EDI met for a two-day session in Wissembourg to further develop the association's key projects and define its strategic direction for the coming months. The meeting served both to coordinate professional matters and to assess the association's position within the broader landscape of professional policy—two areas that have traditionally been closely linked for the BDIZ EDI.

Focus on curricula: structure, quality, and practical relevance

A key focus of the meeting was on the association's three major professional development programmes, which are set to launch in the coming months:

- Court-appointed & private expert reports: starting in October in Munich
- Southern Curriculum Implantology: starting mid-September in Ansbach
- Curriculum Implantology Cologne: the well-established classic, starting in November at the University of Cologne

All three programmes share a common goal: to provide structured, high-quality, and practice-oriented continuing education that equips dentists with both professional confidence and expertise in the field of expert assessment. The board emphasised the importance of a consistent didactic approach and clear guidelines—particularly for the new curriculum for expert assessors, which is intended to play a central role in the BDIZ EDI's continuing education portfolio in the future.

Professional policy issues: clear positions and consistent representation

In addition to continuing education projects, several professional policy issues were on the agenda. The BDIZ EDI reaffirmed its position regarding the ongoing lawsuit against the Federal Ministry of Health concerning the GOZ (German Fee Schedule for Dentists). This legal action remains a key priority for the association; the plaintiffs—six dentists, four of whom are affiliated with the BDIZ EDI—are seeking equal treatment for all dentists in accordance with Section 15 of the Dentistry Act (Zahnheilkundegesetz) and are challenging the failure to increase the GOZ point value, which has remained stagnant for decades. There are, however, no new developments to report from the Administrative Court of Berlin.

There was also intensive discussion regarding the impending GeDIG—the Act on Data and Digital Innovation in the Healthcare Sector. The board analysed the potential impact on dental practice and professional autonomy, formulating clear requirements concerning transparency, data protection, and practical applicability. In this context, the BDIZ EDI legal counsel examines the proposed legislation in the "Law" section.

To continue providing practical support to its members, the BDIZ EDI is planning additional webinars on legal matters and billing. These are intended to address current developments and offer concrete recommendations for day-to-day clinical practice.

Conclusion: tasks for the coming months

The board meeting in Alsace issued clear mandates regarding professional development, quality assurance, and representation of professional policy interests. The focus on structured curricula and an in-depth engagement with professional policy challenges demonstrate that the BDIZ EDI remains centred on the key pillars of its work.

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 will be taking place in Stockholm, Sweden.

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.

AWU



22nd Expert Symposium in Cologne: 6 and 7 February 2027

Insufficient bone volume—what can be done?

The treatment of patients with limited bone volume is one of the most demanding challenges in modern implantology. The question of whether bone augmentation is necessary, or whether short or reduced-diameter implants represent the better alternative, has been the subject of intense debate for years. The 22nd Expert Symposium in Cologne will address this topic on 6 and 7 February 2027, making it the focal point of its scientific programme.

Under the working title "Insufficient bone volume—what can be done?", the symposium addresses one of the key issues in implant treatment planning: how can a treatment approach be found that is both successful in the long term and gentle on the patient in cases of compromised bone conditions? The latest scientific findings, clinical experience and new therapeutic concepts will be examined from a variety of perspectives. The discussion covers both established augmentation techniques and the possibilities, limitations and long-term outcomes of short implants. This is based on the latest developments in science and clinical practice.

Participants can expect a comprehensive overview of modern concepts in bone augmentation, a detailed examination of indications, biomechanical aspects of short implants, and the latest long-term results from clinical practice. The focus is on evidence-based decision-making criteria, patient-centred treatment concepts and the critical evaluation of established treatment principles. The aim is to provide participants with practical guidance for their day-to-day practice and to facilitate decision-making in complex implantology cases. The scientific discussion, chaired by Prof. Joachim Zöller, is specifically designed to promote open, collegial exchange and to bring to-



gether different approaches to solutions. This approach aims to prioritise the question of meaningful criteria for choosing between augmentation and short implants, as well as the combination of both treatment options in the best interests of patients.

Practical guideline 2027

A key focus of the Cologne symposium will be the presentation of the new practical guideline from the European Consensus Conference (EuCC). The revised EuCC guideline is intended to provide clinicians with structured guidance on assessing available bone stock. For the first time, an ABC score for differential diagnosis will be presented. This classification system is designed to simplify clinical assessment and enable a clear correlation with different treatment strategies. The aim is to provide standardised, scientifically sound and, at the same time, practical support for treatment planning.

With its interdisciplinary approach, cutting-edge topics and close link to everyday clinical practice, the 22nd Expert Symposium continues the tradition of successful expert meetings. Cologne will thus once again become the meeting place in early 2027 for dentists specialising in implantology, oral surgeons, maxillofacial surgeons and scientists who wish to discuss and shape the future of treatment for patients with limited bone volume. Hands-on workshops will be offered on Saturday, and on Sunday evening it will once again be "Kölle Alaaf" at the Sunday session of the "Grosse von 1823", to which their President, Prof. Dr Joachim E. Zöller, invites the participants.

Cologne in celebration mode: science meets carnival

Anyone visiting Cologne in early February 2027 will not only experience top-class continuing professional development in implantology but also get to see the city at its most distinctive. The 22nd Expert Symposium takes place during the peak of the Cologne Carnival, when the cathedral city showcases its famous Rhineland attitude in particularly impressive style.

This offers participants a rare opportunity: during the day, the focus is on the latest scientific findings, in-depth specialist discussions and practice-oriented concepts. Once the scientific programme has concluded, the door opens to one of Germany's most time-honoured cultural events.

A particular highlight is the invitation to the final Sunday session of the "Grosse von 1823 Karnevalsgesellschaft e.V. Köln" at the historic Gürzenich. This society is the oldest and ranks among Cologne's most renowned carnival societies. The session in the festively decorated Gürzenich brings together speakers, music groups, dance troupes and Cologne's zest for life to create an extraordinary experience that is renowned far beyond the region.

In this way, the symposium uniquely combines academic excellence with a cultural programme that can only be experienced in Cologne: inspiring days in a city that reveals its very special character during the carnival.

At a glance



22nd Expert Symposium Cologne

Insufficient bone volume—what can be done?
Workshops on Saturday—up to 8 CME credits
Symposium on Sunday—8 CME credits

Date: 6 to 8 February 2027
Venue: Cologne,
Hotel Mondial am Dom

Launching in November in Cologne

A curriculum that sets new standards



The 28th Curriculum Implantology, one of the most prestigious implantology training programmes in the German-speaking world, began in Cologne on 6 and 7 November. Spanning eight modules spread over weekends, the BDIZ EDI curriculum—in collaboration with the University of Cologne—offers a comprehensive, practice-oriented and scientifically sound training programme for dentists who wish to systematically expand their expertise in implantology.

Prof. Dr Dr J. E. Zöller traditionally opens the implantology course at the University of Cologne.



As team leader, Prof. Dr H.-J. Nickenig guides the participants through the eight modules.



Successful completion of the 27th Curriculum Implantology in Cologne by the participants, with team leader Prof. Nickenig (right).

Prof. Nickenig, M.Sc., has updated and further refined the programme for the new series—with a clear structure, up-to-date content and a strong focus on digital and minimally invasive techniques.

A curriculum that covers the entire field of implantology

The Cologne Curriculum has been a benchmark of quality for many years. It offers a comprehensive, seamless programme ranging from the fundamentals through diagnostics and prosthetics to complex augmentation procedures and the management of complications. The leaflet states: "The modules build systematically on one another, so that participants […] receive a comprehensive, integrated package of implantology training for their practice."

Participants are guided by the scientific director, Prof. Zöller, and team leader Prof. Nickenig, alongside renowned guest speakers from the fields of surgery, prosthetics and dental technology.

An overview of the eight modules

Module 1: Fundamentals of implantology (6–7 November 2026)

The introductory section covers the basics: diagnosis, patient education, preimplant risk assessment using the Cologne Risk Score, and the Cologne Defect Classification.

Module 2: Indications, diagnostics & case management (27–28 November 2026)

The central element is the standard implant protocol, including a demonstration and workshop. This is complemented by indication classes, monitoring and emergency management.

Optional: Combined course CBCT specialist training & X-ray refresher course (5 December 2026)

An additional module for radiological expertise—integrated into a combined course for the first time.

Module 3: Implant systems & 3D diagnostics (22–23 January 2027)

Comparison of different implant systems, 3D case demonstrations, digital planning, surgical guides and STL-based workflows.

Module 4: Implant prosthetics I & minimally invasive procedures (19–20 February 2027)

From fixed dentures to flapless surgery, modified bone splitting and 3D-guided sinus floor elevation.

Module 5: Augmentation I (12–13 March 2027)

Sinus floor elevation, immediate implantation and customised bone regeneration (CBR). The workshop covers bone splitting and sinus floor elevation using calf ribs via piezosurgery.

Module 6: Implant prosthetics II & soft-tissue management (9–10 April 2027)

Intensive training in soft-tissue techniques, exposure procedures, removable dentures and connecting elements. On Saturday, there will be an intensive soft-tissue training session using a pig's jaw.

Optional: Combined course, part 2 (17 April 2027)

Continuation of the CBCT specialist training and X-ray refresher course.

Module 7: Augmentation II & distraction (18–19 June 2027)

Advanced augmentation techniques, iliac crest grafting, distraction osteogenesis and complex anterior tooth replacement. The workshop takes the form of a course using human specimens—a unique feature of the curriculum.

Module 8: Recall, complications & future prospects (2–3 July 2027)

Treatment of peri-implantitis, implant removal, crisis management and a look at the future of implantology. Final examination with a case presentation and certificate ceremony.

Practical relevance as a guiding principle

The workshops are a key element of the curriculum. They provide an opportunity to practise the techniques learnt first-hand—from digital planning and piezosurgery to soft-tissue management and complex augmentations. The accompanying workshops facilitate subsequent training in implant surgery and prosthetics. Live surgeries and the opportunity to present one's own cases further enhance the practical value of the course.

Digital, modern, scientifically sound

The updated programme consistently incorporates modern technologies:

- 3D-guided surgery
- Surgical guides
- Integration of 3D printing
- Digital impression-taking
- CAD/CAM technologies for bone regeneration

The curriculum thus reflects the current standards in implantology—and prepares participants for the future.

Conclusion

The BDIZ EDI's 28th Curriculum Implantology offers a structured, practice-oriented and scientifically excellent continuing professional development programme. A new cycle started on 6 and 7 November 2026, catering for both beginners and experienced implantologists and guiding them through eight modules.

Anyone looking for a programme that combines clinical practice, science and modern digital implantology will find a course in Cologne that has stood the test of time—and will once again set new standards in 2026/2027.

FDI World Dental Congress in Prague

Strong in terms of content

The FDI World Dental Congress 2026 in Prague proved to be one of the most substantive scientific congresses of recent years. With a wide range of lectures, workshops and discussion formats, the FDI placed a clear emphasis on evidence-based dentistry, prevention and global quality of care. The scientific sessions reflected the key challenges facing modern dentistry—from materials science and prevention to digital transformation and global public health.





The BDIZ EDI had organised a lunch meeting on the fringes of the FDI Congress at the O_2 Arena in Prague. An exchange between BDIZ EDI President Christian Berger and the President of the Czech Dental Chamber, Dr Roman Šmucler—which was significant from a European perspective—was just one of the discussions at the meeting, which was characterised above all by the participation of many young dentists from all over the world. Another meeting took place with the President of the Croatian Dental Chamber, Dr Hvroje Pezo. Also present were Dr Erion Cerekja from Albania and Dr Wolfgang Neumann, a member of the BDIZ EDI Executive Board.

The 2026 FDI World Dental Congress brought together dentists, researchers and policy-makers from around the world. The scientific programme, developed in collaboration between the FDI, the Czech Dental Chamber and scientific and clinical experts from all fields of dentistry, covered both established clinical disciplines and current areas of development and topics of professional relevance, such as artificial intelligence (AI), digital technologies and workflows, advanced surgical technologies, prevention and sustainability. Responsible for the content: the chairs of the scientific programme, Prof. Falk Schwendicke, Germany, and Dr Roman Šmucler, president of the Czech dental chamber, supported by Dr Antonio Estrada from Venezuela, a member of the FDI Education Committee.

Programme coordinators: Schwendicke and Šmucler

Prof. Schwendicke was responsible for the programme's structure—with a focus on, amongst other things, AI diagnostics, digital dentistry and clinical evidence—as well as for the involvement of international experts. He is regarded as one of the most prominent German scientists in the field of digital dentistry on the international stage and played a key role in shaping the European perspective within the programme.

The president of the host Dental Chamber, Dr Roman Šmucler, was responsible for setting the regional priorities and integrating local expertise and helped to

shape the clinical and surgical sessions. Šmucler represented the European host perspective and ensured the integration of international and regional content.

Focus: evidence-based treatment and minimally invasive dentistry

A key area of the scientific programme was the further development of minimally invasive treatment approaches. In this regard, the FDI presented the new MIICM policy paper, which lays the scientific foundation for tooth-preserving caries treatment.

Key topics centred on remineralisation as an alternative to invasive procedures, new diagnostic methods for the early detection of caries, and clinical evidence regarding non-invasive and micro-invasive techniques. The sessions clearly demonstrated that minimally invasive dentistry is not merely a trend, but a global paradigm shift.

