## Chapter 2 – Prepare for the Procedure

### What are the major actions of this activity?

<table>
<thead>
<tr>
<th>Major Action:</th>
<th>Overview:</th>
<th>Tools, equipment, materials, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Gather the placement armamentarium</td>
<td>Collect all of the supplies you need</td>
<td>PA Radiograph, Panographic Radiograph, Impression of site, Bone mappings</td>
</tr>
<tr>
<td>b. Construct the 3-D Pilot and Osteotomy Drill Guide Stent</td>
<td>Create Model of Proposed Site</td>
<td>Completed Model-Tomographic™, Plaster, Bowl, Spatula, Vibrator</td>
</tr>
<tr>
<td>c. Check the 3-D Pilot and Osteotomy Drill Guide Stent</td>
<td>Verify all measurements are correct and proper fit</td>
<td>Completed 3-D Drill Guide Stent</td>
</tr>
<tr>
<td>d. Autoclave, cold sterilize, and disinfect surfaces as required</td>
<td>Sterilize and disinfect as appropriate</td>
<td></td>
</tr>
<tr>
<td>e. Review tutorials, DVD, patient history, etc.</td>
<td>Make sure there is a complete understanding of procedure</td>
<td></td>
</tr>
<tr>
<td>f. Do a dry run of the placement procedure</td>
<td>Go through entire procedure minus the sterile instruments or patient</td>
<td></td>
</tr>
</tbody>
</table>
a. Gather the Placement Armamentarium  

**Equipment and Set-up For Implant Placement**

1) **Placement Console** – Aseptico** AEU 707-Av2 or Equivelant on stable disinfected work surface  
   Cover film *(568-3909)*

2) **Placement Handpiece** – Aseptico** AHP-85 or Equivelant (Sterile)

3) **Motor-cable assembly** (disinfected)

4) **Foot Control—Cable assembly** (disinfected)

5) **Internal irrigation assembly complete integrated or ancillary** (Sterile)

6) **Disinfected stainless steel tray** (On mayo stand or disinfected work surface.) *(228-2549)*

7) **Set-up instruments and materials on one sterile towel/drape placed on disinfected stainless tray or work surface.** *(084-0058)*
   a) Sterilized BASIC Omni-Tight Placement Instrument box with all instruments.
   b) Sterilized BASIC Implant strips (1st and 2nd choice lengths)
   c) Sterilized stainless steel or pyrex® cup with irrigation solution:
   d) Sterile saline – 250ml bag (24 per case) ***(507-8002)*
   e) Sterile H₂O-1000ml (12 per case) *(674-7398)*
   f) 1 Sterilized Monoject® syringe #412/12cc: *(663-5343)*
   g) 2 Sterilized mouth mirrors *(773-0328)*
   h) Aspirating anesthetic syringe with anesthetic of choice (1:100,000 epi)
   i) Cold sterilized and sterile H₂O washed 3-D drill guide stent
   j) 2 sterilized small tip surgical suction tips *(089-4303)*
   k) Sterilized see-in pouches containing: *(674-5681) *(674-5699) *(674-5707)*
      i) 4mm diameter spoon excavator (double ended and angled) *(370-0697)*
      ii) Small tip mouse-tooth tissue tweezer *(708-1730)*
      iii) Scissors:
         1) Straight *(499-7045)*
         2) Iris *(089-3743)*
         3) Suture *(499-6781)*
      iv) Syngauze 2”X2” 4-ply *(606-3911)*
8) **Ancillary Instruments and Materials:**
   a) Periosteal Elevator *(577-1605)*
   b) Scalpel Handle *(089-4519)*
   c) Needle Holders *(498-6824)*
   d) Suture Material:
      i) Routine Oral Surgery
         Non-absorbable Black silk 6-0 18” C-22 3/8 needle *(371-4136)*
      ii) Grafting Procedures
         (1) Absorbable Plain gut 5-0 18” C-3 3/8 needle *(408-9231)*
         (2) Monocryl (Ethicon) 4-0 18” P-3 1/2 needle *(371-4367)*
   e) Scalpel Blades:
      i) #12 10/pkg *(089-5110)*
      ii) #15 10/pkg *(089-5128)*
   f) Infection Control materials, sprays, barriers, gowns, gloves, etc.

