maxgraft® bonering
Bone augmentation and immediate implantation

Surgical guide

innovative
efficient
atraumatic

tissue
1. Introduction

This surgical guide was created with the support of renowned clinical experts to assist you in achieving the best possible results with maxgraft® bonering.

On the following pages, you will find detailed information on the application of maxgraft® bonering in different clinical situations. Each indication is described by a clinical case from an expert, demonstrating a recommended surgical procedure.

The Bone Ring Technique is an innovative solution for single-stage three-dimensional bone augmentation and implant placement. The simultaneous augmentation and implantation reduces treatment time compared to conventional bone block augmentation.1,2

In clinical practice, the application of allogenic blocks has been established as a reliable alternative to autogenous bone harvesting and alveolar ridge augmentation, thus avoiding donor-site morbidity and limitations in quantity.3,4,5

maxgraft® bonering is a sterilized graft cut into the shape of a ring that originates from living human donor bone by explantation of femoral heads (hip endoprosthesis). Characteristically, it is rapidly incorporated and subsequently remodeled into patients’ own bone.
Indications for maxgraft® bonering

- Single-tooth gap  | Cases page 8-11
- Edentulous space  | Case page 12
- Vertical augmentation (three-dimensional defects)  | Case page 13
- Treatment of periimplantitis with severe bone loss  | Case page 14
- Sinus floor elevation  | Cases page 18-19

Contraindication

- Thin parallel-walled crest (< 6 mm width)
- 1 mm or less bone height in the sinus

Product properties and specifications

- Processed human allograft from living donors
- Osteoconductive properties supporting natural and controlled tissue remodeling
- Stable trabecular structure of the cancellous bone enables rapid revascularization
- Mineralized human collagen for excellent biocompatibility and flexibility
- 5 years shelf life at room temperature
- Standard sizes:

<table>
<thead>
<tr>
<th>Art.-No.</th>
<th>Dimension</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>33160</td>
<td>cancellous ring, ø 6 mm, height 10 mm</td>
<td>1 x</td>
</tr>
<tr>
<td>33170</td>
<td>cancellous ring, ø 7 mm, height 10 mm</td>
<td>1 x</td>
</tr>
</tbody>
</table>

The implant directly fixates the bone graft. The technique does not require osteosynthesis screws.

Sub-gingival healing of the implants is recommended. Therefore, maxgraft® bonering should be used only with bone level implants and is not compatible with tissue level and one-piece ceramic implants.

Pre-operative assessment and precautions

- Patient selection is critical to the outcome of the surgical procedure.
- Special attention should be paid to patient-related risk factors that may affect bone healing; patients with uncontrolled diabetes and heavy smokers (> 10 cigarettes a day) should be excluded from this procedure.
- The soft tissue situation should be carefully evaluated; in some cases, it might be beneficial to perform soft tissue augmentation prior to bone ring surgery.
- All inflammation and infection should be treated prior to surgery.
- Antibiotic treatment should be started one-day pre-op.
- Professional dental cleaning and chlorhexidine rinses prior to surgery are recommended for optimal operating conditions.

The maxgraft® bonering surgical kit is used to prepare the augmentation site for maxgraft® bonering and the bonering fix (special tweezers) are used to safely cut maxgraft® bonering to the desired length. maxgraft® bonering surgical kit instruments should not be used at speeds greater than 800 rpm.
Single-tooth gap & edentulous space

Surgical procedure and guidelines

**Step 1** Determine the diameter of maxgraft® bonering

Once the flap is lifted, the diameter of the defect can be determined by using the trephine drill with an outer diameter of 6 or 7 mm. This measurement helps to determine which diameter of maxgraft® bonering should be used, 6 or 7 mm.

**Note:** When determining the diameter of maxgraft® bonering, the required mesiodistal distance of the implant to the adjacent teeth/implants must be strictly observed. At least 1 mm distance between the ring and adjacent teeth must be kept. For instance, to place a 6 mm ring, at least 8 mm distance between the two adjacent teeth is needed; to place a 7 mm ring, at least 9 mm distance is necessary. An implant of 4.1 – 4.5 mm always requires a 7 mm maxgraft® bonering. 3D diagnostics are recommended.

