Surgical Procedures
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## Surgical Procedures

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*Note: Images shown in the surgical manual may not be to scale.*

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A Leader in Dental Implant Innovation

Patented Technology from Zimmer Dental:

**Implants**
- Internal Hex or Octagon Connection: Prosthetic Simplicity
- Dual Transition Surface: Optimize Tissue Response
- Multiple Lead Threads: Faster Insertion
- Tapered Implant for Bone Expansion: Improves Initial Stability
- Fixture Mount/Transfer Packaging: Surgical Simplicity/Prosthetic Versatility
- Insertion Tool/Healing Collar/Abutment/Healing Collar Packaging
- Cutting Drill for Endosseous Implants

**Prosthetics**
- Angled Abutment (2 Piece)

**Other**
- Method for Immediately Placing a Non-Occlusive Dental Implant Prosthesis
Overview

This Surgical Manual is designed to provide an overview of the pre-surgical and surgical procedures applicable to the Tapered Screw-Vent, Screw-Vent® and AdVent® dental implant systems.

The Screw-Vent implants are designed to be placed with a two-stage surgical procedure. The occlusal aspect (platform) of the implant is the receiving area for the prosthetic component of the restoration. This area of the implant is placed level with the crest of the bone when following standard implant placement procedures, although variations of placement have been clinically accepted. The machined neck and the MTX™ microtextured surface or combination MTX surface and MP-1 Hydroxyapatite (HA) surfaces portion of the implant that includes the threaded area are placed subcrestal.

The AdVent implant is designed to be placed with a one-stage surgical procedure. The fluted machined neck functions as the transmucosal extension of the implant receiving the prosthetic component of the restoration. The MTX microtextured surface or combination MTX and MP-1 HA surfaces portion of the implant that includes the threaded area are placed subcrestal.
Patient Evaluation and Selection

General

Team Approach
Successful implant treatment requires the coordinated efforts of several dental professionals – the restorative dentist, the surgeon (prosthodontist, periodontist, oral surgeon or general dentist), the laboratory technician and the dental hygienist. By holding a presurgical conference, these individuals are able to develop an appropriate treatment strategy. This provides a balance between esthetic, functional and surgical goals. In addition, the coordinated approach ensures that treatment is complete, guarding against omission of important technical considerations such as the use of a surgical guide for implant positioning, and the biomechanical boundaries of the final prosthesis.

Patient Evaluation & Selection
- Take a general medical history
- Undertake a psycho-social evaluation
- Explore indications and contraindications
- Determine anatomical landmark considerations related to implant positioning
- Determine feasible vertical dimensions
- Consider biomechanical requirements of final restoration
- Discuss treatment objectives and patient's expectations
- Perform various radiographic evaluations

Presurgical Planning
Proper stress distribution is essential to the long-term success of both the prosthesis and the implant. Overload is one of the key contributors to implant failure and is especially important in the cuspid and molar regions.

To minimize excessive loads, the following guidelines apply:
- Decrease occlusal forces transferred to the implant by reducing the occlusal table width of the prosthesis.
- Distribute occlusal forces optimally by maximizing the number of abutments used to support the prosthesis.
- Place implants of maximum length and diameter while maintaining esthetics and long-term success of the restoration.
- Position and incline the implants to ensure good prosthetic design, function, and esthetics. Direct forces of occlusion along the long axis of the implant.
- Cantilevering should not be part of a treatment plan due to the force amplification of the resulting moment arm.
- Strengthen the overall treatment plan in patients with a heavy muscular profile or whose occlusal analysis indicates a strong bite by using the largest size implants, maximum numbers of implants and abutments, minimizing the use of cantilevers, and placing abutments for the most even distribution of occlusal loads.
- Design of the proposed restoration should also take into consideration the opposing dentition.

Diagnostic and surgical guides
Implant dentistry is guided by the restorative aspect of the procedure. Therefore, it is a prerequisite to evaluate the position of the surrounding anatomical landmarks and natural teeth relative to the proposed area for implant placement.

