光聚機挑選指南

Part 1 -能量

Q：能量越強越好 ?!

高強度能量優缺點

優　點　短時間快速聚合樹脂

缺　點
- 機身容易發燙
- 高熱導致牙髓損傷
- 過熱當機

理想的光聚機

能　量　每秒光能量1100-1130mW/cm2變換

散　熱　良好散熱系統，持續輸出不發燙

黏　著　連續 Curing Case 全口矯正器黏著或 Veneer Cementation 也不過熱

Part 2 -波長

Q：全波長 vs 純藍光 LED光聚機差別

全波長光聚機優缺點

優　點

適用包含非CQ-based 的 Resin Composite

缺　點
- 市面上85%以上樹脂仍以CQ-based為主
- 紫光波長能量不足，須增加照射時間
- 紫光波長能量不足，須配合輔助工具
- 價格昂貴

理想的光聚機

能　量　460-480nm的波長配合超過1200mW/cm2的能量

C/P 值　具有良好的品質以及性價比

您知道嗎？

近年來光聚機所搭配使用的電池以鋰電池為主，不會有記憶效應的問題。因此 使用完畢後就放回基座上充電，除了不會造成電池壽命減少外，也可以讓光聚機穩定在基座上避免摔到。

Part 3 -電池

Q：續電力越久越好？？

高續電力光聚機

優　點　可連續使用3-5天不用充電

缺　點　搭配高電容量的光聚機會使整體重量上升，操作不方便

理想的光聚機

電　池　至少1個工作天使用不充電的蓄電量

重　量　良好散熱系統，持續輸出不發燙越輕巧＋方便使用

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Severe Class III Malocclusion with Deep Overbite and Blocked-Out Canines: Conservative Correction with Premolar Extractions

Abstract

History: *A 20-year-old female presented with chief complaints of a prominent chin and crowded teeth.*

Diagnosis: *Clinical examination revealed mandibular prognathism, blocked-out canines, skeletal Class III (ANB = -3˚), anterior crossbite, and deep overbite. The Discrepancy Index (DI) was 37.*

Treatment: *Bilateral upper and lower first premolars were removed to gain space for relieving the crowding and retracting the lower anterior segment to correct the anterior crossbite. A passive self-ligating (PSL) bracket system was bonded on the dentition with high-torque brackets on the lower incisors and low-torque brackets on the upper incisors.*

Outcome: *After 24 months of active treatment, this challenging full-cusp Class III malocclusion was corrected to a near ideal result. The Cast-Radiograph Evaluation (CRE) score was 19, with an excellent Pink and White dental esthetic score of 2. (J Digital Orthod 2023;70:28-42)*

Key words:

Skeletal Class III, full-cusp Class III molar relationship, first premolar extraction, passive self-ligating brackets

Introduction

The dental nomenclature for this report is a modified Palmer notation with four oral quadrants: upper right (UR) and left (UL), as well as lower right (LR) and left (LL). Teeth are numbered 1-8 from the midline in each quadrant.

A 20-year-old female presented with chief complaints of anterior crossbite, crowding, and compromised facial esthetics (Figs. 1 and 2). The radiographic documentation of the malocclusion includes a lateral cephalometric film in centric occlusion (C_O) as well as in centric relation (C_R) positions (Figs. 3 and 4), panoramic radiograph (Fig. 6), and temporomandidular joint (TMJ) views (Fig. 7). This malocclusion was associated with skeletal Class III, anterior crossbite, and deep overbite. An anterior functional shift might have exaggerated her Class III malocclusion. To correct the full-cusp Class III and crowding, the patient and her family preferred camouflage treatment with extractions rather than orthognathic surgery to achieve an acceptable although compromised outcome.[1,2]

History and Etiology

This developmental malocclusion was associated with mandibular prognathism (SNB, 85˚). No contributing medical or dental histories were

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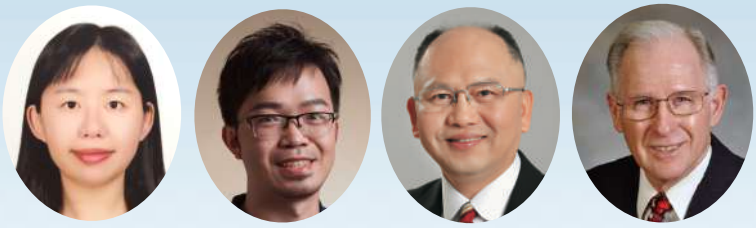

reported. Clinical examination revealed a concave facial profile, lower lip protrusion, anterior crossbite, and crowding (Figs. 1-3).

The panoramic radiograph (Fig. 6) revealed that four wisdom teeth were missing. Lateral cephalometric radiograph revealed decreased inclination of both arches and a relatively straight

Fig. 1: *Pre-treatment facial and intraoral photographs in centric occlusion (C_O)*

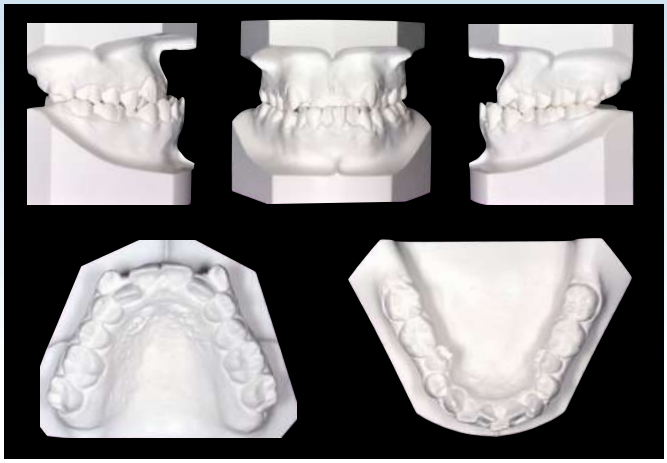

Fig. 2: Pre-treatment dental models (casts) in C_O

Fig. 3: Pre-treatment lateral cephalometric radiograph in C_O

Fig. 4: Pre-treatment cephalometric radiograph in centric relation (C_R)