**Step 2** Determine the implant position with the pilot drill

Check the mesiodistal and orofacial implant position/implant axis for optimal aesthetic positioning of the implant. The use of a surgical drill template is recommended.

**Step 3** Prepare the ring bed with the trephine

Use a 6 or 7 mm trephine depending on the ring size chosen for the circular osteotomy. The preparation depth can be determined by the markings (2–10 mm, in 2 mm increments) on the trephine. The depth of the maxgraft® bonering bed is defined by the size of the defect. Bone chips can be removed using a blunt instrument and reintroduced in other regions of the augmentation site.

**Note:** The bone level of the neighboring teeth is the reference for the height of maxgraft® bonering.

**Step 4** Straighten/decorticate the ring bed

The planator is used on the bottom of the defect to achieve a uniform surface for implanting maxgraft® bonering with a press fit.

**Step 5** Prepare maxgraft® bonering

Use the diamond disc from the maxgraft® bonering surgical kit and the bonering fix to trim the bone ring to the required length.

**Note:** maxgraft® bonering does not need to be rehydrated. The preparation of the ring bed using the instruments from the maxgraft® bonering surgical kit provides close contact between bone ring and the bone bed, allowing blood to quickly perfuse the maxgraft® bonering.

**Step 6** Insert maxgraft® bonering

maxgraft® bonering is ‘press-fit’ in the prepared bone bed.

**Note:** A precise congruence of the ring base to the bone bed is critical for the primary stability of maxgraft® bonering and implant.

**Step 7** Prepare the implant bed

After inserting maxgraft® bonering, the osteotomy for the implant is prepared through the bone ring according to the surgical procedure of the implant system used.

**Note:** The length of the implant chosen should be sufficiently long so that the implant is situated at least 3 mm deep in the residual alveolar bone. Enlargement of the inner ring diameter to match the size of the implant used can be performed extrorally.

**Step 8** Place the implant through maxgraft® bonering

The implant fixtures the ring in the jawbone.

**Note:** The implant should be placed approximately 1 mm below the surface to compensate for possible resorption of the bone ring. If it cannot be stably seated, maxgraft® bonering should be secured with a special screw with a head larger than the diameter of the implant. Ask botsis representatives which implant systems provide these screws: product-management@botsis.com

**Step 9** Round off the edges of maxgraft® bonering

After placing the implant, the edges of maxgraft® bonering must be smoothened using a diamond tulip bur to prevent perforation of the soft tissue.

**Step 10** Cover defects with a bone substitute material

The defect should be covered with non- or slowly resorbable granules. cerabone® with a particle size of 0.5 – 1.0 mm is recommended.

**Step 11** Cover the graft with a barrier membrane and close the wound

The entire augmentation area needs to be covered with a membrane that has a long-barrier function to prevent soft tissue cell invasion and exposure of the augmentation site. The Jason® membrane with its delayed degradation is recommended. Close the wound in a tension-free manner.
**CLINICAL CASE BY**
Amit Patel, Birmingham, United Kingdom

**BONE AUGMENTATION AND IMPLANTATION IN SINGLE-TOOTH GAPS**
Restoration of buccal bone lamella with maxgraft® bonering.

Initial situation shows bone loss due to lack of physical load of bridge retained region 11.

Clinical situation at time of entry shows loss of buccal bone lamella.

Pilot drill to determine later implant position.

Trephine drill 7 mm for maxgraft® bonering 7 mm.

After preparation with the planator, the necessary length of maxgraft® bonering 7 mm is estimated.

Cutting maxgraft® bonering to the required size with bonering fix.

Implant bed preparation through maxgraft® bonering.

Placing the implant in order to fixate maxgraft® bonering.

Smoothing the edges of maxgraft® bonering.

maxgraft® bonering and implant in place.

PrefGel applied as root surface conditioner prior Straumann® Emdogain®.

Applying Straumann® Emdogain® for regeneration of bone around the roots of adjacent teeth.

cerabone® granules for contouring the defect and to help slow down resorption of the bone.

Jason® membrane to protect the bone graft from soft tissue ingrowth.

Flap is sutured with mattress sutures to prevent micromovements of the grafted area.

