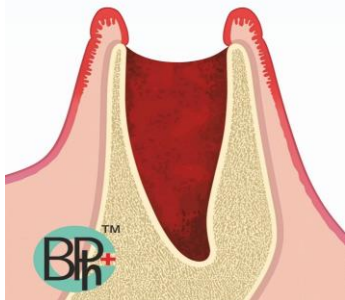


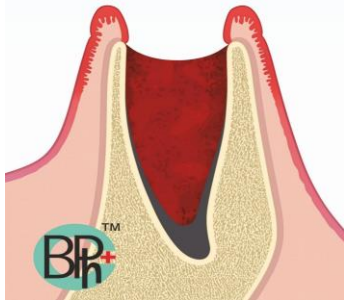
**BLOOD CLOT FORMATION**

within 1-3 hours



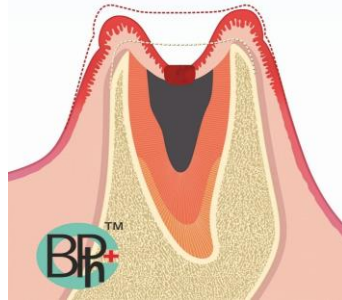
**FORMATION OF GRANULATION TISSUE**

in 1-5 days



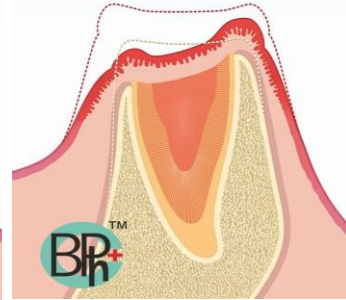
**EPITHELIZATION OF THE HOLE EDGES, FORMATION OF SCAR TISSUE, INITIAL STAGE OF CALCIFICATION OF SCAR TISSUE**

after 5-15 days



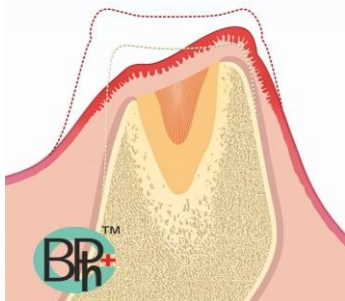
**FORMATION OF RETICULOFIBROSIS BONE TISSUE**

After 1-1,5 month



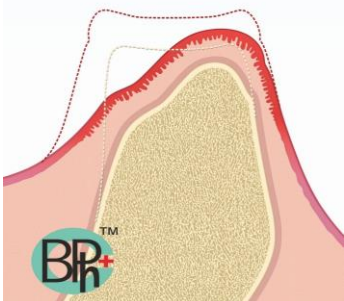
**FORMATION OF TRABECULAR BONE**

After 3 month



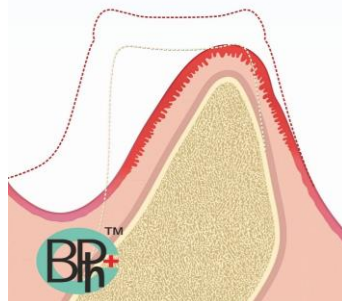
**VESTIBULAR BONE ATROPHY**

After 6-9 month

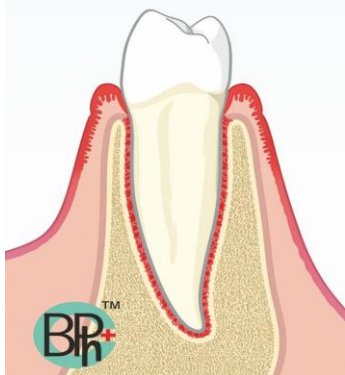


**VESTIBULAR BONE ATROPHY**

After 12 month



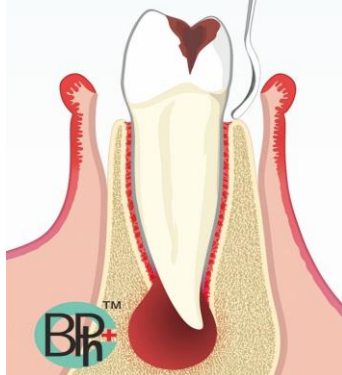
**EXAMPLE OF THE INITIAL SITUATION OF A HEALTHY TOOTH**



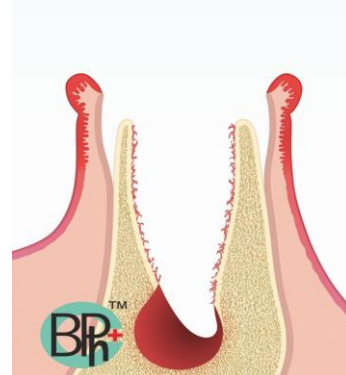
**INDICATION FOR TOOTH REMOVAL** *the inappropriateness of therapeutic treatment*



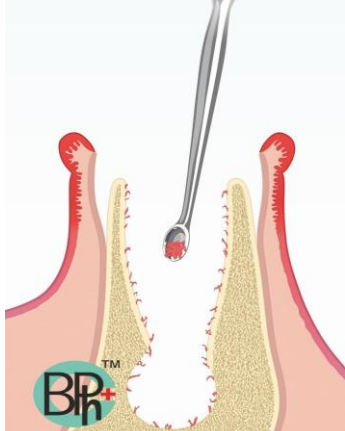
**WE CARRY OUT THE SEPARATION OF THE MUCOUS TOGETHER WITH THE PERIOOSTUS (just below the level of the attached mucosa)**



**VIEW OF THE HOLE AFTER THE REMOVAL OF THE TOOTH**



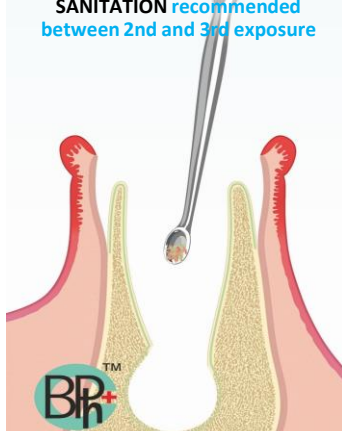
**WE CARRY OUT THE PRIMARY CURETTAGE OF THE HOLE**



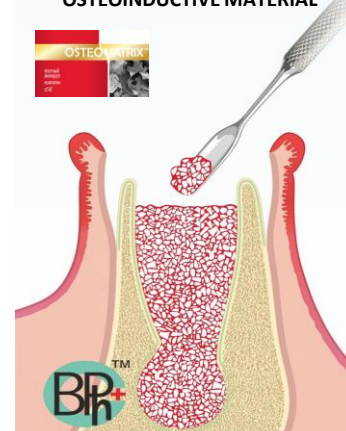
**WE PROCESS THE HOLE WITH ANTIBIOTICS FOR THE PURPOSE OF SANITATION (3 EXPOSURES EACH 1 MINUTE) DOXYCYCLINE and 10% solution of DIMEXIDE**



**REPEATED CURETTAGE OF THE HOLE AFTER WOUND SANITATION** *recommended between 2nd and 3rd exposure*



**FILLING THE HOLE WITH OSTEOINDUCTIVE MATERIAL**



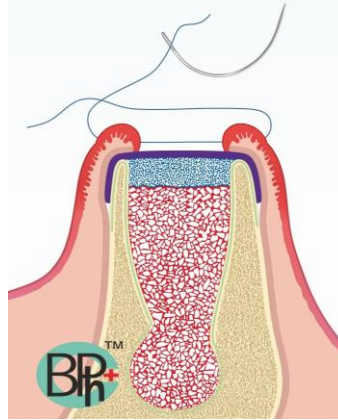
**ADDING A PROTECTIVE LAYER OF OSTEOCONDUCTIVE MATERIAL**



