Qualia™ NeoActive

Conical connection implants

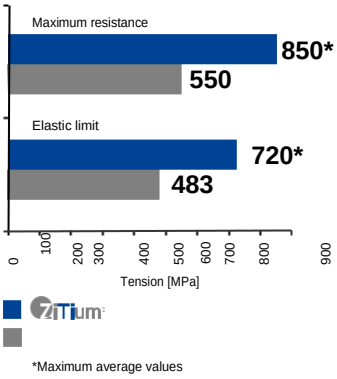
™

Qualia® NeoActive

Where quality meets service

Index

Our Company



Founded in 2018, Headquartered in Dubai. U.A E, Qualia Experiences FZ-LLC is showing the dental implant industry how a strong business model can service the customers effectively and economically. Qualia Experiences FZ-LLC is a full line top quality, compatible dental implants and accessories at a reasonable cost. we supply Dental Clinics, Doctors, Hospitals and laboratories every type of specialized dental equipment for endodontics, implant ology, Bone and membrane, dental kits. we built a well-known, impeccable reputation in the community. Our management has many years' experience in the fields of dental implants.

At Qualia Experiences FZ-LLC we are not only the most-competitively priced, service-oriented supply company in the nation; we are now the best full line compatible dental implants and accessories supply company.

We are located in Dubai, but serve customers across the country of United Arab Emirates and beyond.

Two key differences between Qualia Experiences FZ-LLC and most other distributors are our broad product offering and our supply base. We are very proud to represent the leaders in dental implant manufacturing, and we work closely with our suppliers to make sure that we continue to meet the needs of our customers.

True to our entrepreneurial spirit, we continue to seek new solutions and products that meet the new demands of the sector. Therefore, we entered in agreement with BIOSTAR® Laboratorios, SLU a Spanish manufacture for the exclusive production and manufacture of Qualia™NeoActive implants made of premium high strength materials of high quality and biocompatible.

Like our motto goes "were quality meets service", our promise to our customers is to continue improvement and sourcing out the best quality products available, at reasonable cost combining with best service that goes beyond the sale.

Certified quality

We strive for excellence

Qualia™NeoActive implants are made of extra-high-tension grade 4 titanium which gives it a substantial improvement in its elastic limit and mechanical properties, as well as keep the compliance with the requirements of Standards and Certificates according to the requirements of the Medical Directive 93/42/EEC and its amendment 2007/47/EC by the 0051 notified body. The Qualia™NeoActive implants are sterilized by Beta Rays irradiation at 25kGy.

BIOSTAR® Laboratorios, SLU has the manufacturer's license for medical devices and the commercial authorsation by the AEMPS 6425-PS (Spanish Agency for Medicines and Medical Devices). Our quality management system is certified according to the requirements of the UNE-EN-ISO 9001:2015 and UNE-EN-ISO 13485:2016 standards, also complying with the requirements of GMP 21 CFR 820.

ISO 9001 ISO 13485 0051

Manufacturer
Biostar Laboratorios SLU
C/ Laguna del Marquesado, 19
28021 - Madrid - ESPAÑA

Manufacture Qualia ™NeoActive

Biostar Laboratorios,SLU
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Biostar Laboratorios®

Distributor Qualia ™NeoActive

Qualia Experiences FZ-LLC
Dubai Media City, Building 8
Dubai – United Arab Emirates

Qualia® NeoActive QNA

Qualia Experiences

TM

Qualia™ NeoActive

Conical connection implants

Anatomic healing abutment

Height (H)	DiameterØ	Reference
3.0mm	3.60mm	AC1VH3630
4.0mm	3.60mm	AC1VH3640
5.0mm	3.60mm	AC1VH3650
6.0mm	3.60mm	AC1VH3660
3.0mm	4.60mm	AC1VH4630
4.0mm	4.60mm	AC1VH4640
5.0mm	4.60mm	AC1VH4650
6.0mm	4.60mm	ACV1H4660
3.0mm	5.50mm	ACV1H5530
4.0mm	5.50mm	ACV1H5540
5.0mm	5.50mm	ACV1H5550
6.0mm	5.50mm	ACV1H5560

Impression Abutment

Height (H)	DiameterØ	Reference
13.00mm	3.60mm	AC1VT3600
8.50mm/shor	3.60mm	AC1VT3601
13.00mm	4.60mm	ACV1VT4600
8.50mm/shor	4.60mm	ACV1VT4601
13.00mm	5.50mm	ACV1VT5500
8.50mm/shor	5.50mm	ACV1VT5501

Impression Abutment Screw

Height (H)	Reference
0.00mm	LTSS4000
3.00mm	LTSS4003
6.00mm	LTSS4006
9.00mm	LTSS4009

Implant Analog

3D Implant Analog

Product Name

Product Image

Product Table platform
Height, Length, Diameter ø

Product Features

Symbol	Meaning
ROT	Rotatory element
NO ROT	Non-rotatory element
	Use with manual torque (consult table page 33)
XX Ncm	Maximum torque usage
	Ratchet torque
1,25mm	Screw connection
	Single use product

Symbol	Meaning
	Dynamic Connection
MX.XX	Screw metrics (mm)
45°	45° support angle
90°	90° support angle
	Rotation use with CA
XX Rpm	Maximum turning speed

Symbol	Meaning
Titanium Grade 5	Titanium Grade 5 manufactured
Stainless Steel	Stainless Steel manufactured
Co-Cr +castable	Cobalt-Chromium + castable manufactured
PEEK	PEEK manufactured
	Use with abundant irrigation
XX°	Maximum angle

Qualia™ NeoActive

Conical connection implants

Features

CONNECTION

»Conical connection: 11° morse taper with double internal hexagon
»Conical sealing: no infiltration
»Friction fit: no micro-movements
»RP single platform for all diameters
»Platform switch: soft tissue formation and emergence profile shaping

CORTICAL AREA

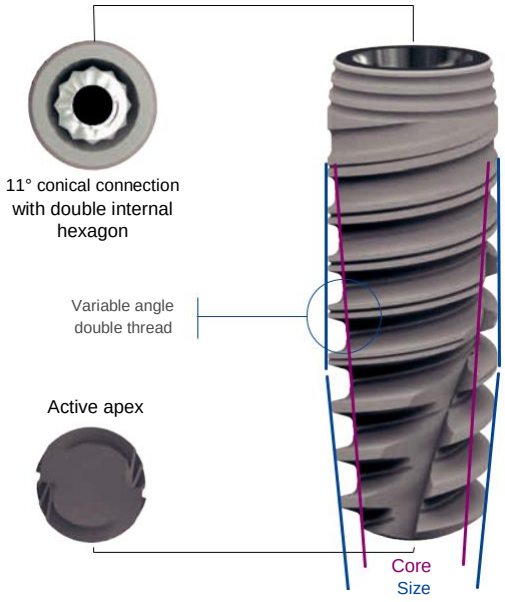
»Micro-thread design: preserves marginal bone, reduces cortical stress and improves load distributions
»Inverted cone cortical macro-design: no cortical compression (except for 3,40mm diameter implant)

BODY

»Double lead thread: quick insertion to reduce surgical time
»Grooved canal threads and plateau: releases bone stress and enables fluid flow
»Variable geometry thread: provides high primary stability:
  »Coronal - thick trapezoidal thread
  »Medium - thinner trapezoidal thread
  »Apical - V-shaped thread
»Optimized morphology
»Apical oblique vents: collect bone detritus during the insertion and facilitates a change of insertion axis
»Active apex (self-tapping): makes the implant insertion easy with undersized drilling technique
»Atraumatic apex: protects anatomical structures

CONICAL DESIGN

»Facilitates bone shaping at low density
»Indicated for immediate loading
»Indicated for immediate post-exodontic placement
»Indicated for apical collapse situations



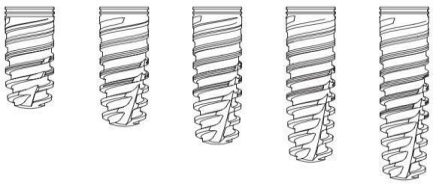
Available diameters and lengths

Lengths in mm

P (Ø3,50 mm)

ØPlatform 2,85mm

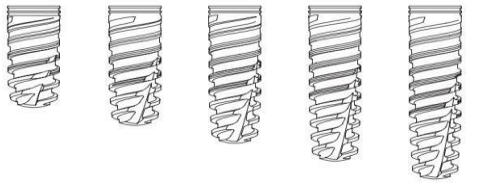
8 10 11.5 13 16



RP (Ø4,00 mm)

ØPlatform 2,85mm

8 10 11.5 13 16



P (Ø4,50 mm)

