

# Implant Dentistry: a reflection on my first implant placement at the Mentee School

**ANWARA CHAMBERS** shares her experiences of time spent at the Mentee School...

The Dental Implant Certificate Course by Ucer Education has been running for more than 20 years under the direction of Professor Cemal Ucer.

This fully structured programme provides academic learning by a very distinguished faculty of experts and clinical training, under Prof Ucer's supervision, to fulfil the requirements of the FGDP/GDC Training Standards in Implant Dentistry (TSID, 2012, 2016). The practical training involved raising flaps, suturing, socket augmentation, the GBR technique and soft-tissue grafts on pigs' heads, and implant surgery was practised initially on plastic jaws utilising different types of implant system. Cemal is an internationally recognised authority in dental implant education and a co-author of the training standards in the UK and Europe, so, as expected, the course he runs is fully structured to achieve all the requirements and learning outcomes necessary for the attainment of clinical competence in this complex field.

Cemal insists that a process of critical appraisal should be performed when selecting a system that can be fully trusted, especially by the beginners. When starting in this field, the practitioner needs to have full confidence on every aspect of the hardware. On-going support from the implant company is another essential requirement.

After the completion of the academic learning we were given the option of treating a patient, either provided by the ICE Postgraduate Institute & Hospital or one of our own, to treat under supervision of an accredited mentor.

Full case assessment, under Cemal's close supervision, revealed that my first case was not as complicated as it seemed. Full risk assessment revealed that the patient was finding it difficult to cope with a denture and did not have a high smile line. The main objective for the patient was improved function and comfort. Her options were limited, due to poor prognosis of the adjacent central incisor. She had a good soft tissue biotype.

A 3D FOV CBCT taken at ICE Diagnostic

Centre revealed sufficient bone in which to place an implant (Fig. 1). The adjacent UR1 was highly compromised with aesthetic deficiencies but the patient was reluctant to have this tooth treated at this stage in absence of any symptoms.

I wasn't really nervous about doing my first case as I had an excellent theoretical teaching and an international expert was mentoring me. I was aware that Cemal had placed over ten thousand implants and has trained a vast number of dentists, including a large number of today's trainers who run their own courses throughout the UK.

Both the overall planning and Cemal's guidance were delivered so well that I was able to carry out the entire treatment from start to finish myself with total confidence and ease.

Inevitably I had to rely completely on my mentor showing me the sequence of surgical drills. The implant representative was so useful in helping me to understand the system, too.

In preparation, we had to gown up and set the surgery for an aseptic surgical procedure. I hadn't done this for many years and so was unfamiliar with the protocols; but there was an experienced nurse to help. There was also a second nurse who was on an NEBDN training programme in dental implant nursing and was being mentored by the more experienced nurse. Implant surgery requires teamwork and typically the surgeon is assisted by an experienced scrub nurse and a second 'circulating nurse'. An aseptic surgical field is thus maintained.

Because we had recently practised raising flaps during the pigs' head sessions, I felt comfortable being able to do this. Cemal then asked me to extend the flap, for better access, without going into the papillae. I was given good instructions, enabling me to continue in a competent manner.

Having not been nervous prior to the procedure, I soon felt the nerves kick in when I had to drill a pilot hole for the implant. I had previously done surgical extractions, but now I was in the position

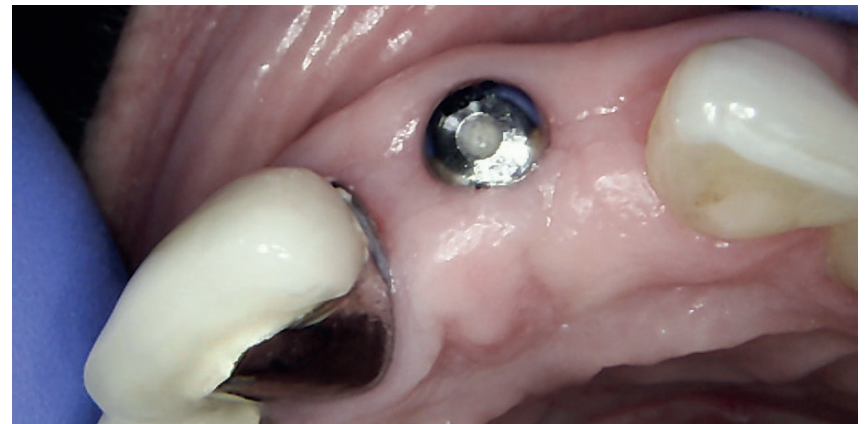


Fig 3: 3mm cover screw at gingival level.