**PREVENTING BONE MATERIAL MIGRATION BY USING A RESORBABLE COLLAGEN MEMBRANE**

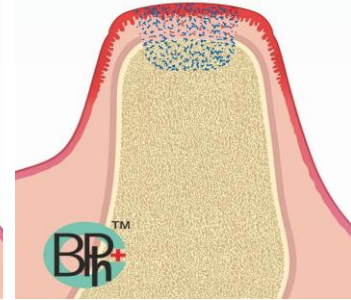


**SUIT THE WOUND**

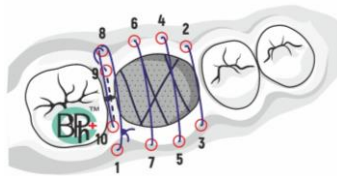


**LONG-TERM RESULT**

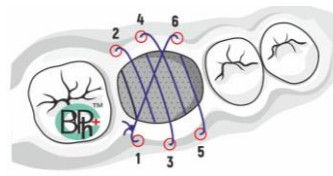
After 6 month



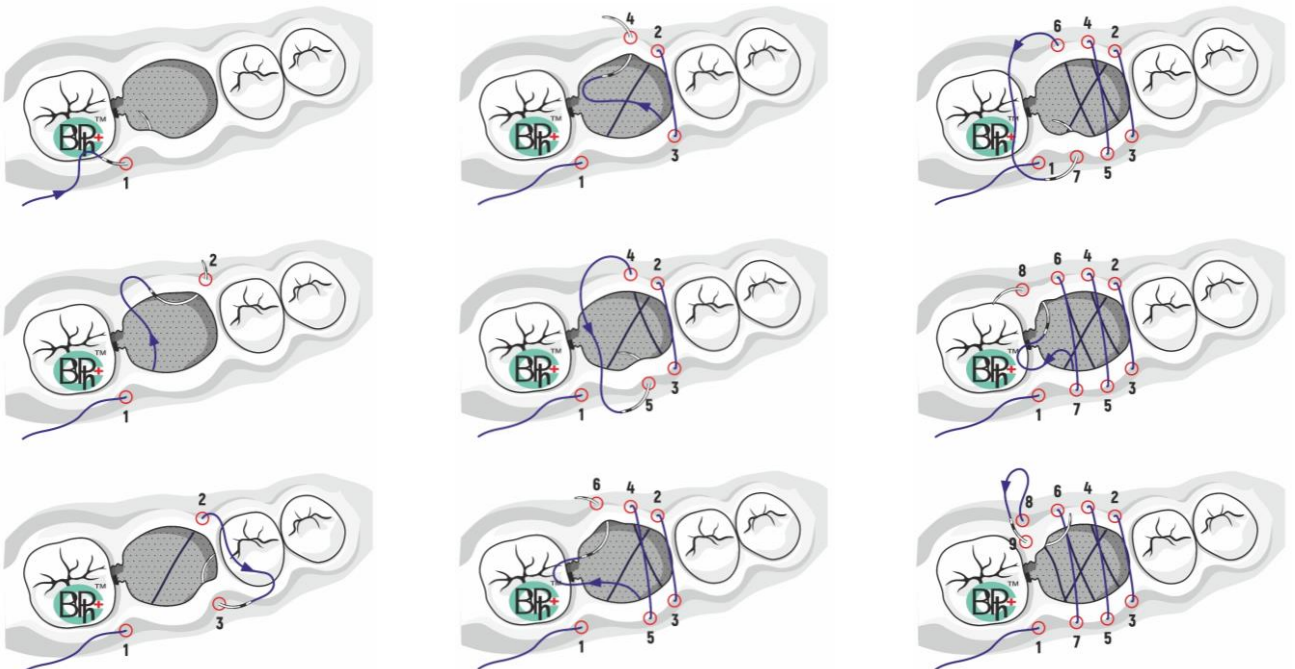
**WOUND SUITATION OPTION IN MUCOUS RUPTURE**

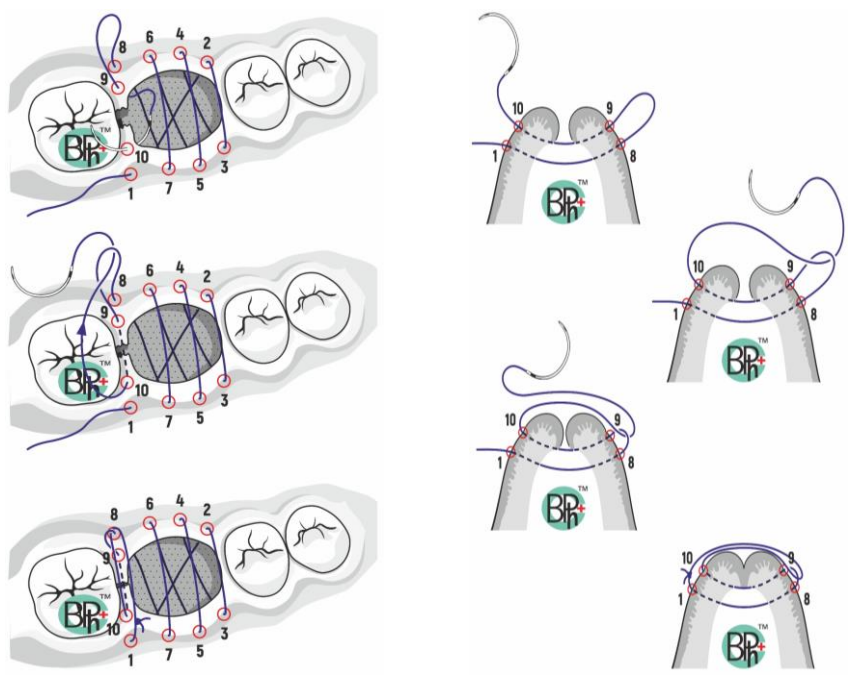


**VARIANT OF WOUND SUITATION WITHOUT RUPTURE OF THE MUCOUS**

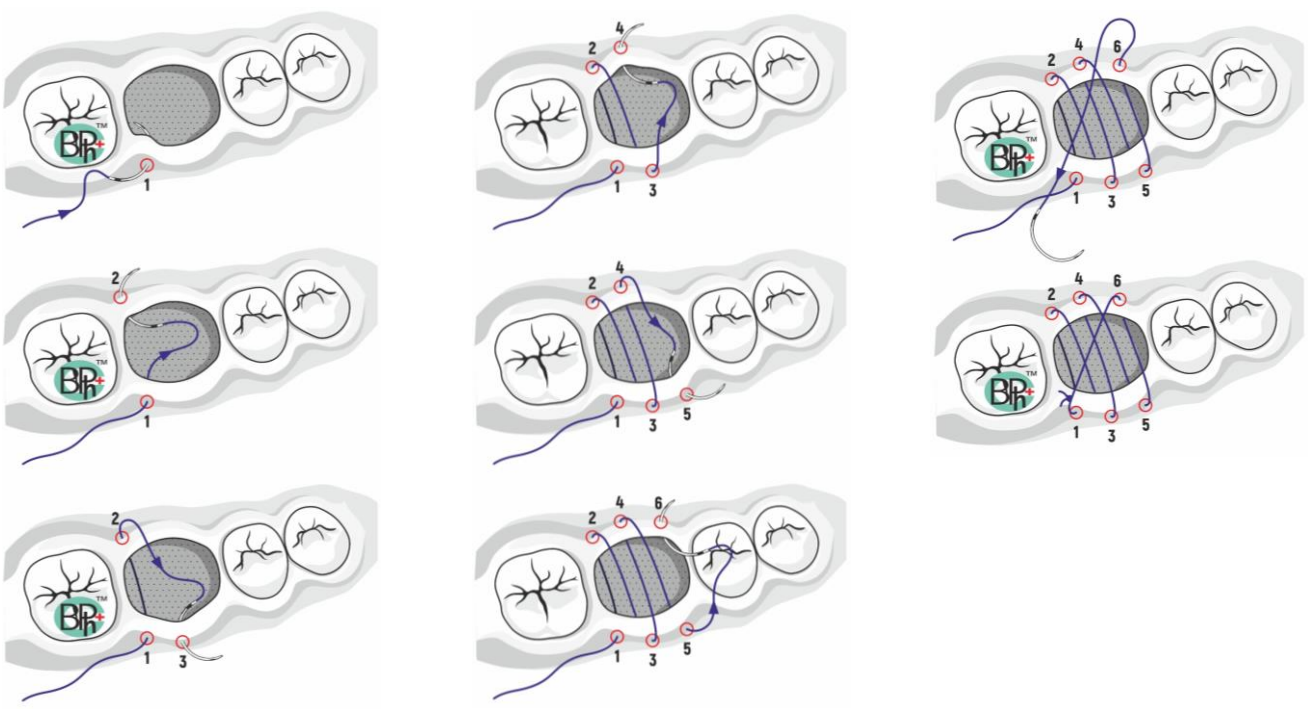


**VARIANT OF WOUND SUITATION WHEN THE MUCOUS IS RUPTURED, PROPOSED BRADLEY ROSS, DMD**



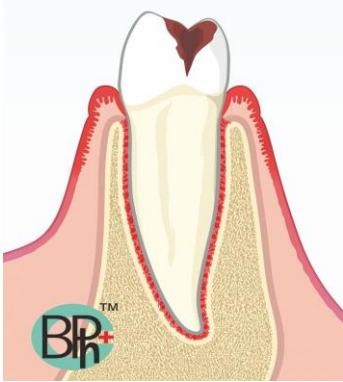


**OPTION OF WOUND SUITATION WITHOUT RUPTURE OF THE MUCOUS, PROPOSED BY ALEXEY IVASHCHENKO**

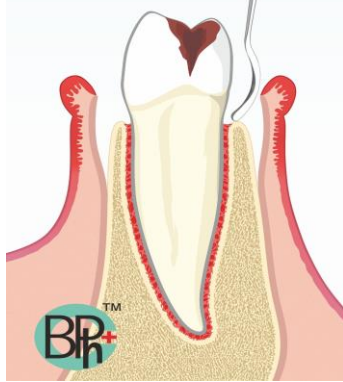


**INDICATION FOR TOOTH REMOVAL**

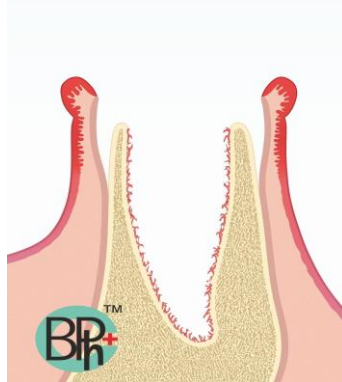
the inappropriateness of therapeutic treatment



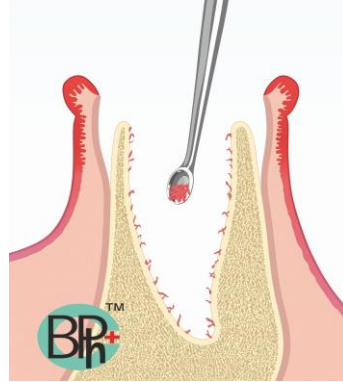
WE CARRY OUT THE SEPARATION OF THE MUCOUS TOGETHER WITH THE PERIOOSTUS (just below the level of the attached mucosa)



