Versalis[s]

SCIENTIFIC JOURNAL

S. I. N.

Versalis
SCIENTIFIC JOURNAL

WHEN SIMPLICITY MEETS CLINICAL VERSATILITY

DR. PABLO ENRICO

In daily clinical practice, each case brings a different challenge, and this is exactly where Versalis shows its strength. From the very first interaction, it is clear that the system was designed for professionals who are in the surgical field every day. The ability to work with a single surgical kit for standard, long, and wide implants completely transforms the workflow. It reduces time, simplifies decision-making, and eliminates the need to switch instruments during the procedure.

With a dual-taper hybrid body and an active cutting apex, Versalis delivers stability even in low-density bone while maintaining torque control and predictability. The thread design, aggressive at the apex and delicate in the cervical region, reflects the balance between mechanical efficiency and biological respect. The 16∞Morse Taper connection, shared across the entire line, reinforces this concept of standardization and prosthetic safety, offering excellent sealing and fatigue resistance.

In practice, what stands out most is how efficiently the system addresses diverse clinical situations using the same set of instruments. From single-tooth cases to full-arch rehabilitation, from the anterior region to narrow posterior areas, it adapts smoothly. This sense of fluidity, of always being prepared for what comes next, is what makes Versalis a trusted partner in the clinic. More than an implant, it represents a work philosophy: less complexity, more control, and total predictability.

AUTHORS:

DRA. BRUNA GHIRALDINI

PhD in Implant Dentistry – Universidade Paulista. MBA in Business Management – Fundação Getúlio Vargas.Master's Degree in Periodontics – Universidade Paulista. Specialist in Periodontics – Universidade Paulista. Postgraduate Degree in Implant Dentistry – INEPO. Postgraduate Degree in Aesthetics – SOESP. Coordinator of the Research and Product Development Department – S.I.N.

DR. BRENNO MARCONDES NEGRI

Master's Candidate in Implant Dentistry – São Leopoldo Mandic (SP); Specialist in Implant Dentistry – UNIP (SP); Specialist in Public and Family Health Dentistry – Unyleya (SP); DDS – FO-USP (SP); National Specialist of the Research and Product Development Department – S.I.N.

DR. UMBERTO RAMOS DEMONER

Degree in Dentistry from the Federal University of Espirito Santo; Specialization, Master's, and PhD in Periodontics from FORP-USP; Sandwich PhD conducted at Augusta University; Visiting Researcher at the Adams School of Dentistry at the University of North Carolina; International Specialist in the Product Research and Development Department – S.I.N.

Versalis[s]

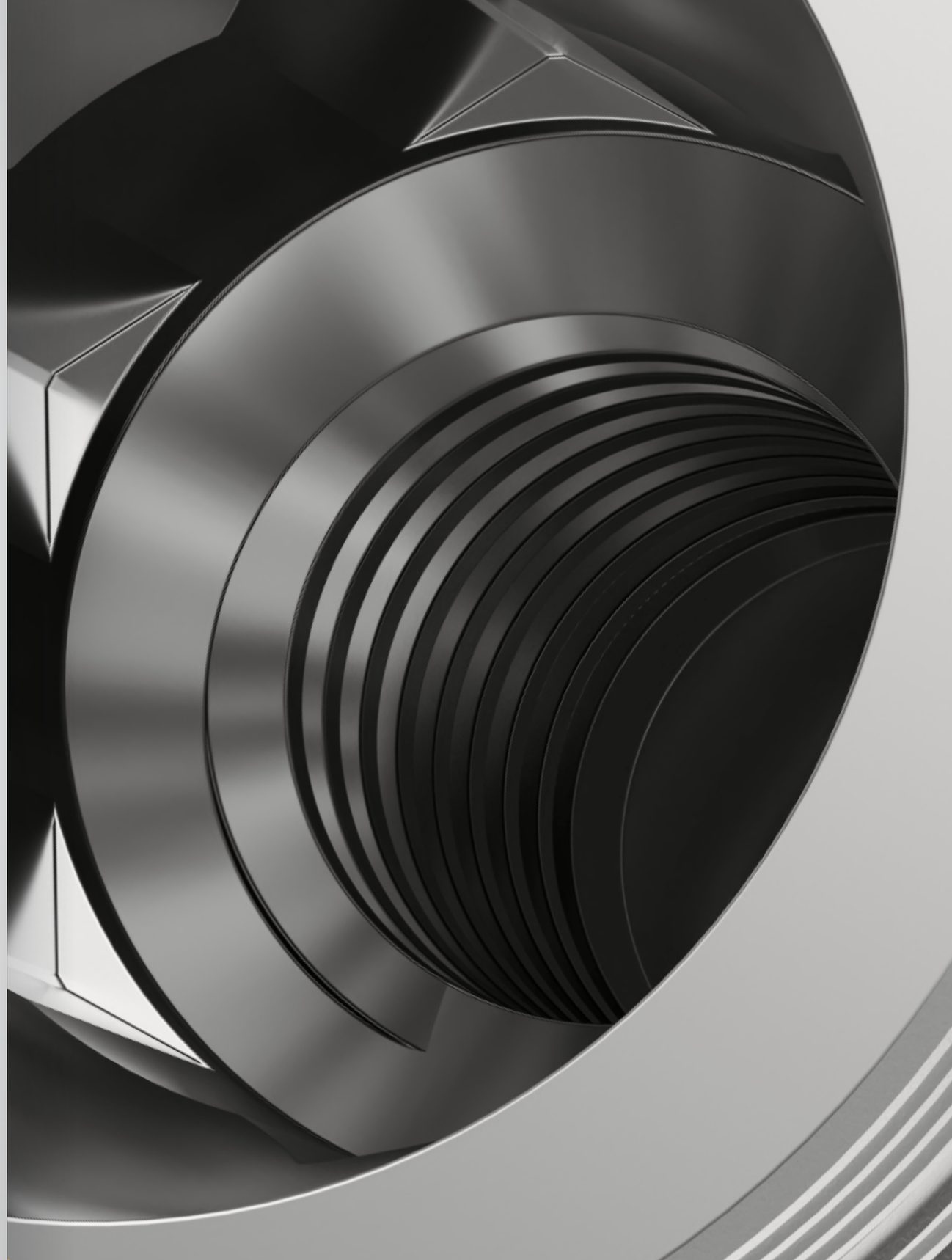
DEVELOPMENT HISTORY

DR. UMBERTO DEMONER RAMOS

S.I.N. is a company known for something remarkable throughout its history: listening to its customers. It has always been this way, from the beginning, in recent developments focused on immediate implantation and special implants for maxillary atrophy cases, and it continues to be true now with its newest development, Versalis.

With the proposal of offering not only an implant but also a versatile kit, this combination was designed to meet the needs of clinicians at all training levels and to reduce the well-known learning curve experienced by every professional, from beginners to the most experienced surgeons. The Versalis Project was born from the need for an implant that could be inserted quickly, but not as fast as the Epikut line, nor as slowly as the Unitite line. The result is a hybrid-body implant with two tapers, one in the thread valley and another in the maximum diameter. These characteristics provide an insertion with a gradual increase in torque, reaching its maximum torque in the final millimeter. This allows greater safety, especially in cases with thin ridges, and enables satisfactory torque for immediate loading in full-arch prostheses or immediate provisionalization in single-tooth cases. The slim apex with gradual tapering facilitates implant engagement when bicorticalization is required.

The kit provides the tools necessary for the installation of standard and long implants. It eliminates the need to open multiple kits for one surgery, as long as no special implants are involved. The Versalis kit also includes essential prosthetic drivers that assist clinicians who work with our straight and angled multi unit abutments for full-arch prosthetic cases. S.I.N. has something that few companies possess: dentists who are S.I.N. users working in its Research and Development department. Versalis is an innovation created to make solutions easier, designed by dentists so that dentists can create smiles.





BACKGROUND & DEVELOPMENT

PERIODONTAL-TYPE MEASUREMENTS ASSOCIATED WITH HYDROXYAPATITE-COATED AND NON–HA-COATED IMPLANTS: UNCOVERING TO 36 MONTHS

HAROLD F. MORRIS, SHIGERU OCHI, J. ROBERT SPRAY AND JOHN W. OLSON

Key words Comparison studies; dental implants; follow-up studies; hydroxyapatite/therapeutic use; periodontal diseases/etiology.

Background: While the use of hydroxyapatite (HA)-coated endosseous dental implants has gained in popularity over the past 10 years, the short-term and long-term predictability and indications for their use remain highly controversial. Some reports suggest that the HA coating may separate from the substructure, undergo dissolution in tissue fluids, and/or contribute to rapid osseous breakdown around the implant. ther reports, however, relate favorable responses to HA-coated implants, which include rapid bone adaptation to the HA, greater stability at uncovering, and increased coronal bone growth. These contradictions may be related to differences in chemical composition of the HA on the implant surface. Most clinicians and researchers may agree that long-term, independent, scientific clinical studies are needed to compare HA-coated and non–HA-coated (titanium-alloy and CP-titanium) implants under the same conditions. Concerns appear in the literature that HA-coated implants experience greater breakdown because they are more susceptible to bacterial colonization due to their roughness and hydrophilicity. Some studies suggest that specific putative periodontal pathogens may adhere to the HA, thereby predisposing the implant to greater peri-implantitis than that experienced by non-HA implants.

Methods: A total of 32 clinical research centers, located in various geographic regions of the United States, were selected to participate in a comprehensive clinical study. More than 2,900 HA-coated and non- HA implants were randomized as to location within one of three jaw regions—maxillary anterior, mandibular anterior, and mandibular posterior—and followed for 36 months. It can be assumed that in each of these

jaw regions, the conditions associated with both implant surface types would be similar enough to permit meaningful comparisons of periodontal-type measurements that have not previously been reported. Periodontal- type measurements (gingiva, plaque, suppuration, and calculus indices; probing depth; attachment levels; recession; and keratinized tissue width) for each aspect of each implant (mesial, facial, distal, and lingual) were recorded at 3, 6, 9, 12, 18, 24, and 36 months following implant uncovering. The implant was considered the experimental unit for analysis using generalized estimating equation and repeated measure methods. Data for the four aspects of each implant, as well as measurements over time, were all clustered in the unit of analysis.

Results: The percentages of implants with zeros recorded for the indices was remarkably similar for both HA-coated and non-HA implants. While statistically significant differences were found for some of the measurements associated with HA-coated and non-HA implants under certain conditions, these differences were too small to be considered clinically significant.

Conclusions: Overall, there was no clinically significant difference between the periodontal-type measurements for HA-coated and non–HA-coated implants followed for a period from 3 through 36 months. Ann Periodontol 2000;5;56-67

FULL ARTICLE

THREE-YEAR MARGINAL BONE LOSS ASSOCIATED WITH PLATFORM-SWITCHED VERSUS PLATFORM-MATCHED CONNECTIONS AND MORSE TAPER VERSUS EXTERNAL HEXAGON IMPLANTS: A SPLIT-MOUTH RANDOMIZED CLINICAL TRIAL

DIONE GONÇALVES PINTO, DDS, MSC,A ALOIZIO FILGUEIRAS, DDS, MSC,B LEANDRO MARQUES DE RESENDE, DDS, MSC, PHD,C AND BRUNO SALLES SOTTO-MAIOR, DDS, MSC, PHDD

Statement of problem. Whether the reduced peri-implant bone loss associated with platform-switched (PS) connections compared with platform-matched (PM) connections is consistent across different implant types remains unclear. Comparative clinical evidence is limited, highlighting the need for studies evaluating the interaction between connection design and implant type.

