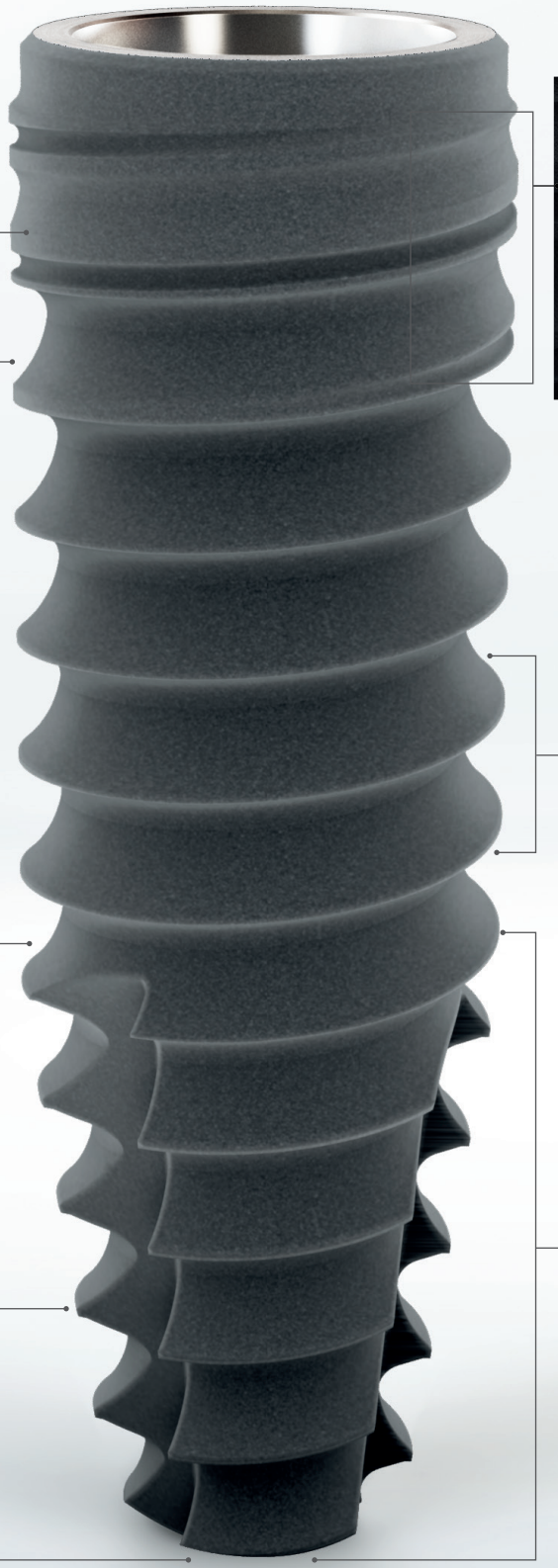
NO BONES ABOUT IT.

CONFIDENCE IN ALL BONE TYPES: PROGRESSIVE-LINE[2]

camlog

biohorizons camlog

FEATURES



Promote® plus surface

Tried and tested sandblasted, acid-etched surface

Crestal anchorage thread

For additional stability with limited bone height [2]

Contour form drill PROGRESSIVE-LINE

Parallel-walled section

Buttress thread with widened flank height

- Deeply engaging threaded flanks
- Improved distribution of axial forces [1]
- Targeted bone compression [1]

Conical area

- Excellent primary stability
- Reduced diameter in areas with limited bone substance [1,2]

Thread down to the apex

Ideal for immediate implantation [1,2]

CONELOG® PROGRESSIVE-LINE implant

NO BONES ABOUT IT.
CONFIDENCE IN ALL BONE TYPES[2]

PROGRESSIVE-LINE implants are designed to achieve high primary stability even in very soft bone or extraction alveoli [1,2]. Based on the clinically tried and tested and user friendly inner connections of the CONELOG® and CAMLOG® implants [3,4], they have many other design features to master complex situations [2] and make processes more efficient.

The apical conical implant body and the progressive, protruding thread design ensure greater assurance in patient-friendly treatment concepts such as immediate implants and restoration [1,2].

