ABSTRACT BOOK

Bone Symposium 2017 Scientific Program 6 - 7 October 2017
MEFFERT IMPLANT INSTITUTU EDUCATION - RESEARCH - QUALITY

Weighing Reward versus Risk of Grafting Procedures: A Prosthodontic Aspect

Assist. Prof. Dr. Mesut TUZLALI[1], Assoc. Prof. Dr. Mustafa ZORTUK[1], Assist. Prof. Dr. Mert BÜLTE[2], Assist. Prof. Dr. Ayşegül SARI[3]

[1]Department of Prosthodontics, Faculty of Dentistry, Mustafa Kemal University, Hatay, Turkey

[2]Department of Oral and Maxillofacial Surgery, Faculty of Dentistry, Mustafa Kemal University, Hatay, Turkey

[3]Department of Periodontics, Faculty of Dentistry, Mustafa Kemal University, Hatay, Turkey

Teeth extractions are followed by a reduction of the bucco-lingual as well as the vertical dimension of the residual alveolar ridge. Resorption of the alveolar ridges after tooth extraction cannot be prevented (Fig 1 & 2). Ridge defects develop as a result of not only teeth extractions but also surgery, trauma, infection, or congenital malformations. It results in unsightly defects and collapse of the lips, and cheeks. Therefore, alveolar ridge defects represents a challenge for dentistry. The application of grafting procedure has been introduced into dentistry mostly to enhance peri-implant bone and place the longest/widest implants possible. Today, soft and hard tissue grafting are safer and more effective than ever before. However, few practitioners are able to perform grafting procedures or regenerations in their daily practice.

Fig 1

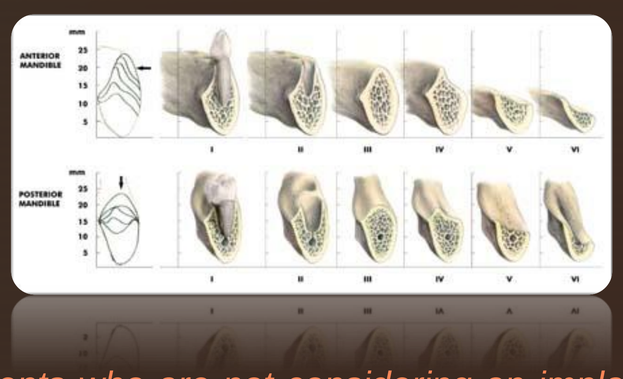


Fig 2

Even for patients who are not considering an implant to replace a tooth that needs extraction, grafting now offers us the chance to preserve the shape and strength of the bony ridge long after the tooth is gone. This is important not only for the health and strength of the teeth surrounding the extraction site, but also for the possibility of implant, repair broken bones, bridge, denture, or partial placement in the future (Fig 3 & 4). Traditional dentures and partials always fit better when the bony ridge is thick and strong. Even bridges placed over extraction sites can be aesthetically compromised by resorption.

Fig 3

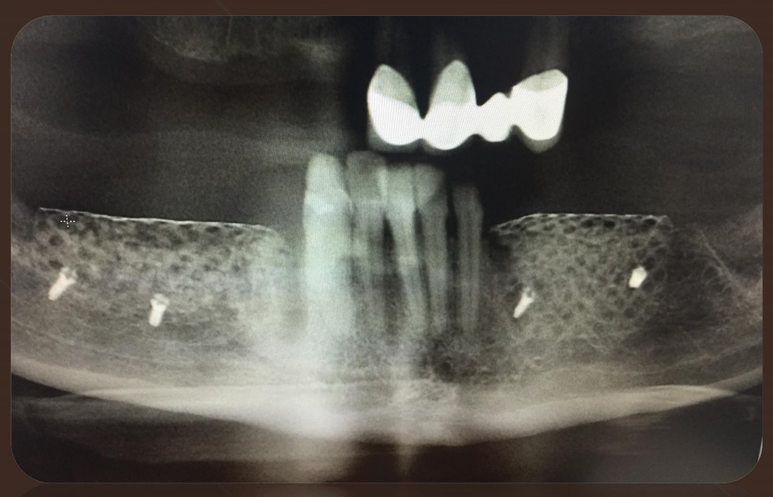


Fig 4

The presence of healthy attached tissue at the tooth and implant soft tissue interface correlates with long-term success and stability in function and esthetics. Also, the mucosal layer provide adequate resiliency to support the denture (Fig 5 & 6). Not only can a lack of keretinized tissue facilitate plaque aggregation around teeth and implants but it can also lead to recession of free soft tissue margin in the esthetic zone.

Fig 5

Fig 6

Simply put, alveolar ridge defect or bone resorption makes every tooth replacement option more difficult, more expensive, more time consuming, less comfortable, less aesthetic, less successful, and sometimes even impossible. These results support the placement of graft over extraction areas under favourable conditions.

Keywords: implant, soft and hard tissue grafting, prosthodontic.

Corresponding author e-mail: mesuttuzlali@gmail.com

BONE GRAFTS
AUTOGRAFT
SOFT TISSUE GRAFTING
FREE GINGIVAL GRAFT
CALCIUM SULPHATE
OSSEOUS
HYDROXYAPATITE
IMPLANT
KERAINIZED TISSUE

İnönü University
Faculty of Dentistry

INCREASING THE ATTACHED GINGIVA AROUND THE IMPLANT : CASE REPORT

Arife Sabancı[1], Abubekir Eltas[1], Mustafa Karaca[1]
[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

INTRODUCTION

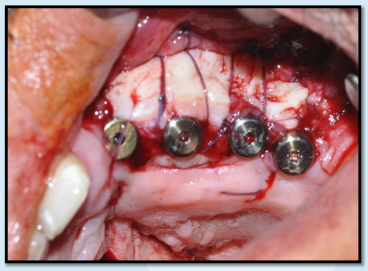
There may be a shallow vestibuler problem in patients with cleft lip and palate. For ideal implant rehabilitation, an adequate stable and healthy soft tissue are required . Aim of this case report was treatment of inadequate atached gingiva around the implant in patient with cleft lip and palate.

MATERIAL AND METHODS

A 36 year old male patient presented to our department with inadequate attached gingiva around the implant at left posterior maxilla. He has cleft lip and palate. After the implant surgery, keratinized gingiva was absent in the buccal of the implant and the vestibular groove was shallow. The free gingival graft(FGG) technique was used to solve the vestibular groove and the absence of attached gingiva around the implant. Periimplant recipient area was prepared. FGG was harvested from the palate and sutured. Sutures were taken postopertaive tenth day and the patient examined 3 months after cemented fixed partial denture.

Preoperative clinical view

Preoperative clinical view



Operation

Clinical view 10 days after the operation

Clinical view 1 month after the operation

Clinical view 3 months after the cemented partial denture

RESULTS

Implant loading and prosthetic restoration showed favorable outcome after operation. The amount of keratinized tissue around the implant was sufficient.

DISCUSSION

Soft tissue defects, such as gingival and connective tissue, play crucial roles in long-term implant success. There are many methods for treatment this defects. This case and current literature show that free gingival graft can provide succesful results around implant.

KEY WORDS: Attached gingiva, cleft lip and palate, free gingival graft

İnönü University
Faculty of Dentistry

REGENERATIVE THERAPY OF PERIODONTAL INTRABONY DEFECTS IN AGGRESSIVE PERIODONTITIS: A CASE REPORT

Mustafa Özay Uslu,[1] Mehmet Kızıltoprak,[1]
[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

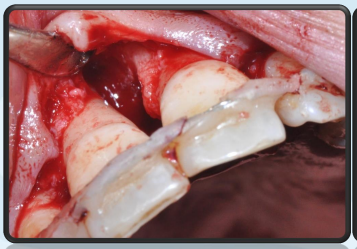
Introduction

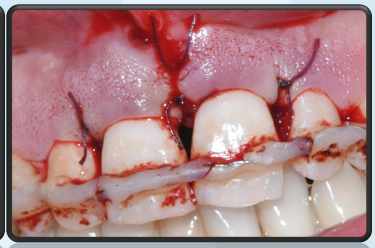
Aggressive periodontitis is characterized by rapid attachment loss and bone resorption. Regenerative therapy helps regenerate the periodontium. This case report presents a successful treatment of an intrabony defect in the aesthetic zone of an aggressive periodontitis patient.

Materials and Methods

A 30-year-old systemically healthy man was referred to our clinic, with a chief complaint of bleeding gums and mobility of the upper right central incisor. Clinical and radiographic evaluations were performed and the patient was diagnosed with localized aggressive periodontitis. After initial periodontal therapy, intrabony defects were planned to treat with flap operation with xenograft (Cerabone 0.5-1mm, Botis Dental GmbH, Germany) and barrier membrane (OsteoBiol Evolution 20×20mm, Tecnoss, Italy) combination. There was severe mobility in the right upper central incisor. Therefore, splinting was performed before operation. The patient was prescribed antibiotics, anti-inflammatory drugs and chlorhexidine gluconate and sutures (4-0 Silk, Doğsan, Turkey) were taken at postoperative 10th day. Postoperative healing of patient was uneventful. Clinical parameters such as average pocket depth, clinical attachment level, gingival recession and tooth mobility were recorded and radiographs were taken at baseline, postoperative first ,third and eighth month. Bone filling of defects was evaluated on standart periapical radiographs. For a more aesthetic appearance, a retainer was made at postoperative 6th month.

Baseline clinical view after splinting





Clinical view during the surgery

Radiographic view at initial visit.

Postoperative 3 months

Postoperative 8 months

Postoperative view at 8 months

Results

There was a reduction of pocket depth and teeth mobility and a significant increase in radiographic bone filling at the postoperative 8th month follow-up.

Discussion

There are many studies in the literature about the treatment of intrabony defects in aggressive periodontitis. Regenerative therapies using bone grafts and membrane combination are an important part of these studies and show successful results.

İnönü University
Faculty of Dentistry

INCREASING THE AMOUNT OF KERATINIZED TISSUE AROUND THE IMPLANT

Arife Sabancı[1], Abubekir Eltas[1], Semih Akgül[1]
[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

INTRODUCTION

Scientific data and clinical observations appear to indicate that an adequate width of attached gingiva may facilitate oral hygiene procedures thus preventing peri-implant inflammation and tissue breakdown. İn order to avoid biologic complications and improve long-term prognosis, soft tissue conditions should be carefully evaluated when implant therapy is planned. İn this case report rehabilitation of soft tissue around of implants with free gingival graft was presented.

MATERIAL AND METHODS

A 35 year- old male patient who was systemically healthy presented to our clinic with inadequate attached gingiva around the implant on left posterior mandibula. After examination, free gingival graft operation is planned. Periimplant recipient area was prepared and FGG was harvested from the palate and sutured. Sutures were taken postoperative tenth day. The patient examined at first and third month.

Initial clinical view

Clinical view 3 months after the surgery

Surgery

Clinical view 10 days after the surgery

Clinical view 1 month after the surgery

RESULTS

The amount of keratinized tissue around the implant and attached gingival level was increased by opearation. Free gingival graft have succesful results for increasing amount of keratinized tissue around the implant.

DISCUSSION

This is based on the data of this case and current scientific literature, free gingival graft can provide succesful results for increasing the attached gingiva around the implant.

KEY WORDS: Keratinized tissue, free gingival graft, implant

İnönü University
Faculty of Dentistry

TREATMENT OF PARESTHESIA CAUSED BY IMPLANT-RELATED: A CASE REPORT

[1]Mehmet Kızıltoprak, [1]Şeydanur Dengizek Eltas, , [1]Abubekir Eltas
[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

Introduction

Nervus alveolaris inferior is a branch of the mandibular nerve. It is most important landmark in the dental implantology. Because, this nerve damage can cause paresthesia. In this case report, treatment of long-term paresthesia due to nervus alveolaris inferior injury following dental implantation at the right posterior mandibula is presented.

