

CAMLOG AND NEW MEDIA

It is an almost indispensable part of everyday life: new media. Internet, tablets, Facebook, Wikipedia have become commonplace even in professional life. From early on, CAMLOG has been looking at new media and is using them to inform, support and network customers, partners and patients.



New website in the works

CAMLOG is currently working on a relaunch, a complete overhaul and redesign, of the corporate websites to offer you more services in a more concise form. Apart from expanding services for customers and partners, the focus of the new sites is the international representation of the company. CAMLOG Schweiz AG will have its own site for the first time at www.camlog.ch. You can certainly look forward to CAMLOG going online with the new international and national websites in the course of the year.

Have you already seen the trailer for the 4th International CAMLOG Congress with the theme "Feel the Pulse of Science in the Heart of Switzerland"? You can find it on the Congress website www.camlogcongress.com or on the CAMLOG YouTube channels.

The variety of CAMLOG websites

CAMLOG's online presence includes several different areas and websites. The corporate websites of CAMLOG Biotechnologies AG (international) at www.camlog.com and CAMLOG

Vertriebs GmbH (German) at www.camlog.de constitute the core presence. There you can learn about products, the company, current news and continuing education events. In addition, most brochures and other documentation are available to download on these sites.

MOST IMPORTANT CAMLOG WEBSITES AND COLLABORATIONS AT A GLANCE:

CAMLOG VERTRIEBS GMBH (GERMANY)	www.camlog.com
CAMLOG BIOTECHNOLOGIES AG (INTERNATIONAL)	www.camlog.com
CAMLOG SCHWEIZ AG (SWITZERLAND)	www.camlog.ch
CAMLOG E-SHOP (GERMANY)	shop.camlog.de
ALTATEC GMBH	www.altatec.de
CAMLOG FOUNDATION	www.camlogfoundation.org
4TH INTERNATIONAL CAMLOG CONGRESS	www.camlogcongress.com
CAMLOG CONNECT (NETWORK FOR PROFESSIONALS)	www.camlogconnect.com
IMPLANTATE.INFO (INFORMATION SITE FOR PATIENTS)	www.implantate.info

CAMLOG Congress and Foundation

The 4th International CAMLOG Congress to be held May 3 - 5 in Lucerne, Switzerland has its own site, too. At www.camlogcongress.com, learn everything you need to know about the Congress, take the opportunity to register online and – as a special highlight – take a sneak peek at the Congress trailer in the "Heart of Switzerland". It's worth it! CAMLOG's online presence also includes the CAMLOG Foundation and its website. Learn about its activities, events and research award of the foundation at www.camlogfoundation.org.

Information for all areas

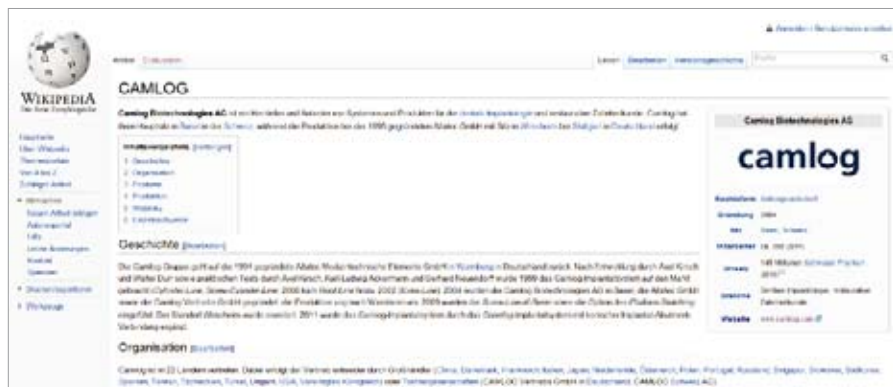
CAMLOG is also working together with various partners on online projects to provide comprehensive information to professionals and patients. We want to tell you about two such projects. The new CAMLOG CONNECT online platform was launched in early 2012 and is intended for professionals. The site at www.camlogconnect.com was created by Dr. Peter Hunt, a long-time user and fan of CAMLOG products. You can find case reports, tutorials, videos and much more on the site. The aim of the site is to network CAMLOG users throughout the world and to give them access to information, continuing education and exchange. Use of the website is free of charge and only requires a one-time registration. More information about CAMLOG CONNECT is available in this magazine on page 19 in an interview with Dr. Peter Hunt.

Facebook, Twitter & Co.

The Internet is going social! More and more people are connecting online with friends and colleagues on networks such as Facebook, Xing or Twitter and are using these sites as well as video platforms such as YouTube to catch up. CAMLOG is also active in these areas. We are on Facebook, Twitter, Google+ and LinkedIn for our international audience. You can network with CAMLOG on these sites and stay up-to-date on the latest happenings. And we are also on Wikipedia, the huge online encyclopedia. Check it out!

Everything on the iPad

Currently, we are also working on a CAMLOG app for the iPad that will give you access to comprehensive information about our products and company in paperless form – and always in the latest version. It's an exciting project in new media. CAMLOG is well equipped for the contemporary online world – join us there!



Wikipedia has become the world's largest encyclopedia. You can find nearly everything on Wikipedia including the most important information about CAMLOG.



INTERESTING

Have you ever asked yourself what these QR codes are all about that you find everywhere nowadays and that sometimes point to CAMLOG, too? They contain a code that delivers additional information to a smartphone directly when

scanned using an appropriate app. For example, you can go to a website directly by scanning a QR code. Give it a try! The apps are already pre-installed on many devices or can be downloaded. Popular apps include i-nigma, BeeTagg or NeoReader.



THE FACETS OF WEB 2.0 FOR DENTISTS

The relationship between dentist and patient has undergone tremendous change since the 1970s. The interfering interaction of changes on social, economic, technical and legal levels is the decisive factor. Due to the ability to choose one's own dentist and a mobile society, a practice's Internet presence is an essential criterion in choosing a dentist.

The Patient 2.0

Two-thirds of all patients make initial contact with a dentist by personal recommendation of friends and acquaintances¹. However, many patients today want to confirm their choice with some research on the Internet². When selecting a doctor or dentist, 87.9 percent choose a specialist recommended by their family doctor or dentist³. However, most also use new media in a second step to confirm their choice.

When there is no personal recommendation, patients increasingly use new media to find their way into a practice. Only three percent of patients still use the yellow pages⁴. In the subjective perception of many patients, the lack of a website or an unprofessional website is often associated with the professionalism, newness and innovation of the practice – although it may not be a reflection of the medical services provided in any way. The higher the education, the more extensive the research on the Internet. Nearly 97 percent of those surveyed with

a college degree indicated having done extensive research on the Internet before choosing a doctor⁵. Among other things, patients also want to assess whether they like the practice and whether the doctor and his team are sympathetic. Women look at medical websites more often than men⁶.