Sutured free of tension.

Rest of Straumann® Emdogain® applied to support wound healing.

Four weeks after surgery eventless healing and healthy soft tissue.

Prosthetic restoration six months after surgery with aesthetical outcome.

maxgraft® bonering in conjunction with Straumann® Emdogain®:

Straumann® Emdogain® can be used to support soft tissue wound healing in oral surgical procedures comprising implantations and peri-implant procedures. Straumann® Emdogain® is a gel containing enamel matrix proteins which stimulate various cell types that are important for the wound healing process. It can be pre-mixed with bone grafting materials and additionally applied on top of the graft before final wound closure. To promote the regeneration of the periodontium of adjacent natural teeth Straumann® Emdogain® can also be applied on the exposed root surfaces.6
**CLINICAL CASE BY**
Dr. Orch einsenbagen, Kassel, Germany

**BONE AUGMENTATION AND IMPLANTATION IN SINGLE-TOOTH GAPS**
Restoration of buccal and lingual bone lamella with maxgraft® bonering

- **Initial situation**: X-ray shows a two-wall bony defect with loss of buccal and lingual lamella
- **Clinical situation of the ring bed after preparation according to protocol (pilot drill, trephine, and planator)**
- **Placement of maxgraft® bonering after adjusting to desired length**
- **Fixation of maxgraft® bonering with an implant after implant bed preparation through the ring**
- **Fixed implant placed in the aesthetic window**
- **X-ray six months after surgery**
- **X-ray six months after surgery shows osseointegrated implant and bone ring with the same radiopacity as the native bone**
- **Clinical situation six months after surgery; vital bleeding bone on the shoulder of the implant**
- **Crestal view after removing the cover screw**
- **Healthy soft tissue situation after removal of the healing abutment**
- **Abutment for final restoration**
- **X-ray seven months after surgery shows bone with the same radiopacity as the native bone**
- **Final restoration**

**SURGICAL GUIDE MAXGRAFT® BONERING**

**CLINICAL CASE BY**
Dr. Orcan Yüksel and Dr. Kris Chmielewski, Frankfurt, Germany

**BONE AUGMENTATION AND IMPLANTATION IN SINGLE-TOOTH GAPS**
Guided bone ring surgery and implantation in aesthetic zone with maxgraft® bonering.

- **Initial situation**: Bone loss due to a lack of physical load and inflammation of region 21 retained with a bridge
- **CBCT and clinical situation showed vertical and horizontal bone loss. Surgery planning with a digital implant planning software**
- **Guided pilot drill to determine the aesthetic implant position**
- **Trephine drilling; the guiding pin in the trephine follows the pilot drilling path. Depth of drilling in this case: 4–5 mm**
- **Ring bed preparation with a 7 mm planator; same size as the trephine**
- **Implant bed preparation through the drill guide according to drilling protocol**
- **Drill guide**
- **Situation three months after tooth 21 extraction and template in place**
- **Guided pilot drill to determine the aesthetic implant position**
- **Trephine drilling; the guiding pin in the trephine follows the pilot drilling path. Depth of drilling in this case: 4–5 mm**
- **Ring bed preparation with a 7 mm planator; same size as the trephine**
- **Implant bed preparation through the drill guide according to drilling protocol**
- **CBCT and clinical situation showed vertical and horizontal bone loss. Surgery planning with a digital implant planning software**
- **Guided pilot drill to determine the aesthetic implant position**
- **Trephine drilling; the guiding pin in the trephine follows the pilot drilling path. Depth of drilling in this case: 4–5 mm**
- **Ring bed preparation with a 7 mm planator; same size as the trephine**
- **Implant bed preparation through the drill guide according to drilling protocol**
- **Initial situation**: Bone loss due to a lack of physical load and inflammation of region 21 retained with a bridge
- **CBCT and clinical situation showed vertical and horizontal bone loss. Surgery planning with a digital implant planning software**
- **Guided pilot drill to determine the aesthetic implant position**
- **Trephine drilling; the guiding pin in the trephine follows the pilot drilling path. Depth of drilling in this case: 4–5 mm**
- **Ring bed preparation with a 7 mm planator; same size as the trephine**
- **Implant bed preparation through the drill guide according to drilling protocol**
- **Drill guide**
- **Situation three months after tooth 21 extraction and template in place**