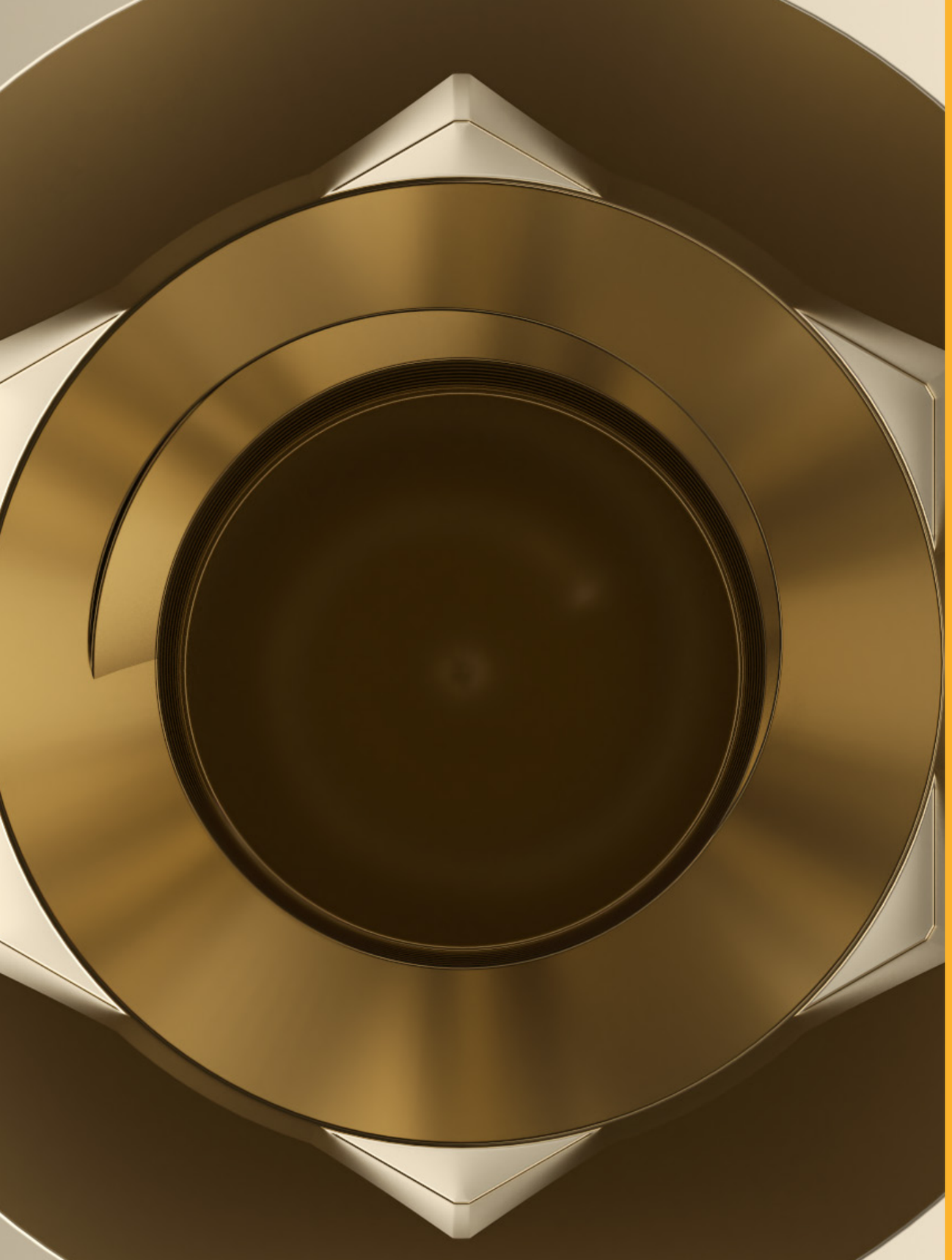
Purpose. The purpose of this split-mouth randomized clinical trial was to evaluate the influence of the interaction between connection design and connection type on vertical and horizontal marginal bone loss (vMBL and hMBL) associated with implant-supported prostheses in the posterior mandible after 3 years of follow-up.

Material and methods. Fourteen participants received 64 implants in the premolar and molar regions. Each side of the mouth received 2 implants—1 Morse taper (MT) and 1 external hexagon EH)—with only 1 connection design, PS or PM, thus forming combinations MT+PS, MT+PM, EH +PS, and EH+PM. While each connection design was assigned to 1 side of the mouth, each implant type was assigned to 1 position on the hemiarch, either molar or premolar. Standardized digital periapical radiographs were obtained by using an acrylic resin device customized for each participant, and MBL was assessed immediately, at 3 months, and at 3 years after prosthesis installation. Three-way ANOVA for repeated measures and the Tukey HSD test were used to analyze vMBL, while the Mann-Whitney and Friedman tests were used for hMBL (a=.05).

Results. vMBL was significantly higher for EH+PS than for MT+PS (P<.05) and higher for MT+PM than for MT+PS (P<.05). hMBL for MT+PS increased significantly over time (P=.009).

Conclusions. The MT+PS combination outperformed the EH+PS combination in terms of vMBL.Additionally, the PM connection design was ineffective in protecting the MT connection type against vMBL, and the hMBL associated with the MT+PS combination increased over time (J Prosthet Dent xxxx;xxx:xxx-xxx)

FULL ARTICLE



CLINICAL CASES

CHALLENGING CASE OF BI-MAXILLARY FULL-ARCH REHABILITATION WITH IMMEDIATE LOADING





BY DR. GUILHERME AMARAL
AND DR. BRENNO NEGRI

Dr. Guilherme Amaral - Specialist in Implant Dentistry (ABO/AL); Specialist and Master in Prosthodontics (São Leopoldo Mandic, Campinas); PhD Candidate in Implant Dentistry (São Leopoldo Mandic, Campinas). President of ABO/AL and S.I.N. Ambassador.

Dr. Brenno Negri - Master's Student in Implant Dentistry (São Leopoldo Mandic – SP); Specialist in Implant Dentistry (UNIP – SP); Specialist in Public and Family Health Dentistry (Unyleya – SP); DDS (FO-USP – SP); National Specialist in the Product Research and Development Department – S.I.N and S.I.N. Ambassador.

CASE INTRODUCTION

The patient had been rehabilitated 20 years earlier with four parallel lower implants using an external hex connection, which resulted in a dysfunctional bilateral distal cantilever, even after the extraction of one premolar on each side to improve the biomechanics of the prosthesis. In the maxillary arch, the patient wore a conventional complete denture. Both esthetically and functionally, the patient was dissatisfied with the rehabilitation. Clinical examination revealed that the vertical dimension of occlusion was not adequate, and the tooth setup and occlusion were unbalanced, giving the impression of insufficient facial support and a facial appearance older than the patient's actual age.

TREATMENT EXPLANATION

The proposed treatment consisted of rehabilitation using four zygomatic implants due to the severity of the maxillary atrophy. In the mandibular arch, the plan involved the removal of the four existing implants, bone leveling, and the placement of four new implants following the classic "all-on-four" protocol, with angled distal implants and parallel anterior implants. The surgery was performed under conscious sedation. The treatment plan included bi-maxillary immediate loading with delivery of the prostheses within 7 days.

PATIENT RECORD

Patient: Female, 69 years old.
Chief Complaint: Esthetics.
Anamnesis: Patient with controlled hypertension, medicated hypercholesterolemia, and medicated depression.
Treatment Plan: Surgery under conscious sedation for upper and lower full-arch rehabilitation, consisting of a superior Quad Zygoma and an inferior classic all-on-four protocol, including explantation of previously installed implants and ridge leveling.Impression, wax rim try-in, and tooth try-in were performed on the same day as the surgery. Bar and teeth try-in took place approximately 3 days post-operative. Final installation was completed at 7 days, on the same day as suture removal.

BEFORE

The patient presented with an upper complete denture and a lower fixed full-arch prosthesis, with an inadequately restored vertical dimension of occlusion. The dental esthetics were not compatible with the patient's skin tone or age, contributing to a more aged facial appearance. Incorrect occlusion resulted in poor masticatory function and awake bruxism/clenching.

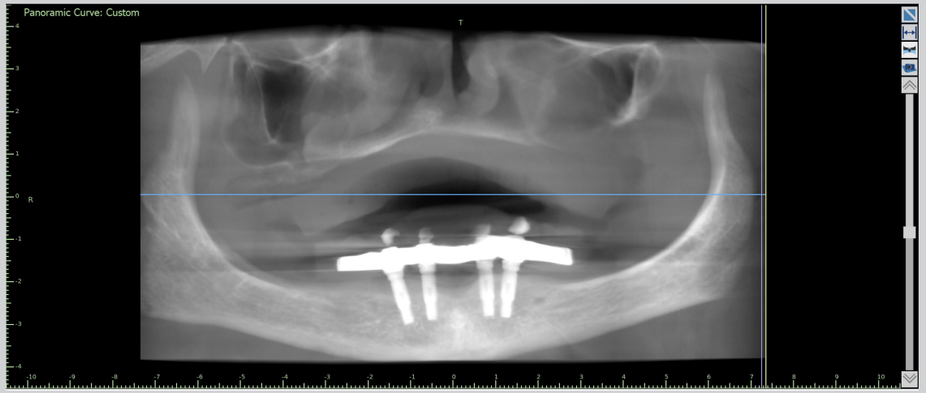




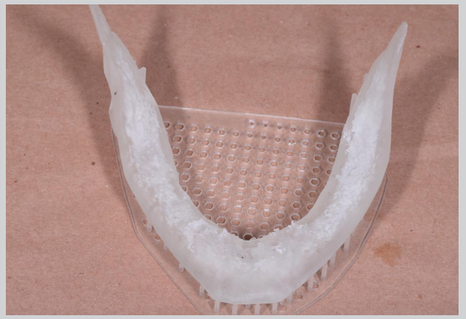


RADIOGRAPHY/TOMOGRAPHY

Panoramic reconstruction of the CT scan showing the severity of the maxillary atrophy and the distribution of the mandibular implants with their excessive distal cantilever. Prototyping and 3D printing of both arches were performed for evaluation.



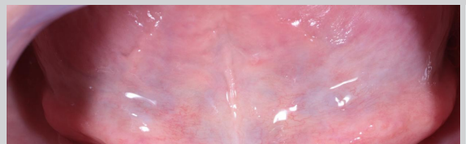




BEFORE

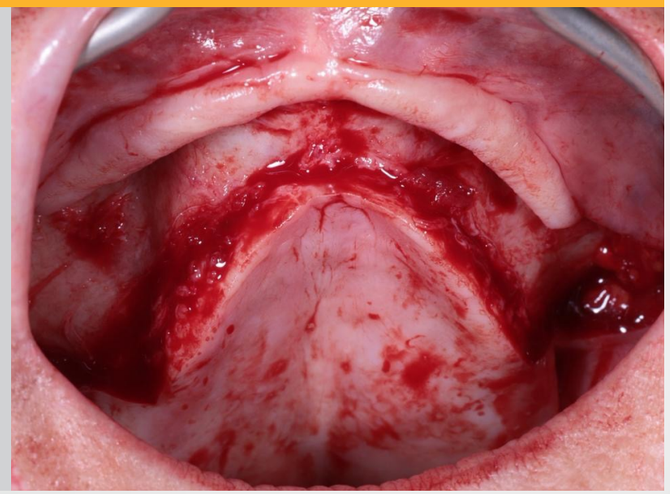
Upper arch showing a good oral mucosa phenotype in the preoperative ridge.
Previously fabricated lower full-arch prosthesis with parallel external-hex implants, showing distal implant emergence between the canine and first premolar, and presenting extensive tissue loss (mucosal dehiscence and bone resorption).





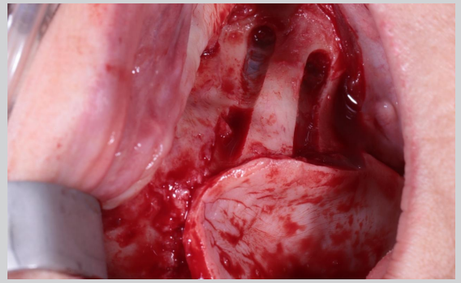
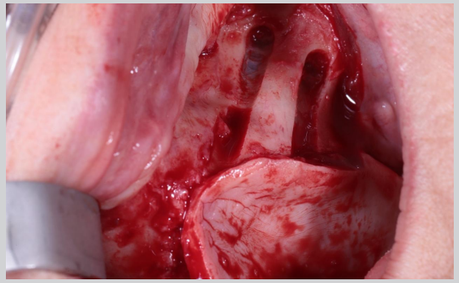

STEP-BY-STEP PROCEDURE

A linear full-thickness incision was made along the crest of the ridge, combined with extensive bilateral releasing incisions. Complete flap elevation exposed the floor of the nasal cavity, the zygomatic arch, and the base of the orbital floor to ensure procedural safety.



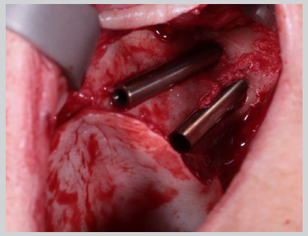
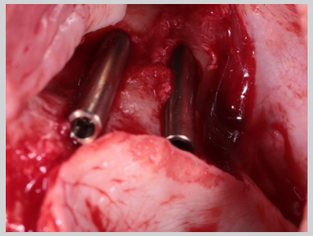
INTRAOPERATIVE

Grooves were created to guide and ensure safe alignment during drilling for the subsequent placement of the zygomatic implants. The grooves were prepared using the inactive-tip diamond bur included in the S.I.N. Zygomatic Plus surgical kit. After the grooves were completed, gentle elevation of the sinus membrane was performed to minimize postoperative complications.

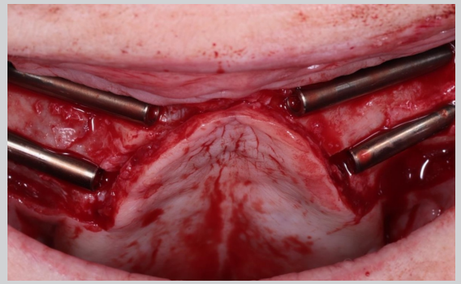
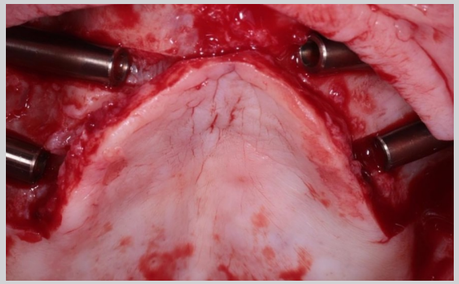
INTRAOPERATIVE

Drilling was performed according to the manufacturer's recommendations. The photo shows a safe osteotomy, with no soft tissue on the drills, only bone debris. The zygomatic implants were placed with ideal spatial distribution for emergence, considering the Roy polygon.

