who wants information about large-diameter implants? How can clinicians obtain more information on the topic? The reason for this question is the wide range of implants available, but there is not a great deal of information about mini implants.

Making mini implants succeed means adequate planning. It means parallelism. It means first placing them in Type IV bone. There are many reasons for mini failure. There are people who think they can place too many minis. We have to remember that mini implants are mini, not mini conventionally.

Some clinicians say that mini implants are good for use in the anterior mandible, but it's not clear how many years they will last. The answer depends on the type of bone. For Type I bone, mini implants can last for 20 years. If the dentist is using a lab that has not routinely placed them, you may consider a casting. If the mini implants are placed too far back, it might be necessary to do some tooth movement. This can be problematic, as we have to compensate for that quite nicely. One thing we can do is extend the canine areas with two mini implants. If the dentist is working with a lingual border, instead of a two-unit connection, you might want to go to one mini and two small-diameter implants. For the mandibular arch, you might get one mini implant.

Regarding lining up the implants — and the problem with mini implants — it's a mandibular overdenture, so that as you go distal from the implant is reduced. I still very strongly prefer the 1.8 mm. It's a big bone distance. The 1.8 mm is a great bone diameter. It's relatively dense. Anything distal to that — the mandible — is not a particularly good indication for small-diameter implants. The posterior mandible is not a particularly good indication for small-diameter implants.

If the mandible is bilateral with conventional-diameter implants in the anterior mandible, you might be putting four implants very nicely on the posterior mandible. IMTEC and others say six implants. I have, over the years, changed to make them a viable long-term option. I usually say two small-diameter implants and go to 2.4 mm, 2.5 mm, 2.9 mm.

Other studies found 91 percent retention, which is very good. We have to think about a major advantage to the clinician. I delivered a program at the World Congress of Minimally Invasive Dentistry, and it was on mini implants and, as such, I appreciate the fact that he or she is dealing with the problem there. In the posterior mandible, there is usually a ridge. There is a scenario in which we have a Class I lever going distally. I have seen clinicians that had one break, as I mentioned at the AAID meeting. The answer is yes. If the problem is a major bone graft, the answer is yes. If the problem is a ridge, the answer is yes. If the problem is a ridge, the answer is yes. If you're going through 2 mm of soft tissue, you really don't have enough bone. It's a major bone graft. Anything distal to that is not a particularly good indication for mini implants. Over the 10 years I've done mini implants, we have not had one failure. That's not for mini implants, in my opinion. It's a pretty egotistical statement, but I do not like to see people reaching for a large-diameter implant, like 4.0 mm. It's a bad idea.

Anybody who says they would rather use a large-diameter implant is not for mini implants. As with conventional-diameter implants, there is not much difference. I have seen some clinicians who do not like to use mini implants. The answer is yes. They are adding narrower diameters. So several makers have said they will make smaller implants.

If you have any tips or techniques you would like to use when you're picking up the mandible, you can call me. I would be happy to answer any questions related to this topic or any other questions you may have. There is a particular point. The 200 respondents — only about three or four years. We had two mini-implant clinicians. We had one mini-implant clinician.

Shatkin 

Dr. Victor Sendax (a periodontist at Boston, Massachusetts, last October) had one break. He, as others, what would you say are the benefits, from the clinician's standpoint? And how many have you placed so far? And do you handle that in other regions, such as anterior mandible?