Materials and methods

A 63-year-old systemically healthy female was referred to our clinic for complaining of paresthesia at the right mandibula. In the dental history of the patient, paresthesia due to the implants was detected in the right mandibula. The implants were made in a private clinic three years ago. Clinical and radiological evaluations were performed and the perforation of the mandibular canal was detected at implant #46. In addition, periapical lesions were detected between implant #41 and tooth #31. #41, #46 implants and tooth #31 was extracted. Implants were extracted with trepan drill. The patient was prescribed antibiotic, analgesic, vitamin B12 and mouthwash.

Initial clinical and radiographic view

Results

A 60% reduction in paresthesia was observed on postoperative 8th day. Paresthesia was not observed on postoperative 22th day. Successful medical and surgical treatment of paresthesia due to mandibular canal perforation was performed.

Postoperative view at 8th day

Postoperative view at 22th day

Discussion

According to current literatüre and this case report, paresthesias due to mandibular canal perforation are frequently encountered. This situation can be reversable when the agent eliminated.

İnönü University
Faculty of Dentistry

TREATMENT OF BONE DEFECTS WITH AUTOGRAFT AND BARRIER MEMBRANE COMBINATION

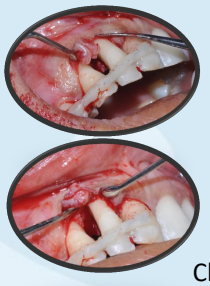
Mustafa Özay Uslu[1], Semih Akgül[1], Arife Çiçek[1]

[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

❖ **Introduction:** Various materials have been used in regenerative treatment of intrabony defects such as bone replacement graft materials, barrier membranes, different growth factors and combination of these. The available bone tissue replacement materials commonly used include autografts, allografts, xenografts and alloplasts. In this case report, regeneration of the defect was presented using autograft and membrane combination.

❖ **Material and Methods**: A 37-year-old female patient was admitted to Department of Periodontology with complaints of mobility and infection of maxillary right lateral tooth. The intrabony defect was treated with autograft which was gained from tuber maxilla by trepan bur and barrier membrane (Osteobiol Evolution 20 × 20 mm, Tecnoss, Italy) combination after tooth splinting. Papilla preservation flap was performed. Periodontal dressing was applied to the operation area (Coe-Pak). Clinical parameters were recorded at baseline, first week and at 6th months, including the probing depth, clinical attachment level and gingival recession. Bone remodelling in the defect was evaluated on standard periapical radiographs.

İnitial clinic view



Clinical appearence during surgery

Postoperative 6th month

Postoperative 18th month

İnitial periapical radiograph

Postoperative 6th month

Postoperative 18th month

❖ **Results:** Postoperative recovery was uneventful, and satisfactory reduction in the average probing depth was observed at 6th month observation, with an increase in the rate of radiographic bone filling. Due to the patient's aesthetic expectation, composite filling was performed to the interproximal region between maxillary right lateral tooth and maxillary right canine tooth.

❖ **Discussion:** The autogenous graft is considered the gold standard for treatment of intrabony defects. With this case selection; surgical technique, bone graft and membrane selection, and postoperative management can be directed towards obtaining the best clinical results.

THE TREATMENT OF MANDIBULAR BRONJ: A CASE REPORT

Ayşegül SARI, DDS, PhD[1], Uğur Can ÜNLÜGENÇ, DDS[2], Berk TURGAY, DDS[2]

1. Mustafa Kemal Universty, Faculty of Dentistry, Department of Periodontology
2. Mustafa Kemal Universty, Faculty of Dentistry, Department of Oral and Maxillofacial Surgery

INTRODUCTION

Bisphosphonate releated osteonecrosis (BRONJ) is characterized by exposure of maxillar or mandibular bone for at least 8 weeks (1). Important risk factors for BRONJ development include any kind of dental surgery procedure involving mucosa and underlying bone such as dental implant applications or tooth extraction (2).

CASE

A 59-year-old female patient was referred to our clinic with severe pain, with wounds in her mouth and flow of purulent exudate. The oral examination revealed exposed bone due to necrosis in the right lower mandibular region (Figure 1). She had placed dental implants at the same area 2 months ago. The flow of purulent exudate from the related region were also evident. In the patiens's radiography, radiolucent areas were observed around the implants (Figure 2). Patient's medical history revealed a ceased oral bisphosphonate use for osteoporosis 2 years ago. As a result of the consultation with the orthopedics departmen, the patient was diagnosed with BRONJ. In the first treatment, under local anesthesia (without vasoconstrictor) the region is swabbed a cotton tip soaked with 3% hydrogen peroxide (Figure 3). We prescribed mixed usage of diluted 3% hydrogen peroxide (Farma Kon, 2x1) and antibiotics (RIF 125 mg) with water as mouthwash. Sytemic antibiotics were not prescribed to the patient because the patient indicated that he has used 13 boxes of antibiotics within 2 months. In the follow-up appointments, debridement was performed with hydrogen peroxide in the necrosed area with conservative approach to the region (Figure 4). After complaints of pain diminished, periodontal initial treatment was performed (Figure 5). In the follow-up appointment after 6 weeks it was observed that intraoral necrosis areas around the implants were healed to a great extent (Figure 6). At the end of 3 months, no necrosis was observed in the patient's mouth during the control appointments, and the patient's complaints were completely resolved (Figure 7). The patient is still being followed-up for the prognosis of dental implants.

Figure 1

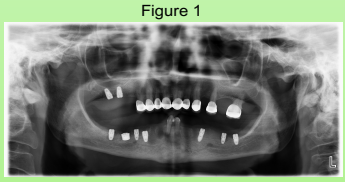


Figure 2

Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

CONCLUSION

In patients using bisphosphonates, care must be taken in dental approaches. Although not a definitive treatment of BRONJ has gained admission, local administration of hydrogen peroxide with antibiotics therapy and debridement of necrosis bone can produce positive results.

RESOURCES

1. Ruggiero SL, Dodson TB, Assael LA, Landesberg R, Marx RE, Mehrotra B. American Association of Oral and Maxillofacial Surgeons position paper on bisphosphonate-related osteonecrosis of the jaw. Aust Endod J 2009;35(3):119-30

2. de-Freitas NR, Lima LB, de-Moura MB, Veloso-Guedes CC, Simamoto PC, de-Magalhaes D. Bisphosphonate treatment and dental implants: A systematic review. Med Oral Patol Oral Cir Bucal 2016; 21(5): 644-51.

Titanium Mesh Complication and Treatment

Ustaoğlu Gülbahar, Şengün Mehmet Cihan
Abant Izzet Baysal University, Faculty of Dentistry, Periodontology Department, BOLU
Bone Symposium 2017 - 5-8 Oct 2017
mcihansengun@gmail.com

Objective: Bone augmentation with the titanium-mesh membrane (Ti-mesh) technique is susceptible to a large rate of complications such as morbidity of bone graft donor site and mesh exposure to the oral cavity.

♂ Patient, 35 Years Old
Systemic disease ø Medicine ø Smoke +

The patient was partially edentulous and did not have any systemic diseases and used to smoke.

Figure 1. Radiographic view


Figure 2,3. Buccal aspect of anterior teeth.

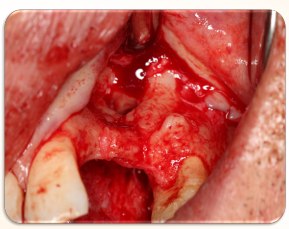
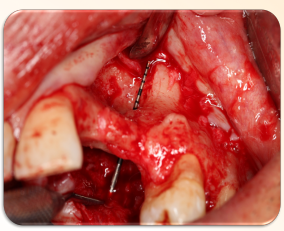



Figure 4,5. In the first surgical operation a full-thickness flap was raised to expose the bone. In the left anterior region there was a bone defect reaching palatinal aspect from buccal cortex. Xenograft and Ti-mesh with screws were placed.

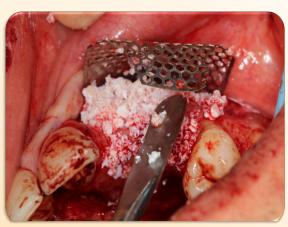
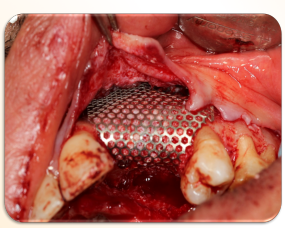



Figure 6,7. Xenograft and Ti-mesh with screws were placed.

Result: Healing was complicated because of exposure Ti-mesh and lost of keratinized tissue in the first and second surgery. Last surgery was succesful, exposed bone surface was covered prf and epithelization completed. CT assessment showed bone gain with last surgery.

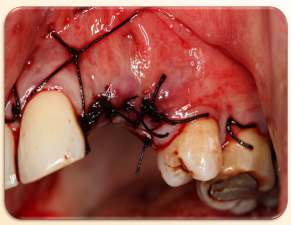
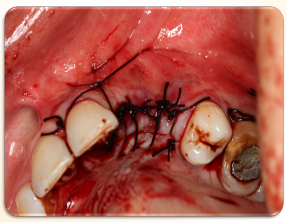



Figure 8,9. After first operation 1 weeks.


Figure 10. 3.days.
Figure 11. 2.weeks.

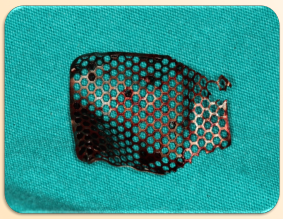



Figure 12. After mesh exposure, connective tissue graft was applied at the second surgical operation. Exposure was recurrenced even after the second operation. Ti-mesh and xenograft in the defect area were removed at last operation.

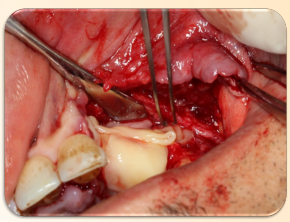
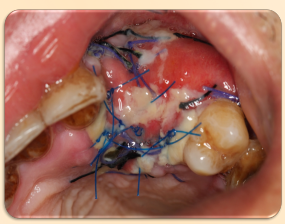



Figure 14. Platelet rich fibrin was applied. Implants were placed after 10 months.
Figure 15. 3.days.

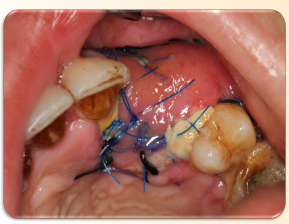



Figure 16. 1. week.
Figure 17. 3.weeks.

Conclusion: The specialist should be more careful if the patient is smoking due to deterioration of vascularity. The patient was talking too much. Tissue stability is very important for healing. Ti-mesh exposure can be provoked significant bone loss.

Titanium-Prepared Platelet Rich Fibrin Provides Advantages on Periodontal Healing: A Randomized Split Mouth Clinical Study

Taner ARABACI, DDS PhD [1,*]
Mevlut ALBAYRAK, DDS PhD [2]
[1]Department of Periodontology, Faculty of Dentistry, Atatürk University, Erzurum, Turkey
[2] Medical Laboratory Department, Health Services Vocational Training School, Ataturk University, Erzurum, Turkey

INTRODUCTION

Conventional open flap debridement (OFD) is a technique which would be beneficial for reduction of periodontal pocket depth in patients with horizontal bone loss due to periodontitis, but don't contribute to periodontal regeneration.[1] The healing after conventional treatment methods occurs generally as long junctional epithelium that is vulnerable to the recurrence of periodontal pocket.[2] Recently, the use of titanium-prepared platelet rich fibrin (T-PRF) has been considered to be a novel therapeutic adjuvant in the management of periodontal soft and hard tissues.[3] However, there is no study in the current literature, analyzing the effects of T-PRF treatment combined with OFD on the growth factor levels and RANKL/OPG ratio in gingival crevicular fluid (GCF).

PURPOSE

The aim of this study was to test the hypothesis that the combination of OFD and T-PRF can predictably enhance periodontal healing by determining periodontal outcomes, and growth factor levels and biomarkers related with bone remodeling in GCF.

MATERIALS AND METHOD

Study Groups & Study Design

29 patients (58 sites) with chronic periodontitis were treated either with autologous T-PRF with OFD or OFD alone. GCF growth factor levels and relative RANKL/OPG ratio at baseline and 2, 4 and 6 weeks postoperatively were analyzed, and clinical parameters such as probing depth (PD), relative attachment level (RAL) and gingival margin level (GML) at baseline and 9 months after surgery were compromised.