Fig. 5: Pre-treatment lateral profile photograph in C_R

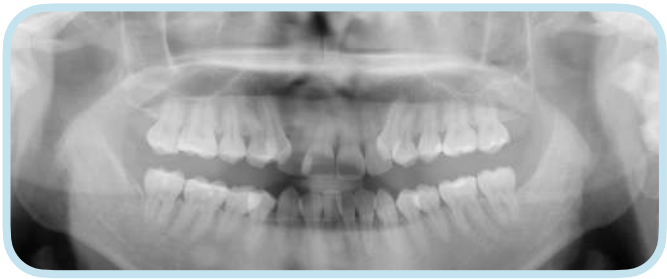

Fig. 6: Pre-treatment panoramic radiograph

profile when the occlusion was in C_R (Figs. 4 and 5). The patient declined orthognathic surgery because of the potential for severe complications.[3-5] She opted to seek conservative treatment for the problem with extractions.

Diagnosis

Skeletal: *Mandibular Protrusion*

- Class III relationship: *SNA, 82˚; SNB, 85˚; ANB, -3˚*
- Mandibular plane angle: *SN-MP, 41˚; FMA, 34˚*

Dental:

- Occlusion: *Bilateral full-cusp Class III molar relationships*

- Overjet: *-5.5 mm*
- Upper Incisors: *Retroclined (U1-to-NA, 2 mm; U1-to-SN, 93˚)*
- Lower Incisors: *Retroclined (L1-to-NB, 5.5 mm; L1-to-MP, 81˚)*

Facial: *Relatively protrusive lower lip*

The UL-to-E-line[7,8] cephalometric measurement was -2 mm, which is consistent with a retrusive upper lip (Fig. 5). However, the mandible was protrusive with a prominent chin, so the relatively protrusive lower lip was actually the problem. Carefully evaluating lip protrusion is an essential aspect in treatment planning.

The American Board of Orthodontics (ABO) Discrepancy Index (DI)[9] was 37 points as shown in the subsequent Worksheet 1. The 19 points for overjet (OJ = -5.5 mm) in the DI worksheet indicated that it was a main issue of this case.

Treatment Objectives

After discussing available options with the patient, the following treatment objectives were established:

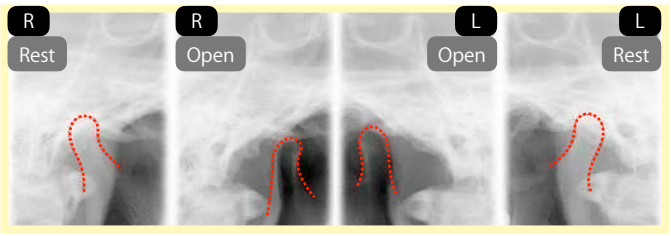

Fig. 7:
Pre-treatment TMJ transcranial radiographs show the right (R) and left (L) temporomandibular joints in rest and open positions. The condyle heads are outlined in red dotted lines.

1. Extract upper first premolars (UR4 and UL4) to resolve the space deficiency.
2. Extract lower first premolars (LR4 and LL4) to gain enough space to retract the lower anterior segment and correct the anterior crossbite.
3. Establish ideal overjet and overbite.

Treatment Alternatives

First Option: Use conventional molar anchorage to close the UR4 extraction space. With this treatment option, 70% of space closure is achieved by retracting the anterior teeth, and the remaining 30% by protracting the posterior teeth. The disadvantage of this option is the inclination of the lower incisors, which is an unfavorable outcome for the patient as her arches were already retroclined.

Second Option: The preferred orthognathic surgical option was Le Fort I with bilateral intraoral vertical ramus osteotomies. However, the patient declined surgery because of the hospitalization, high cost, and risk of complications.

Treatment Progress

All treatment and sequencing details are shown in Table 2 and illustrated in Figs. 8-10.

Two months following the prescribed extractions, 0.022" slot Damon Q® passive self-ligating (PSL) brackets (Ormco, Brea, CA) were bonded on the lower teeth with a 0.014-in copper-nickel-titanium (CuNiTi) archwire engaged. Torque selection of the lower incisors was high torque, so upside-down low-torque brackets were bonded on the lower incisors to serve

Appointment	Archwire	Notes
1 (0 month)	L : 0.014-in Damon CuNiTi	Bond all lower teeth except all 4s, which were extracted. High-torque brackets were selected.
2 (1 month)	U/L: 0.014-in Damon CuNiTi	Bond all upper teeth. Insert open-coil spring to create space for UR2 and UL2. Low-torque brackets for UL2 and UL2; high-torque brackets for UR3 and UL3 Apply early light power chains from UR3 to UR6 and UL3 to UL6. Place bite turbos on the occlusal surfaces of LR7 and LL7.
3~5 (3~8 months)	U/L: 0.014x0.025-in Damon CuNiTi	Remove posterior bite turbos. Place anterior bite turbos from LR2 to LL2. Prescribe tongue depressor to correct anterior crossbite. Apply early light short elastics (Quail, 2 oz; Ormco) from UR6 to LR5 and UL6 to LL5.
6 (10 months)	U/L : 0.017x0.025-in Damon TMA	Change early light short Class III elastics to Fox (3.5 oz) from UR6 to LR3 and UL6 to LL3 to retract the mandibular anteriors. Remove anterior bite turbos, and place posterior bite turbos.
7 (11 months)	U: 0.014x0.025-in Damon CuNiTi	Rebond UR7 and UL7.
8 (12 months)	U: 0.014x0.025-in Damon CuNiTi	Rebond UR5, UR1, UL1, UL2, and UL5. 15˚ archwire adjustment.
9 (13 months)	U/L: 0.017x0.025-in Damon TMA	Class III elastics (Fox, 3.5 oz) from UR6 to LR3 and UL6 to LL3 to retract mandibular anteriors
10 (14 months)	U/L: 0.017x0.025-in Damon TMA	Perform interproximal reduction from UR2 to UL2. Close all extraction spaces with power chains.
11 (15 months)	U/L: 0.017x0.025-in Damon TMA	Rebond LR3, LR1, UL5, and LL1. Torquing springs were applied on UR3 and UL3.
12 (16 months)	U/L: 0.017x0.025-in Damon TMA	Torquing springs were applied on LL5 and LR5.
13 (18 months)	U/L: 0.017x0.025-in Damon TMA	Perform interproximal reduction from LL2 to LR2.
16 (21months)	U/L: 0.017x0.025-in Damon TMA	Instruct patient to hook elastics from UR3 to LR5 and UL3 to LL5.
17 (22months)	U : 0.017x0.025-in Damon TMA L : 0.017x0.025-in Damon TMA	Instruct patient to hook intermaxillary elastics from UR7 to LR7 and UL7 to LL7.
18 (24months)		Remove all appliances. Place fixed retainers from 3 to 3 on both arches, and removable clear overlay retainers for both arches were prescribed for retention.