Focus: radiation protection and digital imaging

With its new FDI Statement on Radiation Safety in Dentistry, the organisation has placed the spotlight on safety in radiological diagnostics. Topics discussed included: the ALARA principle and its practical implementation, quality control of digital imaging systems, AI-assisted image analysis, and radiation protection in paediatric dentistry. The scientific presentations made it clear that digitalisation and safety must be considered together.

Focus: materials science and bisphenol A

Another key focus was the assessment of dental materials—in particular, the debate surrounding bisphenol A. Key topics included: the latest evidence on BPA exposure, alternative materials and their clinical performance, regulatory developments in various regions of the world, and communicating the risks associated with these materials to patients. The FDI aims to send a strong message in support of transparency and patient safety.



Focus: prevention and lifelong oral health

The scientific programme drew on the content of the new "Lifelong Oral Health" statement and highlighted the importance of preventive strategies across all stages of life. Topics discussed included prevention in early childhood, oral health in older people and in care homes, interdisciplinary care approaches, health literacy and public health strategies. There was a particularly strong focus on international public health contributions, which shed light on global differences and challenges.

Focus: training and academic integrity

With two further policy documents, the FDI set clear scientific standards: "Basic Dental Education" and "Research and Scientific Integrity". The focus was on competence-based curricula, quality assurance in teaching, integrity in research and publication, the handling of conflicts of interest, and requirements regarding study design and data quality. The sessions demonstrated that the FDI regards the scientific credibility of dentistry as a strategic issue for the future.

International trends in research

The poster sessions provided a broad overview of current research: biomaterials and adhesive technologies, AI-assisted diagnostics, epidemiological studies on global oral health, implantology and peri-implantitis management, and prevention programmes in resource-limited countries. The strong presence of young scientists, who are increasingly shaping the international research landscape, was particularly striking.

Conclusion

The scientific programme of the 2026 FDI Congress showcased a field of dentistry clearly guided by evidence, prevention and global responsibility. The six new FDI policy papers provide the framework for the coming years—and the scientific sessions made it clear that the international dental community is ready to continue along this path with determination.





FDI Congress in Prague—political work

Guiding principles for international standards

At its general assembly in Prague in 2026, the FDI World Dental Federation adopted new policy statements and further developed existing ones. These set out professional guidelines for training, prevention, materials science, radiation protection and scientific integrity. The documents form the basis for international standards and serve as a guide for national associations in formulating their own positions.

1. Basic Dental Education

The FDI sets out global minimum standards for dental education. The focus is on competence-based curricula, a foundation in scientific knowledge and training structures that ensure patient safety. The statement is intended to contribute to the harmonisation of training standards worldwide.

2. Bisphenol A

The paper assesses the risks posed by bisphenol A in dental materials and calls for exposure to be minimised. The FDI recommends safe alternatives, clear regulatory guidelines and transparent communication with patients.

3. Lifelong Oral Health

Oral health is defined as a lifelong process. The statement emphasises prevention, health literacy and the integration of dentistry into interdisciplinary care approaches—from childhood through to old age.

4. Minimally Invasive Intervention for Caries Management (MIICM)

The FDI sets out principles for minimally invasive caries treatment: evidence-based diagnosis, remineralisation, patient-centred treatment and clear indications. The statement reinforces the shift towards preventive and tissue-preserving treatment.

5. Radiation Safety in Dentistry

Updated standards on radiation protection in dentistry. The FDI emphasises the ALARA principle, the importance of digital imaging, quality control and the responsibility of dental practices to ensure safe procedures.

6. Research and Scientific Integrity in Oral Health

The statement sets out requirements regarding scientific quality and transparency: sound study design, data integrity, the handling of conflicts of interest and publication ethics. The aim is to strengthen trustworthy research in the dental sector.

Conclusion

The 2026 policy statements set out a clear vision for modern, evidence-based and patient-centred dentistry. They address key issues for the future—ranging from training and prevention to materials and radiation protection—and strengthen the scientific credibility of global dentistry.





FDI membership trends

Growth of strategic importance

The FDI's membership trends can be clearly traced from the official annual reports for 2024 and 2025: the FDI is growing steadily, both in terms of the number of National Dental Associations (NDAs—dental unions or associations) and the geographical spread of its members.

Overall development

The FDI comprises National Dental Associations (Regular Members), Affiliate Members and Corporate Members. According to the FDI annual report 2024, the organisation comprises 111 NDAs from 101 countries that have submitted their NLO reports. This demonstrates a stable and globally widespread membership base. In the 2025 annual report, membership is once again highlighted as a key driver of growth, with ongoing new admissions and a strong global presence.

Regional distribution

The FDI covers all regions of the world. The NLO Reports 2025 list the NDAs by region and show a broad distribution:

- Africa: 16 NDAs
- Asia-Pacific: over 25 NDAs
- Europe: strong and stable membership
- Latin & North America: complete regional coverage. This regional diversity is a core component of the FDI's global representation.

New admissions (2024–2026)

The FDI admits new NDAs every year. A clear trend has emerged from the general assemblies of recent years:

- 2024: several new NDAs (details in the Governance chapter of the Annual Report)
- 2025: further admissions, including from Africa and Asia
- 2026 (Prague):
- Zambia Dental Association
- Association Nationale des Chirurgiens–Dentistes du Cameroun
- Association Dentaire Malagasy
- Sierra Leone Medical and Dental Association
- Kuwait Dental Association
- and the International Organisation for Forensic Odonto-Stomatology as an affiliate member

Strategic importance

The annual reports highlight three trends: growth in Africa and Asia—these regions are reporting rising numbers of NDAs and increasing activity; stable membership in Europe and North America, characterised by a high degree of continuity and strong political engagement; and increasing global connectivity, with more NDAs participating in FDI programmes, advocacy and policy processes. The FDI regards its members as its "greatest strength" and is strategically expanding its global reach, as highlighted in the 2024 annual report.

Conclusion

According to its own figures, the FDI has seen a steady increase in the number of NDAs, particularly in Africa and Asia, stable membership in established regions, regular admissions at each general assembly, and growing participation by members in programmes, projects and global advocacy. According to a statement, the FDI is strengthening its role as the world's leading voice in dentistry.



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European Regional Organisation (ERO) in Prague

Focus on the code of ethics and digitalisation

The FDI's European Regional Organisation (ERO) adopted or rather initiated key professional policy and strategic decisions during the FDI World Dental Congress 2026 in Prague. The most significant outcome of the plenary assembly is the new code of ethics, which defines common professional ethical standards for the European dental profession and is intended to serve as a framework of reference for national associations in future.

Another key focus was on digitalisation and the use of artificial intelligence. The relevant working group presented the results of its work to date and received broad support for a European AI education and guidelines project, which is intended to structure the practical application of AI in dentistry and align it with the requirements of the EU AI Act. A formal decision has yet to be taken, but the direction of the project is clearly set out.

In addition, the ERO presented an updated edition of the EU Manual of Dental Practice, which comprehensively documents the professional framework for dentistry in Europe.

The organisation also announced an intensification of cooperation with European and international partners, including the European Dental Students' Association (EDSA) and the ESDE.

The ERO is thus strengthening its role as the European voice of dentistry and aims to set a clear course for ethics, digitalisation and the harmonisation of professional policy.

New leaders

Dr Edoardo Cavallé from Italy was appointed as the new president of the ERO back in June in Almaty. He succeeded MUDr Simona Dianišková, Ph.D., MPH, from Slovakia, whose term in office was characterised by close communication with key European institutions such as the CED in Brussels and the FDI. Prof. Dr Paula Perlea from Bucharest was elected as the new president of the ERO for the period 2028–2031. Other members of the executive board include Dr Doris Seiz from Germany, who serves as secretary-general. She is responsible for operational management, organising the plenary assembly and coordinating the working groups. Dr Oleg Gladkov from Bulgaria, as treasurer, is responsible for financial management and budget planning. Furthermore, Dr Ariel Slutsky from Israel, as a member of the ERO executive board, is responsible for liaising between the executive board and the member associations.

The ERO executive board has a European focus—with strong German representation (secretary-general and secretariat) and broad regional representation from Italy, Romania, Bulgaria and Israel. Its composition reflects the ERO's strategic direction: European networking, harmonisation of professional policy and the modernisation of dentistry.

BDIZ EDI

European Association of Dental Implantologists

Bundesverband der implantologisch tätigen Zahnärzte in Europa e.V.

22. EXPERT SYMPOSIUM OF BDIZ EDI

MANAGING REDUCED BONE VOLUME: HOW TO PROCEED?



SAVE THE DATE

06. – 08. FEBRUARY 2027

IN COLOGNE/GERMANY

Attend **CONGRESS, WORKSHOPS & experience CARNIVAL!**

The 22nd Expert Symposium will take place on Carnival Sunday. This offers the opportunity to experience Cologne's final Carnival session of the season at the Gürzenich with the stars of Cologne Carnival.

More information

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Study at King's College London

Fasting reduces periodontitis

Researchers at King's College London have investigated the extent to which a fasting-like diet can have a positive effect on gum diseases such as periodontitis. Whilst standard treatment focuses on cleaning infected areas around the teeth, researchers are increasingly investigating whether diet can play a role in improving outcomes. Fasting is associated with reduced inflammation in the body. This study establishes a link with gum disease for the first time. The findings offer new insights into the close interconnection between oral and general health. People who follow a short-term low-calorie diet may have reduced levels of inflammatory markers associated with gum disease. The study involved 28 patients from various hospitals in Spain, divided into two groups: those who followed a five-day restrictive diet, compared with a control group who continued their usual diet. Patients who fasted consumed 1,100 calories for two days, then 750 calories for three days. On the sixth day, more calories were gradually introduced in the form of soft foods—then their diet returned to normal on the seventh day. This cycle was repeated three times over a six-month period, with patients reporting that the diet was easy to follow. After six months, samples from the patients were analysed. Those who fasted moderately had reduced markers of inflammation in blood and gum tissue samples compared with those whose diet remained unchanged, including lower levels of C-reactive protein, a general indicator of inflammation in the body. The fasting group also showed a reduction in molecules specifically associated with inflammation in the gums compared with controls. "Our study suggests that lifestyle changes, alongside proper tooth brushing, could be important for patients," said lead author Prof. Luigi Nibali of King's College London. The study was published in the *Journal of Clinical Periodontology (JCP)* and builds on many years of research by King's College London investigating the link between gum disease and general health.

Sources: zm-online, JCP

General Court (European Union)

Change of President

Following the early departure of Marc van der Woude from the office of President of the General Court of the European Union, Savvas Papasavvas has been elected by his fellow judges as President of the General Court for the remainder of the term of office, i.e. from 16 September 2026 to 31 August 2028. Savvas S. Papasavvas was born in Nicosia (Cyprus) in 1969. In 1991, he obtained a degree (Ptychion) from the Faculty of Law of the Ethniko kai Kapodistriako Panepistimio Athinon (National and Kapodistrian University of Athens, Greece). As part of his postgraduate studies, he obtained a Diplôme d'études approfondies (DEA) in public law from the Université de Paris II (France) in 1992 and a Doctor of Laws from the Université d'Aix-Marseille III (France) in 1995. In 1993, he was admitted to the bar in Cyprus (Nicosia Bar Association). He practised as a solicitor until he was appointed a judge at the General Court of the European Union in 2004.

He also devoted himself to teaching, serving as a lecturer from 1997 to 2002 and as a senior lecturer in constitutional law from 2002 to 2004 at the Panepistimio Kyprou (University of Cyprus). Savvas S. Papasavvas was appointed a judge at the General Court on 12 May 2004 and served as president of a chamber for two consecutive terms, from 15 September 2010 to 25 September 2016. He was elected vice-president by his fellow judges on 27 September 2019 and held that office until his election as President of the Court.

Source: Court of Justice of the European Union

Pilot project in France

Head to the pharmacy with toothache

In France, pharmacies in certain areas are to support dental care as part of a pilot project. In accordance with a set protocol, they are to dispense painkillers and antibiotics. The dispensing of antibiotics and stronger painkillers is permitted only to trained pharmacists and only in certain regions of France. In two French departments, access to dental care is becoming increasingly difficult. Consequently, as part of a new care model, selected pharmacies in these areas will now be able to carry out a standardised initial assessment for certain conditions and dispense appropriate painkillers and, where necessary, antibiotics in accordance with a set protocol. The pharmacists authorised to do so have previously been trained by dentists. This has been possible since the beginning of June for non-severe conditions such as inflammation of the dental pulp (pulpitis, colloquially known as a tooth nerve infection), problems relating to a wisdom tooth, or abscesses. If an antibiotic is required, amoxicillin is prescribed as standard treatment; clindamycin is prescribed in cases of penicillin allergy. There are also exclusion criteria specifying when pharmacists are not permitted to prescribe antibiotics. Participation by pharmacies is voluntary. So far, 12 pharmacies in the centrally located department of Creuse and 25 in the department of Drôme in south-eastern France are taking part. Local media reports for Creuse state that there is a shortage of GPs and dentists. In the first month alone, 28 patients there had already made use of the new service. Work on the protocol, which was approved by the regional health authority, took over a year. It was based on protocols that already enable pharmacists in France to provide better care for urinary tract infections and tonsillitis.

