PUBLISHED BY THE AMERICAN ACADEMY OF IMPLANT DENTISTRY / 2023 ISSUE 2

AAID NEWS

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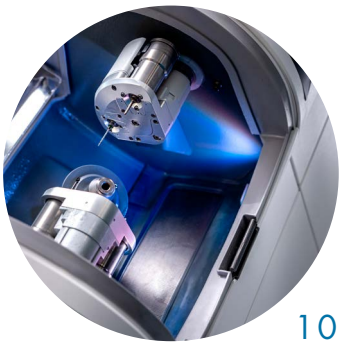
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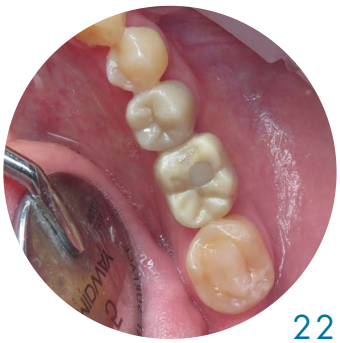
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AAID
AMERICAN ACADEMY OF IMPLANT DENTISTRY

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Lead Stories

Academy News

By Dennis Flanagan,
DDS, MSc, FAAID, DABOI/ID,
AAID Editor

EDITOR'S NOTEBOOK

Does size matter when using autologous dentin as a graft material?

There are recent reports of the use of autogenous dentin as an osseous graft material. The dentin graft particles apparently are resorbed and replaced with bone. Nonetheless, we all have seen residual root tips residing in healed bone that have not undergone resorption. We don't really know what physiologic parameters determine which dentin fragments are resorbed and which are not. There may be an immunologic cascade that determines this.

Using the patient's own dentin as a graft material is convenient and apparently safe when prepared appropriately. The dentin is usually fragmented to less than 1mm diameter and placed in osseous gaps for space maintenance and osteoconduction for bone formation. This usually results in appropriate bone formation and acceptable bone density for dental implant placement. Autogenous dentin is an acceptable alternative to autogenous bone and allograft for osseous regeneration. Nonetheless, the most appropriate particle size has not yet been defined.

During an extraction of a non-infected tooth, a root tip can be left in situ when its removal may endanger an anatomical structure such as a sinus, nerve, or artery. These root tips may or may not be resorbed and replaced with bone.

Osseous sites should be thoroughly debrided and all infectious material removed. Residual infection material will disrupt healing and potentially disrupt a dentin graft.

Dentin fragments need to be resorbed and replaced with vital bone. Nonetheless, complete resorption may not be necessary. Particulate autogenous dentin may also provide a scaffold for bone formation and act as a support for osseous healing.

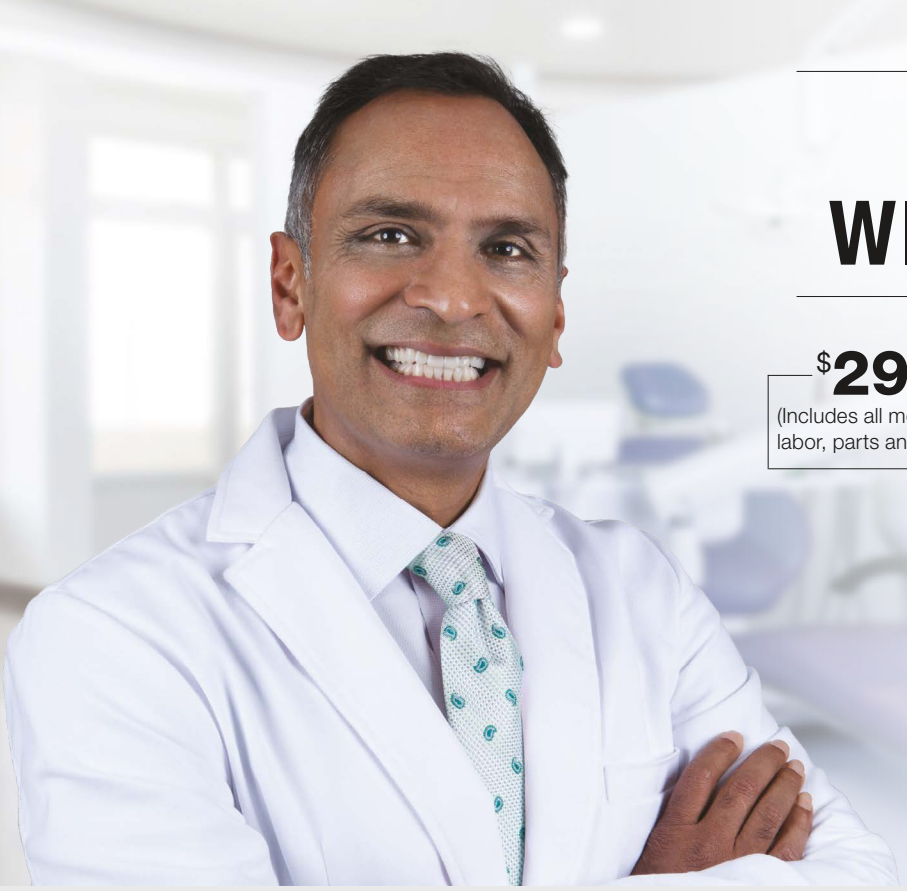
In preparation for site placement, the harvested dentin used for graft material is pulverized and treated with acid and ethanol and dried before being placed in the surgical site. Dentin particles of 200 microns that are acid-etched can lose carbonate and phosphate, which may affect resorption. Any acid etching of the dentin increases the microscopic surface area and increases molecular exposure to physiologic enzymes and reactive agents that may encourage resorption. A smear layer on a dentin particle may affect resorption by being resistant to acidic breakdown.

Generally, dentin particles less than 300 microns have a higher density than larger particles.

After five days, residual dentin fragments are surrounded by inflammatory cells and after 14 days of placement as a graft material, osmiophilic needle-like calcium and phosphorus crystalline structures form on the dentin surface. This is an initial calcification with collagen fibrils and direct calcium apposition. Initial calcification around the dentin fragments can develop various patterns.

Clinical experience shows that dentin resorption may or may not occur. The physiologic parameters are not well understood. The particle size may be a determinant as well as the metabolic condition of the patient, the patient's general health, particle surface conditions, type of bone site, and any number of physiochemical issues. The dentin pulverizer manufacturer seems to think that a particle less that 1mm is appropriate for use as a graft material. Such a concept is not yet proven.

It just may be that dentin particles left in bone as a graft material or from an extraction may resorb if there is no infection and the fragment is less than approximately 1mm. Nonetheless, we cannot predict which fragments will resorb and which will not. Particle processing itself may encourage resorption by altering the organic portion of dentin. It seems that processed small fragments of dentin used as a graft material will resorb and be completely replaced with natural bone and act as a scaffold to support osseous formation. Autogenous dentin does indeed provide an alternative for bone grafting for the clinician.



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> *–Paresh B. Patel, DDS | Implantologist, Educator*
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By Shane Samy, DMD, FAAID, DABOI/ID,
AAID President 2023

PRESIDENT'S MESSAGE

Celebrating Success, Anticipating the Future, and Wishing You a Joyful Summer!

As we reach the halfway point of 2023, I find myself reflecting on the resounding success of our recent Central District meeting in Chicago and anticipating the upcoming Annual Conference, November 1-4 at Caesars Palace in Las Vegas.

The Central District Meeting was marked by vibrant discussions and insightful presentations. Innovative ideas and best practices were shared, empowering us to explore new horizons and discover new ways to expand our personal expertise and practices alike.

Now, we look forward to our upcoming Annual Conference. This flagship event promises to be extraordinary, bringing together industry leaders, innovators, and thought-provokers from around the globe. With an array of captivating Main Podium speakers and engaging hands-on workshops, our Annual Conference will fuel your minds. Together, we will embark on a collective journey of learning, collaboration, and inspiration, poised to shape the future of our industry.

Amidst the anticipation and excitement, it is important to remember to take a moment to pause, rejuvenate, and appreciate the joys of summer. Let us cherish the well-deserved moments of relaxation and leisure with our loved ones. Whether it's embarking on a long-awaited vacation, exploring new hobbies, or simply basking in the beauty of nature, let this summer be a time for revitalization and reconnection.

In closing, I extend my heartfelt gratitude to each member for their unwavering support and commitment to our organization's success. It is your passion, expertise, and collective efforts that propel us forward, setting new benchmarks of excellence year after year. I am truly proud to lead such an exceptional group of individuals, whose unwavering dedication continues to elevate our organization to new heights.

I look forward to meeting you all at the Annual Conference and celebrating our achievements together. Until then, I wish you a summer filled with joy, happiness, and rejuvenation.

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Carolina Hernandez, CAE,
AAID Executive Director

EXECUTIVE DIRECTOR'S MESSAGE

Exciting Things Coming To Your AAID!

It's hard to believe that half of 2023 is already behind us, but it feels like we are finally shaking off the cobwebs and stagnation of the pandemic. The Central District just wrapped up its June meeting in Chicago. It was a combination of old friends, new faces, and dynamic speakers. They created a unique experience by gathering at Wrigley Rooftops to enjoy a performance by Dead & Company at Wrigley Field. This spirit of innovation and reinvention continues in what the AAID has planned for its members in the coming months.

This July, the AAID will unveil a new look and feel to our website – aaid.com. The entire site is being overhauled to condense the content and make it more user friendly. To go with the new site, the new and improved Member Compass™ portal will debut. This streamlined online portal is where you'll be able to update your profile, set your communication preferences, renew your membership, view the Member Directory, and much more. The Member Directory is your way to connect with old friends and new colleagues. Add your headshot to your profile to help your colleagues connect with you.

In addition to the new look, you'll find new functionality on the website. Beginning this fall, you'll be able to set your dues to auto-pay instead of receiving paper invoices and reminder phone calls. The Foundation will get some new options as well. In addition to single donations, members will be able to make pledges that are billed out over several months. Navigating between the website, your member portal, Annual Conference registration, and online education will also be much easier.

Speaking of new looks, have you checked out the AAID Consumer website – aaid-implant.org? This website targeted to consumers provides the resources and information your patients need in a way that you can share by whatever digital media your patients use. Add in your voice by submitting a blog, sharing a video from the site with your patients, or linking the resources provided directly on your own practice's website.

A new look and expanded digital footprint are on the horizon for the AAID. And there's still more to come when the online learning institute debuts this fall at the Annual Conference.

Thank you for being a member of the first professional organization in the world dedicated to implant dentistry. Your membership in the Academy, passion for implant dentistry, and dedication to your patients fuel the innovation and reinvention that makes it exciting for myself and the AAID staff to bring forth these new member initiatives.

All the best,

Carolina Hernandez, CAE
AAID Executive Director

An exciting fall season awaits you in Switzerland!

Take advantage of two exciting offers this fall at the SWISS BIOHEALTH EDUCATION CENTER in Kreuzlingen, Switzerland. At the CIW, you will gain hands-on experience from the creators of the SWISS BIOHEALTH CONCEPT. The second big event this fall is the JOINT CONGRESS for CERAMIC IMPLANTOLOGY, which has established itself as one of the most important events world-wide for practioners of ceramic implantology. This event is not to be missed, so reserve your seat today as they are limited!

FALL BUNDLE #1 for 4,300.00 €*

The following single courses are included:

- Oct. 7th – 11th: CERAMIC IMPLANTOLOGY WEEK (Case Planning, Surgery Hands-On, Prosthodontics Hands-On and **SDS ALLINONE with Dr. Ulrich Volz** on the 10th and 11th)
- Oct. 12th: SDS NEW TALENT CONTEST (as jury member!)
- Oct. 13th: Exclusive JCCI White Night Party
- Oct. 13th – 14th: 3rd JOINT CONGRESS for CERAMIC IMPLANTOLOGY***

FALL BUNDLE #2 for 1,750.00 €**

The following single courses are included:

- Oct. 10th – 11th: **SDS ALLINONE with Dr. Ulrich Volz**
- Oct. 12th: SDS NEW TALENT CONTEST (as jury member!)
- Oct. 13th: Exclusive JCCI White Night Party
- Oct. 13th – 14th: 3rd JOINT CONGRESS for CERAMIC IMPLANTOLOGY***

Scan the QR-Code to register on our website at www.swissdentalsolutions.com/en/courses/special-offer-fall-bundle

* A savings of 400,00 € compared to purchasing singularly
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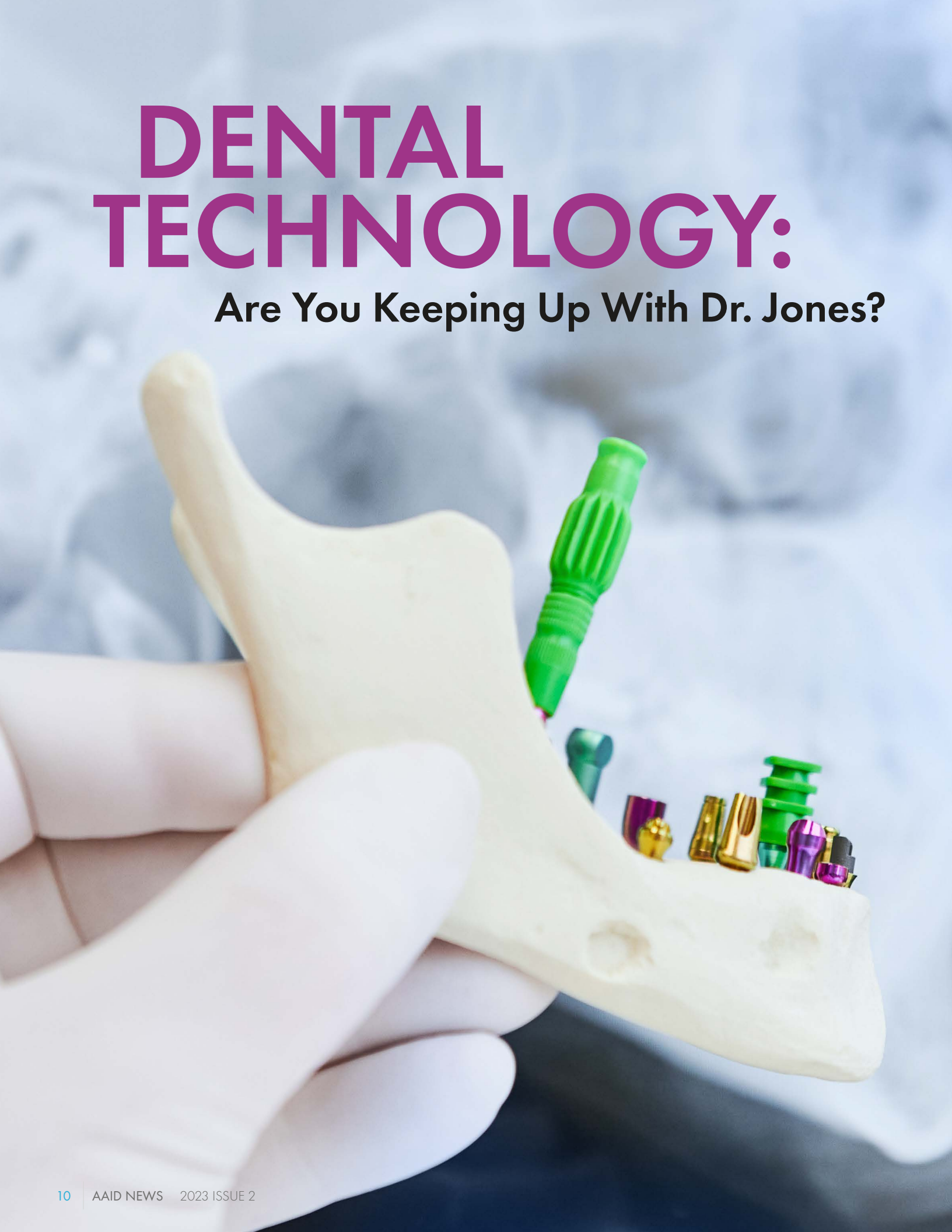
DENTAL TECHNOLOGY:

Are You Keeping Up With Dr. Jones?



Are you keeping up with the latest technology being offered for today's implantologist?

Have you found yourself descending a ChatGPT rabbit hole to see if you can uncover a new program or method to make your practice more efficient? Are you jealous of your techie friends because they seem to know the latest innovations? We at *AAID News* are sympathetic, so we asked an esteemed panel of AAID members to provide insights about the latest and greatest dental technology that is making a difference in their practices today.

We want to hear your thoughts! Did we miss any Trends in Products? Do you disagree with anything we've printed? Email your thoughts to **editor@aaid.com** and we'll include your views in a future AAID publication.

"The key trend in implant dentistry and the entire oral health care profession is incorporating a digital workflow to care for our patients. This starts with the diagnostic phase with cone beam technology being paired with intraoral CAD/CAM scanning to create images that can measure bone volume in a 3D format, position and size implants on the scans, and create a surgical guide to secure the implants. The digital workflow is also used to design the interim and final prosthesis, resulting in a more predictable result while shortening the treatment time for the patient."

– David G. Hochberg, DDS, FAAID, DABOI/ID

One under-the-radar technology with a memorable sci-fi name is the PlasmaX MegaGen Motion machine.

"Most young dentists probably haven't heard of it, but the process and science have been solid for 40 years, and no big company has put so much money into it and produced such an extraordinary product."

– Allen A. Ghorashi DDS, FAAID, DABOI/ID

Artificial Intelligence will have a profound impact on how we diagnose oral disease, check for caries and pathology, and even create the appropriate treatment plan. There are some specific “players” out there… we are in the beginning of this breakthrough technology.

AAID News has written about ceramic implants, but one AAID member said the one material that is being used more is called Trinia.

“It is a fiberglass-reinforced material that can be used for partials, bridges, and hybrid restorations. It has some flexibility so it can be more durable than zirconia. Anyway, I haven’t heard too many people talk about it, but my technician really likes it.”