Surgical Procedures

According the study protocol, one of the quadrants of the jaw of each patient was selected as the control group (OFD) and treated with OFD alone, without addition of any regenerative material; the other quadrant was selected as the test group (OFD+T-PRF), in which T-PRF was used as a membrane both buccally and lingually, combined with OFD. The mucoperiosteal flaps were repositioned and secured in place using 5-0 monofilament polyamide sutures. CoePak® was used as periodontal dressing in every case.

Biochemical Analyses

GCF samples were analyzed to determine the levels of RANKL, OPG and growth factors, including FGF-2, PDGF-BB, and TGF-β1, by using specific enzyme-linked immunosorbent assay (ELISA) kits^ and a quantitative sandwich enzyme immunoassay technique. Analyses were carried out according to the manufacturer's protocol. Test for each biomarker were carried out in duplicate. Results of measurements were estimated using the standard curves included in each assay kit.

RESULTS

The mean PD reduction, RAL gain and GML change were significantly greater in the OFD+T-PRF sites than in the OFD sites. Both groups demonstrated increased growth factor levels at week 2 compared with baseline, followed by reductions at weeks 4 and 6. GCF growth factor levels in test group were seen at higher concentrations with respect to control group until 6 weeks post-surgical period. During the 6 weeks period, relative RANKL/OPG ratio was found significantly lower in OFD+T-PRF group compared to OFD group.

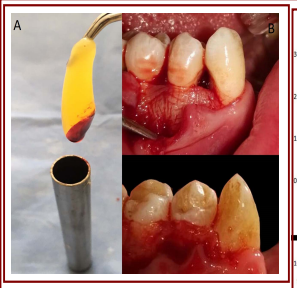


Figure 1: Removing of T-PRF from titanium tube, and adaptation of T-PRF to the teeth.

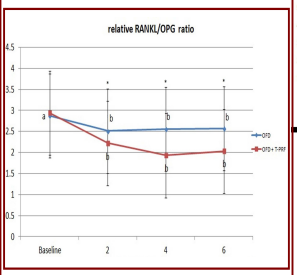


Figure 3: Relative RANKL/OPG ratio.

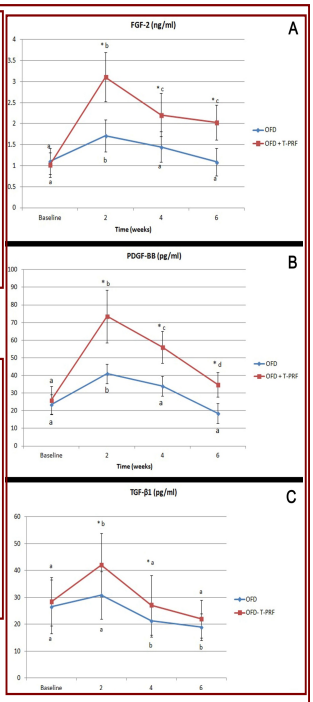


Figure 2: GCF levels of FGF-2, PDGF-BB and TGF-B1.

Table 1: Changes in PD, RAL and GML over 9 months.

	OFD (Mean±SD)	OFD+T-PRF (Mean±SD)	*p* value
PD reduction (mm)	3.01 ± 0.84	4.13 ± 1.06	0.033*
RAL gain (mm)	2.31 ± 0.73	3.65 ± 1.09	0.029*
GML (mm)	-0.33 ± 0.12	0.54 ± 0.23	0.026*

CONCLUSION

OFD is a procedure for horizontal bone loss due to periodontitis, however, recurrence of the pathological pockets and post-surgical gingival recession can be observed after surgery when used alone. PRF is autogenic and very cheap biological material which the literature is growing. Consequently, using T-PRF membrane combined with OFD provided significantly higher concentrations of growth factors and lower RANKL/OPG ratio in GCF for approximately four to six weeks, and improved periodontal healing compared to conventional flap sites.

REFERENCES

[1] Joseph VR, Sam VR, Amol NV. Clinical evaluation of autologous platelet rich fibrin in horizontal alveolar bony defects. J Clin Diagn Res 2014; 8: 43-47.

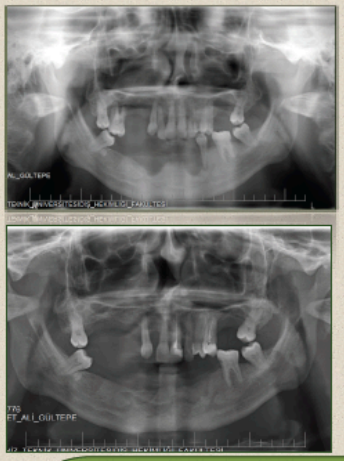
[2] Hagi, TT, Laugisch O, Ivanovic A, Sculean A. Regenerative periodontal therapy. Quintessence Int 2014; 45: 185-192.

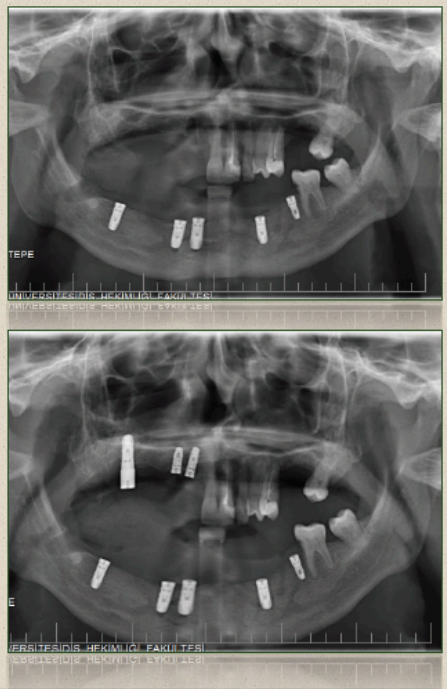
[3] Tunali M, Ozdemir H, Kucukodaci Z, Akman S, Fıratlı E. In vivo evaluation of titanium-prepared platelet-rich fibrin (T-PRF): a new platelet concentrate. *Brit J Oral Maxillofac Surg* 2013; 51: 438-443.

Bone Augmentation With Using Allograft and Titanium-Prepared Platelet-Rich Fibrin Membrane

Gülbahar Ustaoğlu, Kerem Çağlar Gümüş
Abant Izzet Baysal University, Faculty of Dentistry, Periodontology Department, BOLU
Bone Symposium 2017 - 5-8 Oct 2017

Introduction: Generalized form of aggressive periodontitis is chiefly diagnosed by rapid destruction of periodontal tissue and alveolar bone in young patients reporting no other health-related complaints. Implant-supported restorations are documented as the treatment of choice to replace missing teeth. When there is vertical or horizontal bone loss, some augmentation techniques may be needed before place dental implant.





Material and Methods: The patient received full mouth supragingival and subgingival debridement and detailed oral hygiene instructions. The patient's plaque control was evaluated frequently during the treatment planning and consultation phase, and he demonstrated significant improvement. Mandibular teeth were extracted except right second molar and left first and second molar. Radiographic examination showed severe bone loss and a combination of horizontal and vertical bony defects. Mandibular bone defects were treated with using Allograft and titanium-prepared platelet-rich fibrin (T-PRF) membrane. After six months, implants were placed.

Discussion: The T-PRF method is based on the hypothesis that titanium can be more effective in activating platelets than the silica activators used with glass tube leukocyte and platelet-rich fibrin (L-PRF) method. Among the newly introduced approaches to tissue regeneration T-PRF and allograft combination is shown to have significant effect in bone regeneration.

Results: Bone filling was obvious in radiografic examination and adequate vertical bone height was supplied to place dental implants.

İnönü University
Faculty of Dentistry

ROOT COVARAGE WITH A CONNECTIVE TISSUE GRAFT: A CASE REPORT

Semih Akgül[1], Mustafa Özay Uslu[1], Ömer Alperen Kırmızıgül[1]

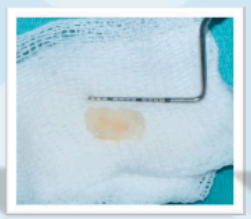
[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

❑ **Introduction:** Gingival recessions cause various problems such as dentin sensitivity, aesthetic problems and root caries. In this case report, treatment of localized gingival recession with lateral sliding flap associated with a connective tissue graft was presented.

İnitial clinic view

Periapical radiograph

❑ **Material and Methods:** A 33-year-old female patient admitted to our clinic with dentin sensitivity and aesthetic complaints. Dental Miller Class-I gingival recession was detected in the intraoral examination performed maxillary left lateral tooth. After the connective tissue graft was obtained by single incision technique, the graft was fixed using 7-0 suture. Following the lateral sliding flap procedure, the operation was completed using 5-0 suture. The area was allowed to heal with Coe-Pak. After 6 months, coronally advanced flap operation was performed.



Clinical appearence during surgery

Postoperative 6th month

Second surgery

Postoperative second operation

❑ **Results:** Postoperative healing was good. After the treatment, it was observed that the gingival width was increased and localized gingival coverage was satisfactory. This case report describes the treatment of gingival recession with the use of connective tissue graft still showed a technique used successfully.

❑ **Discussion:** Obtaining predictable and aesthetic root coverage is the goal of periodontal plastic surgery. The connective tissue graft is considered the gold standard for root coverage procedures. Application of a subepithelial connective tissue graft either in combination with a sliding flap or with the tunnel technique has been reported to achieve successful results.

İnönü University
Faculty of Dentistry

IMPLANT SURGERY WITH CONNECTIVE TISSUE GRAFT IN AESTHETIC REGION: CASE REPORT

Semih Akgül[1], Mustafa Karaca[1], Abubekir Eltas[1]

[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

➢ **Introduction:** The careful management of soft tissue around implant is considered a key factor to obtain aesthetic outcomes and long-term maintenance. In this case report, connective tissue graft and implant operation is described to provide aesthetic of the upper anterior toothless zone.

➢ **Material and Methods**: We report the case of a 43-year-old male with aesthetic and functional problem at maxillar anterior region. The patient exhibited deficient thickness of the alveolar edge and absence of gingival architecture. After oral examination, implant restoration was planned for #15, #12 and #22. Region of #21 had a soft tissue deficit. #12 was extracted and immediately implant was applied in the region of #15, #12 and #22. Soft tissue augmentation was done with palatal connective tissue graft. The flap was sutured using 5-0 suture. Implant healing abutments placed under adequate local anesthesia at post-operative third month and patient was referred to the prosthetic department.

İnitial clinic view

İnitial panoramic radiograph

Clinical appearence during surgery

Postoperative 2 weeks

Healing abutment placement

➢ **Results:** Postoperative healing was satisfied. Implant osseointegration was uneventful. Gingival architecture was improved by connective tissue graft. Aesthetic and functional problems were solved.

➢ **Discussion:** Patients have high expectations at aesthetic operations of maxillar anterior area. Dental implant applications with connective tissue grafts provide extremely successful results.