Source: Pharmazeutische Zeitung

Preventive healthcare

AI in early cancer diagnosis

Several European research projects are working to detect cancer risks at an earlier stage with the help of AI. At Hanover Medical School, the "ROKAVI" project is investigating whether AI models can be developed from health insurance data to predict individual cancer risks and enable more targeted preventive measures.

In the ROKAVI project, the researchers are first identifying which types of cancer—such as prostate, breast, lung or bowel cancer—are particularly well suited to a predictive model. They then develop a traditional statistical model and an innovative model based on artificial intelligence (AI) for a selected type of cancer. The impetus for the project came from the Gesundheitsdatennutzungsgesetz (GDNG, Health Data Use Act), which came into force in 2024. It allows statutory health insurance funds to use routine data to inform insured persons about their individual health risks. Cancer is a key area of this data-driven health prevention.

Source: DeutschesGesundheitsPortal

Horizon Europe project

Virtual twins in development

The Horizon Europe project is developing virtual twins for personalised clinical care. Whilst the focus is not on dentistry, the underlying technologies for individual patient modelling could also become relevant in the future for implantology, orthodontics or surgical planning. Virtual human twins hold great potential for promoting health innovation and personalised care—a priority for the EU. According to the European Commission, this will accelerate tangible benefits for citizens and patients whilst securing and expanding the EU's leadership in science and technology. Virtual human twins already exist in many EU countries. The scientific community, large-scale industry and innovative SMEs have already developed various versions. However, although the number of stakeholders interested in VHTs is growing, the ecosystem in the EU remains highly fragmented. As part of the European Virtual Human Twins Initiative, the Commission intends to strengthen advanced supercomputing capabilities and artificial intelligence to facilitate joint research and technology development in the field of VHTs. This will make it possible to develop, operate and better simulate the models in ways that were previously impossible, thereby accelerating the development of VHTs by enabling the training of large AI foundation models specifically for human health and diseases.

Source: European Commission press release



Key rulings by the European Court of Justice

Three rulings that dentists should be aware of

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Case law from the European Court of Justice (ECJ) rarely affects dentists directly. Nevertheless, several recent rulings have implications for day-to-day practice, particularly in relation to data protection, digitalisation and patient communication.

1. Health data: the ECJ interprets the term broadly

The European Court of Justice is adopting an increasingly broad interpretation of health data. Health data is not limited to diagnoses, medical findings or treatment plans; other information may also be included if it allows conclusions to be drawn about a person's state of health.

For dental practices and ambulatory health care centres, this means that digital appointment booking systems, patient portals, recall systems and AI applications should not be hastily classified as unproblematic under data protection law. The requirements for the processing of sensitive data are becoming increasingly stringent.

2. Data protection is becoming a competitive issue

A ruling by the European Court of Justice (ECJ) on the online sale of medicines deserves particular attention. The Court found that such orders may involve health data and that data protection breaches can, in principle, also be addressed under competition law.

Although the decision concerns pharmacies, its significance extends beyond this: in future, data protection may not only be the subject of supervisory proceedings, but also of disputes between competitors.

Ambulatory health care centres (MVZs) and larger practice networks with extensive digital services should therefore not view data protection solely as a compliance issue.

3. Strict requirements regarding the handling of patient data

The ECJ has also clarified that, when processing health data, both the specific requirements for sensitive data and the general data protection requirements must always be met.

For medical practices and ambulatory health care centres, this brings issues of internal organisation more sharply into focus:

- Who is authorised to access which patient information?
- Are role and authorisation frameworks adequately documented?
- Is access logged in a traceable manner?
- Are external service providers properly integrated in accordance with data protection law?

Larger organisations in particular face greater organisational challenges in this regard.

Classification in terms of professional policy

From the perspective of the dental self-governing body, it is noteworthy that the ECJ has not yet handed down any landmark judgements on investor-owned ambulatory health care centres, bans on third-party ownership or dental professional practice partnerships. The greater momentum currently lies in data protection law, where the new guidelines for digital dentistry are taking shape.

In short: anyone discussing digitalisation, AI, patient portals or networked medical centres today should closely follow the ECJ's case law on health data. It is likely to have a greater impact on the organisation of dental practices in the coming years than many traditional disputes under professional law.

Sources: Healthcare digital, DSGVO-PORTAL

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Prosthetic rehabilitation within seven days

Guided all-on-6 implant placement under analgosedation

Dr Kresimir Mestrovic and MDT Jan-Dominic Viergutz, Germany

Implant-supported rehabilitation of the edentulous mandible is now an established treatment modality in modern implant dentistry. However, cases involving pronounced horizontal and vertical bone resorption remain particularly challenging. Conventional bone augmentation procedures can significantly extend the overall treatment time and are associated with additional patient morbidity. Immediate-loading protocols based on precise three-dimensional implant planning offer an alternative approach, allowing patients with limited bone volume to be rehabilitated without the need for augmentation.

CBCT-based three-dimensional planning, a CAD/CAM-fabricated surgical guide, and a clearly defined prosthetic protocol integrate implant placement and delayed immediate restoration into a predictable treatment workflow.

This case report illustrates how this approach, combined with a fully digital in-house laboratory workflow, enabled definitive prosthetic rehabilitation within seven days in a 69-year-old patient with a mildly atrophic edentulous mandible.

Initial clinical presentation

A 69-year-old woman presented in our clinic with an inadequate, poorly fitting mandibular complete denture. Clinical and radiographic examination, including OPG and CBCT, revealed a mildly atrophic edentulous mandible with pronounced horizontal and vertical bone deficiencies (Figs. 1+2). Her masticatory function and quality of life were significantly impaired. The patient's medical history revealed no contraindications to implant surgery.

The maxilla had previously been restored with a fixed implant-supported prosthesis supported by six implants. The patient therefore expressly requested a compar-

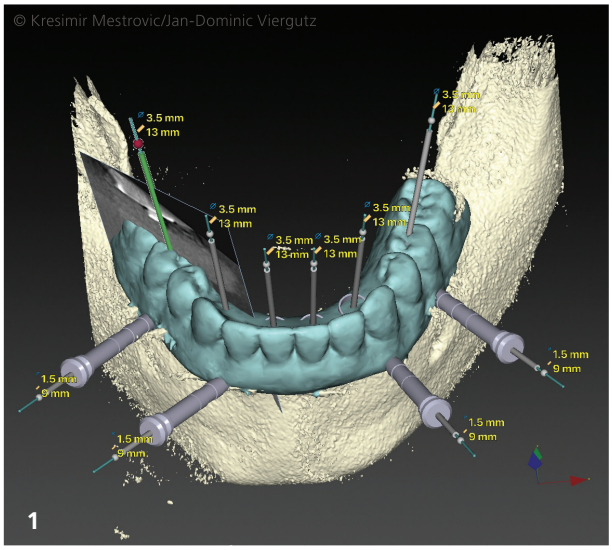
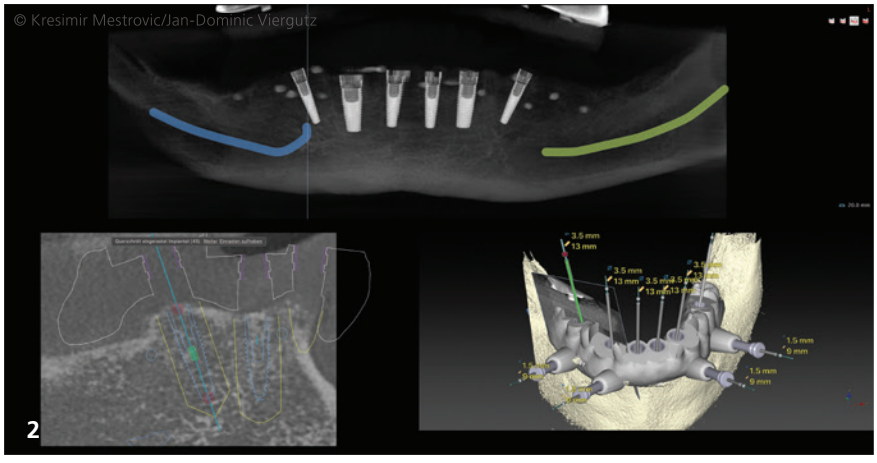


Fig. 1: Implant planning in DTX Studio 1. – **Fig. 2:** Implant planning in DTX Studio 2.





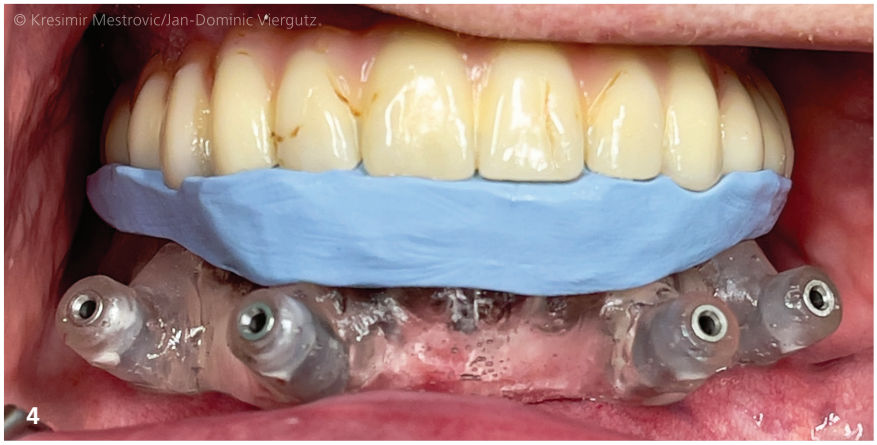


Fig. 3: Preoperative clinical presentation. – **Fig. 4:** NobelGuide® surgical guide with a custom silicone bite registration to verify accurate intra-oral positioning.

able fixed restoration for the mandible. At her request, all procedures were to be performed under conscious sedation and supervised by a specialist anaesthetist.

Treatment planning

Following a thorough discussion of the available treatment options and associated risks, an all-on-6 restoration based on the Nobel Biocare Immediate Solutions™ protocol[1] was recommended, with delayed immediate loading. This prosthetically driven, guided approach allows implant-supported rehabilitation without bone augmentation, even in patients with limited bone volume.

The patient's existing complete denture was duplicated in the dental laboratory to create a radiographic guide. A CBCT scan was acquired with the guide in place, after which the implants were planned three-dimensionally using DTX Studio Clinic (Nobel Biocare). Six NobelReplace NP implants (3.5 mm in diameter and 13 mm in length) were planned for sites 31, 33, 35, 41, 43, and 45. Based on the Nobel Biocare digital planning data, a NobelGuide® surgical guide was fabricated. A custom silicone bite registration was also produced to verify the guide's correct intra-oral position.

Surgical phase—day 1

Implant placement was performed under conscious sedation and local anaesthesia, with a specialist anaesthetist in attendance. The NobelGuide® surgical guide was accurately positioned using the silicone bite registration and secured with fixation pins (Figs. 3+4). All six implants were placed sequentially using a fully guided surgical protocol. An insertion torque of 30–35 Ncm was achieved for each implant, providing sufficient primary stability for delayed immediate loading (Fig. 5). Immediately after implant placement, scan bodies were attached and a digital impression was captured using an iTero® intra-oral scanner (Align Technology; Figs. 6+7). Postoperatively, the patient was prescribed amoxicillin (1,000 mg three times daily for three days) and advised to follow a soft diet for eight weeks.

Laboratory workflow—days 1–3

The digital scan data were used to generate implant models in Model Maker







Fig. 5: Placement of all six implants. – **Fig. 6:** Immediate postoperative clinical situation. – **Fig. 7:** Scan bodies in place for digital impression.

(Zirkonzahn), which were subsequently 3D-printed by CADSPEED. At the same time, an EXMON try-in framework was designed using Zirkonzahn modelling software (Fig. 8).

Clinical try-in—day 3

On day 3, the try-in framework was evaluated clinically, and its fit and complete seating were verified on a panoramic radiograph (Fig. 9). The maxillomandibular relationship was recorded in centric relation using a silicone registration material and documented as the reference for fabrication of the definitive prosthesis.

Laboratory workflow—days 3–7

For the definitive prosthesis, a cobalt-chromium (CoCr) bar was designed and milled to serve as the primary supporting framework. A monolithic full-arch bridge was then designed to fit over the bar and milled from multilayer zirconia (Prettau® 3 Dispersive, Zirkonzahn).[2] This material features integrated gradients in translucency, shade, and flexural strength, providing maximum strength in the cervical region and natural translucency in the incisal region. Because these properties are incorporated into a single monolithic blank, no ceramic veneering is required in the dental region, thereby eliminating the risk of chipping commonly associated with veneered restorations.