Table 1: *Treatment sequence*

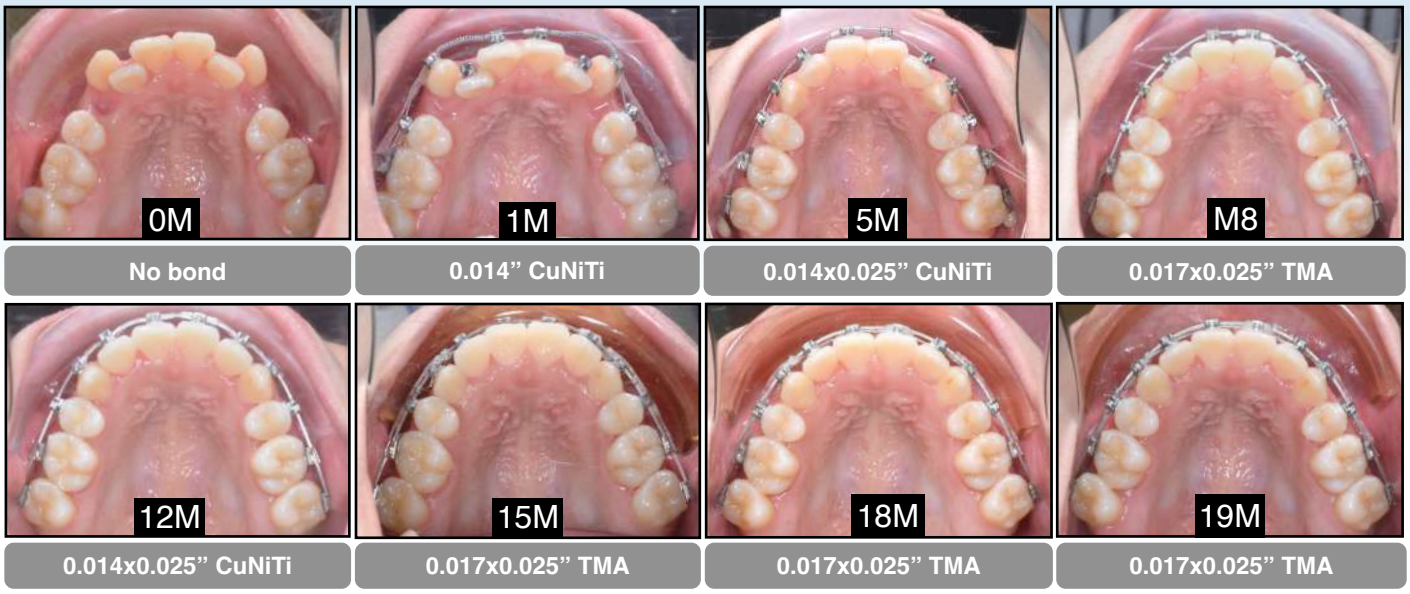

Fig. 8:
A progressive series of upper occlusal photographs show treatment progress and the archwire sequence for the upper arch in months (M) from the beginning of the treatment (0M) to nineteen months (19M).

