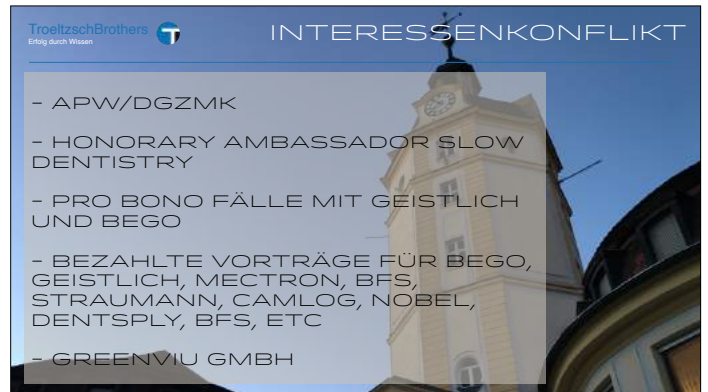
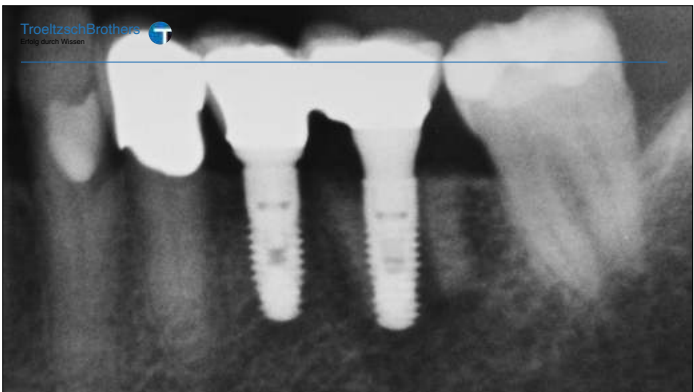
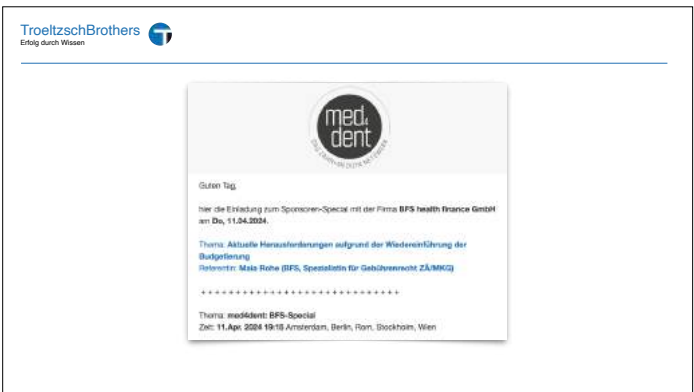
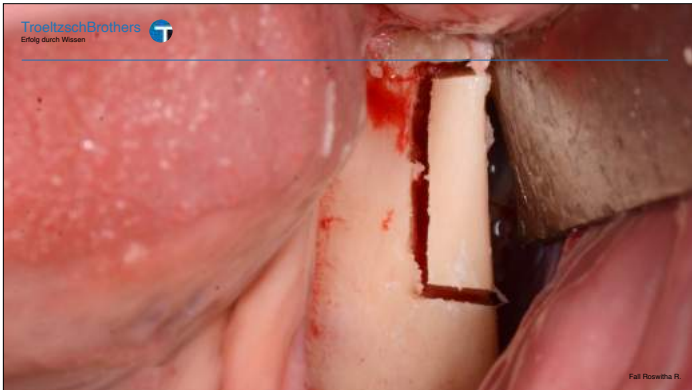
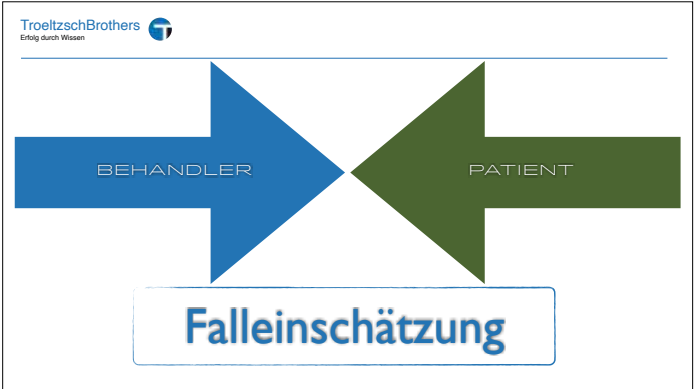
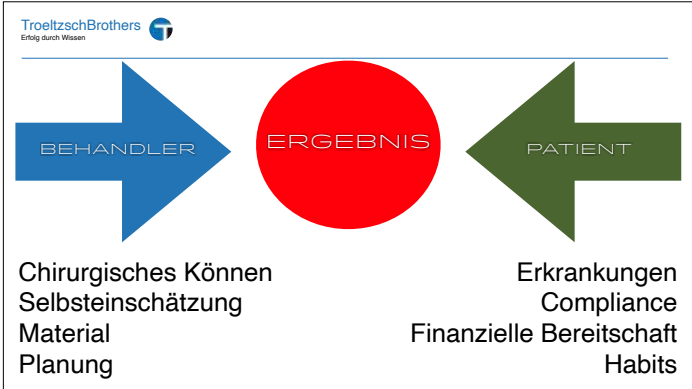
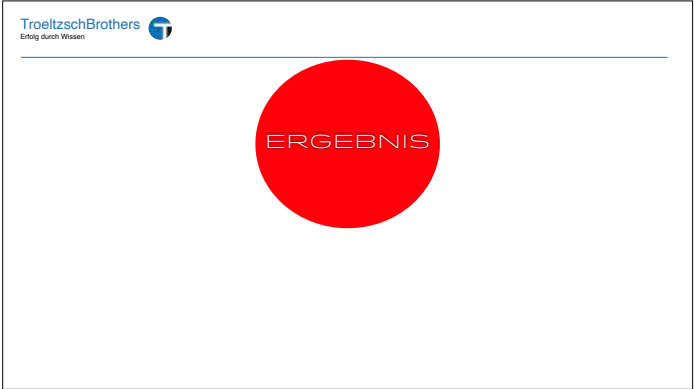
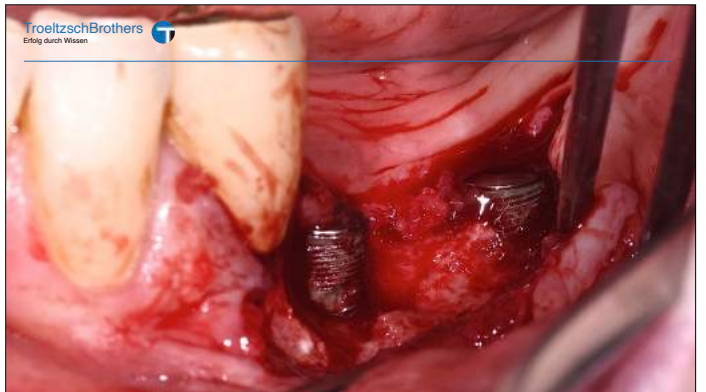
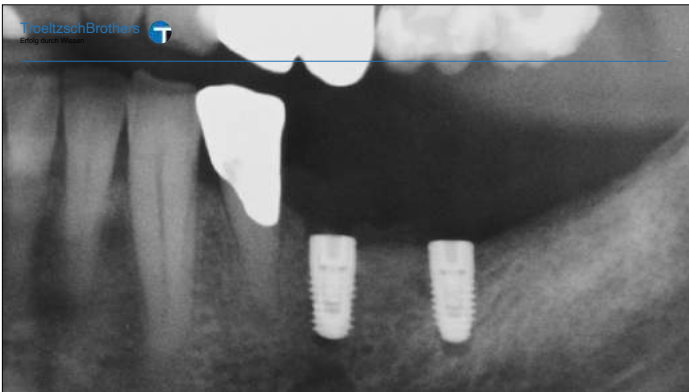
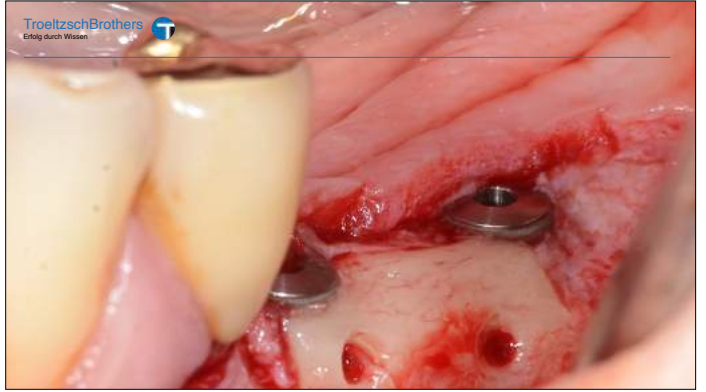