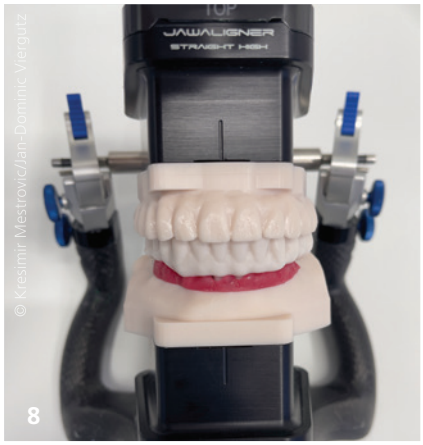
The entire prosthesis was fabricated in-house using a five-axis CAD/CAM workflow. Veneering was limited to the gingival region and performed with Initial Zr-FS (GC Europe). The zirconia bridge was subsequently bonded to the cobalt-chromium bar using Multilink Automix Opaque (Ivoclar Vivadent). Multi-unit abutments were intentionally omitted to minimise treatment complexity (Figs. 10+11).

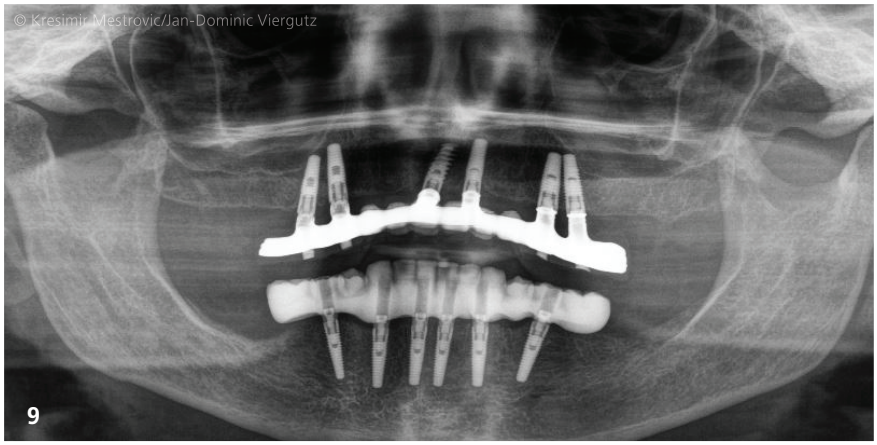
Definitive prosthesis delivery—day 7

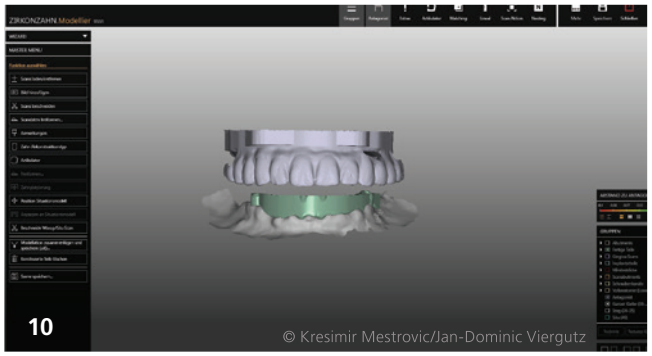
The definitive prosthesis was delivered on day 7, and the retaining screws were tightened to the recommended torque of 30 Ncm. Occlusion and articulation were assessed in centric relation and adjusted as required. A final panoramic radiograph confirmed accurate seating of the framework and a satisfactory implant fit, with no evidence of complications. Immediately after delivery, the patient reported a marked improvement in comfort, masticatory function, and aesthetics (Figs. 12+13).

Discussion

This case demonstrates that a fully digital workflow—from CBCT-based implant planning to in-house CAD/CAM fabrication—can facilitate a definitive full-arch prosthesis within seven days. Three factors were instrumental in achieving this accelerated treatment outcome: precise, CBCT-based guided surgery in accordance with the Nobel Biocare Immediate Solutions™ protocol;[1] immediate intraoral scanning following implant placement; and the manufacturing capabilities of the in-house dental laboratory.







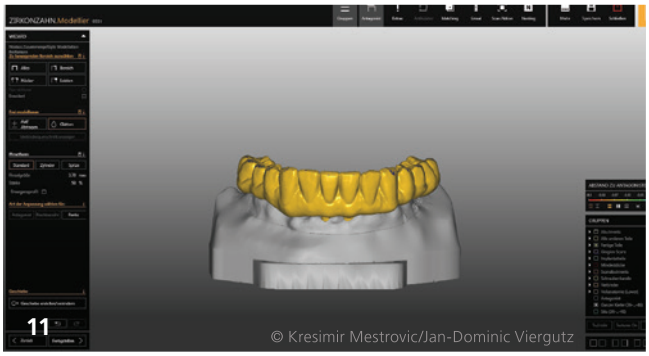


Fig. 8: Try-in framework seated on the implant model. – **Fig. 9:** OPG following the clinical try-in. – **Fig. 10:** CAD design of the primary cobalt-chromium bar. – **Fig. 11:** CAD design of the zirconia bridge.

Delayed immediate loading requires adequate primary implant stability. In the present case, insertion torques of 30–35 Ncm were achieved, meeting the threshold generally regarded in the literature as appropriate for immediate loading. This is also consistent with the Nobel Biocare Immediate Solutions™ protocol,[1] which specifies a minimum insertion torque of 30 Ncm as a prerequisite for immediate loading.

The use of a bar-supported monolithic zirconia restoration (Prettau® 3 Dispersive)[2] reflects current advances in dental materials. Monolithic zirconia bridges substantially reduce the risk of chipping associated with veneered restorations. The cobalt-chromium bar serving as the primary framework provides the required flexural rigidity while allowing a streamlined design, whereas the adhesively bonded zirconia superstructure meets the aesthetic requirements of a full-arch restoration.

The principal limitation of this case report is the lack of long-term follow-up. Clinical reviews at six and twelve months are planned and will be necessary to assess the long-term treatment outcome. Furthermore, conscious sedation, which was provided at the patient's express request, requires a comprehensive pre-anaesthetic assessment, the presence of a specialist anaesthetist, and a suitably equipped clinical facility with appropriate monitoring and emergency support.



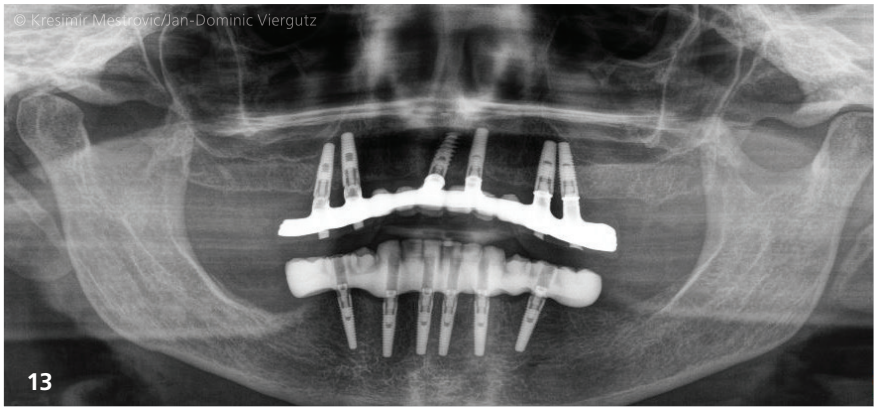


Fig. 12: Definitive prosthesis *in situ* following delivery on day 7. – **Fig. 13:** OPG after delivery of the definitive prosthesis.

References

Conclusion

Combining the Nobel Biocare Immediate Solutions™ protocol,[1] digital intra-oral scanning, and in-house five-axis CAD/CAM fabrication enabled the predictable delivery of a high-quality, definitive full-arch prosthesis for the edentulous mandible within seven days. The bar-supported monolithic zirconia bridge (Prettau® 3 Dispersive)[2] reduces the risk of technical complications while providing long-term aesthetic and functional stability. For appropriately equipped implant centres, this fully digital workflow offers an efficient, predictable, and patient-centred approach to rehabilitating the edentulous mandible in patients with limited bone volume.





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From urgent care to comprehensive oral rehabilitation

Interdisciplinary management of a patient with dental anxiety

Lucas Fahling, Germany

After undergoing numerous restorative and surgical dental procedures, many treatment-weary patients seek professional care only when an acute problem arises. They often present to a new dental practice with a clear request for a rapid, minimally invasive solution. However, clinical assessment frequently reveals conditions that require comprehensive and time-consuming treatment to protect both oral and systemic health.

Establishing trust is essential in these cases. Patients should be helped to understand that their condition may be influenced not only by genetic predisposition but also by behavioural and other factors that modulate inflammatory processes.[1] Empathetic, open discussion is required to identify these underlying causes and encourage patients to make voluntary behavioural changes that will benefit their overall health.

In the following case, the successful resolution of the patient's immediate problem, together with smoking cessation[2], motivated her to undertake an extensive course of treatment aimed at improving both her oral and general health.

Dental anxiety and a lack of trust are common reasons for repeatedly changing clinicians.[3] Consequently, patients may fail to attend routine examinations and oral hygiene appointments, allowing dental problems to progress without timely intervention. When treating anxious patients, it is essential to devote sufficient time to discussing their concerns, exploring the causes of their anxiety, building trust, and encouraging a change in attitude and behaviour.

In addition to providing cause-related dental care—including restorative treatment and the necessary oral hygiene measures—the clinician should carry out a functional assessment to identify any temporomandibular joint or skeletal disorders.[4,5] These issues should be addressed as an integral part of the consultation and discussed openly with the patient.

Clinical and radiographic assessment

In spring 2021, a female patient presented with inflammation and aesthetic concerns involving an implant at site 11 and the adjacent tooth #12. Given her extensive history of dental treatment, she was seeking a rapid solution to the immediate problem. Clinical examination revealed an exposed implant collar that could not be adequately cleaned, together with a visible crown–abutment interface. Radiographic assessment showed severe peri-implant bone loss associated with pronounced palatal angulation and malpositioning of the implant. Periodontal inflammation was also evident around the lateral incisor, which had previously been restored elsewhere with a post-and-core reconstruction (Figs. 1–3).

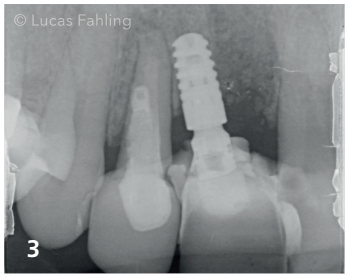
Further clinical examination revealed a veneer on tooth #21, an implant-supported crown at site 24, an implant-supported bridge in the lower right quadrant spanning sites 44–46, and a combined tooth- and implant-supported bridge spanning sites 35–37. The natural teeth exhibited marked wear, suggesting functional disturbance and possible temporomandibular joint involvement.[6] Oral hygiene also required improvement, particularly in areas that were difficult to access. Neither the anterior implant nor the post-restored maxillary lateral incisor was considered salvageable.

The findings and proposed treatment were discussed with the patient. The recommended approach included extraction of tooth #12, removal of the implant at site 11 and the veneer on tooth #21, followed by a staged protocol comprising alveolar ridge reconstruction, a therapeutic provisional restoration, and delayed implant placement. Although the patient wished to receive another implant-supported restoration, she declined immediate bone augmentation and would not accept a removable interim prosthesis.

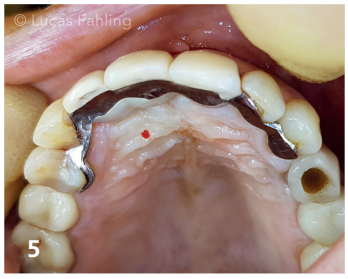
Following impressions, facebow transfer, bite registration, and analysis of the occlusal relationship,[7] a metal-reinforced resin-bonded provisional bridge was fabricated in the laboratory before surgery. The restoration incorporated rests on teeth #14, #13, #22, and #23; pontics replacing teeth #12 and #11; and a long-term provisional crown on tooth #21. It was placed immediately after removal of the implant at site 11, extraction of tooth #12,











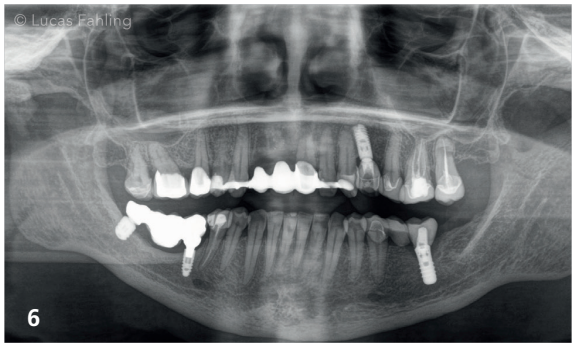
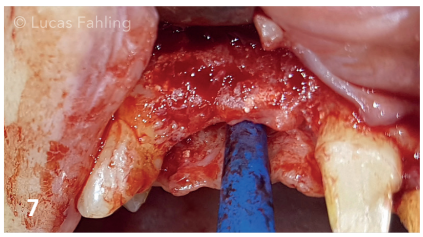


Fig. 1: Initial presentation with inflammatory and aesthetic concerns. – **Fig. 2:** Failing implant and crown restorations. – **Fig. 3:** Radiograph at initial presentation showing a non-salvageable implant at site 11 and periodontal inflammation associated with tooth 12. – **Figs. 4+5:** Modified metal-reinforced resin-bonded bridge, with rests on teeth #13, #14, #22, and #23, pontics replacing teeth #12 and #11, and a long-term provisional crown on tooth #21. The restoration was placed following explantation at site 11, extraction of tooth #12, and removal of the veneer from tooth #21. – **Fig. 6:** Radiographic evaluation following extraction of tooth #12 and removal of the implant at site 11, with the long-term provisional restoration in place.

curettage of the resulting defects, and preparation of tooth #21 (Figs. 4–6). To establish optimal conditions for tissue healing, the patient was strongly encouraged to stop smoking.[2]

In October 2021, after the patient had remained smoke-free for several months, the combined tooth- and implant-supported bridge in the lower left quadrant fractured. The pontic was initially removed, and tooth #35 was provisionally restored. The implant-supported restoration at site 37 remained intact, while the space at site 36 was left unrestored.