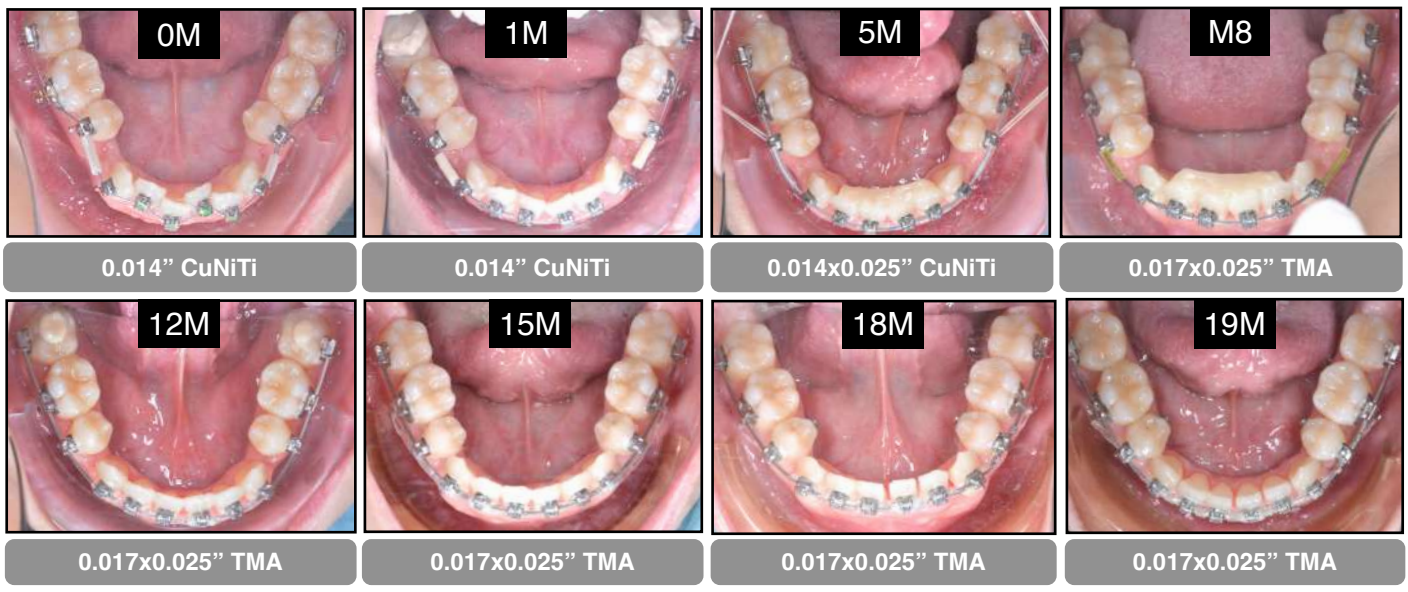

Fig. 9:
A progressive series of lower occlusal photographs show treatment progress and the archwire sequence for the lower arch in months (M) from the beginning of the treatment (0M) to nineteen months (19M).

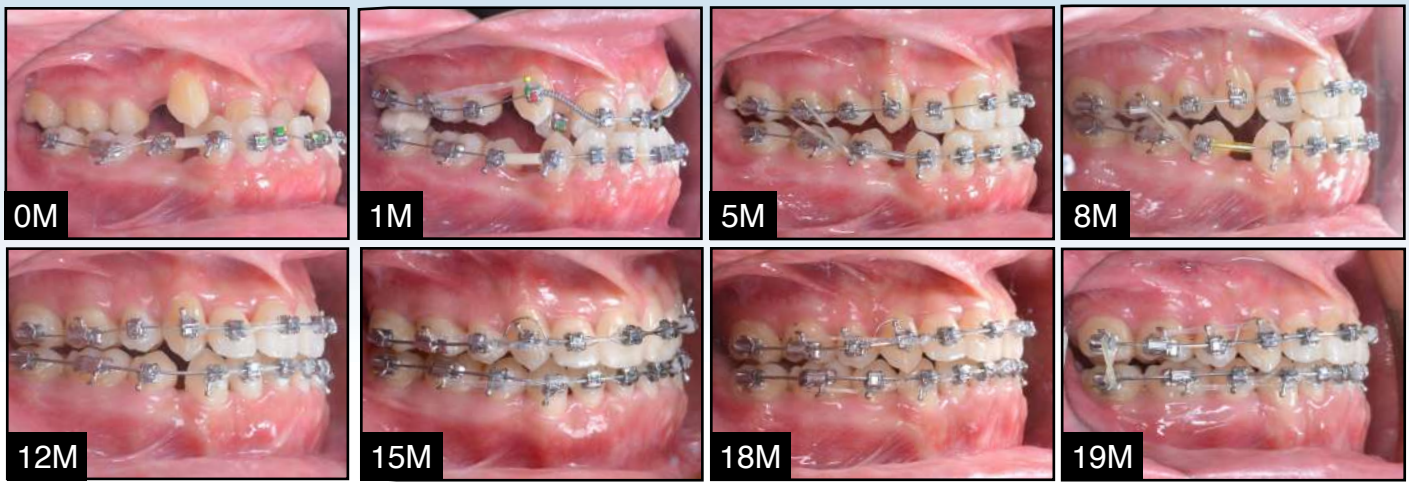

Fig. 10 :
A progressive series of right buccal photographs show treatment progress in months (M) from the beginning of the treatment (0M) to nineteen months (19M).

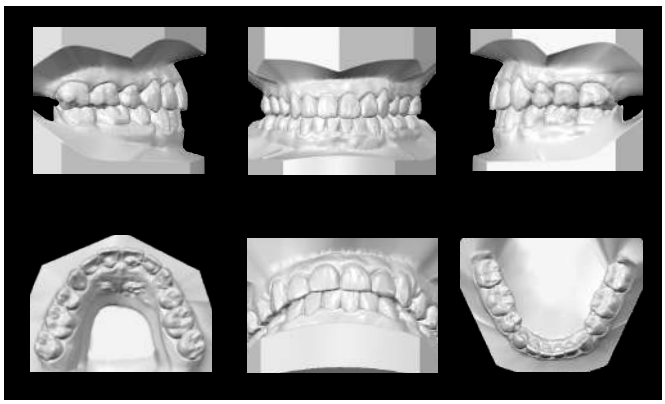

Fig. 11: *Posttreatment dental models (casts) in centric occlusion*

Fig. 12: *Posttreatment panoramic radiograph*

as high-torque brackets to provide more lingual root torque. The sequence for lower archwire was 0.014-in CuNiTi, 0.014x0.025-in CuNiTi, and 0.017x0.025-in TMA.

In the following months, the brackets were bonded in the upper arch with a 0.014-in CuNiTi archwire. The archwire sequence for upper arch was 0.014-in CuNiT, 0.014x0.025-in CuNiTi, and 0.017x0.025-in TMA. From the 5th to the 8th months of treatment, early light Class III elastics were used from U6s to L5s. In the 11th and 12th months, the brackets were re-bonded on UR7, UL7, UR5, UR1, UL1, UL2, and UL5 for better alignment, and the archwire was changed from 0.017x0.025-in TMA to 0.014x0.025-in CuNiTi for better fitting in the bracket slots.