*Patterson Dental Supply USA/Patterson Dental Dentaire Canada*

**Aseptico Inc. or check on availability through local Patterson Branch**

***Henry Schein***
Placement Instruments (Level 1)
- Cold sterilized and sterile H₂O washed 3-D Drill Guide Stent
- Sterile tray drape
- SS sterile saline cup
- Lip retractor
- Perforation detection instrument
- Sterile non-cotton 2 X 2s
- Two suction tips
- Mouse tooth forceps (tweezers)
- Russian forceps (tweezers)
- Small sharp tip scissor
- Larger angled scissor
- Blade handle
- Needle forceps (holder)
- Medium irrigation syringe (412)
- Tissue curettes (2)

Grafting Set Up (Level 2)
- Top sterile tray drape
- Gloves, mask
- Periotome – may be used with mallet
- GBR AlloDerm™ barrier graft material (Life Cell Corp)
- Freeze dried demineralized bone particles – Matrix Plugs (Osteotec™)
- Small SS hydration cup
- Tetracycline capsules (250 or 500 mg)
- #15 blade, #12 blade
- Gut suture – 5.0 with C3 reverse cutting needle (LOOK®)
- Monocryl (Ethicon®) 5.0 P-3 Needle
- Calcium sulfate – medical grade
Aseptico AEU 707–Av2 Setup – Internal Irrigation

1. Internal Irrigation Assembly
   If you are using the recommended AEU 707-Av2 placement console system and the AHP-85, the following is provided:
   - Silicone tubing set
     1. 6’ silicone tubing
     2. Bayonet
     3. Barbed connector
   - Cannula Clip Set
     1. 6” Silicone tube
     2. Bent cannula
     3. Clips for AHP-61 hand piece

   The doctor will provide the sterile H₂O or sterile NaCl H₂O in 250 ml plastic bag container.

2. Bayonet use: Connection from bag to tubing.

3. Silicone tubing must be fully placed into fixture troughs top and bottom so that clear sheath may be placed from front to back over pump and black tube fixture securely in order that the thumb screw may be replaced and tightened through both.
4. Cannula clip set expands over AHP-85 with the cannula proceeding through hand piece head and into internally irrigated osteotomy bur and drill extender if utilized.

5. One light on pump = Low volume of H₂O
   Four lights on pump = High volume of H₂O

Notes:

4. Cannula 6" silicone tubing
   Clamps
   AHP-61 1/64 ratio

5. Pump on and off press switch
   Pump Digital Regulator
Alternative Method of Internal Irrigation

BASIC Implant Company recommends the Aseptico-AEU-707Av2 with the built-in positive pressure irrigation system. Should you already have the Aseptico endo unit AEU-25 (Tulsa Dental) a pressure cuff irrigation system is available which will accept the cannula clip set. This allows you to use internal irrigation with the AEU-25. This product is available from Aseptico at 1-800-426-5913. The product number is NWS-9 BASIC.

Which ever system fits your needs best is up to you but remember that Internal irrigation is a must!

The handpiece recommended is the Aseptico AHP-85, 1/20 reduction contra angle, high torque “E” type handpiece. It is not recommended that a high speed air turbine hand piece be used around surgical sites, air embolism potential is great.

BASIC Dental Implant Company finds Aseptico products to be exceptional, moderately priced, extremely tough and long lasting.

Should you have any questions concerning product choice please call Randy Drumm at 800-426-5913.

Implant failure is the lack of long term osseointegration (ankylosis) of the implant body. This can obviously be the result of numerous factors and conditions. One of the most significant is the overheating of bone during the drilling of the osteotomy channel prior to implant placement. Bone cells are destroyed to some extent when invasive procedures are carried out, but bone drilling without adequate irrigation can spell the death knell to healing around an avascular root of titanium. Sufficient sterile water used as coolant is necessary to insure a good outcome.

