



FAQ's

Keyword	What to do, when..... Situational Trouble Shooting	Variables and/or Reasons	Solution A	Solution B	Solution C
<b>Abutment</b>	Cerec is being used for the final crown...what abutments can be used?	Cerec mandates a defined margin of at least 1 mm for it to properly read impression for fabrication of a crown	The Balance Posterior is the only abutment that meets the requirements		
<b>Abutment</b>	DDS/DMD is using the Balance Base abutment and the driver is not engaging the abutment. What is wrong?	The Balance Base system does not use the tradition 1.0mm hex. The hex used is the 1.8mm hex			
<b>Abutment</b>	Standard Abutments were used on a multiple unit case and they do not draw	The abutments must be parallel in order for the bridge to seat	The lab can make reduction copings in order for the DDS/DMD to prepare abutments in mouth to get them to draw	DDS/DMD can remove the abutments and take a fixture level impression and have lab make customized abutments	
<b>Abutment</b>	Impression being taken on standard abutment.....cap will not come off in impression.	The cap is very secure and is manufactured to be precise. It is designed this way for accuracy.	Always try impression cap onto abutment, pull off and place again. This will make the fit a little more passive	Too much light body material used in the impression - may need to use a heavier body impression material	
<b>Abutment</b>	The doctor is trying to remove an abutment and can not get it out of the implant even though the screw is disengaged	The abutment is rigidly connected to the implant through the friction of the tapered cone connection	Take a 1mm hex tool and place it into the abutment. Apply force in a rocking motion back and forth to break the seal between the abutment and the implant	Use an ultrasonic non-cutting tip on the inside of the abutment (where the screw hole is) and use water constantly to cool down the abutment. Make sure you hear a clicking noise to ensure the screw is really engaged	
<b>Abutment</b>	The doctor places a temporary crown on the abutment and the patient gets inflammation and bone loss	There is cement under the crown that did not get removed or the temporary is shaped in such a way as to irritate the tissues	Use a screw retained temporary or use temporary cement and express the excess cement out of the temp before placing it on the abutment. If the shape of the crown is inadequate (mushroom shaped) modify the temporary crown so that it does not irritate the tissues		
<b>Abutment</b>	The doctor cannot remove a sulcus former and says it is just spinning	Most likely, a balance anterior two-piece sulcus former in place and the doctor may not realize that it is two pieces.	A two piece sulcus former will behave differently than a one-piece. Since the center screw does not necessarily release the friction between the connection, it may require hemostats to gently remove the sulcus former after the screw is removed		

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<b>Abutment</b>	Case comes back from the lab and the abutment and crown are several millimeters too high.	The lab most likely did not insert the repositioning post all the way down in the impression prior to pouring the stone model.	Educate the lab on properly placing the repositioning post until it clicks a couple times in the impression material. They should be able to go back to the original impression, properly place the repositioning post/analog and re-pour the case		
<b>Abutment</b>	Abutment torqued down before trying the crown on and the crown has to go back to the lab for recontouring	Contacts were too tight and required too much modification	The abutment should be finger tightened, the external index removed.. try on the crown, then reseal the index and torque the abutment - crown needs to be tried on prior to torquing in the abutment .. index needs to be reseated before torquing to make sure that the abutment does not move	Ultrasonic used to remove the abutment from the fixture	
<b>Abutment</b>	Restoration will not seat, even with good contacts and an accurate index	The tissues were too narrow and would not accept the base of the crown 1mm subgingival	Use a two piece large anterior sulcus former to open the tissues and create a more substantial emergence profile	Seat the abutment, finger tighten only, seat the crown. Have the pt gently bite on a cotton roll to gently seat the crown further. This needs to be done slowly so as not to cause the tissue too much trauma. There should be only slight blanching which subsides quickly	
<b>Fixture</b>	Doctor is torquing the implants into place and the fixture mount comes loose	If the doctor puts too much pressure on the top of the insertion instrument while he is inserting the implant, it can unscrew the fixture mount	Use the other end of the wrench. The other end of the wrench is to be used as a stabilization key. This will reduce friction and help eliminate loosening of the screw holding the fixture mount		
<b>Fixture</b>	Doctor took out the central screw in the two piece anterior and the sulcus former would not come out	Sulcus former had been tightened excessively and tissue was also holding it in place	Use a cavitron and plastic filling instrument - put the flat end of the plastic filling instrument on the sulcus former and touched the other end with the cavitron tip - This will break the seal and the sulcus former can then be removed with cotton pliers		
<b>Fixture</b>	Fixture mount removed - implant was not subcrestally positioned	Verification xray not taken to ensure depth... difficult to re-engage fixture mount on implant once it is in the mouth	Always taken a confirmation radiograph before removing the fixture mount	Screw the cover screw directly onto narrow gap instrument outside the mouth, and then screw it in to the implant, much less cumbersome	