A crestal anchoring thread ensures additional grip even when the bone height is limited [2]. In order to do this, the thread is continued into the crestal area of the implant and modified. The implant achieves high levels of primary stability without additional measures and scores in many clinical situations such as:

- Soft bone
- Immediate implantation
- Immediate restoration
- Immediate function
- Limited bone height [1,2]

A SURGICAL SET FOR CONELOG® AND CAMLOG® PROGRESSIVE-LINE IMPLANTS

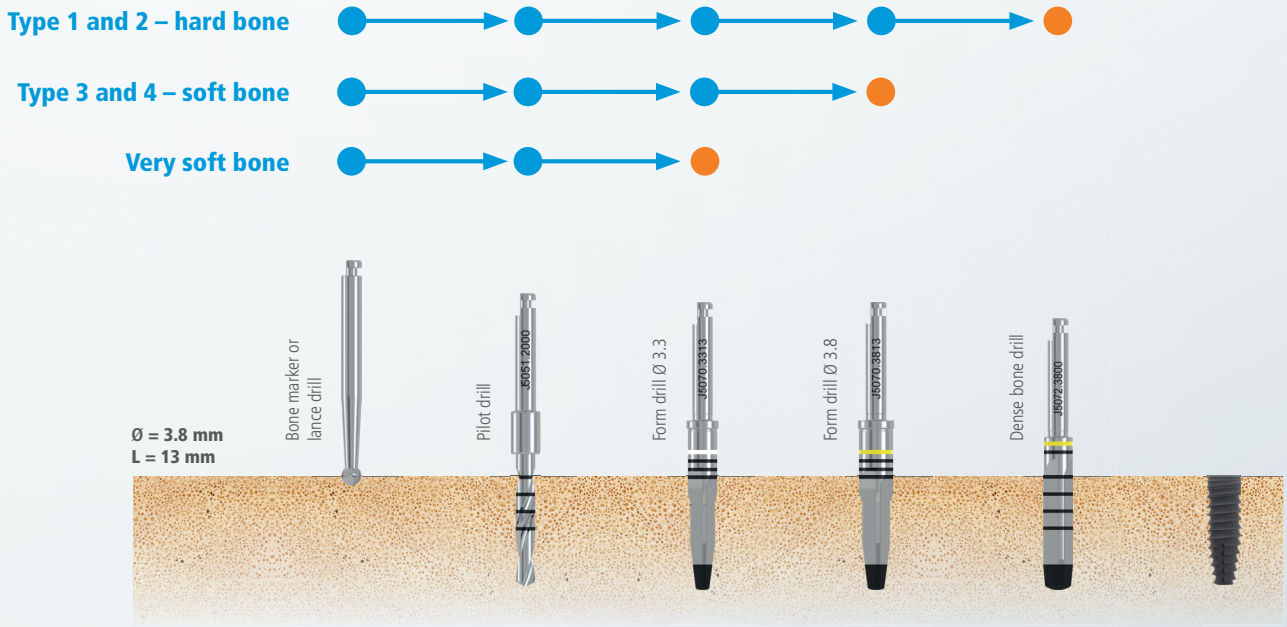
PROGRESSIVE-LINE implants are available as CONELOG® PROGRESSIVE-LINE and CAMLOG® PROGRESSIVE-LINE in the diameters 3.3, 3.8, 4.3 and 5.0 mm and in the lengths 7 (CONELOG® only), 9, 11, 13 and 16 mm. The CAMLOG® and CONELOG® PROGRESSIVE-LINE implants are available with screw-in or snap-in implant posts.

The surgical procedure and the instruments are the same for CONELOG® and CAMLOG® PROGRESSIVE-LINE implants, so the surgical set is the same for both lines. Users from the pilot phase confirmed that the implants has excellent, user-friendly properties [5].

FLEXIBLE DRILLING PROTOCOL – TARGETED PRIMARY STABILITY WITHOUT ADDITIONAL MEASURES

The strengths of the PROGRESSIVE-LINE implant are found in particular in soft bones with no additional treatment steps (such as the use of osteomes) [1,2]. The drilling protocol is extremely flexible and can be tailored to the respective clinical situation.

The drilling protocol can be chosen depending on the bone quality. This means that underpreparation of the implant bed is possible in predominantly spongy bones.