Hide-and-seek or findability on the Internet

When a patient looks for a doctor on Google Maps, for example, more

1,4 Riegl, Gerhard (2003): Zahnarztpraxis als Center of Excellence (Dental Practice as the Center of Excellence). Neue Wertschöpfungen für Zahnärzte und Labors (New Value Creation for Dentists and Laboratories), Augsburg: Verlag Prof. Riegl & Partner

3 Die große Ärzte-Liste (2001) (The Big List of Doctors), Munich: FOCUS Medizin Verlag GmbH

2, 5, 6 Source: Repräsentative Umfrage der Gesellschaft für Konsumforschung (GfK) im Auftrag des Arztbewertungsportals jameda.de (Representative survey of the Society for Consumer Research on behalf of the physician rating site jameda.de). N=1.130

<http://www.aerztezeitung.de/news/article/652722/jeder-fuenfte-sucht-arzt-bewertungsportal.html> from 5/5/2011

7 As of: 2/8/2012

than 6,313 hits for "Dentist Munich" appear⁷ and for a narrower search such as "Dentist Schwabing", there are still 378 hits. In addition to an adequate presence on the Internet, findability also plays an important role in winning patients. A visually appealing homepage is not enough any more. Websites today need to be search engine optimized. Search engines use special algorithms to analyze and evaluate website content. However, Google does not reveal their algorithms and they are constantly changing. Important parameters include length and quality of the content and relevant keywords. The keywords should be defined and checked for the number of searches and competition. The text of the website must include these keywords at a certain frequency. The age of the domain and its name also play a role. Particularly important are backlinks to well-known and highly rated external sites such as portals, social networks and Google entries such as Google Places.

An important aspect is the digital reputation of a practitioner. According to one Internet survey, 88 percent of those surveyed advocated doctor recommendation systems. 71 percent indicated that it influenced their personal choice of a physician⁸. Physician rating systems are another step in making a decision for a practitioner. They operate on the same principles as personal recommendations – only just anonymous and on the Internet.

Patients' ratings

Satisfied patients have an important multiplier function that practices need today more than ever to attract patients. Patients are often unable to adequately assess primary needs such as medical services and quality of results. They decide for or against a doctor by the fulfillment of secondary needs such as mutual trust, the time taken, the atmosphere, the quality of advice or the friendliness of staff and practitioners – ergo aspects which are only peripherally related to the treatment – and justify these decisions rationally.

It is important to ask the question why patients should decide in favor of their own practice and against regional

competitors and how the patient can be supported in doing so.

The secondary needs should be taken into account in the design of a website to radiate professionalism and competence. And these aspects can also be well represented in new media, e.g. on physician rating sites such as Jameda or DocInsider (both are German sites), as well as general recommendation portals. In today's feedback society, services of all kinds are reviewed – medicine is no longer an exception. Therefore, the question then arises for a doctor whether he wants to handle these opportunities proactively and for the benefit of his practice. Rating sites are used as a mirror. They provide recommendations for new patients and personal experiences from existing patients. Therefore, ratings should be scrutinized critically and in earnest and changes made in the practice when necessary. A fear of unfair assessment is unfounded. According to § 5 of the German Constitution, there is indeed the right to freedom of expression; libel and defamation are excluded here. On the popular portals, unqualified reviews can be deleted at any time. As a logical consequence, however, monitoring by the doctor or staff is required. This practice might differ from country to country.

Content is (always) king

For some Internet users, health portals have replaced the doctor as the primary source of information⁹. Accordingly, it makes complete sense to offer patients relevant content on an informative website. Doing so enhances the practice's reputation as the authority, minimizes surfing on the Internet, the potential risk of wrong or too much information and even a possible exodus to the competition.

Where there is light, there is also shadow

Some dentists are already using social media channels such as Facebook and Twitter for patient loyalty and for attracting patients. Among other things, dental hygiene incentives and special arrangements can be offered on practice

sites. The extremely high number of users such as the 22 million German users on Facebook may also sound enticing as the related possibility to strengthen the perception of the patient and to quickly create a positive and contemporary reputation. The use of social media should always be planned long-term and be strategic in nature. It should be stressed that social media presents both opportunities and risks. It is difficult to determine the economic benefits, maintenance of the platform is normally time-intensive, continuous monitoring is required and restrictive statutory provisions apply including the German Medical Products Advertising Act. In addition to these aspects, the practice should have enough content to inspire friends and followers continuously. Accordingly, a careful cost-benefit analysis should be performed in advance.

Dentist 2.0

With all tools of communication, attention should be paid to consistency with actual experience in the practice as patients have expectations even before the first visit.

New media can create greater proximity to the dentist, as well as empower the patient and ultimately serve to increase compliance.



⁸ http://www.die-arztempfehlung.com/medlin_sterne/medlin.php; N=10.000

⁹ <http://www.healthcaremarketing.eu/medien/detail.php?nr=5153&rubric=Medien&, 2/15/2012>



THE EFFECT OF TOBACCO SMOKE ON THE SUCCESS OF IMPLANT TREATMENTS

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That tobacco smoke can have an adverse effect on the success of implant treatments appears obvious when compared to the known periodontal pathogenic effects of smoking. Known effects include significantly more frequent intraoral wound healing problems in smokers and correlation between smoking habits and early implant loss is assumed.

Materials and methods

The following are the findings primarily obtained from the systematic reviews mentioned below.

Klokkevold and Han (2007): The findings were taken from 19 studies. The pooled estimates for implant survival were 89.7% in smokers and 93.3% in non-smokers. More marked differences between smokers and non-smokers were apparent in bone quality. Non-smokers saw an implant survival rate in soft bone (D3-D4) 7.43% better than that of smokers. It was therefore assumed that "soft" bone in particular is adversely affected by smoking. An implant success of 77% in smokers and 91% for non-smokers emerged [1].

Heitz-Mayfield et al (2008): This is a large meta-analysis of 88 studies in total. Most studies indicated significantly higher survival rates in non-smokers statistically. No significant differences were identified in just 17 studies [2–18]. Most studies indicated implant survival rates of 80 - 96% for smokers. The implant success rate in smokers ranged from 43% to 98.3%. Six of seven studies indicated that smoking has an adverse effect on the success and survival of implants in conjunction with augmentations and sinus lift operations. A dose-response relationship of tobacco consumption is likely. Measured in terms of early implant

failure, there is conflicting evidence that smoking has an adverse effect on initial osseointegration [19].

Strietzel et al (2007): Meta-analysis of 29 studies in which no qualification of cigarette consumption was performed. Smoking was associated with significantly higher risks of implant failure and biological complications (peri-implantitis) both in connection with augmentation procedures and without [20].

Hinode et al (2006): This systematic review includes 19 studies. Implant failure was defined as loss of the implant or bone loss that exceeds 50% of the implant length. An increased risk (OR 2.17, 95% CI: 1.67 - 2.83) of implant failure in smokers emerged [21].

Discussion and summary

The many adverse effects of smoking on the body are well documented. Smoking has a long-term adverse effect on many aspects of one's general health and immune system. These include delayed wound healing, decreased collagen synthesis and fibroblast function, reduced peripheral blood flow, as well as impaired function of neutrophilic granulocytes and macrophages [52]. The relationship between smoking and periodontal disease is also known. Smokers have an increased risk of the progression of periodontitis [53].

Due to the similarities between etiology and pathogenesis of periodontal and peri-implant inflammation, the results of the aforementioned studies are less surprising. However, the respective relationships are yet to be fully understood. The biological processes that play a role in the osseointegration of implants or maintenance of peri-implant bone level are likely adversely affected by tobacco smoke, which would explain the lower survival and success rates of implants in smokers [19].

Even if smoking cannot be seen as an absolute contraindication for implant treatment, smokers should be informed that they have an increased risk of implant loss or occurrence of peri-implant inflammation.