Regeneration of Peri-implantitis Bone Defect Using Titanium-Prepared Platelet-Rich Fibrin (T-PRF)

***Gülbahar USTAOĞLU, # Esra ERCAN, # Emine Cansu GENÇ**

***Abant İzzet Baysal University Periodontology Deparment, Bolu, Turkey,**

 # Karadeniz Technical University Periodontology Deparment,Trabzon, Turkey

~~Bone Symposium 2017 - 5-8 Oct 2017~~

INTRODUCTİON

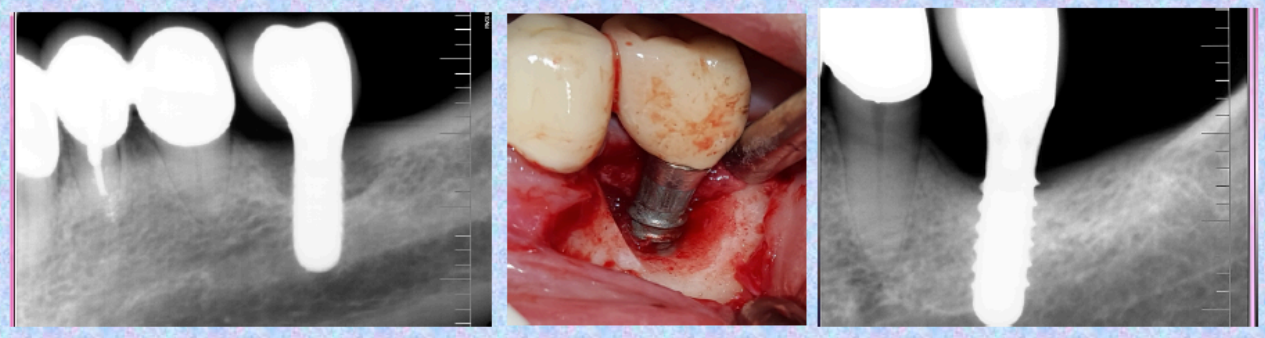
Peri-implantitis is an irreversible inflammatory disease that results in loss of supporting bone. The goal of regenerative techniques is re-osseointegration of exposed implant surface. There are a lot of biomaterials that can be used for this aim. However, there is limited data about the regenerative potential of T-PRF releated with peri-implantitis bone defects.

Material and Methods

A 58-year old systemically healthy female patient was referred for bleeding and supuration around her implant #36 with deep peri-implant pocket (≥7 mm.) and circumferantial bone loss. Phase I therapy with adjunctive use of combined antibiotics was performed with proper oral hygiene instructions. During surgical phase, after mechanical debridement and chemical decontamination with 3% H_2O_2, the circumferantial bone defect was filled with T-PRF firmly, and the defect area was covered with an additional T-PRF membrane. The flap was sutured and the patient recalled 10 days later.

Results

The healing period was uneventful. The one year clinical results indicated the resolution of peri-implantitis lesion. There were no pathologic probing depth, bleeding on probing and suppuration. Additionally the radioopaque area that refered new bone formation at defect area was observed.



Baseline

1 year follow-up

Discussion

Several surgical approaches are used to treat peri-implantitis. T-PRF, as an autologous material, has an encouraging regenerative potential for hard tissues. The efficacy of the described method needs further investigations.

İnönü University
Faculty of Dentistry

RECOVERY OF ROOT SURFACE WITH FREE GINGIVAL GRAFT: CASE REPORT

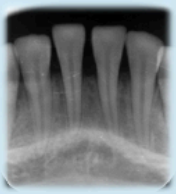
Semih Akgül[1], Mustafa Özay Uslu[1], Ömer Alperen Kırmızıgül[1]

[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

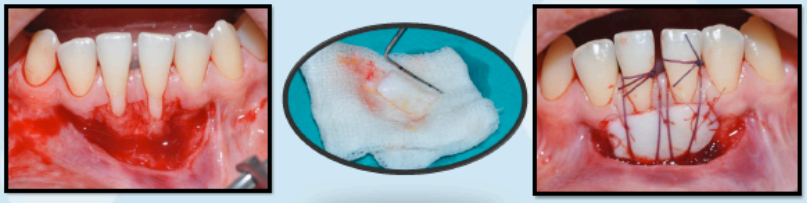
✓ **Introduction:** For the gingival recession,free gingival graft is a predictable technique for increasing the amount of attached gingiva and root coverage. Maxillary frena may jeopardize the gingival health, due to an interference in the plaque control or a muscle pull. In this case report, treatment with localized gingival recession with free gingival graft and maxillary frenectomy prosedure was presented.

✓ **Material and Methods** : A 22-year-old female patient admitted to our clinic with dentin sensitivity and aesthetic complaints. Dental Miller Class- III gingival recession was detected in the intraoral examination performed mandibular central teeth. No mobility was present and no evidence of parafunctional oral habits could be ascertained. Following inspection, maxillary frenectomy planned. After the frenectomy free gingival graft was obtained by traditional technique, the graft was fixed using 7-0 suture. Operation was completed using 5-0 suture. The operation area was allowed to heal with periodontal dressing.

İnitial clinic view



Periapical radiograph



Clinical appearence during surgery

Postoperative clinic view

Postoperative 6th month

✓ **Results:** Postoperative healing both maxillar anterior and mandibular anterior area was nice. After the treatment, it was observed that the gingival retraction was satisfactory.

✓ **Discussion:** Different surgical approaches have been reported to be successful in treating gingival recession. Free gingival autograft has been utilized routinely in the past and has proven to be a predictable mucogingival procedure for the treatment of several mucogingival problems.

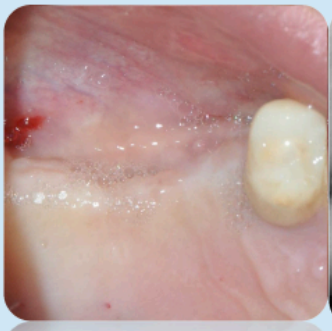
İnönü University
Faculty of Dentistry

INCREASE OF ATTACHED GINGIVA WIDTH AROUND THE IMPLANT: A CASE REPORT

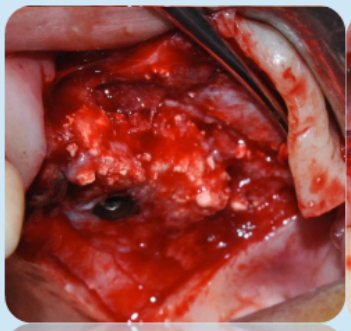
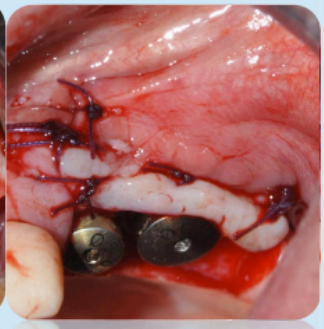
[1]Mehmet Kızıltoprak ,[1]Şeydanur Dengizek Eltas ,[1]Abubekir Eltas
[1]Inonu University, Faculty of Dentistry, Department of Periodontology, Malatya, Turkey

Introduction

Prevention of infection in implant surrounding tissues is essential for long-term success of implant. This is achievable with adequate attached gingiva. In this case report, treatment of mobile mucosa around the implants with apical positional flap was presented.




Initial clinical and radiographic view

Clinical view during the surgery

Materials and Methods

A 50-year-old systemically healthy male was referred to our clinic with complaint for edentulous at the left posterior maxilla. In clinical and radiological evaluations, it was determined bone level was insufficient for implant surgery. Block graft application planned. Six months after the block grafting, two implants were implanted in this region and waited three months for osseointegration. In the course of fitting the healing caps, the full thickness flap was removed with an incision made from the palatinal of the crest. After fitting the healing caps, the flap was sutured to apical position on the buccal surface of the implants.


Postoperative view at 8 months

Results

The amount of attached gingiva around the implant was successfully increased. Performing this procedure during the healing cap application, increase the patient comfort, because of a second additional surgery is not required.

Discussion

There are many methods in the literature to increase the attached gingiva. The apical positional flap is one of these. This case , shows the success of this method.

Sinus Augmentation Using Ultrasonic Piezoelectric Vibration and Repositioning Bony Window

Mert BÜLTE, DDS, PhD[1], Mehmet Baturalp ÇAPRAZ, DDS[1]

1. Mustafa Kemal Universty, Faculty of Dentistry, Department of Oral and Maxillofacial Surgery

INTRODUCTION

In the edentulous posterior maxilla, the presence of the maxillary sinus often limits the available bone height for implant placement. Sinus floor elevation by the lateral window technique is being used to overcome vertical deficiency of atrophic posterior maxilla.
Even though the lateral window technique has been considered to be a predictable method for sinus augmentation a 'Golden Standart' is yet to be determined.
Piezoelectric surgery might spare soft tissues and be helpful to avoid damage to vascular components and tear of sinus membrane. Piezo-surgery also enables 'beveld osteotomies' and makes it possible to replace bony window back to it's original position. This repositioning reduces need of membrane and provides additional osteinduction.

Fig. 1: Severly Atrophic Posterior Maxilla

Fig. 2: Bony Window Prepared

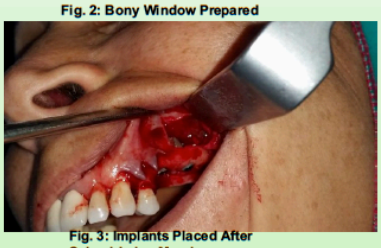


Fig. 3: Implants Placed After Schneiderian Membrane Dissected

Materials and Methods

Surgical Technique

Surgical procedure was performed according to description of Prof. Dr. Dong Seok Sohn (1). Surgery was performed under local anesthesia through maxillary block anesthesia by using 2% articaine (ultracaine forte) that included 0,012 mg/ml epinephrine.
The basic surgical procedure in all patients consisted of maxillary sinus floor elevation via a lateral approach. The lateral wall of the maxillary sinus was exposed after the elevation of a mucoperiosteal flap, Piezosurgery (Synthes) with a thin blade saw (Synthes), was used with saline irrigation to create the lateral window of the maxillary sinus. The anterior vertical osteotomy was made 2 mm distal to the anterior vertical wall of the maxillary sinus, and the distal osteotomy was made approximately 20 mm away from the anterior vertical osteotomy. The height of the vertical osteotomy was approximately 10 mm. The bony window was detached carefully to expose the sinus membrane after completion of the osteotomy in the lateral wall of the maxillary sinus.
After elevation of the sinus membrane superiorly and placement of the graft material, the bony window was repositioned over the graft material as a barrier. This osteotomy design facilitated the precise repositioning of the bony window as a barrier over the bone graft in the maxillary sinus.

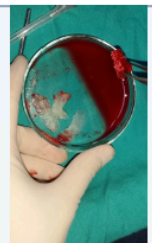


Fig. 4: Enriched Bone Matrix Graft and CGF Membranes

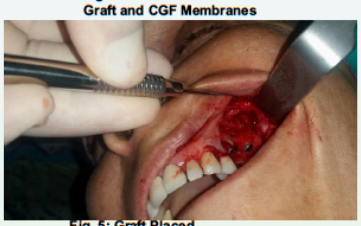


Fig. 5: Graft Placed

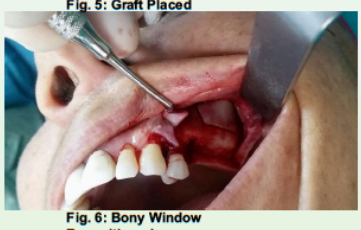


Fig. 6: Bony Window Repositioned

DISCUSSION

Maxillary sinus membrane perforation is the most common complication of sinus augmentations and has been shown to cause postoperative complications and endanger the survival of endosseous implants.(2,3)
Very careful management while creating bony windows and dissecting sinus membrane from the floor of the maxillary sinus are required to reduce the incidence of membrane perforation. In the present case the effects of piezoelectric saw for the creation of lateral windows might have reduced the risk of perforation of the maxillary sinus membrane.
The piezoelectric saw insert has some advantages, such as precision, minimal bone loss, and facilitation of precise replacement of the bony window (1). In the this patient, the lateral bony window was repositioned after bone grafting. The barrier membrane between graft materials and the overlying soft tissue is necessary to prevent growth of fibrous connective tissue in the augmented space.(4)
The repositioned bony window acts as a homologous barrier over the bone graft. As a barrier, the homologous bony window is free from viral crosscontamination of animal or human origin, and precise adaptation of the lateral bony window completely prevents soft tissue ingrowth. The lateral bony window made by the piezoelectric saw insert was repositioned precisely, whether or not bone grafts were used in the sinus for sinus augmentation, because of the tilted osteotomy into the sinus and minimal bone loss during osteotomy.
The bony window also acts as an osteoinductive/osteoconductive substrate in the maxillary sinus in the grafted/nongrafted sinus.(5) The use of the piezoelectric device makes it possible to create a lateral bony window without injury to the intraosseous artery because of its microvibrations and selective cutting (1).

