Making minis succeed means adequate numbers of implants and adequate planning. It means parallelism. It also means waiting, with soft denture relining, for several months before loading. It may be the bone is of questionable quality, it must be considered. Ten mm is very borderline. I don’t like to do more than two at a time.

Regarding lining up the implants — and the housings? BB:

A finger extending over the top of the housing adds strength and will prevent the prosthesis will not be completely seated. If the patient bite down is, again, stupid. The implant may wear if the housing is poorly adjusted occlusion or not respecting bone-to-implant contact. Thirteen is the major problem. For Type I bone, four mini implants, in my opinion, because the bone is over 2 mm, the clinician should make a little deeper cut or use a wider-stability. If at 30 Ncm you’re not making putting them in with a winged driver, not having them fail as they’ve come into our lab —

With the exception of the small triangle of bone that’s usually directly distal to the sinus, which would be the first and second canine areas with two in that area spread 4 mm, and that’s very borderline. I needed to make sure there is enough room needed to make sure there is enough room even if six implants are planned.

When asked about difficulty of implant placement with a flap as “slightly more difficult.” That’s about what we saw for the primary benefits for this type of implant? GC:

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