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Leinfelden-Echterdingen/Germany



**ConeCept**

RatioPlant®Implants  
case study



**Dr. Roland Rist**

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### **Curriculum vitae**

2009	Degree „Curriculum Aesthetic Dentistry“ (DGÄZ)
2008	Degree „Curriculum Laser Dentistry“ (S.O.L.A.)
2008	Degree „Curriculum Implantology“ ( DGI)
2007	Degree in „Curriculum Prosthetics“ (DGPro)
seit 2004	own clinic in Leinfelden-Echterdingen, Germany
2002-2004	employed dentist in the private clinic Dr. E.-P. Drescher, Stuttgart Bad Cannstatt
2000-2002	Assistant doctor in the clinic of Dr. H. Stumpf, Reutlingen, Germany
2003	Dissertation
1994-1999	Studied dentistry at the University of Tübingen

## Patient

female, 46 years, non-smoker  
regio 36, lower jaw  
bone quality (acc. to Misch) D3  
planned implants: 42-100

## Diagnosys

Missing tooth regio 36.

## Planned therapy

Enossal screw implant, prosthetic restoration with metal-ceramic crown on titanium abutment.



## Surgical approach

After a block anesthesia, an alveolar ridge incision was made and a mucoperiosteal flap was prepared, which was not mobilized beyond the mucogingival line.

The implant position was determined by measuring the distance to the adjacent teeth. At the determined implant position, the cortical bone was perforated by using the piezo surgery device (piezosurgery, Mectron S.p.A, Italy).

The further drilling was performed with the drills belonging to the HumanTech ConeCept system: pilot drill (1.5 mm), extension drill (32 100, 38 100), final drill (42 100) as well as the related countersink (4.2mm).

The implant was placed slightly subcrestally (approx. 0.2 mm) with the inserter. The primary stability was monitored by the torque control during insertion. The cover screw, which was charged with chlorhexidine gel, was screwed in. Endogenous bone chips were placed vestibular at the implant. The bone chips were collected by using the piezo surgery device and by gathering the chips of the used drills. No soft tissue mobilization was required for wound closure and no artificial membrane was used. The radiological control shows an ideal prosthetic position of the implant.

Exposure was performed 3 months after implant insertion by ablation of the soft tissue above the cover screw using a CO2 laser beam (CO2 laser US-20D, DEKA M.E.L.A. S.r.l., Italy). The healing cap size M with a height of 4.5mm was used. The osseointegration was checked by using the Periotest method (Periotest M, Medizintechnik Gulden, Germany). The impression was taken with an impression post for an open impression using an impression material with a high final hardness (Honigum heavy, DMG Chemisch-pharmazeutische Fabrik GmbH, Germany).

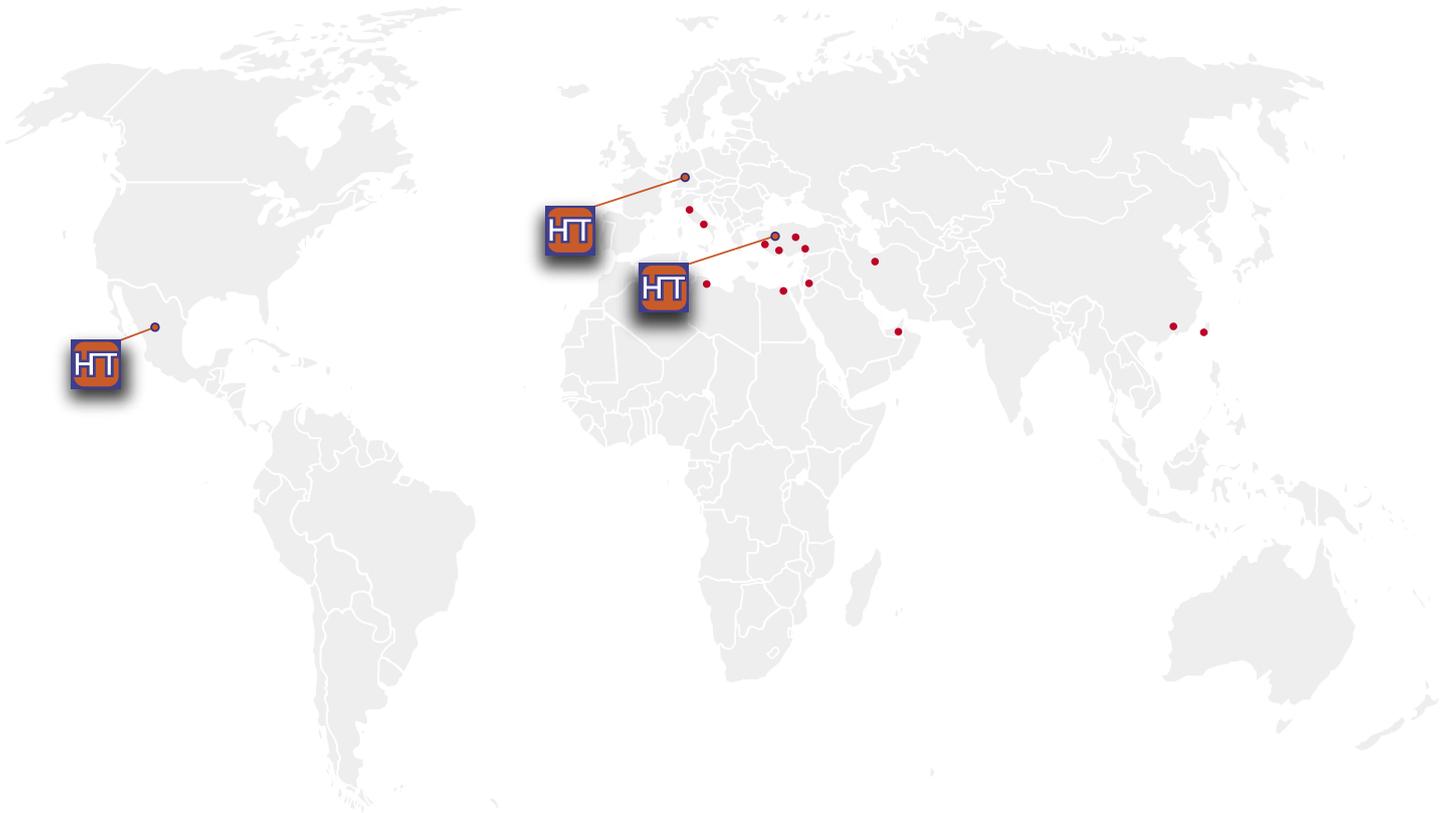
The dental laboratory manufactured a model with a lab analogue on which an all-ceramic crown on an individualized titanium abutment was placed.



## Conclusion

The RatioPlant ConeCept implant system includes implants with four different diameters and five different lengths. A suitable implant is available for every anatomical situation. With the help of the clearly arranged and color-coded RadioPlant ConeCept instrument tray, the implant was inserted in a time-saving manner. The surface roughened up to the implant shoulder (blasted and etched) in combination with the bacteria-proof and mechanically stable internal conical connection enables subcrestal positioning of the implant. The selection of prosthetic abutments allows an individually optimal prosthetic restoration.





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