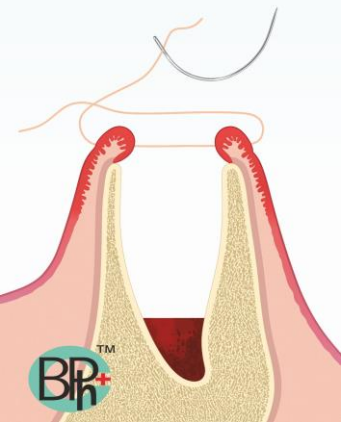
VIEW OF THE HOLE AFTER THE REMOVAL OF THE TOOTH



WE CARRY OUT CURETTAGE OF THE HOLE



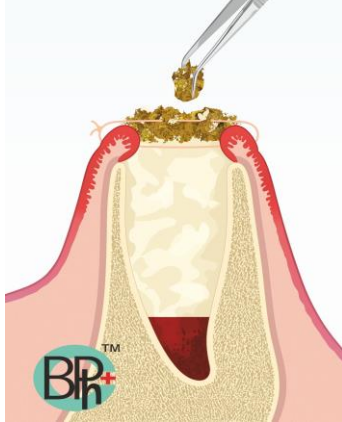
SUIT THE WOUND



FILL THE HOLE WITH A MIXTURE FROM HEPARIN OINTMENT WITH ANY BROAD SPECTRUM ANTIBIOTIC

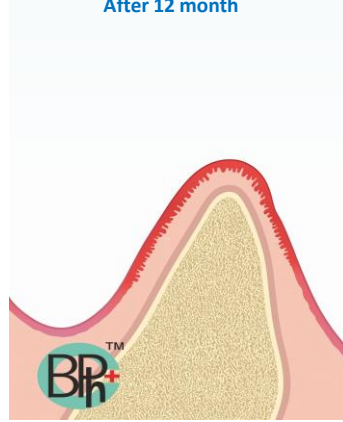


WE PLACE THE ALVEOGIL UNDER THE SEAMS, WHICH HAS PREVIOUSLY BEEN SATURATED WITH IODINE FORM



LONG-TERM RESULT

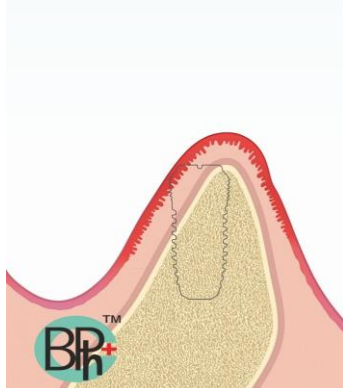
After 12 month



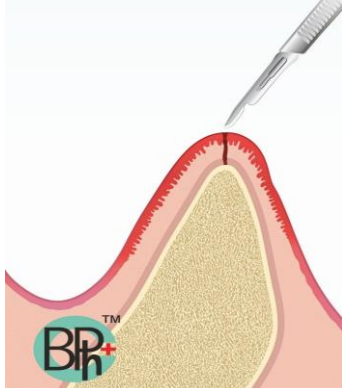
INITIAL SITUATION WITH BONE DEFICIENCY FROM THE VESTIBULAR SIDE



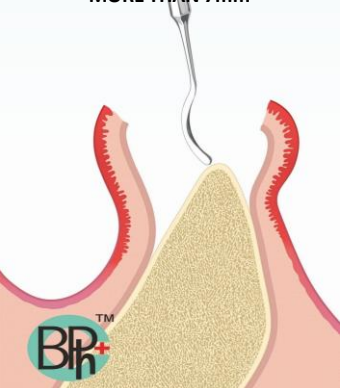
PLANNED LOCATION FOR IMPLANT INSTALLATION



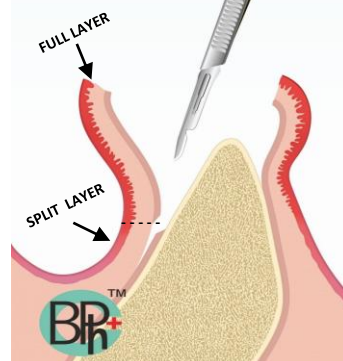
WE MAKE A CUT IN THE MIDDLE - OF THE CRESTS "WHITE LINE"



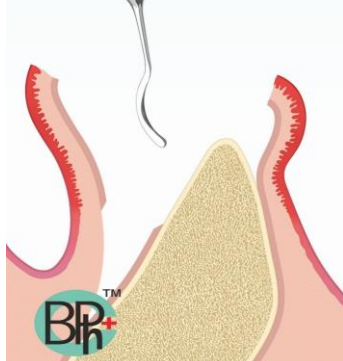
WE SEPARATE THE MUCOSA VESTIBULARY TO THE BORDER OF THE ATTACHED MUCOUS FROM THE LINGUAL SIDE NO MORE THAN 7mm



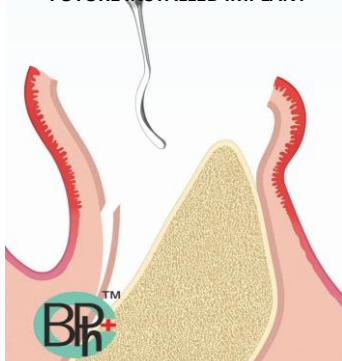
WE FORM A "SPLIT FLAP" FROM THE VESTIBULAR SIDE AT THE BORDER OF THE TRANSITION FROM THE FIXED TO THE MOVABLE MUCOSA



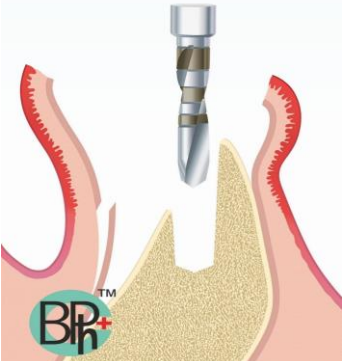
WE SEPARATE THE MUSCLE LAYER FROM THE PERIOOSTEUS WITH A DULL INSTRUMENT



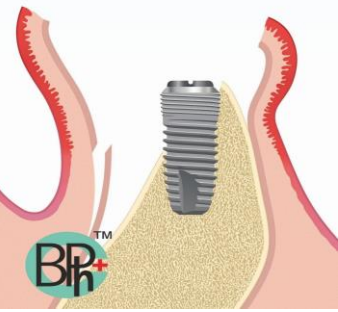
WE REMOVE THE PERIOOSTE FROM THE BONE, FORM A SUBPERIOSTONE POCKET FOR THE MEMBRANE, Slightly BELOW THE LEVEL OF THE APEX OF THE FUTURE INSTALLED IMPLANT



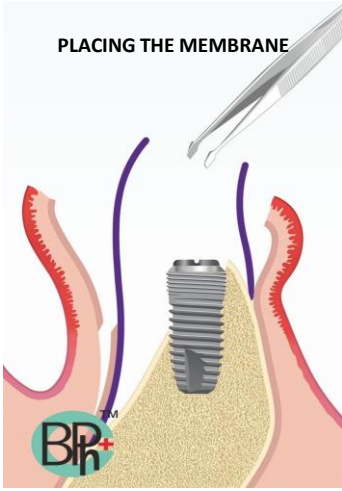
WE FORM A PLACE FOR IMPLANT INSTALLATION



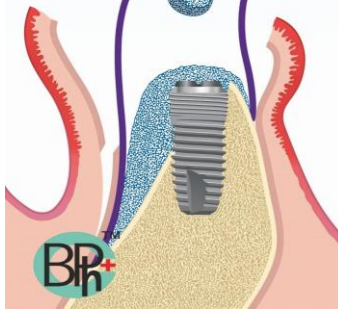
INSTALLING THE IMPLANT



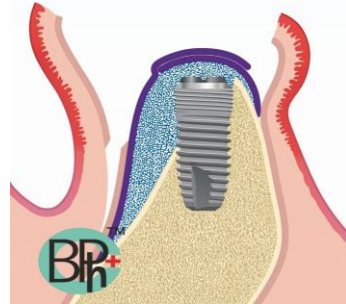
PLACING THE MEMBRANE



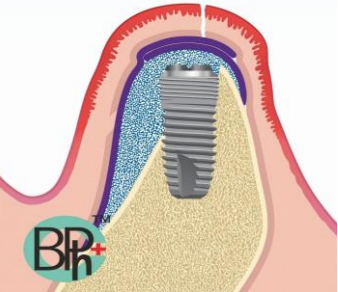
WITH THE HELP OF OSTEOCONDUCTIVE MATERIAL WE RESTORE THE LOST BONE VOLUME FROM THE VESTIBULAR SIDE AND PROTECT THE IMPLANT FROM FIBROINTEGRATION, AND THE BONE FROM RESORPTION



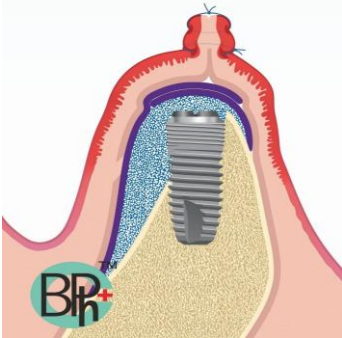
WE "SLAP" THE MEMBRANE ON THE "COAT" PRINCE