Most studies reported survival rates among smokers between 80% and 90% although dose and time effects of consumption have not been adequately studied yet.

Results

	COMMENTS	CONCLUSION / SUMMARY	SOURCES
DOSE-DEPENDENT EFFECT	Studies show inconsistent classifications of "smokers" (No. of cig./day, No. of years "smoked")	Significantly higher rate of complications in heavy smokers (> 20 cig./day). A relationship between the number of years smoked and higher rates of complication are suspected.	[22–27, 42] [*]
GENETIC FACTORS	Less evidence	A synergistic effect of tobacco smoke and a positive IL-1 genotype in terms of increased peri-implant bone loss is suspected.	[9,28–30]
PERI-IMPLANTITIS TREATMENT	Less evidence	A negative impact on the success of peri-implantitis treatment is controversial. A dose-dependent adverse effect is likely.	[31,32] [33]
WOUND HEALING AND OSSEointegration		A negative impact on osseointegration is controversial. Significant negative impact on osseointegration for > 20 cig./day. Significant positive effect on osseointegration by adhering to a smoke-avoidance protocol (one week preoperative, two months postoperative).	[5-7,22, 34–41] [42] [43]
AUGMENTATION AND SINUS LIFT	Significant evidence	Significantly higher failure rates in smokers.	[8,44-49]
IMMEDIATE IMPLANTATION	Less evidence	No significant difference between smokers and non-smokers.	[3,24]
IMMEDIATE LOADING		No significant difference between smokers and non-smokers. Depending on the dose, significantly more marginal osteolysis and lower implant survival rates (> 10 cigarettes per day).	[50] [51]

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Fig. 1: Initial situation in the panoramic radiograph.



Fig. 2: Initial clinical situation.



Fig. 3: Initial clinical situation; attachment between 11 and 21, as well as 23 and 24.



COMPLEX IMPLANT-SUPPORTED RESTORATION AFTER ORTHODONTICS AND HARD- AND SOFT-TISSUE AUGMENTATIVE PROCEDURES

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For reconstruction of the row of teeth with free-end gaps, conventional prosthetics offer various possible solutions. Extension bridges represent a fixed restoration option with which only a premolar should be replaced [1]. In the past, removable solutions were the tool of choice in these cases. The problem with these types of restorations in the absence of distal support are the strong horizontal and possibly even extrusive load of the distal abutment teeth [2]. Frequent fractures of these teeth primarily after endodontic pre-treatment show the practicing dentist this problem [3,4]. Implantation in the distal region of the row of teeth for fixed replacement or as additional distal support for removable work allows us to protect and preserve the remaining natural teeth longer.

For removable hybrid prosthetics, electroformed telescopic copings as the retaining element is the way to go for us. The benefits of the telescopic copings are that the patient's own teeth can be included in the work. A fit free of stress (passive fit) [6] is also possible with intraoral bonding of the electroformed copings according to the Weigl protocol [5]. The CAMLOG® Implant System offers ideal conditions for the electroplating technology: stability against horizontal forces due to the Tube-in-Tube™ connection on the one hand and on the other, the antirotational mechanism due to the groove/cam connection [7], which ensure the exact fit of the prosthetic.

Case report

The patient case presented here demonstrates the care of free-end gaps both fixed and removable. In addition, the report shows the preparatory work that may be required to achieve an optimal result.

The patient first visited at our practice in September 2005 (Figs. 1 to 5). Slight generalized chronic periodontitis was diagnosed. A new restoration was necessary due to secondary caries on the existing crowns. In addition, the crown on tooth 13 splinted with the other crowns was detached. In views of apical osteolysis, root-resected tooth 24 was not worth preserving in the long term.

Treatment planning

Because of the reduced dentition, the maxilla should be treated with a periodontal- and implant-supported removable bridge. A fixed restoration with implants in the molar region is the aim for the mandible. For the purposes of backwards planning, we want to depict the treatment steps and the arising problems and solutions.

After periodontal therapy, the patient was examined to determine which teeth could be saved. The previous restoration had to be removed (Figs. 6 and 7) and the teeth provided with temporary restorations.



Fig. 4: Initial clinical situation. The gaps between the canines and the first premolars indicate protrusion of the anterior teeth.



Fig. 5: The bimaxillary protrusion of the anterior teeth viewed from the side.



Fig. 6: Situation after removal of the previous restoration, caries removal, filling and preparation in the maxilla ...



Fig. 7: ... and in the mandible.



Fig. 8: Orthodontic retraction of the anterior mandibular teeth.



Fig. 9: Long-term temporary restoration in the maxilla; in the anterior region designed as single-tooth crowns to allow orthodontic movement of the teeth.

One obstacle in treating the patient was the bimaxillary protrusion of the anterior teeth (see Fig. 2 to 5). The protrusion can be attributed by massive tongue thrusting. Even when fabricating the previous restoration, an attempt was made to prevent further spreading in the front by splinting the crowns in the maxilla and the attachment between 11 and 21, as well as 23 and 24. With the desired restoration by means of a removable bridge, which is also implant-retained, further protrusion can be precluded.

The protrusion of the teeth in the maxilla did not allow a uniform direction of insertion for a removable restoration. Therefore, the tooth axes had to be corrected orthodontically. Since the position of the teeth also bothered the patient for esthetic reasons, she was open to orthodontic treatment.

Long-term temporary restorations and orthodontics

For the correct axial correction of the maxillary anterior teeth, retraction of

the mandibular anterior teeth was first necessary (**Fig. 8**). In doing so, the gaps between the mandibular canines and the first premolars could be closed. The results were then fixed with a retainer in the region of the anterior mandibular teeth.

The long-term temporary restorations in the region of the maxillary anterior teeth were fabricated as single-tooth crowns (**Fig. 9**), which were fabricated by the dental technician to allow placement in the target dental arch. A canal was also put in each crown to receive a pin to verify the tooth axis during tooth movements. In the second quadrant, teeth 24 (not yet extracted for this reason), 25 and 27 were used as the distal anchor for the orthodontic retraction of the anterior maxillary region. In the first quadrant, it was necessary to insert a distal mini-implant (tomas® pin, Dentaureum) (**Figs. 10 to 14**).

After completing the orthodontic treatment, a new long-term temporary restoration was fitted in the maxilla. All crowns were splinted together to prevent renewed protrusion.



Fig. 10: Pins inserted in the long-term temporary restorations to assess tooth axes without having to remove the crowns.



Fig. 11: Fitted mini-implant (tomas® pin, Dentaureum) as the distal anchor for the orthodontics.



Fig. 12: Distalization of the anterior teeth with the tomas® pin.



Fig. 13: Orthodontic treatment of the maxilla. Pins inserted to assess tooth axes.

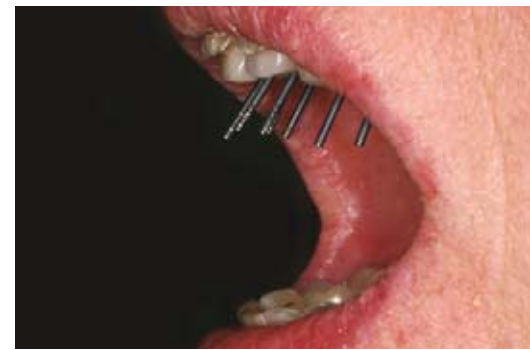


Fig. 14: Parallel pins shortly before completing the orthodontics.