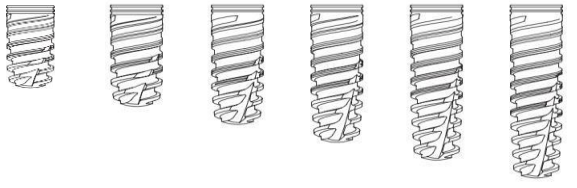
ØPlatform 2,85mm

6 8 10 11.5 13 16

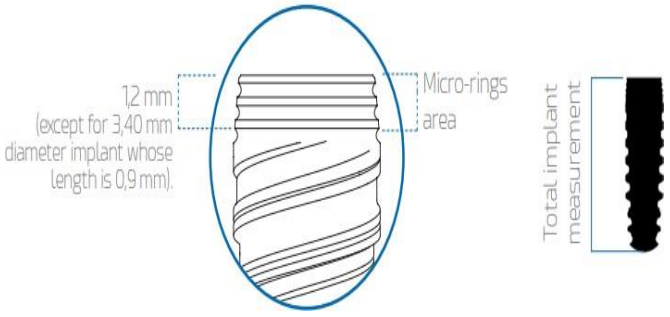
RP (Ø5,00 mm)

ØPlatform 2,85mm

6 8 10 11.5 13 16

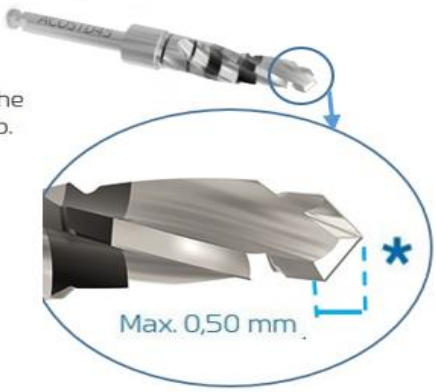


Implant coronal area measurements



IMPORTANT:

* When choosing the implant size, take into account the overdrilling due to the length of the drill tip.



Usage recommendations

All implant planning must respect the natural biomechanical stability of the oral cavity and allow the natural emergence of the dental crown, through the soft tissue, by means of an implant with a pros-thetic platform whose diameter is proportionally smaller than the emergence diameter of the tooth to be restored. The implantologist must assess the quantity and quality of bone in the recipient area of the implant and consider the need for prior or simultaneous bone re-generation as appropriate.

Qualia™NeoActive has a broad range of implants to cover every restoration possibility.

In the odontogram, the inverted trapezoids identified with letters rep-resent the diameters and platforms of the implants recommended for these dental positions. These recommendations apply to teeth re-placement with single restoration, bridges and partial or total implant-retained tissue-supported prosthesis.

Remember to maintain minimum distances between adjacent implants and/or implants and teeth, to preserve papillae, bone vascularization and natural emergence profiles.

The choice of the appropriate implant, in each case, is the exclusive responsibility of the clinician. Qualia™NeoActive Medical recommends taking into account warnings based on scientific evidence contained in product catalogues and website.

CLARIFICATIONS ON MEASUREMENT AND DRILLING TECHNIQUES:

- **IMPLANT SIZE:** identifies implant diameter and length.
- **IMPLANT BODY:** implant core diameter.
- **DRILL MEASUREMENT**: corresponds to the drill diameter and length.
- **UNDERSIZED DRILLING TECHNIQUE:** surgical site prepa-ration with final drill of lower diameter than the implant body. Technique associated with high insertion torque and increased primary stability.

  Important: possible increased risk of bone necrosis due to pressure.
- **SIMPLIFIED DRILLING TECHNIQUE:** technique proposed by Coelho and Cols in 2013 (1). It consists of the use of pilot drill and final drill corresponding to the size of the implant. It re-duces drilling sequence but with risk of bone necrosis due to thermal increase.

Odontogram

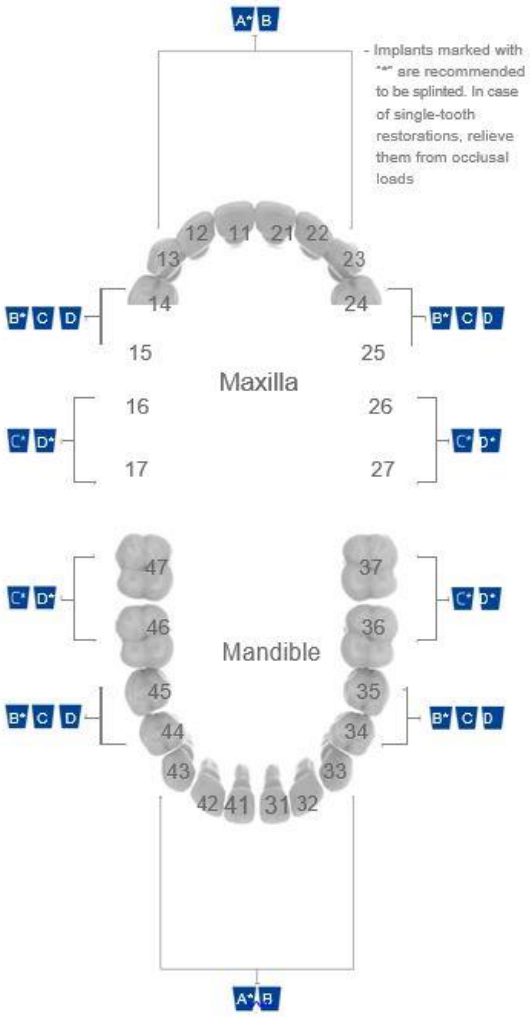
Qualia™NeoActive

Implant diameter

A RP Ø3,50mm | B RP Ø4,00mm | C RP Ø4,50mm | D RP Ø5,00mm

Coronal implant diameter

RP Ø2,85mm



Qualia™NeoActive No Mount

Packaging and product handling

1.Remove the cardboard flap and take out the blister

2.Remove the cardboard flap and take out the blister.

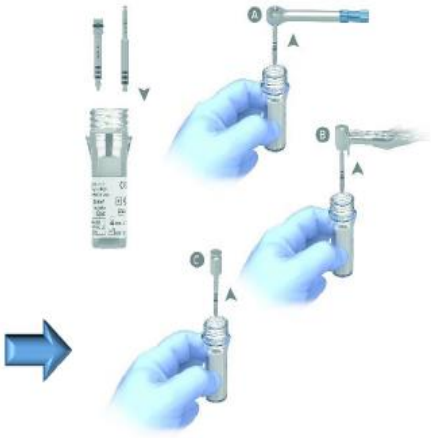
3. Remove the cap by turning

4. Remove the implant from vial by using a tweezer

Implant removal

6. Remember to remove the label from the implant to paste it onto the patient's implantation document and thus maintain product traceability.

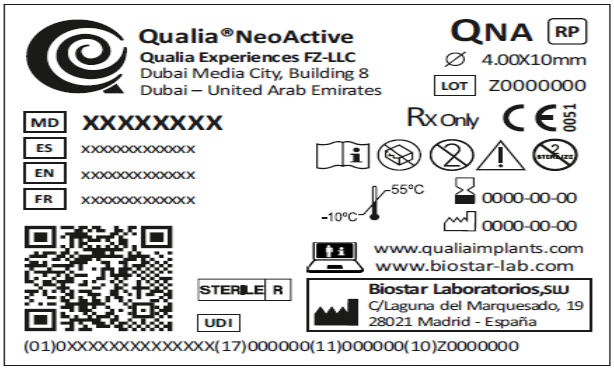
5.Hold the implant carrier vial vertically with one hand and place, for ratchet or CA, insert into the Qualia®NeoActive ... Remove the implant VPress® insertion key assembly by pulling it up vertically to the



Qualia™NeoActive No Mount implants are packaged in a sealed carton box with a product label for immediate identification. It contains:

- **Instructions for Use (IFU).**
- **Implant blister:** heat-sealed, with product identification labels for correct traceability. Its flap facilitates opening in clinic and prevents accidental opening. Contains: implant carrier vial.
- **Implant carrier vial:** contains vertically suspended implant.
- **Product identification label data:** product reference, platform, implant diameter and length, product description, batch number, product manufacturer, expiration date and product identification symbols.

Note. Do not open the sterile container until the time of implant placement.



Description of the symbology used

MDD CE certification and notified body	Do not resterilise
MD Name of the medical device	Do not use if the packaging is damaged
Number of product batch	Non-reusable product
Patient information website	Consult the instructions for use
UDI Unique device identification	Expiry date of the product
Beta sterile product	Date of manufacture
Temperature restriction	Product manufacturer
Caution, consult accompanying documents	Rx Only Caution: federal law prohibite dispensing without prescription

Features and references

Qualia™ NeoActive No Mount implant packaging option allows you to use an insertion key direct to implant, remove it from the implant carrier vial and bring it to your surgical site easily and safety.