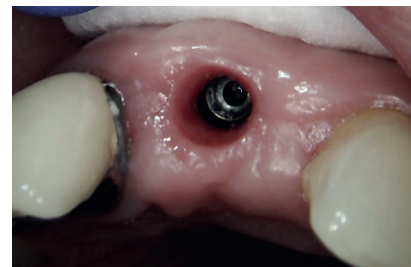


Fig 4: The shoulder of the implant is 3 mm below the gingiva to conform to the biological width.



Fig 5: UL1 implant restoration.

of having to preserve the bone. Implant drills were handed to me by the nurse. I placed the implant using a hand piece set at 10-30 rpm.

There was a feeling of total relief when the healing abutment was placed. Given the very high primary stability achieved, it was not necessary to bury it under the periosteum. Hence, a 3mm healing abutment was fitted. This removes the need to carry out a full surgical exposure procedure prior to the restorative treatment. I felt that the suturing went well, due to the fact that we had practised different techniques during the pigs' head sessions.

On postoperative review, the patient was happy to inform me that she had gone out that evening and had experienced very little discomfort, which was a pleasant surprise! On examination, the site was healing fine (Fig.2).

After the cover screw was removed the gingiva had good contour. The shoulder of the implant had been placed 3 mm subgingivally to conform to the biological width (Figs: 3 and 4).

The final restoration was placed 8 weeks after implantation (Fig: 5).

## Reflection

I have learnt that it is very important that I perform more procedures under supervision before I make the decision to place them independently in my own practice.

TSID 20161, published by the FGDP, recommends "an appropriate quality assured course, having an experienced mentor, maintaining a detailed record of the range of training received, having an experiential log".

It also gives guidance for what would be deemed 'Straightforward' and 'Complex' cases and encourages practitioner's to

be experienced and skilled enough to undertake implant cases based on this.

I am at present continuing to treat patients under Prof Ucer's close supervision at ICE Hospital. I can treat unlimited number of patients provided by the school or bring my own patients to the centre. In doing so I am slowly building my confidence, clinical experience and my portfolio of cases in implantology. I have the option of using my portfolio to sit examination for the PG Dip in Implant Dentistry at FRCS.

I have benefitted from attending Professor Ucer's highly structured Certificate course and being allowed to treat patients at the superb clinical facilities of the Mentee School at ICE Hospital.

I am now looking forward to undergoing further career development in implantology by progressing to the MSc in Implant dentistry programme at Edge Hill University, where Professor Ucer is the Clinical Lead. ■

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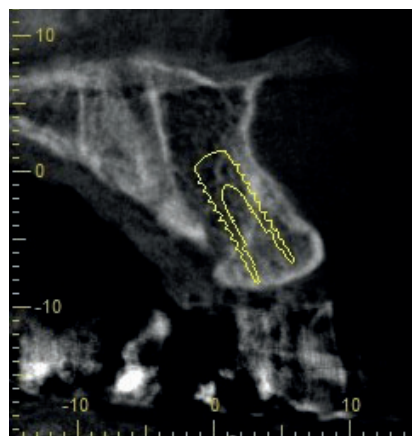


Figure 1: CBCT planning prior to implant placement.

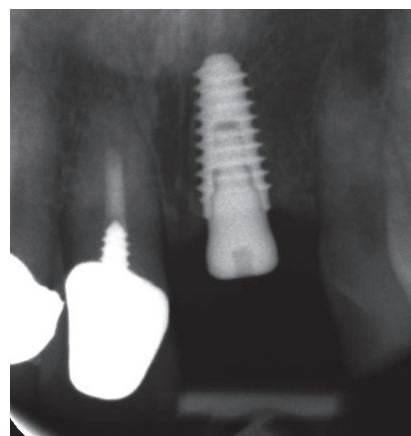


Figure 2: post-op xray

## About the author

**Anwara Chambers** qualified from **Liverpool Dental School in 1990** and bought her own dental practice in **Huyton, Liverpool in 2000**. She has a **PG cert teaching in a clinical context 2013** and was a **Foundation Dentist trainer 2003-2015**.