INTRAOPERATIVE

After completing the drilling sequence, implant placement occurred without complications. Final torque values were 45 N.cm for the posterior implant on the right side (4.0 mm ⅓35.0 mm) and 80 N.cm for the remaining three implants (4.0 mm ⅓45.0 mm anterior right, 4.0 mm ⅓55 mm anterior left, and 4.0 mm ⅓37.5 mm posterior left).

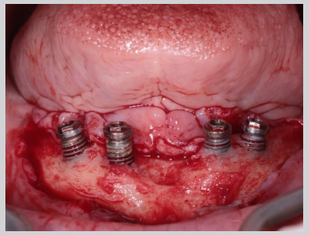
INTRAOPERATIVE

Angled multi-unit abutments of 52∞with a height of 1.5 mm were installed, except for the anterior left implant, which received a 60∞ multi-unit abutment with a height of 1.5 mm. Multi-unit abutment protectors were placed, and simple sutures were performed along the entire incision to close the surgical wound, preparing for impression in the same session.



STEP-BY-STEP PROCEDURE

A crestal incision was made around the pre-existing implants, taking care not to perforate the soft tissue despite the presence of fibrotic tissue resulting from local inflammation due to exposed threads and hygiene difficulty. Bilateral releasing incisions were performed to expose the mental foramen and ensure surgical safety. After explantation using implant retrievers, ridge regularization was required and was carried out with a Maxicut bur.

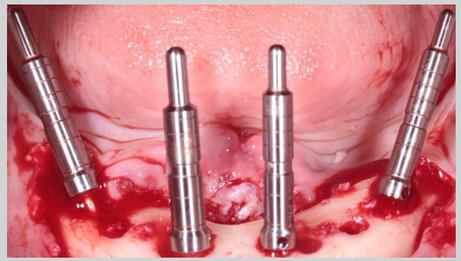


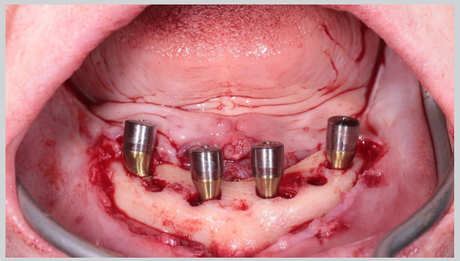




INTRAOPERATIVE

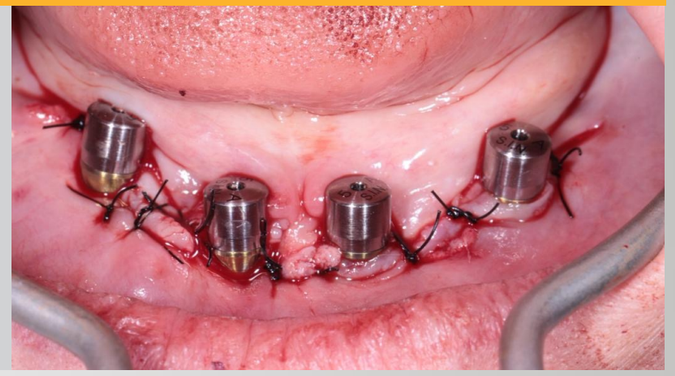
Implants were prepared according to the manufacturers recommendations, reaching torque values of 50 N.cm for the posterior implants and 80 N.cm for the anterior ones. Directional indicators were used to visualize distal angulations and anterior parallelism. Straight anterior multi-unit abutments with 4.0 mm height and angled multi-unit abutments (30∞) with 3.0 mm height in the posterior region were installed. The importance of ridge regularization for proper seating of the future prosthesis is evident.





INTRAOPERATIVE

Protectors for the multi-unit abutments were placed, and simple sutures were performed along the entire incision to close the surgical wound, preparing for impression-taking in the same session.



IMPLANT USED

In the upper arch, for the “Quad Zygoma” configuration, Zygomatic Plus implants were used: 4.0 mm ⅓35 mm in the posterior right position, 4.0 mm ⅓45 mm in the anterior right, 4.0 mm ⅓55 mm in the anterior left, and 4.0 mm ⅓37.5 mm in the posterior left.In the lower arch, a conventional “All-on-four” configuration was performed, using four Versalis Plus implants measuring 3.8 mm ⅓13 mm.





PROSTHETIC PHASE

The patient was impressioned immediately after the surgical procedure, using only heavy-body silicone to avoid postoperative complications in case light-body silicone entered the surgical site. The impression copings were splinted using the nylon technique (dental floss + Duralay), and the impression was taken with an open tray.



PROSTHETIC PHASE

After the record using the trial base and wax rim, the teeth (VITA MFT) were tried in, still within the same session.




PROSTHETIC PHASE

At 4 days post-operative, the bar and setup were tried in, with some adjustments to the teeth. A hematoma is evident due to the extent of the procedure performed; however, the patient was already extremely satisfied with the esthetic result obtained.




PROSTHETIC PHASE

After 7 postoperative days, the sutures were removed and the full-arch prostheses were installed. Occlusal adjustment was performed to achieve bilateral and anteroposterior balance.





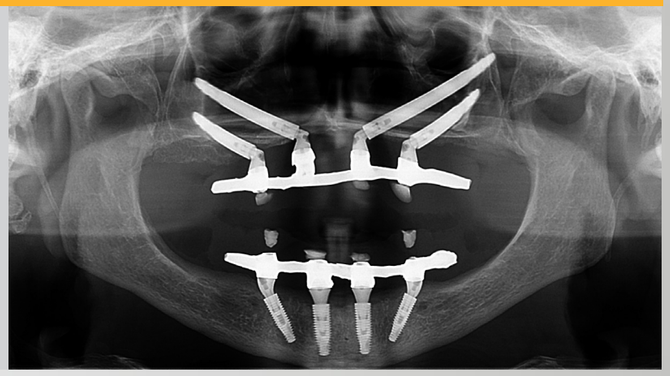
PROSTHETIC PHASE

A forward extension of the upper prosthetic flange was necessary to compensate for the atrophy.Improved ease of hygiene of the lower rehabilitation is noticeable when compared to the previous one the patient had.




FINAL RADIOGRAPH

Panoramic radiograph 10 days post-operative after bi-maxillary rehabilitation installation, with 3 days in function.



FINAL RESULT

The patient was extremely satisfied with the final result, demonstrating that basic prosthodontic principles such as VDO, occlusion, and the correct selection of teeth for the final prosthesis make all the difference in the ultimate success we achieve as oral rehabilitators. These factors, of course, must be combined with well-executed surgical planning and skillful surgical performance





IMMEDIATE IMPLANT AND IMMEDIATE LOADING IN A FRACTURED CENTRAL INCISOR WITH COMPROMISED BUCCAL BONE PLATE



BY DR. BRENNO NEGRI
AND DR. LILIANE CURY

Dr. Brenno Negri - Master's Student in Implant Dentistry (São Leopoldo Mandic – SP); Specialist in Implant Dentistry (UNIP – SP); Specialist in Public and Family Health Dentistry (Unyleya – SP); DDS (FO-USP – SP); National Specialist in the Product Research and Development Department – S.I.N.; and S.I.N. Ambassador.

Dr. Liliane Cury - Advanced Training in Restorative Dentistry – APCD (São Paulo); Specialization in Radiology – APCD (São Paulo); Advanced Training in Implant Prosthetics – ACDC (Campinas); Immersion Course in Esthetic Dentistry – ILUNE (Campinas)

CASE INTRODUCTION

The patient presented with a fractured anterior tooth (21). Extraction of the tooth and immediate implant placement were proposed. Immediate loading was planned using the crown of the extracted tooth, provided if a minimum insertion torque of 45 N.cm was achieved.

TREATMENT EXPLANATION

The patient came to the clinic presenting severe mobility and visible extrusion of the maxillary central incisor (21), gingival edema, and pain. Clinically, a fracture was suspected and later confirmed by CBCT imaging, which contraindicated the tooth due to the position and extent of a complete horizontal fracture. Extraction of the tooth followed by immediate implant placement was proposed. Since the patient had a deep bite with anterior contact, which would make the installation of an adhesive provisional challenging, the initial plan was to perform immediate loading if sufficient insertion torque was achieved, using the patient's own natural crown to maintain an esthetic result similar to what she was accustomed to.

PATIENT RECORD

Patient: Female, 57 years old.
Chief Complaint: Loose tooth and displaced downward (SIC).
Anamnesis: Normoreactive patient, with no systemic conditions, and no history of allergies or complications in previous surgeries.
Treatment Plan: Minimally invasive extraction with an attempt to preserve the thin buccal bone plate. Immediate implant placement was planned to take advantage of the alveolar bone anatomy for primary stability, since the basal bone located apically presents a buccal concavity and does not provide sufficient diameter for implant installation. A xenogeneic particulate graft was planned for the gap. The procedure would be completed with immediate provisionalization, using the patient's own tooth, if a minimum insertion torque of 45 N.cm was achieved.

BEFORE

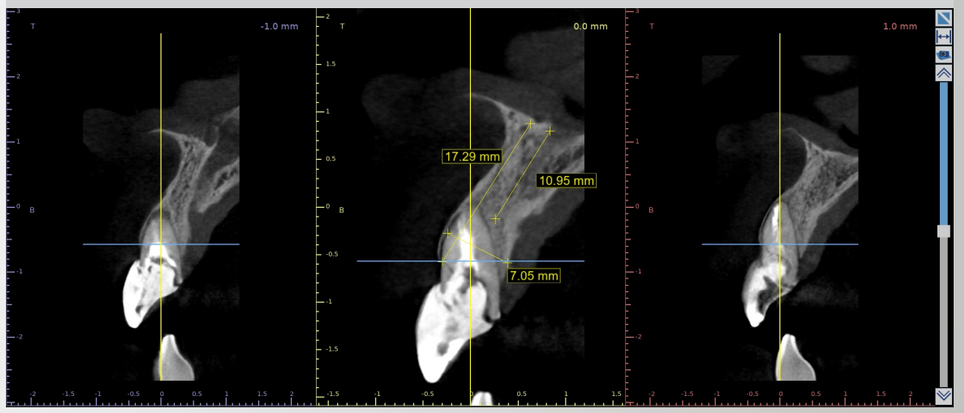
Initial photo showing gingival edema and extrusion of tooth 21, resulting from a horizontal root fracture.





RADIOGRAPHY/TOMOGRAPHY

The CBCT scan confirmed the initial clinical diagnostic suspicion of fracture. There is close proximity to the nasopalatine canal and a prominent concavity in the region apical to the tooth (basal alveolar bone).



STEP-BY-STEP PROCEDURE

Tooth extraction of element 21 was performed. The coronal portion was not continuous with the root portion, and after its removal, a periotome was used to atraumatically remove the remaining root structure.







INTRAOPERATIVE

The drilling sequence recommended by the company was followed precisely, always maintaining support on the palatal wall to achieve maximum primary stability.



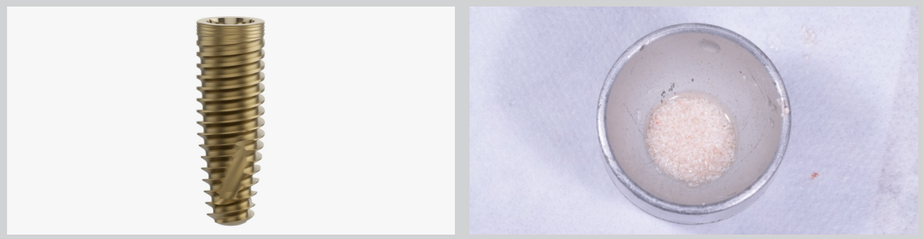
INTRAOPERATIVE

The implant was delivered to the site, with the initial insertion performed using a contra-angle driver and final seating completed with a manual ratchet, reaching 75 N.cm.



IMPLANT USED

The implant used was the Versalis S Plus 3.8 ⅛13 mm, along with a xenogeneic particulate biomaterial placed in the gap between the implant and the buccal bone plate.



PROVISIONALIZATION

The crown of the patient's extracted tooth was used to maintain the same esthetics, but it was completely removed from occlusion. The capture was performed using a transmucosal interface with a height of 3 mm (ICMT 3004).



FINAL RADIOGRAPHY

Postoperative X-ray at 21 days.



FINAL RESULT

Although the surgery was performed flaplessly, a modified vertical mattress suture was placed to provide greater stability to the thin buccal tissue and the particulate graft.Postoperative smile photo taken immediately after surgery, already showing improvement even with the provisional restoration.



MAXILLARY BRANEMARK FULL-ARCH IMPLANTS WITH IMMEDIATE LOADING USING VERSALIS IMPLANTS



BY DR. FABIO GUERRA, DR. CELSO FLEURY BRAGA JUNIOR, DR. LUCAS LUIZ RODRIGUES AND DR. FAIR LAZZARETTI

Dr. Fabio Guerra - Master and Specialist in Implant Dentistry; Specialist in Oral and Maxillofacial Surgery.

Dr. Celso Fleury Braga Junior - Specialist in Implants – INEPO; Specialist in Prosthodontics – INEPO International R&D Analyst – S.I.N. and S.I.N. Ambassador.

Dr. Lucas Luiz Rodrigues - Specialist in Implant Dentistry – FG Postgraduate Program; Specialist in Prosthodontics.