Example drilling protocol for a CONELOG® implant

NO TAPS IN HARD BONES

The new dense bone drill replaces the tap in hard bones. This is as easy to use as a conventional form drill and there is no need for the time-consuming tapping and often arduous searching for the pre-cut thread when inserting the implant. This means PROGRESSIVE-LINE meets the requirement of many dentists working in implantology for reduced treatment times and immediate care protocols.

Advantages

- Same drilling speed as a form drill (dependent on diameter)
- No change of rotational direction necessary (compared to the tap)
- No tedious searching for the pre-tapped thread (compared to the tap)

Four cutting flutes

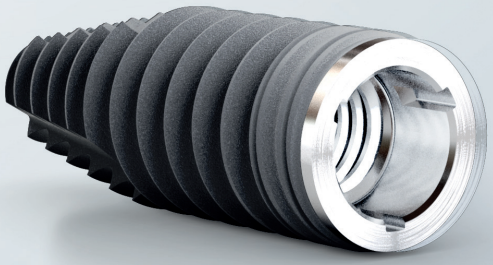
- High cutting performance
- Bone chip collector for accompanying augmentation

Dark drill tip

Typical for all PROGRESSIVE-LINE form drills

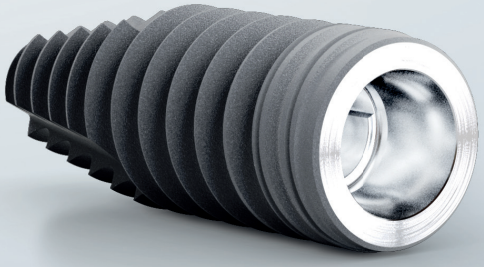
THE CAMLOG® CONNECTION – PROSTHETIC SIMPLICITY

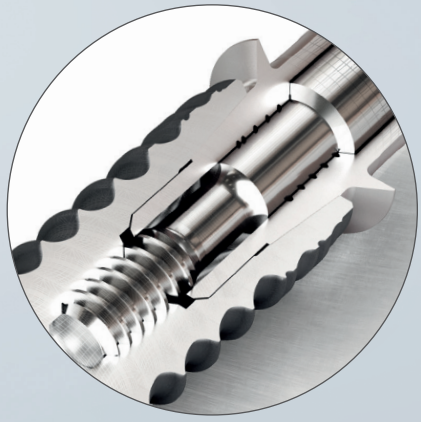
The heart of the CAMLOG® implant system is the tube-in-tube® connection between the implant and the abutment. The precision and the particularly geometric principle with three cams ensures an almost perfect distribution of force and torque, thereby creating a stable connection to the prosthetic components that is protected against rotation. The connection between the implant and the abutment has been biomechanically optimised taking into account time-consuming finite element analyses. It has been tried and tested over several years and in millions of implant insertion procedures.



THE CONELOG® CONNECTION – CONICAL PRECISION [3,4]

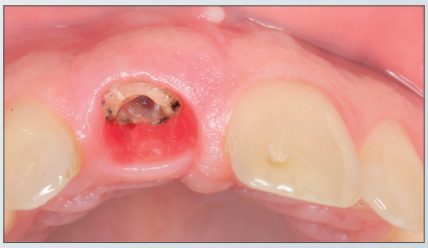
Thanks to its integrated platform-switching combined with the precise conical connection and the Promote® plus surface which extends to the implant shoulder which is at an angle of 45°, the CONELOG® PROGRESSIVE-LINE implant is particularly suitable for epicrestal positioning.



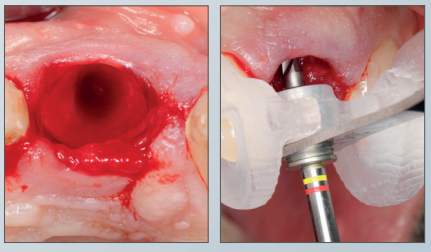


EXAMPLES OF CLINICAL APPLICATIONS

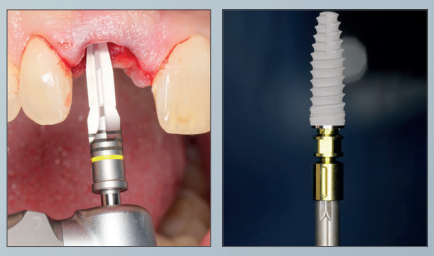
■ Dr. Frederic Hermann, MSc. (from the Implantology Journal Special Edition 03 I 2019)