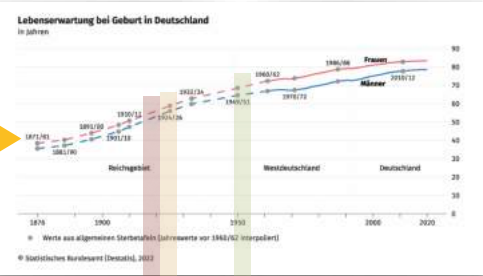




QUANTIFIZIERUNG DES PROBLEMS



https://www.destatis.de/DE/Themen/Querschnitt/Demografischer_Wandel/_inhalt.html



https://www.destatis.de/DE/Themen/Gesellschaft_Umwelt/Bevoelkerung/Statistiken/Lebenserwartung/_inhalt.html#top20094

Deutschliche Lebenserwartung (Periodensterbetafel) Deutschland, Jahre, Geschlecht, Vollendetes Alter															
Sterbetafel Deutschland Deutschliche Lebenserwartung in(x) Jahren															
Geschlecht Vollendetes Alter	2004/06	2005/07	2006/08	2007/09	2008/10	2009/11	2010/12	2011/13	2012/14	2013/15	2014/16	2015/17	2016/18	2017/19	2018/20
männlich															
0 Jahre	76,44	76,69	77,17	77,33	77,51	77,72	77,72	77,86	78,13	78,18	78,21	78,36	78,48	78,61	78,63
10 Jahre	57,24	57,49	57,74	57,90	58,05	58,20	58,24	58,41	58,61	58,69	58,79	58,83	58,90	59,10	59,13
20 Jahre	37,48	37,80	38,10	38,34	38,57	38,80	38,92	39,04	39,24	39,29	39,42	39,45	39,56	39,68	39,69
30 Jahre	28,58	28,75	28,93	29,04	29,16	29,31	29,38	29,38	29,51	29,52	29,62	29,62	29,69	29,77	29,77
40 Jahre	20,77	20,95	21,11	21,22	21,33	21,46	21,46	21,55	21,69	21,71	21,81	21,80	21,87	21,94	21,94
50 Jahre	15,17	15,36	15,55	15,67	15,77	15,88	15,88	15,96	16,09	16,11	16,21	16,20	16,27	16,34	16,34
60 Jahre	10,84	10,95	11,04	11,12	11,20	11,27	11,27	11,34	11,46	11,48	11,56	11,55	11,62	11,69	11,69
70 Jahre	7,24	7,33	7,41	7,47	7,53	7,59	7,59	7,65	7,76	7,77	7,83	7,82	7,88	7,94	7,94
80 Jahre	4,87	4,92	4,97	5,01	5,05	5,09	5,09	5,13	5,23	5,24	5,29	5,28	5,33	5,38	5,38
weiblich															
0 Jahre	82,04	82,25	82,40	82,51	82,59	82,73	82,80	82,88	83,05	83,09	83,20	83,18	83,27	83,38	83,38
10 Jahre	62,14	62,37	62,65	62,97	63,03	63,16	63,22	63,29	63,45	63,46	63,61	63,60	63,67	63,78	63,78
20 Jahre	42,92	43,08	43,20	43,32	43,37	43,50	43,57	43,63	43,77	43,79	43,93	43,92	43,99	44,07	44,07
30 Jahre	34,49	34,61	34,71	34,81	34,85	34,96	35,03	35,07	35,19	35,19	35,32	35,18	35,24	35,31	35,31
40 Jahre	28,18	28,31	28,41	28,52	28,56	28,68	28,74	28,79	28,90	28,90	29,00	28,90	28,99	29,05	29,05
50 Jahre	21,18	21,31	21,41	21,52	21,56	21,68	21,74	21,79	21,90	21,90	22,00	21,90	21,99	22,05	22,05
60 Jahre	15,17	15,36	15,55	15,67	15,77	15,88	15,88	15,96	16,09	16,11	16,21	16,20	16,27	16,34	16,34
70 Jahre	10,84	10,95	11,04	11,12	11,20	11,27	11,27	11,34	11,46	11,48	11,56	11,55	11,62	11,69	11,69
80 Jahre	7,24	7,33	7,41	7,47	7,53	7,59	7,59	7,65	7,76	7,77	7,83	7,82	7,88	7,94	7,94

https://www.destatis.de/DE/Themen/Gesellschaft_Umwelt/Bevoelkerung/Statistiken/Lebenserwartung/_inhalt.html#top20094

BVND BUNDESVERBAND
NIEDERGLIEDERTE
DIABETESKRANKER
E.V.

BUNDESZAHNÄRZTEKAMMER

Pressemitteilung

Wie Diabetes und Parodontitis biologisch zusammenhängen
BVND und SZÄK zum Welt Diabetesstag

Berlin/Heidelberg, 11. November 2022 – Rund 8,5 Millionen Menschen in Deutschland sind an Diabetes mellitus Typ 2 erkrankt. Hinzu kommt eine Dunkelziffer von mindestens 2 Millionen Menschen. An Parodontitis leiden rund 38 Millionen. Biologisch hängen beide Volkskrankheiten zusammen, darauf verweisen der Bundesverband der Niedergelassenen Diabetologen e.V. (BVND) und die Bundeszahnärztekammer (SZÄK) anlässlich des Welt Diabetesstags am 14. November.

https://www.bzsek.de/fileadmin/PDFs/pm22/221111_Diabetestag.pdf

ROBERT KOCH INSTITUT

Gesundheit in Deutschland

Konsequenzen des Alterns

<http://www.gbe-bund.de/pdf/GESBER2015.pdf>

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PMID: [29757930](#)

Andrea V. Fuentes, Moises D. Pineda, and Kalyan C. Nagulapalli Venkata*

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<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6025009>

Peri-implantitis prevalence, incidence rate, and risk factors: A study of electronic health records at a U.S. dental school

Conclusions: Approximately 1/3 of the patients and 1/5 of all implants experienced peri-implantitis. A 4-year/10-dose-designed fixed and cement-retained restorations, and history of periodontitis emerged as the principal risk factors for peri-implantitis.

