Misch International Implant Institute

Newsletter 16 August 2020

UPCOMING COURSES

SURGICAL SESSIONS

Starting in September 2020, the Misch Orlando Surgical Sessions will be held at the new Margaritaville Resort Hotel in Orlando, Florida. This newly constructed hotel features four onsite restaurants and lounges, lagoon style pool and sand beach, 16-acre water park, a spa & wellness center. Within walking distance is the Sunset Walk, which is a fabulous outdoor district containing over 30+ retail and dining hot spots.

Margaritaville Resort Hotel
Orlando Florida

Session 1

Patient Evaluation, Treatment Planning, & Implant Placement into Abundant Bone

SOLD OUT

Session 2

September 25-26, 2020

Multiple Implant Placement and Treatment of the Edentulous Arch

CBCT BOOT CAMP

October 15, 2020

Session 3

October 16-17, 2020

Implant Placement & Bone Augmentation into Compromised Sites

Session 4

November 20-21 2020

Treatment of the Posterior Maxilla: Osteotome & Lateral Wall Technique

Session 5

January 8-9, 2021

Immediate Placement & Loading, Soft Tissue Considerations

INFRAORBITAL NERVE: The Hidden Danger in Maxillary Arch Surgery

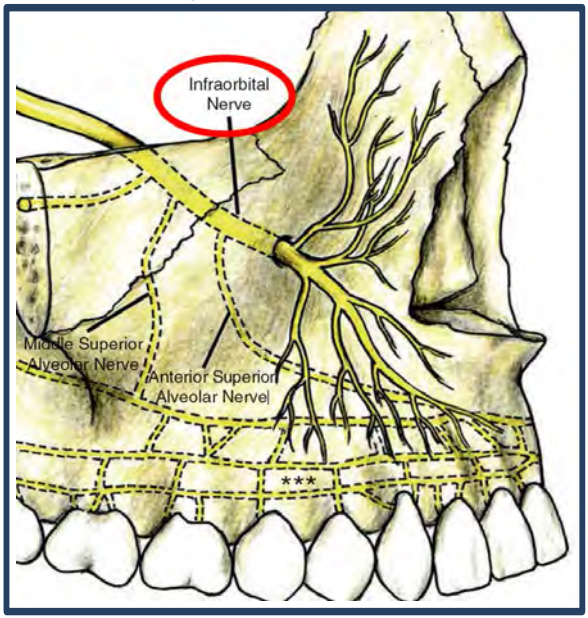
by Randolph R. Resnik DMD, MDS

The infraorbital nerve (ION) is of significant concern when placing implants and bone graft surgery in the maxillary arch. The ION is the largest cutaneous branch of the maxillary nerve (V2) which enters the orbit via the inferior orbital fissure and continues anteriorly as it lies in a groove in the orbital floor before exiting the infraorbital foramen.

The infraorbital nerve normally exits the foramen approximately 6.0 - 7.0 mm apical to the orbital rim. Malpositioned nerves have been reported as far as 14 mm inferior to the orbital rim, which predispose to possible trauma from routine surgical procedures. In addition, anatomic variants have been reported to include complete dehiscence along with the nerve transversing the lumen of the maxillary sinus rather than coursing through the bone within the sinus roof (orbital floor).

Surgical Concern: In the severely atrophic maxilla or in patients with a small cranial base (e.g., elderly females), the infraorbital neurovascular structures exiting the foramen may be close to the intraoral residual ridge. When retracting tissue during maxillary surgery, these nerve branches can be easily traumatized. Therefore, the exact location of the ION should be determined via CBCT and special care should be utilized to minimize direct or indirect trauma to this area from aggressive retraction.

Nerve Damage Concern: Because the infraorbital nerve is responsible for sensory innervations to the lower eyelid, prominence of the cheek, side of the nose, and upper lip, iatrogenic injury to this vital structure can result in significant neurosensory deficits of this anatomic area. Most often the nerve is not severed during dental implant procedures,however is damaged from a stretching type of injury which results in a neuropraxia. Even though this injury is sensory and there is no motor deficit, patients usually have a difficult time adapting to this type of neurosensory impairment.



Management: If an infraorbital nerve impairment occurs, the implant clinician should immediately follow the clinical and pharmacologic neurosensory impairment protocol as outlined in the Avoiding Complications in Oral Implantology Textbook (Chapter 9).