Implant placement in the anterior maxilla was subsequently planned using CBCT data. The advanced horizontal and vertical bone defect was to be reconstructed using the shell technique, followed approximately six months later by the placement of two implants at sites 12 and 11.[8] A connective tissue graft was also planned at the time of implant uncovering to increase peri-implant soft-tissue thickness. At this stage, the prosthetic treatment plan was limited to the region spanning sites 12–21, a crown on tooth #35, and an implant-supported restoration at site 36.



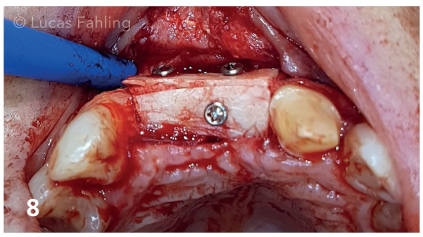






Fig. 7: Surgical exposure of the vertical and horizontal alveolar ridge defect prior to augmentation. – **Fig. 8:** Fixation of the prepared bone plates. – **Fig. 9:** Radiographic evaluation following alveolar ridge augmentation. – **Fig. 10:** Uneventful healing and improved aesthetics at suture removal two weeks postoperatively.

Bone augmentation

In November 2021, alveolar ridge reconstruction was performed to address the horizontal and vertical bone loss resulting from physiological remodelling after extraction and implant removal. Reconstruction was necessary both to create a sufficiently wide bony foundation for implant placement and to establish stable hard- and soft-tissue conditions for a predictable long-term aesthetic outcome in the anterior maxilla. Given the extent of the original defect and the anticipated remodelling of the graft, additional augmentation at the time of implant placement could not be ruled out.

Two cortical bone plates were harvested from the left mandibular retromolar region, adapted to the defect, and rigidly secured with osteosynthesis screws.[9–11] After smoothing any sharp bony edges, the defect was filled with autogenous bone chips and covered with a collagen membrane.[12] The soft tissues were then mobilised to achieve tension-free primary closure.

The metal-reinforced provisional restoration was cleaned, and the pontics were adjusted to avoid pressure on the augmented site during healing (Figs. 7–10). Two weeks after augmentation, healing was uneventful, with no signs of inflammation and a visible improvement in aesthetics, allowing the sutures to be removed.

Implant placement

Six months later, in June 2022, implant placement was performed in the anterior maxilla. Upon elevation of a mucoperiosteal flap, the vertical cortical bone plate was found to be incompletely osseointegrated and was therefore removed in its entirety. The underlying augmented bone was well vascularised and fully integrated (Fig. 11).

Given the potential for subsequent bone resorption, two CAMLOG® SCREW-LINE Promote Plus implants (3.8 mm in diameter and 11 mm in length) were placed subcrestally at sites 12 and 11 despite the residual vertical bone deficiency

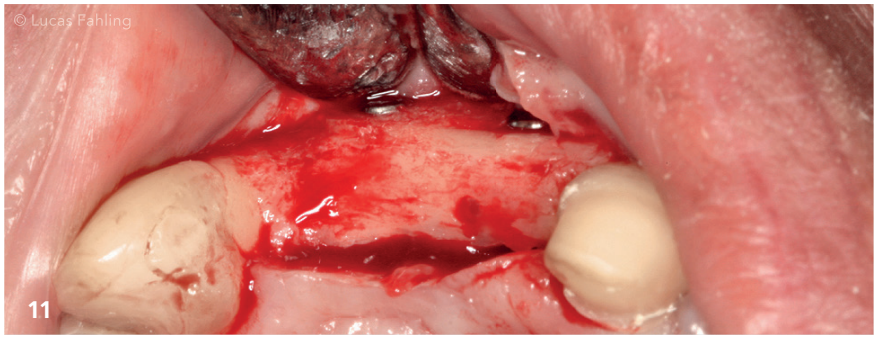


Fig. 11: Decision to remove the vertical bone plate because it had not fully osseointegrated.

(Figs. 12+13).[13] Autogenous bone chips collected during osteotomy preparation were grafted around the implants. The soft tissues were closed with microsurgical sutures, and the provisional restoration was adjusted to the new clinical situation and reinserted.

In July 2022, an additional implant was placed at bone level at site 36.

Management of the temporomandibular dysfunction

Following uneventful osseointegration, the three implants were uncovered in November 2022. A connective tissue graft harvested from the palatal sites 13–15 was placed in a prepared pouch and secured with sutures to increase peri-implant soft-tissue thickness and help preserve the underlying bone over the long term (Figs. 14+15).

At this appointment, the patient reported increasingly frequent pain in the masticatory and cervical muscles and revisited the possibility of increasing the vertical dimension of occlusion, which had been discussed at the initial consultation.[5] It was explained that correcting the reduced vertical dimension to improve masticatory function would require a prolonged course of treatment but could also have wider benefits for her musculoskeletal well-being. She was also advised that, following occlusal splint therapy, definitive correction of the occlusion would require comprehensive full-mouth rehabilitation.

Functional assessment revealed pronounced bilateral muscle tension, mandibular deviation to the left on opening, a lack of occlusal contact in the left posterior region, and a dental midline discrepancy equivalent to approximately three-quarters of the width of a mandibular incisor. In habitual intercuspation, the chin deviated to the right, and the resulting asymmetry contributed to an unbalanced facial appearance. Clicking was also noted in the right temporomandibular joint during mouth opening. The panoramic radiograph showed morphological changes in the right condyle compared with the left.

The proposed treatment plan comprised:

- an implant-supported long-term provisional restoration;
- physiotherapy to relieve muscular tension;
- occlusal splint therapy to guide the mandible to the left and establish a centric condylar position;
- subsequent restoration of the vertical dimension through comprehensive full-mouth rehabilitation.

The patient accepted the proposed treatment plan. Before the fabrication of the occlusal splint, her natural head position was determined using Udo Plaster's PlaneFinder® system.[14,15] An Aqualizer® was used to deprogramme the masticatory muscles and assist in resolving the temporomandibular dysfunction. The vertical dimension was assessed by phonetic testing. Pronunciation of the vowels i and e revealed an excessive interocclusal distance, indicating a reduced vertical dimension. This finding was supported by the absence of maxillary incisor display with the face at rest.

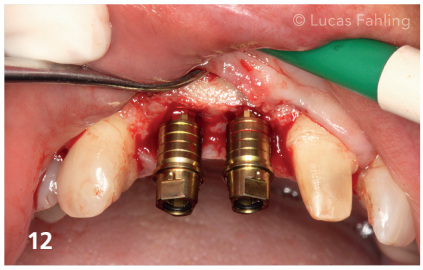
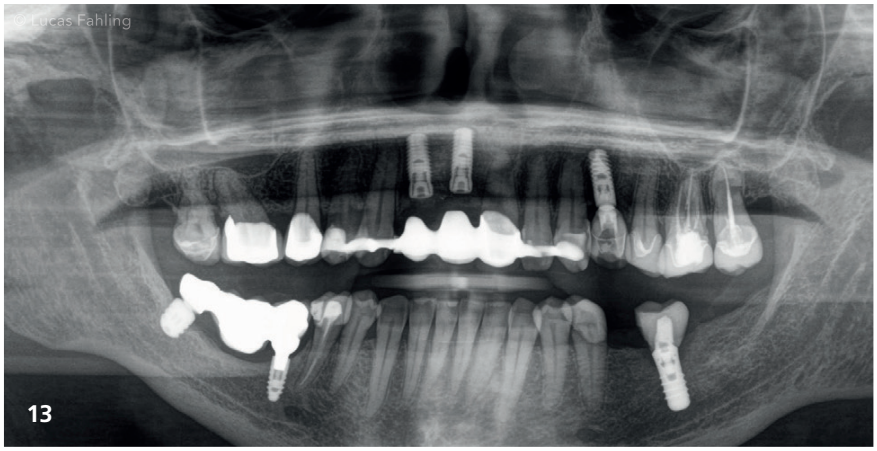


Fig. 12: Subcrestal placement of CAMLOG® SCREW-LINE Promote Plus implants. – **Fig. 13:** Submerged implant healing with pressure-free soft-tissue contouring.



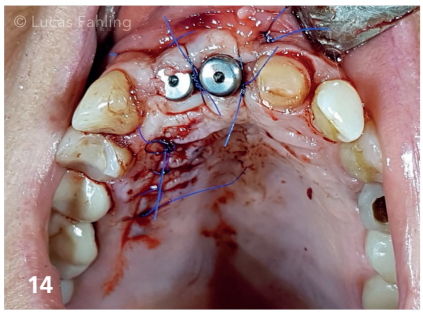
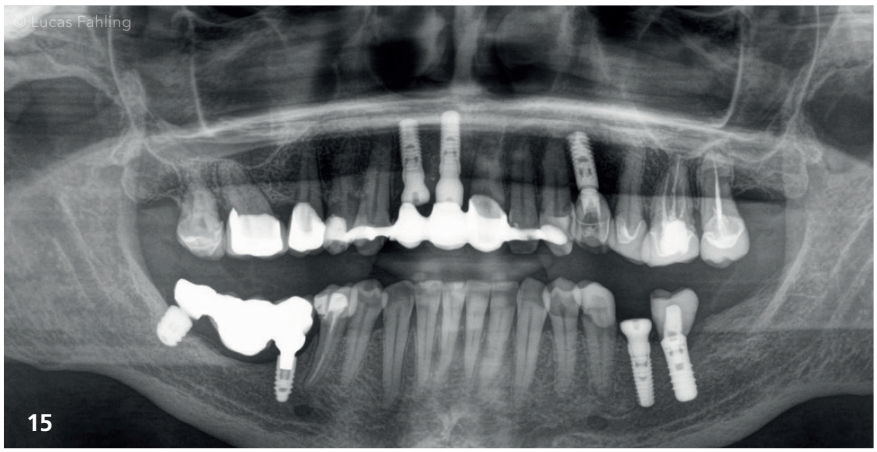


Fig. 14: Implant uncovering and placement of a connective tissue graft to increase soft-tissue thickness. – **Fig. 15:** Modified long-term provisional restoration positioned over the healing abutments.



In December 2022, 18 months after the initial presentation, the implant-supported long-term provisional restoration and occlusal splint were delivered (Figs. 16+17). As the vertical bone plate had been removed at the time of implant placement, the gingival contour was initially asymmetrical. It was planned to compensate for this in the definitive restoration through crown lengthening and the use of pink ceramic.

After several physiotherapy sessions and repeated occlusal adjustments to the splint, the patient returned for further treatment in March 2023. She was very satisfied with the outcome of splint therapy: muscular tension had resolved, joint sounds were no longer present, and extra-oral examination showed a symmetrical facial appearance without the previously retrusive chin profile. She was also proud to have remained smoke-free.

The newly established occlusal relationship was stabilised for a further three months. During this retention phase, the proposed full-mouth rehabilitation was discussed in detail. In July 2023, the facial reference lines were reassessed and impressions were taken for an aesthetic mock-up. The maxillomandibular relationship was recorded with the occlusal splint in place to transfer the corrected vertical dimension and occlusal plane accurately.

In the laboratory, the casts were mounted in an articulator and a functional diagnostic wax-up was completed. The waxed-up casts were then duplicated, and thermoformed matrices were fabricated for production of the provisional mock-up following tooth preparation (Fig. 18).

Definitive rehabilitation

The teeth were prepared using a minimally invasive approach, with partial crowns and veneers used wherever possible to preserve tooth structure (Figs. 19a+b). Full-arch impressions of both jaws, including the natural teeth and implants, were taken to

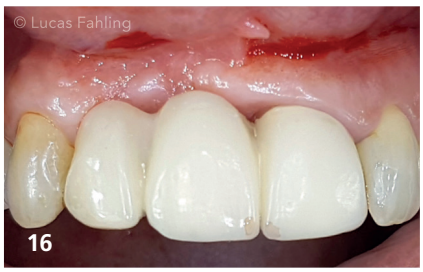




Fig. 16: Implant-supported long-term provisional restoration with a pontic at site 12 and a crown on tooth #21. – **Fig. 17:** Occlusal splint therapy for craniomandibular dysfunction.