<https://pubmed.ncbi.nlm.nih.gov/30768875>

doi:10.1371/journal.pone.0190202.g002

Kang-Hyeon Park², Jin-Hyung Park, Su-Geun Kim, Hyun-Jong Kim[illegible]

<https://pubmed.ncbi.nlm.nih.gov/2045225/>

Sites: A Systematic Review

<https://pubmed.ncbi.nlm.nih.gov/27183060>

Alan Lombard ¹, Adrian Al. Iancu ², Wolfgang Sauter ³, Ronald Karg ⁴, Thomas Aebi ⁵,
György R. Szendrői ¹

<https://doi.org/10.1016/j.sbsbs.2019.05.003>

<https://pubmed.ncbi.nlm.nih.gov/3189030/>

1. VERLUSTURSACHEN
2. WELCHE IMPLANTATE SIND NICHT ZU RETTEN
3. SITUATIONSORIENTIERTE STRATEGIEAUSWAHL
4. FAZIT

1. VERLUSTURSACHEN
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3. SITUATIONSORIENTIERTE STRATEGIEAUSWAHL
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Bruxism and dental implant failures: a multilevel mixed effects parametric survival analysis
J Oral Rehabil. 2018 Nov;45(11):1193-1201. doi: 10.1111/jorh.13014. Epub 2018 Sep 9.

Reasons for failures of oral implants.
J Oral Rehabil. 2014 Jun;41(6):443-78. doi: 10.1111/jorh.12157. Epub 2014 Mar 11.

Group 1 ITI Consensus Report: The influence of implant length and design on clinical and patient-reported outcomes.
J Oral Maxillofac Surg. 2018 Oct;76(10):1669-77. doi: 10.1016/j.joms.2018.08.001.

CONCLUSIONS: It is concluded that short implants (56 mm) are a valid option in situations of reduced bone height associated with augmentation procedures; however, they reveal a higher variability and lower predictability in survival implants with diameters of 2.5 mm and more demonstrated no difference in implant survival rates compared to standard diameter implants. It is further concluded that there are no differences between tapered versus non-tapered medications such as selective serotonin reuptake inhibitors and proton pump inhibitors showed an association with

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RISIKOFAKTOREN

Funktion	Medizin	Habits	Chirurg
KFO	PPI & SSRI	Rauchen	Positionierung
Bruxismus	Antiresorptiva & Bestrahlung	Mundhygiene / Karies	Augmentation
Störkontakt	Stoffwechselerkrankungen	Incompliance	Hart und Weichgewebe
	Parodontitis / Periimplantitis		Implantatform und Belastungsform

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Führt SARS-CoV-2 zu Implantatverlusten?

Ergebnisse

Die Infektion führt zu einem signifikanten Anstieg von Implantatverlusten, und zwar zu allen drei untersuchten Zeitpunkten. Die Infektion ist ein Risikofaktor für Implantatverluste, die innerhalb von 30 Tagen nach der Infektion auftreten. Die Infektion ist ein Risikofaktor für Implantatverluste, die innerhalb von 30 Tagen nach der Infektion auftreten.

1. SARS-CoV-2 infiziert die Osteozyten und führt zu einer erhöhten Apoptose von Osteozyten.
2. SARS-CoV-2 führt zu einer erhöhten Apoptose von Osteozyten.
3. SARS-CoV-2 führt zu einer erhöhten Apoptose von Osteozyten.
4. SARS-CoV-2 führt zu einer erhöhten Apoptose von Osteozyten.
5. SARS-CoV-2 führt zu einer erhöhten Apoptose von Osteozyten.

TroeltzschBrothers
Erfolg durch Wissen

Abstract

BACKGROUND: Aggressive periodontitis renders a great challenge to the conventional implant due to the risks of infection and ongoing marginal bone loss (MBL). A study about full-arch immediate implant and restoration in patients with advanced generalized aggressive periodontitis (GAP) was not read, even though the All-on-4 concept has been proven to be predictable for edentulous patients.

PURPOSE: This prospective study aimed to evaluate the feasibility and medium-term outcomes of immediate implant and rehabilitation based on the All-on-4 concept in patients with advanced GAP via clinical and radiographic analyses.

MATERIALS AND METHODS: Seventeen patients (mean age 39.4 years) with advanced GAP received immediate postextraction implant and rehabilitation based on the All-on-4 concept between January 2009 and January 2014. Eighty implants were inserted into 20 arches (7 maxillae and 13 mandibles). The average follow-up duration was 5 years (range 2-7). Complications, probing depth, and plaque, bleeding, and gingiva indices were evaluated. MBL was measured based on the panoramic radiographs taken immediately after surgery and annually thereafter.

RESULTS: The cumulative survival rate (CSR) of the implants was 96.75% (79/80) after an average of 5 years. One tilted implant failed due to peri-implantitis. The average peri-implant MBL was 0.8 ± 0.4 and 1.2 ± 0.3 mm after 1 and 7 years, respectively. The CSR was 100% (20/20) for definite prostheses, while 85% (17/20) for provisional prostheses. The average probing depth, and plaque, bleeding, and gingiva indices at the last recall visit were 3.0 ± 0.5, 1.2 ± 0.4, 0.5 ± 0.5, and 0.4 ± 0.4 mm, respectively. Patient showed high satisfaction to the overall effects.

CONCLUSIONS: Based on this study, the All-on-4 concept provided predictable outcomes in patients with GAP in 2- to 7-year follow-ups, and averted the severe bone defect area of aggressive periodontitis.

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A comprehensive and critical review of dental implant prognosis in periodontally compromised partially edentulous patients.
Karcusius I¹, Katsoulis S, Pourmoussavi L

Objectives: The outcome of implant treatment in periodontally compromised partially edentulous patients has not been completely clarified. Therefore, the aim of the present study was to perform, applying a systematic methodology, a comprehensive and critical review of the prospective studies published in English up to and including August 2006, regarding the short-term (<5 years) and long-term (≥5 years) prognosis of osseointegrated implants placed in periodontally compromised partially edentulous patients.

Material and Methods: Using The National Library Of Medicine and Cochrane Oral Health Group databases, a literature search for articles published up to and including August 2006 was performed. At the first phase of selection the titles and abstracts and at the second phase full papers were screened independently and in duplicate by the three reviewers (I. K. K., S. K., I. F.).

Results: The search provided 2987 potentially relevant titles and abstracts. At the first phase of evaluation, 2966 publications were rejected based on title and abstract. At the second phase, the full text of the remaining 31 publications was retrieved for more detailed evaluation. Finally, 16 prospective studies were selected, including seven short-term and eight long-term studies. Because of considerable discrepancies among these studies, meta-analysis was not performed.