No Mount system instruments:

» VPress® insertion key for contra-angle.
» VPress® insertion key for ratchet.

Qualia™ NeoActive No Mount implant has the advantage of avoiding its handling to disassemble the Mount, removing the occasional difficulty of access to the location with reduced mouth opening or suppressing the risk of primary stability reduction due to over-instrumentation.

The plastic vial holds the implant vertically between a lower titanium plate and an upper washer also made of titanium, providing stability without movement, while avoiding contact.

Implant view upper washer

Implant view between plate and washer

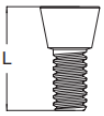
No Mount

* Cover screw:

In Qualia™ NeoActive No Mount option, cover screws are supplied separately. Refer to the references in the table below

IMPLANT				PLATFORM			
Ø (mm)	Ø Core (mm)	Length	Reference	Type	Ø (mm)	Internal Metric	
3.5		8 mm	AC3580	RP	2.85	M 1,60	
		10 mm	AC3510				
		11.5 mm	AC3511				
		13 mm	AC3513				
		16 mm	AC3516				
4.0		8 mm	AC4080				
		10 mm	AC4010				
		11.5 mm	AC4011				
		13 mm	AC4013				
		16 mm	AC4016				
4.5		6 mm	AC4560				
		8 mm	AC4580				
		10 mm	AC4510				
		11.5 mm	AC4511				
		13 mm	AC4513				
		16 mm	AC4516				
5.0		6 mm	AC5060				
		8 mm	AC5080				
		10 mm	AC5010				
		11.5 mm	AC5011				
		13 mm	AC5013				
		16 mm	AC5016				

Cover screw*



Length (L)	Reference
5.10mm	

Osseoactive™
Surface treatment

Osseoactive™ surface, textured by subtraction using sandblasting with white corundum and double etching of hydrofluoric acid and a combination of sulphuric and phosphoric acid, creates a macro and micro porosity with optimum average values whose key characteristics for achieving a correct and rapid osseointegration which gives it reliability and predictability.

Main features:

- Pure TIO_2 surface
- Macro/micro-porosity surface design
- Homogeneous porosity
- Excellent average values
- Osteoinductive surface
- High level of biological stability
- Surface structure similar to human bone
- High level of surface wettability
- Contaminant-free surface topography

Osseoactive™ has a thicker TIO_2 layer than most current surfaces.

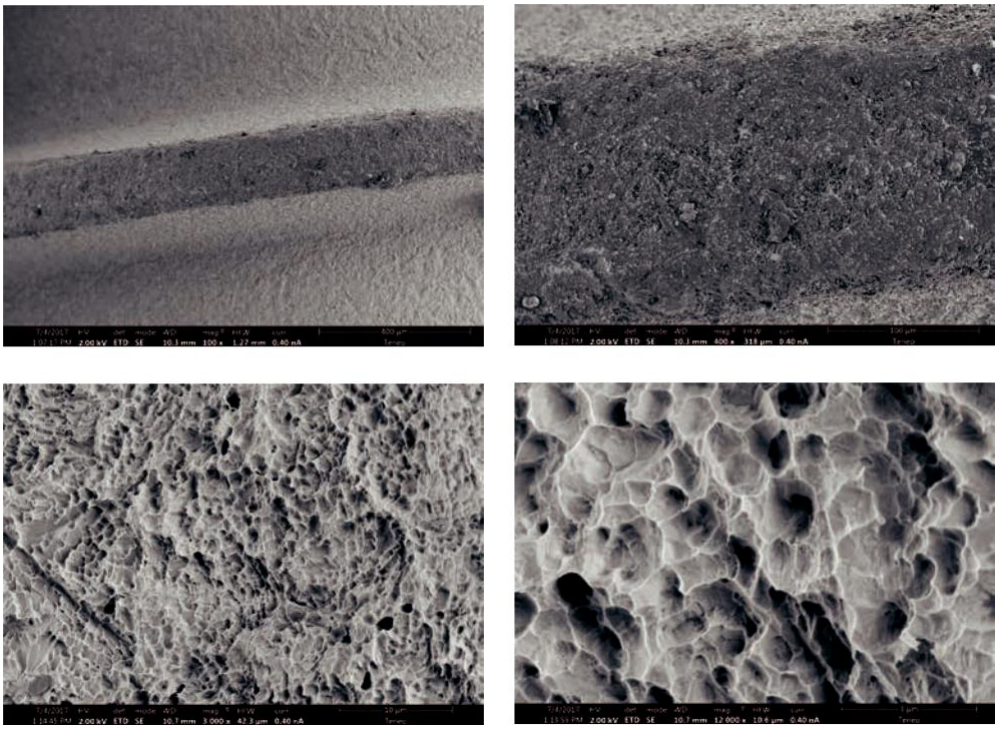
	O (% At)	C (% At)	Ti (% At)	N (% At)	Si (% At)	Ca (% At)	Layer thickness TIO_2 (Nm)
Osseoactive™	43.9	34.9	18.0	0.6	0.5	0.5	16-25
Plasma Spray	45.5	38.9	14.2	1.4	--	--	5.5
Mechanised	39.7	36.9	20.1	1.1	1.7	0.2	5.7
Sandblasting and Etching A.	51.4	34.9	14.5	1.3	Traces	--	5.7
Double acid etching	36.2	53.7	6.8	5.4	3.3	--	Not available

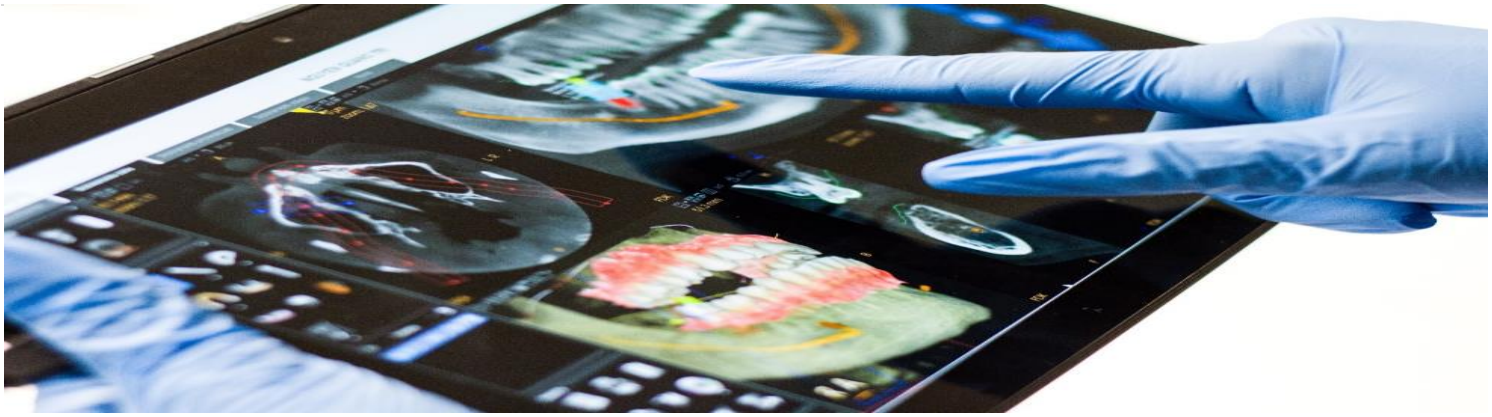
Note:
- The elements are expressed in atomic %
- These are the elements present in the greatest quantity; other elements may be present in trace amounts or lesser proportions.

Shorter times

Several scientific studies have shown that mixed treatment surfaces with a rugged or porous surface considerable increase bone implant contact and accelerate the osseointegration process against implants with conventional surfaces. Osseoactive™ surface facilitates rapid cell adhesion, thus obtaining excellent biological stability that favors the osteogenesis process. At the same time, it significantly reduces the period of osseointegration and increases the percentage of clinical success.