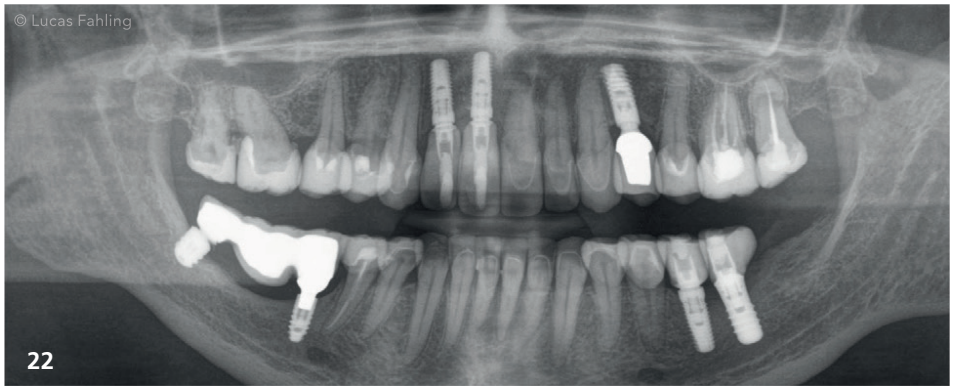












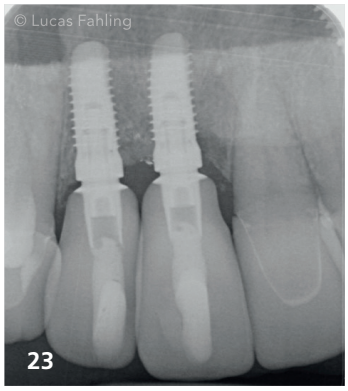


Fig. 18: Aesthetic makeover following completion of craniomandibular therapy and a three-month retention phase. – **Figs. 19a+b:** Final minimally invasive tooth preparations: all-ceramic crowns in the maxilla and predominantly partial crowns and veneers in the mandible. – **Figs. 20a+b:** Definitive all-ceramic rehabilitation consisting predominantly of single crowns, veneers, and partial crowns, with an implant-supported bridge in the lower right quadrant. – **Fig. 21:** The soft-tissue deficit at site 12 was aesthetically masked with pink ceramic. – **Fig. 22:** Completed full-mouth rehabilitation of the maxilla and mandible. – **Fig. 23:** Twelve-month follow-up after delivery of the definitive restorations, showing stable bone levels following remodelling and healthy, inflammation-free tissues.

produce the master casts. Based on the updated facial measurements, the casts were cross-mounted in an articulator, and the definitive all-ceramic restorations were fabricated.[16] Surgical crown lengthening, combined with pink ceramic at the implant-supported crown at site 12, helped create a harmonious gingival contour (Figs. 20–22).

At the one-year follow-up, the patient was delighted with the outcome. Her neuromuscular tension had resolved, the condyles were positioned symmetrically, and a stable, well-balanced occlusion had been established. The residual vertical bone defect resulting from removal of the cortical bone plate remained stable and free of inflammation (Fig. 23).

Conclusion

Empathetic, patient-centred communication can help patients overcome dental anxiety and reluctance to undergo treatment. It can also motivate them to adopt beneficial lifestyle changes—in this case, smoking cessation. Management of the patient's temporomandibular dysfunction alleviated her pain and muscular tension, improved her quality of life, and provided a stable foundation for an aesthetic and functional full-mouth rehabilitation.

Lucas Fahling

References



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EuroPerio12

From Vienna to Baku: a milestone year for the EFP

From EuroPerio11 in Vienna to Perio Master Clinic in Baku, the past year has been one of momentum and strategic progress for the European Federation of Periodontology (EFP). Under the leadership of Past President Spyros Vassilopoulos, secretary general Anton Sculean, and treasurer Andreas Stavropoulos, the federation has advanced its Vision 2030 agenda while strengthening partnerships, widening its international reach, and reinforcing financial sustainability.

Vision 2030 remained at the centre of the EFP's work, guiding progress across science, education, sustainability, international collaboration, and influence.

Education was a particular priority. EuroPerio11 in May 2025 and Perio Master Clinic 2026 brought together thousands of oral-health professionals for scientific exchange and continuing education. Another highlight was the 21st European Workshop on Periodontology in La Granja, Spain, which focused on clinical-practice guidelines for periodontal therapy, gingival diseases, and acute periodontal conditions—an initiative Prof. Vassilopoulos described as a strong example of science translated into practice.

EuroPerio11 was a defining moment for the federation. Held in Vienna, the congress attracted more than 10,000 participants and reaffirmed its position as the world's leading event in periodontology and implant dentistry. It also made a major contribution to the EFP's financial stability and strengthened relationships with partners, many of whom expressed interest in future collaborations.

Perio Master Clinic 2026 in Baku marked another strategic step, extending the EFP's reach into Eastern Europe and neighbouring regions. Despite the challenges of regional instability and travel uncertainty, the meeting succeeded in engaging new audiences and delivered a strong programme.

Public engagement also moved forward. The EFP expanded Gum Health Day through a new three-year campaign model, giving member societies greater flexibility to adapt materials locally. In both Vienna and Baku, public events featuring free dental check-ups, educational outreach, and media engagement helped raise awareness of oral health and increase the federation's visibility.

For secretary general Anton Sculean, the year focused on continuity, co-ordination, and cohesion across the federation. Close collaboration with member societies, committees, and the central office remained a priority, alongside support for younger colleagues and the next generation of leaders.

Financial sustainability also remained central. Treasurer Andreas Stavropoulos emphasised prudent budgeting, careful cost control, and transparent governance. While EuroPerio continues to be the EFP's principal source of revenue, its triennial nature makes long-term planning between congress cycles essential.

Together, these achievements have strengthened the EFP's scientific leadership and international profile. With International Perio Master Clinic 2027 and EuroPerio12 ahead, the federation moves into the next phase of Vision 2030 with growing confidence and reach.

Source: EFP

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EAO Annual Congress 2026

Meeting in Lisbon attracts delegates from across the globe

Founded in the early 1990s, the European Association for Osseointegration (EAO) is dedicated to "bridging the gap between science and clinical practice". The Association brings together researchers, scientists, dental clinicians and other healthcare professionals from around the world to exchange knowledge, define best practice in implant dentistry and promote cutting-edge research in osseointegration, peri-implant biology and implant-supported rehabilitation.





A total of 3,300 delegates gathered in Lisbon, Portugal, for the 33rd Annual Congress of the EAO. Organised in partnership with the Brazilian Society of Periodontology and Implant Dentistry (SOBRAPI), the congress took place from 24 to 26 September 2026.

The theme of this year's meeting was "Delivering Health and Predictability: Shaping the Future of Patient Care". Over three days, the scientific programme featured a comprehensive series of plenary lectures and parallel sessions presented by more than 100 distinguished speakers from 20 countries. Discussions explored innovative and evidence-based approaches to improving patient health, optimising clinical outcomes and enhancing predictability across surgical, prosthetic and peri-implant treatment protocols.

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Collaboration, practical education and leadership

In addition to providing a platform for the dissemination of high-quality scientific and clinical content, the congress offered an extensive programme of social and networking events. Delegates also had numerous opportunities to engage directly with speakers, industry partners and exhibitors, encouraging professional collaboration and the exchange of expertise.

A particular highlight was the hands-on workshop "My First Implant", organised by the EAO Junior Committee. Designed for clinicians with limited experience in implant dentistry, the workshop introduced participants to the biological principles underpinning osseointegration, evidence-based surgical protocols and contemporary prosthetic strategies. Under expert supervision, participants were also able to gain practical experience with a range of implant systems.

During the EAO General Assembly, Prof. Irena Sailer of Switzerland was inaugurated as the Association's 24th president.

Recognising excellence in research and education

The recognition and promotion of excellence in scientific research remain central to the EAO Congress. Dedicated research sessions provided the authors of the highest-rated abstracts with an opportunity to present their findings to an international audience of clinicians, academics and researchers.

Awards were presented across several categories, recognising outstanding contributions to basic, clinical and translational research, as well as innovation and clinical video production:

- Satar Yousefiasl, Norway—European Prize for Basic Research in Implant Dentistry
- Xinbo Yu, China—European Prize for Clinical Research—Surgery
- Carina Boven, the Netherlands—European Prize for Clinical Research—Prosthetics
- Maria José Bendek, Colombia—European Prize for Clinical Research—Peri-implant Biology
- Milda Vitosyte, Lithuania—European Prize for Clinical Innovations in Implant Dentistry
- Jun Li, China—European Prize for Clinical Video on Implant Dentistry

The awards ceremony also celebrated important achievements in postgraduate education and professional development. Eight dentists were awarded the EAO Certificate in Implant Dentistry, while the 2026 cohort of the Master Diploma in Implant Dentistry graduated, with 17 clinicians receiving their diplomas.

Finally, Lino Esteve Colomina received the EAO Distinguished Service Award in recognition of his significant contribution to the EAO Congress Scientific Report. Initiated by Lino and his colleagues in 2015, the report has since been published annually and has become an important record of the scientific advances, clinical insights and key discussions presented at each congress.

Source: EAO

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Global consensus for clinical guidelines

From evidence to clinical implementation

The Global Consensus for Clinical Guidelines (GCCG) reached another important milestone at the EAO Congress in Lisbon, demonstrating how this global scientific initiative is advancing from evidence generation to practical clinical implementation.



Meeting of the GCCG Board and associated representatives of partner organisations during the EAO Congress in Lisbon. From left to right: Bilal Al Nawas (DGI), Ronald E. Jung (ITI), Frank Schwarz (Osteology Foundation), Irena Sailer (EAO), Jay P. Malmquist (FOR), Jong-Yub Kim (KAOMI, online), Christian Hammächer (DGI, online), Yi Yuseung (KAOMI), Ryuji Hosokawa (JSOI, online), Kati Benthaus (ITI, online), Sergio Kahn (SOBRAPI), Tali Chackartchi (EFP), Jaime Jiménez García (SEPES) and Ramesh Chowdhary (OSI). Hongchang Lai (CSA), not pictured, also participated online.

Over the past two years, GCCG has established a pathway for developing and disseminating evidence-based, patient-centred guidance in implant dentistry. Its first edition, focusing on the treatment of the edentulous maxilla, has already led to the publication of consensus proceedings and clinical recommendations. Building on this scientific foundation, the initiative is now entering its next phase: translating evidence into everyday clinical decision-making.

Turning evidence into clinical practice

A key highlight at the EAO Congress was the announcement of a dedicated GCCG clinical translation supplement in the *International Journal of Prosthodontics*. The supplement translates the consensus recommendations into practical implementation, showing how evidence-based guidance can be applied in real-world clinical scenarios. Several articles are already available online ahead of print.

Another major step forward is the launch of the Clinical Guidance Tool for the Edentulous Maxilla. This interactive resource helps clinicians apply GCCG recommendations in practice. By turning scientific conclusions into accessible clinical guidance, GCCG continues to bridge the gap between consensus proceedings and patient care.

Together, these initiatives provide clinicians with valuable resources to support informed decision-making and improve treatment outcomes.

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Tali Chackartchi from Israel and Jaime Jiménez García from Portugal.



Ronald E. Jung, Irena Sailer, both from Switzerland, and Frank Schwarz from Germany.

A growing global partnership

The EAO Congress also gave the GCCG Board and organisational representatives an opportunity to discuss the initiative's future direction. The three Founding Organisations were represented by Irena Sailer for the EAO, Ronald E. Jung for the ITI and Frank Schwarz for the Osteology Foundation. They were joined by members of the growing international partner network. Although not all representatives could attend in person, several participated remotely and contributed actively to the discussions, underscoring the initiative's global commitment.

Reflecting GCCG's growing international relevance, its partnership network continues to expand. Alongside the established partners CSA, JSOI, KAOMI, OSI and SOBRAPI, the initiative recently welcomed EFP, DGI and SEPES, further strengthening its global reach and multidisciplinary perspective.

Building the framework for the next phase

At the meeting, the representative of the member organisation reviewed the organisational framework developed over recent months. Significant progress has been made towards a transparent governance structure designed to safeguard the long-term sustainability, independence and scientific integrity of future GCCG activities.

Preparations for the second edition of GCCG are already under way. Building on the success of the first consensus process, the participating organisations are working closely to define the initiative's next phase and further advance evidence-based, patient-centred clinical guidance.

Further details on GCCG's future direction and upcoming activities will be announced soon.

Source: Global Consensus for Clinical Guidelines (GCCG)

The new Clinical Guidance Tool for the Edentulous Maxilla*

An interactive resource based on the Global Consensus for Clinical Guidelines (GCCG)—now available in a beta version.

The Clinical Guidance Tool for the Edentulous Maxilla is an interactive educational resource designed to support clinicians in applying GCCG consensus recommendations in daily clinical practice. Through structured clinical pathways, recommendations and supporting evidence, it translates scientific guidance into practical clinical decision-making.

Try it and run a patient case

**The tool supports but does not replace professional clinical judgement.*

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Discover Osteology Learn

Osteology Foundation

Evidence-based learning. Anywhere, anytime.

The Osteology Foundation launched Osteology Learn, a new digital learning platform bringing together evidence-based education and expert knowledge in oral tissue regeneration. Designed to support dental professionals in their ongoing development, Osteology Learn offers flexible access to educational content—whenever and wherever it suits the learner.

From self-paced e-learning and live webinars to webinar recordings and clinical videos, users can choose how they learn and explore topics relevant to their clinical practice.

One platform, multiple ways to learn

Osteology Learn brings different learning formats together in one digital environment, making it easier to access and revisit Osteology education beyond physical events. The platform also features a personal dashboard to track learning activities and offers CE credits to support continuing professional development.