Conclusions: No statistically significant differences in both short-term and long-term implant survival exist between patients with a history of chronic periodontitis and periodontally healthy individuals. Patients with a history of chronic periodontitis may exhibit significantly greater long-term probing pocket depth, peri-implant marginal bone loss and incidence of peri-implantitis compared with periodontally healthy subjects. Even though the short-term implant prognosis for patients treated for aggressive periodontitis is acceptable, on a long-term basis the matter is open to question. Alterations in clinical parameters around implants and teeth in aggressive periodontitis patients may not follow the same pattern, in contrast to what has been reported for chronic periodontitis patients. However, as only three studies comprising patients treated for aggressive periodontitis were selected, more studies, specially designed, are required to evaluate implant prognosis in this subtype of periodontitis. As the selected publications exhibited considerable discrepancies, more studies, uniformly designed, preferably longitudinal, prospective and controlled, would be important.

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J Clin Periodontol. 2008 Sep;35(8 Suppl):282-304. doi: 10.1111/j.1600-051X.2008.01275.x.

Peri-implant diseases: diagnosis and risk indicators.

Heitz-Mayfield LJ¹.

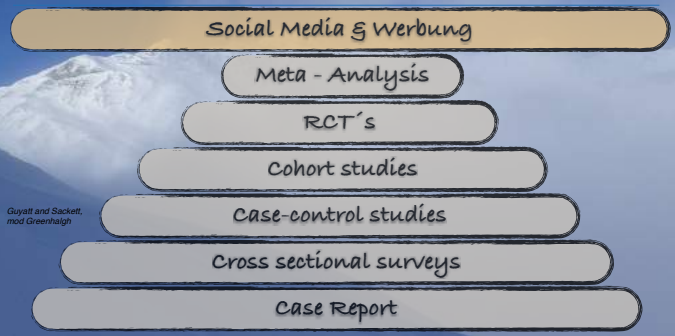
BACKGROUND: Peri-implant diseases include peri-implant mucositis, describing an inflammatory lesion of the peri-implant mucosa, and peri-implantitis, which also includes loss of supporting bone.

METHODS: A literature search of the Medline database (Ovid), up to 21 January 2008 was carried out using a systematic approach, in order to review the evidence for diagnosis and the risk indicators for peri-implant diseases.

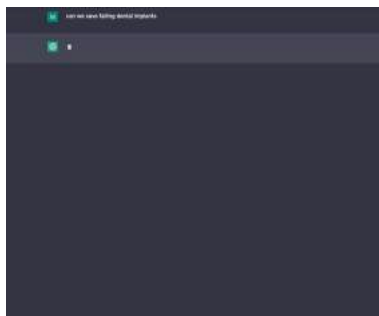
RESULTS: Experimental and clinical studies have identified various diagnostic criteria including probing parameters, radiographic assessment and peri-implant crevicular fluid and saliva analyses. Cross-sectional analyses have investigated potential risk indicators for peri-implant disease including poor oral hygiene, smoking, history of periodontitis, diabetes, genetic traits, alcohol consumption and implant surface. There is evidence that probing using a light force (0.25 N) does not damage the peri-implant tissues and that bleeding on probing (BOP) indicates presence of inflammation in the peri-implant mucosa. The probing depth, the presence of BOP, and suppuration should be assessed regularly for the diagnosis of peri-implant diseases. Radiographs are required to evaluate supporting bone levels around implants. The review identified strong evidence that poor oral hygiene, a history of periodontitis and cigarette smoking, are risk indicators for peri-implant disease. Future prospective studies are required to confirm these factors as true risk factors.



HIERARCHIE DER EVIDENZ



ChatGPT: Optimizing Language Models for Dialogue



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Peer-Review: 100 %
Publ. dental implants: diagnosis, removal and survival of reimplantations.
Journal of Dentistry

Abstract

BACKGROUND: Over time, the percentage of dental implants that fail increases because of biological and technical issues. Inevitably, clinicians will dedicate more time to dealing with ailing and failing dental implants.

METHODS: The authors searched the literature for articles that addressed diagnostic manifestations of failed implants and reasons for their demise, as well as survival rates of dental implant reimplantations.

RESULTS: The authors found that there is no precise cut point (besides 100 percent) with regard to the amount of bone loss in the absence of mobility that indicates an implant has failed. The decision to treat or explant an ailing implant is a judgment call by the treating clinician. Survival rates found in the literature after first and second reimplantations ranged from 71 percent to 100 percent and 50 percent to 100 percent, respectively. The 100 percent findings were based on small groups of implants, and there were scant data addressing implant survival after second reimplantations.

CONCLUSIONS: The decision to remove an implant needs to be based on clinical assessments, radiographic evaluations or both. If the implant is deemed hopeless, there are devices that facilitate their removal. Furthermore, reimplantations can be performed successfully, but their survival rate appears to be lower than that of implants placed at sites from which they were not lost formerly.

PRACTICAL IMPLICATIONS: Ailing dental implants should not be condemned prematurely, because patients often respond to treatment of peri-implantitis. Many patients desire reimplantations in sites in which implants have failed. This procedure is valuable, especially if it makes possible the fabrication of an implant-supported fixed or removable prosthesis.

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Peer-Review: 100 %
Implantitis: Principles of Peri-implantitis: A Systematic Review and Meta-Analysis for Peri-implantitis Diagnosis Proposal.
Journal of Dentistry

Abstract

OBJECTIVES: To review and summarize the literature concerning peri-implantitis diagnostic parameters and to propose guidelines for peri-implantitis diagnosis.

MATERIAL AND METHODS: An electronic literature search was conducted of the MEDLINE (Ovid) and EMBASE databases for articles published between 2011 and 2016. Sequential screening at the title/abstract and full-text levels was performed. Systematic reviews/guidelines of consensus conferences proposing classification or suggesting diagnostic parameters for peri-implantitis in the English language were included. The review was recorded on PROSPERO system with the code CRD42016033287.

RESULTS: The search resulted in 10 articles that met the inclusion criteria. Four were papers from consensus conferences, two recommended diagnostic guidelines, three proposed classification of peri-implantitis, and one suggested an index for implant success. The following parameters were suggested to be used for peri-implantitis diagnosis: pain, mobility, bleeding on probing, probing depth, suppuration/exudate, and radiographic bone loss. In all of the papers, different definitions of peri-implantitis or implant success, as well as different thresholds for the above mentioned clinical and radiographical parameters, were used. Current evidence rationale for the diagnosis of peri-implantitis and classification based on consecutive evaluation of soft-tissue conditions and the amount of bone loss were suggested.

CONCLUSIONS: Currently there is no single uniform definition of peri-implantitis or the parameters that should be used. Rationale for diagnosis and prognosis of peri-implantitis as well as classification of the disease is proposed.