Rule of “P” - Proper Pretreatment Planning Prevents Prosthetic Problems.
Fabricate diagnostic casts with a wax-up of the proposed position of the teeth in the implant prosthesis. The Implant Team will utilize the diagnostic casts to fabricate the following if required:
- Guides with included markers for a variety of radiological exams - panoramic, periapical, computerized tomography (CT scan), etc. These exams can supply the team with information regarding bone quality and quantity, location of vital structures (mental nerve canal, sinus cavities, labial or lingual bone contour, and surrounding roots if present), and soft tissue height relative to the occlusal plane.
- Surgical drill guide to be utilized at time of surgery for implant osteotomy preparation, taking into consideration mesio-distal, bucco-lingual angulation and placement of the implants while maintaining required distance between the implants.
- Occasionally the surgical guide can be resterilized and used by the restoring clinician for planning the contours of the final prosthesis. The guide may also be used in the decision-making process for abutment selection and preparation and/or making the final implant or abutment impressions.
Presurgical Planning
Fabrication of a diagnostic and surgical guide

Making an impression
Use standard impression techniques to make an impression of the edentulous area with surrounding anatomical landmarks and the opposing arch.

1) For partially edentulous areas, make inter-occlusal records of the opposing arches in centric relation.
2) For fully edentulous areas, follow standard clinical procedures for fabrication of a wax occlusal registration rim to create a wax denture tooth try-in.

Mounting the diagnostic casts
To determine the distance between edentulous areas and opposing dentition, mount diagnostic casts utilizing the inter-occlusal records.

For partially edentulous arches, fabricate a diagnostic wax-up of the edentulous area using denture teeth or standard crown and bridge waxing techniques.

For fully edentulous arches, use a wax occlusal registration rim to make a bite registration, then create a patient-approved wax denture tooth try-in.

Duplicating the diagnostic wax-up
Discuss surgical and restorative component options with the implant team prior to preparing the cast and wax-up for duplication.

Use an impression tray with alginate impression material to make an impression of the cast with incorporated wax-up of teeth and surrounding lost soft tissue. Pour the impression in stone and allow to harden.

Use the cast with diagnostic wax-up to fabricate a diagnostic, radiographic, surgical or alternatively a multi-function guide.

Fabricating the clear guide
Create a transparent guide using one of the following procedures:

1) A clear plastic 0.5mm thick sheet is vacuum formed over the duplicate stone cast of the tooth wax-up. Trim the guide according to clinical requirements. The vacuform can be used in its hollow version or using autopolymerizing or light cure acrylic to fill in areas previously occupied by wax and denture teeth.
2) Use a denture duplicator to create a clear version of the patient’s current or new denture.
Presurgical Planning
Fabrication of a diagnostic and surgical guide

Placing the radiographic markers
Using metal radiographic markers when planning for a CT or similar type of scan is not recommended. Dimensionally calibrated metal ball bearings or an orthodontic wire will cause a sunburst or scatter effect rendering the scan unreadable.

Place material such as gutta percha or a mixture of radiographic powder (e.g., barium chloride powder) and resin into pre-drilled diagnostic grooves or holes in the guide. The hole or markers should be placed inclusive of the incisal, cingulum or occlusal height of replacement teeth taking into consideration the vacuform sheet thickness and the point in contact with the soft tissue. Metal markers can be used with standard scan procedures such as a panoramic or periapical.

Seating the clear guide
Place the guide with included radiographic markers into the patient’s mouth, lock into position by engaging the undercut created by the height of contour of the surrounding natural teeth.

Make the required scan best suited for the proposed case design to acquire a working knowledge of the anatomical limitations in the areas of proposed implant placement.

Making the required measurements
The scan is used in conjunction with overlay templates of the implant design to plan the case. Radiographic markers can help the clinician determine:

• The height of the teeth to be replaced
• The thickness of the soft tissue (by subtracting the end of the marker from the start of the bone)
• The position of the restorative margin
• Number of implants
• The length of the implant
• The diameter of implant
• The inter-implant space

Trimming the clear guide
Remove the material from the radiographic/diagnostic guide in the area that is planned for surgery.

The clinician responsible for implant placement determines if they want vertical holes drilled or sections removed from the original guide to assist them in implant placement.
Implants
Technical Information — Implant Properties and Dimensions

Implant Diameter:
This is the dimension taken from the peak of the widest thread to the same point on the other side of the implant, referred to as the outside dimension of the thread. In the following implant systems, there are two distinct two-stage designs and a one-stage implant design:

- Screw-Vent implants are available in three body diameters, 3.3mmD, 3.7mmD and 4.7mmD.
- Tapered Screw-Vent implants are available in three body diameters, 3.7mmD, 4.7mmD and 6.0mmD.
- AdVent implants are available in two body diameters, 3.7mmD and 4.7mmD of the Tapered Screw-Vent implant design.