The platform is particularly suited to early- and mid-career clinicians and final-year dental students, while offering relevant learning opportunities for dental professionals at all stages of their careers.

"With Osteology Learn, we are extending the Osteology Foundation's educational mission into a digital environment," says Purnima Kumar, Foundation Board Member and Member of the Education Committee. "We want to make high-quality, evidence-based knowledge and expert insights more accessible to our community—wherever and whenever they want to learn."

Just the beginning

The launch of Osteology Learn marks the beginning of a continuously growing digital learning environment. New courses, webinars, recordings, and clinical content will be added over time, creating an evolving library of knowledge for dental professionals looking to invest in their professional growth.

A selection of learning modules and content is already available free of charge, giving users the opportunity to explore the platform and start learning without a subscription.

For those looking to access the full offering, an annual subscription provides 12 months of access to all content, including more than 70 hours of CE-eligible learning content. To celebrate the launch, the subscription is currently available with a special launch offer of CHF50 for one year.

Source: Osteology Foundation

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OSSTEM IMPLANT

Beyond implants: OSSTEM expands its vision for modern dentistry

From advanced implant systems to dental equipment and digital solutions, OSSTEM IMPLANT continues to expand its role in modern dentistry. With nearly 30 years of experience in implant development and a presence in more than 100 countries, the company combines established expertise with ongoing innovation.



Two recent developments illustrate this approach: the KS 3 Implant System and the K5 dental unit.

KS 3: A new approach to primary stability

Following its European introduction at EAO 2026 in Lisbon, the KS 3 Implant System represents an important step in OSSTEM's implant portfolio.

Designed for demanding clinical situations, KS 3 combines a fully tapered body, deep threads, a two-step cutting edge and a sharp apex. These features work together to support bone engagement, controlled insertion and strong primary stability, including in low-density bone and extraction sockets.

The stability-focused design also supports immediate-placement and immediate-loading protocols where clinically appropriate, giving clinicians additional flexibility when developing individual treatment strategies.

KS 3 complements OSSTEM's globally established TS Implant System, expanding the range of solutions available for different clinical requirements.

K5: Bringing innovation into the treatment room

OSSTEM's commitment to innovation extends beyond implantology. The K5 dental unit, making its European debut at ADF 2026 in Paris, reflects the company's focus on ergonomics, practitioner efficiency and patient comfort.

Its slim backrest improves access to the patient, while flexible positioning, intuitive touchscreen controls and hygiene-oriented features support everyday clinical workflows.

The K5 is planned for the European market in three configurations: Cart Type, Swing Arm Type and Traditional Type. Allowing practices to choose a setup suited to their working preferences and treatment environment.

More than an implant manufacturer

Alongside implant systems and dental units, OSSTEM's wider portfolio includes surgical instruments, guided surgery solutions, prosthetic components, digital dentistry technologies and regenerative materials.

Professional education and scientific exchange also form an important part of the company's approach, supporting clinicians in developing their knowledge and practical skills.

By combining implant innovation, treatment technologies and education, OSSTEM aims to provide dental professionals with a comprehensive range of solutions for modern clinical practice.

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SEPA

New expert consensus aims to improve peri-implant health

Practical clinical recommendations unite surgical and prosthetic planning to help prevent disease and support long-term implant success.

With more than 6,000 member periodontists and oral health professionals, the Spanish Society of Periodontology (SEPA) is the scientific society dedicated to periodontology and implant dentistry, and is recognised as a global leader in periodontal science and clinical practice.

The society has recently led the development of a major expert consensus report providing clinical recommendations on the influence of surgical and prosthetic factors on peri-implant health and disease. The paper, bringing together the clinical expertise of periodontists, prosthodontists and dental technicians, has been published in the *Journal of Esthetic and Restorative Dentistry*, under the title "Influence of surgical and prosthetic factors on peri-implant health or disease: clinical recommendations from a SEPA expert consensus". "This guidance document stems from the need to offer clinicians a practical framework to prevent peri-implant diseases from the outset of treatment, taking into account both surgical and prosthetic considerations," says Dr Ignacio Sanz Sánchez, co-author of the paper. Dr Beatriz de Tapia, co-author and SEPA board member for education and research, adds:

"Implementing these recommendations may have a meaningful impact both nationally and internationally, by providing clear and consistent criteria for clinicians and dental technicians, and supporting more predictable decision-making in both clinical and laboratory settings."



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Dr Ignacio Sanz Sánchez Dr Beatriz de Tapia

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Peri-implant diseases, including peri-implantitis, remain a major concern in implant dentistry and are frequently associated with prosthesis-related factors. This review highlights the importance of integrating both surgical and prosthetic planning to reduce the risk of disease development. Clinicians are encouraged to prioritise prosthetic designs that facilitate effective oral hygiene. Three-dimensional implant-positioning — guided by the intended prosthetic outcome — is essential to minimise complications. Material selection, including ceramic and zirconia restorations, may also influence plaque-accumulation.

Long-term success in implant dentistry depends on prosthetically driven planning, hygienic prosthetic design, appropriate selection of implant–abutment connections and materials, minimal implant manipulation, and maintenance tailored to patient risk.

SEPA's leading role

SEPA has played a leading role in coordinating and driving this multidisciplinary consensus, bringing together leading expertise in periodontology, prosthodontics and dental technology, with the support of the dental company Eckermann, to translate scientific evidence into practical clinical guidance.

Key topics included three-dimensional implant positioning, implant–abutment connections, prosthetic design and component handling. This collaborative approach reflects SEPA's ongoing commitment to promoting integrated, evidence-based dentistry and improving long-term patient outcomes.

Access the full paper here

Clinical recommendations

The expert consensus is structured around five key clinical domains:

1 Prosthetic design and emergence profile
- Prosthetic factors play a major role in peri-implant health.
- Designs should facilitate effective hygiene for both patient and clinician.
- Overcontouring should be avoided.
- Convex profiles are associated with increased risk of peri-implant disease.
- Straight or concave profiles with an emergence angle < 30° are preferred.

2 Implant positioning and surgical planning
- Implant placement should be prosthetically driven.
- Three-dimensional positioning is essential (mesio-distal, apico-coronal and bucco-palatal).
- Poor positioning may lead to unfavourable prosthetic compromises.
- Guided surgery may be beneficial in complex cases.

3 Implant–abutment interface
- Internal conical connections are preferred.
- Platform switching may improve crestal bone stability.
- Polished-neck implants may benefit higher-risk patients.

4 Prosthetic components and handling
- Intermediate abutments may provide a protective effect in multiple-unit restorations.
- Narrow or concave designs are preferred.
- Abutment height > 2mm may reduce early bone loss, particularly in patients with thin mucosa.
- Placement of the definitive abutment at surgery is recommended.
- The "one abutment–one time" concept may reduce bone remodelling.

5 Materials, retention and maintenance
- Screw-retained restorations are preferred.
- Excess cement is a well-established risk factor for mucositis and a potential contributor to peri-implantitis.
- Zirconia shows favourable soft-tissue response and lower plaque accumulation.
- No clear evidence of reduced peri-implantitis risk versus metal-ceramic restorations.
- Hygienic design, patient education and regular maintenance are essential.

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Dentaurum

Individual solutions begin at the base

The brand new CAD/CAM titanium base VARIO from Dentaurum comes with a revolutionary design offering efficient, flexible and reliable handling. It's an effective and innovative addition to the patented tioLogic® TWINFIT implant system—a system that has already convinced numerous users. The Abutment Switch allows you to change between cone and platform abutments at any time. You can also adapt the base to various heights and individually adjust the screw aperture, easily and digitally.

Complicated storing was yesterday—today is VARIO

With a chimney height of 8.5 mm, the CAD/CAM titanium base VARIO offers optimum support for high restorations and increases the area to be bonded. The innovative design allows adhesive cylinder lengths from 4.0 mm to 8.5 mm in 1.5 mm steps.

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A new look, the same passion: The new brand identity of OEMUS MEDIA AG

OEMUS MEDIA AG is embarking on a new chapter in its history. After more than 30 years, the Germany-based media company is unveiling a new brand identity—one that reflects its transformation from a traditional specialist publisher into an integrated media, events and community-driven enterprise. For more than three decades, the company's previous logo appeared across OEMUS MEDIA AG's magazines, congresses, websites, newsletters and trade show displays. During that time, the company continued to evolve. What began as a traditional specialist publishing house has long since become an integrated media company, with its print, online, event, study and corporate divisions working together to shape communication within the dental industry. The new brand identity brings this evolution to life visually.

A smile at the core of the brand

At the heart of the new identity is "oemus"—lowercase, pared back and focused. Its defining feature, the redesigned "u," evokes a smile and reflects the company's dental roots. It also stands for "you," "us" and "we," symbolising the community and collaboration that have long shaped OEMUS MEDIA AG: #welovewhatwedo.

The new colour palette pairs Deep Viola—combining professionalism and creativity—with a modular system that gives each business division its own secondary colour. This creates clear visual structure while maintaining a cohesive identity. The distinctive "u" also forms a brand pattern used across magazines, websites, social media, congresses, newsletters and trade shows. Together, these elements create a comprehensive, instantly recognisable design system.

Modern in appearance, true to our values

The new brand identity builds on everything OEMUS MEDIA AG has stood for over the past three decades: close ties to the market, a passion for dental topics and a strong network connecting people, knowledge and communication. The visual language may be more modern, but the values behind it remain unchanged. They will continue to provide the foundation for everything that defines the OEMUS brand.

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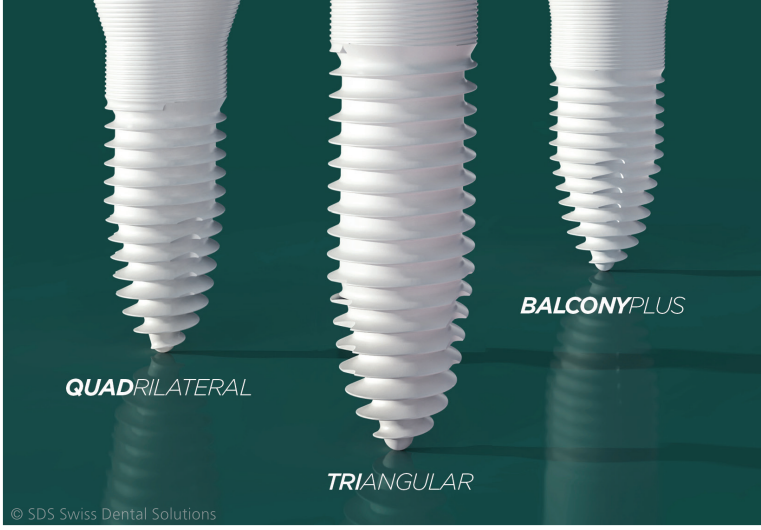
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SDS SWISS DENTAL SOLUTIONS

Cutting edge performance—designed for aesthetics

More than implants: a new dimension of aesthetically and anatomically oriented implantology. With the SDS Aesthetic and Anatomic series, SDS SWISS DENTAL SOLUTIONS presents a system that consistently combines design, function, and clinical requirements.

In the anterior region, the SDS Aesthetic series offers oval and new triangular implant shapes that are aligned with natural tooth contours. They deliberately create interproximal space to preserve the papillae and support a consistent emergence profile. At the same time, the geometry enables precise positioning and supports efficient surgical workflows.

In the posterior region, the SDS Anatomic series complements the concept with a quadrilateral design and a further developed Balcony+ approach. This shape supports both effective coverage of the alveolar space and peri-implant hard- and soft-tissue healing, while allowing flexible adaptation to different anatomical conditions. The new implants follow a clear principle: implant design aligned with natural anatomy, creating the foundation for reproducible, functional, and aesthetically demanding outcomes.

Further information on the SDS ceramic implant system can be found at www.swissdentalsolutions.com.

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CleanImplant Foundation

CleanImplant Foundation expands digital visibility for certified practices

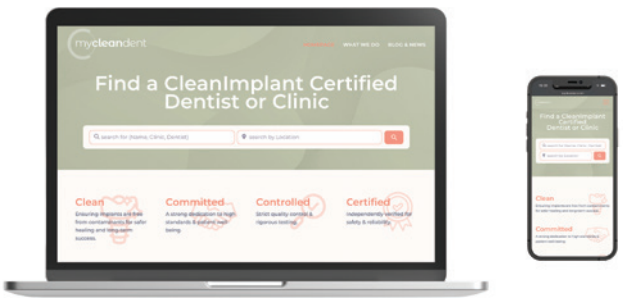
As patients increasingly seek transparency, orientation, and trustworthy quality standards in implant dentistry, digital visibility has become an essential factor for modern dental practices. To address this growing demand, the CleanImplant Foundation has launched mycleandent.com, a new patient-focused platform designed to connect patients with independently quality-certified implantology providers.

As part of the expanded CleanImplant membership programme, every CleanImplant Certified Dentist receives an individual landing page that is locally optimised, search-engine supported, and editorially maintained by CleanImplant. This allows certified practices to strengthen their online presence precisely where patients actively search for reliable information and quality-oriented treatment providers.