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OPTIONEN

Symptome: Lockerung, Pus - Sekretion, Schmerz auf Belastung

Entscheidung: Mit dem Patienten für / wieder Erhaltversuch

Konsequenz: Wenn kein Erhaltversuch sinnvoll
—> Entfernung mit / ohne Regeneration

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HANDLUNGSOPTIONEN

Nur entfernen

Erhalt des Kieferkammes mit „Ridge Preservation“

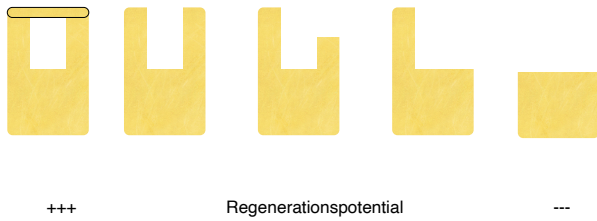
Kieferkamm weiter augmentieren

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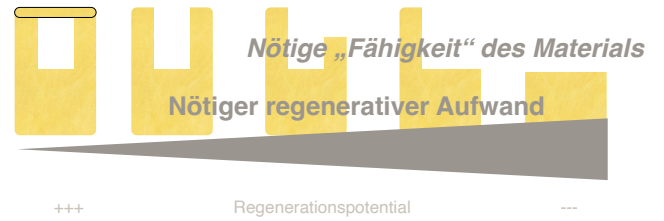
HANDLUNGSOPTIONEN

	Nur entfernen	Kieferkamm erhalten	Kieferkamm augmentieren
Dafür	Schnell, „Billig“, Infektion kann ausheilen	Schnell, moderater Mitteleinsatz	Größtmöglicher Hart- und Weichgewebsgewinn
Dagegen	Hart- und Weichgewebsverlust	Fremdmateriale in Infektion, Größere Defekte können nicht regeneriert werden	Fremdmateriale in Infektion, Planungsaufwand, finanzieller Aufwand
Folge	Alveolarkamm kollabiert	Erhalt der vorhandenen Gewebe kann erreicht werden	Erfolg: Implantierfähiges Lager Misserfolg: Muss nachaugmentiert werden

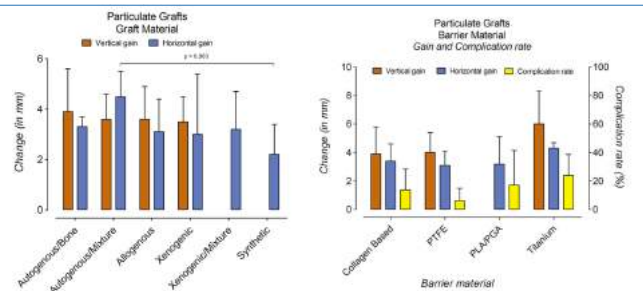
Defekt - Biologie



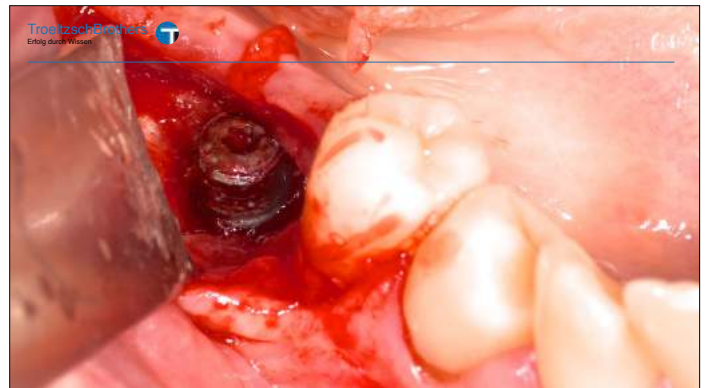
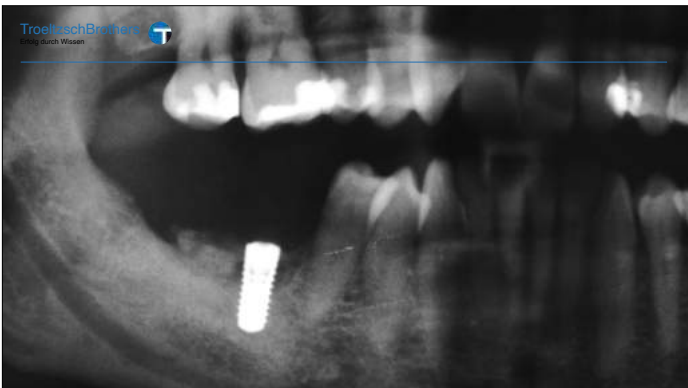
Defekt - Biologie



Defekt - Biologie



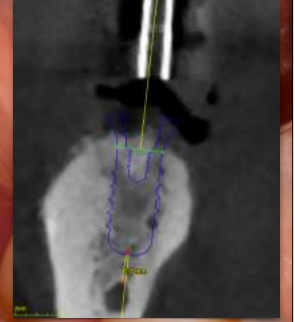
Troeltzsch M. et al., Clinical efficacy of grafting materials in alveolar ridge augmentation: A systematic review, Journal of Cranio-Maxillo-Facial Surgery 2016



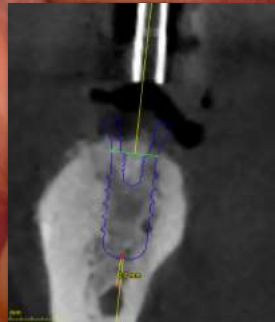
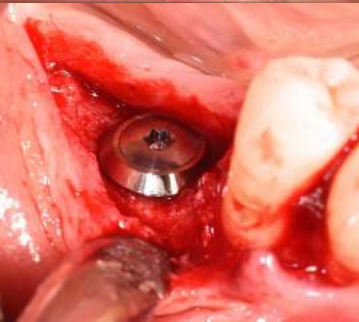




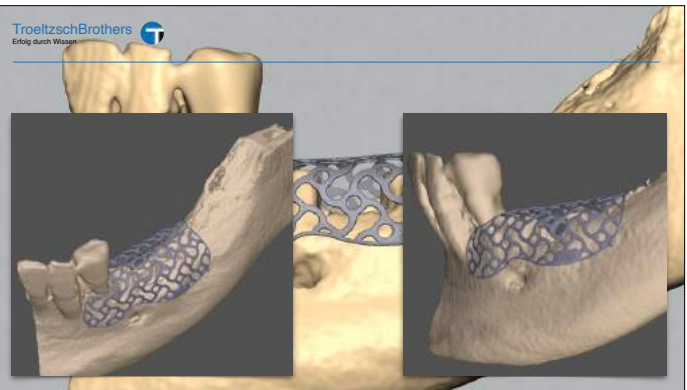
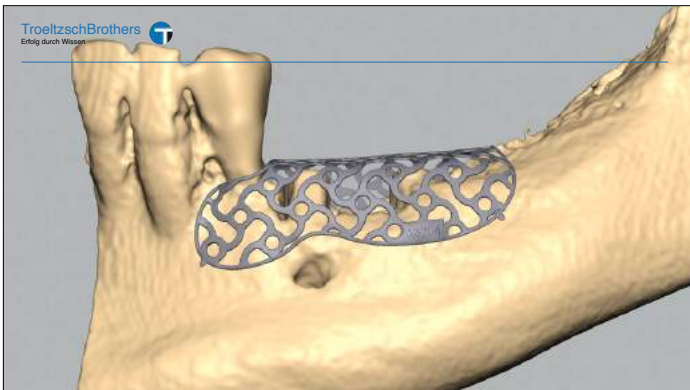
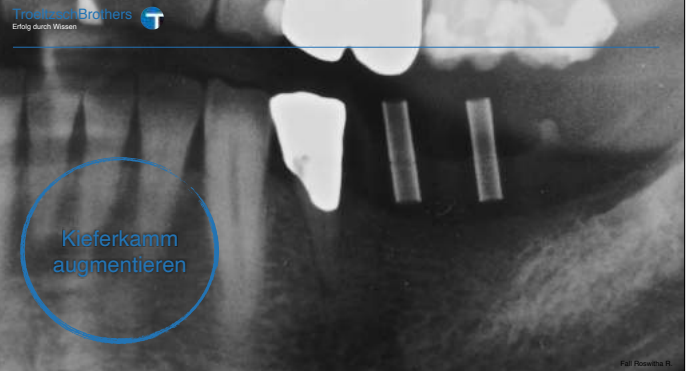
4,8 / 10MM