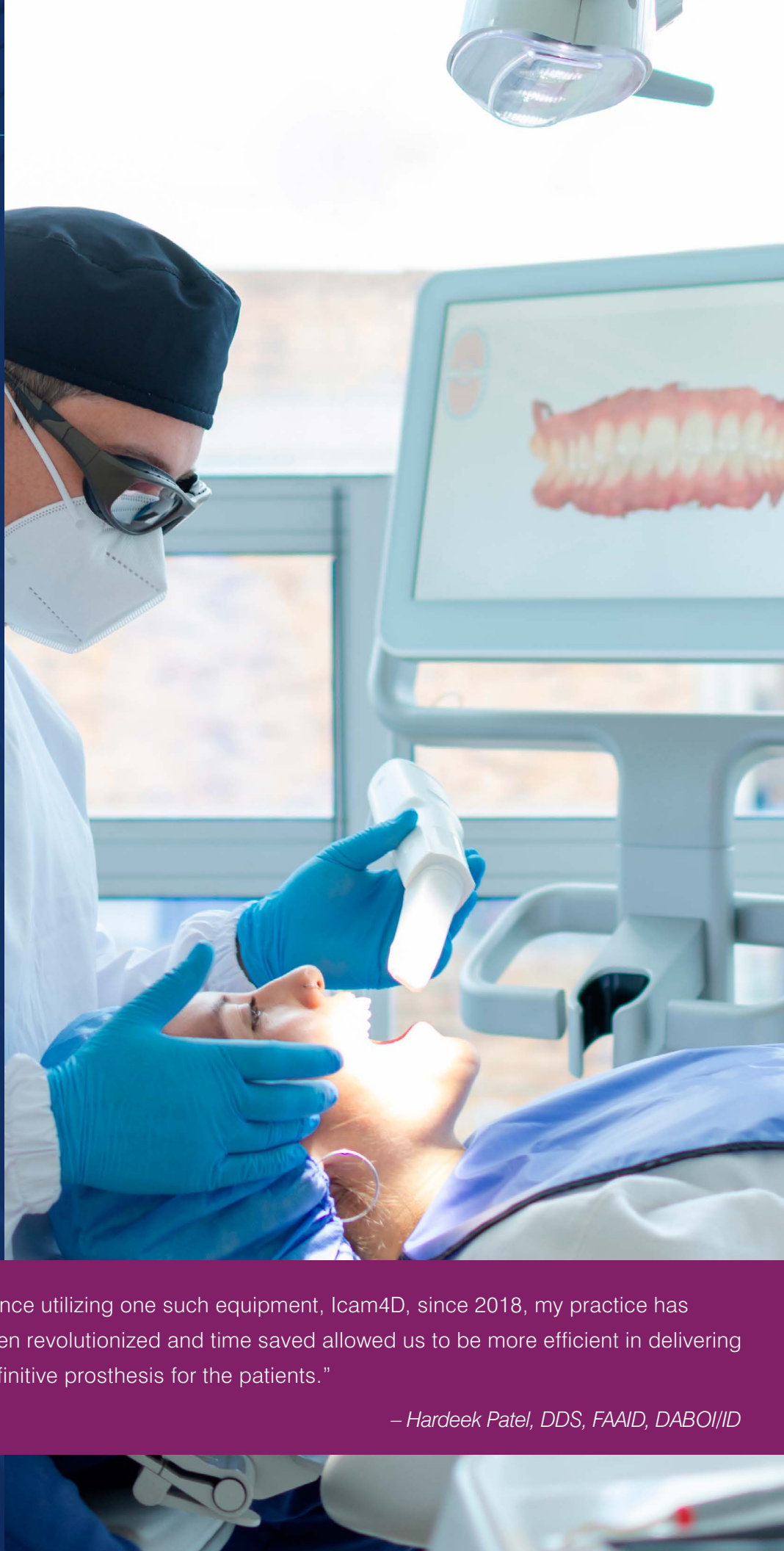
– Janice Wang, DDS, FAAID, DABOI/ID

While many dentists had unique tech tips, there was only one trend mentioned by a majority of our panel: photogrammetry.

According to Michael S. Fioritto, DDS, FAAID, DABOI/ID: “We’re using infrared scanners to take impressions for full arch implant cases. The process is called photogrammetry, and it’s a hot topic in the implant world now. The scanners are on backorder throughout the world due to the high demand. Using the scanners helps our patients to get their work done faster and with better accuracy.” He singled out the companies PiC and iCam but noted that new products are coming on the market. Due to the demand, wait times can be expected.

Photogrammetry could replace the use of putty impressions commonly used now. These steps take a lot longer in the chair for the patients and then require weeks of time between appointments until the lab technicians return their work. The photogrammetry allows us to eliminate putty impressions and cut out months of extra time and appointments.

Another panelist, Hardeek Patel, DDS, FAAID, DABOI/ID echoed these findings: “Since utilizing one such equipment, Icam4D, since 2018, my practice has been revolutionized and time saved allowed us to be more efficient in delivering definitive prosthesis for the patients. The duration from the intraoral photogrammetry to designed prosthesis was less than an hour.”



“Since utilizing one such equipment, Icam4D, since 2018, my practice has been revolutionized and time saved allowed us to be more efficient in delivering definitive prosthesis for the patients.”

– Hardeek Patel, DDS, FAAID, DABOI/ID

In keeping with the theme of this article, we decided to prompt ChatGPT to weigh in on dental technology. Here's what our prompt returned:

1. **DIGITAL DENTISTRY AND GUIDED IMPLANT PLACEMENT:** Digital technologies have revolutionized dental implant procedures. Computer-aided design/computer-aided manufacturing (CAD/CAM) systems, cone beam computed tomography (CBCT), and intraoral scanners are increasingly being used to create digital impressions, plan implant placement, and fabricate custom implant restorations. Guided implant surgery using 3D-printed surgical guides enhances precision and accuracy.

2. **SHORTER IMPLANTS AND NARROW-DIAMETER IMPLANTS:** Shorter dental implants, typically less than 10 mm in length, have gained popularity. They allow for implant placement in areas with limited vertical bone height. Additionally, narrow-diameter implants are being used in situations where there is limited space between adjacent teeth or insufficient bone width.

3. **IMMEDIATE LOADING AND SAME-DAY IMPLANTS:** Traditional implant protocols involve a healing period of several months before attaching the final restoration. However, advancements in implant design, surface modifications, and surgical techniques have enabled immediate loading of dental implants. This approach allows for the placement of a temporary or final restoration on the same day as implant surgery.

(Continued on pg. 16)

(Continued from pg. 15)

4. **IMPLANT SURFACE MODIFICATIONS:** Researchers and manufacturers continue to explore surface modifications of implant materials to enhance osseointegration (bonding of the implant with the surrounding bone). Surface treatments such as sandblasting, acid etching, and incorporation of bioactive coatings promote faster and stronger bone integration.

5. **ZIRCONIA IMPLANTS**: Zirconia dental implants are gaining popularity as an alternative to traditional titanium implants. Zirconia is a ceramic material that offers excellent aesthetics, biocompatibility, and favorable tissue response. It is particularly advantageous for patients with thin gingival biotypes or those who have concerns about the visibility of metal in their smile.

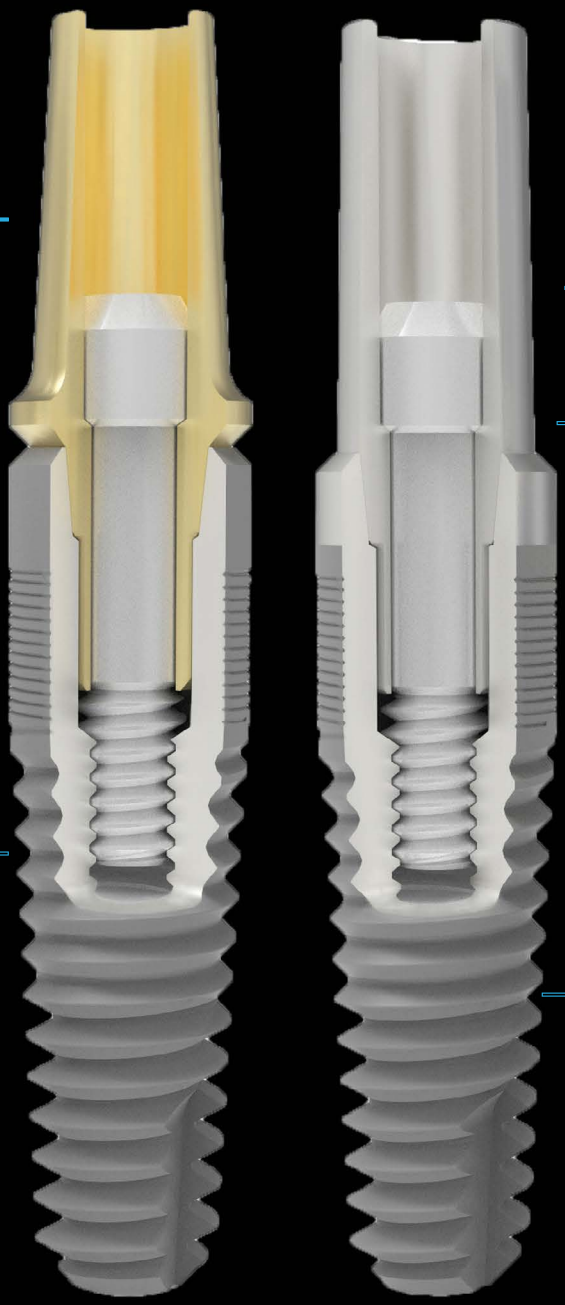
6. **CUSTOMIZED ABUTMENTS AND PROSTHETICS:** CAD/CAM technology allows for the precise fabrication of custom abutments and implant-supported prosthetics. Customized components provide better fit, aesthetics, and functional outcomes, as they are designed to match the patient's individual anatomy.

7. **DIGITAL WORKFLOW AND AUGMENTED REALITY:** The integration of digital workflows, including intraoral scanning, virtual treatment planning, and 3D printing, streamlines the implant process. Augmented reality (AR) technologies are also being explored to assist dentists during implant surgeries, providing real-time guidance and visualization.

How would you rate this AI technology's ability to assess the future of dental technology?

Integrity Implant System

By Tatum Surgical



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By Max G. Moses, JD, CPA, MBA

LEGALBITE

The Pace Quickens

(Editor's Note: This article contains information as of June 30, 2023)

Changes in scope of practice, advertising, and specialty rules by state dental boards have historically moved at a glacial pace. Perhaps it is the result of climate change or maybe something else, but recently, several states have accelerated the pace of addressing these key issues of interest to the American Academy of Implant Dentistry (AAID) and the American Board of Oral Implantology/Implant Dentistry (ABOI/ID).

In Issue 1 of the 2023 edition of *AAID News*, we published information on three key states in which implant dentists have a keen interest: Oregon, Oklahoma, and South Dakota. A fourth state – Ohio – is beginning to again move in the direction of addressing implant dentistry through the state rulemaking process. This article updates what has happened over just the past couple months and what is anticipated in the near future.

OKLAHOMA
– a focus on quality of care

In the most recent "Legal Bite," we reported on Senate Bill 754. This bill as originally introduced would required any dentist wanting to perform the surgical phase of implant placement surgery in Oklahoma to have an "implant designation" on his or her license. Specialists licensed in oral and maxillofacial surgery, periodontics, prosthodontics, and endodontics would be exempted from the 80 hours of implant specific CE. Notably, those dentists who hold a current certification as an AAID Associate Fellow or Fellow, and/or are Diplomates of the ABOI/ID would be automatically granted the implant designation.

That language was removed from the legislation by a Senate Committee early in the life of the bill.

Since our last report, Oklahoma SB 754 passed the Oklahoma House of Representatives and was signed into law by the Governor on May 5, 2023.

Changes in scope of practice, advertising, and specialty rules by state dental boards have historically moved at a glacial pace. Perhaps it is the result of climate change or maybe something else, but recently, several states have accelerated the pace of addressing these key issues of interest to the American Academy of Implant Dentistry (AAID) and the American Board of Oral Implantology/Implant Dentistry (ABOI).

The version signed by the Governor didn't specially address implant placement surgery. Instead, it specially made practice under the standard of care as one of the potential reasons for discipline of a dentist. The new law removes *"Representing himself or herself to the public as a specialist whose practice is limited to a dental specialty, when such representation is false, fraudulent, or misleading as a criteria for potential discipline."* It replaced that language with a standard of care concept, to wit: *"Practicing below the basic standard of care of a patient which an ordinary prudent dentist with similar training and experience within the local area would have provided including, but not limited to, failing to complete proper training and demonstrate proficiency for any procedure delegated to a dental hygienist or dental assistant."*

Despite strenuous objections from the AAID, the South Dakota Board of Dentistry continues to support new rules that would limit specialty advertisement to those dentists who complete an advanced education program of at least two years and that is accredited by an agency or dental school recognized by the United States Department of Education.

OREGON

– affirmation of the deal

In 2022, a settlement agreement was entered between the AAID and the Oregon Board of Dentistry. The agreement stated that the Board would not enforce the advertising statute or certain rules adopted by the Board relating to specialty advertising while it repealed its specialty advertising regulation and recommended to the Governor to repeal the corresponding statute.

In late March 2023, the Board filed a notice of proposed new rules that potentially could violate both the letter and spirit of the agreement. A 30-minute public hearing was scheduled and held on May 10, 2023 with the opportunity to offer comments to the Board set as June 2, 2023.

On May 5, 2023, the AAID's retained legal counsel submitted a letter to the Board's executive director and to the Board's counsel from the Oregon Department of Justice seeking clarification of the Board's intentions. The letter stated, in part, that the "Oregon Board of Dentistry's (the "OBD") consideration of various proposed changes to its specialty advertising rules (818-015-005, 818-015-007, 818-021-0012, and 818-021-0015), which—if adopted—would recognize only ADA-approved specialty areas of dentistry. After reading the proposed changes, we are concerned that—under the amended rules—the OBD might view any AAID member / ABOI/ID Diplomate's advertisements describing themselves as a "specialist" or "specializing in" implant dentistry as "misleading" and subject the licensee to disciplinary action."

The letter wrote to "confirm, consistent with the terms of the parties' settlement agreement, that if the OBD does adopt the proposed rule changes, Oregon will not take the position that AAID Member / ABOI/ID Diplomate advertising is misleading or otherwise a proper basis for disciplinary action because it identifies a relevant provider as a "specialist" or someone "specializing in" implantology."

AAID's legal counsel spoke with counsel for the Oregon Board of Dentistry who confirmed that the Board's proposed regulations are in in furtherance of complying with the settlement agreement with AAID. Importantly, she also confirmed that the Board has no intention of bringing disciplinary actions against AAID members for misleading or deceptive advertise based solely on their advertising as a "specialist" or "specializing in" implant dentistry provided their qualifications support it.

SOUTH DAKOTA

– the next step

On June 2, 2023, the South Dakota Board of Dentistry voted to approve new rules relating to specialization and advertising of such. Despite strenuous objections from the AAID, the South Dakota Board supported new rules that would limit specialty advertisement to those dentists who complete an advanced education program of at least two years and that is accredited by an agency

or dental school recognized by the United States Department of Education.

The approved rules now go before the South Dakota Legislature's Interim Rules Committee for further review and, if approved by the Committee, will become effective shortly thereafter. AAID's retained legal counsel continues to strenuously object to the Board's proposed rules. In consultation with its retained legal counsel, AAID's Board of Trustees and Legal Oversight Committee are reviewing additional legal remedies to further challenged the Board's proposed rules.

OHIO

– talks may have a positive result

AAID filed a lawsuit in 2018. Thereafter, a stay of litigation with a corresponding stay in enforcement of regulations was negotiated. At the end of 2022, the judge in the case, seeing no activity, decided to close the case and invited parties to reopen if they wished.

Substantive discussions have occurred between AAID Counsel and legal counsel for the Ohio State Dental Board to determine their appetite for a negotiated settlement much like what was achieved in the states of Oregon and Michigan. AAID is negotiating with Ohio a revised regulation that closely resembles those that were supported successfully in North Carolina and Iowa.

The Ohio Board agreed to working with AAID to rewrite its specialty advertising regulation with language similar to the negotiated North Carolina specialty advertising regulation. AAID's legal counsel is working closely with counterparts at the Ohio Board to draft a regulation that, once agreed upon by the Board and AAID, would proceed through the formal rulemaking process.

Perhaps it is just a coincidence that the glacial pace of dental regulations and climate change happen to be occurring simultaneously. Or maybe it is because AAID's LOC and Board of Trustees continue to actively pursue the rights and interests of implant dentistry in the states.

Max G. Moses retired as the Executive Director of the Academy of General Dentistry and, prior to that, was the Director of Communications and Marketing for the AAID.

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Dr. Suhail S. Mati,
DMD, AFAAID, DABOI/ID

CLINICALBITE

Case Studies: Ceramic Implants as an Alternative to Titanium Implants

ABSTRACT

With the growing discussion surrounding ceramic implants, a few implantologists have started offering the zirconia-grade material as an alternative to the standard titanium implant procedure to their respective patients. Zirconium implants have proven to be tissue-friendly and viable for those with a metal allergy or sensitivity. This article includes three case studies from a private practice in Bingham Farms, Michigan, discussing the procedure and methods used on each patient as well as the results. Overall, these three unique case studies illustrate the benefits of this alternative procedure and what appropriate measures future dentists should take when considering ceramic implants for their patients.

INTRODUCTION

Titanium implants are the standard metal fixture for implantologists to use on patients as they have been proven to be safe and reliable. Over the years, implant dentists have sought to develop new and effective material and methods as an alternative to titanium implants. One of the more promising materials comes from zirconium. Zirconium, like titanium, is a chemical element and can be processed into zirconia, a ceramic material.