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SURGICAL SESSION 2:

Multiple Site & Edentulous Arch Implant Placement

September 25-26, 2020 Orlando, FL

COURSE TOPICS:

- Multiple Implant Treatment Planning
- Multiple Implant Surgery
- Edentulous Implant Treatment Planning
- All on Four Surgery
- Mandibular Edentulous Implant Placement
- Maxillary Edentulous Implant Placement
- Pharmacological Protocol in Oral Implantology
- Post-Op / Incision Line Opening
- Mental Foramen Exposure Technique
- Avoiding Posterior Mandible Complications
- CBCT Dual Scan Technique
- Full -Arch Zirconia Prostheses
- CBCT Interactive Treatment Planning
- Practice Management - Integrating Implants In Your Practice
- ***HANDS - ON LAB:***
- Aseptic Technique + Lab
- Overdenture Implant Placement
- Acellular Dermal Matrix
- Full Arch Implant Placement
- Bone Supported Templates
- Advanced Surgical Techniques

CLICK HERE TO REGISTER

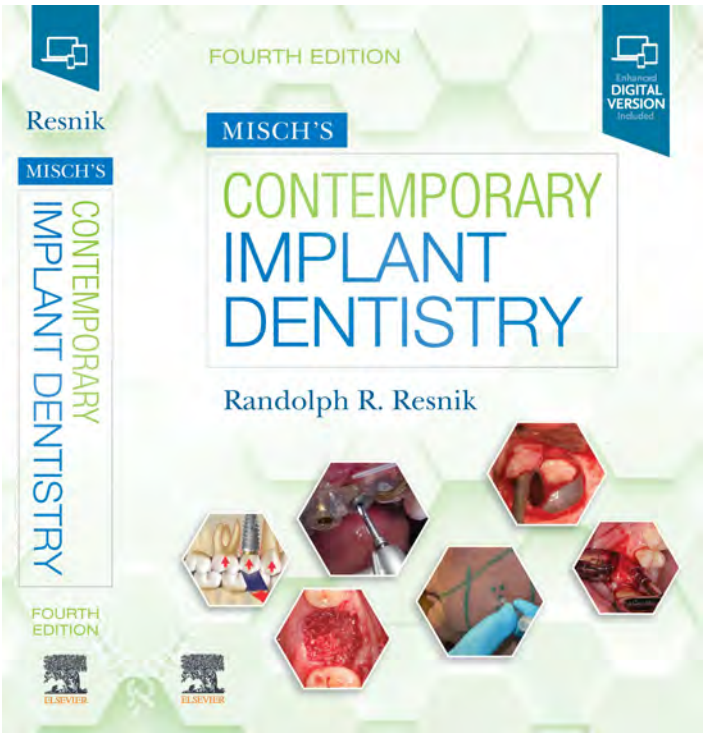
NEW MEETING GUIDELINES DUE TO COVID-19

The Misch Institute is dedicated to providing a safe, heathy environment for our future meetings. Strict social-distancing protocols will be implemented along with COVID-19 prevention supplies being made available to all staff and attendees. In addition, the Misch Institute has integrated the following CDC recommended strategies and guidelines;

- All lectures will be in an enlarged space (Main Ballroom)
- One attendee per 6-foot table
- Enlarged Exhibitor space and tables
- Hand Sanitizer , Disposable Facemasks, and trash baskets available
- Service stations to be sanitized once per hour along with common and high-traffic areas
- Coffee and other breakout times will be served with disposable cups
- Bottled water in lieu of water carafes on meeting tables
- Temperature evaluation and questionnaire completion prior to meeting

The Misch Institute along with the Margaritaville Resort and Hotel will continually monitor the latest CDC guidelines and implement new policies as necessary. We appreciate everyone's understanding and flexibility with this very difficult situation. If you have any questions, please contact Heidi at 248-642-399.

Respectfully,
Randolph R. Resnik, DMD, MDS
Director – Misch Implant Institute



4th Edition Contemporary Implant Dentistry by Randolph R. Resnik

"a must read"
" most comprehensive reference available"

Gordon J. Christensen, DDS, MSD, PhD

- Over 1300 Pages
- 42 Chapters

CLICK HERE TO PURCHASE

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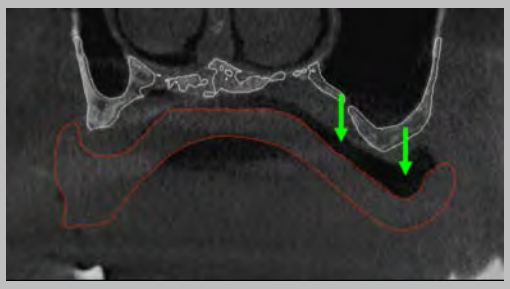
QUESTIONS OF THE MONTH

#1: CBCT QUESTION OF THE MONTH



After taking a dual CBCT scan for an immediate placement/load prosthesis in an edentulous maxilla, you notice a radiolucent area between the bone and prosthesis. What is this radiolucent area and why is it present? To minimize inaccuracies with the immediate prosthesis, what should you do?