IMAGES TAKEN USING AN ELECTRONIC MICROSCOPE S.E.M

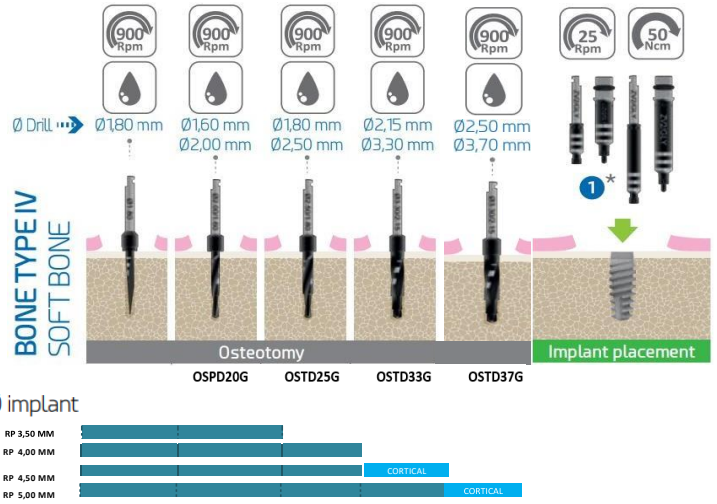




Surgical drilling protocol with Qualia™ NeoActive

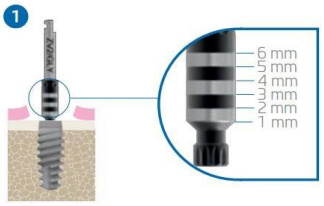
Rotation | Irrigation required | Ø Drill diameter | See instructions | Torque

Detailed speeds are the recommended



NeoActive® DRILLS CORTICAL ZONE

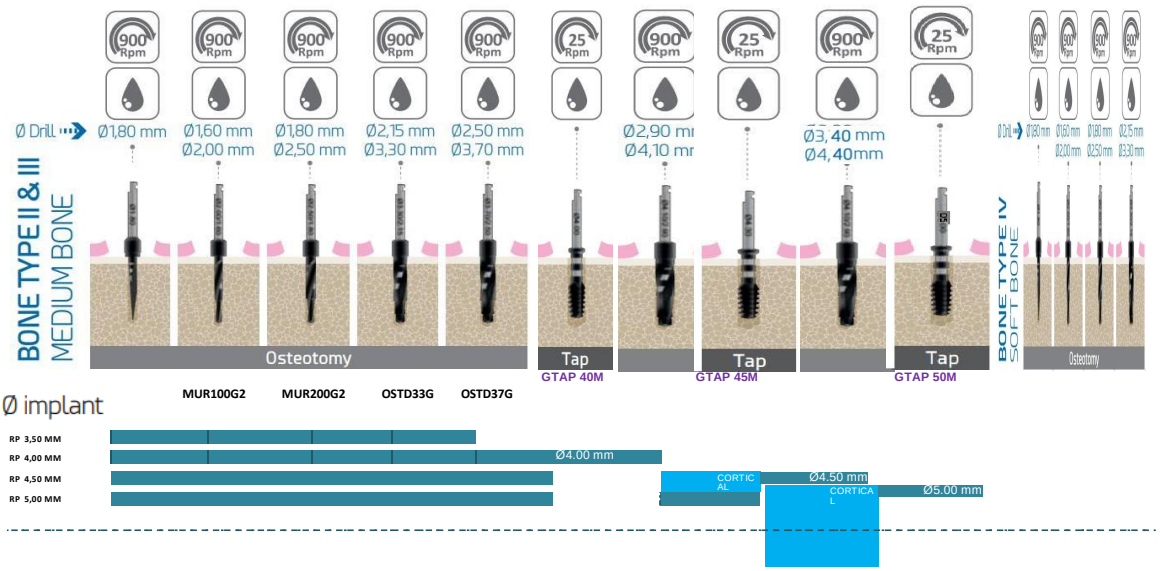
When CORTICAL is indicated in the protocol, it is recommended to drill according to the length of the cortical bone thickness for each clinical case.



VPress® depth measurements

VPress® insertion keys for RP have horizontal marks to guide the depth of the implant placement, according to each clinical case.

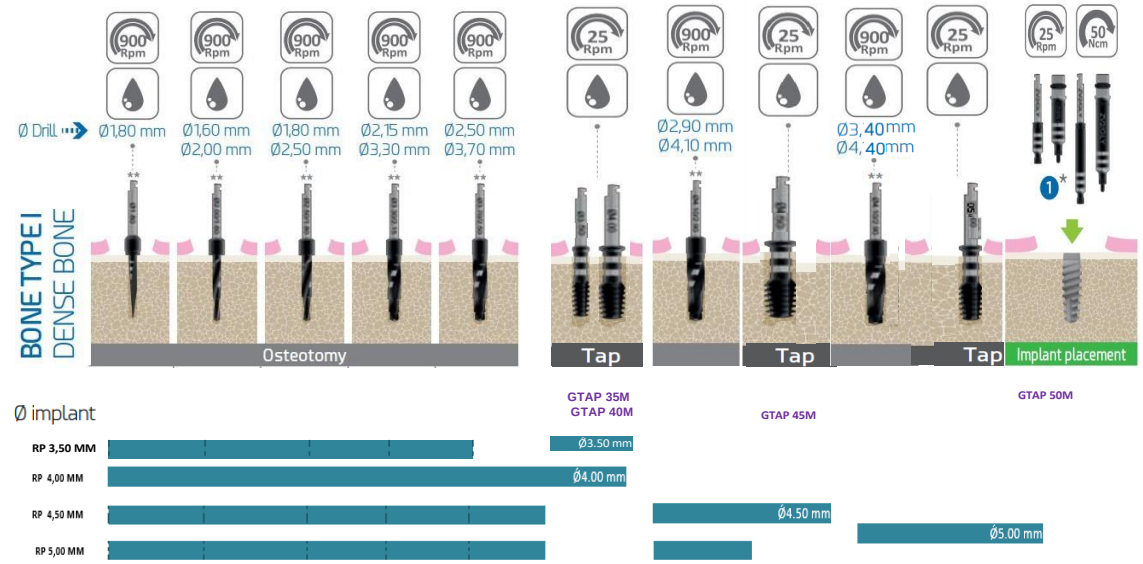
* If the implant is not fully inserted using the maximum recommended torque, the implant must be removed and the drilling repeated, then the insertion must be performed.