Dr. Fair Lazzaretti - Specialist in Oral Rehabilitation – Prosthodontics and Implant Dentistry.

CASE INTRODUCTION

The patient presented with only three remaining teeth, (17), (13), and (23), with absence of all other teeth, and was using a removable partial denture supported by the remaining teeth.

TREATMENT EXPLANATION

After clinical evaluation, we suggested the placement of four osseointegrated implants to support a screw-retained fixed prosthesis. Following the assessment, we identified the need for extraction of the remaining teeth, bone reduction to accommodate the fixed full-arch prosthesis and ensure adequate interocclusal space, and the execution of immediate loading.

PATIENT RECORD

Patient: Female, 51 years old.
Chief Complaint: Use of an upper removable prosthesis.
Anamnesis: Diabetic patient with hypothyroidism, taking gliclazide, Puran, and metformin, and allergic to benzathine penicillin (Benzetacil) and metoclopramide (Plasil).
Treatment Plan: Maxillary total exodontia, Versalis implants for immediate loading.

BEFORE

During the initial evaluation, we identified the need for extraction of the patient's remaining teeth and the fabrication of a multifunctional surgical guide for immediate loading, following a reverse-planning approach.





RADIOGRAPHY/TOMOGRAPHY

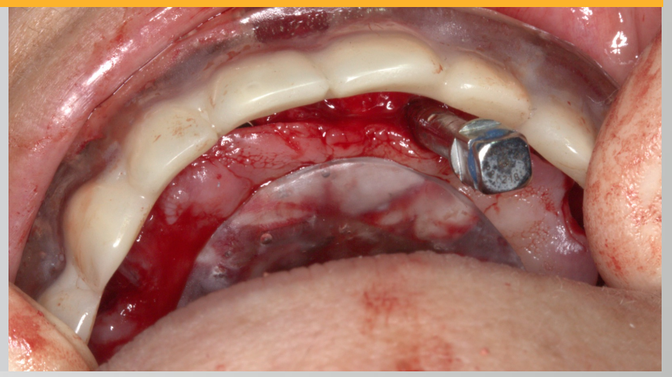
Limited bone availability was observed, requiring the use of a reduced-diameter implant.





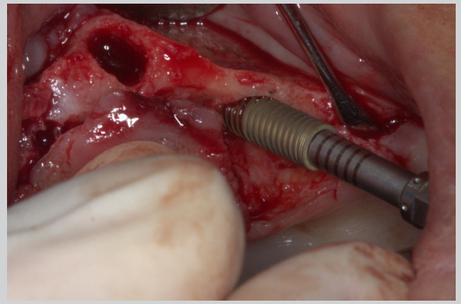
INTRAOPERATIVE

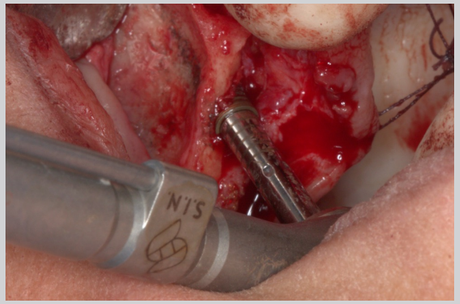
Trial of the multifunctional guide after placement of the first implant.



INTRAOPERATIVE

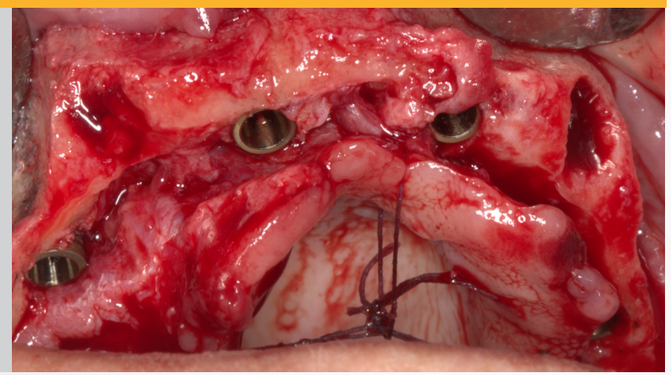
Even though the bone presented low density, the implants achieved excellent insertion torques suitable for immediate loading.





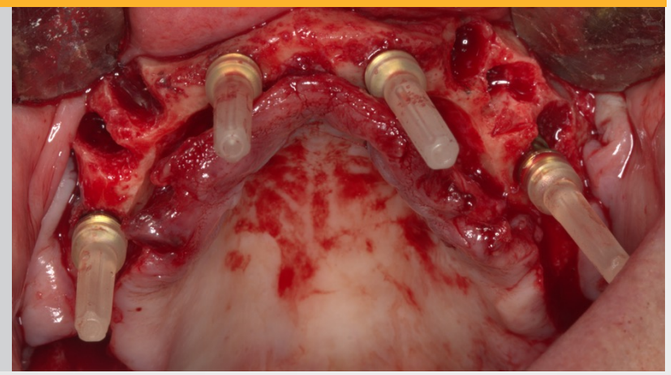
INTRAOPERATIVE

Four Versalis implants were placed: In regions 26 and 16, 3.8 mm ⅓ 13 mm implants were installed with 60 N.cm of torque. In regions 12 and 22, 3.5 mm ⅓10 mm implants were installed with 45 N.cm of torque.



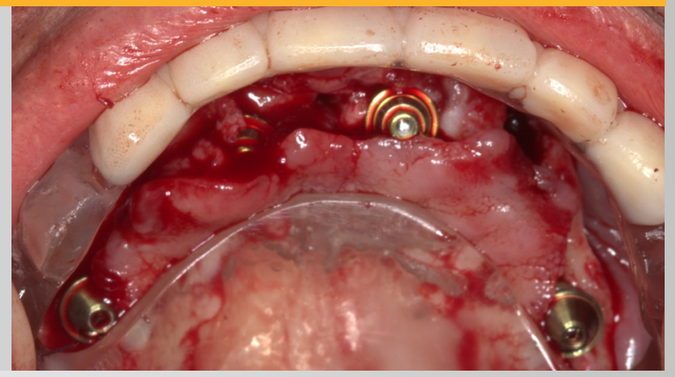
INTRAOPERATIVE

Multi-unit abutments were installed with 20 N.cm torque, according to the manufacturer's recommendation.



PROSTHETIC PHASE

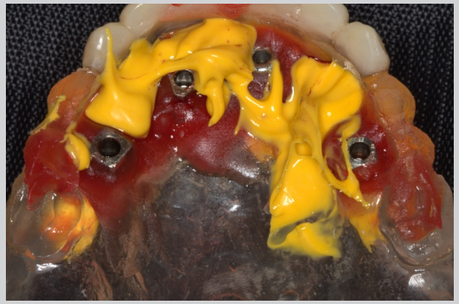
The multifunctional guide was positioned for the transfer impression, aiming to achieve the highest possible accuracy in fabricating the immediate full-arch prosthesis.



PROSTHETIC PHASE

Transfer procedure performed using the multifunctional guide with a rigid bite registration in Duralay.

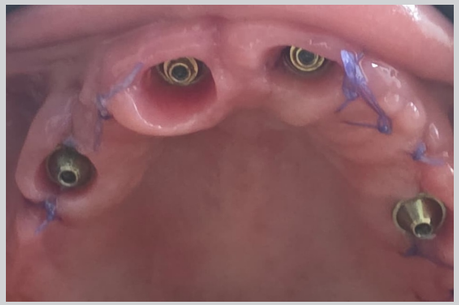




INTRAOPERATIVE

Customized healing abutments, 7-day postoperative.





IMPLANT USED

Versalis 16∞ Implants: 2 implants with a diameter of 3.8 mm and a length of 13.0 mm, 2 implants with a diameter of 3.5 mm and a length of 10.0 mm.



PROSTHETIC PHASE

Placement of an upper full-arch prosthesis with immediate loading.



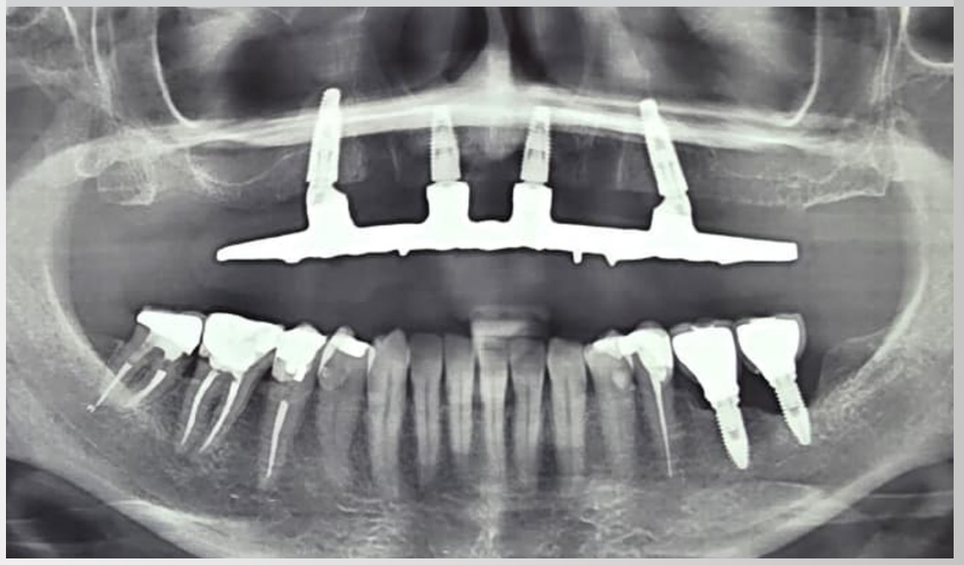
PROSTHETIC PHASE

Prosthesis installed, showing proper lip support.



FINAL RADIOGRAPHY

Final postoperative X-ray showing perfect adaptation of the bar.



FINAL RESULT

Case completed within the planned timeline, with the patient satisfied with the result.



IMMEDIATE IMPLANT PLACEMENT COMBINED WITH PRESERVATION OF THE ALVEOLAR ARCHITECTURE AND A CUSTOMIZED HEALING ABUTMENT





BY DR. FABIO RODRIGUES DE AZEVEDO AND DR. JOS¶XAVIER DE MORAIS NETO

Dr. Fabio Rodrigues de Azevedo - Specialist in Implant Dentistry; Master in Periodontics; MBA in Healthcare Management – FGV; PhD Candidate in Periodontics / Surgery; Member of the S.I.N. Scientific Council and S.I.N. Ambassador.

Dr. JosÊXavier de Morais Neto - Degree from the State University of Londrina (UEL); Training in Minor Oral Surgery – ABO Sorocaba; Training in Conscious Sedation with Nitrous Oxide – Garça Branca Pantanal College (FGB).

CASE INTRODUCTION

The patient presented to the clinic reporting moderate to severe pain during chewing. Clinical, radiographic, and CBCT examinations revealed a fracture line along the long axis of the tooth, leaving no alternative other than extraction and immediate implant placement.

TREATMENT EXPLANATION

Immediate implant placement was proposed, combined with bone regeneration for alveolar preservation, and a customized healing abutment to maintain and stabilize the gingival architecture and the emergence profile.

PATIENT RECORD

Patient: Male, 33 years old.
Chief Complaint: Pain and dental mobility (crown).
Anamnesis: Good overall health, with intense bruxism. Botox and a myorelaxant splint were recommended.
Treatment Plan: Extraction followed by immediate implant placement, combined with particulate xenogeneic bone grafting and a customized healing abutment.

BEFORE

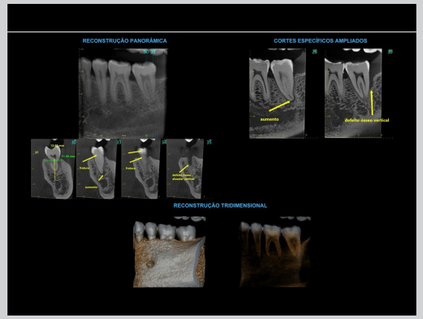
Initial appearance showing a visible continuity line on the crown (fracture).

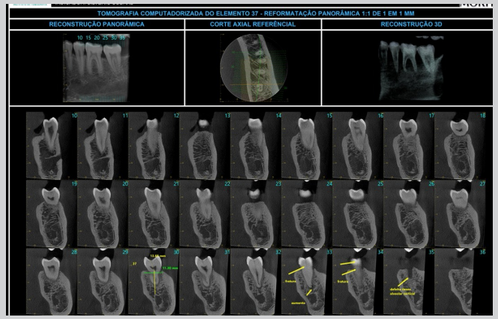




RADIOGRAPHY/TOMOGRAPHY

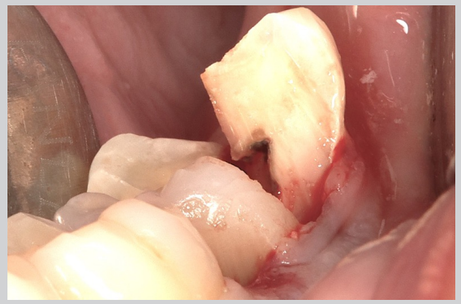
CBCT slice showing the tooth fracture, resorption, and bone defect of the socket along with the remaining apical bone.