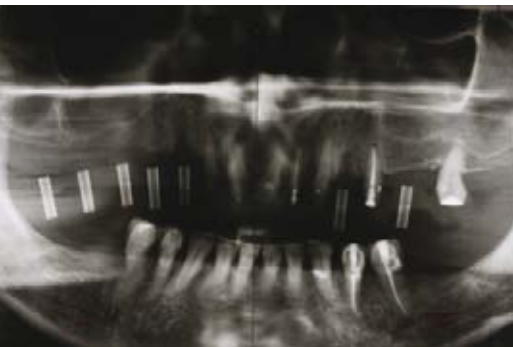


Fig. 18: Panoramic radiograph with the maxilla drilling template inserted.



Fig. 19: Panoramic radiograph with mandible template drill.

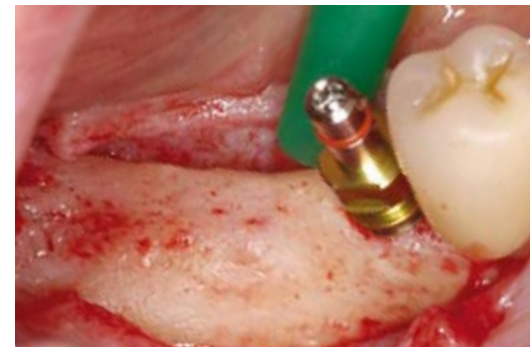


Fig. 20: Implantation of a CAMLOG® SCREW-LINE Promote® implant with a diameter of 3.8 mm in region 46.



Fig. 24: Indirect sinus lift using the osteotome technique of region 26. There is buccal bone fenestration.



Fig. 25: Implants inserted in regions 24 and 26. Augmentation of region 24 and film technique.



Fig. 26: Implantation in region 13; augmentation material from natural bone and Bio-Oss®. The augmentation material is covered by an OsseoGuard® membrane and a Bio-Gide® membrane.

Teeth 13 and 24 not worth preserving were extracted before placement of the temporary restoration (**Figs. 15 and 16**).

Drilling templates

The drilling templates were fabricated based on a wax-up. Implementation of planning introduced implants in regions 36, 46 of the mandible and in regions 13, 24, 26 of the maxilla. In addition to the implant in region 13, it was planned to place at least one implant in region 14 to 17. In region 14 to 17, the bone supply was very limited both in terms of width and height (**Figs. 17 to 19**).

Implantation

In April 2008, the implants were inserted. To do so, the long-term temporary restoration was removed and basally ground in the area of the implants to prevent pressure on the areas of the implantation and augmentation when inserted again. Therefore, the dental technician had to ensure already when fabricating the long-term temporary restoration that the metal reinforcement was far enough occlusal in the bridge member area.

Upon implantation in the mandible where the incision line was extended

to region 38 or 48, a bone collector (Safescraper® Micros, Meta) was used to harvest particulate bone in the area of the mandibular angle. The bone grafts were preserved in autologous blood. The implants for region 36, 46 were introduced as planned and augmentation was not required. No implant was placed in region 47 (**Figs. 20 to 22**).

Implantation in the maxilla began in the second quadrant (**Fig. 23**). An indirect sinus lift was required in region 26 (**Fig. 24**). After inserting the implants, there was a dehiscence defect of region 24 and a fenestration defect of region 26.



Fig. 15: Preparation for the splinted long-term temporary restoration after orthodontics. Teeth 13 and 24 have been extracted.



Fig. 16: Splinted long-term temporary restoration.



Fig. 17: Maxilla drilling template in situ.

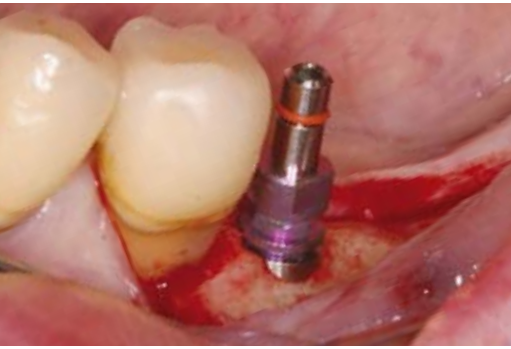


Fig. 21: Implantation of a CAMLOG® SCREW-LINE Promote® implant with a diameter of 4.3 mm in region 36.

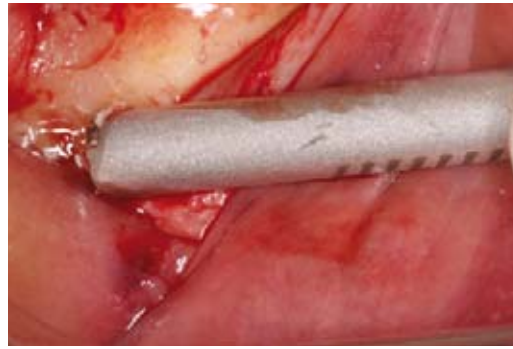


Fig. 22: Harvesting of particulate bone using a Safescraper® Micros (Meta).

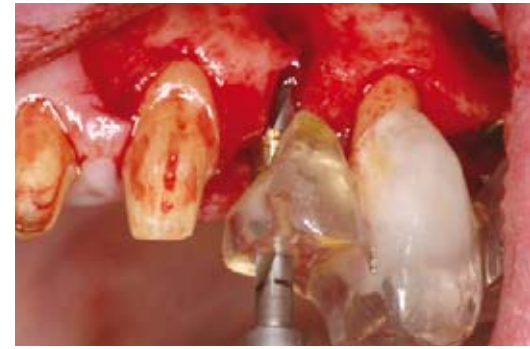


Fig. 23: Pilot drill of the implant for region 24. Note the remaining alveolus.



Fig. 27: Sinus lift of region 16. View of the exposed maxillary sinus mucosa.



Fig. 28: The maxillary sinus mucosa was covered with a Bio-Gide® membrane. A bone height of approx. 3 mm can be seen on the implant channel.

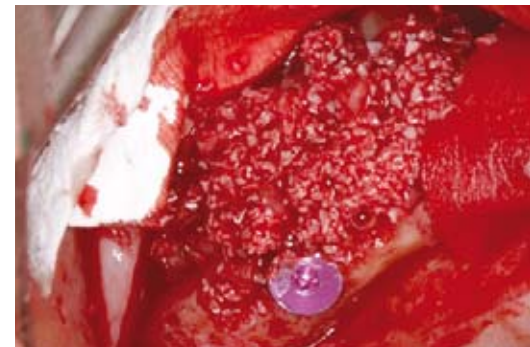


Fig. 29: Implant inserted in region 16 after sinus lift and augmentation.

The patient's own particulate bone and a layer Bio-Oss® (Geistlich) mixed with blood was used to augment the area. The augmentations were covered with OsseoGuard® membranes (Biomet 3i) and a Bio-Gide® membrane (Geistlich) and fixed using resorbable polylaktide pins (Inion® Tacks, Riemser) (**Fig. 25**).