#2 IMPLANT STUDY OF THE MONTH:

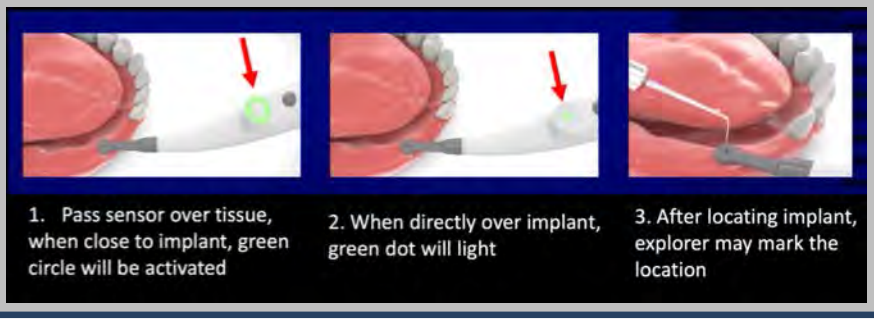
Following implant placement and recall examinations, case reports have shown the genesis of periapical lesions (radiolucency) surrounding the implant apex, while the coronal portion of the implant remains free of bone loss. These periapical lesions have been termed apical peri-implantitis or retrograde peri-implantitis. In a recent retrospective study (2020) of over 8000 implants, various risk factors where identified which predispose to this condition. Which of the following increases the frequency the most in developing these periapical lesions?

a. Immediate Implant Placement
b. Existence of an apical lesion in tooth being replaced
c. Past endodontic treatment with tooth being replaced
d. Presence of adjacent endodontic tooth
e. Tooth root < 1.5 mm from implant apex

NEW IMPLANT PRODUCT OF THE MONTH

Have you ever had difficulty in locating a buried implant? Salvin Dental (704-442-5400) has recently released the " Smart Implant Detector", which allows the clinician to easily locate implants underneath the tissue without making unnecessary incisions which result in loss of keratinized tissue. An easy to use cordless wand accurately detects the exact position of implants via special sensors, similar to a metal detector.

Locate Buried Dental Implants with the NEW "Spotter Smart Implant Detector" by Salvin Dental



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ANSWERS

#1: CBCT QUESTION OF THE MONTH

ANSWER:

The radiolucent area is an air space caused by improper seating of the prosthesis during the CBCT. Ideally, to prevent inaccuracies in the immediate load prosthesis (i.e. incorrect vertical or occlusal relationship), a new dual scan should be completed. The denture (CBCT prosthesis) should be relined or complete seating must be confirmed prior to and throughout the scan.

#2 IMPLANT STUDY OF THE MONTH:

ANSWER:

b. (Existence of apical lesion in tooth being replaced)

Additional Results:

a. Immediate Implant Placement (21-Fold Increase)
b. Existence of apical lesion in tooth being replaced (26- Fold Increase)
c. Past endodontic treatment with tooth being replaced (3- Fold Increase)
d. Presence of adjacent endodontic tooth (0.97- Fold Increase)
e. Tooth root < 1.5 mm from implant apex (5- Fold Increase)

Peñarrocha-Oltra, David, et al. "Factors associated with early apical peri-implantitis: A retrospective study covering a 20-year period." Int. J. Oral. Implantol 13 (2020): 65-73.

LISTEN TO DR. RESNIK'S WEBINARS *(click link to view)*

Current:

- **3DDX # 3: Advanced CBCT Tx Planning- Aug 21, 2020 @ 1:00 pm EST**

Past:

- 3DDX # 1: CBCT Treatment Planning (April 29, 2020)
- 3DDX # 2: CBCT Treatment Planning (May 12, 2020)
- Glidewell # 1: Systemic Health and Dentistry: Patient Premedication, Antibiotics, Steroids, Pain Medication
- Glidewell # 2: Surgical Complications: Etiology, Management and Prevention
- Glidewell # 3: Principles of Occlusion for Implant Restorations
- Glidewell # 4: Literature-Based Socket Preservation Protocol

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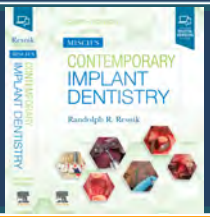

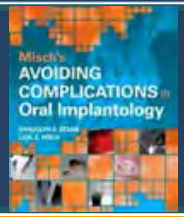

TEXTBOOKS FROM MISCH INSTITUTE

Contemporary Implant Dentistry Surgery - 4th Edition
Misch's Avoiding Complications in Oral Implantology -1st Edition

ADA C·E·R·P® Continuing Education Recognition Program
ACADEMY of GENERAL DENTISTRY