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<i>Fixture</i>	Fixture place - fixture mount being removed - mount screw broke in the implant	The torque on the motor was set too high...25 Ncm maximum - final seating with torque wrench	Can use a Piezotome or a P5 unit with an ultrasonic tip to vibrate fixture mount out like a separated instrument		
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<i>Fixture</i>	Removal of cover screw.... the fixture came out of the osteotomy instead of the cover screw	Absence of primary stability - fixture was not securely engaged in the osteotomy	Fixture rethreaded back into site with cover screw - 3 to 4 months of healing - second stage uncover	Change fixture to next size up - persist with second stage uncover approach	Use standard sulcus former and place within the cover screw...primary closure of the tissues over the former
<i>Impression</i>	Case comes back from the lab and the abutment and crown are several millimeters too high	The lab most likely did not insert the repositioning post all the way down in the impression prior to pouring the stone model	Educate the lab on properly placing the repositioning post until it clicks a couple times in the impression material. They should be able to go back to the original impression, properly place the repositioning post/analog and re-pour the case		
<i>Impression</i>	The doctor sends an impression with the transfer post to the lab and the lab says they can not get the transfer post to seat	It is important to place a little wax over the 1mm hex opening so that impression material won't get inside the transfer coping. If impression material gets inside it can interfere with a positive seat of the impression post	Place wax inside the slot for the 1mm hex drive on the impression post		
<i>Impression</i>	The doctor can not remove the denture after trying to pick up the gold SynCone copings.	The denture is locked into the mouth because acrylic has gotten under the abutments	Use a rubber dam or the rings provided to cover the abutments and prevent the acrylic from flowing under the abutments - if there are undercuts and the acrylic is in place, then the denture will have to be cut off		
<i>Cementation</i>	Irritation in the peri-abutment tissues - cement retention or thin biotype	Thin facial tissue - connective tissue graft to correct deficiency Cement retention - use of Implaplast Temp - an acrylic - retrievable Use of ZnPO4 cements or water soluble cements i.e. TempBond	Film thickness with Temp Bond can lead to open margins. Resin cements are not water soluble nor are they retrievable. Can use lingual venting hole, however, water soluble cements may dissolve - lose retention. Use extra analog for cementation - fill crown with cement and fit to analog outside the mouth..removes excess cement - then cement in the mouth		