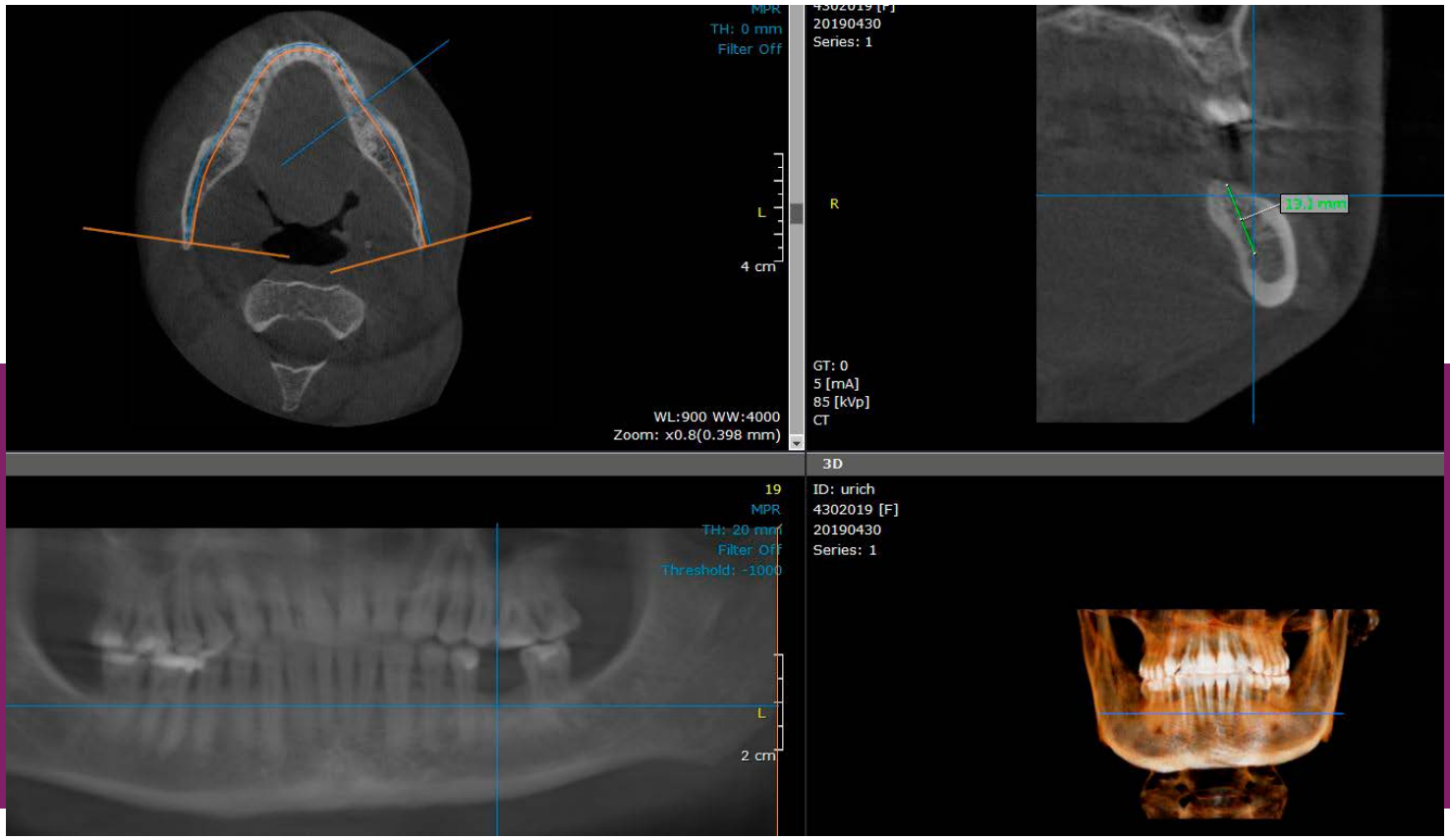
Some patients oppose titanium implants and have sought out zirconia-grade ceramic implants due to existing metal allergies or sensitivities, or because of personal interest in the alternative material because of its non-metallic composition and ivory appearance.

Although ceramic implants aren't widely used in most practices, implantologists like Suhail Mati, DMD have started to offer the zirconia-grade material as an alternative to titanium implants. His private practice in Bingham Farms, Michigan has allowed his patients in need of tooth implants to receive the better-suited operation as needed.

The objective of this research is to present three unique case studies from Dr. Mati's practice as evidence for ceramic implants being a safe and effective alternative to titanium implants.

CASE STUDIES

The patients who participated in these case studies gave their consent to share information about their respective procedures and follow-up appointments, detailing the perceivable benefits post operation.



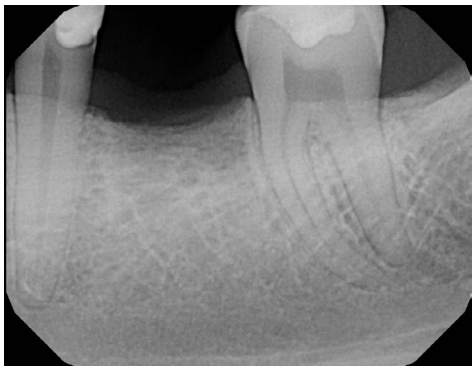
Preop CBCT scan

CASE 1

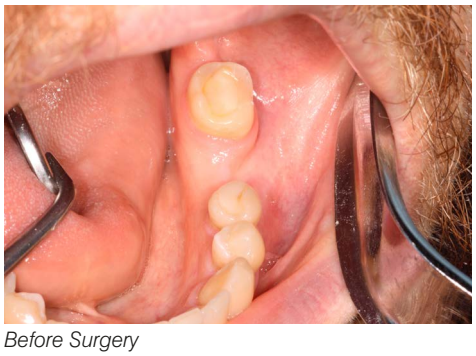
Procedure and Methods

Sam, a 26-year-old male, expressed an interest in the metal-free implant at his first appointment. A comprehensive diagnosis was performed prior to the operation including a Cone Beam Computed Tomography (CBCT) scan. CBCT is a detailed 3D imaging of the jaw, teeth, and nerves in the mouth to ensure better accuracy for tooth implantation and restoration. After a thorough discussion of the benefits, risks, and alternatives, the patient selected a ceramic implant as the most suitable tooth replacement option.

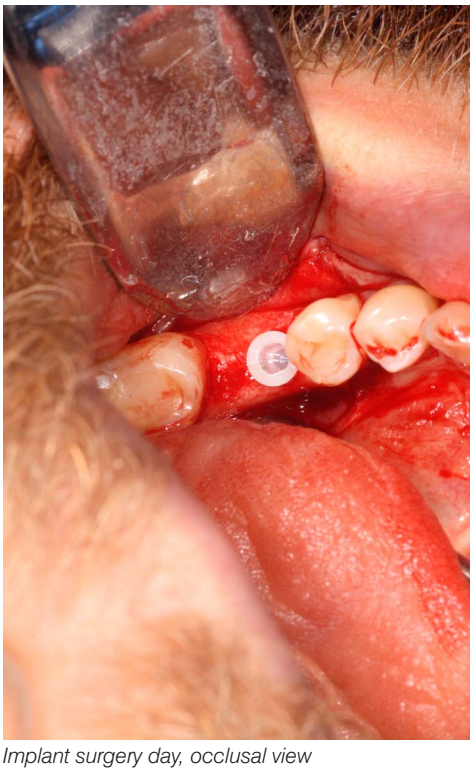
The surgical implant procedure was performed on April 3, 2019. The patient was premedicated with 1000 mg of Amoxicillin one hour preoperatively. He was fully draped for surgery after having the face and intra-oral area swabbed with Chlorhexidine Gluconate 0.12%. Local anesthesia was administered via 2 carpules of 1.8 cc, 2%



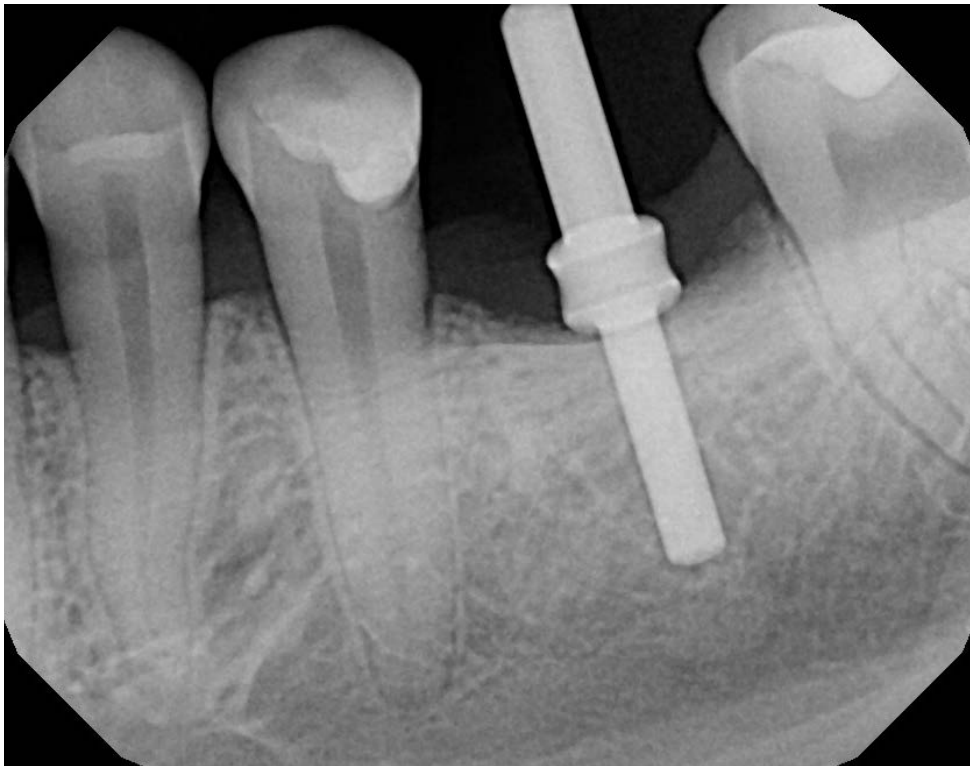
February 20, 2019, before placement



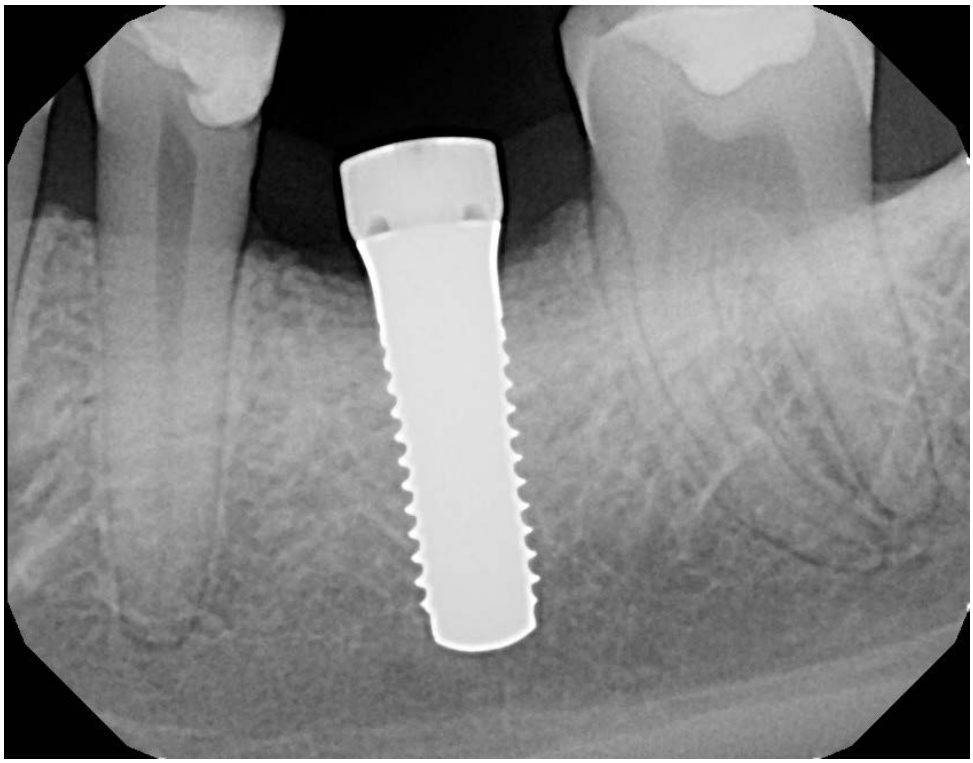
Before Surgery



Implant surgery day, occlusal view



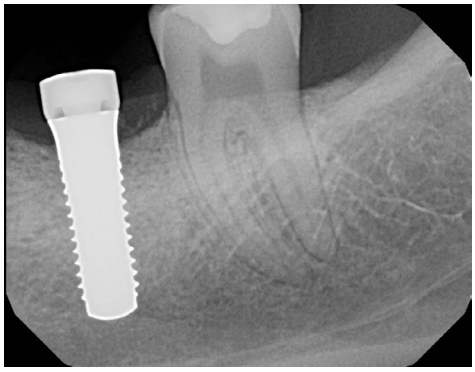
April 30, 2019, PA of indicator pin



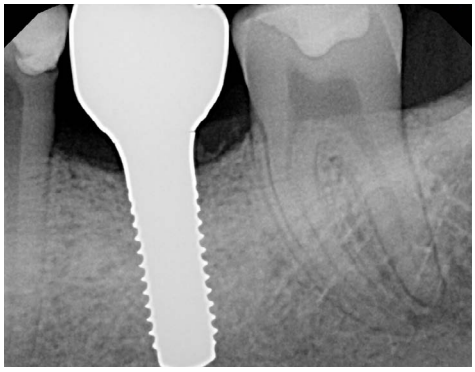
April 30, 2019, PA of implant

Lidocaine with 1:100,000 epinephrine, and one carpule of 1.8 cc, 0.5% Marcaine with 1:200,000 epinephrine. Intravenous venous (IV) access was obtained for platelet rich fibrin (PRF) with a butterfly syringe gauge 19 from the left hand. A total of two 10 mL red vials of blood were collected and centrifuged for the procedure.

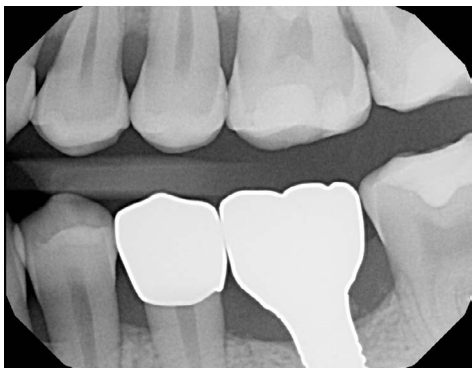
The tissue at site #19 was incised along the crest of the edentulous ridge to the level of the bone. A conservative full thickness reflection was made to expose the alveolar crest. Initial preparation of the bone was made using a 1.5 mm pilot drill. This osteotomy was extended to the full depth of 12 mm from crestal bone. The osteotomy was enlarged using a series of progressively larger externally irrigated osseodensification ridge expansion burs and protocols. Per protocol, the final diameter bur of the osteotomy was finished slightly smaller than the final diameter of the implant to be placed. The sterile 4.1 x 12 mm Straumann pure ceramic implant was placed into the site. The implant was seated to full depth utilizing a rachet. The healing abutment titanium 5.2 mm diameter was placed on the implant utilizing a titanium screwdriver. The titanium healing abutment was used on this ceramic implant as it was the only abutment product available when the surgery took place. Allograft hydrated with PRF liquid was used to augment the buccal ridge, and PRF membrane was placed over the graft. The tissue was approximated and secured using 3.0 Polytetrafluoroethylene (PTFE) sutures. Then, an ice pack was placed on the patient's face.