- **Initial situation**: Bone loss due to a lack of physical load and inflammation of region 21 retained with a bridge
- **CBCT and clinical situation showed vertical and horizontal bone loss. Surgery planning with a digital implant planning software**
- **Guided pilot drill to determine the aesthetic implant position**
- **Trephine drilling; the guiding pin in the trephine follows the pilot drilling path. Depth of drilling in this case: 4–5 mm**
- **Ring bed preparation with a 7 mm planator; same size as the trephine**
- **Implant bed preparation through the drill guide according to drilling protocol**
- **Initial situation**: Bone loss due to a lack of physical load and inflammation of region 21 retained with a bridge
- **CBCT and clinical situation showed vertical and horizontal bone loss. Surgery planning with a digital implant planning software**
- **Guided pilot drill to determine the aesthetic implant position**
- **Trephine drilling; the guiding pin in the trephine follows the pilot drilling path. Depth of drilling in this case: 4–5 mm**
- **Ring bed preparation with a 7 mm planator; same size as the trephine**
- **Implant bed preparation through the drill guide according to drilling protocol**
- **CBCT and clinical situation showed vertical and horizontal bone loss. Surgery planning with a digital implant planning software**
- **Guided pilot drill to determine the aesthetic implant position**
- **Trephine drilling; the guiding pin in the trephine follows the pilot drilling path. Depth of drilling in this case: 4–5 mm**
- **Ring bed preparation with a 7 mm planator; same size as the trephine**
- **Implant bed preparation through the drill guide according to drilling protocol**

**SURGICAL GUIDE MAXGRAFT® BONERING**

It is advisable to save the geometrical shapes of bone rings in your planning software to visualize the optimal position and size of maxgraft® bonering.

- Ø 7 mm and 10 mm length
- Ø 6 mm and 10 mm length

In areas where facial muscles, the tongue or oral cavity might exert tensile stress to the augmentation site, it is recommended to place apical mattress sutures deep into the vestibulum. This prevents micromovements of the graft and reduces mechanical irritation of the incision line.
BONE AUGMENTATION AND IMPLANTATION IN EDENTULOUS SPACES

CLINICAL CASE BY
Dr. Orcan Yüksel and Andrea Seyfer, Frankfurt, Germany

Restoration of incisors in aesthetic zone with two maxgraft® bonerings

Initial situation: Young patient with loss of teeth in region 21 and 22 after trauma

Clinical situation after lifting flap

Prepared ring bed according to protocol

Implantation of maxgraft® bonering

Two maxgraft® bonerings fixated with implants

Defect covered with cerabone®

Jason® membrane tacked on the buccal aspect

L-PRF matrix support wound healing

Single sutures free of tension

Abutments for prosthodontics

Final restoration

Aesthetic outcome one year after loading

Bone augmentation procedures may be beneficial for soft tissue healing, maturation of bone grafts and aesthetic results of soft tissue. Its application can be considered in bone augmentation procedures.

CLINICAL CASE BY
Dr. Anke Isser, Frankfurt, Germany

VERTICAL BONE AUGMENTATION AND IMPLANTATION IN FREE-END SITUATION.

Advanced vertical augmentation in posterior maxilla with maxgraft® bonering

Initial situation: X-ray shows severe bone loss due to inflammation in region 13

Treatment plan: Extraction of teeth 13 and 14 and augmentation of site after healing

Situation after extraction and healing phase shows insufficient bone in posterior maxilla

Vertical bone loss of 7mm

Implant and ring bed preparation

7 mm vertical augmentation with maxgraft® bonering and immediate implantation

Defect covered with cerabone® and Jason® membrane

Sutures free of tension

Post-op CBCT shows nice seating of the implant

Clinical situation seven months post-op with eventless healing

X-ray seven months post-op shows newly formed bone with almost the same radiopacity as the native bone

Clinical situation at re-entry shows healthy bleeding bone

Every vertical bone augmentation procedure has its limit. The bone height of adjacent teeth is the maximum level for augmentation. Mobilization of the periosteum is particularly important for achieving an optimal outcome.