REFERENCES

1)Dong-Seok Sohn, DDS, PhD1/Jee-Won Moon, DDS2/Hyun-Woo Lee, DDS3/ Byung-Ju Choi, DDS, PhD4/Im-Hee Shin, PhD5

2) Proussaefs P, Lozada J, Kim J, Rohrer MD. Repair of the perforated sinus membrane with a resorbable collagen membrane: A human study. Int J Oral Maxillofac Implants 2004;19:413–420.

3) Misch CE. Contemporary Implant Dentistry. St Louis: Mosby, 1999:469–508.

4) Wallace SS, Froum SJ. Effect of maxillary sinus augmentation on the survival of endosseous dental implants: A systematic review. Ann Periodontol 2003;8:328–343.
5) Sohn DS, Lee JS, Ahn MR, Shin HI. New bone formation in the maxillary sinus without bone grafts. Implant Dent 2008;17: 321–331.

Autologue Fibrin Glue as a Stabilizator for Particulate Graft

Mert BÜLTE, DDS, PhD[1], Mehmet Baturalp ÇAPRAZ, DDS[1]

1. Mustafa Kemal Universty, Faculty of Dentistry, Department of Oral and Maxillofacial Surgery

INTRODUCTION

Implant supported dental restorations have become a major option in the treatment of edentulous alveolar ridge for the past several decades. However extensive loss of alveolar bone presents a complex challenge for reconstruction prior to implant placement. Numerous augmentation techniques are currently in use to create sufficient bone volume for reliable placement of endosseous implants in severely resorbed edentulous alveolar ridges. To correct such deficiencies, a clinician has to utilize ridge augmentation techniques such as guided bone regeneration, ridge splitting, distraction osteogenesis, block grafts, and sinus lift procedures. Autogenous bone graft is presently regarded as being the golden standard, however allografts, xenografts, and bone substitutes of human, bovine or synthetic origin are used alone or in combination with autogenous bone or blood. Bloc grafts are structurally stable however block bone becomes necrotic after the grafting procedure and to survive it needs to regain its vascular supply by means of creeping substitution. Particulated grafts are suitable for packing into defects. Compared to the cortical graft it regains its normal biological properties faster. However to avoid migration of graft material into the surgical site and to maintain space titanium meshes, titanium screws, pins or titanium reinforced membranes are often needed.
A relatively new concept of 'Autologous Concentrated Growth Factors Enriched Bone Graft Matrix' enables clinican to mold the graft material by means of biological polymerization and stabilize to recipent bed without using complex hardware.

Fig. 1: Defect Site

Fig. 2: Centrifugal Device

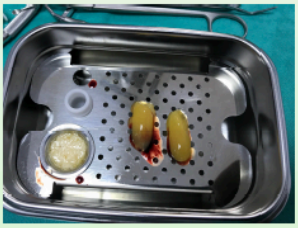


Fig. 3: Concentrated CGF

Fig. 4: Enriched Bone Matrix Graft

Materials and Methods

Technique

CGF membrane and autologous fibrin glue (AFG) to make Enriched Bone Graft Matrix (also known as sticky bone) is prepared at the same time. For an alveolar augmentation usually 20-60 cc of patient's venous blood is taken from patient's vein in patient's forearm. The blood is divided to one non-coated vacutainer (white cap) to obtain autologous fibrin glue (AFG), which will make sticky bone and 2-7 glass coated test tubes (red cap) without anticoagulants to obtain CGF layer.
All vacutaniers are centrifuged at 2400-2700 rpm using specific centrifuge (Medifuge, Silfradent srl, Sofia, Italy) with a rotor turning at alternated and controlled speed for 2 minutes. Than white cap vacutainers are removed to obtain AFG and remaining red cap vacutainers are centrifuged for additional 10 minutes to obtain CGF.
The non-coated tube shows 2 different layers. The upper layer is autologous fibrin glue (AFG) layer and red blood cell is collected in bottom layer which will be is discarded. The vacant slot is filled with water filled test tube for weight balance and continued centrifugation to prepare CGF. After centrifugation, silica coated tube shows three different layers. The most upper layer is platelet poor plasma, and the middle layer is fibrin buffy coat layer represented by a very large and dense polymerised fibrin block containing the concentrated growth factors. The bottom layer is red blood cell layer (1).
CGF is taken in test tube and placed in the metal storage box and compress with metal cover to convert to CGF membrane. The upper AFG is obtained with syringe and mixed with particulate bone particulates and allows for 5-10 minutes for polymerization in order to produce Enriched Bone Graft Matrix (sticky bone) which is yellow colored.
For acceleration of polymerization of AFG, exudate taken in the bottom of metal storage box after compression of CGF layer is added when AFG and particulate bone graft is mixed. The exudate contains growth factors and autologous thrombin in RBC layer, therefore auto-polymerization will be completed very rapidly. The sticky bone mixed with autologous thrombin in RBC layer shows red in color.

Fig. 5: Withdrawal of Autologue Fibrin Glue

Fig. 6: Defect Side Grafted

Fig. 7: CGF Membrane Placed

Fig. 8: Sutured

DISCUSSION

Platelets are known to release high quantities of growth factors such as platelet-derived growth factor (PDGF), transforming growth factor-b1 (TGF-b1) and b2 (TGF-b2), fibroblast growth factor (FGF), vascular endothelial growth fac-tor (VEGF), and insulin-like growth factor (IGF), which stimulate cell proliferation, matrix remodeling, and angiogenesis (2).
Several techniques to collect platelet aggregate have been utilized to accelerate tissue healing in dental and medical field (3-7). Choukron's PRF and Sacco's CGF are recently developed platelet aggregation. Unlike PRF using constant centrifugation, CGF utilize altered centrifugation speed from 2,400-2,700 rpm to isolate much larger, denser and richer in growth factors enriched fibrin matrix.(8)
For successful GBR, stability of bone graft, space maintenance, angiogenesis, and tension free primary suture are essential(9-10). Space maintenance with particulate bone graft should be provided during healing period. However particulate bone graft is easily migrated when grafted on the large horizontal/vertical bone defect. To reconstruct large one or two wall bony defect or for the 3-dimensional ridge augmentation, bone tack on the collagen membrane or titanium mesh is required to contain particulate bone graft during healing but these procedures are surgically time consuming and technique sensitive. In addition, the early exposure of titanium mesh causes bone loss and infection which causes failure of bone augmentation(11-12). For solid space maintenance in the severely atrophic alveolar ridge, block bone graft procedure is widely accepted but this technique has several disadvantages such as early exposure of bone graft, neurosensory disturbance, increased patient's postoperative discomfort and surgical cost, delayed surgical time and additional surgery from donor site(13-14).
As alternative to titanium mesh or block bone procedure, sticky bone was introduced in 2010 by Donk-Seok Sohn. Enriched Bone Graft Matrix (sticky bone) is biologically solidified bone graft which is entrapped in fibrin network. This sticky bone doesn't migrate even shaking it thanks to strongly inter-linked fibrin network, so the bone loss on the defect during healing period is minimized without use of bone tack or titanium mesh.

REFERENCES

1) Dong-Seok Sohn, DDS, PhD1 • Bingchen Huang, MD, PhD2 • Jin Kim, DDS, MS3 W. Eric Park, DDS4 Charles C. Park DDS5
2) Intini G. The use of platelet-rich plasma in bone reconstruction therapy. Biomaterials. 2009;30:4956–4966.
3) Marx RE, Carlson ER, Eichstaedt RM, et al. Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 1998;85(6):638-646.
4) Anitua E, Orive G, Pla R, Roman P, Serrano V, Andia I. The effects of PRGF on bone regeneration and on titanium implant osseointegration in goats: a histologic and histomorphometric study. J Biomed Mater Res A. 2009;91(1):198-185.
5) Plachokova AS, Nikolidakis D, Mulder J, et al. Effect of platelet-rich plasma on bone regeneration in dentistry: a systematic review. Clin Oral Implants Res. 2008;19(6):539-545.
6) Dohan DM, Choukroun J, Diss A, Dohan SL, Dohan AJ, Mouhyi J, Gogly B. Platelet-rich fibrin (PRF): a second-generation platelet concentrate. Part II: technological concepts and evolution. Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 2006;101(3):e37-44.
7) Corigliano M., Sacco L., Baldoni E. CGF-una proposta terapeutica per la medicina rigenerativa. Odontoiatria n°1-anno XXIX- maggio 2010, 69-81.
8) Rodella LF, Favero G, Boninsegna R, et al. Growth factors, CD34 positive cells, and fibrin network analysis in concentrated growth factors fraction. Microsc Res Tech. 2011;74(8):772-777.
9) Wang HL, Boyapati L. "PASS" principles for predictable bone regeneration. Implant Dent. 2006;15(1):8-17.
10) Wang HL1, Al-Shammari K. HVC ridge deficiency classification: a therapeutically oriented classification. Int J Periodontics Restorative Dent. 2002;22(4):335-343.
11) Rasia-dal Polo M, Poli PP, Rancitelli D, Beretta M, Maiorana C. Alveolar ridge reconstruction with titanium meshes: a systematic review of the literature. Med Oral Patol Oral Cir Bucal. 2014;1;19(6):e539-4535
12) Lizio G, Corinaldesi G, Marchetti C. Alveolar ridge reconstruction with titanium mesh: a three-dimensional evaluation of factors affecting bone augmentation. Int J Oral Maxillofac Implants. 2014;29(6):1354-1363.
13) Nkenke E, Neukam FW. Autogenous bone harvesting and grafting in advanced jaw resorption: morbidity, resorption and implant survival. Eur J Oral Implantol. 2014 Summer;7 Suppl 2:S203-217.
14) Aloy-Prósper A, Peñarrocha-Oltra D, Peñarrocha-Diago MA, Peñarrocha-Diago M. The outcome of intraoral onlay block bone grafts on alveolar ridge augmentations: A systematic review. Med Oral Patol Oral Cir Bucal. 2015;1;20(2):e251-258.

POSTER SUNUMLARI

5-6-7 Ekim 2017 Bodrum Rixos Otel'de yapılmış olan Bone Sempozyum'da aşağıda isimleri listelenmiş kitapçıkta sunumları yer alan hekimler poster sunumlarını sergilemiş ve poster kurulu tarafından yapılan seçimde

Dr Taner Arabacı 'nın

Titanium-Prepared Platelet Rich Fibrin Provides Advantages on Periodontal Healing: A Randomized Split Mouth Clinical Study

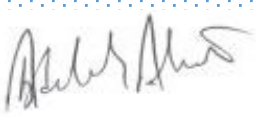
Poster sunumu birinci seçilmiş , ödüle layık görülmüştür.

POSTER SUNUM KATILIMCI LİSTESİ

Dr Mert Bülte
Dr Mesut Tuzlalı
Dr Mehmet Baturalp Çapraz
Dr Mehmet Kızıltoprak
Dr Abubekir Eltas
Dr Semih Akgül
Dr Mustafa Özay Uslu
Dr Gülbahar Ustaoğlu
Dr Mustafa Karaca
Dr Kerem Çağlar Gümüş
Dr Taner Arabacı
Dr Mehmet Cihan Şengün
Dr Ayşegül Sarı
Dr Arife Çiçek

PROF.DR
ASLAN YAŞAR GÖKBUGET

DOÇ.DR
ABDULLAH AKMAN



DR ALİ ARİF
ÖZZEYBEK

Bone Symposium 2017

ÖDÜLLER + RISK

KONUŞMACILAR

- PROF. DR. CHARLES KHOURY
- PROF. DR. HOMA ZADEH
- PROF. DR. GEORGE ROMANOS
- PROF. DR. DIEGO VELASQUEZ
- PROF. DR. HECTOR SARMIENTO
- PROF. DR. TIZIANO TESTORI
- PROF. DR. JOSE CARLOS ROSA
- PROF. DR. MARIUS STEIGMANN

MEFFERT İMPLANT ENSTİTÜSÜ

BONE SEMPOZYUMU

BODRUM-**RIXOS**
5-8 Ekim 2017

Merhaba

www.meffertimplant.com

Prof. Dr. Aslan Y. Gökbuget
SEMPOZYUM BAŞKANI
MEFFERT İMPLANT ENSTİTÜSÜ
ONURSAL BAŞKANI

Değerli Meslektaşlarım,

Uzun yıllardır ülkemizde temel ve ileri implant eğitimi programları gerçekleştirmiş olan Meffert İmplant Enstitüsü bu kez yine ülkemizde bir "ilk" e imza atmaya hazırlanıyor. "Bone Symposium". Herşeyden önce Meffert implant enstitüsünü 20 yıldır tavissiz ve amatör bir hevesle bu eğitim programlarını gerçekleştirdiği için kutlamak istiyorum. İkinci kutlamam ise uzun yıllardan beri implantoloji ile ilgilenen ve kongrelerine gerek konuşmacı gerekse dinleyici olarak katılmış bir meslektaşınız olarak enstitünün bu kadar seçkin konuşmacıyı bir araya getirmesinden dolayıdır.