Excellence deserves visibility: CleanImplant Certified Dentists work with award-winning implant systems and demonstrate a clear commitment to uncompromising product quality. Through mycleandent.com, patients gain access to a trusted platform that supports informed treatment decisions and highlights practices dedicated to independently validated quality standards in implant dentistry. The benefits for participating practices extend beyond enhanced digital visibility. CleanImplant also provides high-quality communication and marketing materials that support consistent patient engagement and strengthen trust-based consultations. These include personalised quality certificates, acrylic reception displays, and educational patient brochures for waiting and consultation areas.

In addition, certified members benefit from access to a practice-oriented expert network, professionally designed social media templates, and reliable analytical data on dental implant systems. *Further information is available at cleanimplant.org.*

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STEINSOHN Sp. z o.o.

Activate the bone. Redefine implantology.



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Modern implantology does not begin with implant placement. It begins with understanding bone.

The MERIDIAN Implant System is based on a distinctive material concept combining silicon dioxide, calcium oxide, magnesium oxide and potassium oxide. This bioactive glass-ceramic was not developed simply to be white. It represents a new approach in ceramic implantology: moving beyond purely mechanical anchorage toward a material-oriented concept that rethinks the relationship between implant surface and bone.

At the center of this concept is Activating Bone Intelligence. MERIDIAN is not simply placed—it follows a specific activation protocol. This protocol prepares the implant, the bone site and the surgical workflow so that the surface can unfold its full potential. A key aspect of this concept is the targeted activation of the M2 phase of macrophages, which are associated with tissue regeneration and healing. The goal is to create a favourable biological environment during the early healing phase and to support the interaction between implant and bone in a targeted way.

For dentists, this means that ceramic implantology becomes not only material-driven, but protocol-driven. Clinical success is not determined by implant design alone, but by the interaction of planning, bone management, activation, insertion and prosthetic strategy.

This is exactly what we teach in our hands-on courses. Participants do not only learn about the implant itself, they learn the complete clinical workflow and how to influence biological healing processes through activation protocols, including strategies aimed at supporting the M2 macrophage response. From case planning and activation to safe implementation in daily practice, the focus is on translating biological principles into predictable clinical outcomes.

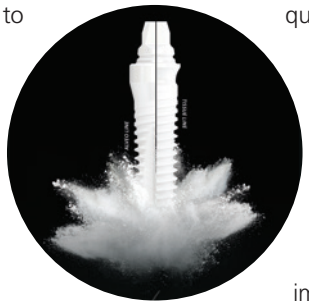
MERIDIAN Implant—not only placed, but activated.

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bredent medical GmbH & Co. KG

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.

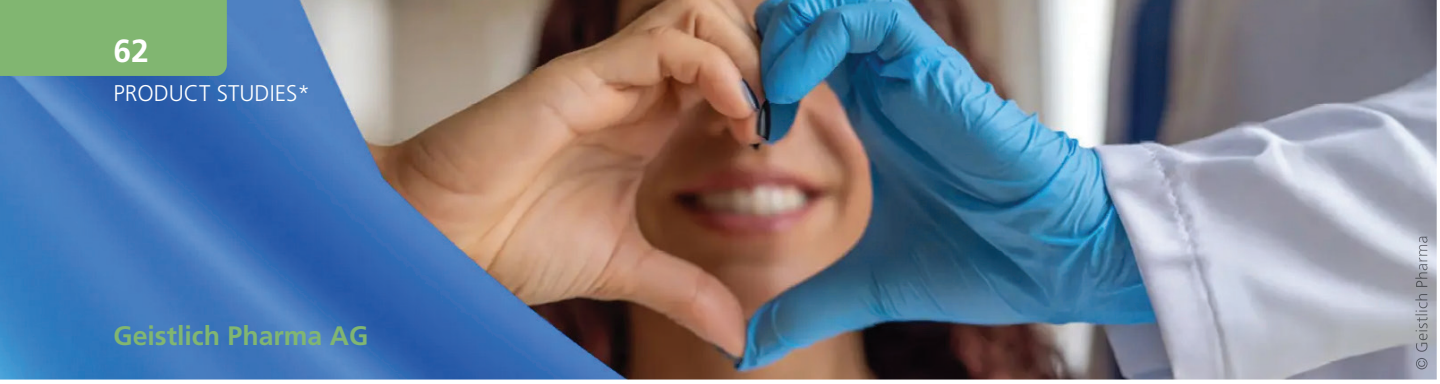


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Optimal conditions for soft-tissue attachment and high mechanical stability

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.

Contact address
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www.bredent-implants.com



Support a patient. Apply regeneration. Make an impact.

As part of its 175-year Jubilee, Geistlich has launched a new patient support programme designed to improve access to regenerative dental treatment for patients who would otherwise remain untreated due to financial limitations.

The initiative reflects a central principle of regenerative dentistry: the restoration of oral tissues can also restore function, confidence, and quality of life.

In daily practice, clinicians frequently encounter patients with clear indications for regenerative therapy whose treatment plans are delayed, modified, or abandoned because of cost. Procedures such as ridge augmentation, guided bone regeneration, and soft-tissue regeneration are well established and science-based, yet the financial burden associated with biomaterials, implants, and reconstruction can place them beyond reach for some patients. The new Geistlich programme aims to help close that gap.

What this means for clinicians

The programme offers clinicians the opportunity to treat patients with a clear regenerative indication without allowing cost to become the determining factor. While support is provided for selected cases, full clinical responsibility remains with the treating clinician, including diagnosis, treatment planning, case execution, and follow-up care.

By focusing on predictable, evidence-based regenerative treatment, the initiative supports clinicians in delivering care that is both biologically sound and potentially life-changing for patients who may have previously declined therapy for financial reasons. Only a limited number of cases will be selected worldwide, underscoring the programme's emphasis on careful case review and meaningful patient impact.

How it works

To keep participation efficient, the submission pathway has been structured as a simple two-stage process. The first step consists of a short, anonymised application that includes a brief case overview, key clinical details, and the proposed treatment plan. This initial review allows cases to be assessed without requiring full documentation at the outset. If a case is selected, the second stage requires complete documentation, including patient consent, confirmation of eligibility, and relevant clinical records. This approach is intended to reduce administrative burden while ensuring that selected cases are supported by thorough and appropriate documentation before final approval.

Eligibility and support

The programme is open to licensed dentists and specialists in their respective countries who are committed to evidence-based regenerative treatment. Suitable patient cases must present a clear clinical indication for regenerative therapy, have a history of treatment being declined due to financial constraints, and offer the potential for a predictable clinical outcome.

Selected cases will receive full coverage of Geistlich biomaterials, along with a 50 per cent contribution toward implant costs and a 50 per cent contribution toward crown costs. Professional fees remain the responsibility of the treating clinician.

What makes a strong application?

Applications are expected to demonstrate a meaningful opportunity to improve a patient's condition through regenerative treatment that might not otherwise be possible. Strong submissions typically include a clearly defined regenerative indication, a predictable treatment concept using Geistlich biomaterials, and high-quality clinical documentation such as radiographs and photographs.

Cases involving ridge augmentation, guided bone regeneration, or soft-tissue regeneration are particularly well aligned with the aims of the programme. Clinicians with experience in regenerative procedures and a structured approach to documentation are especially well positioned to contribute strong applications.

A jubilee initiative with clinical and human impact

With this programme, Geistlich is linking its anniversary celebration to a practical effort to improve patient access to advanced regenerative care. The initiative highlights not only the clinical value of regenerative dentistry, but also its potential to address unmet need when financial barriers stand in the way of treatment.

By supporting selected cases around the world, the programme reinforces the importance of combining scientific rigour with patient-centered action. In doing so, it offers a timely example of how industry-supported initiatives can help extend the benefits of modern regenerative therapy to those who need it most.

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More information and submission guidelines

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Digital workflows have long been standard in modern dentistry. With the ICX-P5, you benefit from a high-performance scanner solution that perfectly combines precision, efficiency and cost-effectiveness.

The scanner enables quick and convenient capture of the intra-oral situation—entirely without traditional impression material. The data is processed digitally immediately and can be transferred directly to the dental laboratory.

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ICX-BAMBOO PRO: Maximum mobility for your ICX-P5 intra-oral scanner

With the ICX-BAMBOO PRO, you can transform your ICX-P5 into a fully mobile scanning solution. The system combines powerful hardware, a large touchscreen and an integrated high-performance battery—for maximum flexibility in everyday practice.

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This ensures more efficient processes, shorter distances and optimal integration of digital workflows into your practice.

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For even greater freedom of movement, the ICX-FREE is also available.

The wireless scanner impresses with its ergonomic handling and particularly flexible use in the treatment room.

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- Maximum freedom of movement whilst scanning

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  Compatible with STL and PLY—for maximum flexibility in the digital workflow.
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  High scanning accuracy for reliable results with crowns, bridges and implant restorations.
- **Intuitive operation**
  Simply start and scan—without complex settings or lengthy training.
- **Cost-effective**
  Attractive value for money and no ongoing licence costs.
- **More efficient workflows in your practice**
  With the ICX-P5, you can seamlessly integrate digital impressions into your daily practice routine.



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WITAR Consulting GmbH

Ideal solution for all indications

AWI ceramic implants from WITAR offer superior aesthetics, stability, accuracy and healthy osseointegration. A sophisticated design combined with modern materials make for an ideal solution for all bone classes and indications. Made of zirconium dioxide, AWI dental implants are metal-free and thus fully biocompatible. The cemented zirconia abutment allows an individual design. The transgingival shoulder has an ideal surface for interacting with soft tissue for any type of indication. The conical micro-thread allows great primary stability and axial loading. Studies have shown that the thread roughness of 1.7 µm leads to optimal osseointegration. Also, the surface is coated with a bioactive BIOVERIT I nano-coating. This surface-thread combination enables superior osseointegration for all bone classes. The self-tapping implant tip provides space for bone chips and low-compression insertion. AWI ceramic implants are now available in gingiva colour too, which leads to even better aesthetics and optimised risk areas.

Contact address
WITAR Consulting GmbH
www.witar.de

ZiNova

ZiNova & Z7 ceramic implant systems— a new biological approach to implantology

ZiNova (USA) and Z7 (international markets) represent a next-generation ceramic implant platform developed by MABB—Bioengineering & Biomaterials, focused on biologically driven, metal-free implantology.

Manufactured using advanced ceramic injection molding (CIM) technology and yttria-stabilised zirconia (Y-TZP), the system combines high mechanical strength, tissue stability, and optimised biological integration.

A key differentiator is its proprietary 3D native surface technology, generated directly during the CIM manufacturing process without sandblasting or aggressive acid etching. This approach aims to preserve surface integrity while reducing potential contamination risks, supporting favourable biological behaviour for both hard and soft tissues, while also contributing to a more sustainable manufacturing philosophy with lower environmental impact.

The implant philosophy is centered on tissue-level concepts, aiming to reduce micro-movements, bacterial infiltration, bio-tribocorrosion-related risks, and long-term peri-implant inflammation commonly associated with metallic systems.



The Z7 platform currently includes:

- FDA-cleared one-piece zirconia implant system in the United States under the ZiNova brand
- one-piece and two-piece systems approved in Argentina (ANMAT)
- regulatory expansion activities ongoing in Brazil (ANVISA)
- CE certification process currently underway in Europe

Today, more than 300 clinicians are actively using Z7 systems in South America, supported by growing clinical evidence, international collaborations, and presentations at scientific meetings such as the Z7 & ZiNova Experiences and the Global Ceramic Implant Summit held in Buenos Aires and to be programmed in the US, Brazil, Europe and Asia.

The vision behind ZiNova/Z7 is simple: to help drive implant dentistry toward a more biological, aesthetic, tissue-friendly, and metal-free future.

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	Event	Location	Date	Details/Registration
11/2026	11. Nose, Sinus & Implants	Berlin Germany	27–28 November 2026	noseansinus.info
02/2027	22. Expert Symposium of BDIZ EDI	Cologne Germany	6–8 March 2027	www.bdizedi.org
03/2027	IDS International Dental Show	Cologne Germany	16–20 March 2027	www.ids-cologne.de
04/2027	20. Europe Symposium of BDIZ EDI	Tirana Albania	23–24 April 2027	www.bdizedi.org

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

Manuscript submission
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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Pages should be numbered consecutively, starting with the cover page. The cover page should include the title of the manuscript and the name and degree for all authors. Also included should be the full postal address, telephone number, and e-mail address of the contact author.
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Each article should contain a minimum of 20 and a maximum of 50 pictures, except in unusual circumstances. Our publishing house attaches great importance to high quality illustrations. All illustrations should be numbered, have a caption and be mentioned in the text.
The photos should have a size of 10 x 15 cm, the image or graphic files must have a resolution of 300 dpi. TIFF, EPS and JPG file formats are suitable. Radiographs, charts, graphs, and drawn figures are also accepted.
Captions should be brief one or two-line descriptions of each illustration, typed on a separate page following the references. Captions must be numbered in the same numerical order as the illustrations. Tables should be typed on a separate page and numbered consecutively, according to citation in the text. The title of the table and its caption must be on the same page as the table itself.

References
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).

Review process
Manuscripts will be reviewed by three members of the editorial board. Authors are not informed of the identity of the reviewers and reviewers are not provided with the identity of the author. The review cycle will be completed within 60 days. Publication is expected within nine months.

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I hereby apply for a membership in the BDIZ EDI
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.....

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

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