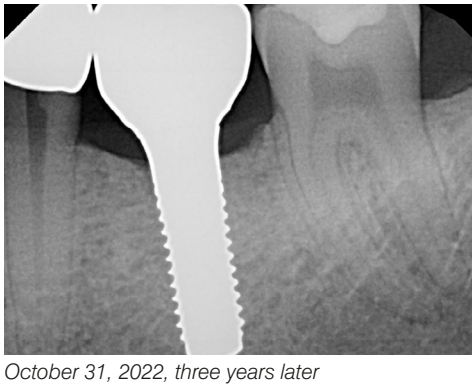
July 16, 2019, implant after three months of healing



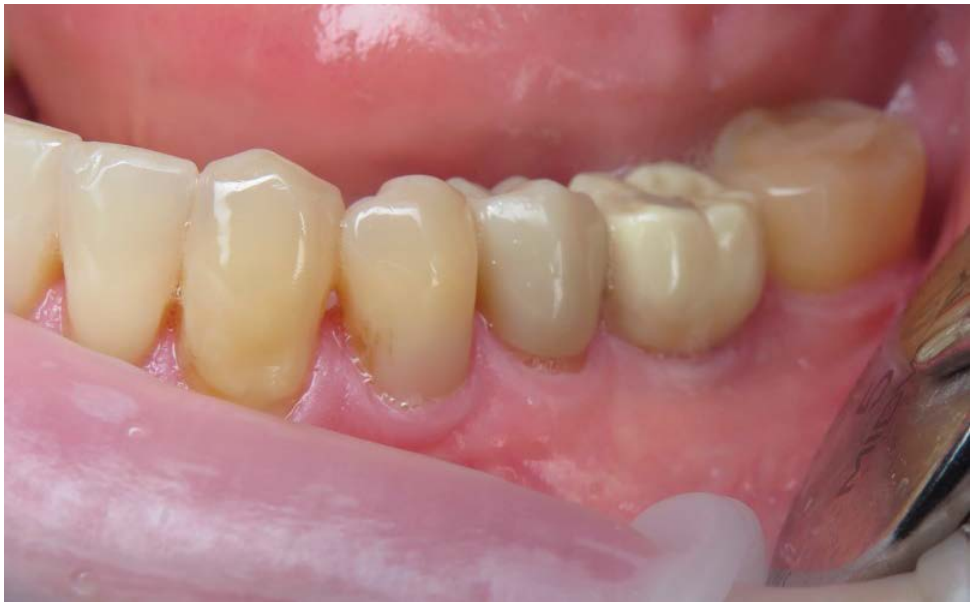
July 31, 2019, day of crown placement, three months after implant surgery



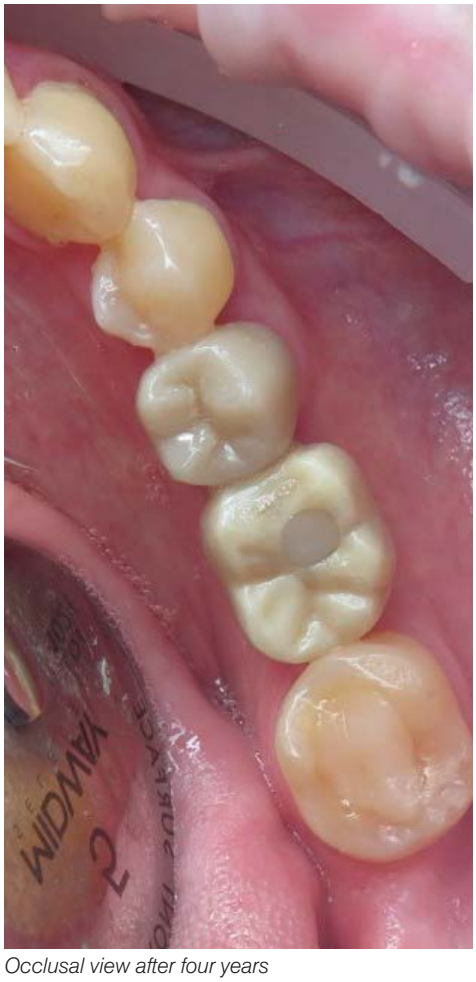
August 21, 2019, one-month check



October 31, 2022, three years later



Buccal view after four years



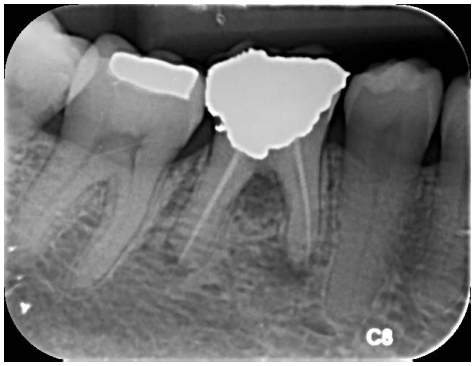
Occlusal view after four years

Results

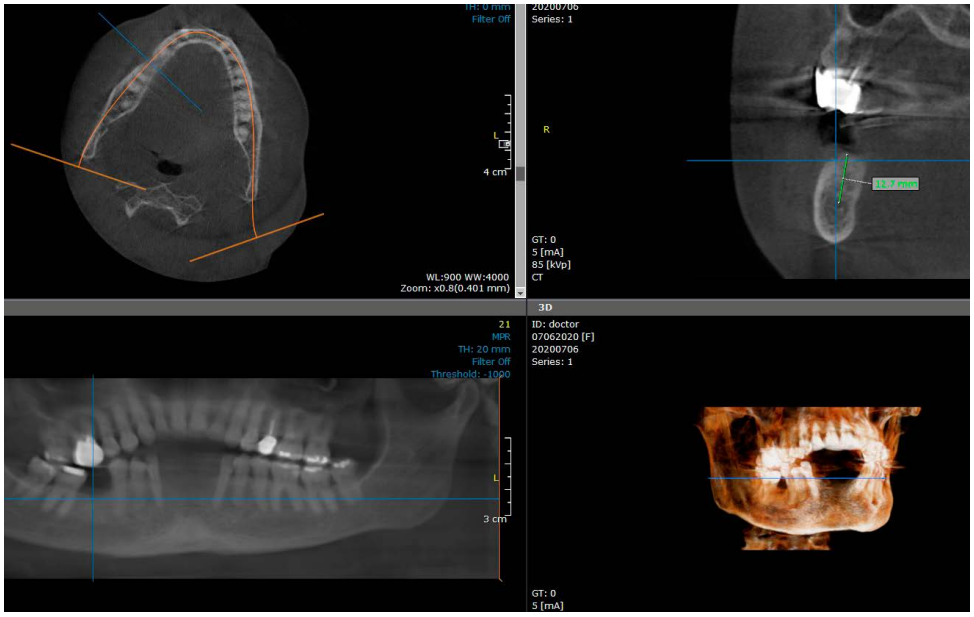
Sam was discharged with appropriate post-operative instructions after getting a ceramic implant. His ceramic implant was restored via a digital workflow employing a scan body on July 16, 2019.

After the procedure, the patient was monitored with regular x-ray films and exams to make sure his implant was healing properly.

During one of the follow-up appointments, Dr. Mati noticed the surrounding tissue looked healthier with much less inflammation than expected. The patient continues to come back for regular maintenance.



PA showing vertical fracture



Preop CBCT

CASE 2

Procedure and Methods

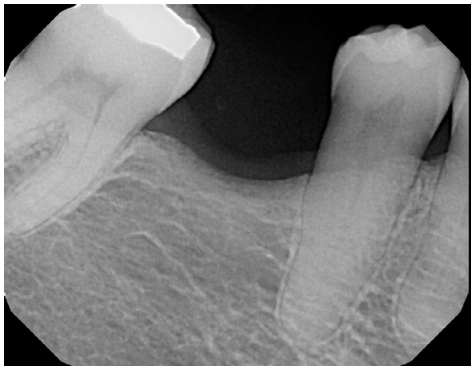
Colleen, a 63-year-old female, has been a patient of Dr. Mati since 2010. She has a medical history of hypothyroidism and takes a thyroid supplement because of an autoimmune disease and a daily aspirin for heart disease prevention. In 2010, her tooth #30 was extracted, revealing a vertical fracture.

She didn't receive an implant procedure until 2019. When she re-engaged with treatment, a CBCT scan assessed the area around #30. After reviewing the CBCT scan, titanium implant placement surgery was performed. A 4.6 x 9 mm titanium screw was placed with no complications during the procedure. Two months later, the patient came back complaining of pain and discomfort around the implant site. Clinically, there was inflammation around the area, purulent visible, and mobility of the implant. An X-ray film revealed the implant did not osteointegrate, meaning it didn't anchor with the surrounding bone in the area. As a result, Dr. Mati removed the implant, debrided the area, and performed a bone graft with guided bone regeneration, all in the same day.

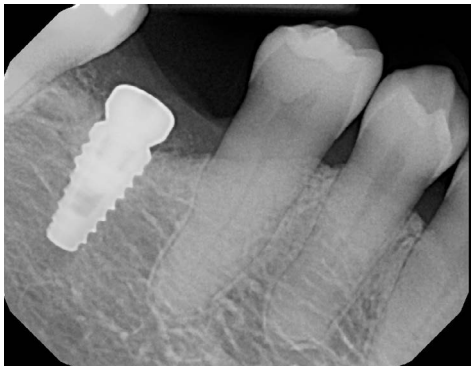
After five months, the tissue had healed, and the decision was made to place a ceramic implant. At this point, the patient indicated that she was allergic to certain jewelry and titanium, something that wasn't brought up previously. At this point, it was fair to wonder if her allergy played a role in her body rejecting the first implant or if there was a co-morbid condition that was compromising her body's ability to accept the titanium implant.

After reviewing the patient's medical history once again, any medical condition that might've interfered with the body's ability to heal was ruled out. She was not a patient with diabetes, for instance, and herhypothyroidism should not be problematic. Therefore, it was hypothesized that the reason her titanium implant failed was a result of her metal allergies.

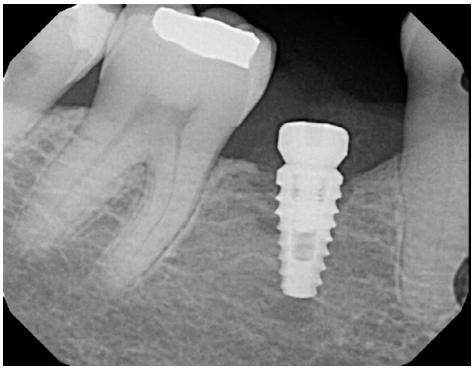
On July 22, 2020, the patient returned in for a ceramic implant. A 4.1 x 10 mm Straumann tissue-level pure ceramic was placed using a surgical technique similar to Case 1.



December 30, 2019, before implant placement



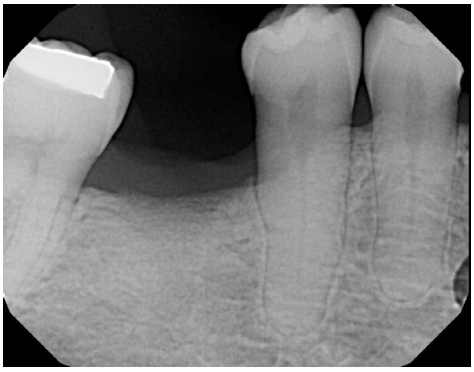
December 30, 2019, after titanium implant



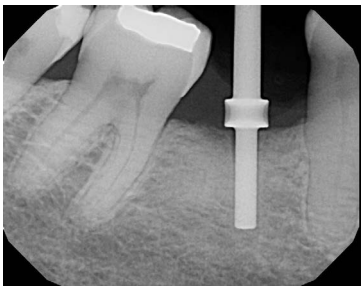
February 3, 2020, implant failed

Results

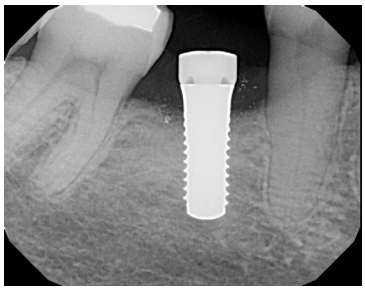
On November 10, 2020, after approximately four months of healing, the patient's ceramic implant was restored with a digital workflow. The patient came back to Dr. Mati's office in the spring of 2023, at which point implant appeared to be healthy and on the path toward restoration.



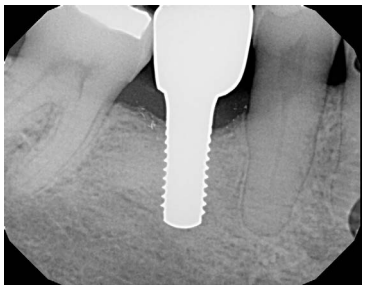
June 8, 2020, before ceramic implant



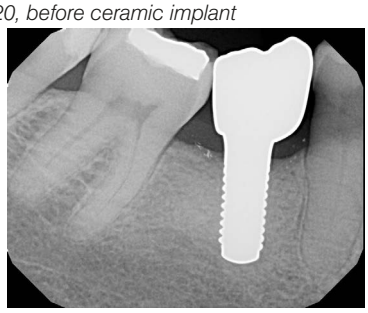
July 22, 2020, indicator pin for ceramic implant



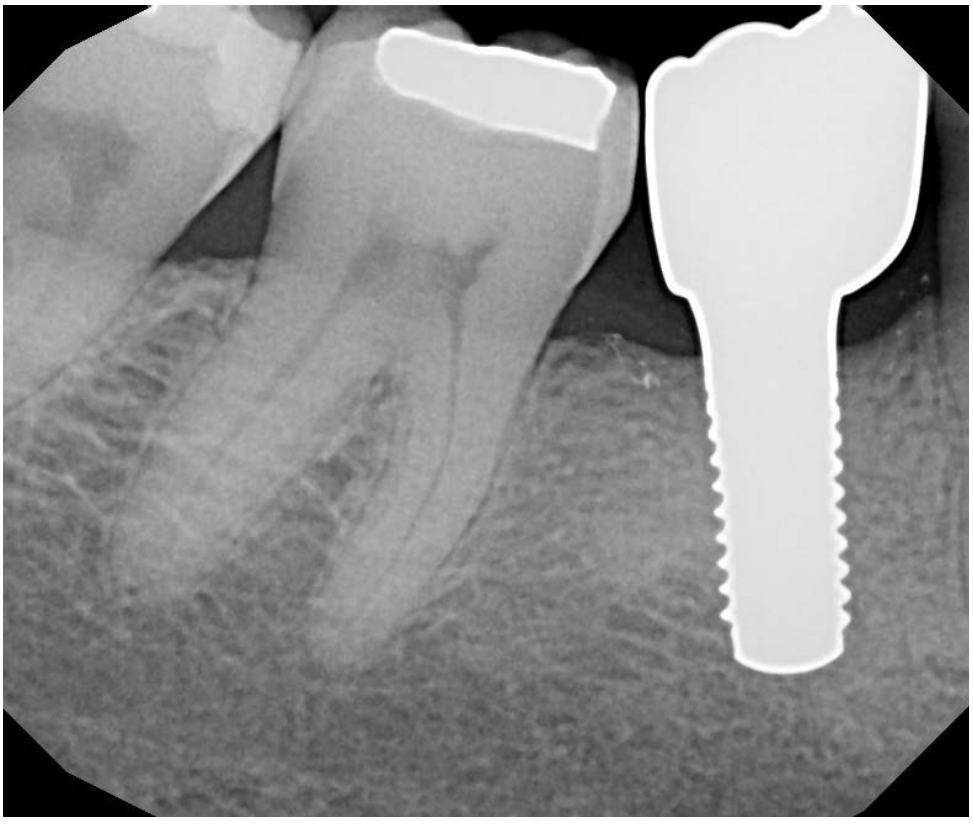
July 22, 2020, ceramic implant placed



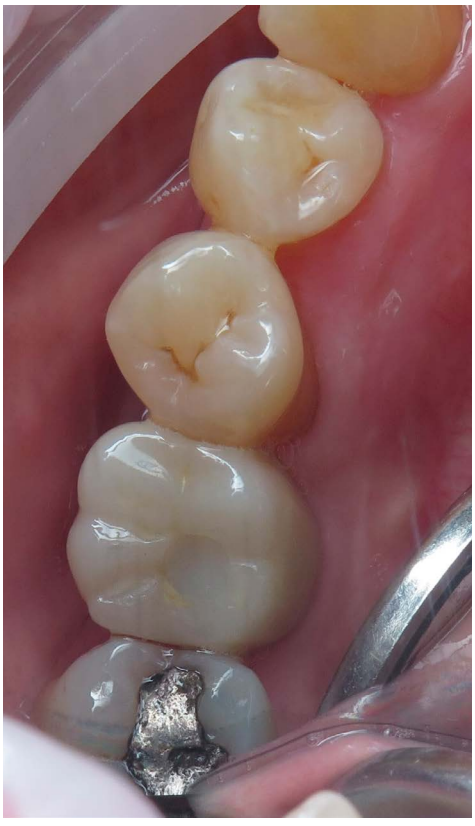
January 18, 2021, crown placement



May 7, 2021, four months after crown placement



March 20, 2022, one year and two months after



Occlusal view of the final crown

CASE 3

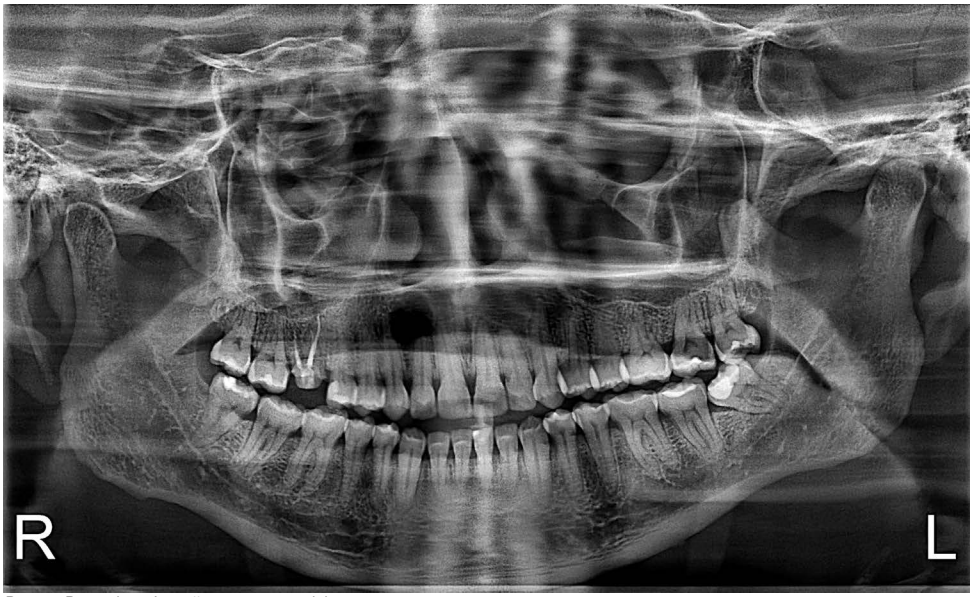
Procedure and Methods

AC, a 52-year-old female, was presented with a gross fractured tooth #3, which was not restorable as deemed through clinical examination and X-ray films. All treatment options were explained, and the patient was given the option to choose between a titanium implant and a ceramic implant. After further discussion of each type of implant, she chose the latter.