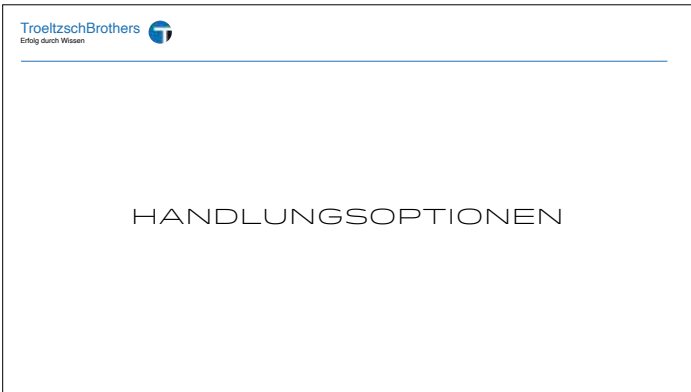
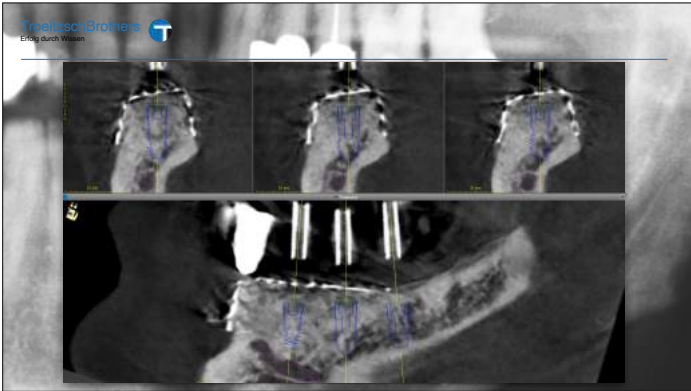


4,8 / 10MM



Kieferkamm
augmentieren





Troeltzsch Brothers
Erfolg durch Wissen



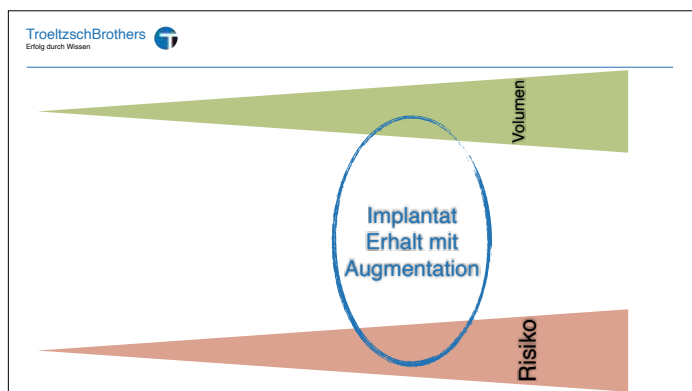
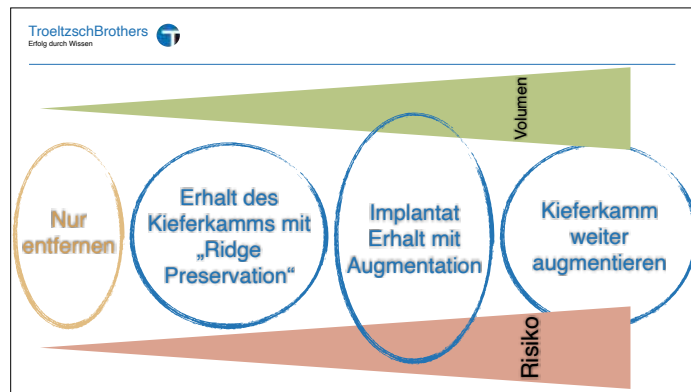


Block + Resorptionsschutz
Insgesamt: 6 Fälle
Leichte Komplikationen: 0
Fehlschläge: 6

Block ohne Resorptionsschutz

2018: über 20 Fälle
Leichte Komplikationen: 1
Fehlschläge: 0





TroeltzschBrothers
Erfolg durch Wissen

diamond burs, polishers, plastic and metal hand instruments, air scaler and air flow devices	Kister et. al, 2017	https://pubmed.ncbi.nlm.nih.gov/2782402/
nonsurgical (mechanical, antiseptic, and antibiotics), surface decontamination (chemical and laser), and surgical (air powder abrasive, resective, and regenerative)	Rokoya et. al, 2020	https://pubmed.ncbi.nlm.nih.gov/3288216/
The current evidence indicates that regenerative approaches to treat peri-implant defects are unpredictable.	Rokoya et. al, 2020	https://pubmed.ncbi.nlm.nih.gov/3288216/

TroeltzschBrothers
Erfolg durch Wissen

Treatment of Peri-implantitis-Electrolytic Cleaning Versus Mechanical and Electrolytic Cleaning-A Randomized Controlled Clinical Trial-Six-Month Results

Schlee et. al, 2020 <https://pubmed.ncbi.nlm.nih.gov/32724424/>

The present randomized clinical trial assesses the six-month outcomes following surgical regenerative therapy of periimplantitis lesions using either an electrolytic method (EC) to remove biofilms or a combination of powder spray and electrolytic method (PEC).

EC needs no further mechanical cleaning by powder spray. Complete re-osseointegration in peri-implantitis cases is possible

TroeltzschBrothers
Erfolg durch Wissen

DEFEKT - BIOLOGIE

A Weichgewebemantel

B Wundheilung

C Augment

D Augment

Autoren:
Markus Troeltzsch
Peer W. Klemmer
Andreas Pöhl
Matthias Troeltzsch
Philipp Kaufmann
Eike Schlegelm
Philipp Bruchmayer
Bliss Al-Nawas

S2k-Leitlinie (Langversion)
Implantologische Indikationen für die Anwendung von Knochenersatzmaterialien
AWMF-Registernummer: 063.009

AWMF
AWMF-Registernummer: 063.009



HANDLUNGSOPTIONEN			
	Nur entfernen	Kieferkamm erhalten	Kieferkamm augmentieren
Dafür	Schnell, „Billig“, Infektion kann ausheilen	Schnell, moderater Mitteleinsatz	Größtmöglicher Hart- und Weichgewebsgewinn
Dagegen	Hart- und Weichgewebsverlust	Fremdmateriale in Infektion, Größere Defekte können nicht regeneriert werden	Fremdmateriale in Infektion, Planungsaufwand, finanzieller Aufwand
Folge	Alveolarkamm kollabiert	Erhalt der vorhandenen Gewebe kann erreicht werden	Erfolg: Implantierfähiges Lager Misserfolg: Muss nachaugmentiert werden