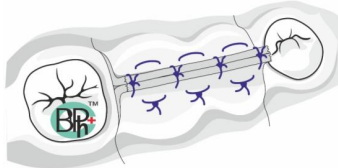
REDUCING THE EDGES OF THE MUCOUS



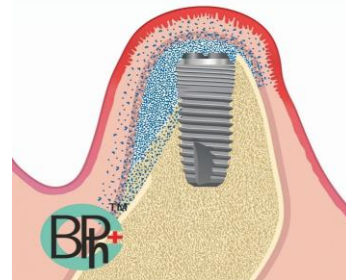
SURGUE THE MUCOSA



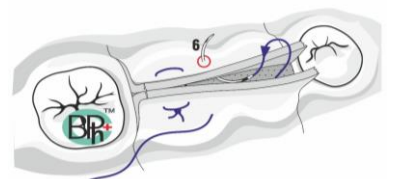
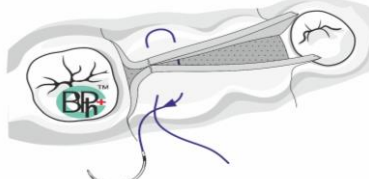
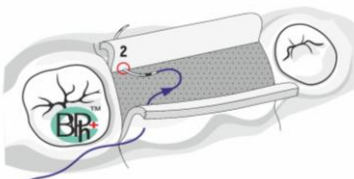
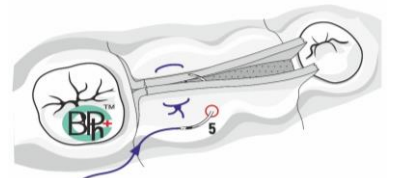
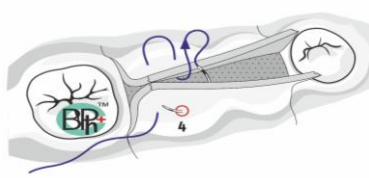
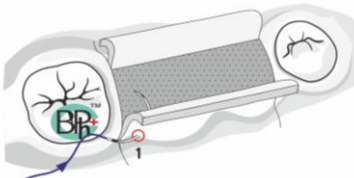
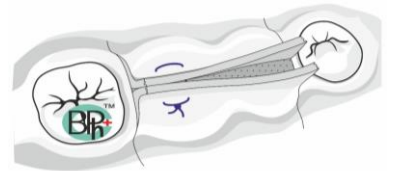
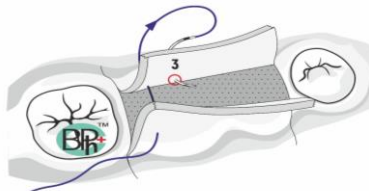
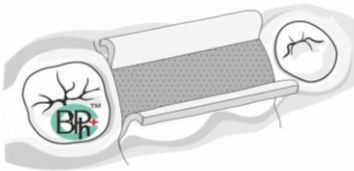
LOWER JAW SUITATION OPTION RECOMMENDED BY ISHTWAN URBAN AND NAOSHI SATO

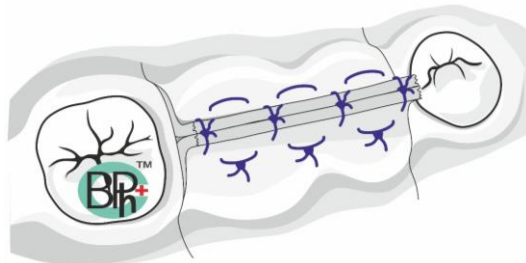
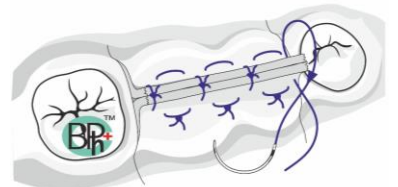
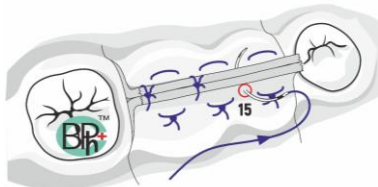
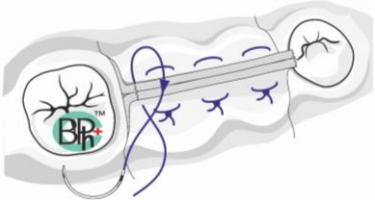
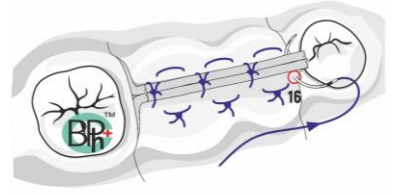
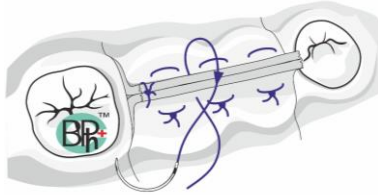
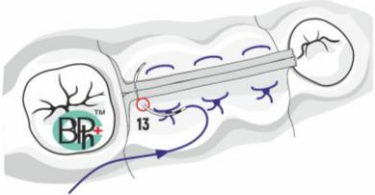
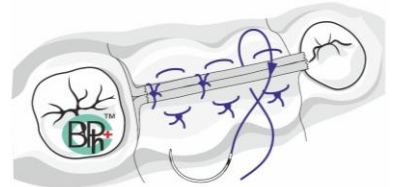
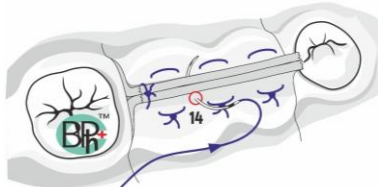
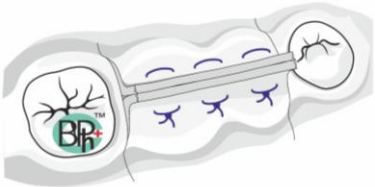
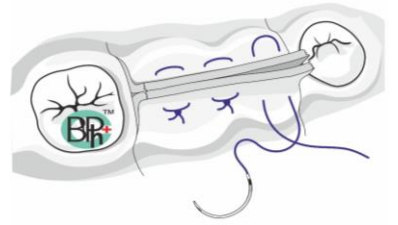
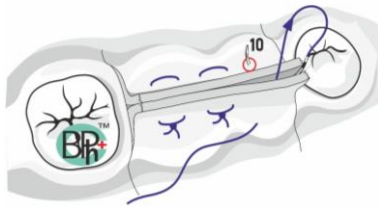
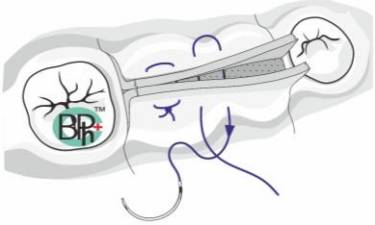
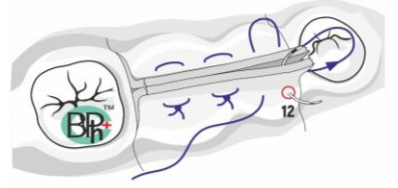
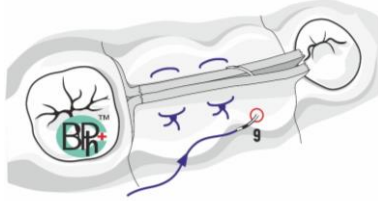
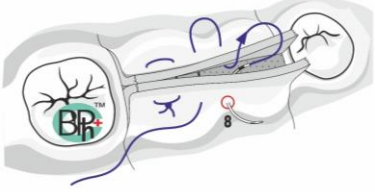
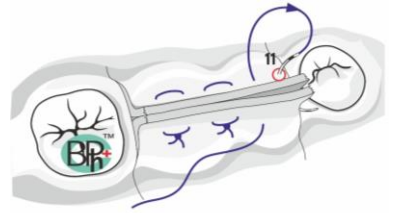
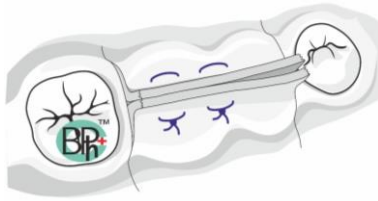
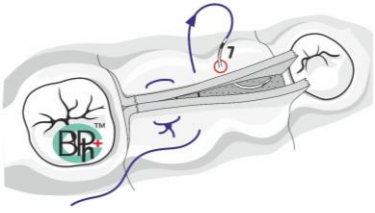


RESULT IN 3 MONTHS

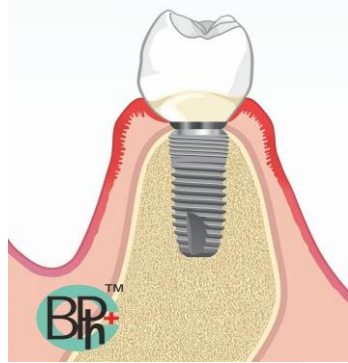


LOWER JAW SUITATION OPTION RECOMMENDED ISHTWAN URBAN AND NAOSHI SATO





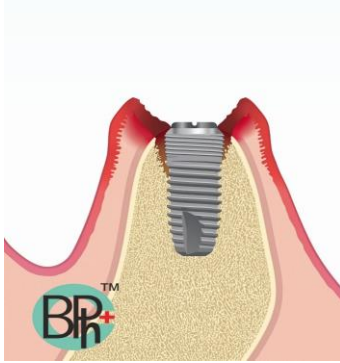
INITIAL SITUATION



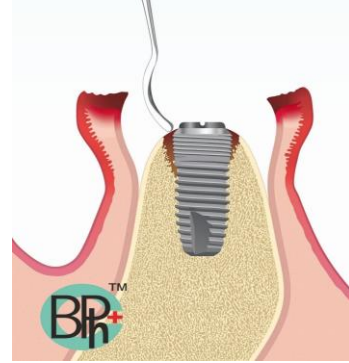
PERI-IMPLANTITIS OCCURRED



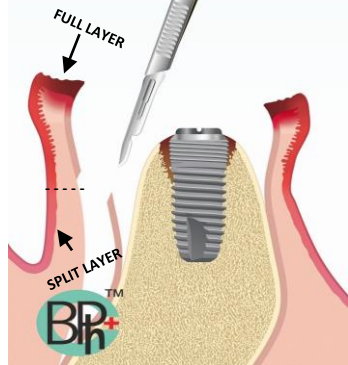
REMOVED THE CROWN AND INSTALLED THE PLUG