Screw-Vent Implant:
The start of the implant thread is approximately 3.0mmL on the 3.3mmD series and 2.5mmL on the 3.7mmD and 4.7mmD series from the coronal aspect of the implant. The parallel straight wall of the implant traverses the implant body to the start of the apical taper. The 10° taper at the apical end (last 3 threads or 1.8mm from the apex) is designed to assist with alignment and placement into the osteotomy.
Tapered Screw-Vent and AdVent Implants:

Tapered Screw-Vent implants taper along the length of the implant originating at the first thread, 2.5mmL from the coronal aspect of the implant. AdVent implants take into account the one-stage design concept and therefore has the taper originating 5mmL from the coronal aspect of the implant. In the MP-1 HA surface coated implants this is the point at which the coating starts. The degree of taper on the implants varies between 1.0° and 2.5° depending on their length to ensure that the apical diameter is consistent with all 4 lengths of implants. So, shorter the implants, the greater the degree of taper.

3.5mmD Platform with a 2.5mmD Internal Hexagon
3.7mmD Tapered Screw-Vent implant
3.0mmD Apex Diameter

4.5mmD Platform with a 2.5mmD Internal Hexagon
5.7mmD Platform with a 3.0mmD Internal Hexagon

AdVent Implants
3.7mmD AdVent implant
3.0mmD Apex Diameter

4.5mmD Platform with a 3.0mmD Internal Hexagon
5.7mmD Platform with a 3.0mmD Internal Hexagon

Technical Information — Implant Properties and Dimensions

Implant Design and Specifications 8
Tapered Screw-Vent and Screw-Vent Implants
Technical Information — Implant Properties and Dimensions

Implant platform:
The diameter is measured across the most coronal part of the implant. The Screw-Vent implant systems have three implant platform diameters and designs:

• **3.5mmD platform** - (Fig. 1a & b). A 44° internal lead-in bevel extends from the outermost diameter (3.5mmD) of the implant platform into the internal hex of the implant. The internal hex configuration is 2.5mmD flat-to-flat with a depth of 1.5mm. Below the hexagon is a continuation of the inner chamber which leads into the threaded area where the fixation screw is received.

This platform is on all lengths of the SVM, SV and TSV series of implants.

• **4.5mmD platform** - (Fig. 2a & b). A 44° internal lead-in bevel extends from the outermost diameter (4.5mmD) of the implant platform into a flattened area or ledge. This ledge extends from the base of the lead-in bevel to the internal hex of the implant. The internal hex configuration is 2.5mmD flat-to-flat with a depth of 1.5mm. Below the hexagon is a continuation of the inner chamber which leads into the threaded area where the fixation screw is received.

This platform is on all lengths of the SVW and TSVW series of implants.

• **5.7mmD platform** - (Fig. 3a & b). A 44° internal lead-in bevel extends from the outermost diameter (5.7mmD) of the implant platform into a flattened area or ledge. This ledge extends from the base of the lead-in bevel to the internal hex of the implant. The internal hex configuration is 3.0mmD flat-to-flat with a depth of 1.5mm. Below the hexagon is a continuation of the inner chamber which leads into the threaded area where the fixation screw is received.

This platform is on all lengths of the TSV6 series of implants.

---

3.5mmD Platform

4.5mmD Platform

5.7mmD Platform

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Fig. 1a

Fig. 2a

Fig. 3a

Fig. 1b

Fig. 2b

Fig. 3b

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Note: Images are labeled as Fig. 1a, Fig. 1b, Fig. 2a, Fig. 2b, Fig. 3a, Fig. 3b.
AdVent Implants
Technical Information — Implant Properties and Dimensions

Implant platform:
The diameter is measured at the height of contour (widest point above the undercut of the fluted neck) of the implant transmucosal portion. This dimension will vary from the actual coronal prosthetic platform referred to in the two-stage implant section. The AdVent implant system has two implant platform diameters and designs:

- **4.5mmD** - (Fig. 1a & b). A 8° external beveled shoulder tapers up from the height of contour of the implant to the coronal area. Surrounding the opening is a narrow (0.25mmD) ledge which functions as the interface circumference for a majority of the prosthetic components (some components use the height of contour as the prosthetic margin). The height of this bevel extends 1.0mm above the height of contour (4.8mmD). From the edge of the opening, a 44° tapered internal beveled wall leads into a 3.0mmD flat-to-flat hexagon which is 1.25mm deep. Below the hexagon is a continuation of the inner chamber which leads into the threaded area where the fixation screw is received.