By the 12th month, the anterior crossbite was corrected. From the 13th month till the end of the treatment, the archwires for both arches were 0.017x0.025-in TMA. In the 15th month, torquing springs were used on UR3 and UL3 to achieve more lingual root torque. In the 22nd month, intermaxillary

Fig. 13: *Posttreatment facial and intraoral photographs*

Fig. 14: *Posttreatment lateral cephalometric radiograph*

elastics were used from UR7 to LR7 and UL7 to LL7 to improve the occlusion. In the 24th month, all appliances were removed.

Retention

Fixed retainers were bonded on all mandibular and maxillary canines and incisors (3-3). Removable clear overlay retainers were also delivered for both arches for full-time wear for the first 6 months and nights only thereafter. Instructions were also given for home hygiene and maintenance of the retainers.

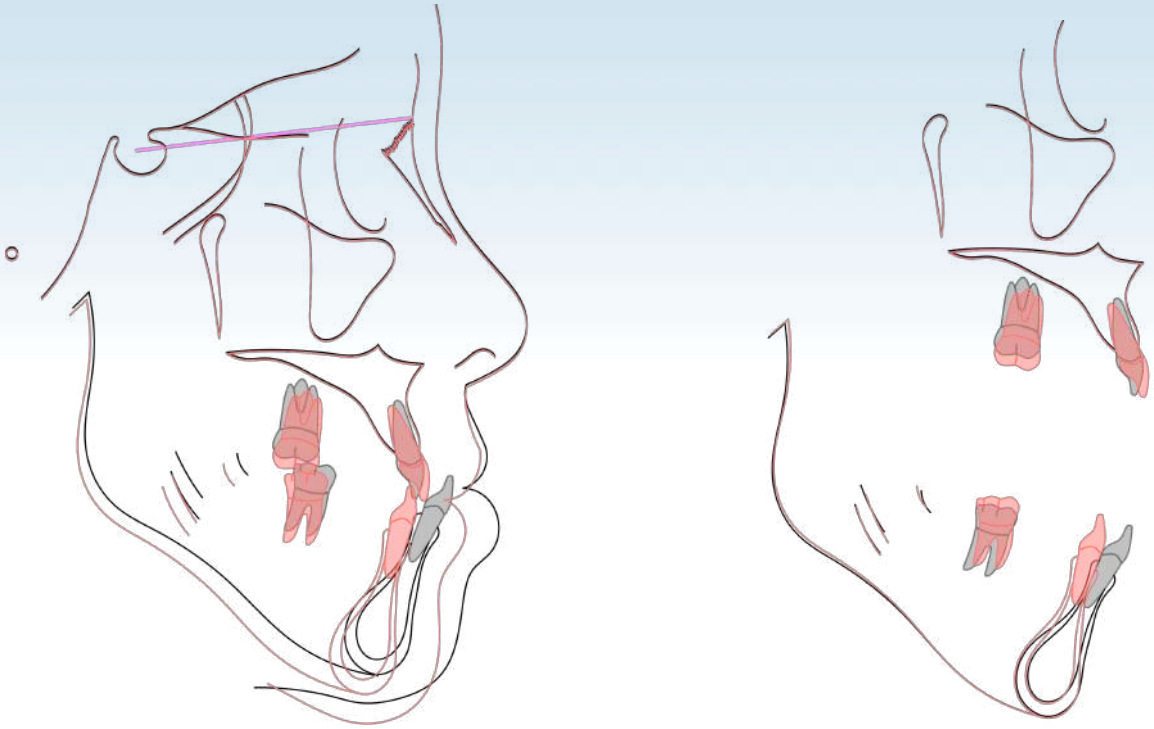

Fig. 15:
Superimposed cephalometric tracings show dentofacial changes over active 24 months of treatment (red) compared to the pre-treatment records (black). See text for details.

Treatment Result

After 24 months of active treatment, both the patient and the clinician were satisfied with the outcomes (Figs. 11-14). Correcting the anterior crossbite improved the patient's profile because the lower lip was retracted. Both arches were well aligned in a near ideal Class I occlusion with coincident midlines. Posttreatment panoramic radiograph showed good axial alignment of the dentition (Fig. 12), and cephalometric superimpositions revealed that the mandibular incisors were retracted about 7 mm with acceptable axial inclination (Fig. 15). These results indicated the retroclination of lower anterior teeth would become worse without the high-torque brackets in the archwire. The 2 mm flaring of the maxillary incisors

	Ext.	Not
1. Profile	Protrusive	Straight
2. Md. angle	High	Low
3. Bite	Open	Deep
4. Ant. inclination	Flaring	Flat
5. Crowding	> 7mm	None
6. Decay/missing	Present	????
7. P't perception	OK	No
8. Etc...		

Table 2:
According to Chang's extraction decision chart, the current case presented favorable factors for an extraction treatment, including a protrusive facial profile and crowding > 7 mm.

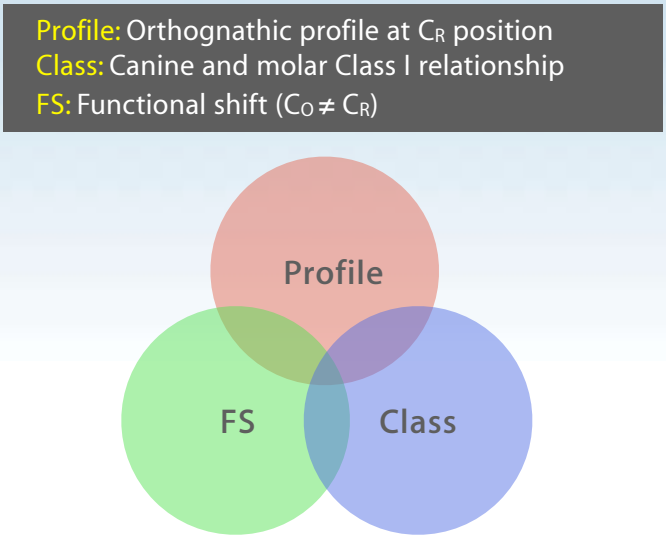

Fig. 16:
Lin's Class III diagnostic system evaluates whether Class III malocclusion patients require surgery or not based on profile, functional shift, and dental classification.

from the original anterior-posterior (A-P) plane was acceptable. Although the data in the chart was not perfect, the result was satisfactory for a severe skeletal Class III malocclusion. Using Class III elastics may rotate the mandible clockwise by extrusion of the lower molars, and retracting the lower incisors improved the profile by correcting the protrusive lower lip (Fig. 15).

