The Foundation of Knowledge

6th Consensus Document on 16 Approved Methods of Corticobasal® Implant Placement (2024)

Executive Summary

This consensus document defines 16 clinically approved methods for Corticobasal® implant placement. These methods are based on established biomechanical principles, evidence-based outcomes, and accumulated expert experience. The purpose is to standardize approaches, ensure predictable immediate loading, and support clinicians in planning and executing Corticobasal® implant treatments, as well as to come to reasonable expert opinions if cases of failure. The method-consensus avoids for trained users of the technology the necessity for the presence of medical device advisors in the implantologists office.

Key Consensus Statements:

- Corticobasal® implantology requires anchorage in stable cortical bone structures, not in cancellous or alveolar bone.
- Immediate functional loading is the standard objective across all methods.
- The number of implants per jaw or segment depends on biomechanical needs and differs from conventional implantology. Minimum amounts of implants per jaw are mentioned in the manufacturer's written instructions for the devices.
- Site-specific approaches allow implant anchorage in various anatomical regions while avoiding invasive augmentation procedures.
- Clinical safety depends on strict adherence to method-specific guidelines.

1. General Principles

Consensus statement: Corticobasal® implants are placed with the primary goal of achieving stable bicortical or multicortical anchorage, enabling immediate prosthetic rehabilitation and full functional loading.

- Osseointegration is not the primary objective; mechanical stability is decisive. This stability is created by the surgeon.
- Spongious bone anchorage may be used when applying IF® Methods 2a, 3, and 14 only
- Prosthetic splinting is required to ensure stability and distribute functional loads.

2. General Methods (1a–1i)

Consensus statement: The general methods emphasize implant positioning, cortical anchorage, and stabilization strategies.

- **Method 1a**: Multidirectional insertion with parallelization via bending, angle adapters, or grinding.
- **Method 1b**: Strategic implant placement with obligatory bicortical / multicortical anchorage.
- **Method 1c**: Independent anchorage in the 2nd or 3rd cortical.
- **Method 1d**: Placement in sites with active periodontal disease following extraction and debridement, with immediate rigid splinting.
- **Method 1e**: Avoidance of alveolar spongiosa for anchorage.
- **Method 1f**: Fixation of polished implants in cortical regions of the maxillofacial skeleton.
- **Method 1g**: Anti-rotation achieved by bending intra-osseous shafts.
- **Method 1h**: Use of wide apical implants for additional vertical bone condensation.
- **Method 1i**: Anchorage in transplanted bone, when clinically indicated.

3. Site-Specific Methods (2–16)

Consensus statement: Site-specific methods adapt Corticobasal® implant placement to regional anatomical conditions.

- **Method 2a–2b**: Placement in anterior mandible between mental nerves, with or without caudal cortical engagement.
- **Method 3**: Anterior anchoring with long implants positioned between canine root and mental foramen.
- **Method 4a–4b**: Nerve-bypass techniques in the posterior mandible, with or without caudal cortical penetration.
- **Method 5a–5c**: Lingual or vestibular cortical anchorage in distal mandible; implant paths may run below the inferior alveolar nerve.
- **Method 6**: Bicortical support in extraction sockets or premolar / maxillary tuberosity regions, engaging palatal/lingual and vestibular cortices.
- **Method 7a–7b**: Nasal floor anchorage, with or without bypassing alveolar bone.
- **Method 8a–8b**: Maxillary sinus floor anchorage, with or without septal support.
- **Method 9a–9b**: Canine root bypass techniques for nasal floor or midline anchorage.
- **Method 10a–10b**: Pterygoid plate anchorage, single or double implants.
- **Method 11a–11b**: Anchorage on palatal side of sinus or in midline suture of the maxilla.
- **Method 12**: Zygomatic bone anchorage, either trans-sinusal or extra-sinusal.

- **Method 13**: Vestibular placement in anterior mandible with anchorage in caudal cortex.
- **Method 14**: Fresh extraction socket anchorage for premolars.
- **Method 15**: Fresh extraction socket anchorage for palatal roots of upper molars.
- **Method 16a–16b**: Paired implants in premolar / molar regions, including canine bypass and alternative to tuberopterygoid anchorage.

4. Clinical Recommendations

Consensus statement: Each method has defined indications and should be applied with respect to anatomy, biomechanics, and patient-specific conditions.

- Immediate splinting with rigid prosthetics is required.
- Careful radiographic and clinical planning ensures safety, particularly near nerves and sinus structures.
- Methods should be selected based on bone availability and resistance-stable cortices.

5. Summary of Consensus

- Corticobasal® implantology relies on defined surgical methods to achieve immediate function loading without any augmentation.
- Sixteen methods (and their sub methods) are recognized as safe and effective when applied correctly. This evaluation is based on long term clinical studies,
- Treatment plans should prioritize cortical anchorage, immediate loading, and prosthetic stability.

Overall consensus: The 16 approved methods provide a comprehensive framework for Corticobasal® implant placement, ensuring reproducibility, safety, and predictability across diverse clinical scenarios.

Approved by the expert consensus group, Version 8, August 2024.