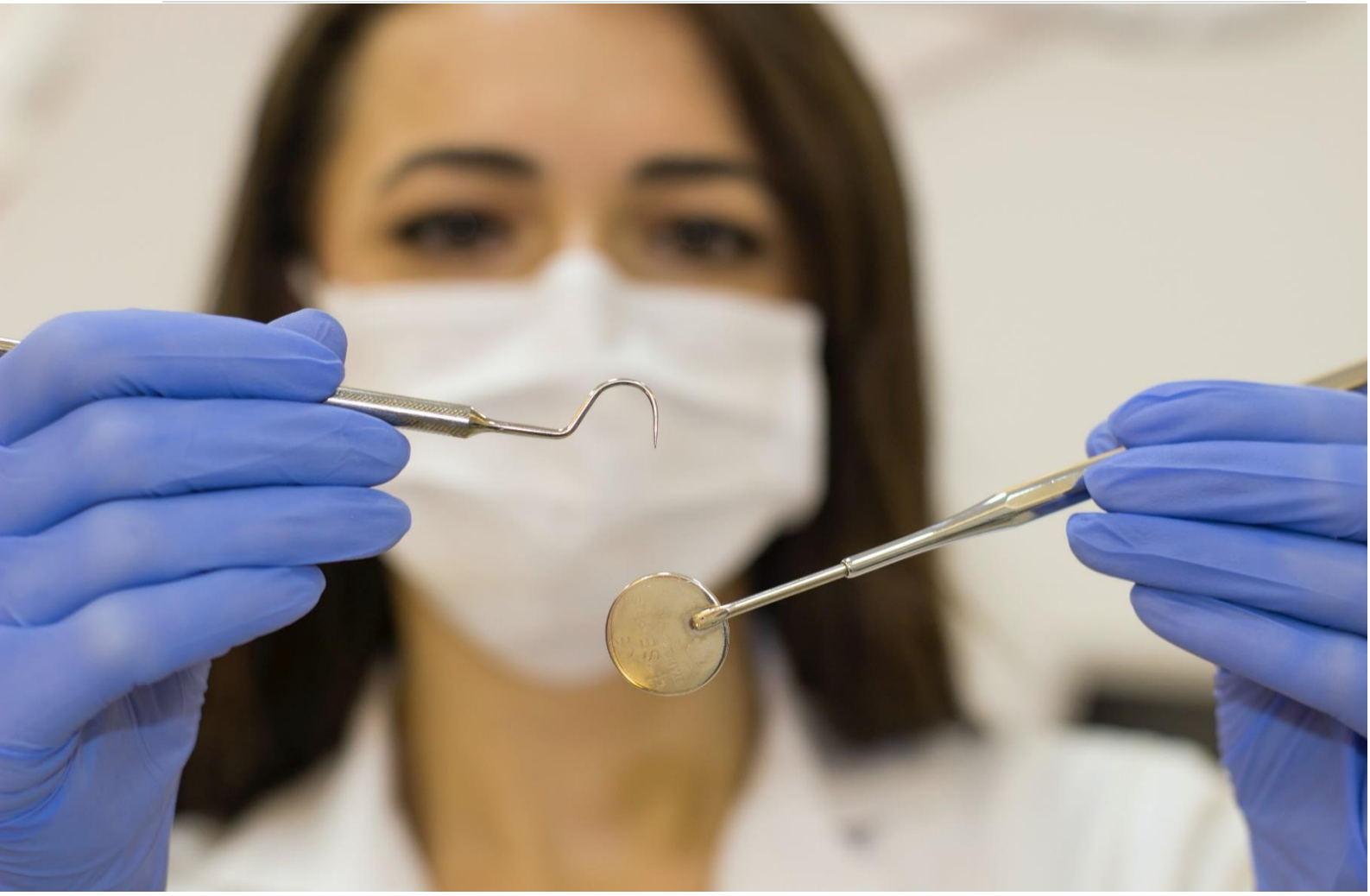


Surgical drilling protocol with Qualia™NeoActive

Rotation | Irrigation required | Ø Drill diameter | See instructions | Torque

Detailed speeds are the recommended





Qualia™NeoActive

CONICAL CONNECTION PLATFORMS

Anatomic healing abutment

Height (H)	DiameterØ	Reference
3.0mm	3.60mm	AC1VH3630
4.0mm	3.60mm	AC1VH3640
5.0mm	3.60mm	AC1VH3650
6.0mm	3.60mm	AC1VH3660
3.0mm	4.60mm	AC1VH4630
4.0mm	4.60mm	AC1VH4640
5.0mm	4.60mm	AC1VH4650
6.0mm	4.60mm	ACV1H4660
3.0mm	5.50mm	ACV1H5530
4.0mm	5.50mm	ACV1H5540
5.0mm	5.50mm	ACV1H5550
6.0mm	5.50mm	ACV1H5560

Impression Abutment

Height (H)	DiameterØ	Reference
13.00mm	3.60mm	AC1VT3600
8.50mm/shor	3.60mm	AC1VT3601
13.00mm	4.60mm	ACV1VT4600
8.50mm/shor	4.60mm	ACV1VT4601
13.00mm	5.50mm	ACV1VT5500
8.50mm/shor	5.50mm	ACV1VT5501

Impression Abutment Screw

Height (H)	Reference
0.00mm	LTSS4000
3.00mm	LTSS4003
6.00mm	LTSS4006
9.00mm	LTSS4009

Implant Analog

Length (L)	Reference
12.00mm	AC1VIA34

3D Implant Analog

Length (L)	Reference
12.00mm	AC1VIA34D

Provisional Abutment

HEX

Height (H)	Length (L)	Reference
1.50mm	10.50mm	AC1VTRU3615
3.00mm	12.00mm	AC1VTRU3630

Provisional Abutment

NON-HEX

Height (H)	Length (L)	Reference
1.50mm	10.50mm	AC1VTNU3615
3.00mm	12.00mm	AC1VTNU3630

Base Abutment +Castable Abutment

HEX

Length (L)	Reference
10.50mm	AC1VRUB36

NON-HEX

Length (L)	Reference
10.50mm	AC1VNUB36

UCLA

HEX

Height (H)	Length (L)	Reference
1.50mm	10.50mm	AC1VRU3615
3.00mm	12.00mm	AC1VRU3630

NON - HEX

Height (H)	Length (L)	Reference
1.50mm	10.50mm	AC1VNU3615
3.00mm	12.00mm	AC1VNU3630

Straight Abutment

HEX

Height (H)	Length (L)	DiameterØ	Reference
1.50mm	9.00mm	3.6	AC1VXS3615
2.50mm	10.50mm	3.6	AC1VXS3625
3.50mm	10.50mm	3.6	AC1VXS3635
1.50mm	9.00mm	4.6	AC1VXS4615
2.50mm	10.50mm	4.6	AC1VXS4625
3.50mm	10.50mm	4.6	AC1VXS4635
1.50mm	9.00mm	5.5	AC1VXS5515
2.50mm	10.50mm	5.5	AC1VXS5525
3.50mm	10.50mm	5.5	AC1VXS5535

NON -HEX

Height (H)	Length (L)	DiameterØ	Reference
1.50mm	9.00mm	3.6	AC1VXS3615N
1.50mm	9.00mm	4.6	AC1VXS4615N
1.50mm	9.00mm	5.5	AC1VXS5515N

17D Angled Abutment

HEX

Height (H)	Length (L)	DiameterØ	Reference
1.50mm	9.00mm	3.6	AC1VX3615
2.50mm	10.50mm	3.6	AC1VX3625
3.50mm	10.50mm	3.6	AC1VX3625
1.50mm	9.00mm	4.6	AC1VX4615
2.50mm	10.50mm	4.6	AC1VX4625
3.50mm	10.50mm	4.6	AC1VX4625

NON-HEX

Height (H)	Length (L)	DiameterØ	Reference
1.50mm	9.00mm	3.6	AC1VX3615N

30D Angled Abutment

HEX

Height (H)	Length (L)	DiameterØ	Reference
1.50mm	9.00mm	3.6	AC1VX23615
2.50mm	10.50mm	3.6	AC1VX23625
3.50mm	10.50mm	3.6	AC1VX23635
1.50mm	9.00mm	4.6	AC1VX24615
2.50mm	10.50mm	4.6	AC1VX24625
3.50mm	10.50mm	4.6	AC1VX24635

NON-HEX

Heigth (H)	Length (L)	DiameterØ	Reference
1.50mm	9.00mm	3.6	AC1VX23615N

Scan Body for Implant

Length (L)	Reference
9.00mm	AC1VFNSY36

Scan Body to Ti Base

Length (L)	Reference
7.00mm	AC1VFNSY36T

Ti Base

HEX

Height (HG/HT)	DiameterØ	Reference
1.00/5.50	3.8	AC1VFRI3810
2.00/6.50	3.8	AC1VFRI3820
3.00/7.50	3.8	AC1VFRI3830
1.00/5.50	4.4	AC1VFRI4410
2.00/6.50	4.4	AC1VFRI4420
3.00/7.50	4.4	AC1VFRI4430

NON - HEX

Height (HG/HT)	DiameterØ	Reference
1.00/5.50	3.8	AC1VFRI3810N
2.00/6.50	3.8	AC1VFRI3820N
3.00/7.50	3.8	AC1VFRI3830N
1.00/5.50	4.4	AC1VFRI4410N
2.00/6.50	4.4	AC1VFRI4420N
3.00/7.50	4.4	AC1VFRI4430N

Dynamic Ti Base

HEX

Height (HG/HT)	DiameterØ	Reference
1.00/6.50	3.8	AC1VFRI38NV
2.00/7.50	3.8	AC1VFRI38NV
3.00/8.50	3.8	AC1VFRI38NV
1.00/6.50	4.4	AC1VFRI44NV
2.00/7.50	4.4	AC1VFRI44NV
3.00/8.50	4.4	AC1VFRI44NV

Multi Unit Abutment Straight

NON - HEX

Height (HG/HT)	DiameterØ	Reference
1.00/6.50	3.8	AC1VFRI38NVN
2.00/7.50	3.8	AC1VFRI38NVN
3.00/8.50	3.8	AC1VFRI38NVN
1.00/6.50	4.4	AC1VFRI44NVN
2.00/7.50	4.4	AC1VFRI44NVN
3.00/8.50	4.4	AC1VFRI44NVN

Multi Unit Abutment Angled 17D

Height (H)	Reference
1.50mm	MAUS15
2.50mm	MAUS25
3.50mm	MAUS35

Multi Unit Abutment Angled 30D

Height (H)	Reference
2.50mm	MAUA1725
3.50mm	MAUA1735
4.50mm	MAUA1745

Impression Transfer Multi Unit Abutment

Height (H)	Reference
3.50mm	MAUA3035
4.50mm	MAUA3045

Multi Unit Analog

Length (L)	Reference
13.00mm	MAUAN

Height (H)	Reference
10.50mm	MAUT

Multi Unit Analog 3D

Length (L)	Reference
13.00mm	MAUAN3D

Healing Multi Unit Abutment

Height (H)	Reference
5.00mm	MAUH

Plastic Cylinder Multi Unit Abutment

Length (L)	Reference
8.00mm	MAUP

Cylinder Multi Unit Abutment

Length (L)	Reference
9.50mm	MAUCY

Scan body Multi Unit Abutment

Length (L)	Reference
7.00mm	MAUSB

SURGICAL INSTRUMENTS

Surgical Drills

Lance Drill

Length (L)	DiameterØ	Reference
2.00mm	2.0	SID010

Calibrated Drill Stop

Type	Length(L) implant	Reference
1	6.00mm	
	8.00mm	GTPD185
	10.00mm	GTPD110
	11.50mm	GTPD115
	13.00mm	GTPD113
	14.50mm	GTPD114
2	6.00mm	
	8.00mm	GTPD285
	10.00mm	GTPD210
	11.50mm	GTPD215
	13.00mm	GTPD213
	14.50mm	GTPD214