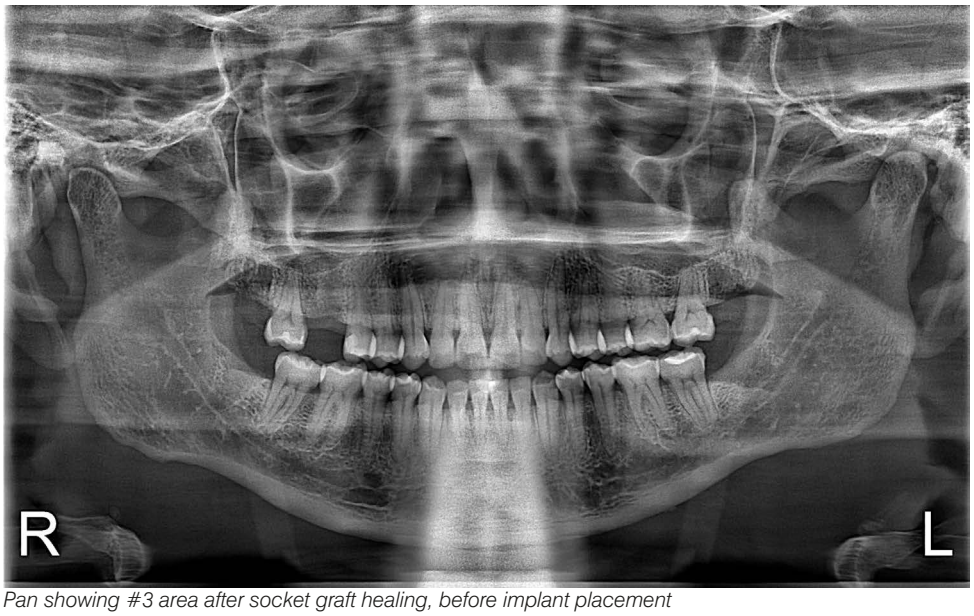
The patient reported no medical or health issues and had no history of metal allergies. Everything about her case was unremarkable, and the entire process went smoothly.

On October 19, 2021, tooth #3 was extracted and a socket graft was performed with allograft (cortical cancellous mix) and cytoplast membrane.

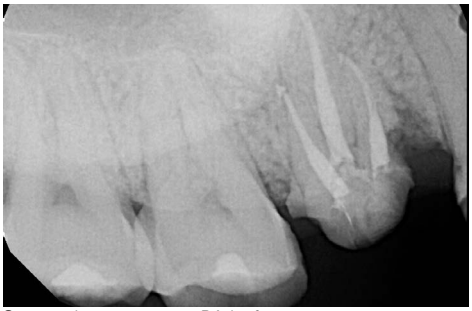
On February 10, 2022, the healed ridge was evaluated. A 4.1 x 10 mm Straumann tissue pure ceramic implant was placed using a similar surgical protocol to Case 1. Due to the D4 quality of the ridge, the decision was made to place the implant subgingival to avoid the trauma of micro movement during healing.

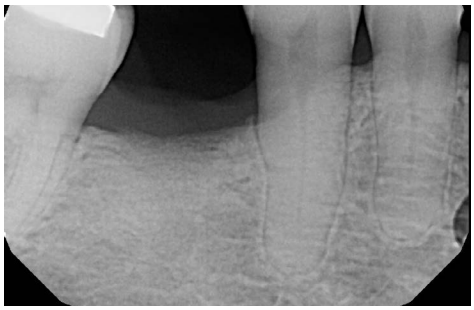


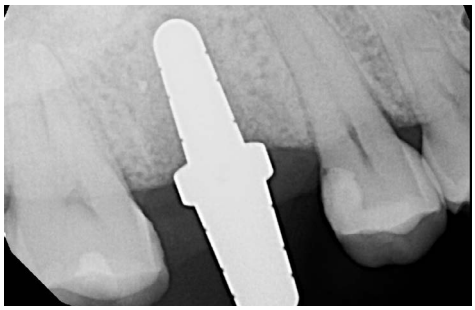
Preop Pan showing #3, unrestorable

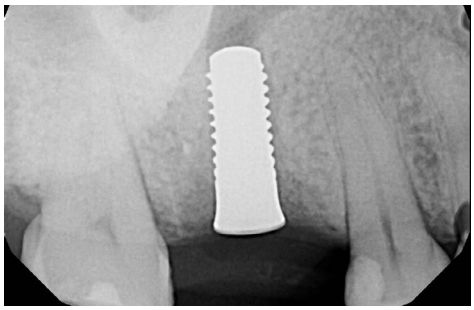


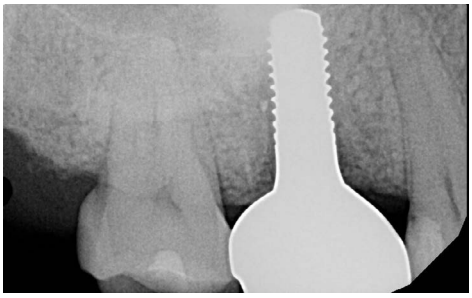
Pan showing #3 area after socket graft healing, before implant placement


September 28, 2021, PA before

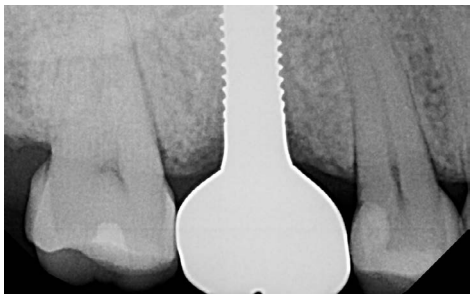

February 10, 2022, extraction and bone graft healing


February 10, 2022, indicator pin during surgery

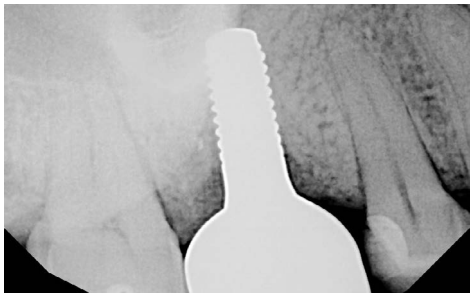

February 10, 2022, implant placement, surgery day



June 30, 2022, seating crown



July 28, 2022, one month after crown



February 6, 2023, eight months after crown

Results

Since this was the third ceramic implant case, Dr. Mati was sensitive to the amount of torque required to tighten the implant crown screw. Unfortunately, he opted to tighten the patient's screw with less force than he might while placing a titanium implant crown. Because of this, the patient came back to the office after the screw was placed, complaining that it was loose. This was as a result of a slight crestal bone loss noticed around the implant, which could've caused the loose crown to harvest some bacteria. At this point, the implant crown screw was torqued to 30 N/ Cm.

The patient's bone was a little soft when the implants were placed. It went in a little deeper at the bone level to prevent it from being exposed to the outside.

After the final implant was placed, her tissue healed correctly, and subsequent follow up with her found that her ceramic implant was successfully placed.

DISCUSSION

While titanium is the standard material for tooth implants, the inclusion of zirconia-grade ceramic implants in some dental practices could predict a widespread increase in the alternative procedure over time. Highlighting the benefits of ceramic implants in comparison to titanium implants prior to the operation will allow patients to make an informed choice.

With that, extensive research on ceramic implants confirms the reliability and effectiveness of this low-risk procedure. For example, further research regarding the results of Case 1 reveal that ceramic implants may reduce levels of bone resorption, inflammation, and the formation of biofilm. (https://www.aegisdentalnetwork.com/id/2019/03/zirconia-implants-in-the-esthetic-zone). Additionally, it has been claimed that the oral biofilm on the implant surface releases ions and titanium particles at the implant site. Following the main response associated with the oral biofilm causing bone loss and inflammation, the release of ions was referred to as a secondary inflammatory response. The word for this secondary reaction is metallosis, which is described as the deposition and accumulation of metal particles in the body's soft tissues. Natural teeth do not exhibit metallosis, but it has been seen to contribute to the bone loss around dental implants (https://aap-online library-wiley-com.ezproxy.libraries.udmercy.edu/doi/epdf/10.1002/JPER.20-0208). In Case 1, using a ceramic implant seemed to cause less irritation in the surrounding tissue.

There is also evidence for metal allergies playing a role in unsuccessful titanium implants. One study featuring a 64-year-old female who received a failed titanium implant was quite similar to the circumstances regarding Colleen's (Case 2) medical history. The research stated that the female complained of several symptoms following the placement of the implant including pain, swelling, and a burning sensation. It was then noted in her medical history that she has an allergic reaction to jewelry. This may be the connection as, though titanium hy-

DISCUSSION *(continued)*

persensitivity is rare, it is still possible. In this case study, the patient's implant was also removed, proving that those who have titanium hypersensitivity may be more prone to implant failure.

For future research, implantologists should discuss the level of torquing required to place a ceramic implant and whether the screw used to retain the crown of the ceramic implant is better placed at the tissue or bone level.

There is a perception among practitioners that dentists should remain sensitive while placing the screw for a ceramic or zirconium implant because of the modulus of elasticity, which could lead to a fracture. In Case 3, the screw was not torqued tightly enough, and it eventually loosened.

This concern may force dentists to revisit the issue of bone-level versus tissue-level before performing a ceramic implant. As discussed in a previous case study article published in *AAID News* in 2022, there are good reasons to choose either a bone-level or tissue-level implant.

Tissue-level implants offer ease of restoration. As the implant fixture is placed at the bone level, the interface between the implant abutment and implant fixture are above bone level or supra-crestal. This interface is the junction where micro movement of the superstructure can lead to inflammation and secondary bacterial contamination with the possibility of bone loss and increased risk of peri-implantitis.

Tissue-level implant placements also offer the benefit of supra-crestal margins to reduce the risk of bacterial contamination at the crestal bone interface. In turn, this will eliminate the need to use multi-unit abutment (MUA) in full-arch cases, reducing treatment costs for patients.

Additional benefits include the ease of taking impressions or intraoral scans of tissue-level implants vs. bone-level implants. Since bone-level implants are often sub-crestal, their placement can hinder passive placement of impression coping or scan-body due to hard and soft tissue impingements. Tissue-level implant placement scans increase the accuracy of the transfer of the implant fixture position for prosthetic fabrication.

On the other hand, bone-level implants can yield a bulkier prosthetic in the transition zone through the gingiva, increasing the chance for plaque accumulation at the crestal bone level. There are other risks found with cement-retained restorations that can increase the risk of cement-induced peri-implantitis, including compromised access to home care.

Bone-level implants require two surgeries: one to place the implant and another to reopen and expose the healed implant to complete the procedure (second phase surgery) which can be a negative for medically compromised patients.

Conclusion

As with other restoration procedures, dentists should be prepared to discuss treatment options and offer both ceramic and titanium implants, carefully reviewing each patient's medical history before deciding to pursue a bone-level or tissue-level implant. Implantologists shouldn't hesitate to tighten the screw to the crown of a ceramic implant with the same force you would use for a titanium implant crown (25 ncm - 30 ncm).

Zirconium material is tissue-friendly and does not irritate the surrounding area. When comparing it to titanium implants, bone resorption and the inflammatory response are reduced, and the development of biofilm and associated plaque levels are reduced as well.

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BUSINESSBITE

Whole Life – A Valuable Tool, But Not For Everyone

The road to practicing dentistry or medicine is indeed a long one filled with challenges, both academic and financial. However, once you reach the point you envisioned, you will most likely be well rewarded for your hard work and investment. Not only is it rewarding to be able to make a difference in people's health and wellbeing, the successfully practicing professional is rewarded with a positive financial picture.

Having a solid revenue stream brings with it the question of how best to spend today and where to save for the future. We thought we would focus this topic on the established dental and medical practitioner, someone who has a solid career path, a healthy cash-flow, has fully funded emergency funds and retirement accounts, and has tapped out tax-advantaged savings options. Perhaps that is you.

The road to practicing dentistry or medicine is indeed a long one filled with challenges, both academic and financial. However, once you reach the point you envisioned, you will most likely be well rewarded for your hard work and investment.

Even if you are not quite "there" yet, perhaps this is your dream. In which case, this article may be useful as you think of your future savings opportunities. If you already make a good living or are on your way to making a good income, then you will need to have a financial plan to best get to your destination. That is our recommendation to all our clients. And within that financial plan, our hope is that you will have the opportunity to fully fund your retirement accounts. In situations where there is plenty of cash flow, our clients are always looking for other ways outside of the conventional vehicles (which they may have maxed out) to satisfy their savings needs.

Begin At The Beginning: Once You Leave Residency

Before we get ahead of ourselves, let's go back to the beginning. Let's go to when you completed your training. For many people, the duration of their training is financed at least partly with loans. Once you are out of training, you finally start building your financial foundation. In the beginning, people typically secure their necessary insurances and start figuring out their student debt repayment plan. On the professional front, they start practicing, either as an associate, owner, partner, or as an employee within a larger organization. Then they set up an emergency fund, say 3-6 months of living expenses in cash. Perhaps they save up a down payment to buy a home or to stage themselves for practice ownership.

In the beginning, people typically secure their necessary insurances and start figuring out their student debt repayment plan.

The question of how much to save often comes up – and where or in what savings vehicles? Over time, income increases and so does the capacity to save. Upon fully funding qualified plans (a qualified plan is a tax-advantaged savings plan, like an SEP or a 401(k)), there is often still a deficit in the amount of savings needed to create financial independence. This is where other financial tools are needed. Whole life insurance could be one potential piece – which provides both the protection afforded by life insurance as well as the opportunity to save money in a non-correlated asset class. A non-correlated asset class is one that performs counter to equity and bonds markets. Some investors use non-correlated asset classes to 'temper' the behavior of the other asset classes and provide some stability in their overall portfolios, especially during volatile market cycles.

What Is Whole Life?

Whole life insurance is, as the name states, life insurance. It falls in the category of permanent insurance, in contrast to term insurance which provides only limited coverage. Permanent life insurance stays in force for as long as the owner pays the premiums to maintain the policy.

Beyond offering permanent coverage, whole life is a life insurance product with many other features, the most notable of which is a savings component – your premiums provide both life insurance coverage and accrue what's called a 'cash value.' The cash value accrues over time, frequently with contractual guarantees, as well as additional potential growth through company dividends from the issuing company. While the savings feature of a whole life insurance policy may provide stability in one's overall financial picture, it's also important to point out that it will not yield

returns that are as high as other asset classes. You will be exposed to less volatility, but you will also find that the returns are lower.

This is why it is important to consider the cash value in whole life as a diversification tool and to understand that the returns should not be compared to riskier asset classes like the stock market. Few advisors would suggest an investment allocation of 100% stocks. Most may suggest a portion of your investment be placed in a safer, historically lower performing asset class like bonds to reduce the overall risk in the portfolio.

It is much more appropriate to compare the qualities and returns of whole life to other "safer" assets like municipal bonds, CDs, money markets, and savings accounts. When this comparison is made, whole life can be evaluated more fairly and the benefits can be seen more clearly. While whole life has had historically similar returns to these types of vehicles, there are contractual guarantees and tax advantage growth on the underlying cash value, options to include riders providing disability and long-term care protection, as well as death benefits for legacy planning.

Due to these features, whole life is used in sophisticated financial planning scenarios to offer tax-advantaged growth, assist in income planning, and to transfer wealth to future generations.

Why Whole Life Is Not For Everyone

Due to its complexity, whole life is widely misunderstood – by financial advisors and the public. Occasionally, there is controversy around whole life insurance because it's considered by some to be expensive, inappropriate, or low performing. The truth is that whole life is a valuable, multi-purpose tool, but it is most certainly not for everyone.

When And Why Would You Consider Whole Life?

1. You need life insurance. You care for someone or something and want to ensure that they are provided for when you are no longer able to do so yourself.

2. You have a student debt repayment strategy in place.
3. You have 3-6 months of living expenses in cash set aside for emergencies.
4. If you plan to purchase a home or have done so.
5. If you plan to purchase a practice or you have done so, or if this is not your plan, your employment and income are stable.
6. You are fully funding qualified plans and tax-advantaged accounts.
7. You have a cash surplus and a retirement savings shortage.

Now, you can look at whether whole life makes sense for you. You may have heard the argument to 'buy term and invest the rest.' While this is a catchy slogan, it does not provide all the information for you to make an educated decision. For people who may have a desire to provide a legacy and can use at least one of the other powerful features of the policy, whole life may very well be the answer.

If You Must Buy Term

We tell people that if you must buy term, buy it from a state-of-the-art company that provides conversion privileges to best-in-class whole life policies. Meaning: don't buy cheap term, don't buy it online, and don't assume that all term is created equal. It's not.

Also, as a dental or medical professional-in-training, there are opportunities to purchase 'convertible' term insurance. These policies are flexible in that they allow you to convert your term insurance into permanent insurance without regard to future changes in health. Buying convertible term is a smart way to "lock in" your good health ratings today. Consequently, a potential health event or illness won't get in the way of your being able to purchase whole life insurance in the future.

Using Whole Life Strategically

By now you may have realized that whole life is a whole lot more than life insurance. While this is by no means an exhaustive list of how whole life may be used creatively to support your financial plan and savings strategy, we thought we would share with you just a few of the strategic uses of whole life.

Be Smart About How You Implement Whole Life

1. Use it for retirement income. There are opportunities to take income via policy loans tax-free at retirement.

2. Borrow from it in 'down markets.' When equity markets are down, you may consider taking a loan against the cash value of your life insurance. The cash value in whole life is not exposed to market volatility and it is a smart idea to avoid selling equities in a down market.

3. Pass it on. Whole life provides a great way to pass money on to heirs, and life insurance proceeds are tax free.

4. Use it for deferred compensation. Whole life is a tool that is frequently used for deferred compensation for executives in corporations.

5. In some states it is a protected asset from lawsuits. In the event of a malpractice suit against you, whole life is one of the few things outside of your retirement plan that might provide credit or protection.

If Whole Life Is Right For You, Work With A Specialist

Many people have purchased whole life insurance at the wrong time or in the wrong situation, and that hurts every person who has been improperly advised to purchase whole life. Even if the time and situation were correct to implement a whole life strategy, they also may have purchased the wrong policy. Not all permanent life insurance policies are the same. Be sure to work with an advisor that understands and can articulate the differences. Overall, if you have a need for life insurance, have enough cash flow to support it, and have tapped out other tax-advantaged means for saving for the future, you should take a first (or second) look at whole life.

Whatever you do, work with someone who understands the financial needs of dental and medical professionals and understands how whole life fits into the bigger picture of your financial plan. Because when used properly, this may be just the missing piece in your toolkit.