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<b>Trouble Shooting</b>	Fractured screw internal hex or precise cone connection (exceedingly rare)	Over-torquing of screw, cantilevering	Ultrasonic P5 tip - utilized at high setting. Rotate the tip counterclockwise. Will remove majority of broken screw cases. If that doesn't work, the CAREFULLY cut a slot in the top of the fractured screw and use a modified slotted driver to remove it. Concern is damage to interior of fixture		
<b>Trouble Shooting</b>	Lost implants in the maxillary sinus is a complication one must know how to retrieve if doing maxillary sinus grafts.	Inadequate fixture diameter	Find out where the implant is using a cacti scan or periapical x-ray and proceed to do a lateral wall entry. Surgical suction will usually grab the implant for easy removal or sometimes fibrous encapsulation may have resulted, so a little tug with a curved hemostat will usually dislodge the implant. Complete the lift or close with membranes		
<b>Trouble Shooting</b>	Sinus augmentation - contributed by Dr. W. Cohen	Considerations	Use of the piezotome is a nice adjunct in performing lateral wall sinus lifts, however, you still have to be careful in dissection of the occlusal and mesial aspects of the sinus membrane. You may need to use more hand instrumentation than expected Perforation of the sinus membrane remains a high probability---piezotomes still can perforate if not careful. For the bleeders you see, use a bovey cautery machine to stop those small bleeds that can block your vision in the site. The flap design must prevent a problem with trauma or sutures getting loose this would expose your membrane and sinus graft. Never place the vertical incision near the sinus site. Go mesial at least one to two more teeth. You will have more relaxation of your flap, more visualization, and less soft issue getting in your way. Lastly, use a Minnesota elevator to hold the flap back---this elevator will enhance your vision. Using PRP helps in micro-bleeds inside the sinus cavity and it will aid in keeping the membrane together. Even with the most careful lifts, there can be micro-tears. PRP helps this and it also extends your graft--- softens it against the delicate membrane. Consider placing a membrane on top of the floor of the sinus.....it aids in compartmentalization of the lift and if there is an undetected tear in the membrane		
<b>Trouble Shooting</b>	Contributed by Kurt Magnus	The loosening of the screw on a fixture mount should be done with a small 1 mm hex. Let's also be clear that I'm talking about the screw on the new fixture mount which tightens briefly again as the screw is pushed simultaneously between the both the implant threads and the pre-mount threads. This should break without excessive force. If the implant has a high insertion torque, I have heard that a 1/8 reverse turn of the implant may be necessary to remove the mount before relieving the tension. We have seen complications in the past, when folks DON'T use the conical reamer....the conical reamer is not optional - EVER.			

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<i>Trouble Shooting</i>	Contributed by Bill Cohen	On occasion, the you will find that the fixture will not seat properly. This occurs with all systems in Type I and II bone. The surgical protocol must be followed to the nth degree. In this type of dense bone, one must back up the implant and go forwards and backwards until final seating. <b>DO NOT OVERTORQUE THESE IMPLANTS - or you will have breakage.</b>			
<i>Trouble Shooting</i>	Contributed by Barry Goldenberg	At this point, there is no UCLA or CAD-CAM abutment available. The CAD-CAM may be available by the end of 2010...probably 2011. We have had to modify the abutments on some occasions. You would not use the Standard but rather the Balance. One simple way is to wax to it, engage the buccal line angles, cast a gold telescope, and cement it to the abutment with a resin cement. Actually, Renzo Casselini published an article on this in Spectrum Dialogue last year. We have done this over the past five years and never a problem. Another solution is to cast a gold telescope and use a horizontal pin to keep it locked in prior to cementing the crown. I guess you could also cast titanium and laser weld although I've never done that..just the first two options. You cannot use the UCLA approach because it would damage the precise connection during investing, casting, and deinvesting. It would also damage the screw which is laser welded on to the shaft. Honestly, there has never been a situation which we could not restore even though lacking those abutments.			
<i>Trouble Shooting</i>	Interesting exchange	<p>Clinical progress report - written by referring dentist - The Ankylos abutment fits well. I had ----- at the lab make a rotational index, as non-indexed implants are a complete pain to work with and I have enough experience to anticipate rotational issues with this system. I used the index to fit the abutment, screwed it in hand-tight, took a PA and dry-fit the crown. All perfect so far. Excellent crown, nice appearance and good snug fit without cement. Upon torquing the implant in tighter, the crown no longer fit. I'm convinced it rotated slightly on torquing. Did I mention that I hate non-indexed implants for single units? I am so glad they are coming out with an indexed version. Of course, the abutment can never be removed once torqued, so the crown's going back to the lab for modification. I'll keep you updated, but Ken, please don't place any more non-indexed Ankylos implants for my patients. They are considerably harder than other systems to deal with prosthetically.</p> <p>Response from Barry Goldenberg - First of all, as Dwayne said once the abutment is placed it CAN be removed. There is no problem with this. I would love to see how the transfer guide was made. As long as your lab encompassed the entire abutment within the resin, it should notmove. Maybe your hand tightness was not as tight as you thought. Did you torque it with or without the transfer guide? I'm sure you will find that the non-indexed implant is not difficult at all. Yes, you can use the indexed version of the abutment now but only on one of the abutments. Be open minded. I assure you that your perceived hassle will be worth it when you look at radiographs down the road.</p>			
<i>Trouble Shooting</i>	Perimplantitis fix - see blog - GOING SOUTH - by Bill Cohen	To address peri-implantitis situation, Bill Cohen wrote - Full flaps buccal lingual verticals total access, removing granulation tissue--plastic instrumentation treatment of the threads (tetracycline is my choice), Emdogain, MFDBA, platelet rich plasma, Bio-oss, and a resorbable membrane. Dwayne Karateew adds - what Bill has written is basically known as the Mellonig protocol which is well established. Bill is adding Emdogain which is utilized a lot around implants. While not cleared for this purpose it is used by many clinicians in this fashion. Traditionally emdogain is utilized to reestablish the entire periodontal complex (three components)...but has the additional benefit of demonstrating an angiogenic potential (in the lit) which is mucho useful...			