The Cast-Radiograph Evaluation (CRE)[10] score was 19 points, as shown in the supplementary Worksheet 2. The major residual discrepancies were the buccolingual inclination (3 points), occlusal contacts (10 points), and occlusal relationship (3 points). Dental esthetics were acceptable with a Pink and White esthetic score of 2, as shown in Worksheet 3. After 24 months of active treatment, the patient was very pleased with the outcomes achieved by this conservative treatment.

Discussion

Orthognathic surgery is a treatment method for malocclusions with skeletal or dentoalveolar anomalies that cannot be corrected with tooth movement alone.[3] This patient's overjet was -6 mm, and her molar discrepancy was 5 mm Class III. According to the American Association of Oral and Maxillofacial Surgeons, she may need an orthognathic surgery, because the horizontal overjet is zero or negative and the A-P molar discrepancy is ≥ 4 mm Class III. However, camouflage treatment could solve the problem with an acceptable compromised result that is associated with less pain and minimal surgery.

1. Lin's 3-Ring Diagnosis and Chang's Extraction Table

Lin's 3-Ring Diagnosis[11,12] should be used to evaluate whether Class III malocclusion patients are eligible for a camouflage treatment or not (Fig. 16). The patient's profile was good in centric relation (C_R), with an orthognathic profile (acceptable facial balance), buccal segments near Class I, and an A-P functional shift of ~3 mm into maximal intercuspation. To achieve a more functional occlusion, Class III malocclusion patients may subconsciously protrude the mandible and result in incisal interference. A non-surgical treatment may be feasible by correcting the functional shift and increasing lower facial height.

Chang's[13,14] extraction decision table (Table 2) provides good indications for designing the treatment plan. Since both arches of this patient were crowded, four bicuspid extractions could efficiently relieve the crowding while maintaining the nasolabial angle.

CEPHALOMETRIC SUMMARY			
	PRE-TX	POST-TX	DIFF.
SKELETAL ANALYSIS			
SNA° (82°)	82°	83°	1°
SNB° (80°)	85°	82°	3°
ANB° (2°)	-3°	1°	4°
SN-MP° (32°)	41°	45°	4°
FMA° (25°)	34°	38°	4°
DENTAL ANALYSIS			
U1 TO NA mm (4 mm)	2	4	2
U1 TO SN° (104°)	93°	102°	9°
L1 TO NB mm (4 mm)	5.5	4	1.5
L1 TO MP° (90°)	81°	66°	15°
FACIAL ANALYSIS			
E-LINE UL (-1 mm)	-2	-2	0
E-LINE LL (0 mm)	4	-1	5
%FH: Na-ANS-Gn (53%)	56%	56%	0%
Convexity: G-Sn-Pg' (13°)	-1°	0°	1°

Table 3: *Cephalometric summary*

Fig. 17:
Upside-down low torque brackets (-11°) results in high-torque (+11°) in the lower arch. See text for details.

2. Torque selection

When lingually-tipped lower incisors (L1-MP, 81°) are retracted, torque is best controlled using high-torque brackets. Turning low-torque brackets upside down is a good way to produce high-torque effect on the lower arch (Fig. 17).[15] Otherwise, placing a pre-torqued archwire such as 0.016x0.025-in or 0.019x0.025-in NiTi can also produce high torque effect. When comparing the pre-treatment and posttreatment cephalometric measurements (Table 3; Fig. 15), there was substantial incisor torque loss (81-66°).

3. Bite turbos

Bite turbos (glass ionomer cement or glass ionomer resin, occlusal bite raisers) placed in the posterior segment are effective to open the bite and prevent premature occlusal contact on brackets. Using bite turbos in the anterior segments is an effective and efficient way to correct an anterior crossbite. All teeth were aligned in eight months.

Conclusions

To decide the treatment plan for Class III malocclusion requires a thoughtful evaluation. Lin's 3-Ring diagnosis can help to determine if the problem is suitable for conservative treatment or requires orthognathic surgery. When camouflage treatment was deemed feasible, Chang's extraction table clarified that the deficiency of space could be relieved by extraction effectively and efficiently. With the right torque selection, desirable outcomes were achieved in only 24 months. In retrospect, the

treatment time could be reduced with a thorough diagnosis, a well thought out treatment plan, and clinical tips. Since the L1-to-MP angle was 66° in the end, stability and maintenance of the occlusion need long-term follow-up.

Acknowledgments

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Discrepancy Index Worksheet

TOTAL D.I. SCORE 37

OVREJET

0 mm. (edge-to-edge)	=	
1 - 3 mm.	=	0 pts.
3.1 - 5 mm.	=	2 pts.
5.1 - 7 mm.	=	3 pts.
7.1 - 9 mm.	=	4 pts.
> 9 mm.	=	5 pts.

Negative OJ (x-bite) 1 pt. per mm. Per tooth =

Total = 19

OVERBITE

0 - 3 mm.	=	0 pts.
3.1 - 5 mm.	=	2 pts.
5.1 - 7 mm.	=	3 pts.
Impinging (100%)	=	5 pts.

Total = 2

ANTERIOR OPEN BITE

0 mm. (Edge-to-edge), 1 pt. per tooth
Then 1 pt. per additional full mm. Per tooth

Total = 0

LATERAL OPEN BITE

2 pts. per mm. Per tooth

Total = 0

CROWDING (only one arch)

1 - 3 mm.	=	1 pt.
3.1 - 5 mm.	=	2 pts.
5.1 - 7 mm.	=	4 pts.
> 7 mm.	=	7 pts.