The BASIC protocol calls for cool internal irrigation along with periodic drilling rests. These 20 seconds rest periods allow the bone adjacent to the channel preparation to return to a fairly normal temperature.
b. Create the Pilot / Osteotomy Drill Guide Stent
For most implant placement except in edentulous arches or where excessive bone volume of correct anatomy is present, we at Bio Anatomical Systems recommend the use of our three dimensional pilot and osteotomy channel drilling guide in the Omni-Tight series implant protocol. Our guide utilizes the complete Model-Tomographic™, PP in accomplishing the 3-D directional fabrication. The definition of a ‘complete Model-Tomographic™’, centers around the fact that B/L (transverse) drilling direction in the site bone has been established using the P.A. Film Overlay. From this direction for the implant body channel, a guide pin (rod) pathway has been finalized in the Model-Tomographic™.

b.1 Gather the required materials. The require materials are:
- Accurate complete Model-Tomographic™, PP
- Two-inch chromed directional pin
- Delrin double cylinder guide of correct size (included in strip)
- Triad™ material (Densply VLC custom tray material – clear - #89904) or Triad™ Gel
- Petroleum jelly and small brush
- Metal trimming instrument for Triad™ material (wax carver – sharp, will work)
- Light curing oven or hand held wand
- Acrylic trimming burs (cylinder & flame)
- Boley gauge
- Scissors

b.2 Add lubrication

After the pilot channel filing is complete and you are satisfied with the final direction, lubricate the adjacent several crowns with petroleum jelly.

b.3 Anchor the guide cylinder

Place the chromed guide pin into the pilot channel and slide the directional Guide Cylinder onto the guide rod and down to the plaster tissue. The non-circumferentially inscribed end slides down first. (This double drill Guide Cylinder is supplied in the implant and component strip.)

Note: Sometimes the bottom of the Guide Cylinder will need to be trimmed just a bit at the edge so that an intimate seat at the “plaster tissue” will be attained. Never remove the whole base of the internal pilot drill guide cylinder. Place a red Sharpie® dot on the outer and inner cylinder at the point of this adjustment so that replacement can occur correctly.
b.4 Cover the guide cylinder

Now place a strip of clear Triad™ tray material over the guide pin, puncturing the Triad™, and onto the occlusal lubricated surfaces of the several adjacent model teeth.

Triad Gel™ or Eclipse can also be used in place of the tray material.

b.5 Form the stent top

The Triad™ is now finger formed into intimate contact with the crowns (and especially onto the guide cylinder) being sure not to extend past the greatest convexity of the crowns or into the interproximal undercuts. This soft material is formed and trimmed to preclude excess cured retention. This is very important to note because difficult removal of an over-extended cured stent will break the plaster teeth. A very minimal “snap on” is ok and actually desirable but when you can’t get it seated in the mouth, it becomes a problem. Take the little extra time in this part of the fabrication.

If there is a proposed implant site unbounded by distal dentition, then it is very important in the stent fabrication to include more teeth anterior to the site for stability of the stent purposes. I would recommend even progressing around the curve of the arch onto anterior crowns to facilitate this stability so necessary to preclude the stent from rocking down at the guide cylinder area, thereby possibly changing the M/D pilot and osteotomy drill direction. One may carry the Triad material distal to the retromolar pad area if desired, but the main stability will come from anterior to site dentition around the curve of the dental arch.

**Hint:** Always have a duplicate unpinned cast available for stent adjustments should cast crowns break.
b.6 Cure and cut

After curing for three (3) minutes in the LC oven, remove the stent and trim for slight undercuts and sharp edges. Be sure that there is no “saddle” effect present at the ‘plaster tissue’ interface with the guide cylinder. If present, remove without touching the bottom of the cylinder. Next, reduce the Triad™ encased drill cylinder from the top down to the determined drill cylinder guide height by using the formula printed on the P.A. overlay (Guide Height = Constant number – Gingival thickness). Cut carefully and measure often with the Boley gauge so that you do not over-reduce the height.

b.7 Option: If the guide stent is to be shorter than 6 mm, do this:

During fabrication, guide stents are adjusted from the top down to a pre-determined height in order to control the depth of the implant placement. If the adjusted guide cylinders are to be at least 6 mm long, skip this step.