In the mandible, soft tissue should be mobilized lingually; primarily, the periosteum should be detached up to the mylohyoid muscle with a dull elevator and the superficial fibrils mobilized in direction of the base of the mouth, as this can gain up to 10 mm of soft tissue.

In free-end cases, apical mattress sutures are always recommended to avoid dehiscence.
Surgical Guide: Maxgraft® Bonering

Clinical Case by Dr. Bernhard Giesenhagen, Kassel, Germany

Treatment of Severe Periimplantitis
Single implant removal and immediate bone augmentation and implantation with Maxgraft® Bonering

Defect is measured with either a 6 or 7mm trephine.

Infected bone and implant is removed with a trephine.

Infected bone and implant is removed with a trephine.

Infected and exposed implant.

Initial situation: X-ray shows severe periimplantitis at tooth 15 with bone loss of up to 1/3 of the implant.

Crestal incision shows exposed implant shoulder.

Infected and exposed implant.

Impacted implant including the infected bone.

Disinfected augmentation site.

Maxgraft® Bonering fixated with an implant.

X-ray after surgery.

Clinical situation eight months after surgery.

Implants covered with healing abutments and transgingival healing.

Clinical situation eight months after surgery.

Conventional periimplantitis treatment prescribes surface decontamination of the implant using different means. However, as shown in most case studies, subgingival bacteria is not completely eradicated and surgical intervention is most effective in cases of progressed periimplantitis. Nevertheless, for long-term clinical success, proper decontamination is essential. Antibiotics or photodynamic therapy are applicable in combination with the Bone Ring Technique.

Please note that the technique above requires trephines without guiding pins to remove the infected implant. These are not included in the Maxgraft® Bonering surgical kit.

Sinus Floor Elevation with Maxgraft® Bonering

This chapter describes the Maxgraft® Bonering technique with simultaneous sinus floor elevation (SFE) and implant placement. This method combines the lateral window approach with crestal implant insertion.

Allogenic bone blocks are known to be a successful alternative to autogenous blocks in sinus augmentation procedure with both immediate and late implantation.

If the residual bone height of the maxilla is less than 3 mm, or in cases with a subantral bone height of 3-6 mm where primary stability cannot be obtained, SFE procedures require a two-stage surgical protocol. The final prosthetic treatment may take place as late as 15 months after the surgery.

With Maxgraft® Bonering, a one-stage procedure can be performed and overall treatment time drastically reduced. Furthermore, a second surgical procedure becomes unnecessary, offering an alternative treatment option for patients who have concerns regarding multiple surgeries and long treatment times.

Guidelines for the application of Maxgraft® Bonering in the sinus:

- The technique requires a special screw to secure the implant in Maxgraft® Bonering. The screw head diameter needs to be larger than the shoulder of the implant. The screw must ensure close contact with the crestal bone to provide stability during the healing phase, as well as prevent the ring and the implant from moving into the sinus cavity.
- The bone ring can be kept in place in the sinus cavity with special tweezers: ‘bonering tweezers sinus’, available from Ustomed Instrumente (www.ustomed.de / Art. No. 10-824-165).
- Pre-op planning is mandatory for thoroughly reviewing the patient’s anatomy of the maxillary sinus, its adjacent structures, and residual bone height/quality.
- Placement of the implant and Maxgraft® Bonering must be correctly planned and performed to achieve a successful prosthetic rehabilitation.
- Care must be taken to keep the Schneiderian membrane intact.
- The sinus should be sufficiently wide, i.e. not too narrow at the base otherwise the ring cannot be placed flush with the bone.
- If the implant lacks primary stability, the residual bone height is too thin or the bone is of poor quality, it is recommended to switch to a two-staged standard lateral window SFE procedure.
- Healing time is approximately eight to nine months until final restoration.

Indication
Maxillary bone height of 1-3 mm, or if no primary stability can be obtained with direct implantation.

A residual bone height of less than 1 mm is contraindicated. Furthermore, the quality of the residual bone must always be evaluated when using this technique.
Sinus floor elevation
Surgical procedure and guidelines

**Step 1** Prepare the lateral window
After flap elevation, carefully prepare a lateral window with a burr or piezoelectric instrument.