SEPARATE THE MUCOUS



WE FORM A "SPLIT FLAP" FROM THE VESTIBULAR SIDE AT THE BORDER OF THE TRANSITION FROM FIXED TO MOBILE MUCOSA



WE REMOVE GRANULATE ON MUCOUS WITH SCISSORS



WE REMOVE GRANULATE FROM DEFECT WITH CURETTE



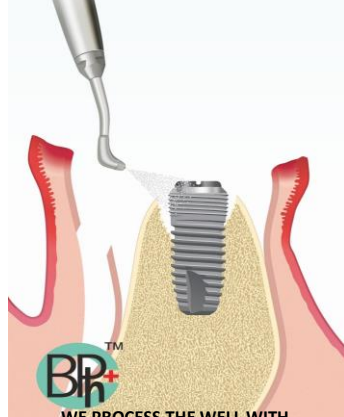
WE PROCESS ONLY THE BONE EDGE OF THE DEFECT WITH ULTRASOUND (WITHOUT HITTING THE IMPLANT)



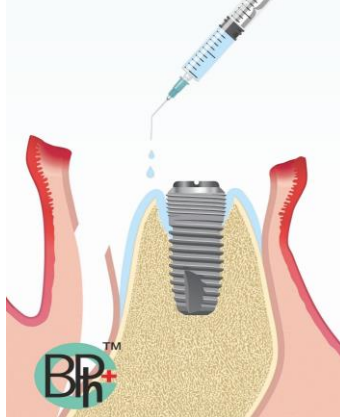
WE PROCESS THE IMPLANT WITH A BRUSH 10% solution of DIMOXIDE WITH DOXYCYCLINE



WE PROCESS THE DEFECT WITH SODA



WE WASH WITH HYDROGEN PEROXIDE



AGAIN WE PROCESS USING ULTRASOUND ONLY THE BONE EDGE OF THE DEFECT (WITHOUT HITTING THE IMPLANT)



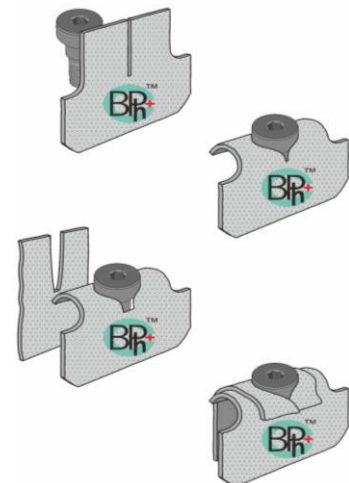
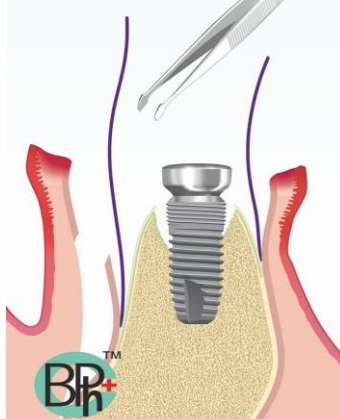
REPLACING THE PLUG WITH THE GINGIVAL FORMER



WE PROCESS THE WELL WITH ANTIBIOTICS FOR THE PURPOSE OF SANITATION (3 EXPOSURES EACH 1 MINUTE) DOXYCYCLINE and 10% DIMOXIDE solution



FILLING THE MEMBRANE SUBPERIOSTALLY

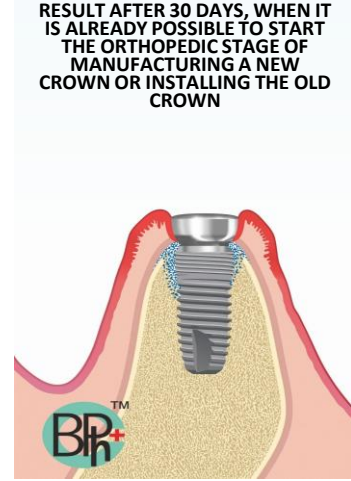
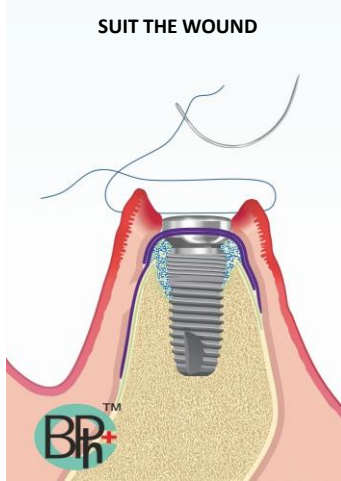
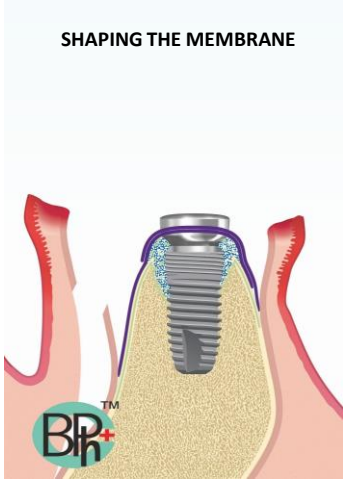
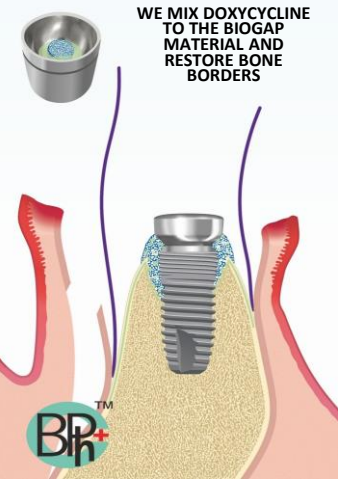


WE MIX DOXYCYCLINE TO THE BIOGAP MATERIAL AND RESTORE BONE BORDERS

SHAPING THE MEMBRANE

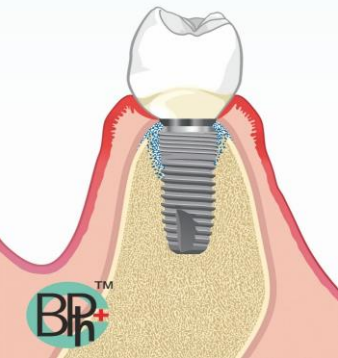
SUIT THE WOUND

RESULT AFTER 30 DAYS, WHEN IT IS ALREADY POSSIBLE TO START THE ORTHOPEDIC STAGE OF MANUFACTURING A NEW CROWN OR INSTALLING THE OLD CROWN



FINAL RESULT AFTER CROWN INSTALLATION

PERIIMPLANTITIS - WE KNOW HOW TO FIGHT IT CORRECTLY!!!



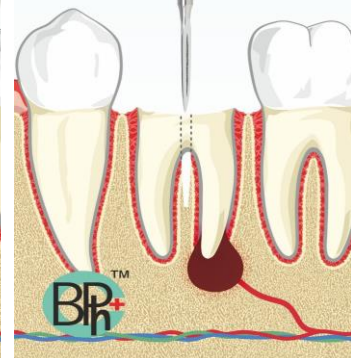
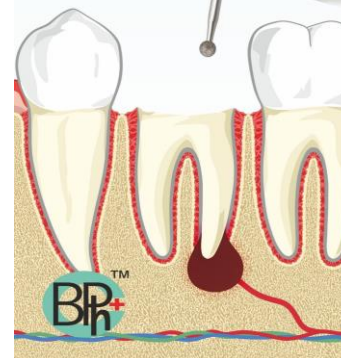
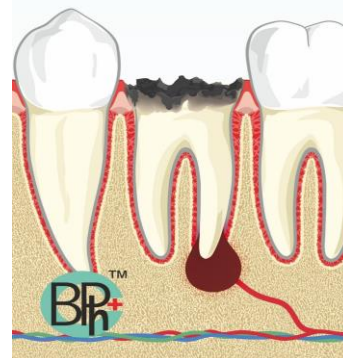
INITIAL SITUATION

INDICATION FOR TOOTH REMOVAL

the inappropriateness of therapeutic treatment

WE REMOVE CARIOUS DECAF WITH A Spherical BOR (CAREFULLY)