If the adjusted guide will be shorter than 6 mm, we recommend that you remove the inner cylinder, cold sterilize it, bag it, and set it aside until the time of placement procedure. Adjust only the outer cylinder prior to the surgical sequence. This will allow the clinician to have full-length cylinder guidance for an accurate pilot channel drilling step no matter how short the outer cylinder needs to be to fulfill the guide height formula.

During the placement procedure (EA 3-4) the unadjusted inner cylinder is used for initial pilot hole drilling. Then, after radiographic verification of accurate direction, the inner cylinder is taken away from the patient area and adjusted to the proper height following the guide height formula. The pilot hole can then be drilled to final depth.

Suggested Option: Do this shortening procedure away from the patient to preclude any plastic debris entering the mouth or pilot drill channel. Some doctors prefer to have a guide height adjusted inner cylinder standing by, sterilized, ready to place into the outer cylinder thereby bypassing all grinding in the placement area.

- **Hint:** If ever, by accident the drill cylinder is over-reduced, don’t discard the stent and start over. Just use 1 mm thick colored A-lastics™ supplied in your placement kit to shim at the collar stop of the drilling instruments. This in effect “shortens” the drill depth to compensate for the over-reduced stent.

- **Hint:** When the implant is long (15 mm) and/or the tissue is thick, the guide height will be short. For this reason, be sure that the stent is “beefed up” around the double guide all the way to its base. This will ensure adequate strength. TRIAD™ is weak if not bulked up and can break at a critical time.
Hint: Adapt in oversized ridge. In an oversized ridge bone the practitioner would probably not need a guide stent, when all the correct placement techniques are deeply ingrained. This is not recommended until 25 or more implants have been placed.
Exercise: Study Model Analysis

The excellent soft plaster study models from the three-way tray alginate impressions that capture all pertinent anatomy, are important for the following reasons:

- We can see the M/D space available for the implant prosthesis (crown or crowns).
- We can better visualize the available B/L bone mass to house the implant body size after our study of the Model-Tomographic™, PP (do we need to utilize a smaller diameter implant size than first thought from the M/D film view?). Think 3-D!
- We can mark the implant site point where the soft and hard tissue will be entered (review the M/D and B/L data before marking the site point).
- We can check again, with the 3-way models hand articulated, the interocclusal room available for the crown prosthesis.
- Fabrication of the Model-Tomographic™, PP.
- Viewing of numerous site models is beneficial for initial sense of ridge appropriateness.
c. Check the 3-D Pilot and Osteotomy Drill Guide Stent - The Doctors

Responsibility

c1. Check Drill Guide Cylinder Height:

This is an important determination due to the proximity of vital structures. These structures include the inferior alveolar nerve and blood supply channel, the mental foramen, the sinus floor, lateral cortical plates that cut back (sub-mandibular gland fossa), bent adjacent tooth tips etc.

Remember that for a 3.5mm and 4.0mm wide implant, an 11mm implant should ideally be in the bone 10mm etc. A 4.5mm and 4.5mm wide diameter implant should ideally be in the bone 9mm. Verify that the height of the guide cylinder is correct by performing the following exercises.

Check #1 - Verify the usable length of the pilot drill.

1. What is the crestal soft tissue thickness? ......................................... mm
2. What is the implant length? ............................................................ (+) mm
3. The desired distance between the implant platform and the bone. ... (-) 1 or 2 mm
   (Subtract 1 for 3.5 & 4.0mm diameter implants. Subtract 2 for 4.5 & 4.5 wide diameter implants.)
4. Add lines 1 and 2 and subtract line 3. ............................................. mm
5. Place the pilot drill into the guide stent and measure the length of drill that extends beyond the bottom of the guide cylinder. Write that number here......................................................... mm

- If Lines 4 and 5 are the same: The guide cylinder is the correct height.
- If Line 4 is greater than Line 5: Reduce the guide cylinder from the top by an amount equal to the difference between Line 4 and Line 5.
- If Line 4 is less than Line 5: Either have a new guide stent manufactured or add a 1mm o-ring to the pilot drill below the stop collar and adjust the stent so that the length of drill that extends beyond the bottom of the guide cylinder is equal to the measurement of Line 4. During implant placement, drill with the 1mm o-ring placed below the stop collar of the pilot drill and the osteotomy drill.