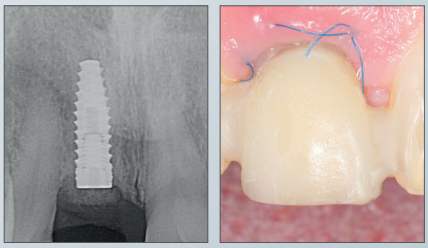
Initial situation: a post crown broken in the root canal and a deep apical fracture in the root. Revision was contraindicated.



After the minimally invasive removal of the root, the pilot hole was drilled and the first form drilling carried out using a template created before the operation.

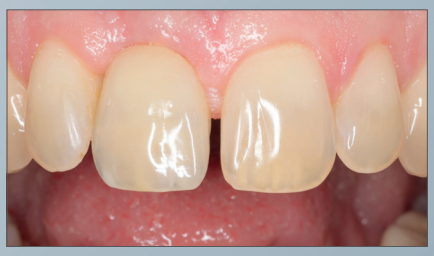


The final drilling was carried out freehand. The distal positioning was due to the retention of the diastema.



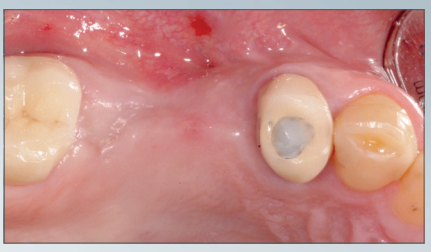
The PROGRESSIVE-LINE implant Ø 3.8 mm/L13 mm was positioned in a 0.4 mm supracrestal position in line with the protocol. The patient's own tooth was used to stimulate the attached gingiva as a temporary measure.

The anatomical shape of the hard and soft tissue was determined using replacement materials. The mould was made using the open tray technique.

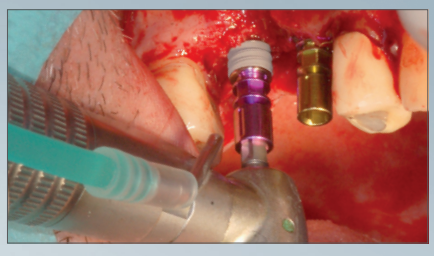


The final treatment: a hybrid abutment made of zirconium dioxide created in a CAD/CAM process onto which a layered lithium disilicate crown was cemented.

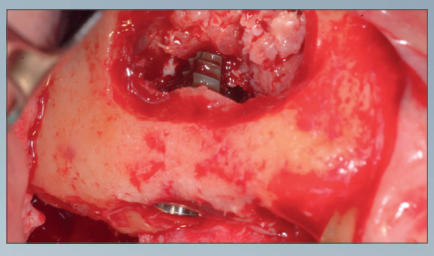
■ Dr. Jörg-Martin Ruppin



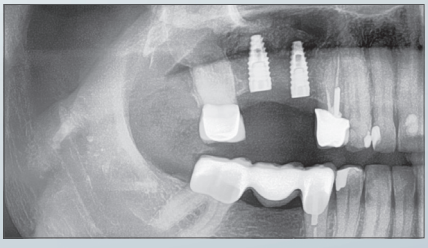
The occlusal view of the initial clinical situation shows a vertical and horizontal defect of the alveolar chamber in regions 15 and 16.



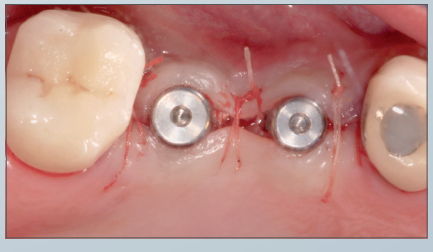
After the incision and the preparation of a mucoperiosteal flap, the Schneiderian membrane was lifted by opening a lateral window. The cavity was first filled with a mixture of autologous and bovine bone substitute material.