WE FORM A PERFORATION IN THE CENTER OF THE REMAINING TOOTH WITH A PILOT DRILL

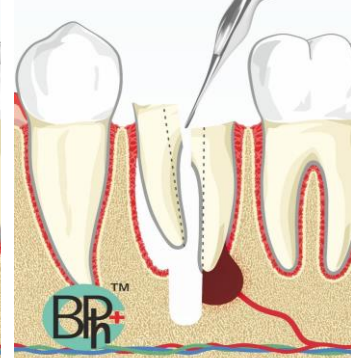
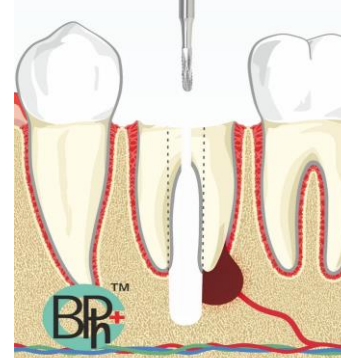
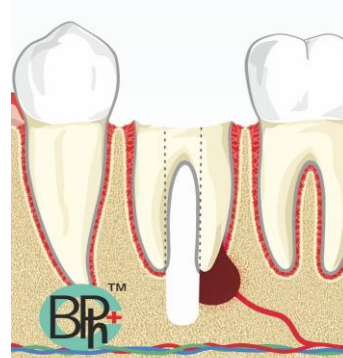
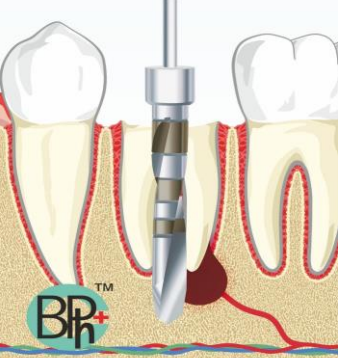


WE FORM A PLACE OF THE FUTURE IMPLANT (for the entire length and 50% of the estimated diameter)

VIEW AFTER THE FORMATION OF A PLACE FOR THE IMPLANT

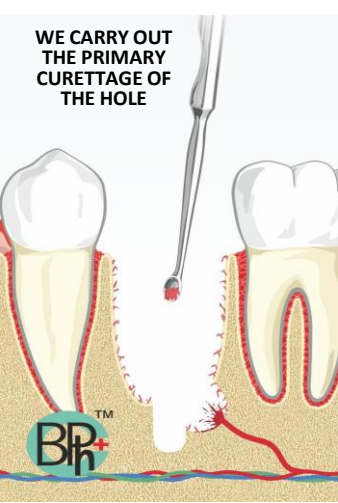
WE PRODUCE THE SECTION OF THE ROOTS WITH A SURGICAL BUR

ATRAUMATICALLY REMOVE TOOTH ROOTS

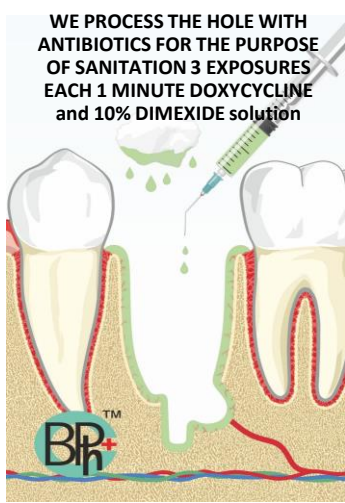




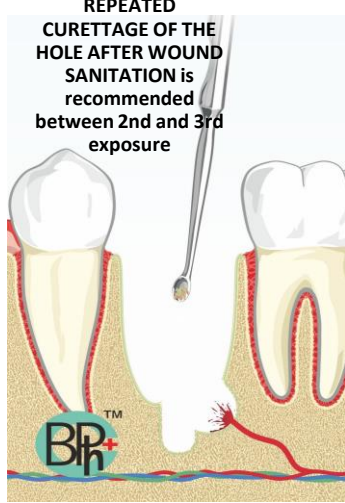
WE CARRY OUT THE PRIMARY CURETTAGE OF THE HOLE



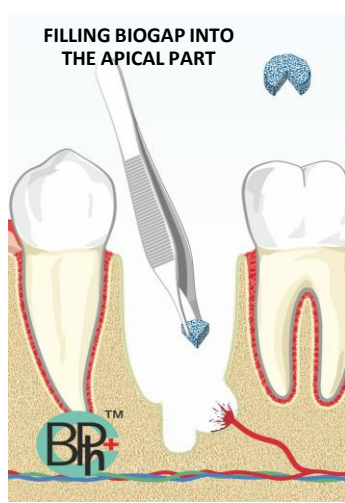
WE PROCESS THE HOLE WITH ANTIBIOTICS FOR THE PURPOSE OF SANITATION 3 EXPOSURES EACH 1 MINUTE DOXYCYCLINE and 10% DIMEXIDE solution



REPEATED CURETTAGE OF THE HOLE AFTER WOUND SANITATION is recommended between 2nd and 3rd exposure



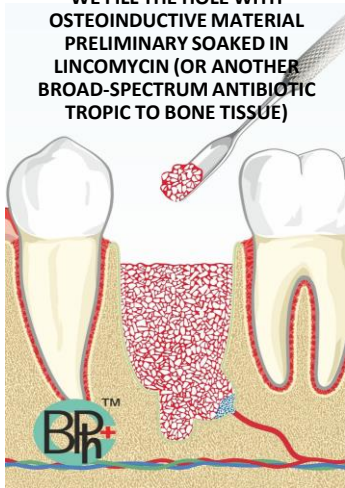
FILLING BIOGAP INTO THE APICAL PART



WE MAKE FILLING WITH BIOGAP OF THE EXIT OF THE VASCULAR BEAM (to stop bleeding and growth of fibrous cells)



WE FILL THE HOLE WITH OSTEOINDUCTIVE MATERIAL PRELIMINARY SOAKED IN LINCOMYCIN (OR ANOTHER BROAD-SPECTRUM ANTIBIOTIC TROPIC TO BONE TISSUE)



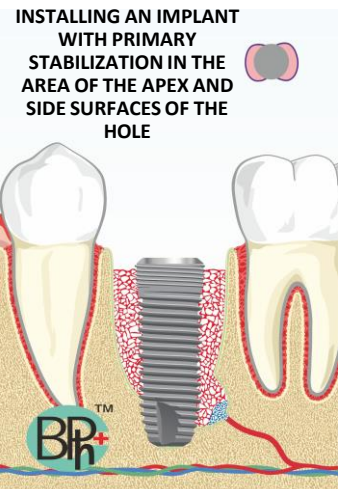
WITH A DRILL ONE DIAMETER LESS THAN THE ESTIMATED DIAMETER OF THE IMPLANT WE PASS THROUGH THE MATERIAL (AT LOW RPM)



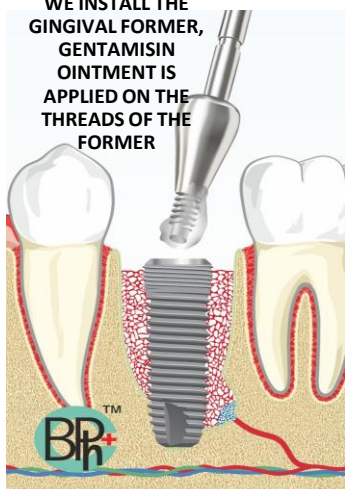
VIEW AFTER DRILLING



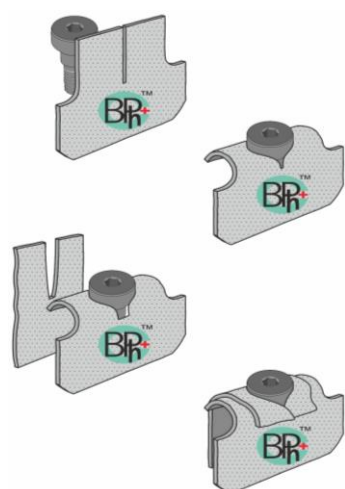
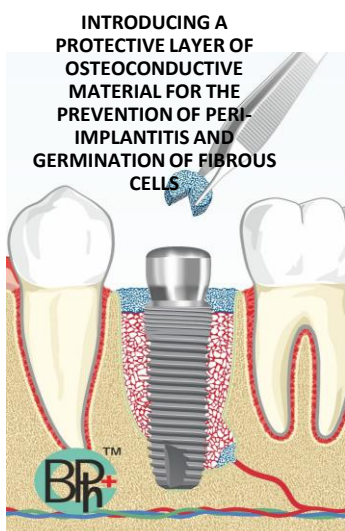
INSTALLING AN IMPLANT WITH PRIMARY STABILIZATION IN THE AREA OF THE APEX AND SIDE SURFACES OF THE HOLE



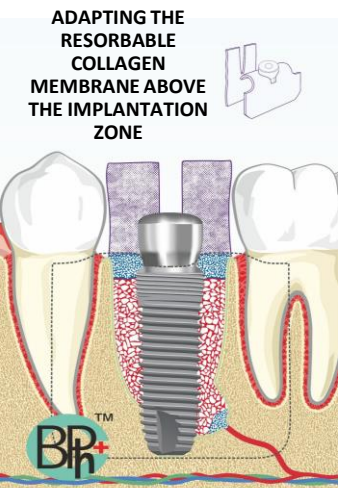
WE INSTALL THE GINGIVAL FORMER, GENTAMISIN OINTMENT IS APPLIED ON THE THREADS OF THE FORMER