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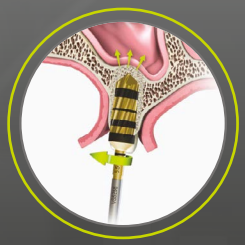

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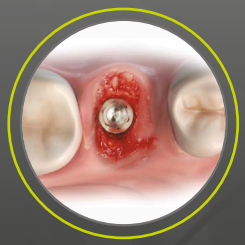
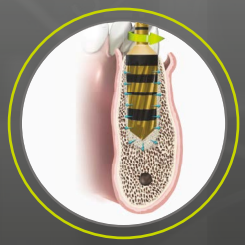
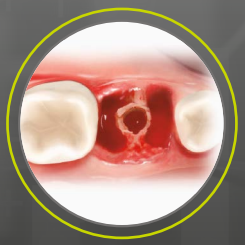


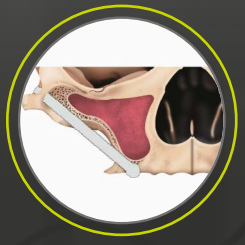
Immediate Implant Placement



Borderline Ridge



Molar Septum Expansion



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Q&A:

Matt Young Explores Origins of Christian Coachman's Digital Dentistry Success

In this wide-ranging interview held at the 2022 Annual Conference in Dallas, AAID Treasurer Dr. Matt Young spoke with Dr. Christian Coachman of Digital Smile Design about the evolution of digital dentistry and how his career as a dental laboratory technician helped lead him to his current position as a digital dentistry consultant, serving dentists interested in transitioning into digital dentistry.

Q&A: Christian Coachman

AAID **Dr. Coachman--you're a leader in implant restorations, implant dentistry, smile analysis. You also have the unique quality that you're a certified dental technician and also a master clinician and worldwide lecturer. Tell us about your journey and how you got here.**

CHRISTIAN COACHMAN Okay, so my whole family is in dentistry. My father, my uncle, my brother, my grandfather, and it goes back to six generations actually. So, it's kind of a genetic disease I joke. My brother and I decided to go to dental school. We finished dental school, but I decided to start working as a dental technician instead. So even though I was a doctor, I started to work as a technician, as a ceramicist. And that allowed me to really open the doors of the world as doctors from outside Brazil started to invite me to work for them.

The first big one was Team Atlanta, where I worked for five years as their head ceramicist there. And then from there, moving into Europe and working with some top guys there as well. Always playing this role of ceramicist, but also as a dentist doing some of the work in the mouth, but above all, participating in the process of smile design and treatment planning. That was always my passion. And then from there, I started to get into digital dentistry and developing the Digital Smile Design concept that is the company that I run today.

AAID **Tell us about some of the learning curve you've had with smile analysis over the years from when you were in dental school and early as a technician and some of the hurdles you had to overcome to get to this point where you can really deliver a predictable smile.**

CHRISTIAN COACHMAN The whole idea of Digital Smile Design started from my work as a technician. As a technician, I was always trying to understand how to be more efficient. I wanted to work a little bit less and make a little bit more money, to control the stress, be more predictable. And I realized that even though I was a good technician, and I was working with very good dentists, there was still some flaws, some mistakes, some pitfalls, some bottlenecks, some back and forth, some redoings, and some outcomes that were not exactly the way we wanted them to be. I started to try to challenge the status quo and ask myself, "How can we do things better? What type of systems can I as a technician implement to improve the life of my doctor? Can we improve the documentation process? Can we create a more professional communication system? Can we create better checklists? Can we improve the whole process of rehabilitating a smile?"

I asked myself where this whole process starts, and oral rehabilitation starts from the face, starts from analyzing where you want to be and reverse engineering how to get there. The reverse engineering idea that I was able to learn from friends from outside dentistry, and, oh, you start with the end in mind, right? And the end in mind in dentistry is the smile design. You design a smile based on facial analysis and airway analysis, and then you set this goal and then you start to look into the specialties and see how to connect them to get there. So, I realized that I could become a different technician by calling myself not a technician, not a ceramicist, but a smile designer, a smile architect. And that's the way I started to present myself to my doctors.

I don't want to just do the final restorations. I want to help you actually diagnose the case, make better decisions, plan the case, and even also help you sell the case. I started to get involved as well on strategies to increase case acceptance, to really make the patient value a more comprehensive service, a more comprehensive treatment, how to change people's priorities, how to change behavior, storytelling, body language, visual communication. This was the birth of what I call Digital Smile Design, improving the harmony of smile design, the starting point of the plan, improving treatment planning by creating a more efficient communication process, and then creating a strategy for the patient to actually buy it. That's how I see this: design, plan, and sell–and this is how I started to lecture about the DSD concept around 12 years ago.

AAID **Oh, it's amazing. One of the things you touched on was communicating with the patient. A patient's smile builds confidence, it builds their net worth, it makes them feel good about themselves. When someone has a smile that they're not happy with, they don't know how to take that first step. And also, when they're talking to a clinician, sometimes the clinician may not be able to relate to them what they can do. How do you bridge that gap and let the patient know that when they leave and they're done with treatment, they're going to have a smile that they're happy with and confident with?**

CHRISTIAN COACHMAN Creating perceived value and impacting people's decisions is an emotional game. It's not a rational game. And dentists usually try to explain things rationally, like: why you should come to the dentist twice a year, why you should invest this amount of money on your full-mouth rehabilitation. And people end up undervaluing it, and we end up only treating desperate people. They need to be aesthetically desperate or desperate because of pain. They usually choose to do other things with their money, and dentistry is a low priority. To change people's priorities in life we need to understand the psychology of decision making and understand that this is actually an

emotional game. So, when a patient decides to call your office and book the first appointment, they're giving it a try.

It's a huge honor that they're actually putting some time to come to you. And from that moment until the moment where you present the estimate and you say, "This is what we need to do and this is how much it's going to cost," that piece of the journey is key for achieving success as a dentist. And that journey is an emotional journey. So, I started to work with dentists on everything we can do to change this journey emotionally and take the patient completely away from the perception of going to a dentist and all the negativity that people generally bring when they think about going to the dentist. It is a complete disruption of the experience of the patient as they go to the dentist. And that's what makes the magic.

AAID

Very nice, being able to connect with the patients and have them understand that you are really analyzing everything for them, and you have their best interest in mind.

CHRISTIAN COACHMAN But the whole, every sense counts from the tone of the voice on the phone to what do you do in the waiting room, front desk, the way you communicate at the beginning, the way you say hello, the way you look into their eyes, the way you listen, the way you serve your coffee, the way you present your technologies, the way you show that you're looking beyond, that you are above average. How can you make somebody understand that you are above average without you saying, "I'm above average." Because that doesn't work.

AAID

Yeah, you're right. Digital dentistry has really revolutionized my practice. I've been practicing for about 22 years now, and I had my hurdles and frustrations. Digital dentistry for implant dentistry, for restorations, guided surgery, and smile analysis has been amazing for me, but it's very overwhelming for someone who's not in a digital dentistry.

How would you encourage someone who is not currently involved with digital dentistry to take that first step, and what is the first step?

CHRISTIAN COACHMAN The first step is the mindset. It's not buying technology. Where do you want to be in five years? That's the first step. Because if you see yourself in five years running a modern, comprehensive smile rehabilitation practice, you are going to understand that you need the technology. If you want to do average quadrant dentistry forever, that's what is enough for you. Maybe you don't need that much. The first question is where do you want to be in five years? And then understand what type of mindset you need to bring to yourself to make the changes that you need to be where you want to be.

And then even more and very important, more important than actually buying technology, is creating the systems that the technology will fit. People buy technologies, but they don't think about the workflows.

They don't think about the process. They don't think about protocols. They don't think about the systems. We didn't learn in dental school how to build systems. And modern dentistry is a team sport. You cannot be a digital dentist. You can only be a digital team. And to be a team, you need a leader. And to have a team that works, you need systems. You need everything clear from A to Z, how to connect the dots. And then when you buy the technology, it can fit very well into this system.

People buy technology without systems and the technology ends up underutilized in the corner. Sometimes we use it, sometimes we don't. And then it doesn't become a routine. And if it doesn't become a routine, you don't find the solutions to overcome the learning curve that exists. And you stay in that limbo. You stay in that gray zone that I see. Maybe 99% of the doctors that are buying technology are in what I call the gray zone. I like it, but I don't like it. I do it, but I don't do it. I don't know exactly how to take full advantage of it. And taking full advantage of technology depends on systems and having the strength and the resilience and the discipline to make that decision become a routine.

AAID

You mentioned earlier somebody incorporating digital dentistry and asking them where they want to be in five years? What kind of dentist do you want to be? What excites you about the next five years of your practice and dentistry and how do you see progression?

CHRISTIAN COACHMAN So, I don't practice anymore. I discontinued my practice when Digital Smile Design became a company, and now we serve dentists, right? With education, with services, with planning services, with lab services, with marketing services, with team training services. So, we have the DSD company, which is a service company for dentists. This is a full-time job besides

lecturing, so I haven't been doing clinical cases for seven years. So, I cannot speak anymore from the clinical perspective, but from the dental future perspective, I can say that the next five years will be the most disruptive five years in our business.

We see that all the players are set. All the scenarios are ready to really change dentistry the way it's run. It's run basically from the business perspective, so investors, corporations, DSOs, big companies, are changing dentistry. And some dentists are really seeing what is happening and preparing themselves. But many dentists are just in the comfort zone. And I believe that in the next five years, being in the comfort zone is a dangerous place to be.

AAID

Yeah, I agree. We're here at the AAID annual meeting, and one of the great things about the annual meeting is having great lecturers like yourself... and the main podium lectures. Another great thing is the camaraderie that we have, talking to people like yourself and talking to other leaders and seeing what they're doing in practice. And it gets you out of your comfort zone and you see what they're doing, and you say, "All right, how do I get to that level?" And that camaraderie that we have in the conference area and the lunchrooms is really what helps to drive the Academy. What are your thoughts about our AAID organization and our members?

CHRISTIAN COACHMAN So, as I mentioned, this is the first time I'm participating in this event. Of course, I heard about AAID before. I have much experience lecturing for some of the most traditional implement groups, congresses, AO, and AAP. But what I see is that they are becoming more specialized and more and more oriented

for these super specialists. And the feeling that I have is that AAID is the channel for any doctor that wants to succeed with implants. That's the feeling I have. So, you have a lot of GPs, you have a lot of restorative dentists, you have, of course, a lot of periodontists and surgeons. But that's my feeling about AAID, and that's maybe the reason why it's growing while other traditional ones are shrinking, so I'm happy to be here, and I hope that this is not going to be the last time.

AAID

Absolutely. Well, it's great to have you here. And some of the great things about our conferences are that we have a lot of hands-on courses and hands-on training so people can go to the lectures and also have the hands-on experience. We also have bonafide credentials. The bonafide credentials are a pathway for the dentist to keep achieving more with implant dentistry, both with their clinical cases and clinical testing. So, it's amazing to have you here today. We're very honored, and I'm looking forward to your lecture, actually moderating your program.

Yeah, thank you very much. And you've given our Academy a lot to think about. Some of your points about where you want to be in five years are something we all have to think about.

And digital dentistry is a way for us to continue to grow and have enjoyment in our practices. And I can tell that you enjoy what you do.

JOISAMPLER

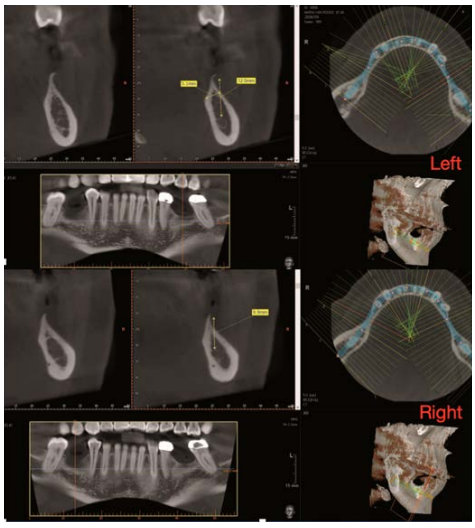
Editor's Note: Because of your busy schedule, you may not have time to read the dozen or so articles in each issue of the *Journal of Oral Implantology*. In this section of *AAID News*, we select a few articles that have broad applicability to daily practice and provide a brief summary of key points so you can decide if you wish to read the complete article. The following articles are from Volume 49, Issue 2 (2023).

Journal of Oral Implantology, Volume 49, Issue 2

GUEST EDITORIAL

Antibiotics for Dental Implant Surgery: Extracting Available Evidence, Risks, Benefits, and Insights to Consider

In this guest editorial, authors conducted the first US study evaluating antibiotic use among private practice dentists. Throughout their study it is learned that many different prophylactic and post-procedure antibiotic regimens are used. Check out there observations in their guest editorial.



CBCT images showing the left and right sites

CASE REPORT

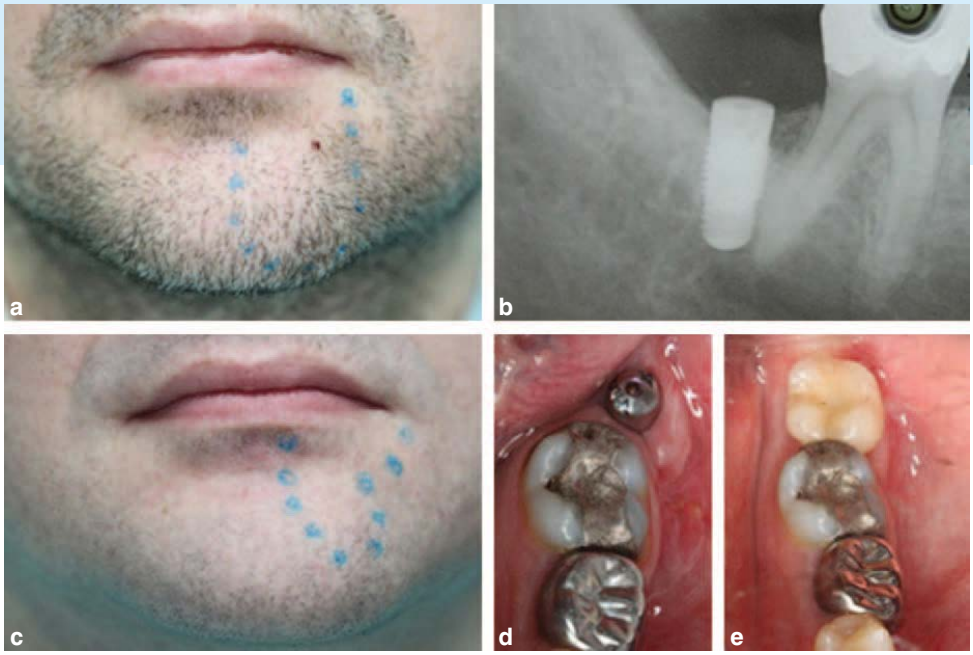
Natural Implant Restoration in Stable Alveolar Bone (NIRISAB)-Concepts in Clinical Practice: Long-Term Follow-up on Three Cases of Ridge Reconstruction Using the Tunnel Approach With Remote Incision

In this study, researchers describe the clinical application of a remote incision in various ridge augmentation surgeries as developed by Dr. Hilt Tatum.

LITERATURE REVIEW

Neuropathic Pain After Dental Implant Surgery: Literature Review and Proposed Algorithm for Medicosurgical Treatment

The purpose of this literature review was for researchers to provide an algorithm for the medicosurgical treatment of dental implant-induced neuropathic pain.

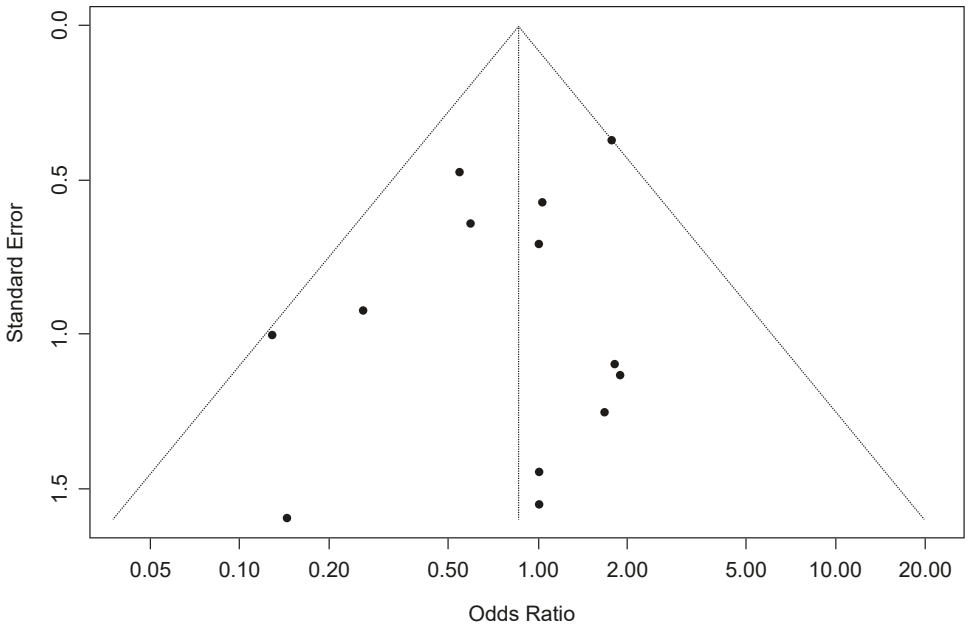


Case of a patient with neuropathic pain (DN4 score ¼ 7/10) due to dental implant surgery at the left mandibular second molar site

CLINICAL ARTICLE

A Systematic Review and Meta-Analysis of the Clinical Outcomes for Adjunctive Physical, Chemical, and Biological Treatment of Dental Implants With Peri-Implantitis

In this article, researchers described the treatment for peri-implantitis and determined whether the use of adjunctive therapies improved the clinical and radiographic outcomes of conventional mechanical debridement.