Bunların dışında ülkemizin en güzel beldelerinden bir tanesi olan Bodrumun en seçkin otellerinden birinde yaza veda etme şansı da yakalamış olacağız.

Bodrum Rixos otelde "Bone Symposium'da" görüşmek üzere.

Merhaba

www.meffertimplant.com

Dr. Ali Arif Özzeybek
MEFFERT İMPLANT
ENSTİTÜSÜ BAŞKANI

Sayin Meslektaşlarim,

Sizleri Meffert Enstitüsünün 2017 Kemik Sempozyumu'na davet ediyorum. Bu benzersiz program dünyadaki 8 usta klinisyenin sert ve yumuşak doku greftleme protokollerini en uygun şekilde paylaşmalarını içerecektir. Her konusmacının sunumları 2 saat olacak.

Bu sempozyum hem başlangıç seviyesindeki hemde klinik olarak ilgili ve kanıta dayali bilgiler ile greft prosedürleri üzerindeki bilgilerini geliştirmek isteyen ileri seviye hekimler içindir.

Bu sempozyum sert ve yumuşak doku greft ile tüm çeneden tek dise rehabilitasyonları hem bilimsel hem de klinik yönlerinden ele alınacaktır.

MEFFERT İMPLANT ENSTİTÜSÜ
EĞİTİM - ARAŞTIRMA- KALİTE

SEMPOZYUM BAŞKANI
Prof. Dr. Aslan Y. Gökbuget

BİLİMSEL KOMİTE
Prof. Dr. Aslan Gökbuget
Prof. Dr. Ata Anıl
Dr. Ali Arif Özzeybek

POSTER SUNUM KOMİTESİ
Yrd. Doç. Dr. Barış Güncü
Doç. Dr. Abdullah Akman

SOSYAL KOMİTE
Dr. Ali Osman Emiroğlu
Dr. Sonay Gökhan
Dr. Ekin Yapıcı

SERGİ KORDİNATÖRÜ
Adem Şahin

Web :www.meffertimplant.com
E-mail :adem@meffertimplant.com
Facebook: /meffertimplant
Cep: 05414273631
Tel-Fax : 90 312 427 36 31

PROF. DR. CHARLES KHOURY

6 EKIM 2017

8:30-10:00

1988' de Beyrut'ta St. Joseph Universitesinden Diş Hekimligi diplomasını aldı.
1989 dan beri: St. Joseph Üniversitensin'de Asistan ve Uzman Asistan Profesor,
1999'dan beri Beyrut'ta German Centre of Implant Dentistry'nin direktörü,
1996: Endodonti'de yüksek öğrenim diploması, Beyrut St. Joseph Üniversitesi,
1999: Prostodonti'de yüksek öğrenim diploması, Beyrut St. Joseph Üniversitesi,
2002: Implant Diş Hekimliği University diploması, Claude Bernard Üniversitesi Lyon, Fransa,
2004'ten beri Dubai'de Dentine Kliniginde Oral Cerrah: Kemik greftleri, dental implantlar, diş transplantasyonu, komplike gömülü dişler,
2006'dan beri: Almanya Muester Üniversitesi'nde implant yüzey özellikleri üzerine deneysel çalışmalar,
2008: Oral Tip ve Implantoloji Uzmanlığı, Almanya Muester Üniversitesi,
Bir kac Uluslararasi Yayin,
Kemik greftleri, Implantoloji, Endodonti ve Prostodonti üzerine uluslararası kurslar vermektedir.

- *2004'ten beri IDEA - Advanced Continuing Dental Education*
- *Almanya Zahnarzt Olsberg, Privatzahnklinik Schloss Schellenstein www.implantologieklinik.de/*
- *Fransa, İspanya, Güney Kore, Yunanistan, Turkiye, Misir'da egitimler vermistir.*

Minimal İnvazivden Major Alveoler Kemik Rekonstruksuyonuna Kadar Otojen Greftlemenin Biyolojik Konsepti

Otojenik, allojenik ve alloplastik veya yönlendirilmiş kemik rejenerasyonu gibi farklı teknik ve materyaller alveolar kretteki kemik defektlerinin rekonstruksuyonunda tavsiye edilmektedir. Fakat, otojen kemigin üstünlüğü biyolojik, immunolojik, yasal sebepler ve hatta tedavi süresi göz önüne alındığında defalarca gösterilmiştir. Patofizyolojik olarak tum otojen kemik kaynakları benzer değildir. Daha iyi bir prognoz ve tahmin edilebilir sonuçlar için kemiğin biyolojik olarak yeniden değişimi konseptine dayanan bir teknik greftleme esnasında yeterli kanlanmayı sağlamak amacı ile kullanilarak greftin dogru vaskulerizasyonu garanti altına alınmalıdır.

Öğrenilecekler

Bu sunumda mandibuler donor bölgelerin farklılıkları gösterilip, özel cerrahi enstrumanlar ile minimal invazivden daha geniş çapli kemik elde edim teknikleri ile otojen kemik greftlemesinin yeni "Biyolojik Konsepti" tartışılacaktir.

PROF. DR. HOMA ZADEH

6 EKIM 2017

10:30-12:30

Dr. Zadeh , Southern California (USC) Üniversitesi Herman Ostrow Diş Hekimliği fakültesinde, Associate Professör ve post-doctoral periodontoloji programı direktörüdür ve American Board of Periodontoloji diplomat üyesidir. Dr. Zadeh, dds ünvanını USC Ostrow Diş Hekimliği Fakültesinden almıştır. Aynı zamanda University Connecticut Üniversitesi Dental Medicine and Medicine Okullarında Periyodontoloji ileri klinik eğitmini tamamlamış ve immunoloji alanında PhD derecesini almaya hak kazanmıştır. Dr. Zadeh klinik ve bilimsel uzman olarak uluslaraarası olarak tanınmaktadır. Klinik ilgi alanları estetikten, doku mühendisliği de dahil olmak üzere mimimal invasive periyodontal ve implant cerrahiye kadar uzanmaktadır. Dr. Zadeh, USC'de Immunoregulation ve doku mühendisliği Laboratuarını (LITE) yönetmektedir ve dental implantların sonuçları olarak klinik vakalar da dahil olmak üzere sağlıklı/hastalıklı durumlar altında kemik regulasyonu ve doku rejenerasyonu/yıkımı üzerine temel mekanizmalar üzerine çalışmalar yapmaya kendini adamıştır. Kitap bölümleri de dahil olmak üzere çok geniş alanda bir çok yayını vardır. Son altı yıldır etkinliği olan USC-Taiwan Comprehensive Surgical and Restorative Implant Training Program da dahil olmak üzere, şuan 41 inci yıllık toplantısını düzenleyen USC International Periodontal and Implant Symposium direktörüdür.
American Academy of Periodontology (AAP), Academy of Osseointegration (AO), American Academy of Esthetic Dentistry (AAED) and American Association for Dental Research (AADR) 'de aktif üyedir. Dr. Zadeh aynı zamanda güney Kaliforniyada Periyodontolojiyle sınırlı olmak üzere part-time muayenehanecilik yapmaktadır.

Peri-Implant Yumuşak Doku Yönetimi Implant Çevresinde Keratinize Sert Doku Gerekli mi?

Peri-Implant kemik uzun zamandır implant sağlığının idamesinde en önemli faktör olarak düşünülmektedir. Peri-implant yumuşak doku ise çoğunlukla implant destekli restorasyonların estetik yönüyle ilişkilendiriliyordu. Fakat, son çalışmlar ideal kalite ve kalınlıktaki peri-implant mukozanin peri-implant dokulardaki enflamasyon kontrolu ve kemik stabilitesi ile uzun dönemdeki sağlığı üzerindeki etkisinin önemini göstermektedir. Bu sebeple implant tedavisi öncesinde özellikle yumuşak doku miktar ve kalitesinin detaylı olarak incelenmesi ve risk değerlendirilmesi yapılması gerekmektedir. Yumuşak doku ogmentasyonu ihtiyacına karar verilmesine yardımcı bir tablo gösterilecektir.

Öğrenilecekler

Sunum sonunda katılımcılar bu konularda bilgi sahibi olurlar
- Peri-implant yumuşak doku biyotipinin önemi ve keratinize mukoza
- Yumuşak doku ihtiyacına olup olmadığına karar verme.
- Yumuşak doku ogmentasyonunda farklı teknik ve materyaller.

PROF. DR. GEORGE ROMANOS

6 EKIM 2017

13:45 -15:45

New York's Stony Brook Ünivesitesi Diş Hekimliği Fakültesi'nde Periodontoloji Profesöru; Johann, Wolfgang Goethe Üniversitesi'nde Oral Cerrahi ve Implantoloji Profesörü, Periodontoloji, Prostodonti ve Oral Cerrahi Üzerine Almanya ve New York'da egitim görmüştür;
Almanya'da Oral Cerrahi ve Implantoloji üzerine sertifikalidir. Roachester Üniversitesinden Periodontoloji sertifikalıdır.
2012-2014 Stony Brook Üniversitesi Diş Hekimliği Fakültesi Klinik İşler Dekan Yardımcısı,
2007-2012 Rochester Üniversitesi Klinik Diş Hekimliği Profesörü,
2004-2007 NYUCD'de Lazer Bilimleri profesör ve direktörü,
New York ve Avrupa'da diş hekimliği lisanslı. Academy of Osseointegration, Int. College of Dentists, ICOI, ITI Foundation, American Society for Laser Medicine and Surgery ve International Academy for Dental Facial Esthetics topluluklarında Fellowship sahibi.
Journal of Periodontology, Int. J Oral Maxillofacial Implants, Clinical Implant Dent Related Res, J Prosthodontics, Odontology (Associate Editor), Photomedicine Laser Surgery, Materials, Quintessence Int, Compendium, Int. J Dent ve diğer birçok dergide editöryel kurul üyeligi. 350'den fazla yayın. 5 kitabın yazarı, 45'den fazla ülkede 800'ün üstünde sunum ve birçok bilimsel kurulda üyelik ve yöneticilik.

Sert Doku Augmentasyon Gelismeler ve Dişhekimligindeki Komplikasyon Yonetimi

Kemik ogmentasyonları kullanılan greft materyaline ve yüksek kalite membranların stabilitesine bağlı olarak farklı başarı ve rezorpsiyon seviyelerine sahip olan son teknoloji cerrahi prosedürlerdir. Bu derste kemik stabilitesi ile yönlendirilmis kemik rejenerasyonu tekniğinin uygulanisini ve greft uygulanmış kemiğin rezorpsiyonunu kontrol altına almak için protokol ve seçenekler tartışılacaktır. İmplant diş hekimliginde krestal kemik kaybina bağlı olarak gelişen komplikasyonlar sunulacak ve implant çevresinde kemik kaybının yönetimi ve uzun dönem implant hayatta kalımı üzerine vurgu yapılacaktır.

Öğrenilecekler

Graft materyallerinin biyolojisini daha iyi seviyede öğrenmek. Krestal kemik stabilitesini sağlamak için teknikler, Periimplantitis tedavi seçenekleri.