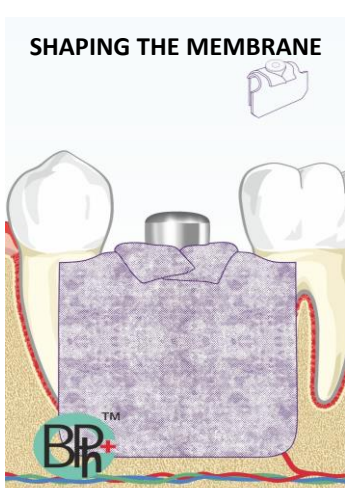
INTRODUCING A PROTECTIVE LAYER OF OSTEOCONDUCTIVE MATERIAL FOR THE PREVENTION OF PERI-IMPLANTITIS AND GERMINATION OF FIBROUS CELLS



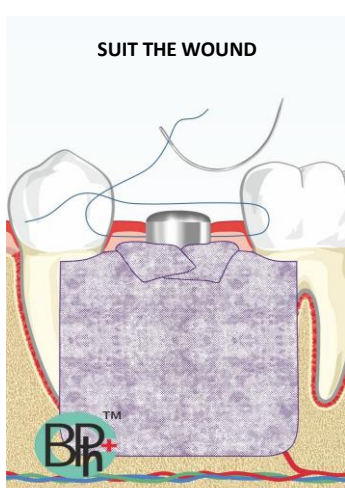
ADAPTING THE RESORBABLE COLLAGEN MEMBRANE ABOVE THE IMPLANTATION ZONE



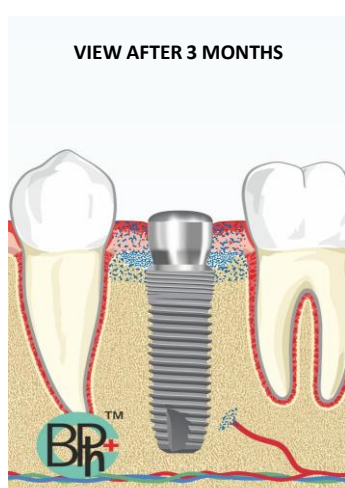
SHAPING THE MEMBRANE

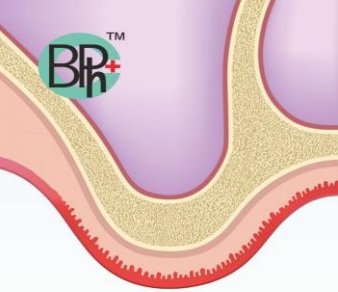


SUIT THE WOUND

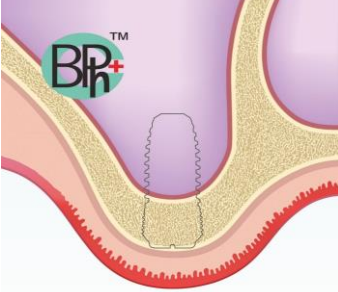


VIEW AFTER 3 MONTHS





INITIAL SITUATION



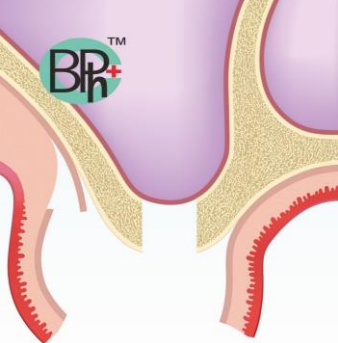
PLANNED IMPLANT INSTALLATION LOCATION



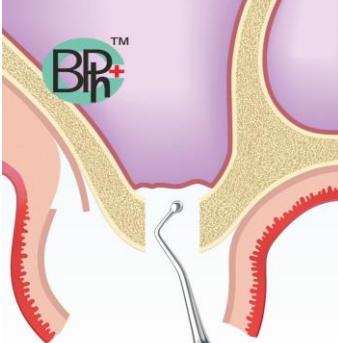
WE MAKE A CUT IN THE MIDDLE - THE "WHITE LINE" OF THE COMB



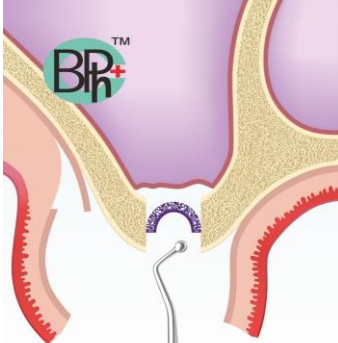
WE SEPARATE THE VESTIBULAR MUCOSA TO THE BORDER OF THE ATTACHED MUCOUS \* FROM THE LINGUAL SIDE NO MORE THAN 7mm WE FORM A "SPIVATED FLAP" FROM THE VESTIBULAR SIDE AT THE BORDER OF THE TRANSITION OF THE FIXED TO MOBILE MUCOUS PERIOSTONE



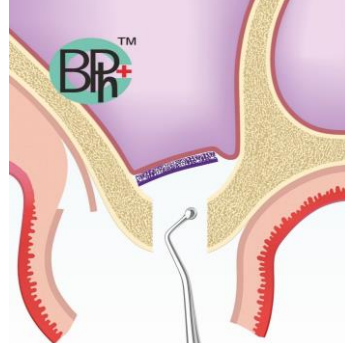
WE FORM A PLACE FOR IMPLANT INSTALLATION



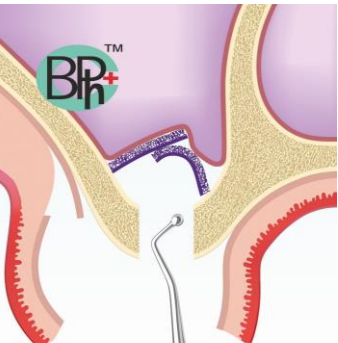
WE LIFT THE SCHNEIDER MEMBRANE WITH A BALL-SHAPED SMOOTHER



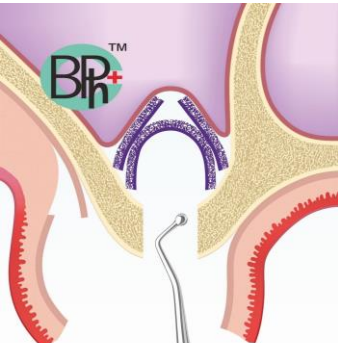
WE CUT A PIECE OF FLEECE AND BRING IT INSIDE



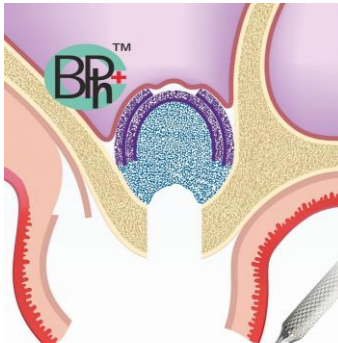
WE PUSH THE SCHNEIDER-MEMBRANE EVEN MORE THROUGH THE FLEECE



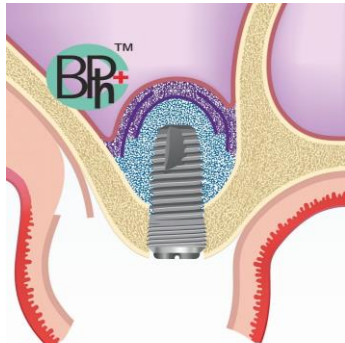
WITH THE SECOND PIECE OF FLEECE WE CONTINUE TO PUT OFF THE SCHNEIDER MEMBRANE



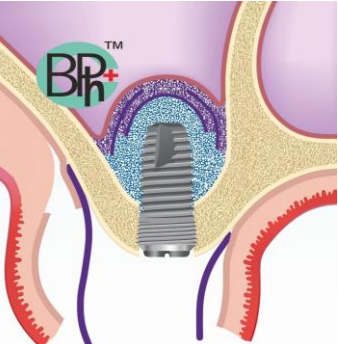
WE FORM A "DOME" WITH THE THIRD PIECE OF FLEECE



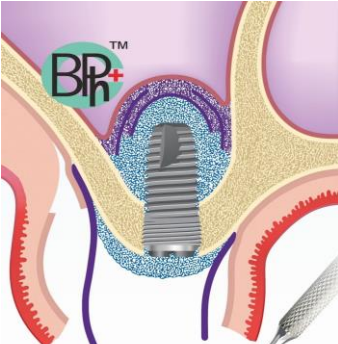
FILLING OSTEOCONDUCTIVE MATERIAL



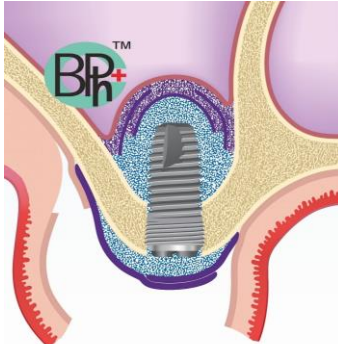
INSTALLING THE IMPLANT



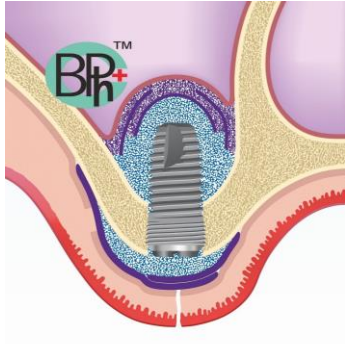
PUTTING THE MEMBRANE



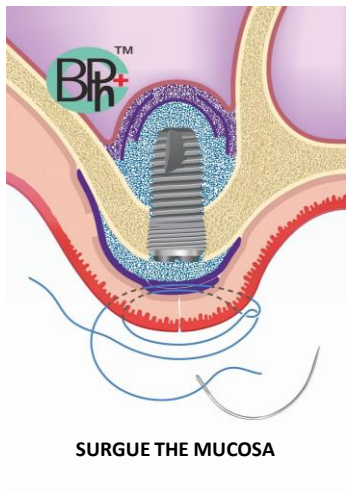
WITH THE HELP OF OSTEOCONDUCTIVE MATERIAL WE RESTORE THE LOST BONE VOLUME FROM THE VESTIBULAR SIDE AND PROTECT THE IMPLANT FROM FIBROINTEGRATION, AND THE BONE FROM RESORPTION