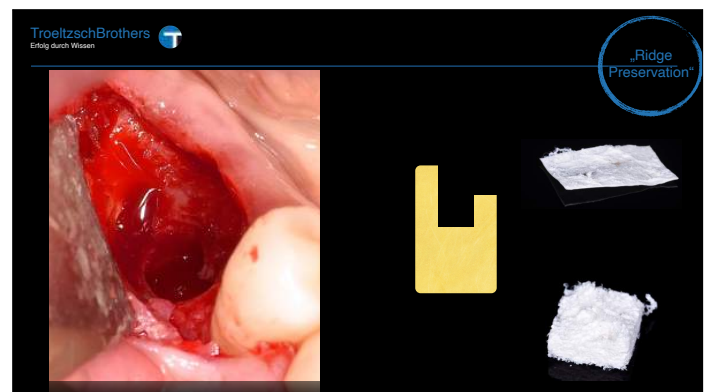
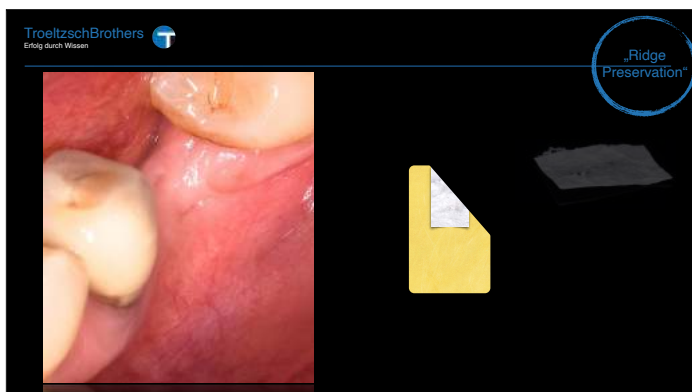
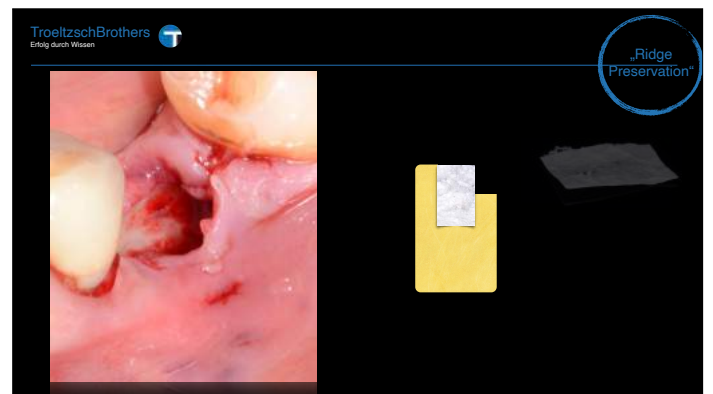
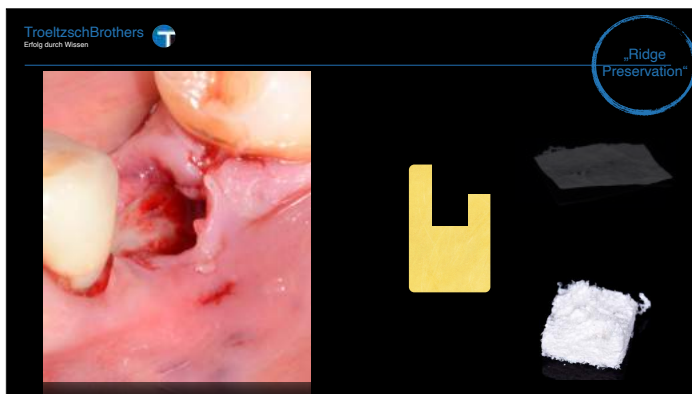
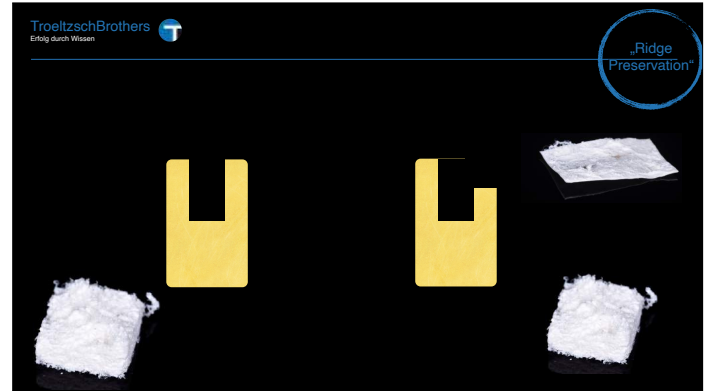
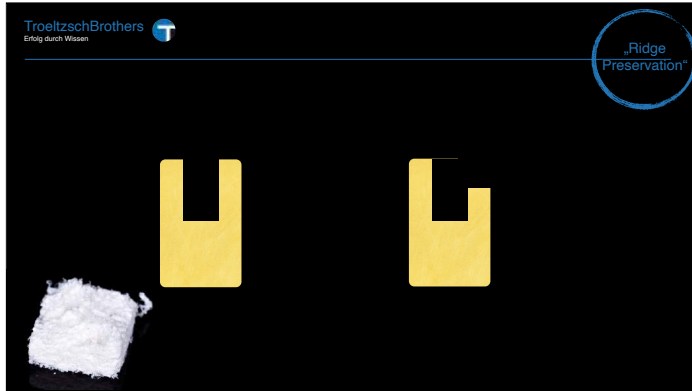
HANDLUNGSOPTIONEN				
	Nur entfernen	Kieferkamm erhalten	Implantatrettung	Kieferkamm augmentieren
Dafür	Schnell, „Billig“, Infektion kann ausheilen	Schnell, moderater Mitteleinsatz	Implantat und Suprakonstruktion können erhalten bleiben	Größtmöglicher Hart- und Weichgewebsgewinn
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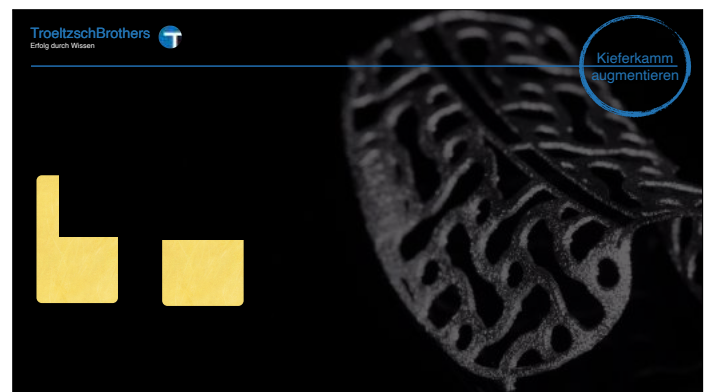
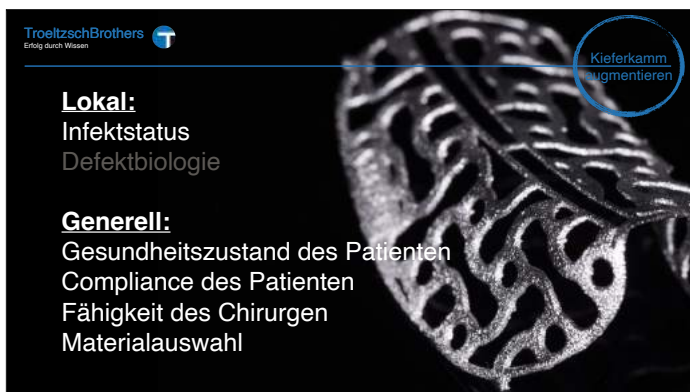
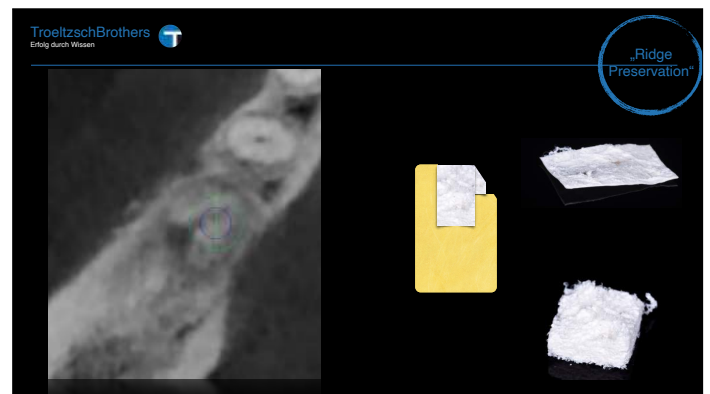
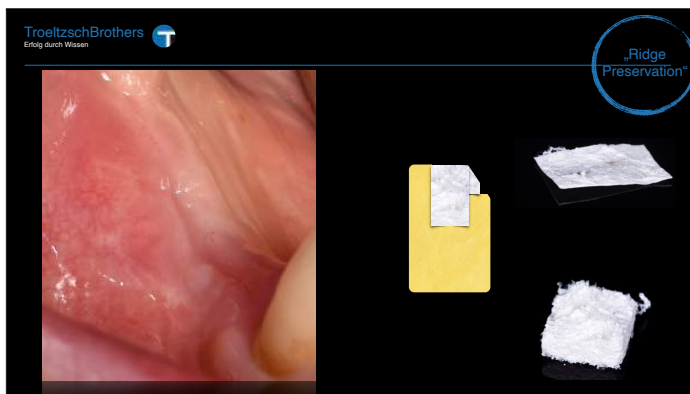
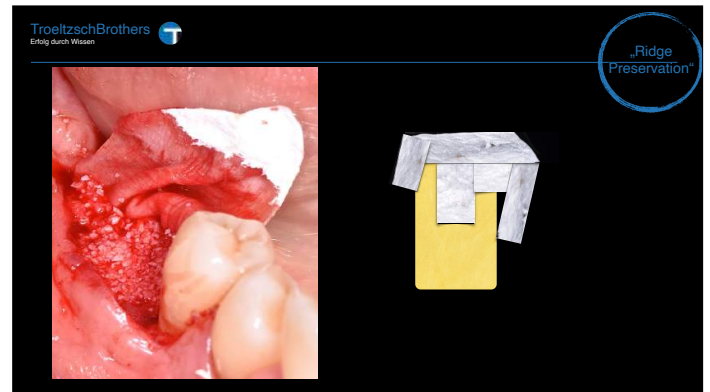
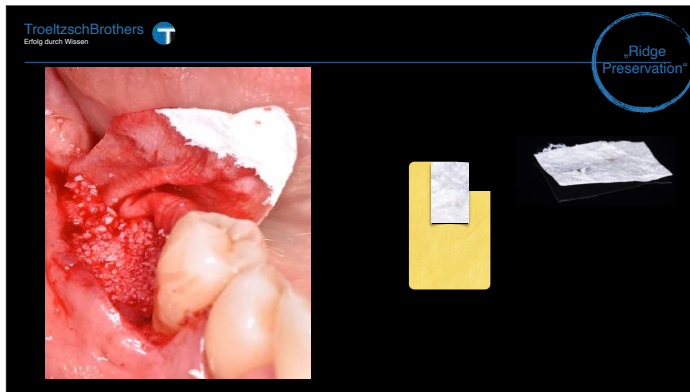
HANDLUNGSOPTIONEN				
	Nur entfernen	Kieferkamm erhalten	Implantatrettung	Kieferkamm augmentieren
Indiziert	Schwere Infektion, Kaum vorhandenes Gewebe, Medizinische Risikofaktoren, Habits	Infektion, vorhandenes Restgewebe, Patient Compliant	Schwere Infektion, Regenerierbarer ossärer Bestand, Supra abnehmbar	Grosser Defekt, nicht Infiziert, Patient gesund, Patient Compliant
Kontraindiziert	Restgewebe vorhanden, nicht Infiziert, Patient gesund	Schwere Infektion, kaum vorhandenes Gewebe, medizinische Risikofaktoren, Habits	Erwartungen des Patienten	Schwere Infektion, nicht mobilisierbares Weichgewebe, medizinische Risikofaktoren, Habits
Material	—	DBBM - C & Resorbierbare Kollagenmembran & PRF	Reinigungsmethode, DBBM - C & Resorbierbare Kollagenmembran & PRF	Individuelles Titangitter / Schalentechnik & Partikuläres Material & Resorbierbare Kollagenmembran & PRF