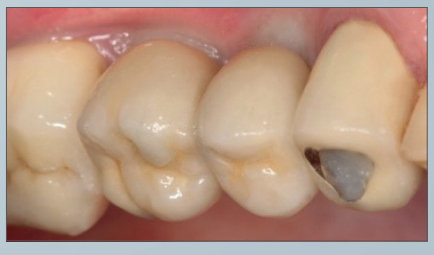
Two PROGRESSIVE-LINE implants were inserted. Primary stability of the implants was predominantly achieved by means of the crestal anchoring thread. Once the operation site had been augmented and the implants were covered, the soft tissue was able to be closed.



The control image shows the sinus floor elevation and the augmented area after the wound had been closed. The area was exposed after three months of covered healing.

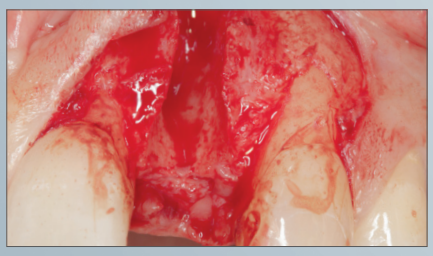


This occurred three months after the insertion.
The prosthetic care started with the shaping of the soft tissue using gingival shapers.

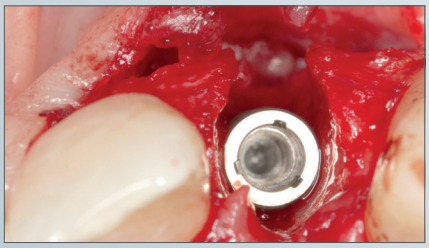


In referral practice, final treatment is provided in the form of two monolithic zircon crowns being cemented onto modified titanium abutments.
Image: Drs Fischer, Weilheim i. Obb.

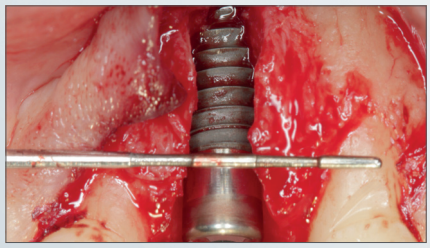
Dr. Christian Hammächer (from CAMLOG Special Edition 01 | 2019)



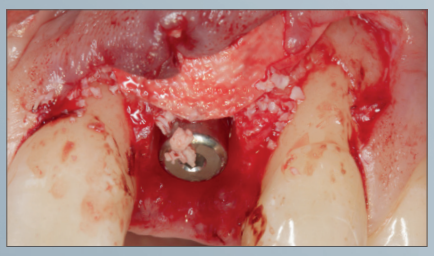
Following the incision and reflection of a mucoperiosteal flap, a pronounced hard tissue defect was identified in the buccal wall.



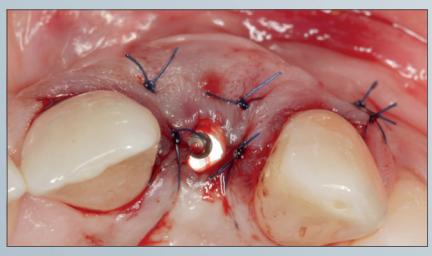
As there was sufficient horizontal and vertical bone, the implant was able to be positioned in a three-dimensional manner in the extraction alveolus.



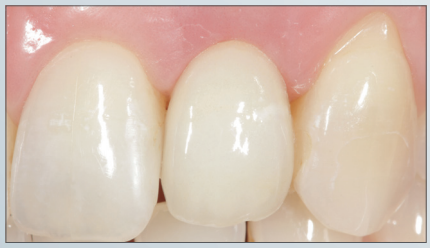
The correct vertical positioning was achieved by the placing of the implant shoulder around three to four millimetres below the cementoenamel junction. The implant healed held open using a gingival shaper.



A mixture of autologous bone and bovine bone substitute material was used to reconstruct the alveolar bone and the incongruity defect. The defect was covered using a barrier membrane.

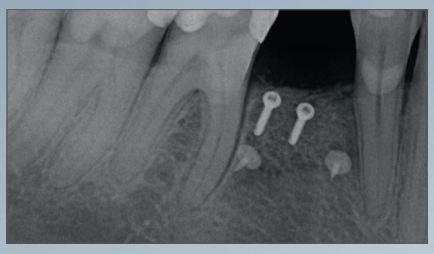


To counteract the change in volume during the reconstruction process, the augmented area, which ultimately also determines the position of the soft tissue, is generally overcontoured.