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<p><i>Zirconia Abutments</i></p>	<p>Contributed by Dwayne Karateew</p>	<p>Customizing zirconium abutments is a tricky situation. When Zirc is handled incorrectly, it can lead to microfractures in the crystalline structure which are not visible to the naked eye. This may lead to complete fracture of the abutment at a later date. Taking a direct impression of any of the balance anterior abutments is easy. Have a lab pour the models is not easy. Separating the stone or epoxy from the impression after it has set can lead to a breakage of the model. Ideally, the lab will admit to this and inform the doctor. If they don't, and try to repair the model with cyanoacrylate, this can lead to major inaccuracies. One abutment one time sounds good ; however it is much harder to achieve in reality.</p>	<p>Place implant (primary stability) and place abutment - absolutely necessary to note what type of implant was placed, sulcus depth, angulation et al. Make a chairside GC resin coping over the torqued abutment; let it set and trim (you need a solid positive seat). Please resin jig back over the abutment and take a pickup impression. When the impression material is set, remove with the resin jig embedded in impression material. Seat EXACTLY the same abutment with the attached implant analogue back into the resin jig and master pick up impression. Pour with gingival moulage and stone. When set, separate and restore.</p>		
<p><i>Immediate Loading</i></p>	<p>Exchange between Chaz Sandoval and Barry Goldenbergh</p>	<p>Chaz - I recently heard both Drs. Weigl and Abboud discuss immediate load and bone training. Their consensus was 6 weeks tissue former, 6 weeks temporary abutment with no functional load. Dr. Abboude commented that at 3 months, implants were 80% integrated within a reasonable range for individual patients. St. Louis Louis - AKA Barry - Let's start with the esthetic zone. For a single or partially edentulous situation - we try to avoid any loading on the implant provisional crown; in essence, a fancy sulcus former with no occlusion. The tongue, lips, food boli will load it inevitably. Immediate provisional restorations are based upon primary stability having been achieved - while the literature is vague, the implant placement torque can be used as a guide.</p>	<p>We in general wait 12 weeks for final impressions....Dr. Abboud apparently waits 6 weeks.</p> <p>In regard to 1 abutment 1 time - this is okay if you are content with a Standard or Regular abutment and understand the limitations with regard to ceramic crowns because of its feathered margin. If you desire a more esthetic abutment, you may not be able to consider 1 abutment 1 time UNLESS you place the abutment and do NO modification. You can have a composite coping made for a pick up impression and then place another abutment (as there is no analog) within the impression for your final cast. Always have a backup - ie. Essix or RPD if primary stability is not achieved.</p> <p>In general, we go to 1<sup>st</sup> bicusipds for immediate provisionals. Distal to that is a 1 stage or delayed approach unless it's part of a full arch provisional. While provisionalizing multiple implants, they should always be splinted during this phase. This helps primary stability. They may be restored as individual crowns, but not during the provisional phase.</p>		