Titanium Grade 5

Pilot Drill

Length (L)	DiameterØ	Reference
17.00mm	160/2.00	OSPD20G

Stepped Surgical Drill

Length (L)	Diameter	Reference
17.00mm	1.80/2.50	OSTD25G
17.00mm	2.15/3.30	OSTD33G
17.00mm	2.50/3.70	OSTD37G
17.00mm	2.90/4.10	OSTD41G
17.00mm	3.40/4.40	OSTDG44

Crestal Surgical Drill

DiameterØ	Reference
4.10mm	CLD34
5.10mm	CLD50

Drill Extender

Length (L)	Reference
13.5mm	DEXT10

Depth Gauge/Paralleling Pins

Length (L)	DiameterØ	Reference

26.00mm	2.00/1.60	MUR100G2
27.00mm	2.50/1.80	MUR200G2
26.00mm	3.30/2.10	MUR300G2
26.00mm	3.70/2.50	MUR400G2

TAPS

Surgical Tap. CA

DiameterØ	Reference
3.40mm	GTAP34M
3.70mm	GTAP37M
4.00mm	GTAP40M
4.30mm	GTAP43M

SCREWDRIVERS AND ADAPTORS

Vpress Insertion Key. Ratchet Manual

Length (L)	Reference
11.80 mm/Short	
18.80 mm/Long	
11.47 mm/Short	
18.47 mm/Long	

Surgical Screwdriver Manual

Abutment Extractor Screw

Extractor Screw

Length (L)	Reference
15.00mm	
15.00mm	

RATCHETS

Regulable Torque Wrench

Length (L)	Reference
99.00mm	

Insertion Key. CA

Length (L)	Reference
20.80 mm/Short	
30.80 mm/Long	
19.27 mm/Short	
29.27 mm/Long	

Screwdriver Tip CA

Length (L)	Reference
2.80 mm/Mini	
9.50 mm/Short	
14.50 mm/Long	
27.00 mm/Extra Long	

Length (L)	Reference
20.00 mm/Short	
25.00 mm/Long	

PROSTHETIC INSTRUMENTS

SCREWDRIVERS AND ADAPTORS

Screwdriver Tip. Ratchet Manual

Length (L)	Reference
10.90 mm/Short	
15.90 mm/Long	
28.40 mm/Extra Long	

Tx30 Screwdriver Tip. Ratchet Manual

Length (L)	Reference
13.40 mm/Short	
19.40 mm/Long	

Screwdriver Tip. CA

Length (L)	Reference
20.00 mm/Short	
25.00 mm/Long	

Screwdriver Tip Tx30 CA

Length (L)	Reference
26.00 mm/Short	
32.00 mm/Long	

Tx30 Prosthetic Screwdriver Manual

Length (L)	Reference
12.00 mm/Short	
18.00 mm/Long	

Qualia™NeoActive

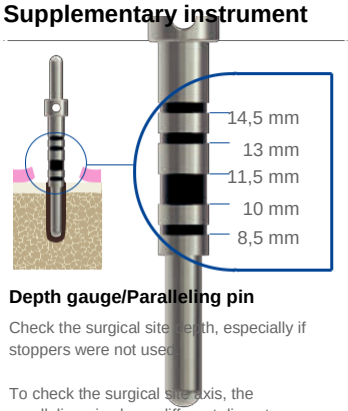
General recommendations

Treatment Planning

Patient Evaluation → **Preparation for intervention** → **Surgical procedure**

Clinical evaluation · X-Ray Test · Lab Test · Psychological analysis · Informed Consent · Personal and instrument preparation · Patient preparation · Surgical Incision · Surgical drill · Implant placement · Suture

Supplementary instrument



Depth gauge/Paralleling pin

Check the surgical site depth, especially if stoppers were not used.

To check the surgical site axis, the paralleling pins have different diameters according to the drilling sequence.

Consider during intervention

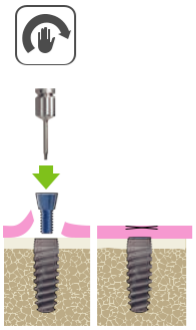
Surgical drills should be inserted in the contra-angle with the surgical motor stopped, ensuring correct anchoring and rotation before starting drilling. Treat the drills with great care: the slightest damage to the tips can compromise their effectiveness.

Each instrument must be used only for the specific use recommended by the manufacturer.

Damaged instruments must be disposed according to the regulations established by the manufacturer.

The clinician must keep in the patient's file the identification label supplied with the product, for proper traceability.

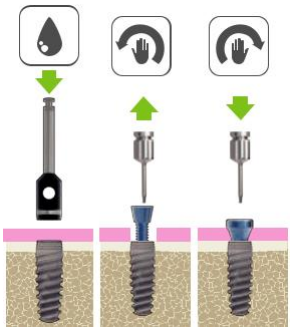
Cover screw handling



Position the cover screw on the screwdriver. Approach the implant by avoiding accidental dropping and ingestion of the screw. Insert it into the implant with manual torque and clockwise.

Second phase surgical procedure

Healing abutment placement



The healing abutment should correspond to the implant platform, considering the option of applying the platform switch technique with anatomical abutments and be in accordance with the height of the gingival tissue to avoid abutment occlusion. Excessive height could expose the implant to premature loading, compromising the Osseo integration process.

IMPORTANT WARNINGS

About implant placement

Excessive compression to the bone can lead a non-Osseo integration of the implant.

Failure to follow the steps described in the surgical sequence may result in:

- Lack of primary stability due to loss of support bone.
- Difficulties during the implant placement.

Exceeding the torque (50 Ncm) at the implant insertion can produce:

- Irreversible distortions in the internal/external connection.
- Irreversible deformations in the instruments indicated for insertion of the implant.
- Difficulty of disassembling the instrument/implant assembly

Maximum insertion torque and speed

The recommended insertion torque is between **35 and 50 Ncm** according to each case without being limited to a single torque [1], [2]

The Implant placement should be performed with controlled torque and according to the density and bone.

Insertion instruments or contra-angle (CA) screwdrivers use maximum speed of:

You can consult the bibliography at the end of this catalogue.

Qualia™NeoActive implants

Qualia™NeoActive surgical protocol establishes a crestal position of the implant platform.

To avoid cortical stress and deformation of the key and/or connection of the implant, insertion with contra-angle (CA) must respect the maximum recommended rpm (**25 Rpm**) and the maximum indicated torque (**50 Ncm**).

If the implant is not fully inserted using the maximum recommended torque, the implant must be removed and the drilling repeated, then the insertion must be performed.

Check the final insertion torque with the regulable torque wrench Ref. TORK70 or with CA.

Make sure that the entire implant with Osseoactive®surface treatment is completely covered with bone.

Surgical drills

The Qualia™NeoActive surgical drill length measuring system is simple and intuitive and allows you to guide you through the surgical site drilling process. It is recommended for use with irrigation and is made of stainless steel with a maximum use limit of 45. It is important to note the length of the end drill tip, because it is NOT INCLUDED in the length measurements of the end drill..

Millimeter drills:

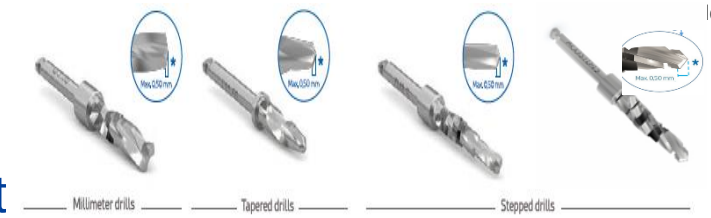
Laser marking on the drills rod identifies their diameter, and the band horizontal laser marking in its active part represents the different lengths of the implants. They are used in straight or cylindrical body implants.

Tapered drills:

Laser marking on the drills rod identifies its largest and smallest diameter and length. The drills have conical geometries adapted to the size of each implant, both in diameter and length. That it's means, every diameter and length of implant has a final drill. They are used in conical body implants.

Stepped drills:

The stepped geometry of the drills has been specially designed for the tapered core or reduced apical diameter implants. The laser marking on the drill rod identifies its diameter and the horizontal band of the laser marking. The active area represents the different lengths of the implants.