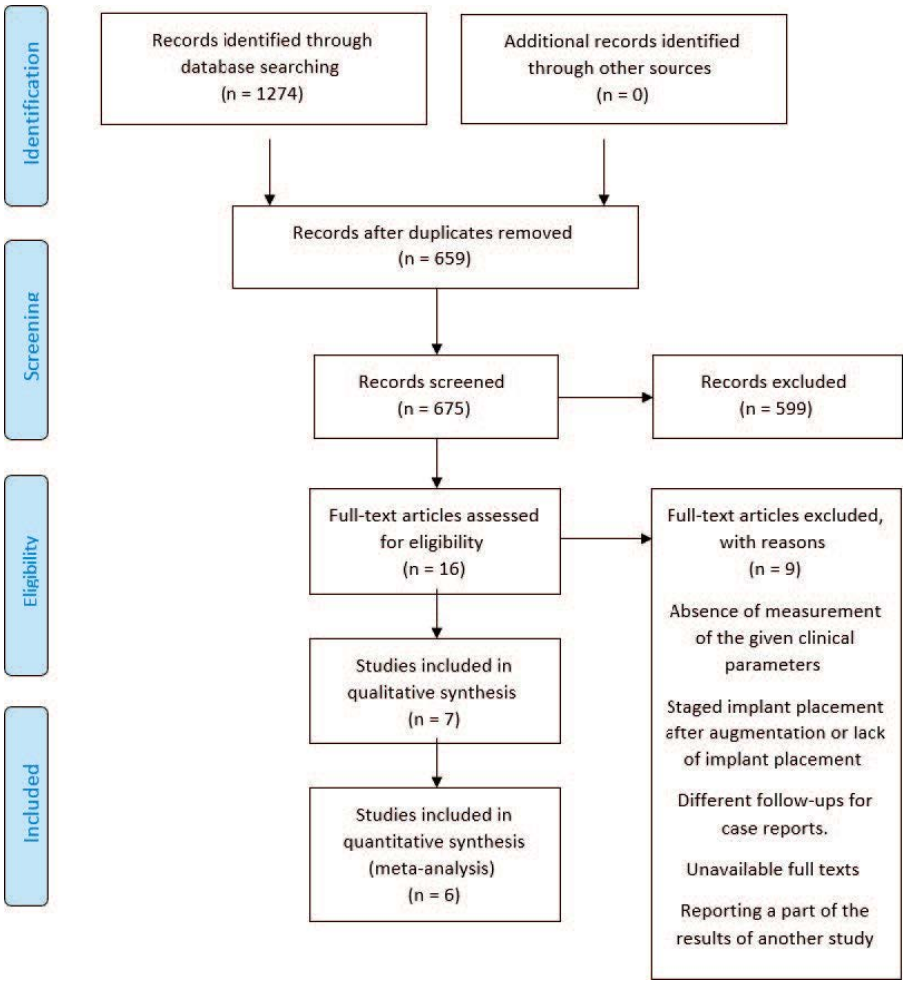
Funnel plot for bleeding on probing (BOP) reduction

JOI Sampler

SYSTEMATIC REVIEW

Efficacy of Acellular Dermal Matrix in Soft Tissue Augmentation Around Dental Implants: A Systematic Review and Meta-Analysis

In this systematic review article, authors executed a systemaic review and meta-analysis of the studies on the efficacy of acellular dermal matrix in increasing soft tissue thickness and keratinized mucosal width around dental implants.



Right: Searching flowchart

AMERICAN ACADEMY OF IMPLANT DENTISTRY TO BE FEATURED IN AWARD-WINNING DOCUMENTARY SERIES "VIEWPOINT WITH DENNIS QUAID"

The commercial will air in more than 60 million households over the next calendar year.

The American Academy of Implant Dentistry (AAID), the first organization in the world dedicated to implant dentistry, will be featured in the award-winning documentary series *Viewpoint with Dennis Quaid.* This long-running series, hosted by well-known actor Dennis Quaid, features educational documentaries on a range of topics including business and technology – with a focus on innovation around the world.

Beginning in June 2023, these one-minute informational videos featuring the AAID will begin airing in households nationwide.

Viewpoint is distributed in the United States through public television stations and major networks, including but not limited to: CNBC, FOX Business, Bloomberg TV, Discovery Channel, History Channel, National Geographic, and HLN; and is aired in more than 60 million households nationally.

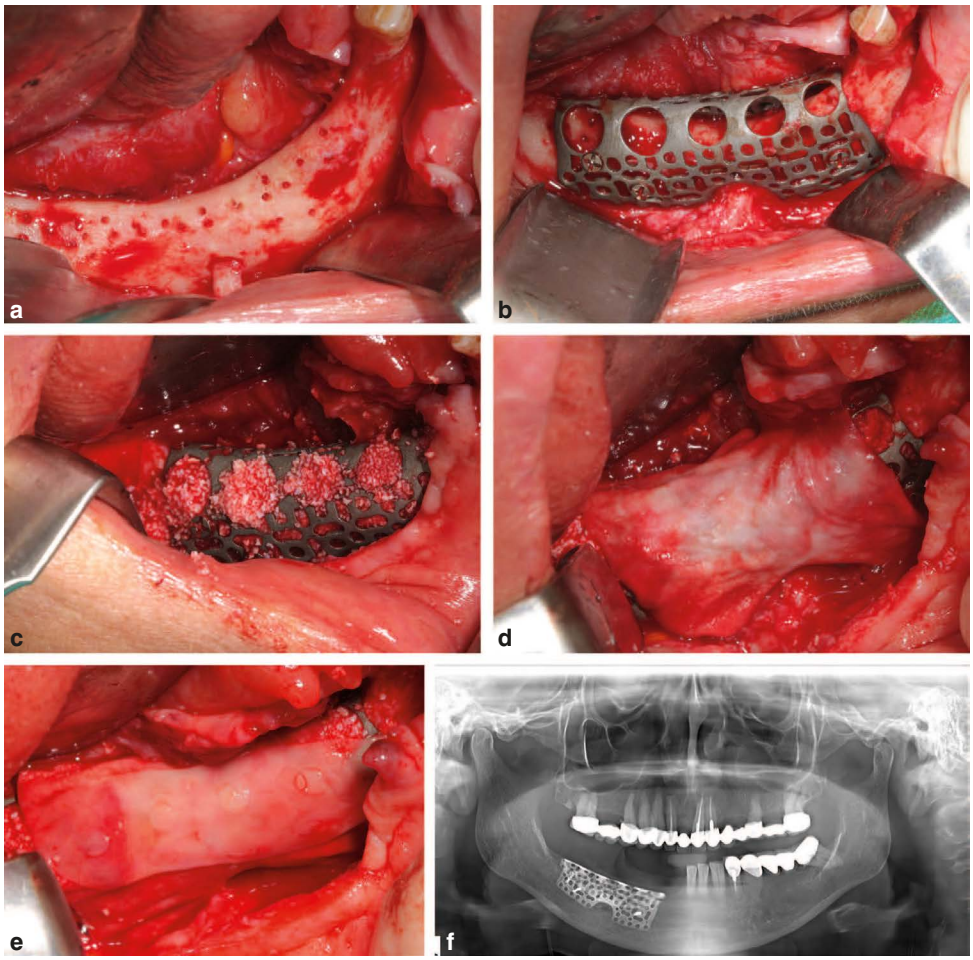
"There is a great deal of uncertainty and misinformation regarding dental implants among consumers," said Dr. Bernee Dunson, DDS, FAAID, DABOI/ID. "We hope this nationwide campaign will help educate the public on the lifelong benefits that working with an AAID-credentialed dentist offer."

"By passing our rigorous examination and case presentation process, AAID-credentialed dentists have proven not just their

CASE LETTER

Vertical Bone Augmentation With Customized CAD/CAM Titanium Mesh for Severe Alveolar Ridge Defect in the Posterior Mandible: A Case Letter

In this report authors described the reconstruction of a severe vertical bone defect when using CTM covered by collagen membrane and A-PRF+, combined with autogenous bone, DBBM, and i-PRF, after the implant removal because of advanced PI. In this article we see the radiologic, histologic and clinical results.



Right: ***(a)*** *Evidence of severe vertical bone defect: decortication of the alveolar cortical bone and adequate flap release of the buccal and lingual flaps to achieve passive primary closure.* ***(b)*** *Surgical stabilization of CTM with 3 screws.* ***(c)*** *Filling the prefixed CTM with autogenous bone and DBBM, applied with i-PRF.* ***(d)*** *CTM covering by CM.* ***(e)*** *CM covering by A-PRF.* ***(f)*** *Postoperative X-ray image after CTM application*

dedication to the profession, but that their skills and abilities can help patients reclaim the smile of their dreams," said Dr. Brian Jackson, DDS, FAAID, DABOI/ID.

Potential patients can find more information on dental implants and the benefits of choosing an AAID-credentialed dentist on AAID's consumer-facing site, aaid-implant.org.

newmembers

The AAID is pleased to welcome the following new members who joined between February 22, 2023 and May 9, 2023. The list is organized by state, with the new member's city included. International members are listed by country and province (if applicable). If you joined the AAID recently and your name does not appear below, it will be listed in the next issue of *AAID News*.

PLEASE WELCOME THESE NEW MEMBERS IN YOUR AREA.

Alabama
Bradley Kirkpatrick, Birmingham

Arizona
Shaveta Behl, Gilbert
Carlos Benavides Davila, Vail
Sarah Chang, Tucson
Jesse Engle, Tucson
Erick Figueroa Perez, San Luis
Joseph Larsen, Oro Valley
Gianira Lopez, Phoenix

California
Mariam Al Shakarchi, Lake Elsinore
Majed Altoman, Loma Linda
Mitin Bhatia, Fresno
Ahmed Bokhari, Loma Linda
Naeem Etemadi, Irvine
Athena Goodarzi, Newport Coast
Nicole Hoang, Danville
Kelly Hong, Apple Valley
Jason Huang, San Gabriel
Achman Jaswal, Sacramento
Jose Lara, Atwood
Joseph Marvizi, Beverly Hills
J Alexander Mendoza, San Jose
Sarkis Papazian, Van Nuys
Roger Wei, Modesto
Travis Yarris, Napa
Alexander Zaykov, Loma Linda
Cheng Zhu, Danville

Colorado
Ryan Bond, Longmont
Chris Freimuth, Lakewood
James Grant, Colorado Springs
Brandt Jones, Castle Rock
Randall Kelley, Grand Junction
Amiee Rawlings, Montrose
Trey Thygerson, Berthoud

District of Columbia
Abdullah Tikreeti, Washington

Florida
Lauren Alfred, North Miami
Theodore Chamberlain, Belleair Bluffs
Gustavo De Oliveira, Orlando
Rafael Llanes, Port St. Lucie
Grace Lopez, Fort Lauderdale
Arian Melgarejo, Miami
John Pasiczny, Naples

Georgia
Vinamra Bhasin, Warner Robins
W. Kevin Dancy, Sandy Springs
Lincoln Fantaski, Atlanta
Michael Lefkove, Milledgeville
Colin Lentz, Buford
Mark Martindale, Fayetteville
Ronak Patel, Atlanta

Hawaii
Patrick Ferguson, Honolulu
Elliot Kim, Honolulu
Summer Wood, Kailua

Illinois
Laurence Daitch, Deerfield
Gerel Emgushova, Lake Forest
Marta Kmit, Elmhurst
Bilus Poles, Arlington Heights
Khalil Qatu, Chicago
Colleen Shandley, Barrington
Ronald Townsend, Chicago

Indiana
Manuel Carranza, Goshen
Teerthesh Jain, Fishers

Kansas
Sujan Rijal, Andover

Kentucky
Jason Chen, Blue Ridge Manor

Maryland
Charuta Modak, Ellicott
Taimour Raja, Bethesda

Massachusetts
Madhav Shrirao, Upton

Michigan
Daryl Duncan, Redford
Enkee Ganbatar, Ann Arbor

Mississippi
Catherine Mincy, Booneville

newmembers

Missouri
Sharif Naem, Lebanon
Grant Olson, Springfield

New Jersey
Stella Backos, Fords
Edgar Ralff, Trenton

New Mexico
Reddy Guddeti, Albuquerque
Justin Porter, Silver City

New York
Vasundhara Bhatt, Flushing
Dwayne Bodie, New York
Saleh Elahwal, Brooklyn
Glacendy Espinosa, Queens
Syed Masihuddin, Warwick

North Carolina
Tristan Parry, Summerfield
Nathan Sommer, Wake Forest

Ohio
Shannon Duqum, South Euclid
Nour Hejazin, Westlake
Fadi Mdanat, Westlake

Oklahoma
Aubrey Henshaw, Sallisaw
Kenneth Moore, Jenks

Pennsylvania
David Azizyan, King of Prussia
Jack Fitzgerald, Berwyn
Aarti Lala, Warwick
Jignesh Patel, Allentown
Krunal Patel, Warwick
Fredrick Sams, Pittsburgh

South Carolina
Brandon Evert, Beaufort

Tennessee
Keith Gilmore, Dickson
Hogan Whitmire, Hixson

Texas
Chris Caldwell, Conroe
Omel Cardenas, Harlingen
Ashraf Harhash, Sugar Land
Nitin Joshi, Granbury
Brenda Landeros, Harlingen
Vikram Shad, Houston
Glenn Stern, Canton
William Sung, Richmond
Mihai Tiplea, Allen
Reza Zamanian, Arlington

Utah
Daniel Norris, Enoch

Virginia
Sonia Ahsan, Alexandria
Tommy Han, Richmond

Washington
Kwansoo Lee, Spanaway

Wisconsin
Forrest Gearhart, Adams
David Lubin, Francis

CANADA

Alberta
Linda Xie, Edmonton

Ontario
Maha Toamah, Mississauga

INTERNATIONAL

Bahrain
Charis Joseph

India
NK Kamaraj Tamil Nadu

Kuwait
Aseel Al Ajlan
Abdulaziz Aljazzaf
Muhammad Aljundi
Bashar Obeid
Mamon Tinawi

Mexico
Boris Schwartzman

Oman
Abdallah Almajarfi
Abdulla Alsiyabi
Gogulanathan Muthukrishnan

Romania
Kamel Earar
Cristian Lordache

Saudi Arabia
Yaser Alhazmi
Mouhammad Rihan

South Korea
Dabin Che
Lee Keydong
SungJoon Koh
Daegeun Lee
Yoon Seok Oh

United Arab Emirates
Nasali Abdurahiman
Niran Algobori
Mohamad Alqam
Wisam Alsammarraie
Mohammed Al Tatari
Ramzi Al Hasayna
Abeer Al Khalili
Ola Alahmed
Khalifa Alhamadi
Anas Alsaadi
Ahmed Alsallami
Ala Awad
Ahlam Azkoul
Nour Bdeir
Abdelrahman Elberry
Adham Eldesouk
Bola Farid
Satpal Gill
Hashem Gurayfi
Shahla Imthiaz
Soulih Masho Elbeh
Sahar Musa
Varun Raj
Dhifaf Sahhaf
Amer Shaker
Asmaa Wajeeh
Nariman Salahat
Sudhir Varma

Student Members
Amir Akhras
Leuman Barreras Pestana
Jordan Dobbin
Philip Horning
Joosang Lee
Indira Sanchez Concepcion
Christopher Xiao
Ting Xue

NEW GUIDELINES REGULATING COMMERCIAL INFLUENCE ON DENTAL EDUCATION TAKE EFFECT JULY 1

AAID well-positioned for changes

In April 2019 the American Dental Association Commission for Continuing Education Provider Recognition revised the CERP Eligibility Criteria stating that effective July 1, 2023, commercial interests will no longer be eligible for ADA CERP recognition. The goal of these new guidelines is to reduce or eliminate commercial influence on continuing dental education.

The trend toward more formal separation between commercial entities and health care accelerated after a 2009 Institute of Medicine report found that while collaborations between medicine and industry can benefit society, financial ties between medicine and industry may create conflicts of interest and create a risk of undue influence on professional judgment. The report stated that these ties can compromise the objectivity of medical education and patient care and undermine the public's trust. IOM called for guidelines to reduce conflicts of interest and bias in education and practice.

Organized medicine has been following these guidelines for a decade and dentistry has matched this approach by taking this last step to remove any commercial influence or penetration into continuing education programs or sessions.

Jon Sprague, AAID's Director of Education and Credentialing, reports that since AAID has been following these guidelines for several years, most members won't notice.

"AAID provides a survey for members who attend continuing education sessions to report suspected biases to us," he said. "Additionally, if we see any bias occurring during a session, we will end the session."

Sprague emphasized that the new guidelines would make it difficult for commercial interests to get on an AAID podium or influence attendees at AAID events.

"We can't have commercials on our stages," he said. "We need to have evidence-based medicine and speakers selected through an abstract process using scientific experience that have been showed in the curriculum for implantology."

According to the ADA CERP, continuing education must:

- Be based on accepted science
- Be Independent from commercial influence
- Lead to improvements in professional knowledge, performance or practice and benefit the patient and public health

The CERP Glossary defines "commercial interest" as follows: Commercial Interest: (1) An individual or entity that produces, markets, re-sells or distributes health care goods or services consumed by, or used on, patients, or (2) an individual or entity that is owned or controlled by an individual or entity that produces, markets, resells, or distributes health care goods or services consumed by, or used on, patients. Providing clinical services directly to or for patients (e.g., a dental practice, dental lab, or diagnostic lab) does not, by itself, make an individual or entity a commercial interest.

ADA CERP Recognition terms of all commercial interests will expire no later than June 30, 2023. Any organization that is an ADA CERP recognized provider and is also a commercial interest, as defined by CERP, will be able maintain its recognition status through June 30, 2023 by fulfilling normal program requirements. To retain recognition, continuing dental education providers must comply with CERP Standards and criteria as modified.