Total = 7

OCCLUSION

Class I to end on	=	0 pts.
End on Class II or III	=	2 pts. per side 2 pts.
Full Class II or III	=	4 pts. per side 4 pts.
Beyond Class II or III	=	1 pt. per mm. additional ____ pts.

Total = 6

LINGUAL POSTERIOR X-BITE

1 pt. per tooth Total = 3

BUCCAL POSTERIOR X-BITE

2 pts. Per tooth Total = 0

CEPHALOMETRICS (See Instructions)

ANB ≥ 6° or ≤ -2° = 4 pts.

Each degree < -2° _____ x 1 pt. = _____

Each degree > 6° _____ x 1 pt. = _____

SN-MP

≥ 38° = 2 pts.

Each degree > 38° _____ x 2 pts. = _____

≤ 26° = 1 pt.

Each degree < 26° _____ x 1 pt. = _____

1 to MP ≥ 99° = 1 pt.

Each degree > 99° _____ x 1 pt. = _____

Total = 0

OTHER (See Instructions)

Supernumerary teeth	_____ x 1 pt.	=
Ankylosis of perm. Teeth	_____ x 2 pts.	=
Anomalous morphology	_____ x 2 pts.	=
Impaction (except 3rd molars)	_____ x 2 pts.	=
Midline discrepancy (≥ 3mm)	@ 2 pts.	=
Missing teeth (except 3rd molars)	_____ x 1 pt.	=
Missing teeth, congenital	_____ x 2 pts.	=
Spacing (4 or more, per arch)	_____ x 2 pts.	=
Spacing (Mx cent. diastema ≥2mm)	@ 2 pts.	=
Tooth transposition	_____ x 2 pts.	=
Skeletal asymmetry (nonsurgical tx)	@ 3 pts.	=
Addl. treatment complexities	_____ x 2 pts.	=

Identify:

