



periodontics**TODAY**

Periodontal Endoscopy

A NEW STANDARD OF NON-SURGICAL PERIODONTAL TREATMENT

The new Maxi implant

Allowing immediate molar replacement for the first time

SPECIALIST IN PERIODONTOLOGY

• IMPLANTS



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DV2 PERIOSCOPE

IN PERIODONTOLOGY, WE NOW HAVE ACCESS TO AN INCREDIBLE VISUALISATION TOOL FROM THE MEDICAL FIELD.

Real-time visualisation using the 24x to 48x magnification of the DV2 Perioscopy System allows me to see even the smallest deposits of residual calculus, along with furcations and root anatomy, soft tissue inflammation, root fractures, sub-gingival caries, open crown margins and more.

The master control unit features ports for video recording, water irrigation and fibreoptic endoscope interconnections.

Fibreoptic Micro-Endoscope

A miniature 0.99 mm diameter endoscope incorporates an integrated light source for illumination and visualisation of sub-gingival root surfaces at 24x to 48x magnification.

The compact, transportable DV2 Perioscopy System integrates a miniature fibreoptic endoscope and disposable sheath with a medical-grade CMOS camera, digital processor and a flat panel video monitor that captures and displays real-time images. Irrigation and illumination are controlled with an easy to use foot activated control system.

I can now see and access, without surgery, what I could never see before. This instrument allows pinpoint residual calculus removal after traditional therapy. It removes tenacious deposits more thoroughly, and allows visualisation of furcations and areas of soft tissue inflammation. It offers all our patients a reassuring, minimally invasive alternative to conventional surgical approaches.

I have been using this wonderful tool for two years and the results have been very good. It has made a positive change to treating cases which previously required surgery and patient perception and feedback have been excellent.



Fig 1 The DV2 Perioscope unit.



Fig 2 The fibreoptic light in the handpiece that assists with subgingival visualisation.

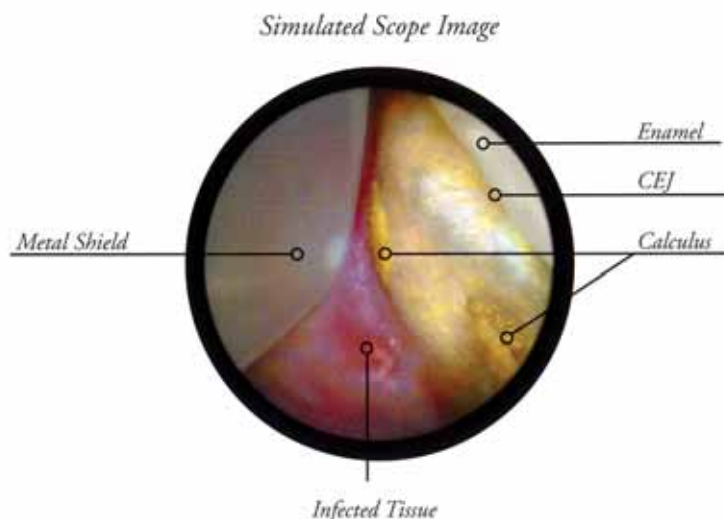


Fig 4 Simulated scope image.



Fig 3 Variety of handpieces for different areas in the mouth.

SOUTHERN IMPLANT'S NEW MAXI IMPLANTS

IMMEDIATE IMPLANT PLACEMENT INTO A MOLAR
EXTRACTION SOCKET.

A new implant design called the MAX implant now allows for immediate placement in molar extraction sockets.

The immediate placement of a conventional dental implant into a molar extraction socket poses a number of difficulties. Most significantly, the size and shape of the multi-rooted molar socket is not suited to optimal placement of a typical dental implant, often resulting in compromised implant positioning, poor primary stability or the inability to place an implant at all.

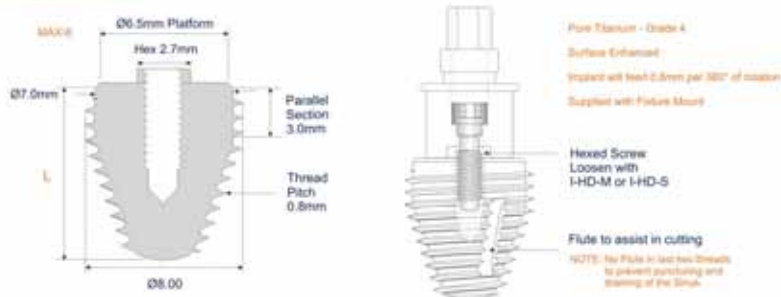
This may result in the need for a waiting period of 3 to 4 months to allow for healing of the socket prior to attempting implant placement. Often, the healed extraction site presents with reduced bone height, inadequate for implant placement, resulting in the need for bone augmentation procedures, especially in the maxilla. This leads to further lengthening of treatment time with increased cost and complexity.

An alternate approach has been to place a 6.00mm diameter implant into one socket of a multi-rooted extraction site, typically the palatal socket of a maxillary molar. Problems associated with the latter approach include adverse biomechanical forces resulting from the implant being off-centre and off-axis to the application of load, poor emergence profile and difficult hygiene maintenance resulting from the unavoidable buccal overhang of the restoration.

The MAX Concept:

The concept of the MAX implant provides for a design of implant and a surgical protocol which makes immediate placement of the implant into a multi-rooted molar socket attainable, thus obviating the multiple problems discussed above.

Technical Data



The MAX implant features a body with larger than conventional diameter to fill the molar site and achieve primary stability from engagement of the perimeter bony wall of the specially prepared molar socket. The greater taper of the implant body allows for maximal preservation and engagement of inter-radicular bone within the socket of a molar with divergent roots. In the case of a molar tooth with tapering root form, the implant body has a natural fit to the socket shape. The tapered geometry of the implant allows excellent primary stability to be achieved by the threaded implant.

CLINICAL APPLICATION



Fig 1 A maxillary first molar to be removed.

Fig 2 Large temporary restoration replacing most of the crown.



Fig 3 The clinical crown is removed.

Fig 4 The roots are surgically separated.



Fig 5 Roots are removed without damage to bony socket walls.

Fig 6 Extraction socket intact. Centrally located interradicular crest prepared.



Fig 7 Implant and healing abutment placed.

Fig 8 A Max-9-11 implant in place.