  This platform is on all lengths of the **AV** and **AVW** series of implants.

- **5.7mmD** - (Fig. 2a & b). A 11° external beveled shoulder tapers up from the height of contour of the implant to the coronal area which has a 5.7mmD prosthetic platform. The height of this bevel extends 1.0mm above the height of contour (6.1mmD). From the edge of the opening, a 44° tapered internal beveled wall leads into a flattened area or ledge that extends to a 3.0mmD flat-to-flat hexagon which is 1.5mm deep. Below the hexagon is a continuation of the inner chamber which leads into the threaded area where the fixation screw is received.

  This implant utilizes all prosthetic components used with the 6.0mmD **Tapered Screw-Vent** implant.
Implant surface:
The medium-rough MTX surface is created by blasting the surface with HA particulate. The MTX texturing process produces a surface which has uniform micropits in the critical 1-to-2 micron size range deemed optimum for bone apposition. The blasting and cleaning process preserves thread sharpness necessary for self-tapping.

The MP-1 HA surface is applied to the mid-section of all three implant designs in varying configurations. The pressurized hydrothermal post-plasma spray MP-1 process was developed to convert the amorphous components of plasma sprayed HA coatings back into a high quality crystalline HA. The rate of calcium dissolution for the MP-1 coating was significantly lower than other commercially available HA coatings.

Implant material:
Tapered Screw-Vent, Screw-Vent and AdVent implants are all manufactured from a medical grade titanium alloy with an Ultimate Tensile Strength of 130 ksi (896 MPa) and can withstand between 346-639 lbs (1539-2842N) of compression at 30°.

*Data on file.*
Implants
Technical Information — Implant Properties and Dimensions

Implant thread design:
The Screw-Vent external thread is based on an industry standard “V” type 60° thread and varies between the straight and tapered implant systems.

- Screw-Vent implants of all diameters, 3.3mmD, 3.7mmD, and 4.5mmD, have a single-lead thread with a uniform 0.35mm thread depth and 0.6mm thread pitch (peak-to-peak). The pitch lead or lead angle at which the thread traverses around the implant is 3°. These implants have a large cutting blade with an apical thru hole and vent.

- Tapered Screw-Vent implants, 3.7mmD, 4.7mmD, and 6.0mmD, have a triple-lead thread with each thread starting at 120 degrees offset from one another. The implant has a uniform 0.35mmD thread depth with a 1.8mmD thread pitch (0.6mmD peak-to-peak due to the triple lead thread design). The pitch lead or lead angle at which the thread traverses around the implant is 20° to accommodate for the regular spacing required between each thread. The increase in pitch angle in combination with the increased thread pitch, are the reason why this design of implant will progress into the osteotomy at three times the rate of the standard thread design. The tapered design of the implant and the speed of insertion are contributing factors for the increase in primary stability of the implant at time of placement.

Screw-Vent Implant with single-lead thread
Fig. 1a) Side view of thread.
Fig. 1b) Apical end of the Screw-Vent implant indicating the start of the single thread.

Tapered Screw-Vent Implant with triple-lead thread
Fig. 2a) Side view of three threads, colored blue, green, or red.
Fig. 2b) Side view of implant with one thread colored to indicate the presence of three threads traversing the length of the threaded portion of the implant.
Fig. 2c) Apical end of the Tapered Screw-Vent implant indicating the start of the three threads 120° from each other.
Implants
Guidelines for Implant Selection

Anatomical Criteria for Implant Selection and Placement

During the process of case diagnosis and treatment planning, the question always arises: “What is the right implant for the proposed restoration?”

The design, quantity, diameter, and length of implants to be placed will depend on the following anatomical criteria:

- Quality and quantity of available bone.
- Partially or fully edentulous restoration affects placement and spacing between implants from the restorative aspect, normally 1.0mm on either side of the prosthetic platform. The mesial/distal surgical requirement is normally an additional 1.5-2mm between implants (Fig. a).
- Fully or partially implant supported restoration (determines quantity of implants).
- Cement- or screw-retained restoration (determines implant angulation as well as buccal-lingual placement).
- Mesial and/or distal boundaries.
  a) Natural dentition requiring review of sub- and supra-crestal constraints:
     - Mesial and distal borders of surrounding coronal contours. Example: In Fig. b, the 3.7mmD implant platform is preferable to the 4.7mmD due to mesial distal constraints. At least 1mm on either side of the platform diameter is the minimum requirement for restorative contours.
     - Convergent or divergent roots. Tapered implants allow for larger diameter in same area (Fig. c & d).
  b) Mental foramina. Vertical height above mandibular canal is often not sufficient distal to the foramen.