**Step 2** Elevate the Schneiderian membrane
Gently detach the Schneiderian membrane from the inner aspect of the sinus cavity. The bony lid of the lateral wall of the sinus should be carefully reflected to allow visualization of the bony floor of the sinus and the area for bone ring implantation.

**Step 3** Prepare the implant position
Mark the planned implantation site from the crestal side with a diamond tulip.
Use a pilot drill to access and prepare the planned implant bed and axis. Take care to keep the Schneiderian membrane intact.

**Step 4** Place maxgraft® bonering
maxgraft® bonering is placed through the lateral window of the osteotomy. The height of maxgraft® bonering depends on the thickness and anatomy of the sinus floor and the length of the planned implant. Usually half of maxgraft® bonering (5 mm) is sufficient to stabilize the implant in the sinus cavity.

**Note:** It may be necessary to adjust the shape of the bone ring further to fit onto the floor of the sinus.

**Step 5** Place the implant
During the placement of the implant, hold maxgraft® bonering inside the sinus cavity through the lateral window using forceps to prevent rotation. The special tweezers from Ustomed can help to apply gentle pressure while screwing in the implant.

**Note:** The implant should be placed 1 mm subcrestally. See case 2 from Dr. Chmielowski for an alternative treatment procedure in case of very thin sinus floors.

**Step 6** Place a fixation screw
A special screw secures the implant within maxgraft® bonering. The screw head needs to be larger than the shoulder of the implant.
Ask botiss representatives which implant systems provide these screws: product-management@botiss.com

**Step 7** Fill sinus with bone substitute material
The remaining space in the sinus cavity should be filled with particulate bone substitute material thanks to its volume stability, cerabone® is recommended.

**Step 8** Cover the lateral window and close the wound
The lateral window should be covered with a resorbable collagen membrane (such as collprotect® or Jason® membrane). Closure of the flap for submerged healing should be carried out in a tension-free manner to facilitate healing.

**Note:** botiss offers a 3D printed model based on CT/CBCT sinus scans of the patient. This helps to visualize the sinus cavity, the necessary positioning of the ring and the lateral window and enables to train the hard-tissue procedure on the actual anatomical situation.
maxgraft® bonebuilder dummy Art. No. 32100 maxgraft® bonering sample Art. No. BOC-33SAM
Please contact botiss for further information.
**CLINICAL CASE BY**
Dr. Bernhard Giesenhagen, Kassel, Germany

**SINUS FLOOR ELEVATION AND IMPLANT PLACEMENT.**
Single-tooth restoration of maxillary bone height of 1.5 mm with maxgraft® bonering

- **Initial situation:** X-ray shows maxillary bone height of 1.5 mm in region 15
- **Preparation of a lateral window for external sinus floor elevation**
- **Gentle detachment of the Schneiderian membrane**
- **Insertion of maxgraft® bonering through the lateral window after preparing the implant position crestally**
- **The sinus cavity filled up with cerabone® and implant in place**
- **Cover screw with threads to fit the fixation cap**
- **Fixation cap secures the implant in place and prevents the ring and implant from moving into the sinus cavity**
- **Closure and fixation cap to provide stability during the healing phase**
- **X-ray eight months after surgery shows a stable bone situation and sufficient maxillary bone height**

**SURGICAL GUIDE**
**MAXGRAFT® BONERING**

---

**CLINICAL CASE BY**
Dr. Kris Chmielewski, Gdansk, Poland

**SINUS FLOOR ELEVATION ON BOTH SIDES OF THE MAXILLA**
Alternative treatment option to place an implant subcrestally in an eggshell thin sinus floor with maxgraft® bonering

- **Initial situation:** X-ray shows eggshell thin sinus floor (1–3 mm) and planned maxgraft® bonerings on both sides of the maxilla
- **Lateral window prepared with a piezoelectric instrument**
- **Detaching the Schneiderian membrane**
- **Defect filled with cerabone®**
- **Direct implant placement in the area with sufficient maxillary bone height**
- **Preparing ring and implant extracorally. The implant should be placed a below the margin of maxgraft® bonering**
- **Bone ring and implant placed through the lateral window and secured with a membrane screw**
- **Sinus cavity filled with more cerabone®**
- **Jason® membrane secured with titanium pins**
- **PRF matrix to support soft tissue healing**
- **Wound closed with single stitches and apical mattress sutures**
- **Second site treated in the same manner**
- **Nine months after surgery: Eventless healing and gingiva former in situ**