Check #2 - Use the formula printed on the bottom of the P.A. Film Implant Overlay

1. What is the constant number for the implant length chosen? .......... mm
2. What is the crestal soft tissue thickness? .......................................... (-) mm
3. Subtract Line 2 from Line 1 ............................................................. mm
4. Using a caliper measure the height of the guide cylinder. ............... mm

- If Lines 3 and 4 are the same: The guide cylinder is the correct height.
- If Line 3 is greater than Line 4: Reduce the guide cylinder from the top until the guide cylinder height is equal to the Guide Cylinder Height determined in Line 3.
- If Line 3 is less than Line 4: Either have a new guide stent manufactured or add a 1mm o-ring to the pilot drill below the stop collar and adjust the stent so that the length of the guide
cylinder plus the 1mm o-ring is equal to the Guide Cylinder Height determined in Line 3.

Check #3 - Include all measurements involved.
1. What is the measured height of the Guide Cylinder? ................. _______ mm
2. What is the crestal soft tissue thickness? .................................. (+) _______ mm
3. What is the implant length?................................................... (+) _______ mm
4. Subtract amount of implant that is above crest of bone.).............. (-) 1 or 2 mm
   (Subtract 1 for 3.5 & 4.0mm diameter implants. Subtract 2 for 4.5 & 4.5 wide diameter implants.)
5. Add lines 1, 2 and 3 and subtract line 4. ................................. _______ mm

- If Line 5 equals 21mm: The guide cylinder is the correct height.
- If Line 5 is greater than 21mm: Reduce the guide cylinder from the top until by the difference between Line 5 and 21mm.
- If Line 5 is less than 21mm: Either have a new guide stent manufactured or add a 1mm o-ring to the pilot drill and osteotomy drill below the stop collar and adjust the stent so that the length of the guide cylinder plus the 1mm o-ring is equal to the Guide Cylinder Height determined in Line 3 of Check #2.

c2. Check Mesial-Distal Guide Cylinder Direction:

The mesial-distal direction of the 3-D drill guide stent cylinders will really be an interpolation derived from the P.A. radiograph of the site, panoramic radiograph, and lining out adjacent coronal inclination of the natural teeth via the stone cast. These three directional aids taken together normally bring us quite close to M/D accuracy for a transverse cut of the site cast.

1. **Verify that the correct size implant has been selected** for the available mesial-distal bone volume by viewing the P.A. overlay on an excellent P.A. Film.

2. **Examine the transverse cut** on the pinned model and verify that it is in an appropriate angle based on the available information from P.A. radiograph of the site, panoramic radiograph, and lining out adjacent coronal inclination of the natural teeth via the stone cast.

3. **Check the mesial-distal angulation**. With the panoramic radiograph on a view box. Place the chrome guide pin into the guide stent and view the stent in profile accurately “placed” upon the panoramic teeth. Verify that the chrome guide pin extends through the guide cylinder, out the bottom and “into” the panoramic radiographic site bone thereby noting if the desired M/D direction of the drilling will be attained.

   The direction can be altered a degree of two during the implant placement with a slight pressure on the handpiece in the stent in the opposite direction to the desired correction of the apex of the drill. Always depend on that first
film of the surgical depth gauge pin in the incomplete pilot drill channel before determining if direction alteration is necessary.

c3. Check Buccal-Lingual Guide Cylinder Direction:

The Buccal-Lingual direction of the 3-D drill guide stent cylinders will be quite accurate as long as the bone volume and direction is determined by excellent bone mapping measurements and these soft tissue thickness measurements are accurately transcribed to the surface of the cast site.