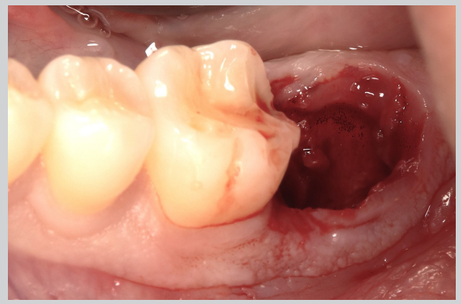




STEP-BY-STEP PROCEDURE

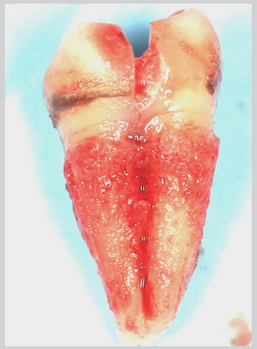
Moment of removal of the distal third of the tooth, with the socket preserved at the end of the minimally traumatic extraction process.





INTRAOPERATIVE

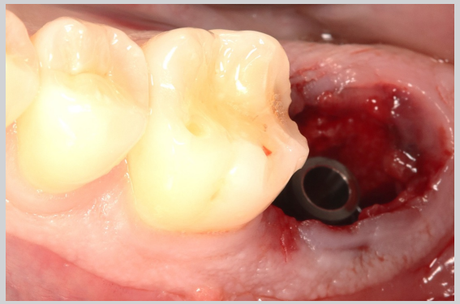
Aspect of the fracture along the long axis of the tooth.





INTRAOPERATIVE

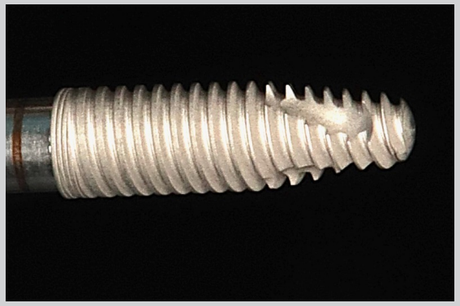
Implant placed 2.0 mm below the bone crest, positioned in the interradicular septum, with 45 N.cm of torque. A provisional cylinder with a 4.5 mm transmucosal height was selected to preserve the biological width and the future architecture of the prosthetic emergence profile.





IMPLANT USED

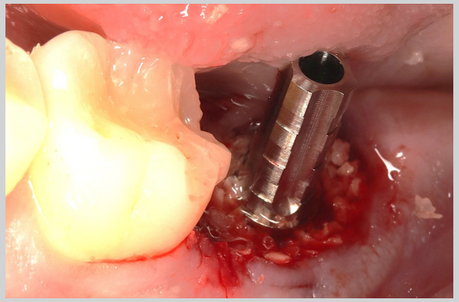
Versalis implant 4.0 mm x 13.0 mm.





PROVISIONALIZATION

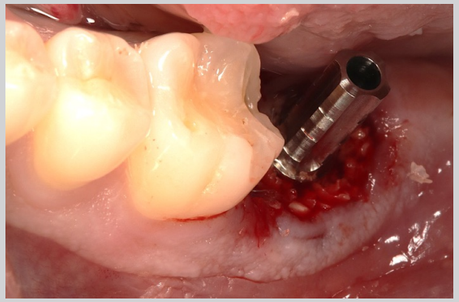
Cylinder installed with good 3D positioning, and the socket filled with biomaterial, a medium-granulation particulate bovine xenogeneic substitute.

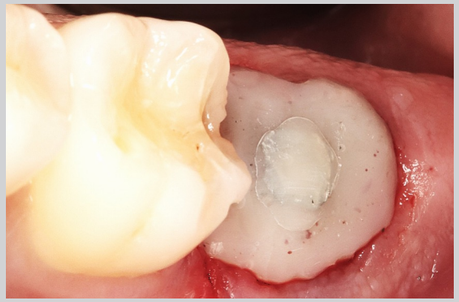




PROVISIONALIZATION

Customization of the healing abutment with flow resin, followed by finishing with an ultra-fine diamond bur and polishing with abrasive rubber points.





FINAL RADIOGRAPHY

Final X-ray showing apical anchorage of the implant in the 5.0 mm of remaining bone and absence of an osseous septum.



FULL-ARCH MAXILLARY REHABILITATION





BY DR. FABIO RODRIGUES DE AZEVEDO AND DR. ANA CAROLINA LOYOLA BARBOSA

Dr. Fabio Rodrigues de Azevedo - Specialist in Implant Dentistry; Master in Periodontics; MBA in Healthcare Management – FGVPhD Candidate in Periodontics / Surgery; Member of the S.I.N. Scientific Council; and S.I.N. Ambassador.

Dr Ana Carolina Loyola Barbosa - Degree in Dentistry – UFES; Specialist in Periodontics and Implant Dentistry; Master in Oral Biology (FORP/USP); PhD Candidate in Periodontics (FORP/USP); International Analyst, Product Research and Development Department – S.I.N.; and S.I.N. Ambassador.

CASE INTRODUCTION

The patient presented to the clinic reporting a lack of stability in the maxillary complete denture, experiencing difficulties with chewing, smiling, and social interactions. She also reported loss of taste and thermal sensitivity to foods due to the denture material covering the palate.

TREATMENT EXPLANATION

A treatment plan using the All-on-Four technique with an immediately loaded protocol-type prosthesis was proposed.

PATIENT RECORD

Patient: Female, 48 years old.
Chief Complaint: Lack of retention and stability of the prosthesis.
Anamnesis: Good overall health, with no reported allergies.
Treatment Plan: Four implants were placed in the maxilla using the All-on-Four technique for immediate-load rehabilitation.

BEFORE

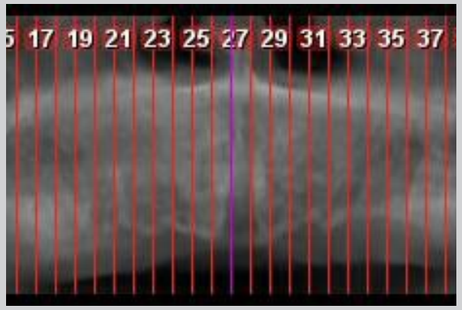
Lack of lip support when smiling without the prosthesis. The prosthesis had been in use for over 15 years and showed wear due to the passage of time.

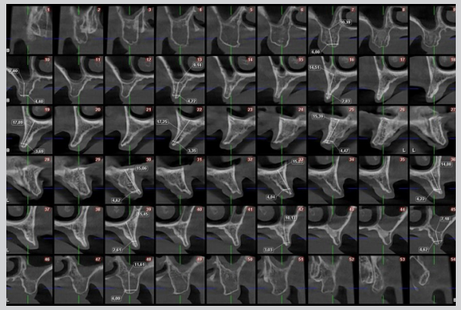




RADIOGRAPHY/TOMOGRAPHY

CBCT sections showed a satisfactory bone remnant with maxillary sinus pneumatization. Angled implants were planned to achieve improved biomechanical performance of the rehabilitation.

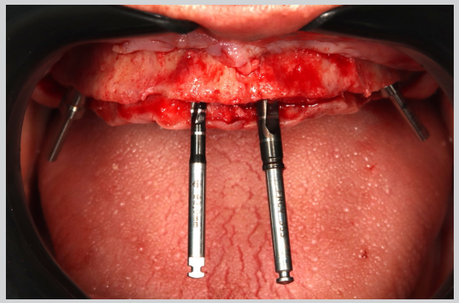




STEP-BY-STEP PROCEDURE

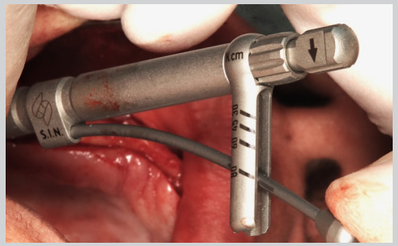
An excessive volume of soft and hard tissue was observed, with insufficient prosthetic space, as well as an asymmetric ridge surface. Therefore, osteotomy and ridge recontouring were indicated to create adequate prosthetic space and a more symmetrical ridge, facilitating hygiene and the flange of the future prosthesis.

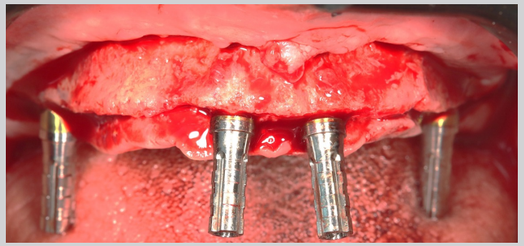




INTRAOPERATIVE

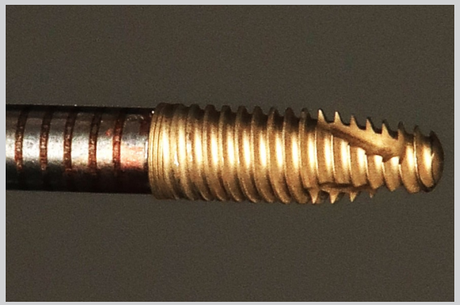
Implant placement in the prepared socket was performed, and both implants achieved excellent primary stability greater than 60 N.cm. This was followed by installation of the mini abutments with 20 N.cm of torque, and subsequently the titanium cylinders with 10 N.cm of torque.

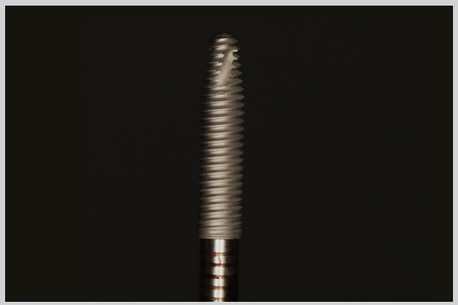




IMPLANT USED

Versalis Plus implants were placed as follows: 3.8 mm ⅓11.0 mm in the anterior sites (11 and 21), and 4.0 mm ⅓18.0 mm in the posterior sites (15 and 25).





PROVISIONALIZATION

A continuous scalloped suture was performed along the linear incision, and simple sutures were placed on the releasing incisions using absorbable sutures, preserving the keratinized tissue. A new acrylic complete denture was captured as an immediate provisional prosthesis. This approach avoids the need for future relining of the definitive prosthesis and prevents a visible transition line in the restoration. Note the appropriate contour, which facilitates oral hygiene.





PROVISIONALIZATION

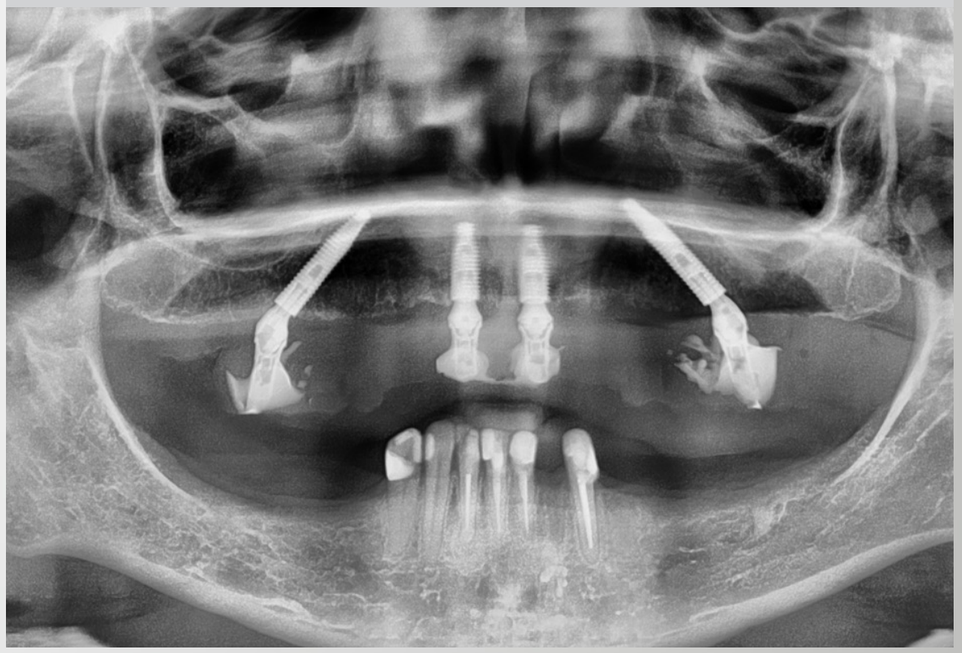
Smile immediately after prosthesis capture. The patient was still under the effects of anesthesia.





FINAL RADIOGRAPHY

Planned versus executed, showing accurate 3D positioning that faithfully reproduces the planned outcome.