COMMERCIAL INTERESTS

- Dental product manufacturer
- Dental products distributor
- Medical/dental device manufacturer
- Pharmaceutical company
- Education company owned or controlled by commercial interest

NON COMMERCIAL INTERESTS

- Education company (unless owned or controlled by commercial interest)
- Dental lab (unless it markets a proprietary product)
- Dental practice
- Insurance company
- Dental school (for profit or not for profit)

For more information, visit
CCEPR.ADA.org/resources-for-ce-providers

AAID MaxiCourse®
PRACTICAL IMPLANT EDUCATION

Abu Dhabi AAID MaxiCourse®
Abu Dhabi, UAE
Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Assistant Director: Ninette Banday, BDS, MPH
Email: drsiyer@aol.com
Phone: 908-527-8880
Website: www.maxicourseasia.com

Augusta University AAID MaxiCourse®
Augusta, GA
Director: Douglas Clepper, DMD, FAAID, DABOI/ID
Assistant Director: Michael E. Pruett, DMD
Contact: Lynn Thigpen
Email: lbthigpen@augusta.edu
Phone: 706-721-1447
Website: www.georgiamaxicourse.com

Bangalore AAID MaxiCourse®
Bangalore, India
Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Assistant Director: Ninette Banday, BDS, MPH
Email: drsiyer@aol.com
Phone: 908-527-8880
Website: www.maxicourseasia.com

Boston AAID MaxiCourse®
Boston, MA
Director: Brian Jackson, DDS, FAAID, DABOI/ID
Contact: Jana Selimovic, Program Coordinator
Email: education@bostonmaxicourse.com
Phone: 315-922-2176
Website: www.bostonmaxicourse.com
Instagram: bostonmaxicourse_bic
Facebook: Boston MaxiCourse

Chicago AAID MaxiCourse®
Chicago, IL Director: Christopher Petrush, DDS, FAAID, DABOI/ID
Assistant Director: Frank Caputo, DDS, MDS, FAAID, DABOI/ID
Contact: Monika Elek
Email: Monika.Chicagomaxicourse@gmail.com
Phone: 773-236-2352
Website: www.aaidchicagomaxicourse.com

Las Vegas AAID MaxiCourse®
Las Vegas, NV
Director: John Minichetti, DMD, FAAID, DABOI/ID
Assistant Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Contact: Sarah Rock
Email: sarah.englewooddental@gmail.com
Phone: 201-871-3555
Website: www.dentalimplantlearningcenter.com

Long Island AAID MaxiCourse®
West Islip, NY
Director: Mike Calderon, DDS, FAAID, DABOI/ID
Assistant Director: Marcelo Calderon, DMD, AFAAID
Contact: Gio Heyser
Email: ipagiomayra@gmail.com
Phone: 631-328-5050
Website: www.longislandmaxicourse.com

Nagoya, Japan AAID MaxiCourse®
Nagoya, Japan
Director: Yasunori Hotta, DDS, PhD, FAAID, DABOI/ID
Assistant Directors: Hiroshi Murakami, DDS, PhD, FAAID Koji Ito, DDS, PhD, FAAID Komat su Shinichi DDS, PhD, FAAID Takashi Saito, DDS, PhD, FAAID
Contact: Yasunori Hotta, DDS, PhD, AFAAID
Email: hotta-dc@ff.iij4u.or.jp
Phone: +81-52-794-8188
Website: www.hotta-dc.com

New York AAID MaxiCourse®
Englewood, NJ
Director: John Minichetti, DMD, FAAID, DABOI/ID
Assistant Director: Joseph C. D'Amore, DDS, AFAAID, DABOI/ID
Contact: Sarah Rock
Email: sarah.englewooddental@gmail.com
Phone: 201-871-3555
Website: www.dentalimplantlearningcenter.com

Newport Beach AAID MaxiCourse®
Newport Beach, CA
Director: M. Ali Mostafavi, BDS, DDS, FAAID
Assistant Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Contact: Megan Gutierrez
Email: megan.gutierrez@glidewelldental.com
Phone: 866-791-9539
Website: www.maxicourseca.com

Nova Southeastern University AAID MaxiCourse®
Fort Lauderdale, FL
Director: Jack Piermatti, DMD, FAAID, DABOI/ID
Assistant Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Contact: Linnette Dobbs-Fuller

Rutgers School of Dental Medicine AAID MaxiCourse®
Newark, NJ
Director: Jack Piermatti, DMD, FAAID, DABOI/ID
Assistant Director: Shankar Iyer, DDS, MDS FAAID, DABOI/ID
Contact: Janice Gibbs-Reed, MA
Email: gibbs@sdm.rutgers.edu
Phone: 973-972-6561
Website: cde.sdm.rutgers.edu/maxicourse/

Salt Lake City AAID MaxiCourse®
South Jordan, UT
Director: Bart Silverman, DMD, FAAID, DABOI/ID
Assistant Director: Shankar Iyer, DDS, MDS, FAAID, DABOI/ID
Contact: Rachana Hegde, DDS, MS, AFAAID
Email: rhegde@roseman.edu
Phone: 973-709-5835
Whatsapp: 201-238-5438
Website: www.maxicourseutah.com

San Juan, Puerto Rico AAID MaxiCourse®
San Juan, PR
Director: O. Hilt Tatum, DDS, FAAID DABOI/ID
Assistant Director: Jose Pedroza, DMD, MSC
Contact: Miriam Montes
Email: prmaxicourse@gmail.com
Phone: 787-642-2708
Website: www.theadii.com

Washington, DC AAID MaxiCourse®
Washington, DC
Director: Bernee Dunson, DDS, FAAID, DABOI/ID
Contact: Tracey Allison, Esq
Email: dcmaxi@dunsondental.com
Phone: 404-897-1699
Website: www.dcmaxicourse.com

Waterloo, Ontario AAID MaxiCourse®
The TI-MAX Institute
Director: Rod Stewart, DDS, FAAID, DABOI/ID
Assistant Director: George Arvanitis, DDS, FAAID, DABOI/ID
Contact: Chantel Furlong
Email: info@timaxinstitute.com
Phone: 905-235-1006
Website: www.timaxinstitute.com

Vancouver AAID MaxiCourse®
Vancouver, BC
Director: William Liang, DMD, FAAID, DABOI/ID
Contact: Andrew Gillies
Email: andrew@implant.ca
Phone: 604-330-9933
Website: www.vancouvermaxicourse.com

AAID Active Study Clubs

UNITED STATES

AAID Bergen County Dental Implant Study Group
Location: Englewood, NJ
Director: John Minichetti, DMD
Contact: Lisa McCabe
Phone: 201-926-0619
Email: lisapmccabe@gmail.com
Website: bit.ly/2rwf9hc

Alabama Implant Study Club
Location: Brentwood, TN
President: Michael Dagostino, DDS
Contact: Sonia Smithson, DDS
Phone: 615-337-0008
Email: aisgadmin@comcast.net
Website: www.alabamaimplant.org

Bay Area Implant Synergy Study Group
Location: San Francisco, CA
Director: Matthew Young, DDS
Phone: 415-392-8611
Email: young.mattdds@gmail.com
Website: www.youngdentalsf.com

Calderon Institute Study Club
Location: Queens, NY / Oceanside, NY
Director: Mike E. Calderon, DDS
Contact: Andrianna Acosta
Phone: 631-328-5050
Email: calderoninstitute@gmail.com
Website: www.calderoninstitute.com

Hawaii Dental Implant Study Club
Location: Honolulu, HI
Director: Michael Nishime, DDS
Contact: Kendra Wong
Phone: 808-732-0291
Email: mnishimedds@gmail.com
Website: www.advancedrestorativedentistry808.com

Hughes Dental Implant Institute and Study Club
Location: Sterling, VA
Director: Richard E. Hughes, DDS
Contact: Victoria Artola
Phone: 703-444-1152
Email: dentalimplant201@gmail.com
Website: www.erhughesdds.com

Implant Study Club of North Carolina
Location: Clemmons, NC
Director: Andrew Kelly, DDS
Contact: Shirley Kelly
Phone: 336-414-3910
Email: shirley@dentalofficesolutions.com
Website: www.dentalofficsolutions.com

Mid-Florida Implant Study Group
Location: Orlando, FL
Director: Rajiv Patel, BDS, MDS
Contact: Rajiv Patel, BDS, MDS
Phone: 386-738-2006
Email: drpatel@delandimplants.com
Website: www.delandimplants.com

SMILE USA® Center for Educational Excellence Study Club
Location: Elizabeth, NJ
Director: Shankar Iyer, DDS, MDS
Contact: Terri Baker
Phone: 908-527-8880
Email: dentalimplant201@gmail.com
Website: www.malosmileusaelizabeth.com

CANADA

Vancouver Implant Continuum
Location: Surrey, BC, Canada
Director: William Liang, DMD
Contact: Andrew Gillies
Phone: 604-330-9933
Email: andrew@implant.ca
Website: www.implant.ca

INTERNATIONAL

Aichi Implant Center
Location: Nagoya, Aichi-Ken, Japan
Director: Yasunori Hatta, DDS, PhD
Phone: 052-794-8188
Email: hotta-dc@ff.iij4u.or.jp
Website: www.hotta-dc.com

Beirut AAID Study Club
Location: Beirut, Lebanon
Director: Joe Jihad Abdallah, BDS, MScD
Phone: 961-174-7650
Email: beirutidc@hotmail.com

Courses presented by AAID credentialed members

UNITED STATES

The Dental Implant Learning Center - Basic to Advanced Courses in Implant Dentistry
John C. Minichetti, DMD
Contact: Jennifer Yang
Phone: 866-586-0521
Email: jenn.englewooddental@gmail.com
Website: www.dentalimlpantlearningcenter.com/ce-courses/register-online

California Implant Institute
Dr. Louie Al-Faraje, Academic Chairman
Phone:858-496-0574
Email: master@implanteducation.net
Website: www.implanteducation.net

Connecticut Dental Implant Institute
Location: Manchester, CT
Various Courses available
Dr. Joel L. Rosenlicht
Contact: Michelle Marcil
Email: michelle@jawfixers.com
Website: www.jawfixers.com

East Coast Implant Institute
Location: Utica, NY
Dr. Brian J. Jackson
Contact: Jana Selimovic
Phone: 315-922-2176
Email: education@bostonmaxicourse.com
Website: eastcoastimplantinst.com/upcoming-courses/

Implants in Black and White
Dr. Daniel Domingue
Dr. Jerome Smith
Contact: Maggie Brouillette
Phone: 337-235-1523
Email: maggie@jeromesmithdds.com
Website: www.blackwhiteimplants.weebly.com

Courses presented by AAID credentialed members

Introductory Implant Placement
6-Day Dental Implant Course
48 CE in 6 days
Dr. Michael Shulman
Email: info@shulmandds.com
Phone: 201-840-7777
Website: www.adiseminars.com

Midwest Implant Institute
Drs. Duke & Robert Heller
Advanced Courses:
(311) Preserve This: Introduction to Extraction, Socket Preservation and PRP
(411) The All Inclusive Live Surgical Course
(601) Bone Grafting & Sinus Elevation
(603) Implant Prosthetics
(605) Digging Out of Problems
Contact: 614-505-6647
Email: samantha@mii1980.com
Website: www.midwestimplantinstitute.com

Mini-Residency Implant Program
for Dentists in Any State
NJ State Board approved for Live Surgery Training - 150 hours CE credits
Course Director: Shankar Iyer DDS, MDS
September through July, biweekly
Contact: terri@smileusa.com
Phone: 908-527-8880
Website: www.smileusacourses.com

Pikos Implant Institute
Michael A. Pikos, DDS
Soft Tissue Grafting Sinus Grafting Alveolar Ridge
Strategies: Single Tooth to Full-Arch Fully Guided Full-Arch Immediate Implant Reconstruction
Contact: Kali Kampmann
Phone: 727-781-0491
Email: learn@pikosInstitute.com
Website: www.pikosinstitute.com/programs-and-courses/coursecontinuum-overview

Single Tooth to Anchored
Denture Continuum:
Live Patient, Mentored Training
Location: Lutz, FL
85 CE Hours
Dr. Sarah Jockin
Contact: Jay Jockin
Phone: 813-774-2916
Email: jay@fullarchsuccess.com
Website: www.fullarchsuccess.com

Stanley Institute for
Comprehensive Dentistry
Dr. Robert Stanley
Contact: Megan Carr, Interim Director of Continuing Education
Email: megan@stanleyinstitute.com
Phone: 919-415-0061
Website: www.stanleyinstitute.com

Train for Success: Live!
Dental Implant Continuum
Dr. Joseph A. Leonetti
Contact: Scott Lauer
Email: scottlauer@implantedco.com
Phone: 949-257-5696

University Implant Educators Live
Patient Surgical Course (All Inclusive)
4 Day Live Patient Surgery Courses
40 CE Hours, San Diego, CA
Professor Francis Jones
(University of Nevada Las Vegas)
Contact: Grace Terrazona
Email: info@universityimplanteducators.com
Phone: 877-709-6623
Website: www.universityimplanteducators.com

CANADA

Pacific Implant and Digital
Dentistry Institute
Dr. Ron Zokol
Contact: Barbara Cox
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Contact: Mahia Cheblac
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AAID NEWS STAFF

EDITOR
Dennis Flanagan, DDS, MSc, FAAID, DABOI/ID
editor@aaid.com

AAID EXECUTIVE DIRECTOR
Carolina Hernandez, CAE

AAID MARKETING & COMMUNICATIONS DIRECTOR
Matthew S. Switzer

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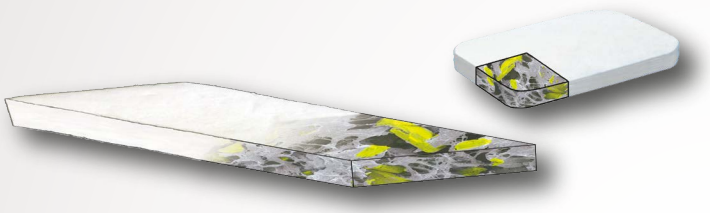

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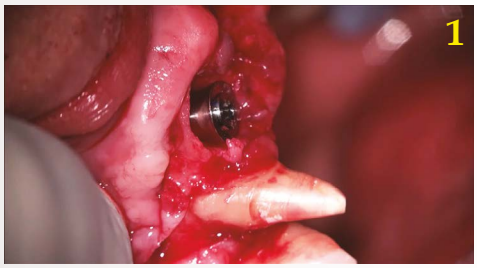
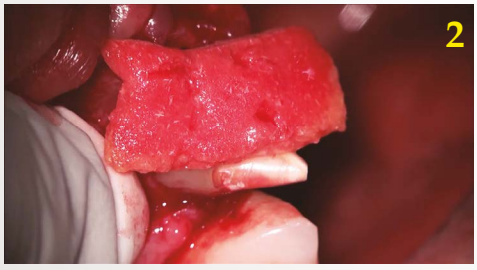
The Impladent Ltd OsteoGen® Bone Grafting Strip infuses OsteoGen® bone graft crystals into a collagen sheet which eliminates issues associated with particulate migration. The OsteoGen® Strips are a predictable solution for grafting gaps around immediately placed implants and can be utilized in the sinus or anywhere particulates are typically used.

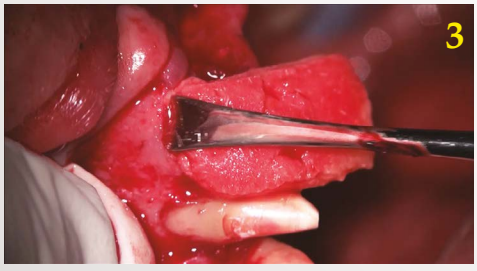
CLINICAL CASE EXAMPLE



Implant is placed lingually following extraction. OsteoGen® Strip will be used to fill gaps and to reinforce the buccal wall

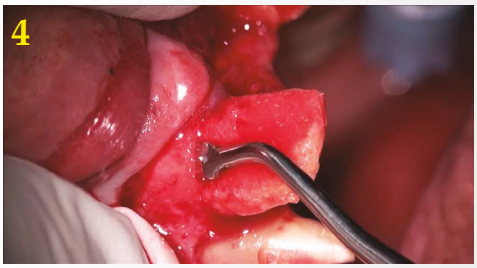


OsteoGen® Strip is hydrated with patients blood from the surgical site and, if desired, autologous serum or other growth factors prior to delivery

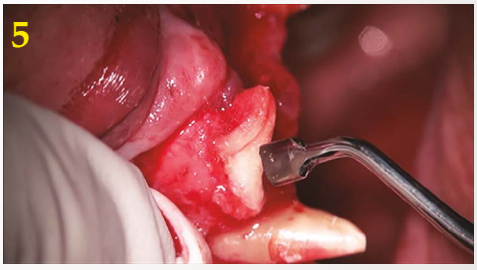


Buccal plate is reinforced by feeding the Osteo-Gen® Strip down-wards in between the implant and the buccal wall

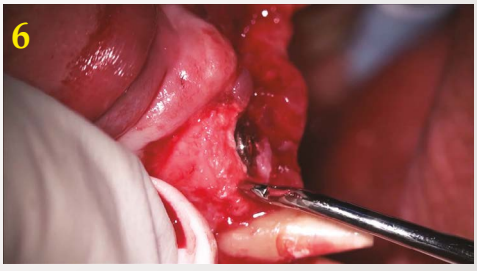
The OsteoGen® Strip is a hydrophilic material that can be hydrated with patients blood and substantially compressed to fill a variety of defects



OsteoGen® Strip can be folded after hydration and prior to or during placement with a blunt instrument for additional bone width and stability



OsteoGen® Strip is in place which reinforces the buccal wall while grafting the gaps between the buccal plate and the implant



Clinical images courtesy of Robert Miller, MA, DDS, FACD, DABOI

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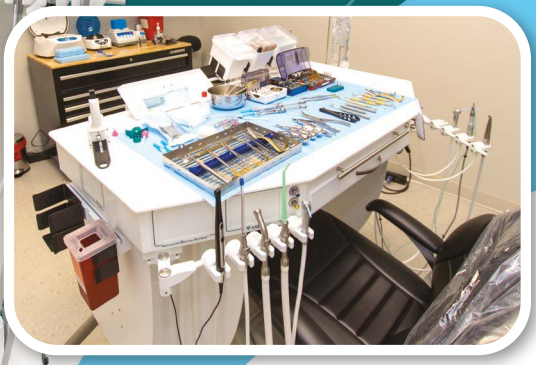

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