Pat

A surgical procedure is always preceded by a consultation between dentist and patient. Having different informative visual media suitable for the patient, brochures and leaflets, is important and necessary, to show clear and easily the advantages of the treatment. All the contents of this material have a scientific basis and are presented clearly and easily to understand. The aim is to help the professionals to explain all medical and technical issues using images and texts.

It helps patient to better understand the information provided during the consultation in the clinic before the intervention and widen his knowledge through further readings.

Qualia™NeoActive

Includes:

- Large show-piece implant Qualia™NeoActive
- Milling abutment with crown
- Conventional bridge
- Removable prepared teeth
- Detachable gingiva

Instructions for cleaning and disinfection of: instruments and boxes (surgical and prosthetic)

Protocol to be carried out by qualified personnel for the preparation of instruments and surgical/prosthetic boxes for use.
ATTENTION: the instruments and surgical/prosthetic boxes must be cleaned and disinfected after each use and sterilized before their next use. Pay attention to sharp elements, the use of gloves is recommended to avoid accidents during handling when following these instructions. Do not clean or disinfect instruments of different materials together.

Cleaning and disinfection of instruments

1 - Disassembly

- Disassemble the instruments that require it such as manual ratchets (see diagram below), drills and drill stops...
- Disassemble the surgical/prosthetic boxes into their components for proper cleaning.
- Uncouple the micro-implants insertion key from the handle (see diagram below).

2 - Cleaning

- Immerse the instruments in a solution of a cleaning agent suitable for dental instruments to facilitate the removal of adhering biological debris.
- Remove biological residue manually with a soft brush and pH-neutral detergent.
- Rinse with plenty of water.
- Perform a final rinse with deionized water.
- Always use pH-neutral detergents and non-abra-sive tools to clean surgical/prosthetic boxes so as not to damage the surfaces of the box.

3 - Disinfection

- Immerse the instruments in a disinfectant explicitly indicated for dental instruments.
- For disinfection with ultrasonic equipment: immerse the material in the ultrasonic bath.
- Rinse with plenty of deionized water to remove any residues of the disinfectant.
- Dry the material with filtered compressed air.

IMPORTANT:

- Follow the instructions of the disinfectant manufacturer to determine concentrations and times.
- Follow the instructions of the manufacturer of the ultrasound equipment to determine temperature, concentration and times.

4 - Inspection

- Check that the instruments are perfectly clean, otherwise repeat the above cleaning and disinfection steps.
- Discard instruments that show damage and replace them for the next surgery.
- Verify that the instruments and surgical/pros-

Bibliography

Surface treatment

- **Surface roughness alters osteoblast proliferation, differentiation and matrix production in vitro. And participates in the determination of phenotypic expression of cells in vivo.** Martin JY1, Schwartz Z, Hummert TW, Schraub DM, Simpson J, Lankford J et al. Effect of titanium surface roughness on proliferation, differentiation, and protein synthesis of human-osteoblast-like cells (MG63). .J Biomed Mater Res.1995;29(3):389-401.

- **The response of bone cells to systemic hormones is modified by surface roughness and increases the responsiveness of MG63 cells to 1 alpha, 25- (OH) 2 D3**
  Boyan BD, Batzer R, Kieswetter K, Liu Y, Cochran DL, Szmuckler-Moncler S, Dean DD, Schwartz Z. Titanium surface roughness alters responsiveness of MG63 osteoblast-like cells to 1 alpha, 25-(OH)2D3. J Biomed Mater Res. 1998;39(1):77-85.

- **Surface roughness can modulate the activity of cells that interact with an implant, and therefore affect tissue healing and implant success.**
  Kieswetter K1, Schwartz Z, Hummert TW, Cochran DL, Simpson J, Dean DD et al. Surface roughness modulates the local production of growth factors and cytokines by osteo-blast-like MG-63cells. J Biomed Mater Res. 1996;32(1):55-63.

- **When comparing different surface topographies, it should be noted that surface chemistry can be an influential variable**
  Morra M1, Cassinelli C, Bruzzone G, Carpi A, Di Santi G, Giardino R et al. Surface chemistry effects of topographic modification of titanium dental implant surfaces: 1. Surface analy-sis. Int J Oral Maxillofac Implants. 2003;18(1):40-45.

- **Surface roughness produced by sand blasting and acid etching affects cell adhesion mechanisms, providing better osseo-integration.**

- **Highest degree of bone-implant bonding on a sandblasted surface and acid etching than others.**
  Buser D, Schenk RK, Steinemann S, Fiorellini JP, Fox CH, Stich H. Influence of surface char-acteristics on bone integration of titanium implants. A histomorphometric study in minia-ture pigs. J Biomed Mater Res. 1991;25(7):889-902.

  Orsini G, Assenza B, Scarano A, Piattelli M, Piattelli A. Surface analysis of machined versus sandblasted and acid-etched titanium implants. Int J Oral Maxillofac Implants. 2000;15(6):779-84.

- **Among the most desirable characteristics of an implant are those that ensure that the implant-tissue interface will be established quickly and can be maintained.**

  Gupta A, Dhanraj M, Sivagami G. Status of surface treatment in endosseous implant: a literary overview. Indian J Dent Res. 2010;21(3):433-8.

- **Review of the literature on the influence of micro-design of dental implants on their osseo-integration.**

  Aljateeli M, Wang HL. Implant micro-designs and their impact on osseo-integration. Im-plant Dent. 2013;22(2):127-132.

- **The success of a dental implant depends on the chemical, physical, mechanical, and topographic characteristics of its surface. The structural and functional attachment of the live-bone implant is greatly influenced by the surface properties of the implant. The influence of the topography of the osseo-integration surface has been translated into the shorter healing times of the placement of implants for the restoration. This article presents a discussion of the surface characteristics and the design of the implants, which should allow the clinician to better understand osseo-integration and the information coming from implant manufacturers, which allows a better selection of the implant.**

  Ogle OE. Implant surface material, design, and osseo-integration. Dent Clin North Am. 2015;59(2):505-20.

- **Implants with mixed surface treatment (SLA type) presented increased bone crest at 3 and 12 months under loading conditions.**

  Valderrama P, Bornstein MM, Jones AA, Wilson TG, Higginbottom FL, Cochran DL. Effects of implant design on marginal bone changes around early loaded, chemically modified, sandblasted Acid-etched-surfaced implants: a histologic analysis in dogs. J Periodontol. 2011;82(7):1025-1034.

Implant size choice

- **When it comes to severe atrophy of the jaws, short and wide implants can be placed suc-cessfully (28 included studies, between 1991 and 2011).**

  Karthikeyan I, Desai SR, Singh R. Short implants: a systematic review. J Indian Soc Peri-odontol. 2012;16(3):302-312.

- **Survival of the implants (short <10 mm) is improved with longer length, placement of the mandible with respect to the maxilla, and in non-smokers (a systematic review of the prognosis of short implants, [<10 mm], in the partially edentulous patient).**

  Telleman G, Raghoebar GM, Vissink A, den Hartog L, Huddleston Slater JJ, Meijer HJ. A sys-tematic review of the prognosis of short (<10 mm) dental implants placed in the partially edentulous patient. J Clin Periodontol. 2011;38(7):667-676.

- **Among the risk factors examined, most failures of short implants can be attributed to poor bone quality in the maxilla and surface treatment (35 studies in humans met the criteria.) The studies included 14,722 Implants, failure rates of implants with lengths of 8.5 and 9, were 3.2%, and 0.6% respectively).**

  Sun HL, Huang C, Wu YR, Shi B. Failure rates of short (≤ 10 mm) dental implants and factors influencing their failure: a systematic review. Int J Oral Maxillofac Implants.
  2011;26(4):816-825.

- **Short-surface rough implants should be considered a solution for restoration of posterior teeth in highly reabsorbed areas (short threaded implants with a rusted surface to restore posterior teeth: 1 to 3 years of results from a prospective study of 107 implants , 69.2% were 7 mm long, 30.8% were 8.5 mm long, survival rate 98.1%).**

  De Santis D, Cucchi A, Longhi C, Vincenzo B. Short threaded implants with an oxidized sur-face to restore posterior teeth: 1 to 3-year results of a prospective study. Int J Oral Maxil-lofac Implants. 2011;26(2):393-403.

- **The wide platform provides increased mechanical strength of the connection being im-portant for mechanical stability (the results of a 3-year prospective multi-centred clini-cal trial and the results at 1 year from a multi-centre 2 retrospective clinical study. Wide diameter implants for molar replacement).**

  Polizzi G, Rangert B, Lekholm U, Gualini F, Lindstrom H. Brånemark System Wide Platform implants for single molar replacement: clinical evaluation of prospective and retrospec-tive materials. Clin Implant Dent Relat Res. 2000;2(2):61-69.