Fig. a
Minimum surgical space between implants
3.5mm, 4.5mm and 5.7mm two-stage implant platforms
4.0mm and 4.8mm one-stage implant platforms

Fig. b
Prosthetic requirement of implant placement
4.7mmD
3.7mmD

Fig. c
3.3 straight
3.7 tapered
3.7 overlay 3.3

Fig. d

Minimum surgical space between implants
1.9+3.5+2.4
0.7, 0.8mm
2.4+5.5+3.0
0.8-0.9mm
2.4+3.5+2.4
0.6-0.7mm
4.8mm and 4.8mm one-stage implant platforms
Implants
Guidelines for Implant Selection

Anatomical Criteria for Implant Selection and Placement, continued

• Buccal and/or lingual boundaries.
  a) Buccal and/or lingual restoration contours. Minimum requirement for restorative contours is 1mm on either side of the platform diameter.
  b) Restorations require space for substructures and substantial veneering materials (i.e., denture).
  c) Buccal and/or lingual osseous depressions require the use of narrow or tapered implants (Fig. e & f).
  d) Width of the crestal bone requires the use of implants that have a neck diameter which allows for a minimum of 1-1.5mmD of bone on buccal and lingual borders (Fig. f).
  e) Available bone to allow placement such that the occlusal force is axial through the center of the implant body.

• Anatomical vertical limitations.
  a) Allow spacing of 1-2mm above the mandibular canal (Fig. g).
  b) Allow spacing below the floor of the sinus cavity unless sinus grafting procedures are planned.
  c) Correct the plane of occlusion of opposing dentition to eliminate the restriction often created by over eruption of unopposed dentition. This will allow for sufficient space for the final restoration.
  d) If free-standing retentive anchors are proposed for the restoration, implants greater than 10mm are required, as well as sufficient ridge height to prevent excessive lateral load being applied to the implant (see section on Ball Abutments in the Tapered Screw-Vent and Advent Restorative Manual).
  e) Placement of the restorative platform relative to the type of restoration being performed: sub-gingival for esthetic restorations and supra-gingival for non-esthetic restorations (Fig. h) will ultimately determine the length and type of implant to be placed.
  f) Maintain an acceptable crown to implant ratio, preferably 1:1.

• Anatomical dimensions of the tooth or teeth being replaced. The surface area of the implant that is sub-crestal should approximate as close as possible the surface area of the tooth being replaced.

Charts of teeth and implants are on following pages.
Per Ante’s Law, “The total periodontal membrane area of the abutment teeth should equal or exceed that of the teeth to be replaced.” The following tables provide the average surface areas of natural teeth and of Tapered Screw-Vent and Screw-Vent dental implants.

### Root Surface Area of Natural Dentition

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<tr>
<th>Tooth</th>
<th>Maxillary Surface Area (mm²)</th>
<th>Ranking</th>
<th>Mandibular Surface Area (mm²)</th>
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<tr>
<td>Central</td>
<td>204</td>
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<td>154</td>
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<tr>
<td>Lateral</td>
<td>179</td>
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<td>Canine</td>
<td>273</td>
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<td>268</td>
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<tr>
<td>First premolar</td>
<td>234</td>
<td>4</td>
<td>180</td>
<td>5</td>
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<td>Second premolar</td>
<td>220</td>
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<td>First molar</td>
<td>433</td>
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<td>Second molar</td>
<td>431</td>
<td>2</td>
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## Specifications

### Implant Surface Dimensions

The surface area of the implants are measured from the top of the implant to the apex of the implant. The measurement includes apical vents and cutting blade surfaces. The surface area of the AdVent implants are not shown as the surface area is similar to the Tapered Screw Vent system of implants.

<table>
<thead>
<tr>
<th>Implant Type</th>
<th>Implant Length (mmL)</th>
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<td><strong>Tapered Screw-Vent</strong></td>
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