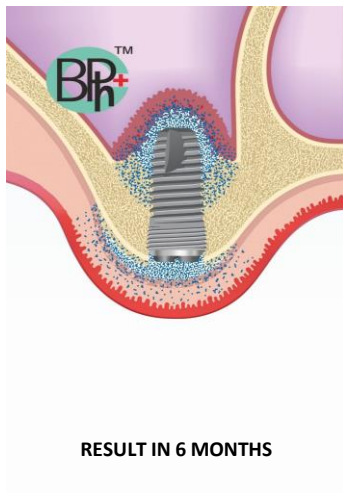
"SLAP" THE MEMBRANE ON THE "COAT" PRINCE



REDUCING THE EDGES OF THE MUCOUS



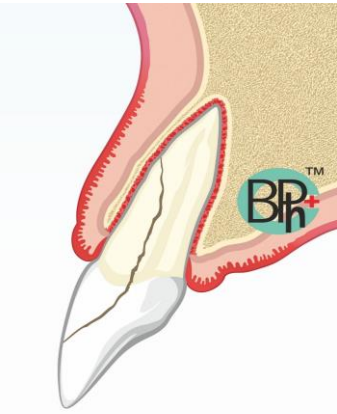
**SURGUE THE MUCOSA**



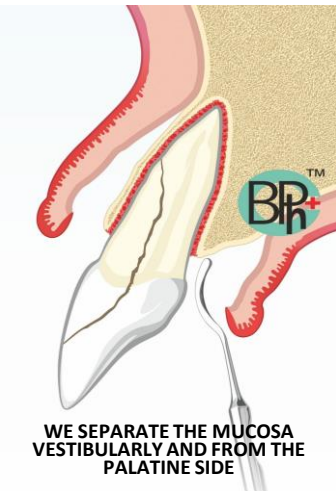
**RESULT IN 6 MONTHS**



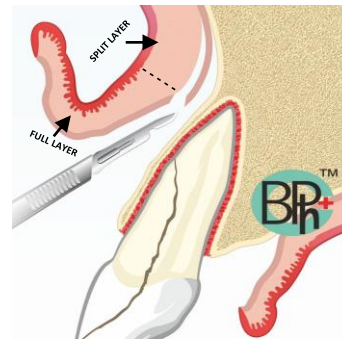
SCAN TO VIEW  
VIDEO ON  
CLOSED SINUS  
LIFTING



**CRACK IN THE ROOT OF THE TOOTH**



**WE SEPARATE THE MUCOSA VESTIBULARY AND FROM THE PALATINE SIDE**



**WE FORM A "SPLIT FLAP" FROM THE VESTIBULAR SIDE AT THE BORDER OF THE TRANSITION OF THE FIXED AND NON-FASTENED MUCOUS WE SCREW THE PERIOOSTUS AND PUSH THE SOFT TISSUES AWAY WITH A BLUNT INSTRUMENT**



**WE CARRY OUT ATRAUMATIC REMOVAL**



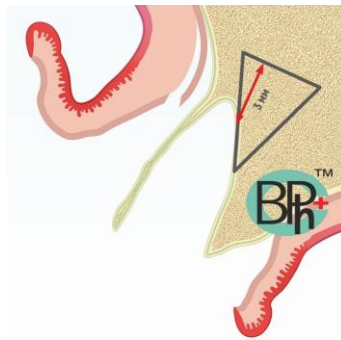
**WE DO MECHANICAL CURETTAGE OF THE HOLE OF THE EXTRACTED TOOTH**



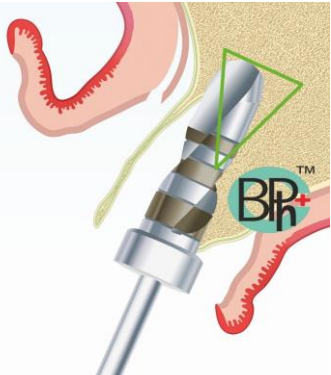
**WE PROCESS THE HOLE WITH ANTIBIOTICS FOR THE PURPOSE OF SANITATION (3 EXPOSURES EACH 1 MINUTE) DOXYCYCLINE and 10% DIMEXIDE solution**



**REPEATED CURETTAGE OF THE HOLE AFTER WOUND SANITATION is recommended between 2nd and 3rd exposure**



**IT IS RECOMMENDED TO CREATE A BONE SUPPORT BY INTRODUCING THE APICAL THIRD OF THE IMPLANT INTO THE NATIVE BONE TO A DEPTH OF NOT LESS THAN 3mm AND SOME MUCH MORE PALATINA RELATIVE TO THE ROOT OF THE REMOVED TOOTH**



**WE FORM A BONE SITE UNDER THE IMPLANT, ACCORDING TO THE ZONE OF ERUPTION AND EXIT OF THE SCREW CHANNEL FOR TRANSACCLUSION FIXATION**



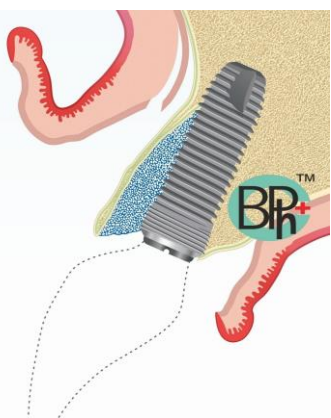
**FILLING THE ENTIRE DEFECT WITH OSTEOCONDUCTIVE MATERIAL BIOGAP**



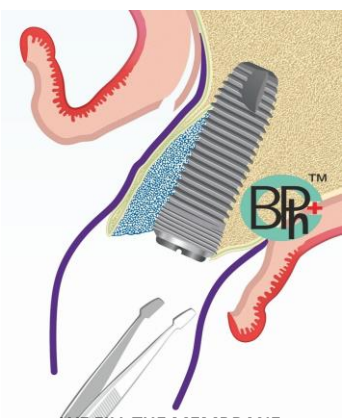
**WITH A DRILL ONE DIAMETER LESS THAN THE INTENDED DIAMETER OF THE IMPLANT, WE FORM A DIRECTION FOR THE IMPLANT AND THEREFORE SEALING THE MATERIAL APICALLY AND LATERALLY**



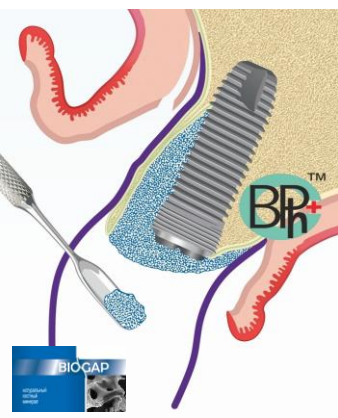
**VIEW OF THE HOLE AFTER DRILLING**



**THE IMPLANT IS INSTALLED, THE PLUG IS TURNED IN**



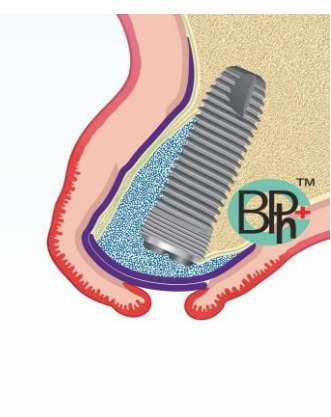
**WE FILL THE MEMBRANE SUBPERIOOSTALL, FROM THE VESTIBULAR SIDE BELOW THE IMPLANT APEX**



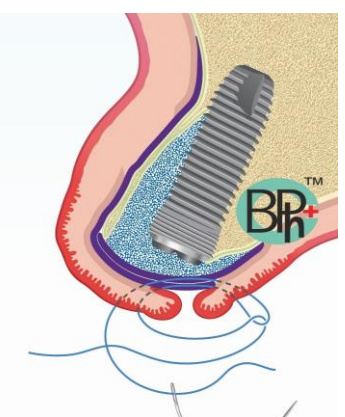
**FILLING A PROTECTIVE LAYER OF OSTEOCONDUCTIVE MATERIAL FOR THE PREVENTION OF PERI-IMPLANTITIS AND GERMINATION OF FIBROUS CELLS**



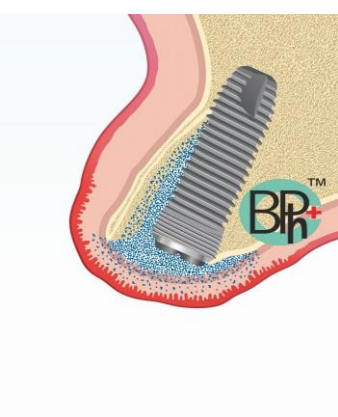
**COLLAPSE THE COLLAGEN MEMBRANE ABOVE THE IMPLANTATION ZONE**



**REDUCING THE EDGES OF THE MUCOUS**



**WE SUIT THE WOUND, FULL DRAWING IS NOT REQUIRED**



**RESULT IN 90 DAYS**