In the presentation of the bone in the first quadrant, the very narrow alveolar ridge in regions 14 and 15 was expected (**Figs. 26 to 28**). In these areas, we decided against implantation because placement of implants would have required a second procedure with a bone block and sinus

lift. Therefore, one implant was placed in region 13 (see Fig. 26) and one implant in region 16. In area 16, a direct sinus lift was required.

Direct sinus lift

After exposing the maxillary sinus and preparing the Schneiderian membrane and implant cavity, we normally line the maxillary sinus mucosa with a Bio-Gide® membrane for the direct sinus lift (**Figs. 27 and 28**). The medial portion of the cavity created is filled with a mixture of bone, Bio-Oss® and blood. The CAMLOG® SCREW-LINE Promote® implants are then

inserted and the remaining cavity filled with the augmentation mixture.

The alveolar process of region 16 was augmented laterally as in region 13 with particulate natural bone and on top a layer of Bio-Oss® blood mixture. As before, again it was covered with OsseoGuard® and Bio-Gide® membranes (**Figs. 29 and 30**).



Fig. 30: Panoramic radiograph after implantation of CAMLOG® SCREW-LINE Promote® implants (region 16 L13 x 4.3 mm, region 13 L13 x 3.8 mm, region 24 L13 x 3.8 mm, region 26 L11 x 3.8 mm, region 36 L9 x 4.3 mm, region 46 L11 x 3.8 mm).



Fig. 31: Exposure of the implant in region 26 with the mucosal flap technique.



Fig. 32: The fixed healing cap bottleneck and the prepared split flap.



Fig. 36: Buccal mucosa thickening with part of the connective tissue graft in region 16.

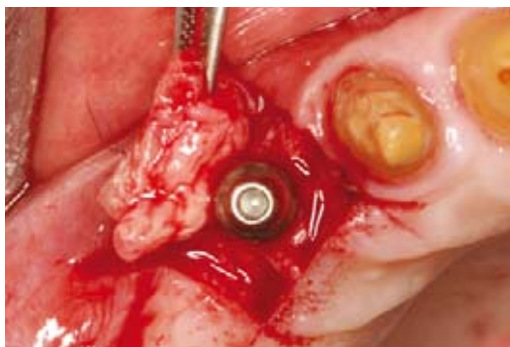


Fig. 37: Exposure of the implant in region 13 with mucosal flap technique and additional mucosa thickening with buccal connective tissue graft.

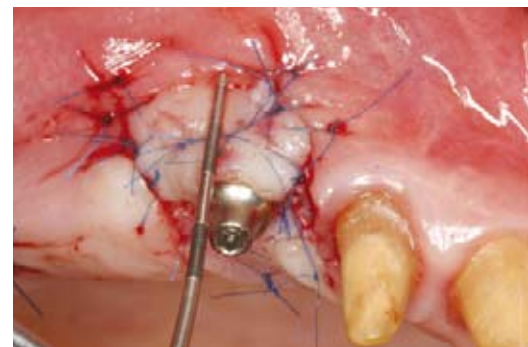


Fig. 38: The exposed implant in region 13.



Fig. 42: Maxilla after final preparation; the sulcus sutures are placed and the impression posts for the open impression screwed into the implants.



Fig. 43: Mandible prepared for impression.



Fig. 44: The fitted primary telescopic copings and impression posts prior to impression taking. A small drop of temporary cement was used to fit the primary telescopic copings on the teeth.

Implant exposure and soft tissue management

The implants were exposed in November 2008. A mucosal flap technique was used in regions 13, 24 and 26 to expose the implants. This technique makes it possible to move fixed gingiva from the palatal to the buccal side to create a broad and thick band of functional gingiva buccally of the implant (**Figs. 31 to 33**). A simple exposure was chosen for region 16. The required crestal cut was extended to the maxillary tuberosity. Doing so made it possible to harvest more connective tissue from area 17,

18 (**Figs. 34 and 35**). The connective tissue was divided. Part of the tissue was used buccally of the implant in region 16. The second part was used for additional labial expansion of the mucosal flap in region 13 (**Figs. 37 and 38**).

When exposing the implants of region 36 and 46, the rest of the fixed gingiva was moved lingually on each side. To create functional gingiva buccal to the implant, a free mucosal graft (FST) in the area of the palate was taken and divided. Each part was transplanted buccal to the implant in region 36 and 46 and

sutured into place (**Figs. 39 to 41**). After a healing phase of eight weeks, work on the final prosthetic restoration could begin.

Final prosthetic restoration

The teeth were prepared and the final impressions taken with individual open trays (**Figs. 42 and 43**). The long-term temporary restorations were then relined in the dental laboratory. The implant for region 13 was also integrated in the maxilla in the LZP as support, i.e. the existing bridge was redesigned for the implant crown.



Fig. 33: After exposing the implants in regions 23 and 26, the fixed gingiva moved buccally is clearly visible.

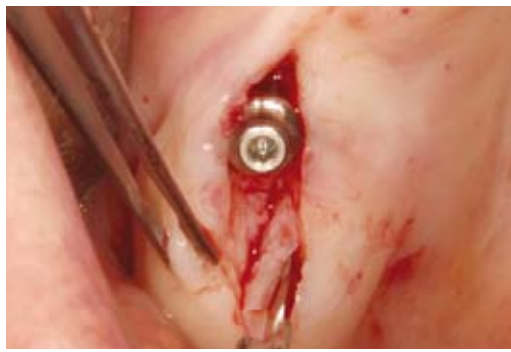


Fig. 34: Exposure of region 16 and harvest of free connective tissue from the tuber region.

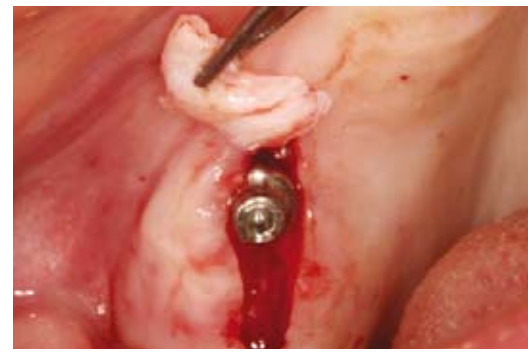


Fig. 35: The harvested connective tissue.



Fig. 39: Incision to harvest a free mucosal graft (FST).

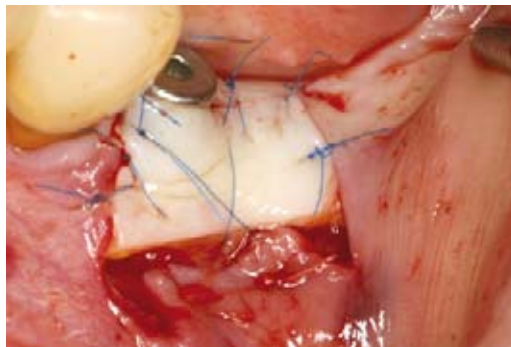


Fig. 40: Introduced FST in region 36; the locally fixed gingiva was completely moved lingually in advance.

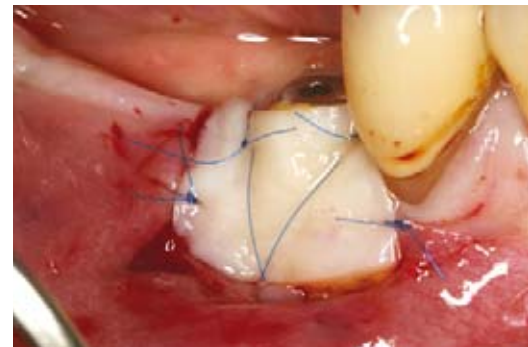


Fig. 41: Introduced FST in region 46; the locally fixed gingiva was also moved lingually in advance.