FINAL RESULT

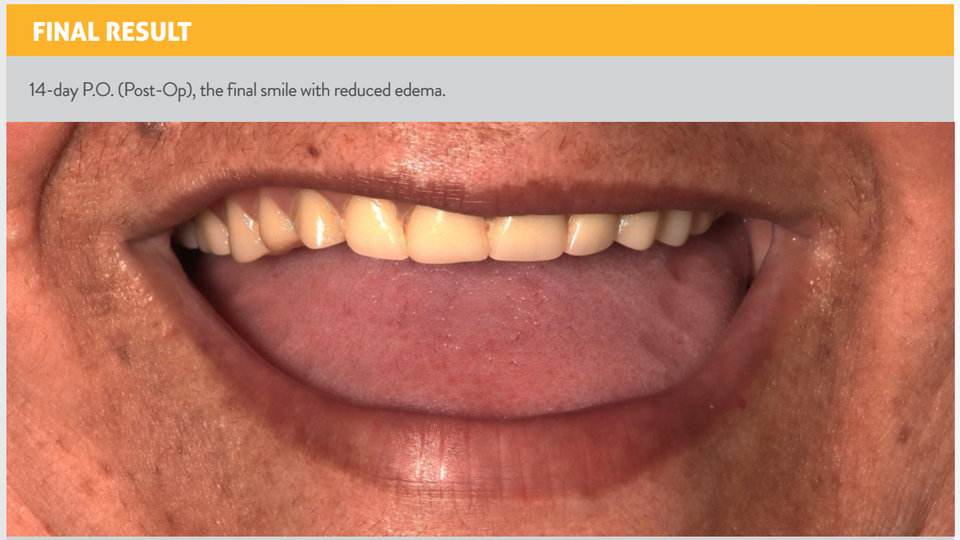
Case completed, with adequate lip support and smile line.





FINAL RESULT

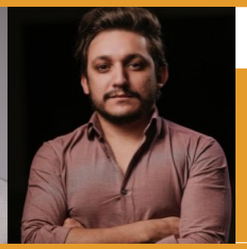
14-day P.O. (Post-Op), the final smile with reduced edema.





CLINICAL VERSATILITY AND PREDICTABLE REHABILITATION WITH VERSALIS IMPLANTS IN A COMPLEX RETREATMENT CASE





BY DR. PABLO ENRICO MONTEIRO MARTINS AND DR. GUSTAVO MOMESSO

Dr. Pablo Enrico Monteiro Martins - Master's Candidate in Implant Dentistry; Professor and Coordinator of the Implant Dentistry Specialization Program – IEO Bauru; International Specialist, Research and Development (R&D) Department – S.I.N.; Member of the Teaching Team for Implant Dentistry Specialization Programs – ABO Presidente Prudente and FG Pós São José do Rio Preto, SP and S.I.N. Ambassador.

Dr. Gustavo Momesso - Bachelor's Degree in Dentistry – Araçatuba School of Dentistry, UNESP; Master's Degree in Oral and Maxillofacial Surgery and Traumatology – Araçatuba School of Dentistry, UNESP; PhD in Oral and Maxillofacial Surgery and Traumatology – Araçatuba School of Dentistry, UNESP; Professor in the Undergraduate Dentistry Program – Santo Amaro University (UNISA); Professor in the Postgraduate Program in Implant Dentistry – Santo Amaro University (UNISA); International Specialist in Research and Development – S.I.N. and S.I.N. Ambassador.

CASE INTRODUCTION

The male patient, wearing a fixed maxillary full-arch prosthesis supported by three implants, presented with complaints of prosthetic mobility and masticatory discomfort. Clinical and CBCT evaluation revealed the absence of one implant in the right quadrant, improper positioning of the two anterior implants, and significant peri-implant bone loss in the left posterior region, with partial communication to the maxillary sinus. Given the structural and biomechanical compromise of the rehabilitation, a treatment plan was proposed involving removal of the remaining implants, bone recontouring through osteotomy, and placement of four new Versalis 16° implants, enabling fabrication of an immediate full-arch prosthesis with loading after 48 hours.

TREATMENT EXPLANATION

After clinical and CBCT evaluation, structural compromise of the previously placed implants was identified, with peri-implant bone loss and significant prosthetic mobility. The treatment plan consisted of removal of the remaining implants, osteotomy for regularization of the maxillary alveolar ridge, and subsequent placement of four new Versalis 16° implants, ensuring improved biomechanical distribution and adequate torque for immediate loading within 48 hours. This approach aimed to restore masticatory function, comfort, and esthetics, thereby improving the patient's quality of life and providing clinical predictability through a fixed maxillary rehabilitation.

PATIENT RECORD

Patient: Male, 63 years old.
Chief Complaint: Difficulty eating, pain and discomfort caused by mobility of the maxillary fixed prosthesis, as well as esthetic concerns and embarrassment when smiling.
Anamnesis: The patient reported progressive loss of stability of the maxillary full-arch prosthesis, with a history of loss of one implant and fracture of a component. Imaging exams confirmed the absence of an implant in the right quadrant, improper positioning of the two anterior implants, and extensive bone loss in the left posterior region.
Treatment Plan: Removal of the existing implants, ridge regularization through osteotomy, placement of four new Versalis implants, immediate impression, and installation of a provisional full-arch prosthesis within 48 hours.

BEFORE

In the first image, the maxillary full-arch prosthesis in use can be seen, presenting a bulky vestibular flange, which contributed to food debris accumulation and made hygiene difficult. The prosthetic assembly showed mobility and visible esthetic wear.In the second image, after removal of the prosthesis, the initial clinical condition of the mucosa and the remaining implants is noted, with marginal inflammation and evident bone loss, demonstrating the need for a new surgical intervention and complete rehabilitation.

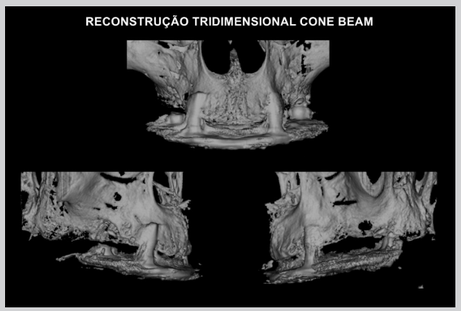




RADIOGRAPHY/TOMOGRAPHY

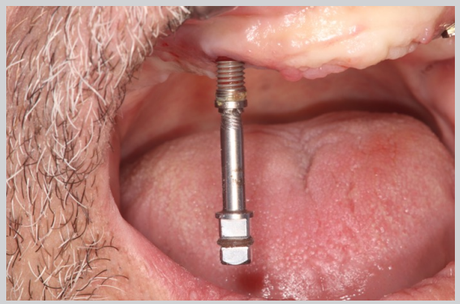
Panoramic imaging and three-dimensional CBCT reconstruction revealed the absence of one implant in the right quadrant, improper positioning of the anterior implants, and significant bone resorption in the left posterior region with partial communication to the maxillary sinus.





STEP-BY-STEP PROCEDURE

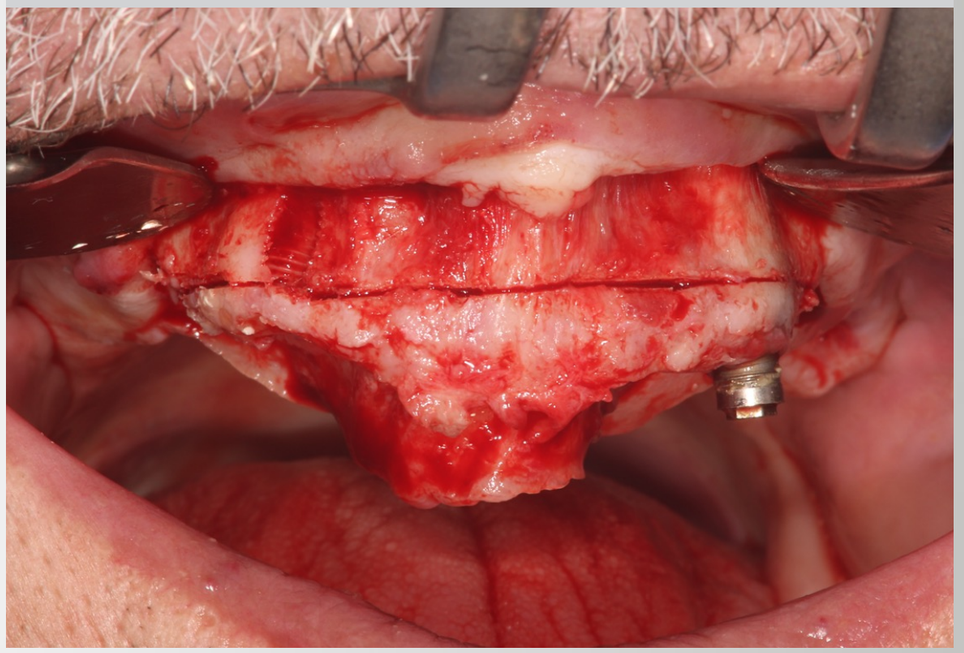
Removal of the malpositioned implants was performed using a Retriever wrench, allowing controlled explantation and maximum preservation of the remaining bone tissue. The procedure was carried out with progressive reverse torque, ensuring safety and predictability for the new surgical plan.





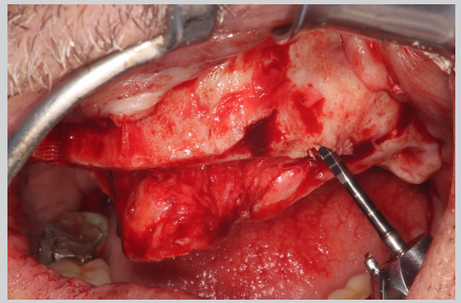
INTRAOPERATIVE

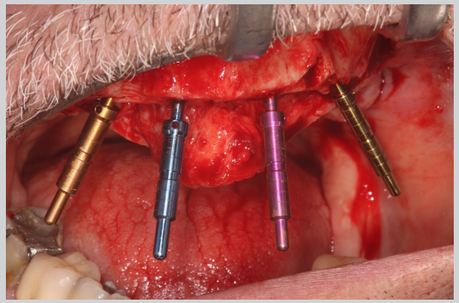
The procedure was performed using a piezoelectric device (Mectron), allowing greater surgical control and tissue preservation during ridge regularization.The implant located near tooth 23 was removed after the initial osteotomy, as it presented an internally fractured screw, making conventional removal with the Retriever wrench impossible.



INTRAOPERATIVE

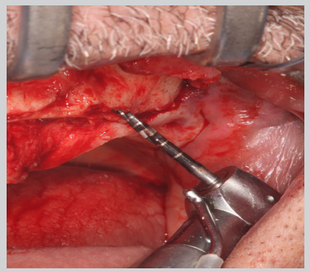
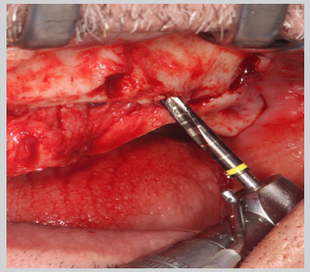
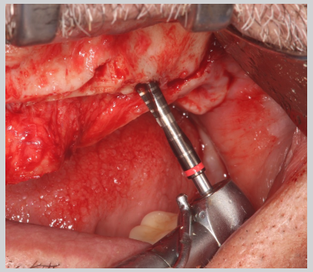
Initial drilling was performed using a lance drill in the four previously planned sites. Next, direction indicators were placed to verify and adjust angulation as needed, ensuring correct three-dimensional orientation for the placement of the Versalis implants.





INTRAOPERATIVE

Drilling was performed according to the Versalis surgical protocol, respecting the planned diameter and depth and demonstrating the controlled progression of the burs.At the end of the sequence, direction indicators were positioned to confirm the drilling trajectory and proper three-dimensional alignment with the multifunctional guide in place before implant installation.

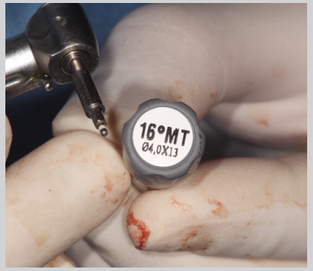




IMPLANT USED

Four Versalis implants (16∞Morse taper) were placed as follows:
‘ 2 units of 3.8 mm ⁄11.5 mm
‘ 1 unit of 3.8 mm ⁄15.0 mm
‘ 1 unit of 4.0 mm ⁄13.0 mm
Implant selection followed the tridimensional planning and the available bone volume and density in each region, ensuring balanced biomechanical distribution for the immediate maxillary full-arch prosthesis.

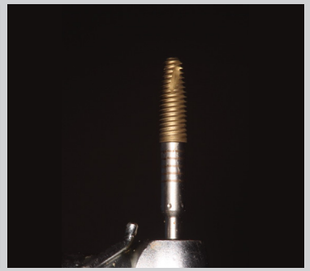






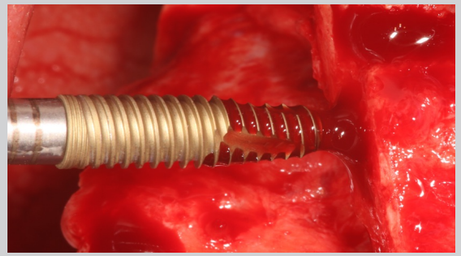
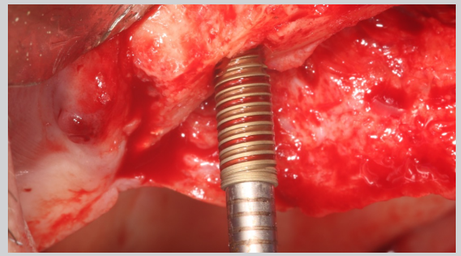
IMPLANT USED

The Versalis 16∞Cone Morse implant was delivered using a contra-angle driver, featuring a hybrid conical–cylindrical macrogeometry that provides ideal characteristics for stability and biomechanical performance in immediate-loading full-arch protocols.