1. **Check the model tomograph** to make sure that the soft tissue measurements have been accurately transcribed to the cross-sectioned model.

2. **Verify that the long access of the implant is at an appropriate angle Buccal-Lingually** by overlaying the P.A. Film Implant Overlay onto the cross-sectioned model. This will also allow you to **verify the correct implant diameter from a Buccal-Lingual aspect**.

In those cases that remain in question a CAT scan can be made of the patients site with the 3-D drill guide stent in place along with the depth-gauge pin inserted into the pilot drill cylinder in order to double check correct stent fabrication Buccal-Lingually.
d. Autoclave, Cold Sterilize, and Disinfect Surfaces as required

The Omni-Tight™ Implant Series is supplied non-sterilized and must be sterilized before use. The full placement kit, implant, healing cap, and emergence profiler as well as the transfer device, must be sterilized in the steam autoclave at 121° C (250° F) for 15 minutes. Also place all of the secondary instruments, hand piece, powder free gloves, towels, 2 X 2’s etc., in the autoclave at this time. All the other surgical articles that can’t endure the heat and pressure may be cold sterilized in the correct solutions for the time stated and then rinsed off with sterile water.

Omni-Tight™ implants come individually packaged in a convenient strip that must be sterilized and not opened until the time of implant placement and then the appropriate parts only handled by their respective sterilized carriers, thereby precluding handling contamination. Never place a contaminated implant!

d.1 Use caution around the implant placement kit

Because all of the placement kit instruments are stainless steel, sharp and small, extreme care must be taken to assure their complete cleanliness and sterilization after each procedure. The use of small, disinfected brushes and port wires are useful before the instruments are placed into the heated Ultrasonic cleaner before steam sterilization. At the time of sterilization, the instruments may be placed in their respective spots in the blue kit box and sterilized with the top in place wrapped and taped with sterilization tape. This procedure maintains cleanliness, correct order of instruments, sterilization, and freedom from contamination. Be sure the kit box is kept upright after loading and maintained upright when moved from the auto-clave to the sterile drape on the mayo stand tray. It is important to keep a sterile field about the tray and its set up. Be sure the first set of sterile powder free exam gloves are used to set the tray up:

d.2 Arrange the placement area

- Sterile drape the top of the disinfected stainless Mayo stand tray.
- Place the unopened placement kit and hand piece on the covered tray.
- De-bag the secondary instruments and place them around the covered tray in convenient locations.
- Fill the Stainless Steel cup with cold sterile water or normal saline for additional irrigation by syringe (monojet 412)
- Be sure the implant strip and sterile scissors are close at hand on the tray.
- When the draped tray is completely set up, then cover the tray and all instruments with the second sterile drape. See Set Up Tutorial.

Note: It is strongly recommended that sterile internal irrigation with very cold irrigation be used for the osteotomy portion of the placement procedure. Some placement surgical units have integrated pumps to provide irrigant flow to the placement site. Some units don’t. For those units that don’t have a built in pump, an internal irrigation squeeze pump set is satisfactory.
d.3 On the morning of the placement, steam sterilize all instruments including the slow speed, high torque hand piece

— Lubricate the headpiece (Kavo spray) before sterilization. Use red sterilization plugs in motor and at connection end of cable.
— Cold sterilize those items that cannot withstand the heat and pressure (Pilot drill guide stent, for example) of autoclave sterilization, as per manufacturer’s instructions
— Wash all cold sterilize parts with sterile H2O prior to use
— Spray disinfectant and wipe down the Mayo stand and tray
— Set up the draped tray with sterile exam gloves (powder free) with all sterilized instruments and other articles (sterile H2O, 2X2’s, sterile placement gloves, a 412 monoject syringe and the internal irrigation set (canula, clips, and tubing), hand piece, etc.) before being finally top draped ready for the procedure

Notes:

d.4 Ready yourself

You and your assistant are properly attired for cleanliness and protection. Sterile exam gloves are used for everything but the procedure itself where fitted, sterile, surgical non-powdered gloves are used. Be sure that the patient is not latex sensitive, if they are then use ONLY vinyl gloves. Barrier the chair, unit, console, light, suction, water and all syringe, x-ray head, etc. as you deem appropriate.