Fig. 45: For the aesthetic try-in, the electroformed copings are fixed in the finished veneered tertiary structure with wax.



Fig. 46: Mandible with the attached abutments before insertion of the final restoration. Note the width and thickness of the functional gingiva around the implants.



Fig. 47: The finished mandibular restoration from the top. The implant crowns are screwed on horizontally from the lingual side.

The additional advantage of support on the rigid implant was that migration or travel of the anterior teeth could be eliminated especially for this patient with a strong tongue thrust. The dental technician then fabricated the primary telescopic copings.

In the meantime, non-vital teeth 12, 23, 44 and 45 were treated endodontically. As the next step, a pick-up impression was taken of the primary telescopic copings and impression posts again with open tray and the centric jaw relationship redetermined. Before the pick-up impression, the primary telescopic copings were fitted to the

teeth with a small drop of temporary cement (Temp-Bond NE™, Kerr) (Fig. 44).

We use a modified *Weigl* protocol. The electroformed secondary telescopic copings are not bonded in the "naked" tertiary structure until it is fully veneered. Bonding also occurs in the mouth of the patient with this modification. With this procedure, fabrication of a travel prosthesis is not required. Our protocol for the patient played out as follows. After the dental technician had finished the electroformed secondary telescopic copings and tertiary structure, the tertiary structure was veneered and tried

in the mouth of the patient for esthetic purposes (Fig. 45). The secondary telescopic copings were only secured in the tertiary structure with wax. The wax becomes elastic after heating, so that small inaccuracies in the fit can be corrected and the removable bridge slides onto the implants and teeth.

The final restoration was fitted in April 2009. We began in the morning by fitting the crowns in the mandible (Figs. 46 and 47).



Fig. 48: Healthy gingival conditions in region 16. Thick gingiva after connective tissue transplant.



Fig. 49: The primary telescopic copings inserted.



Fig. 50: The electroformed copings before bonding. They have already been partially bonded in the cervical area.



Fig. 51: Intraoral bonding. The electroformed coping that is bonded is held in position during the setting phase of the adhesive.



Fig. 52: Part of the secondary crowns is already attached in the tertiary structure.



Fig. 53: Panoramic radiograph after insertion of the restoration.



Fig. 54: Anterior view after insertion. The discolorations in the root base of the mandible teeth does not bother the patient.



Fig. 55: Finished restoration in the second and fourth quadrants.



Fig. 56: Finished restoration in the first and third quadrants.



Fig. 57: Finished restoration – view of the maxilla.



Fig. 58: Side view. The original protruding position of the teeth is no longer visible.



Fig. 59: View of the lips with the finished restoration.

In the maxilla, the primary telescopic copings were screwed into the implants at a torque of 20 Ncm or cemented to the teeth (Figs. 48 and 49). The electroformed copings are then individually bonded to the tertiary structure intraorally (Figs. 50 to 52). When bonding, it is important that the secondary crowns are held in position during the setting phase to prevent the formation of any gaps between the primary component and the abutment (see Fig. 51). Subsequent veneering of the

adhesive gaps and cervical areas can be simplified when the secondary crowns are already provided and pre-veneered with opaquer (see Fig. 50). After bonding all parts, a new impression is taken of the mandible. In the laboratory, the removable bridge was fully veneered and again mounted to the new mandibular model. In the evening, the new removable bridge could also be inserted along with the new mandibular restoration already in place (Figs. 53 to 59).

The patient was again instructed about important oral hygiene measures (based on the new prosthetic situation) and scheduled for a regular follow-up program.



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"IMPLANT PROSTHETICS" DVD COMPENDIUM SOON AVAILABLE: FOUR TEAMS – THEIR CONCEPTS AND SOLUTIONS

Brand new from the Quintessence Publishing Company, a high-end video production will soon be released in collaboration with four outstanding teams of authors and CAMLOG as a cooperating partner. The publication date and "unofficial world premiere" of the "Implant Prosthetics" DVD compendium is scheduled for the 4th International CAMLOG Congress to be held May 3rd - 5th, 2012 in Lucerne, Switzerland.

Against the backdrop of new technologies, materials and procedures, implant-supported treatment concepts have radically changed, further developed and produced a broad spectrum of restoration options in recent years. This change has been promoted and accelerated by intensive collaboration and communication in a team of specialists, which should be viewed in implant prosthetics as a prerequisite for high-quality treatment results. Soon to be released by the Quintessence Publishing Company, the DVD compendium "Implant Prosthetics" will cover all relevant aspects and parameters for success.

Four Teams – Their concepts and solutions

is a video production of four volumes in HD quality.

The videos will be available on DVD individually and as a compendium. Prices: € 66 (each) or € 224 (complete). Please ask your local distributor for further information.

THE AUTHORS AND TITLES

- **Volume 1: Axel Kirsch, Karl-Ludwig Ackermann, Gerhard Neuendorff:**

3D planning and template-guided implantation in an edentulous arch (Case 1) and in a partially edentulous arch (Case 2).
Playing time approx. 44 min. (Case 1) and approx. 39 min. (Case 2)