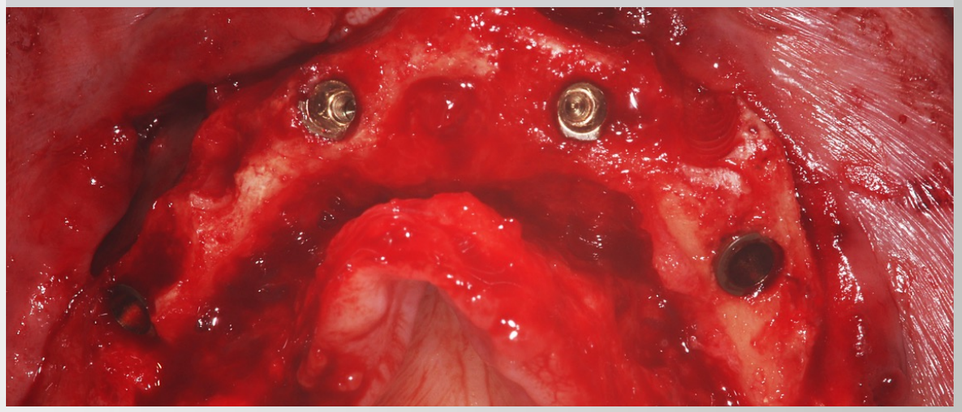

IMPLANT USED

The HAnano Surface (Plus Line) exhibits high immediate wettability, promoting rapid fluid dispersion, protein adsorption, and early cellular adhesion, which supports accelerated osseointegration.

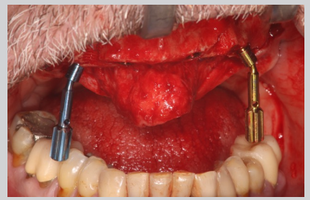
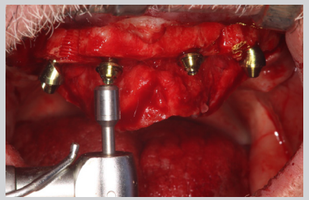
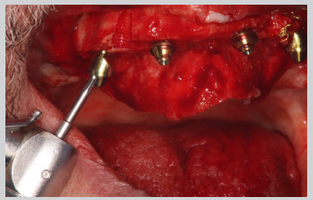
IMPLANT USED

All implants were placed according to the surgical plan, achieving insertion torques greater than 60 N.cm, compatible with an immediate loading protocol. The image shows the occlusal view of the four positioned Versalis implants.



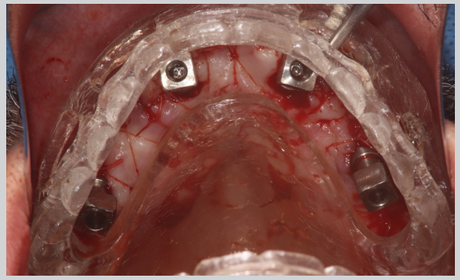
STEP-BY-STEP PROCEDURE

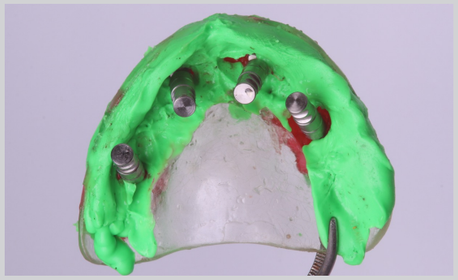
The initial selection of angulation was performed using angled direction indicators for mini abutments, allowing precise definition of the ideal inclination of each implant in relation to the multifunctional guide. Next, straight and angled multi-unit abutments were torqued using the contra-angle driver, ensuring controlled torque application. All instruments used, including direction indicators and mini abutment installation drivers are part of the new Versalis surgical kit, which streamlines the clinical workflow for immediate-loading protocols.

PROSTHETIC PHASE

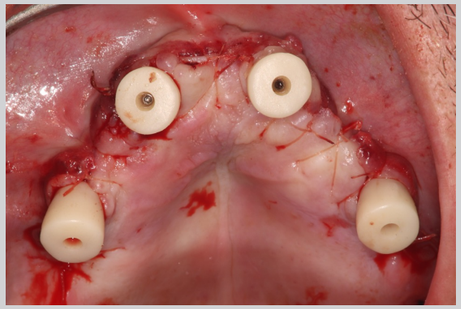
The multi-unit abutment transfer copings were installed, followed by testing of the multifunctional guide to verify adaptation and passivity.The transfer copings were splinted to the guide using GC Pattern acrylic resin, ensuring rigidity and stability during the impression. A silicone addition impression was then performed, ensuring accurate implant positioning and precision of the working model for fabrication of the immediate full-arch prosthesis.

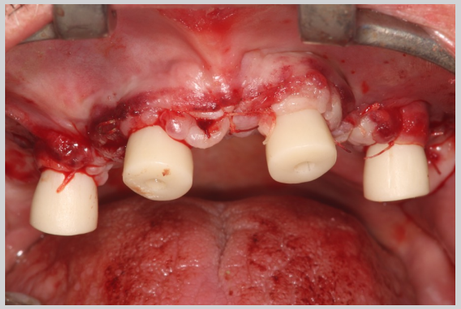




PROSTHETIC PHASE

Expanded zirconia protective caps were installed and adapted to the mini abutments to preserve peri-implant tissue and prevent mechanical irritation during the immediate healing period. These components maintain proper soft-tissue clearance, ensuring patient comfort and ideal conditions for installation of the immediate full-arch prosthesis after 48 hours.





PROSTHETIC PHASE

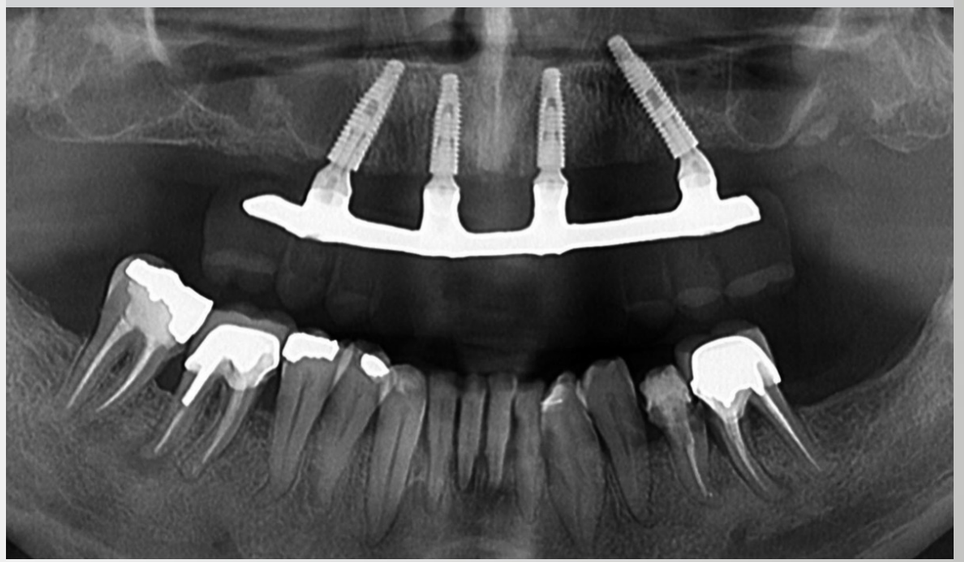
After 48 hours, the immediate maxillary full-arch prosthesis was installed, showing perfect passive fit over the mini abutments. The patient reported no pain, swelling, or discomfort, experiencing full functional and esthetic comfort within the first hours of prosthesis use.





FINAL RADIOGRAPHY

Panoramic radiograph obtained after installation of the definitive full-arch prosthesis, showing perfect passivity between the prosthetic components and the implants, as well as balanced distribution of the Versalis implants within the remaining bone structure. Precise adaptation of the metal bar and absence of tension can also be observed, confirming the immediate biomechanical stability of the rehabilitation.



FINAL RESULT

Photograph showing the clinical result 7 days after implant placement and installation of the immediate full-arch prosthesis, with the patient in full masticatory function and restored occlusal comfort. Excellent esthetic integration and smile harmony can be observed, with the patient fully satisfied with the outcome.



CLINICAL VERSATILITY AND PREDICTABLE REHABILITATION WITH VERSALIS IMPLANTS IN A COMPLEX RETREATMENT CASE





BY DR. PABLO ENRICO MONTEIRO MARTINS AND DR. UMBERTO DEMONER RAMOS

Dr. Pablo Enrico Monteiro Martins - Specialist in Implant Dentistry and Prosthodontics; Master's Student in Implant Dentistry; Professor and Coordinator of the Implant Dentistry Specialization Program – IEO Bauru; International Specialist, Research and Development (R&D) Department – S.I.N.; Member of the Teaching Team for Implant Dentistry Specialization Programs – ABO Presidente Prudente and FG Pós São José do Rio Preto, SP; and S.I.N. Ambassador.

Dr. Umberto Demoner Ramos - Degree in Dentistry from the Federal University of Espírito Santo; Specialization, Master's, and PhD in Periodontics from FORP-USP; Sandwich PhD Program completed at Augusta University; Visiting Researcher at the Adams School of Dentistry, University of North Carolina; Assistant Professor of Periodontics at the University of Doha for Science and Technology; International Specialist in the Product Research and Development Department – S.I.N.; and S.I.N. Ambassador.

CASE INTRODUCTION

A 43-year-old female patient sought care reporting pain and discomfort in the lower arch and an inability to use a lower removable partial denture due to recurrent mucosal injuries. She described significant functional and social impact resulting from masticatory difficulty and compromised esthetics.
Clinical and radiographic evaluation revealed multiple missing teeth. Given the remaining bone condition and the patient's desire for an immediate fixed rehabilitation, the decision was made to place four implants following the All-on-4 concept with immediate loading, aiming for a predictable esthetic and functional restoration.
This case report presents the planning, surgical execution, and initial outcome of the mandibular rehabilitation with a fixed full-arch implant-supported prosthesis, demonstrating the positive impact on masticatory function and the patient's quality of life using the Versalis implant line.

TREATMENT EXPLANATION

Surgical-prosthetic planning was carried out for full-arch mandibular rehabilitation with immediate loading, using four implants from the Versalis line. After extraction of the lower teeth and regularization of the alveolar ridge, the implants were placed following the All-on-4 concept, with two anterior implants in axial position and two posterior implants tilted distally, respecting the limits between the mental foramina.
The implants achieved excellent primary stability, allowing immediate installation of the screw-retained full-arch prosthesis. The choice of the Versalis MT 16° system was based on its macrogeometry and internal conical connection, which enhance anchorage and provide biomechanical predictability to the rehabilitation.

PATIENT RECORD

Patient: Female, 43 years old
Chief Complaint: Difficulty chewing and speaking due to mobility of the lower teeth and inability to use a lower complete denture, reporting pain and frequent gagging.
Treatment Plan: Full-arch mandibular rehabilitation with a protocol-type prosthesis, using four Versalis 16° implants with immediate loading, following the All-on-4 concept.

BEFORE

Initial clinical presentation showing partial absence of lower teeth and the inability to use a lower removable denture due to discomfort and a pronounced gag reflex. At the time of evaluation, the patient had no lower prosthetic rehabilitation, reporting both functional and esthetic impairment.





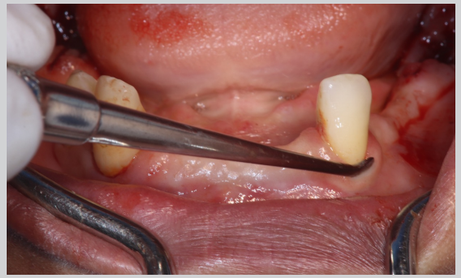
RADIOGRAPHY/TOMOGRAPHY

Panoramic radiograph showing the absence of multiple lower teeth and early horizontal bone resorption. A favorable condition for implant placement between the mental foramina was observed, confirming the feasibility of mandibular rehabilitation with a fixed implant-supported prosthesis following the All-on-4 concept.



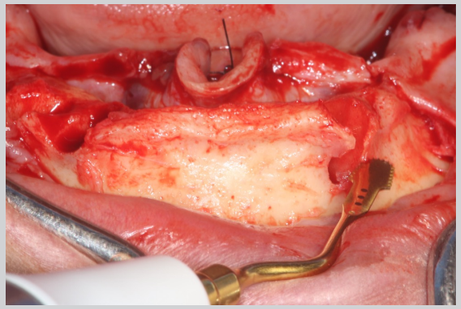
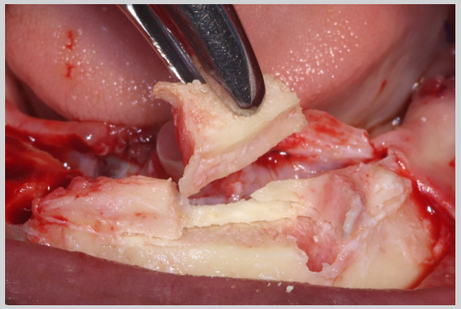
STEP-BY-STEP PROCEDURE

Local anesthetic infiltration was performed in the planned mandibular regions (especially interforaminal areas), ensuring adequate analgesia for the extractions and ridge preparation, with emphasis on patient comfort and transoperative bleeding control. Syndesmotomy and atraumatic extraction of the remaining lower teeth were performed.