**Note:** This procedure is only recommended if the sinus floor is very thin or of poor quality because the lateral window requires a larger surgical site than the crestal approach and may therefore be more traumatic for the patient.
Surgical precautions and post-op care

- Tension-free wound closure is the key to success for every augmentation. Therefore, sufficient mobilization of the flap should be achieved. This is essential for vertical augmentations.
- Mattress sutures are recommended to remove tension from the lip and the facial muscles to avoid micromovements within the augmentation site.
- Sutures:
  - 4-0 Apical mattress sutures/single sutures
  - 5-0 Free gingival grafts
- The sutures are removed after approximately ten days.
- Mattress sutures are removed approximately three weeks after surgery.
- No pressure should be exerted on the healing site from temporary prosthesis. In the first three weeks, it is recommendable to renounce on any temporary provision.
- Advise patients to:
  - Avoid mechanical stress on the augmentation site. No solid food and excessive tooth brushing in the first days post-op.
  - Abstain from physical exercise in the first week after surgery.
  - Be examined immediately if inflammation or dehiscence is detected.

Healing time:

Healing times are approximately six months in standard bone ring procedures and eight months in sinus floor elevation procedures. The exact amount of time must be estimated individually by the surgeon depending on the location, type, and extent of the defect. The age of the patient should also be considered, as significant variations in patients of different age have been reported in terms of new bone formation. X-ray or CBCT follow-up is recommended

Re-entry

For an optimal aesthetic outcome, it is advisable to perform a special incision technique to produce an ideal emergence profile. The mean-der, or split finger, technique consist of a circular incision line around the implant to relocate attached gingiva to the buccal side around the implant.  

Courtesy of Dr. Bernhard Giesenhagen and Dr. Orcan Yüksel

Representative histological image of the healing and integration behavior of maxgraft® allogenic bone blocks at six months after surgery. The allograft becomes optimally integrated within new build bone (asterisks) (HE-staining, 10x magnification). Biopsy provided by Dr. Bernhard Giesenhagen.
Complication management

Thorough and regular follow-ups are essential to discover infection and dehiscence as soon as possible (three days, one and two weeks after surgery).

In case of dehiscence, the exposed graft needs to be removed to an extent so that bleeding occurs. The wound margins should be trimmed and mobilized again for wound closure. Additionally, a pedicled connected tissue graft (CTG) can help to close the augmentation area. If the flap keeps reopening, removal of the implant should be considered.

In all cases, patients should be treated with antibiotics and rinsed with chlorhexidine.

Pedicled palatal CTG in the upper jaw

Small fenestrations should be immediately covered by connective tissue graft after decontamination of the surface. A diamond round drill can be used to reduce the infected and exposed bone ring.

Rotated CTG from palatinal to cover the soft tissue defect and fixed with single sutures

Six weeks after CTG procedure

Courtesy of Dr. Bernhard Giesenhagen and Dr. Orcan Yüksel

References


Continuing education

Like every new surgical procedure, the Bone Ring Technique has its learning curve. To achieve ideal clinical results, it is highly recommended to attend a course prior to your first surgery.

Visit us on: https://botiss-academy.com/
For more clinical cases, videos and handling tips visit: http://www.indication-matrix.de/en/product/maxgraft-bonering
Innovation.
Regeneration.
Aesthetics.

Distributed by:
International Headquarter
Institut Straumann AG
Peter Merian-Weg 12
CH-4002 Basel
Switzerland
Phone  +41 (0)61 965 11 11
Fax    +41 (0)61 965 11 01

Pharmaceutical Entrepreneur:
botiss biomaterials GmbH
Hauptstr. 28
15806 Zossen
Germany
Tel.:  +49 33769 / 88 41 985
Fax:   +49 33769 / 88 41 986

www.straumann.com
www.botiss.com
www.botiss-dental.com
facebook:  botissdental

soft tissue
education
hard tissue