Lokal:
Infektstatus
Defektbiologie

Generell:
Gesundheitszustand des Patienten
Compliance des Patienten
Fähigkeit des Chirurgen
Materialauswahl

„Ridge Preservation“





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1. VERLUSTURSACHEN
2. WELCHE IMPLANTATE SIND NICHT ZU RETTEN
3. SITUATIONSORIENTIERTE STRATEGIEAUSWAHL
4. FAZIT

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RISIKOFAKTOREN

Funktion	Medizin	Habits	Chirurg
KFO	PPI & SSRI	Rauchen	Positionierung
Bruxismus	Antiresorptiva & Bestrahlung	Mundhygiene / Karies	Augmentation
Störkontakt	Stoffwechselerkrankungen	Incompliance	Hart und Weichgewebe
	Parodontitis / Periimplantitis		Implantatform und Belastungsform

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RISIKOFAKTOREN IM DEMOGRAPHISCHEN WANDEL

Funktion	Medizin	Habits	Chirurg
KFO	PPI & SSRI	Rauchen	Positionierung
Bruxismus	Antiresorptiva & Bestrahlung	Mundhygiene / Karies	Augmentation
Störkontakt	Stoffwechselerkrankungen	Incompliance	Hart und Weichgewebe
	Parodontitis / Periimplantitis		Implantatform und Belastungsform

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Material	—	DBBM - C & Resorbierbare Kollagenmembran & PRF	Reinigungsmethode, DBBM - C & Resorbierbare Kollagenmembran & PRF	Individuelles Titangitter / Schalentechnik & Partikuläres Material & Resorbierbare Kollagenmembran & PRF

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11 Schritte für morgen

Wir geben diese Informationen weiter, um medizinisches Fachpersonal dabei zu unterstützen, sofortige Maßnahmen in Richtung Nachhaltigkeit zu ergreifen. Diese Schritte können morgen ohne erhebliche Investitionen unternommen werden und können einen bedeutenden Beitrag zur Reduzierung der Umweltauswirkungen von Gesundheitspraktiken leisten. Durch die Umsetzung dieser Schritte können medizinische Fachkräfte den Energie- und





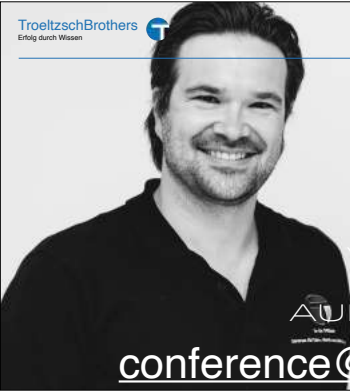







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