PROF. DR. DIEGO VELASQUEZ

6 EKIM 2017

16:15-18:15

Dr.Diego Velásquez, DDS, MSD , Kolombiya Pontificia Üniversitesi Javeriana Diş Hekimliği Fakültesi mezunudur. Rotary Kurumu elçilik bursu ile Indiana Üniversitesi Diş Hekimliği Fakültesinde Prostodonti ve Dental materyaller üzerine postdoctoral eğitimini tamamlamıştır ve aynı zaamnda Diş Hekimliği biliminde master derecesini almıştır. San Antonio' da Teksas Sağlık Bilimleri merkezi Universitesinde Periodontoloji eğitimini tamamlamıştır.
Dr. Velasquez Fenton, Michigan Üniversitesi Diş Hekimliği fakültesinde Profesör olarak görev yapmaktadır. American Board of Periodontology diplomat üyesidir ve halen Journal of Periodontology, Clinical Advances in Periodontics' de heyet üyesidir ve The International Journal of Periodontics and Restorative Dentistry'de danışmandır. Yurtiçi ve yutdışında bir çok konferans vermiştir ve prostodonti, periyodontoloji ve dental implantlarla ilgili konularda birçok yayını vardır.
Dr. Velasquez, American Academy of Periodontology Kurumunun, "Dr. and Mrs. Gerald M. Kramer Scholarship for Excellence" ödülünü almıştır. Birçok farklı kapasitede liderlik konumunda görev yapan bir çok profesyonel dernekte aktif olarak çalışmaktadır.

Tahmin Edilebilir Kollajen Temelli Yumuşak ve Sert Doku Greft Alternatifleri: Güncelleme

Gelecekteki implant tedavisine hazırlık olarak çekim sonrası farklı biyomateryallerin asimile olması tetiklenerek kemik ve yumuşak dokunun iyileşmesinin geliştirilmesi.

Öğrenilecekler

1- Tum biyomateryaller aynı değildir. Farkli materyaller farklı koşullar altında daha iyi sonuçlar doğururlar. Bu konseptlerin anlaşılması ve uygulaması üzerine bir değerlendirme.
2- Defekt seçimi, cerrahi teknik rehberleri, tedaviyi destekleyen sonuç ve araştırmalar katılımcılarla paylaşilacaktır.

PROF. DR. HECTOR SARMIENTO

7 EKIM 2017

08:30 - 10:00

Eğitim
2006 D.M.D. Universidad Cuauhtemoc (Mexico)
Mezuniyet sonrası eğitim ve görevler:
2006 Universidad Cuauhtemoc (Meksika) Prostodonti Fellowship üyeliği,
2008 Loma Linda Üniversitesi Cerrahi /Protez İmplant Diş Hekimliği,
2009 ISSSTE Hospital (Meksika) Maksillofasiyal Cerrahi,
2011 Rochester Üniversitesi Genel Diş Hekimliği (AEGD) ileri eğitim,
2013 Pensilvanya Üniversitesi Ağrı yönetimi,
2014 Pensilvanya Üniversitesi Periodontoloji,
2014 Pensilvanya Üniversitesi Oral Biyoloji Masteri,
2014 J Morita, Irvine, Ca Klinik Laser Eğitimi,
Faculty Appointments:
2011- 2014 Pensilvanya Üniversitesi Periodontal öğretim görevlisi,
2011- 2014 Pensilvanya Üniversitesi Predoktoral Klinik öğretim görevlisi,
2014- 2015 Pensilvanya Üniversitesi Postdoktoral Klinik öğretim görevlisi,
2015- Pensilvanya Üniversitesi Postdoktoral Klinik Profesörü,
2016- ISSSTE Hastanesi Maxillofasyial & Rekontruktif Cerrahi Anabilim Dalı Profesörlük,
İş Deneyimi :
2006-2010 Sarmiento Dental Private Practice (Guadalajara),
2007-2010 Sarmiento Dental Private Practice (Tijuana) ,
2014-2015 Dr. Stuart Froum, DDS, PC Private Practice (New York New York),
2015- Pollack Periodontal Associates Private Practice (New York New York).

Perimplantitisin Anlaşılması ve Sınıflaması

Peri-implant kemik seviyesi patolojik ve patolojik olmayan koşullardan etkilenir. Peri-implant hastalıklar son yıllarda daha iyi anlaşılmıştır. Birçok yayın peri-implant hastalıları şiddetine göre sınıflandırmıştır, etiyoloji mevcut sınıflandırmalarda dikkate alınmamıştır. Bu sunumun hedefi peri-imlantitise sebep oabilecek birçok etiyolojiyi ve risk faktörünü değerlendirmektir. Tartışmada temel olarak bakteriyel, kalmış sement, komşu dokulardaki patolojiler, iyatrojenik faktörler ve keratinize gingivanın eksikliğinden kaynaklanan peri-implantitisi içeren beş kategorili sınıflandırma esas alınacaktır.

Öğrenilecekler

Peri-implantitisin etiyolojisini ve tedavi sonuçlarını anlama, hastalıkların ana sebeplerini ayırt etmek için beş kategorili sınıflandırmanın sunulması.

PROF. DR. TIZIANO TESTORI

7 EKIM 2017

10:30 - 12:30

İtalya Milan Universitesinden 1984'de diş hekimi ve 1986 yılında Ortodonti uzmanı ünvanını almıştır. Loma Linda CA Loma Linda Üniversitesi, 1991'de , Diş Hekimliği Fakültesi Oral ve Maksillo-Fasiyal Cerrahi Anabilim Dalı , Fellowship üyeliği, Miami FL Miami Üniversitesi Tip Fakültesi 2000'de Oral ve Maksillo-Fasiyal Cerrahi Bölümü (Head: Robert E. Marx, DDS), Fellowship üyeliği almistir. Halen, Italya Milan'da Milan Üniversitesi, IRCCS, Galeazzi Enstitüsünde, Biomedikal, Cerrahi ve Diş Hekimliği Bilimleri Anabilim Dalı Baskani , İmplant Diş Hekimliği ve Oral Rehabilitasyon Bölüm Başkanı. İtalya Milan'da Milan Üniversitesi Diş Hekimliği Fakültesin de Profesor olarak gorev yapmaktadir.
Oral Cerrahi ve İmplantoloji (SICOI) İtalyan Topluluğu eski başkanı (2007 – 2008) CE programları için İtalyan Sağlık Bakanlığı Komitesinde Oral Cerrahi and İmplant Diş Hekimliği alanında hakemlik , Oral Health Grubunda , eleştirmen, European Board of Oral Surgery (EFOSS) aktif üyelik birçok dergide ve kitapta editörlük yapmıştır. 2007 International Journal of Oral and Maxillofacial Implants (IJOMI)' da yayınlanan en iyi makale William R. Laney Ödülü sahibi . PubMed indeksden 101 uzerin de atif da bulunulmustur. 2017-2018 yilin da Italyan Academy of Osseintegration Topluluğunun Başkanı olacak(IAO).

Çagdas Sinus Cerrahisi ve Tedavideki Alternatifler Posterior Maksilla Atrofisinin Çagdas Tedavisi

Bu sunumda dental implantlarla birlikte uygulanan sinüs ogmantasyonlarının klinik başarısı ve sonuçları tartışılacaktır. Aynı zamanda piezo cerrahi ve geleneksel yöntemlerde yapılan cerrahi kıyaslanacaktır. Sinüs agmantasyonlarında değişik greft materyalleri, membranlar ve greftleme teknikleri de vakalar üzerinde irdelenecektir. Sinüs ogmantasyonlarında greflemeyle birlikte implantların aynı seansta nasıl yerleştirildiği kanıta dayalı olarak değerlendirilecektir. Yöntemin başarısı bakımından klinik, radyografik ve histolojik bulgular ve alternatif tedavi yöntemleride ayrıntılı olarak tartışılacaktır.

Öğrenilecekler

- Komplikasyonları önlemek ve en iyi sonuçları elde etmek için gerekli cerrahi anatomi.
- Doğru cerrahi öncesi planlama.
- Adım adım cerrahi teknik.
- Greft materyali seçimi.
- Adım adım protetik teknikler.

PROF. DR. JOSE CARLOS ROSA

7 EKIM 2017

13:30 - 15:30

- Dishekimligi Fakultesi - Federal University of Santa Maria –BRAZIL - 1988,
- Periodontoloji Uzerine Uzmanlik Kursu, São Paulo Association of Dental Surgeons – Brazil, 1991,
- Prostodonti Uzerine Uzmanlik Kursu, Center of Dental Research São Leopoldo MandicBrazil, 2003,
- Prostodonti Mastiri, Center of Dental Research São Leopoldo Mandic --Brazil, 2005,
- Oral Implantoloji Doktorasi, Center of Dental Research São Leopoldo Mandic – Brazil, 2013,
- "Immediate Dentoalveolar Restoration - Immediately loaded implants in compromised sockets" kitabinin yazari.
- Caxias do Sul/RS Brezilya'da ozel muayenehane sahibi.

Immediat Detoalveolar Restorastyon (IDR) - Defektli Alveolar Soketlerde (Immediate) Yüklenen Implantlar - Adım Adım Teknik ve Kemik Biyolojisi

Estetik bölgede tek dişin değiştirilmesi dental implantların yerleştirilmesi endikasyonlarından en sık rastlanınlardandır. Kemik kaybı ve diş eti çekilmesi gibi defektli durumlar farklı klinik seçimleri ortaya çıkabilir. Immediat Dentoalveoalar Restorasyon (IDR) tek tek dişleri immediate yükleyebilme endikasyonlarını genişletmek için oluşturulmuş bir tekniktir. Bu şekilde farkli doku eksiklikleri implant yerleştirilmesi ile aynı cerrahide ve geçici kron yerleştirilmesi sırasında giderilerek randevu sayısı azaltılır ve estetik tahmin edilebilirlik arttirilir. Ders sırasında bilimsel altyapı, adım adım uygulama, endikasyon ve kemik morfolojisi üzerinde duracağız. Koruyucu cerrahi teknikleri, flepsiz prosedürler ile IDR teknigi tekrarlanabilir ve geçerli bir alternatif oluşturmaktadır. Ayrıca, ilgili dişte alveolar kortikal kemik defektleri olan ve dişeti çekilmesi ile veya dişeti çekilmesi olmadan seyreden bazıları 10 yil takip süreleri olan vakaları röntgen ve tomografi görüntüleri ile sunacağiz.

Öğrenilecekler

1. Bu kurs çekim soketine yaklaşımlarını iyileştirmek isteyen klinisyenler için tasarlanmıştır.
2. IDR tekniğinin temellerini, teknik ve endikasyonlarini anlamak.
3. Kortiko - kanseloz - greflerin kullanımı, alveolar - defektin tamamen düzeltilmesi ve uçlu greft kullanımı.
4. Ideal Kuron çıkış profili.
5. Implant destekli restorasyonlarda modern konseptler.

PROF. DR. MARIUS STEIGMANN

7 EKIM 2017

15:45 - 17:45

• Michigan Üniversitesi Periodontolji Anabilim Dalın da • Boston Üniversitesi, Oral and Maksillofasiyal cerrahi bolumun de, Pensilvanya Üniversitesi Endodonti Anabilimdalın da Profesor olarak gorev yapmaktadir • Bucharest Üniversitesi "Carol Davila " onur profesörü, • Szeged Diş Hekimliği fakültesi davetli profesör • Temeschburg. İmplantoloji bölümü davetli professor olarak da gorev yapmaktadir • Dr.Steigmann çok geniş sayıda konferanslar vermekte ve yayınlar yapmaktadır Birçok farklı kurum ve kuruluşa üyeliği vardır (DGOI, FIZ veBDIZ). diğer Avrupa topluluklarında diplomat üyeliği vardır, DGOI üyeliği vardır Dr. Steigmann aynı zamanda Budapeşte Üniversitesi oral and maksillofasiyal cerrahi bölümünden "Semmelweiss" nişanı almıştır. • Dr. Steigmann 2005 yılında Neumarkt Üniversitesinden Phd derecesini almıştır. • 2002-2012 "Update Implantoloji Heidelberg" Kurucu ve bilimsel başkanı • "Steigmann Institute" kurucu ve direktörü • Dr. Steigmann halen Almanya Neckargemünd'de muaynehanecilik yapmaya devam etmektedir.