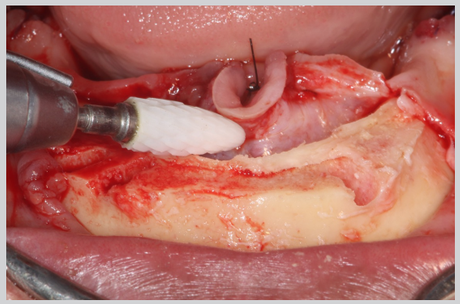
INTRAOPERATIVE

A piezosurgical device was used to perform the initial osteotomy of the remaining alveolar ridge, allowing controlled bone regularization and reducing heat generation in the adjacent structures. This approach enabled broader osteotomies with greater patient comfort and improved tissue preservation.

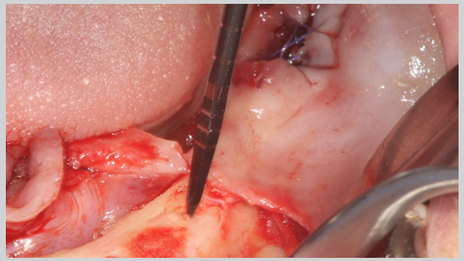
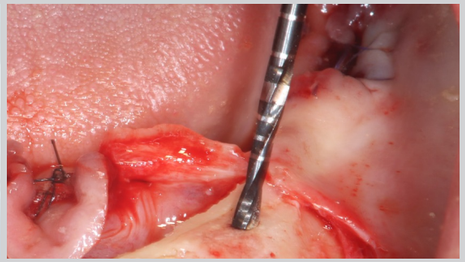
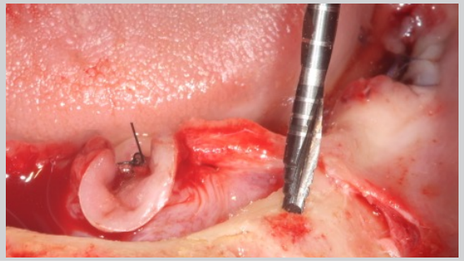
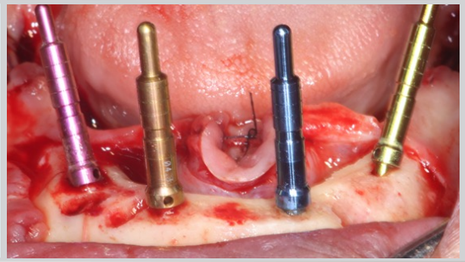
INTRAOPERATIVE

The osteotomy was completed by refining the ridge with a zirconia MaxiCut bur, aiming to smooth sharp edges and achieve uniform bone regularization, thereby preparing the recipient site for implant placement.



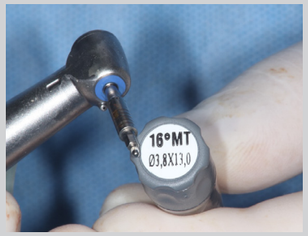

INTRAOPERATIVE

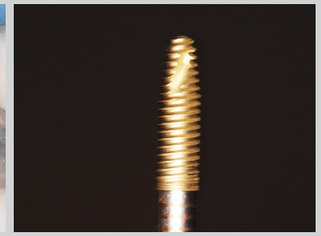
The drilling sequence was performed according to the Versalis surgical protocol, respecting the planned diameter and depth for each implant site. In the final image, the direction indicators are positioned, allowing verification of parallelism and correct angulation before implant placement.

IMPLANT USED

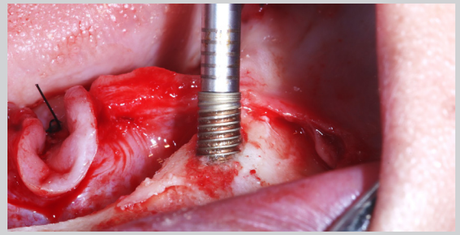
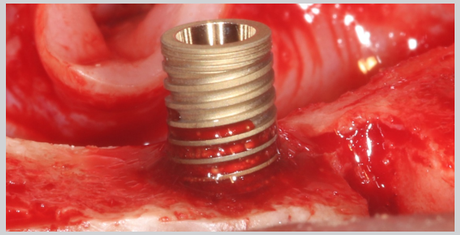
Selection and delivery of the Versalis 16∞implant, dimensions 3.8 mm ⅓13.0 mm, featuring an internal conical connection and 16∞ angulation. This model was chosen for its excellent stability, providing predictability and safety for immediate loading.



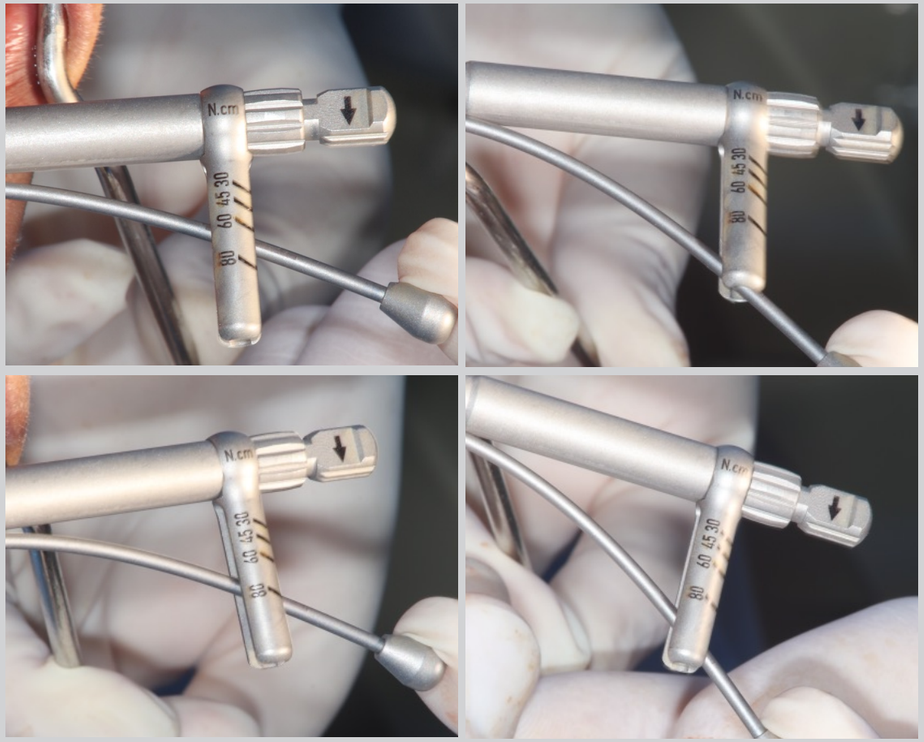
IMPLANT USED

Clinical view of the HAnano surface of the Versalis implant in initial contact with the osteotomy site, showing rapid fluid dispersion over the titanium, a characteristic of its high wettability.

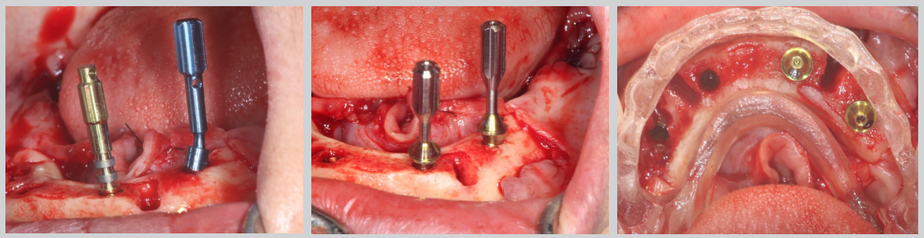
IMPLANT USED

The four Versalis MT 16∞implants (3.8 mm ⅓13.0 mm) were placed with insertion torque greater than 60 N.cm, ensuring excellent primary stability and enabling immediate loading for the mandibular full-arch rehabilitation.



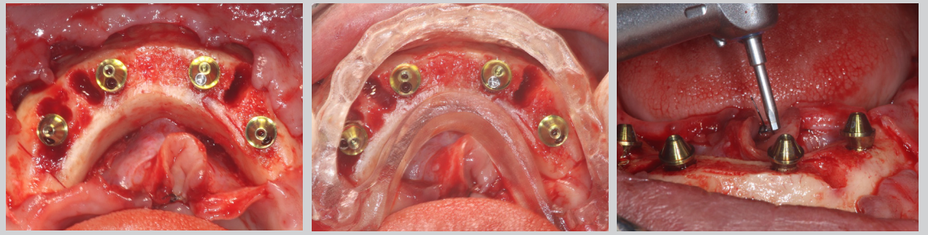
PROSTHETIC PHASE

Initial use of a 17∞angled direction indicator and a straight indicator (both included in the Versalis surgical kit) to verify the relationship between the implants and the multifunctional guide. Two 17∞angled multi-unit abutments were initially selected to improve parallelism and ensure prosthetic passivity for the immediate fabrication of the mandibular full-arch prosthesis.



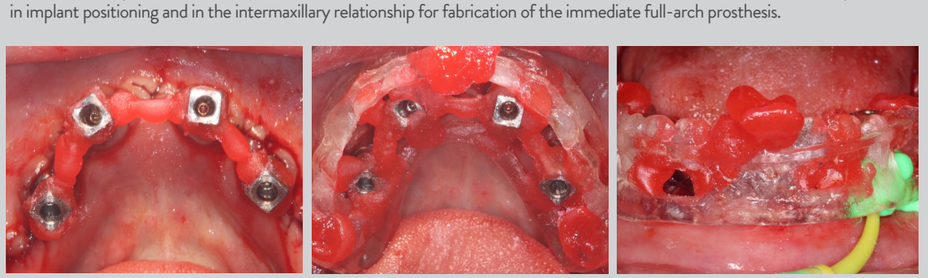
PROSTHETIC PHASE

After installation of the four mini abutments and verification of their adaptation relative to the multifunctional guide, the components were torqued using the contra-angle driver from the kit, ensuring precise torque and optimal stability for the immediate fabrication of the mandibular full-arch prosthesis.



PROSTHETIC PHASE

After installation of the mini-abutment transfer copings, they were rigidly splinted with GC Pattern acrylic resin and secured to the multifunctional guide. Next, a three-point occlusal record was taken, followed by an addition-silicone impression, ensuring accuracy in implant positioning and in the intermaxillary relationship for fabrication of the immediate full-arch prosthesis.



PROSTHETIC PHASE

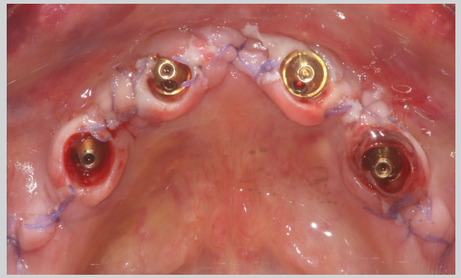
The impression was made with the analogs connected to the transfer copings, ensuring an accurate copy of the implant positions and the adjacent mucosa. Expanded protection caps (6 mm diameter) were installed to maintain proper soft-tissue clearance and support healing, allowing for the installation of the provisional prosthesis within 48 hours.



PROSTHETIC PHASE

Gingival aspect after 48 hours, following removal of the protective caps, showing appropriate peri-implant tissue healing. On the left, the acrylic mandibular full-arch prosthesis ready for installation, fabricated from the impression and occlusal record obtained during the surgical procedure.





PROSTHETIC PHASE

The full-arch prosthesis was installed without pain, bleeding, or discomfort.The patient was functionally and esthetically rehabilitated, showing excellent occlusal adaptation and harmony of the smile.





FINAL RADIOGRAPHY

In the first radiograph, the implants can be seen with the protective caps placed over the multi-unit abutments. In the second image, the installed mandibular full-arch prosthesis is shown, displaying perfect adaptation between the multi-unit abutments and the metal bar, confirming proper seating and precise prosthetic fit.





OUR GLOBAL PRESENCE



POINT YOUR PHONE'S CAMERA AT THE
QRCODE AND SEE WHERE S.I.N. IS PRESENT

sinimplantsystem.com
CNPJ: 04.298.106/0001-74
SAC: 0800 770 8290
sin@sinimplantsystem.com

SUPERIOR QUALITY AND TECHNOLOGY

WE WARRANT, BECAUSE WE ARE PROUD OF OUR PRODUCTS.

LIFETIME WARRANTY · HIGH QUALITY STANDARDS ·

S.I.N. main priority is assuring the quality and safety to our clients. Offering the best for implants, components, surgical kits and tooling is the base of all our action.

INSPECTION IN A 100% OF THE BATCHES MANUFACTURED

We apply rigorous quality control to all S.I.N. products, ensuring success in surgeries for our clients, meeting the highest quality standards, and adding value to those who choose to restore smiles.

IMPLANTS WITH WARRANTY FOR LIFE*

5 YEARS OF WARRANTY PROSTHESIS COMPONENTS*

*SCAN THE LATERAL QR CODE TO ACCESS S.I.N WARRANTYTERMS OR ACCESS THE LINK https://www.sinimplantsystem.com/lifetime-warranty/



S.I.N. 360°

S. I. N.

1-866-507-9315

sin360.us | sinimplantsystem.com

Visit our social networks

@sindentalUSA

@sindentalUSA

@sindentalusa