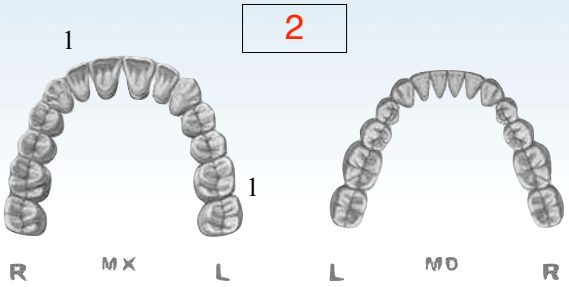
Total = 0

Cast-Radiograph Evaluation

Total Score: 19

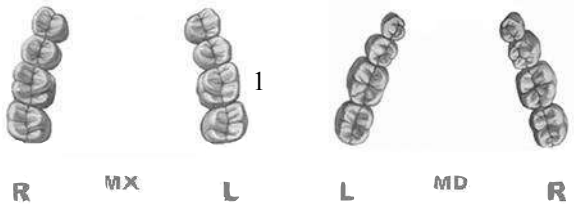
Alignment/Rotations

2



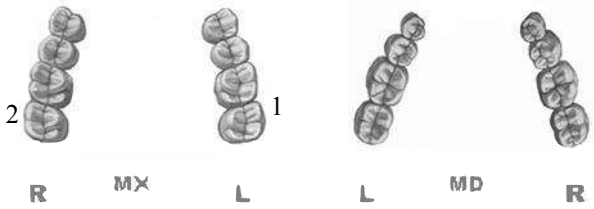
Marginal Ridges

1



Buccolingual Inclination

3

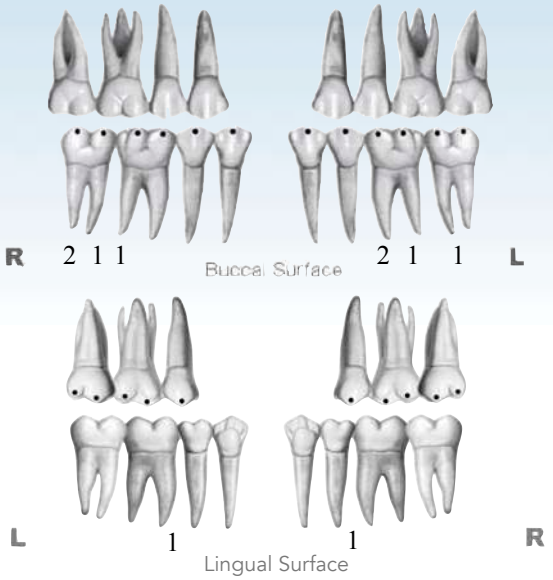


Overjet

0

Occlusal Contacts

10

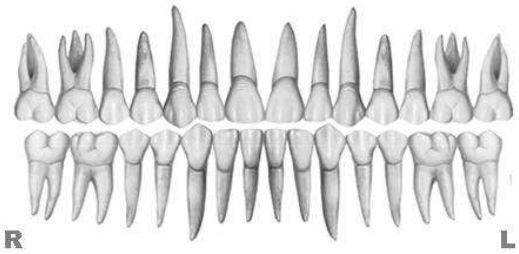


Occlusal Relationships

3

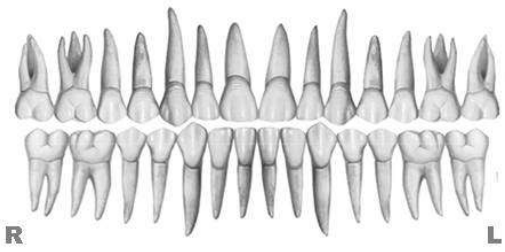
Interproximal Contacts

0



Root Angulation

0



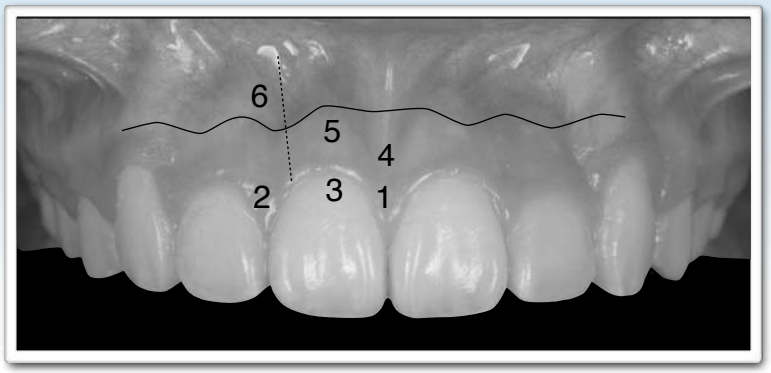
INSTRUCTIONS: Place score beside each deficient tooth and enter total score for each parameter in the white box. Mark extracted teeth with "X". Second molars should be in occlusion.

IBOI Pink & White Esthetic Score

Total Score = 2

1. Pink Esthetic Score

Total = 1

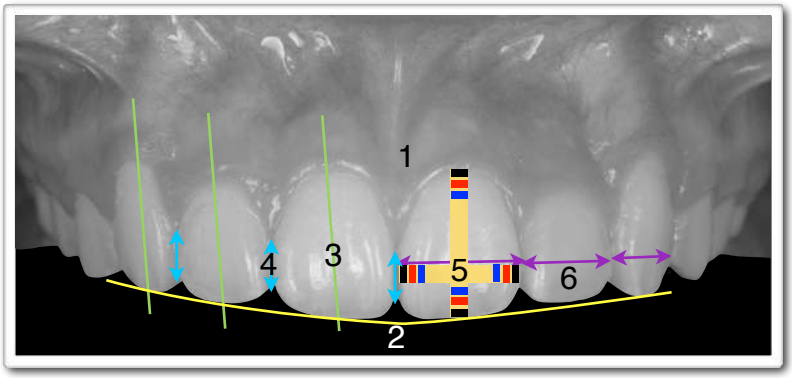


1. M & D Papillae	0	1	2
2. Keratinized Gingiva	0	1	2
3. Curvature of Gingival Margin	0	1	2
4. Level of Gingival Margin	0	1	2
5. Root Convexity (Torque)	0	1	2
6. Scar Formation	0	1	2

1. M & D Papillae	(0)	1	2
2. Keratinized Gingiva	(0)	1	2
3. Curvature of Gingival Margin	(0)	1	2
4. Level of Gingival Margin	0	(1)	2
5. Root Convexity (Torque)	(0)	1	2
6. Scar Formation	(0)	1	2

2. White Esthetic Score (for Micro-esthetic)

Total = 1



1. Midline	0	1	2
2. Incisor Curve	0	1	2
3. Axial Inclination (5˚, 8˚, 10˚)	0	1	2
4. Contact Area (50%, 40%, 30%)	0	1	2
5. Tooth Proportion	0	1	2
6. Tooth to Tooth Proportion	0	1	2

1. Midline	(0)	1	2
2. Incisor Curve	(0)	1	2
3. Axial Inclination (5˚, 8˚, 10˚)	(0)	1	2
4. Contact Area (50%, 40%, 30%)	(0)	1	2
5. Tooth Proportion	(0)	1	2
6. Tooth to Tooth Proportion	0	(1)	2

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  感溫性鎳鈦合金線 - Level and Align
- **.014 x .025 Damon Copper Ni-Ti x 20 條**
  感溫性鎳鈦合金線 - Begin Torque Control
- **.016 x .025 Damon SS x 20 條**
  不鏽鋼合金線 - Space Closure
- **.017 x .025 Damon Low-Friction TMA Wire x 20 條**
  低摩擦力鈦鉬合金線 - Finishing and Detailing

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贈 Power Chain x 5 卷

(任選open/close/wide)

矯正專用彈力鏈

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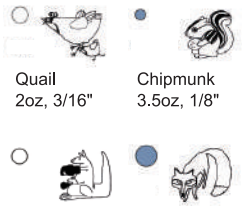
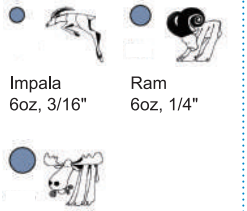


Aligner 熱銷動物圈



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International Association for Orthodontists & Implantologists

Join the *iAOI* the future of dentistry!

About our association-iAOI

International Association of Orthodontists and Implantologists (iAOI) is the world's first professional association dedicated specifically for orthodontists and implantologists. The Association aims to promote the collaboration between these two specialties and encourage the combined treatment of orthodontic and implant therapy in order to provide better care for our patients.

How to join iAOI?

Certified members of the Association are expected to complete the following three stages of requirements.

1. Member

Doctors can go to http://iaoi.pro to apply for membership to join iAOI. Registered members will have the right to purchase a workbook in preparation for the entry exam.

2. Board eligible

All registered members can take the entry exam. Members will have an exclusive right to purchase a copy of iAOI workbook containing preparation materials for the certification exam. The examinees are expected to answer 100 randomly selected questions out of the 400 ones from the iAOI workbook. Those who score 70 points or above can become board eligible.

3. Diplomate

Board eligible members are required to present three written case reports, one of which has to be deliberated verbally. Members successfully passing both written and verbal examination will then be certified as Diplomate of iAOI.

4. Ambassador

Diplomates will have the opportunity to be invited to present six ortho-implant combined cases in the iAOI annual meeting. Afterwards, they become Ambassador of iAOI and will be awarded with a special golden plaque as the highest level of recognition in appreciation for their special contribution.

For more information on benefits and requirements of iAOI members, please visit our official website: http://iaoi.pro.

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- ◆ *Keynote speakers for iAOI annual workshops*
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  ABO case report - 2 points
  Clinical tip - 1 point

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