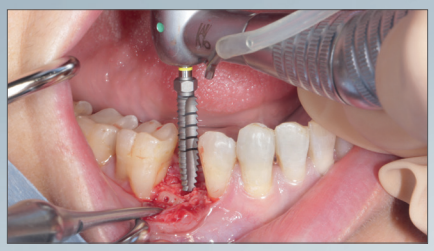


The peri-implantar soft tissue is anatomically shaped five months after the insertion. A week after the integration of a zircon abutment adhered to the CAD/CAM titanium base and the full ceramic crown cemented on this, there was a harmonious red-white ratio.

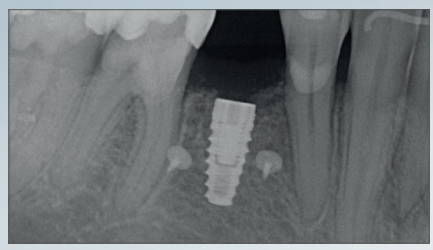
Dr. Martin Gollner (from DGOI Journal of Oral Implantology 2 I 2019)



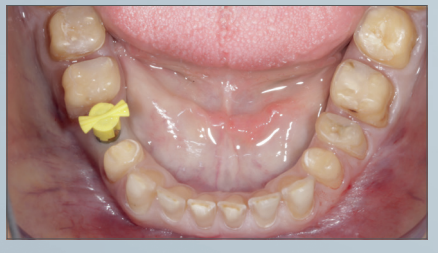
Following the successful augmentation of the hard tissue with a bone block and membrane cover, the osteosynthesis screws were removed and a CAMLOG® PROGRESSIVE-LINE implant inserted.



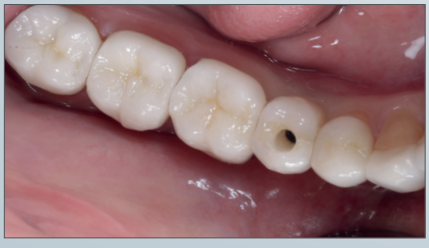
The preparation of the areas to be drilled was carried out in line with the standard protocol. Since the bone was hard and augmented, a tap was used to avoid excessive pressure on the peri-implantar bones during insertion.



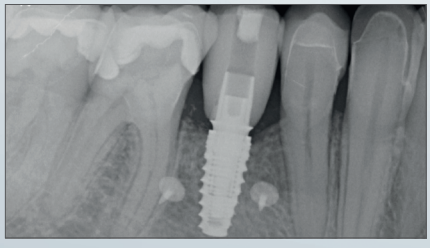
The smooth/rough transition came to lie flush with the bone when inserting the CAMLOG® PROGRESSIVE-LINE implant. For healing, the implant was closed and healed covered for eight weeks.



The implant was exposed and the soft tissue shaped. Orthodontic treatment was carried out before the implant. The natural teeth were prepared in a minimally invasive manner in terms of the overall functional treatment. Closed shaping was then carried out.



The view shows the adhered table tops and the directly screwed implant crown before closure of the canal. This can be harmoniously inserted into the dental arch thanks to the perfect implant position. This achieved optimal function and aesthetics that will be stable for a long time.



The x-ray taken after the integration of the hybrid crown shows the bone deposition. The bone structure is deposited in a stable manner right up to the smooth/rough transition in the region of the anchoring thread in particular.

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References

[1] Conserva E. Initial stability after placement of a new buttress threaded implant. A case series study. implants. 2019(3):24-28.
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[3] Semper-Hogg W, Kraft S, Stiller S, Mehrhof J, Nelson K. Analytical and experimental position stability of the abutment in different dental implant systems with a conical implant-abutment connection. Clin Oral Investig 2010;17(3):1017-23
[4] Semper-Hogg W, Zulauf K, Mehrhof J, Nelson K. The influence of torque tightening on the position stability of the abutment in conical implant-abutment connections. Int J Prosthodont 2015;28:538-41
[5] Data on file

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