d.5 Set up the Placement Tray

Placement Tray Checklist:

— Disinfected equipment tray (stainless steel is best)
— Two sterile towels – one over tray, one over surgical set-up that then goes over chest of patient sterile side up as the surgical placement begins.
— Sterilized Omni-Tight™ instrument block with all placement instruments and first and second choice implant sizes.
— Internal irrigation integrated pump set-up and ready for use with cold bag of sterile H2O or saline. (“Squeeze Pump” may be used as alternative to integrated pump).
— Sterilized Monoject™ plastic 12cc syringe.
— Aspirating anesthetic syringes with anesthetic of choice. Use Septocain sparingly – (½-1 carp. Max.) and only for infiltration!
— Sterilized low speed contra angle high torque hand piece (electric #400-600 RPM).
— Cold sterilized pilot/osteotomy drill guide.
— Two cold sterilized surgical suction tips (small tip size).
— Sterilized surgical spoon excavators (medium & small) straight & angled.
— Sterilized small hemostat or mouse tooth tweezers (small).
— Sterilized cotton roll holder with two sets of sterile cotton rolls.
— Six sterilized non-cotton 2 X 2’s.
— Sterilized scissors.
— Powder free sterilized gloves (2 sets).
— Jigger of chlorhexidine for pre-op mouth rinse only. Rinse for 1 min.
— All pre-written instructions; Rx’s antibiotics, discomfort, no chlorhexidine, just warm salt H2O rinses when appropriate.
e. Review Tutorials, DVD, Patient History, etc.

Again when just starting this journey of implant placement or when time has elapsed since last placement, it is very important to review tutorials, play the Dr. Christensen DVD and again read the patients med. History form to be certain that nothing of impact on the procedure has been overlooked. This may even mean talking briefly with the patient’s primary care MD if any questions need addressing. The patient will appreciate knowing of your extra care and the MD will appreciate being conferred with and brought into the loop of care. Prepare, prepare it pays off in the final analysis. It’s excellent time spent.

f. Do a Dry Run of the Placement Procedure

There are two important reasons for doing a “dry-run” of the placement procedure that day before the appointment:

1. It allows the ancillary equipment to be set up in a sterilized and disinfected, and barriered condition i.e., console with motor, cables, hand piece, controllers, pump, sterile saline (H₂O), hoses, canula, bayonette, x-ray head, etc.
2. Dry-run through with assistant present and verbal communication really focuses for the upcoming procedure especially if time has elapsed since last placement or when one is just starting out.
Example: Pre-Placement Sequence

It’s Monday morning and your staff has informed you that at 10:00 AM on Wednesday, Mrs. Hicks is presenting for implant placement in the mandibular right second bicuspid #29 site.

Two days before placement:

- Ensure that you have thoroughly evaluated the medical and dental history, indications and cautions
- Discuss any pre-meds (Ibuprofen, Diazepam, etc.)
- Re-state to the patient the possible risks that may be associated with a failed implant (1 in 20 fail) and summarize the informed consent form that she and you must sign with a witness
- Finalize any financial questions or issues
- Summarize the entire placement procedure (show-and-tell pictures or short patient video), to ensure comprehension of the procedure, time to osseointegration (site healing), and timeline before crown is placed.
- Ensure the films, models, and analysis with the overlay has been accomplished and only finishing touches remain to complete the pilot drill guide and a re-check of double cylinder height in the finished stent
- Ensure all placement instruments, both primary and secondary, are clean, bagged where indicated and ready for steam sterilization on placement day
- Sterilize the implant strip
- Be sure that the implant lot # is written into the chart as well as the size of implant or use the peel-off label on the strip envelope
- Call and remind the patient 24 hrs prior to placement time to be sure and start he antibiotic regimen and to wear comfortable, loose fitting clothing with no make-up
- Have all prescriptions and directions written along with the chlorhexidine present that is used only prior to the procedure