- **Small diameter implants can be successfully included in implant treatment. Preferable in cases where space is limited. Overall survival rate of 95.3% (192 small diameter implants placed in 165 patients from 1992 to 1996. Of 2.9 mm or 3.25 mm in diameter, the overall survival rate was 95.3%) .**

  Vigolo P, Givani A, Majzoub Z, Cordioli G. Clinical evaluation of small-diameter implants in single-tooth and multiple-implant restorations: a 7-year retrospective study. Int J Oral Maxillofac Implants. 2004;19(5):703-709.

- **Associated narrow-diameter implants could be considered for use with fixed restorations and lower overdentures, as their success rate appears to be comparable to that of regular-diameter implants (42 studies from 1993 to 2011. 10,093 FDI approximately 2,762 The reported survival rates for SDI are similar to those reported for standard width implants.**

  Sohrabi K, Mushantat A, Esfandiari S, Feine J. How successful are small-diameter im-plants? A literature review. Clin Oral Implants Res. 2012;23(5):515-525.

- **For complete superior best 6 implants, survival rates: 97.9% at 5 years and 95.9% at 10 years. For partial dentures fixed on 2 to 4 implants, survival rates: 98.9% at 5 years and 97.8% at 10 years. For complete upper set on 4 to 6 implants, survival rates were 97.9% at 5 years and 95.9% at 10 years (from 210 articles were selected 51).**

  Heydecke G, Zwahlen M, Nicol A, Nisand D, Payer M, Renouard et al. What is the optimal number of implants for fixed reconstructions: a systematic review. Clin Oral Implants Res.2012;23(6):217-228.

Morse taper connection

- **Among the risk factors examined, most failures of short implants can be attributed to poor bone quality in the maxilla and surface treatment (35 studies in humans met the criteria.) The studies included 14.722 Implants, failure rates of implants with lengths of 8,5 and 9, were 3,2%, and 0,6% respectively). Survival rate of the one-piece implant: 96.79% after 5 years. Review 20 articles (1995-2011).**

  Barrachina-Diez JM1, Tashkandi E, Stampf S, Att W. Long-term outcome of one-piece implants. Part I: implant characteristics and loading protocols. A systematic literature review with meta-analysis. Int J Oral Maxillofac Implants. 2013 Mar-Apr;28(2):503-18. doi: 10.11607/jomi.2790.

- **In Morse Taper connection implants and change of platform there is less appearance of periim-plantitis and bone loss, as well as less inflammation and less loss of peri-implant soft tissue.**

  Macedo JP1, Pereira J1, Vahey BR2, Henriques B3, Benfatti CA3, Magini RS1, López-López J4, Souza JC3. Morse taper dental implants and platform switching: The new paradigm in oral implantology. Eur J Dent. 2016 Jan-Mar;10(1):148-54. doi: 10.4103/1305-7456.175677. From 287 studies identified (1961-2014), 81 studies were selected.

- **The internal connection of Morse Taper is more effective in relation to biological aspects, allowing less bone loss and bacterial filtration in individual implants, including aesthetic regions. In addition, this type of connection can be successfully indicated for fixed partial dentures as it shows high mechanical stability.**

  Goiato MC1, Pellizzer EP, da Silva EV, Bonatto Lda R, dos Santos DM. Is the internal connec-tion more efficient than external connection in mechanical, biological, and esthetical point of views? A systematic review. Oral Maxillofac Surg. 2015 Sep;19(3):229-42. doi: 10.1007/s10006-015-0494-5. Epub 2015 Apr 25.

- **Implant systems with Morse Taper connection provide better results in terms of abutment fit, connection stability and antibacterial seal performance.**

  Schmitt CM1, Nogueira-Filho G, Tenenbaum HC, Lai JY, Brito C, Döring H, Nonhoff J. Perfor-mance of conical abutment (Morse Taper) connection implants: a systematic review. J Biomed Mater Res A. 2014 Feb;102(2):552-74. doi: 10.1002/jbm.a.34709. Epub 2013 May 9.

- **Subcrestal placement (SCL) of contiguous Morse Taper connection implants with 'platform change' was more efficient in preserving interim crestal bone than in equicrestals (ECL).** Barros RR1, Novaes AB Jr, Muglia VA, Iezzi G, Piattelli A. Influence of interimplant distances and placement depth on peri-implant bone remodeling of adjacent and immediately loaded Morse cone connection implants: a histomorphometric study in dogs. Clin Oral Implants Res. 2010 Apr 1;21(4):371-8. PMID: 20128832 DOI: 10.1111/j.1600-0501.2009.01860.x

- **The characteristics of the implant-abutment joint could be a reason for the observed differ-ences in mechanical stability. Micro-space observed in the internal hexagon connection ver-sus undetectable separation in the Morse Taper.**

  Scarano A1, Mortellaro C, Mavriqi L, Pecci R, Valbonetti L. Evaluation of Microgap With Three-Dimensional X-Ray Microtomography: Internal Hexagon Versus Cone Morse. J Craniofac Surg. 2016 May;27(3):682-5. doi: 10.1097/SCS.0000000000002563.

Radiographic templates

- For the choice of the size during the surgical planning, in those cases that is only available the diagnostic image in Orthopantomography format (OPG), there are available transparent acetate overlay, such as radio logical templates, different for each QUALIA™NEOACTIVE ® implants family morphology, with the figures of the implants in scales 1:1,00 and 1:1,25 that are superimposed over OPG for thought comparison and measurement, to help to the choice of adequate diameter and length. The extensions of the templates correspond to magnifications of the most of OPG that are detailed. . **QUALIA™NEOACTIVE ® recommend the planning of the treatment with dental implants based on Cone-Bean Computed Tomography: CBCT**

- **Literature support the use of CBCT in dental implants treatment planning, especially in what means to lineal measures, tridimensional evaluation of the alveolar topography, proximity to vital anatomical structures and manufacturing of surgical guides.** Benavides E1, Rios HF, Ganz SD, An CH, Resnik R, Reardon GT, Feldman SJ, Mah JK, Hatcher D, Kim MJ, Sohn DS, Palti A, Perel ML, Judy KW, Misch CE, Wang HL. Use of cone beam computed tomography in implant dentistry: the International Congress of Oral Implantologists consensus report. Implant Dent. 2012 Apr;21(2):78-86. doi: 10.1097/ ID.0b013e31824885b5.

- **Pre operatory planning with CBCT implants allowed planning of the treatment with a high grade of prediction and concordance in comparison with surgical standard, based on panoramic radiography, which the prediction of the implant was deficient with.** Guerrero ME1, Noriega J2, Jacobs R3. Preoperative implant planning considering alveolar bone grafting needs and complication prediction using panoramic versus CBCT images. Imaging Sci Dent. 2014 Sep;44(3):213-20. doi: 10.5624/isd.2014.44.3.213. Epub 2014 Sep 17.

- **In difficult cases with alveolar lateral deficient bone, the diagram of the increase could be evaluated better from CBCT to avoid sub-estimation , that appears more often when is based just in panoramic radiographies.** Dagassan-Berndt DC1, Zitzmann NU2, Walter C2, Schulze RK3. Implant treatment plan-ning regarding augmentation procedures: panoramic radiographs vs. cone beam com-puted tomography images. Clin Oral Implants Res. 2016 Aug;27(8):1010-6. doi: 10.1111/ clr.12666. Epub 2015 Jul 30.

- **AAOMR recommend that traversal image need to be used for evaluation of every dental im-plant places and CBCT is the method of the image selection for obtaining this information .** Tyndall DA1, Price JB, Tetradis S, Ganz SD, Hildebolt C, Scarfe WC; American Academy of Oral and Maxillofacial Radiology. Position statement of the American Academy of Oral and Maxillofacial Radiology on selection criteria for the use of radiology in dental implan-tology with emphasis on cone beam computed tomography. Oral Surg Oral Med Oral Pathol Oral Radiol. 2012 Jun;113(6):817-26. doi: 10.1016/j.oooo.2012.03.005.

Use of the interface in zirconium restorations

Scientific evidence to recommend the use of the interface in zirconium restorations:

The maximum load capacity of a crown or framework made with a titanium plus zirconium interface is significantly higher [1] than when the crown or framework is made entirely of zirconium directly connected to the implant. The use of an intermediate metal component has a beneficial influence on the stability of the zirconium oxide abutments. [2] The failure mode in zirconium restorations depends on the support material and its design. [3] In zirconium restorations with intermediate abutment, initially only partial deformation of the components occurs and cracks occur prior to some fractures of the zirconium abutment. [4] The dimension of the interface (connector) on which to cement the zirconium prosthesis is clinically relevant. [5] The Interface reduces wear on the implant connection in cases of zirconium restorations [6] [7].

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