- **Volume 2: Arndt Happe, Andreas Nolte:**

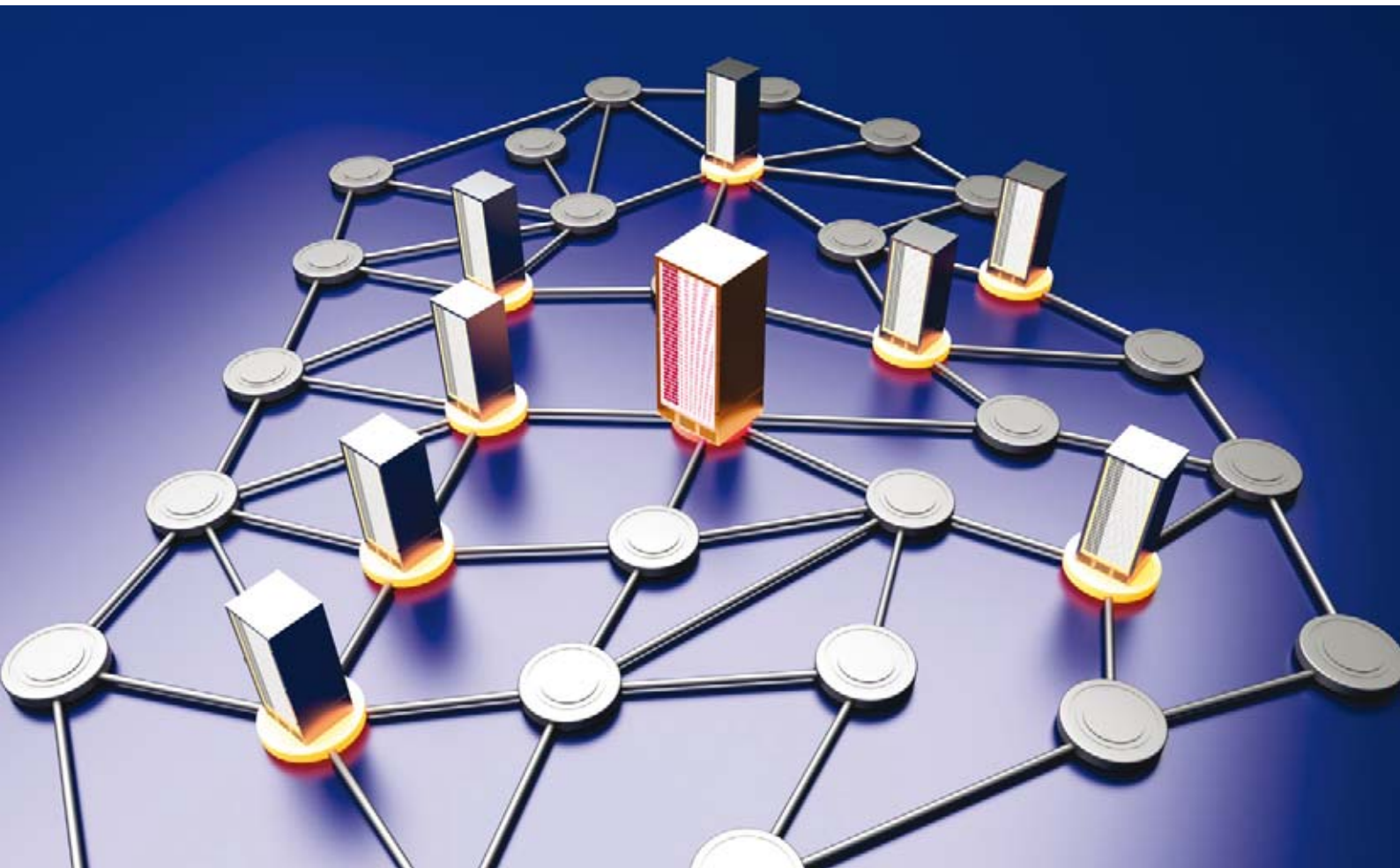
Immediate implantation and all-ceramic restoration in the anterior region of the maxilla – an individual and interdisciplinary treatment concept.
(In this case, the CONELOG® Implant System was used.)
Playing time approx. 61 min.

- **Volume 3: Stefan Wolfart, Volker Weber:**

Removable restoration on implants – implant-supported forms of restoration in an edentulous arch.
Playing time approx. 100 min.

- **Volume 4: Florian Beuer, Michael Stimmelmayer, Josef Schweiger:**

Innovative treatment concepts for fixed restorations on implants using CAD/CAM technology.
Playing time approx. 67 min.



BRANCH PRACTICES – OPPORTUNITIES FOR GROWTH OR RISK TO EXISTENCE?



Author: Oliver Drifthaus, Leinfelden-Echterdingen, Germany

Recently, the concept of branch offices for dental practices seems to flare up again and again in the consulting and support practice. The basic idea is remarkably simple. Branch offices attract more patients for the high-value services of the main practice – surgery in particular – and one or more salaried dentists make more money in the branch practice for the practice owner. Nevertheless, experience with this concept in practice varies greatly.

New concept – "Old" problems

It starts with just the location of the branch practice. We have not encountered any *new* startups as a branch practice until now. In the past, practices were always taken over by one supplier. In legal terms, it is a so-called "business transfer" and apart from the lease agreement, all employees are also taken over. The same problem as for the "traditional" purchase

of a practice then often occurs, i.e. *employees only come along conditionally in the event of changes*. Modifications to the treatment concept and procedures are in fact not backed by employees or only backed by individual employees. So it is essential to make employees aware of the changes: *Change management* is introduced. Success is only possible when employees do not in effect undermine the innovations. This is even more necessary than carrying over procedures from the

main practice and it can lead to a feeling of downgrading in the branch. The prescribed procedures could then likely be rejected if not actively counteracted.

Know-how and infrastructure transfer

In contrast to the emotional state just described, however, it is one of the advantages of the branch practice concept that the know-how of modern

patient management is carried over to the branch practice that is often not (or not any longer) cutting edge as the supplier practice in appearance and concept of treatment. This ranges from central monitoring of the order book, recall procedures and computer equipment to the digital x-rays of the practice. It is not technically difficult today to network telephone systems. This leads to better accessibility for patients. In addition, central HR planning is also possible, e.g. help can be assigned from the main practice in the event of illness. This is easily possible as procedures were previously unified between headquarters and the branch. This requires close proximity between practices. Therefore, this should already be the case, so that the practice owner can check on things at any time. *Despite all the requirements, it cannot happen without some presence on the ground.* Employees expect this even more than patients.

Leadership skills in demand

The dentist working in the branch practice occupies the central role. Despite support from the main practice, it is ultimately his responsibility to manage and develop the practice branch locally. This is often a salaried dentist. Ultimately, it is irrelevant whether the dentist is salaried or a partner with no equity stake. His personality and entrepreneurial skills are key success factors for the branch concept. If the salaried dentist is *unable* to manage the practice and in particular employees and *unable* to satisfy patients, the branch practice will ultimately fail in the long run. On the other hand, a motivated dentist is hardly or only limited in time to inspire *for a salaried position*. And continuous change in the practice does not lead to the necessary patient loyalty in the branch practice. So then the task is to give the salaried dentist a perspective of his own professional success.

Possible forms of partnership

In general, there are two basic types of employees. Even among dentists, one increasingly encounters colleagues who are primarily seeking *long-term employment* that meets their need for security. The specification of procedures and the treatment concept of the branch practice

gives them security and with reasonable, often fee-based compensation, the desire for their own autonomy is set aside. In contrast, colleagues who have chosen a clear perspective of their own independence are not satisfied with straight salaried employment in the long run. As a minimum, such colleagues need the prospect of capital equity that is agreed on in advance. Otherwise, they bail out fast – *too fast* in relation to patient loyalty – and go into practice on their own. Experience has shown that dentists who seek success in their own practice often have better leadership skills and are more persuasive to their patients. The revenues and profits of the branch practice grow accordingly. *Here the task is to find a strong dentist to manage the practice that doesn't bail out too quickly.* One solution may be participation as a partner taking care that the young dentist is not paid according to the practice value he has created.

To complement rather than reproduce

Apart from personnel decisions, the treatment concept is another success factor. The branch practice is not a copy of the main practice. It is not possible to offer the same range of high-quality treatments in the branch practice. Because of the selection of salaried dentists, this would not work. And for purely economic reasons, this would hardly make sense. The branch practice is not equipped to the same level and does not have to be due to the range of treatments. A solid base of services should be offered, but the absolute top-quality services are reserved for the main practice where the technology and knowledge can be found. Patients are referred to the main practice for specific services and only patients, who want to pay for or can afford such services. *Coordination of the treatment concept and possible referrals between practices is the major conceptual task of the practice owner.*

Complementary concepts necessary

Without clear instructions and expectations, the practices run quickly side by side and the economic success falls far short of objectives. Due to this separation of treatment

concepts, it becomes clear why *takeover of a supplier practice* has prevailed as the basis for the branch practice. The inherited patients do not have to be completely "converted". High-value services can still be offered and thus stimulate further demand for services of the main practice. This different treatment philosophy is often taken into account in the external appearance. *The visual appearance of the branch practices is clearly different to avoid diluting the brand of the main practice.* This is certainly the greatest danger in the concept of the branch practice and can ultimately become a risk to the existence of the practice owner due to further investment.