İmplant Cerrahisinde Riski Azaltıp Estetiği Geliştirme ve Diş ve İmplantların Çevresindeki Yumusak Dokunun Estetik Tedavisi

Klinik olarak immediat veya geçikmeli implant yerleştirilmesi sonrasında doğal gingival estetik sağlamak çok zor bir görevdir. Implant cerrahisi sırasında yumuşak dokunun stabilitesi implant bölgesi ve komşu dişler için özellikle greft uygulaması gerekli ise çok önemlidir. Estetik bölgede, karmasık vakalarda büyük yumuşak doku manipulasyonlari gerektiğinde yeni insizyon metodları, farklı flep tasarımları ve dikişler gerekli olmaktadır. Bu derste yumuşak dokunun biyotipine göre implantlar için tahmin edilebilir yumuşak doku manipülasyon metodları açıklanacaktır. Yumuşak doku manipülasyonudaki klinik tecrübelerimize dayanarak yumuşak doku cerrahisini değiştirebiliriz.
İyileşme sonrası yapılan geçikmiş implant yerleştirilmesinde ise papillerin ve midfasyal yumuşak dokuların rekostruksuyonunu sağlamak daha da zordur. Böyle durumlarda cerrahi /protetik algoritma gerekli hale gelmektedir. Estetik bölgeye yerleştirilen immediat veya gecikmiş implantların sayısındaki artışla beraber karşımıza papil kaybı ve yumuşak doku çekilmesi gibi komplikasyonlarla karşılaşıyoruz. Bu derste papil yüksekliğini arttırma ve implant çevresindeki yumuşak dokuların çekilmesini düzeltmek için önğörülebilir bir metod yoktur. Bu yüzden de bu gibi vakalarda daha çok tedavi seçenegine ihtiyaç vardır. Yumuşak doku kompleksi yönünden istenen sonuçları planlama aşamasında elde etmek için greft uygulaması ve prostetik uygulamalar kesinlikle gereklidir.

Öğrenilecekler

1. Estetik bolgede çıkıs profilinin önemini anlamak ve doğal yumuşak doku için gereklilikler
2. Implant ve kron arasındaki geçiş bölgesini düzeltmek için cerrahi seçenekleri anlamak
3. İmplant estetiği için doğru iyileşme abutmenti veya geçici kronu seçmek
4. Çok sayıdaki implant cerrahisi ve prostetik tekniğin tedavi akışına aşina olmak
5. Klinisyenler farklı durumlara göre farklı tedavi planları oluşturmayı öğrenecekler
6. Güncel prostetik teknoloji ile implantlar için yumuşak doku rekonstuksiyonunu öğrenecekler
7. Katılımcılar prostetik ve estetik olarak implant konumunu planlayacaklar.

TARTIŞMA

7 EKIM 2017

17:45- 18:30

19:00 GALA YEMEĞİ

- Prof.Dr Homa Zadeh
- Prof.Dr.George Romanos
- Prof.Dr.Tiziano Testori
- Prof.Dr.Jose Carlos Rosa
- Prof.Dr.Marius Steigman
- Prof.Dr.Diego Velasquez
- Prof.Dr.Hector Sarmiento
- Prof.Dr.Charles Khoury

POSTER BİLDİRİ ÖZETİ GENEL KURALLARI

Bildirilerin ingilizce olarak yazılması ve yazım kurallarına uyulması zorunludur. Poster bildirilerde tüm yazarların ad, soyad ve adres detayları açık olarak yer almak zorundadır. Bildiriler giriş, gereçler ve yöntem, sonuçlar ve tartışma olarak düzenlenmelidir. Kısaltmalar ilk yer alışta açıklamalı olarak yer almalıdır. Kaynaklar genel olarak yer almazlar, ancak zorunlu koşullarda birkaç adet yer alabilir. İnsanlar üzerinde yapılan araştırmalar ile ilgili olarak bildirilerin etik kurul onayları kanunlarına uygun olması koşulu aranacaktır. Özetin tamamı, başlık ve yazar adı dahil 250 kelimeyi. Başlık ise en fazla 10 sözcük içermelidir. Yazı karakteri olarak Calibri kullanılmalı ve punto büyüklüğü 10 olmalı ve özetlerin içerisinde tablo, grafik, şekil olmamalıdır.

"Kabul edilen posterlerin bilimsel programda yer alması için sorumlu yazarın 15 Agustos 2017 tarihine kadar sempozyum kayıt yaptırmış olması gereklidir. Symposium kayıt yaptırmayan sorumlu yazarlara ait poster bilimsel programında yer almıyacaktır. 250 kelimeyi aşan özetler komite tarafından kabul edilmeyecektir

Poster Konuları

Yumuşak ve sert doku graft uygulamaların da riskler ve ödüller

Bildirilerin Gönderilmesi

meffert@meffertimplant.com adresine email gönderilecektir. Değerlendirme internet üzerinden araştırmacıların ad / soyad ve kurumları gizli tutularak, bildiri değerlendirme kurulunca yapılacaktır. Bildirilerin değerlendirmeye alınabilmesi için sunu yapacak yazarın kongre kayıt işleminin tamamlanmış olması gerekmektedir. Değerlendirme sonucu tüm bildiri sahiplerine sonuç yazısı olarak gönderilecektir. Bu konuda kongre düzenleme kurulu tam yetkilidir.

"Poster Sunu" olarak kabul edilen bildiriler, Kongre merkezinde oluşturulacak olan Poster Alanı"nda sergilenecek olup; belirtilen tarih ve saatte, oturum başkanları nezaretinde sunulacak ve tartışılacaktır.

Dereceye giren posterler seçilecektir.

KONAKLAMA

RIXOS PREMIUM BODRUM

Rixos Premium Bodrum, 187 bin metrekare alana sahip olup kalite ile mükemmelliği birleştirerek lüksü ve konforu beraberinde sunuyor. Mavi bayraklı denizi , Özel plajı , havuzları, üst düzey konforla donatılmış oda, süit ve villaları, A'la Carte restoranları, barları ve muhteşem SPA'sı ile hayallerinizin ötesinde bir tatil sunuyor.

Lokasyon

- Rixos Premium Bodrum; sahip olduğu benzersiz konumla herkes için harika bir tatil olanağı sunuyor.
- Bodrum merkeze 10 km mesafe.
- Milas - Bodrum Havalimanı'na 25 km mesafe.
- Tarihi, kültürel , doğal güzellikler ve eğlence dünyasına yakınlık.

Konaklama

Ege Denizi'nin huzurlu atmosferinde; güneşin, denizin, eğlencenin, yeme içmenin tadına varacağınız; hafızanızda yer edecek bir tatil Rixos Premium Bodrum'da sizi bekliyor.

GALA YEMEGİ BODRUM TRAFO

Bodrum trafo da yapılacaktır. Gala yemeginde Gizem Berk bizlerle olacaktır. En güzel şarkılarını grubu ile beraber seslendirecek.

2. solo albümü "Elimi Bırakma"yı Nisan 2015'de Ada Müzik etiketiyle yayınlanan Gizem BERK'in, Oğuz Sırmalı ve Cem Adrian ile düetleri de bulunmaktadır.

DİPLOMAT-FELLOW SERTİFİKA TÖRENİ

Gala yemeginde Fellow ve Diplomat üyelige yükselen doktorlara tören ile sertifikaları verilecektir. Fellow ve Diplomatlık sınav için Adem Şahin ile lütfen temasa geçin.

GENEL BİLGİLER

Sempozyum Dili
Sempozyum dili İngilizce ve Türkçe 'dir.

Sıcaklık
Ekim ayında beklenen sıcaklık 28-33°C

Bodrum Havalimani- Rixsos Otel Ulaşim
Bodrum Milas Uluslararas havaalanı ve sempozyum merkezi arasındaki mesafe 25 km uzaklıktadır. Havaalanına arasındaki ulaşım için bodrum tur ile temasa gecebilirsiniz.

ANASPONSOR

NucleOSS™ Dental Implant

SPONSORLAR

T.C. MUĞLA BÜYÜKŞEHİR BELEDİYESİ · ORTOPLAST · OsteoBiol · medipac medical supplies · BODRUM BELEDİYESİ · Duru Dental · GC · Geistlich Biomaterials

KATILIMCI KAYIT BİLGİ FORMU

Tarih: ..... / ...../ .....

Adı Soyadı : .....

Adres : .....

Telefon : ..... **Cep :** ..... **Fax:** .....

E-mail : .....

Ödeme Tutarı (Rakamla) : ..... TL Günlük Kur Üzerinden Çevrilir

Ödeme Tutarı (Yazıyla) : .....

Ödeme Tarihi : .....

VISA ☐ **MASTERCARD** ☐

KART NO ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Son Kullanma Tarihi: **Ay** ☐☐ **Yıl** ☐☐

Güvenlik Kodu: ☐☐☐

Kredi kartı tek çekim ve taksitlendirmede komisyon ilave edilir.

EURO HESAP BİLGİLERİ

AKBANK	Şube Kodu - Adı : 0116 - KAVAKLIDERE/ANKARA
HESAP ADI	MEFFERT İMPLANT ENSTİTÜSÜ DERNEĞİ
Hesap No	0101075
IBAN	TR 5000 0460 0116 0360 0010 1075

TL HESAP BİLGİLERİ

AKBANK	Şube Kodu : 0116 KAVAKLIDERE/ANKARA
HESAP ADI	MEFFERT İMPLANT ENSTİTÜSÜ DERNEĞİ
Hesap No	0100769
IBAN	TR420004600116888000100769

					REFAKATÇİ
İLK	80 kişi için	3 gece konaklama her şey dahil	DUBLE odada kişi başı	450 euro	275 euro
İLK	80 kişi için	3 gece konaklama her şey dahil	SİNGLE odada kişi başı	550 euro	300 euro
İLK	80-160 kişi için	3 gece konaklama her şey dahil	DUBLE odada kişi başı	550 euro	325 euro
İLK	80-160 kişi için	3 gece konaklama her şey dahil	SİNGLE odada kişi başı	650 euro	350 euro
160	kişi sonrasi	3 gece konaklama her şey dahil	DUBLE odada kişi başı	700 euro	425 euro
160	kişi sonrasi	3 gece konaklama her şey dahil	SİNGLE odada kişi başı	750 euro	450 euro

////DOLDU////

PROGRAM ÜCRETİNE DAHİL OLANLAR

- 3 Gece her şey dahil KONAKLAMA
- 5 Ekim giris saat 19.00 da HOŞ GELDİN KOKTEYL
- 6-7 Ekim BİLİMSEL PROGRAM
- 7 Ekim saat 19.00 de GALA YEMEĞİ
- 8 Ekim 12:00 Otel Çıkış
- Simultene Çeviri
- Sertifika

Refakatçiler herşey dahil sistemi ile konaklayacaktır.

FAXLAYINIZ: 0312 427 36 31

ÖDEME BİLGİSİ

Yukarıdaki bilgilerin doğru olduğunu kabul ediyorum.
Eğitim programının yapılması için MEFFERT İMPLANT ENSTİTÜSÜ DERNEĞİ tarafından yukarıda belirtilen bilgiler doğrultusunda bağış kaydedilmesini beyan ederim. Formun aslının faxlanması veya elden teslim edilmiş olması gerekmektedir. Enstitü Programlarda gereklilik durumunda değişiklik yapma hakkına sahiptir. Evrak imzalandığı tarihten itibaren işleme girer iade ve iptaller şu şekildedir.
1 Mayıs 2016 – 1 Haziran 2016 tarihlerinde iptallerde katılım ücretinin %10 iade edilmez.
1 Haziran 2016-1 Temmuz 2016 tarihlerinde iptallerde %20 iade edilmez.
1 Temmuz 2016 dan sonraki kayıtlarda iade ve iptal yapılmaz. Uyumsuzluk halinde Ankara Mahkemeleri selayetindedir.

AD SOYAD **İMZA**

www.meffertimplant.com