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camlogconnect
By Camlog Users – For Camlog Users



Dr. Peter Hunt

CAMLOG CONNECT – AN ONLINE PLATFORM FOR ALL CAMLOG USERS



In January 2012, CAMLOG CONNECT went online, a platform for users to exchange information about any subject and question about CAMLOG products. Dr. Peter Hunt, a long-term CAMLOG user from Philadelphia, built the platform together with Andrew Lovatt, a partner from the IT industry. In an interview with logo, Dr. Hunt explained what CAMLOG CONNECT is all about and what opportunities the platform offers CAMLOG users.

Dr. Hunt, you created CAMLOG CONNECT. Could you briefly describe what that is?

Dr. Hunt: Thank you for the question. The answer is simple: CAMLOG CONNECT is an online platform for the global community of CAMLOG users. Members can share and discuss their cases with other users, watch videos, obtain information about CAMLOG technologies and products, ask questions and get answers as well as learn new things about implant dentistry. The key concept behind it is: By CAMLOG users – for CAMLOG users, the motto of the website.

There are several areas on CAMLOG CONNECT: Videos, Cases, Discussions, Tips, Tutorials and even a lexicon. Could you briefly describe what each area involves?

Dr. Hunt: Of course. In "Cases", visitors can view case studies as presentations –

similar to PowerPoint presentations. In "Videos", visitors can watch operations and various treatments. The "Discussions" area is an online forum in which questions can be asked and topics discussed. The "Tips" area primarily involves special cases and problems in treatment. The lexicon includes terms around implant dentistry and CAMLOG products. In addition, there is also an "FAQ" area where you can find frequently asked questions and answers to those questions. Members who want to contribute their own materials can find all the information they need under "Contribute" and can contact us with problems or other questions under "Contact".

The site really offers many different options. How did you even get the idea to build such an online platform?

Dr. Hunt: I've already been using CAMLOG® implants in my practice

for more than a decade. Many first-time users have asked me for help. Consequently, I have created several tutorial videos for my students to watch. And then one thing led to another. After a while, we had accumulated case studies in which the use of CAMLOG products was demonstrated. One of my patients, Andrew Lovatt, suggested that I make everything available on a web-based system. In the meantime, Andrew Lovatt has become my partner on the project. He designed and now manages the site while I edit the content. The content is not only available to a small group now, but to everyone on CAMLOG CONNECT – around the world and at any time.

Can really just anyone access the content and view the tutorials and videos?

Dr. Hunt: Well, it's a site for members only. In other words, the target audience are CAMLOG users – that also includes



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the entire team of technicians and assistants. These professionals can easily register on CAMLOG CONNECT at no cost. However, the site is not intended to provide information to patients.

In your opinion, CAMLOG CONNECT primarily appeals to whom? Primarily to students or do experienced CAMLOG users also register on the site?

Dr. Hunt: We've already conducted some tests and it turns out that CAMLOG CONNECT has something to offer to the entire spectrum of CAMLOG users – from beginners to experts. Once available worldwide, we'll have the opportunity to quickly expand the site. The content we have now is only the beginning to show the options we have. We now hope to get more material from CAMLOG users – everyone should join in and participate.

About the keyword "participate" ... The website says that anyone can contribute. How and what can CAMLOG users contribute?

Dr. Hunt: Actually, it is easier to participate than most think – you need only to ask colleagues who have already contributed. We are looking for good "stories" with a beginning, middle and end. Best is to look at the material already published on CAMLOG CONNECT. The examples there show what we are looking for. Contributors can easily send the material to us – it doesn't even have to be in English. We will translate it and determine if it is suitable. We will also get it into the correct format and of course, send it for approval before publishing it. Most presentations consist of about 40 slides and are about five minutes long. Users also have the option of sending us raw video. We will take care of processing,

add a title, etc. We want to make it as easy as possible for users to contribute their material.

*Thank you for your time,
Dr. Hunt. We wish you much success
with CAMLOG CONNECT.*



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LUCERNE RESTAURANTS & NIGHTLIFE



Of course, while the main emphasis is on the content of the workshops offered, you can let your hair down, too. In fact, as the motto of the Congress, "Feel the Pulse of Science in the Heart of Switzerland" suggests, they will round off the Congress nicely. You might like to explore the exceptional Lucerne food and night-life a little, too. Here is a brief selection, but there is much more!



Restaurants

Restaurant Jasper

Gourmet restaurant with a purist, not "cold", but carefully selected design and above-average food: 16 Gault-Millau points, one Michelin star. "Sophisticated taste combinations hold the promise of a superlative dining experience," as Jasper says of itself. Terrace with stunning views of Lake Lucerne and the Alps.

www.palace-luzern.ch

La Perla

Elegant, but uncomplicated Italian restaurant with a guest mix of celebrities from politics, sports and culture. Traditional ristorante in "an airy, spacious and clearly arranged" layout. "The decorative interior design as well as the mollusk shells on the columns have a light, warm-reddish touch that fits the color concept."

www.laperla-luzern.ch

Schiffsrestaurant Wilhelm Tell

Permanently anchored, the 100+ year old salon paddle steamer Wilhelm Tell is just a few minutes by foot from the Lucerne Train Station. Enjoy fine dining in the art nouveau captain's salon or on the panoramic deck with views of the Alps, the historic center and the Culture and Convention Center Lucerne.

www.schiffrestaurant.ch



Old Swiss House

The traditional Swiss restaurant with its impressive history carries you off to a bygone era where knights ate at the round table. Explore the exclusivity of the "Mouton Rothschild" collection and the many antiques from many centuries.

www.oldschwisshouse.ch



BLUE – Bar & SMOKERS' LOUNGE

The unusual blend of Asian influences and Baroque-inspired elements provides a unique atmosphere. Spacious rooms and the tastefully staged mixture of styles offer varied perspectives and a pleasant stay.

www.schiller-luzern.ch



Penthouse ROOF TOP BAR

This dignified penthouse lounge on the top floor of the Hotel Astoria with stunning views of Lucerne has long been a highlight of Lucerne. The perfect setting for a circle of friends and colleagues to end a successful congress.

www.astoria-luzern.ch



Night life

Grand Casino Lucerne

The Grand Casino Lucerne is the pearl of the Swiss casinos. In a fantastic location right on the lake and in an elegant, neo-baroque bijou from the turn of the century, the Grand Casino Lucerne not only quickens the hearts of gaming lovers, but also lovers of gourmet, culture enthusiasts and partygoers.

www.grandcasinoluzern.ch

Casineum

Under the auspices of the Grand Casino Lucerne, the Casineum opened in 2004 and with its varied entertainment lineup has become a popular event location in Central Switzerland. The range of offerings includes theaters, concerts, parties and clubbing events. The Casineum is exactly the right place for anyone who wants to turn the night into day.

www.casineum.ch

Suite Lounge & Bar

Fittingly lose track of time, high above the roofs of Lucerne. The Suite Lounge & Bar was the winner of the Swiss Bar Award in the category of Best Newcomer in 2008/2009. No longer a newcomer in 2012, it is a cozy bar with plenty of atmosphere and extensive food and beverage offerings.

www.suite-lounge.ch