



16 SURGICAL METHODS AND SUB METHODS FOR CORTICOBASAL® IMPLANTS

EVIDENCE AND RESEARCH DEPT.
INTERNATIONAL IMPLANT FOUNDATION IF®

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The Foundation of Knowledge

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Slide 1



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16 Surgical Methods and Sub Methods
for Implants in Cortical and Basal
anchorage

Illustrated and commented
Version of IF Standard Lecture
No. 23-3

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The picture which is given to you by this lecture should not prevent you from making your own conclusion about the clinical situation and to act by using all your knowledge. We recommend that you take rather small steps to develop your own technique and that you observe them for some time before you decide to use them in general.

Not all cases shown in this lecture have been treated by the lecturer.

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Foreword

The following descriptions and illustrations represent an expanded and condensed version of the manufacturer's information and instructions for use for the following implant systems:

BCS®, Mythbreaker®, Corticobasal®, Strategic Implant®, GBC®, BECES®, BECES® N.

The manufacturers Dr. Ihde Dental AG, Simpladent GmbH, and Onewaybiomed GmbH, each based in Switzerland, commissioned the International Implant Foundation through a scientific cooperation agreement in 2012 to develop and update these and other illustrations and other technical information.

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In 2019, two comprehensive studies^{1,2} were published on one-piece implants and, specifically, on polished screw implants for basal and cortical anchorage. Both studies show excellent results that far exceed those that can and have been achieved with conventional, osseointegrating implants.

In 2020, the International Implant Foundation (Munich) published a compilation of the most beneficial methods for using these implants³. Since 2019, these methods have become established worldwide among users of the aforementioned cortical and basal-anchored implants. These methods are demonstrated to practitioners by medical device consultants from the three aforementioned companies; they are also an integral part of training and on-site application support. They are the results of clinical research and practical application.

In 2024, a new, very comprehensive study⁴ on cortical and basal-anchored implants was presented for the first time at an international congress. In terms of scope and significance, this study far exceeds any previous scientific contributions on dental implants, even by universities. This study was conducted at two centers in Europe and included 1,680 complete jaw implantations with more than 17,000 Strategic Implant® implants. The study was first published in 2025 with the release of a PPT presentation.

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All of the aforementioned studies demonstrate that the consistent application of the "16 methods and sub-methods" as presented in the following publication leads to excellent clinical results and lasting success.

The application of these methods has represented the state of the art in oral implantology since 2019.

Munich, June 29, 2025

International Implant Foundation IF®
Prof. Dr. Antonina Ihde
Head of Dental Implants Faculty (since 2019)

Slide 7



Literature for the Foreword

¹ Lazarov A. Immediate functional loading: Results for the concept of the Strategic Implant®. Ann Maxillofac Surg 2019;9:78-88.

² Dobrinin Oleg, Lazarov Alexander, Konstantinovic Vitomir S., Sipic Olga, Siljanovski Damir, Milicic Biljana Immediate Functional Loading Concept with one-piece implants (BECES/BECES N/ BOI) in the mandible and in the maxilla. A multicenter retrospective study. J. Evolution Med. Dent. Sci./eISSN- 2278-4802, pISSN- 2278-4748/ Vol. 8/ Issue 05/ Feb. 04, 2019.

³ Department of Evidence and Research of the International Implant Foundation IF®, Munich, Germany, Consensus Regarding 16 Recognized and Clinically Proven Methods and Sub Methods for Placing Corticobasal® Oral Implants. Ann Maxillofac Surg 2020;10:457-62.

⁴ Ihde S., Sipic O., Ihde A. A Prospective Long-Term Study on the Strategic Implant® - This Study Changed the Dental World and the „Gold Standard“ in Oral Implantology. Experience-Based and Evidence-Oriented Corticobasal® Implantology (EECI), Vol. 19, No. 1, International Implant Foundation Publishing, 2025.

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General Methods

Method No	Description
1a General	Multi-directional implant placement, with the implants being placed under angle to each other, followed by - either parallelization of the abutment heads through bending of vertical implant shafts, or - parallelization through cemented angulation adapters, or - parallelizing through grinding the abutments in the mouth, or - utilizing screw connection (MU)
1b General	Placement of implants in Strategic Position and adding stabilizing implants in other parts of the jawbone
1c General	Anchorage of implants in the 2 nd or 3 rd cortical, independent of the „alveolar bone“. Preferred places of anchorage are resorption-stable corticals.

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Method No	Description
1d General	Placement of Strategic Implant® in cases with profound and active periodontal involvement. Under protection of strong topical disinfection agents, the teeth and subsequently the periodontally involved soft tissues are removed. Strategic Implant® are placed instantly and they are then splinted by a rigid prosthetic construction.
1e General	Spongious and alveolar bone areas are avoided for anchorage. Achieving "osseointegration" is not the primary aim of implant placement.
1f General	Fixation of polished implant bodies made from implantable material with the aim of achieving mechanical anchorage in cortical bone areas of the maxillo-facial skeleton. Subsequent splinting by the prosthetic construction in an immediate loading protocol.

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Method No	Description
1g General	Creating anti-rotation features for an implant by bending intra-osseous parts of the shaft of the implant.
1h General	Achieving primary stability by vertical condensation of the spongy bone by <u>wide body</u> BCS®.



Wide body = big volume of implant material in the thread

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Method No	
1k Maxillo-facial application	Engaging screwable Corticobasal® implants into transplanted bone areas & engaging some of the implants in native bone to increase the polygon and create some cross-arch stabilization 

Slide 12



Method No	
1k Maxillo-facial application	Engaging screwable Corticobasal® implants into transplanted bone areas & engaging some of the implants in native bone to increase the polygon and create some cross-arch stabilization 

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Method No	
1k Maxillo-facial application	

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Regional Methods

Regional methods will be applied in their specific ways in specific regions of the jawbones

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Stable vs. Unstable Corticals

Example of unstable corticals:

- Floor of the maxillary sinus, area 4 – 6
- Lamina cribrosa after tooth extraction

Examples of stable corticals:

- Floor of the nose
- Fusion zone between distal maxilla / pterygoid process

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What Makes a (Basically) Stable Cortical Become an Unstable Cortical?

- Internal resorption (changes in internal morphology)
- Osteoporosis
- Changes in outer morphology (e.g. formation of exostoses)

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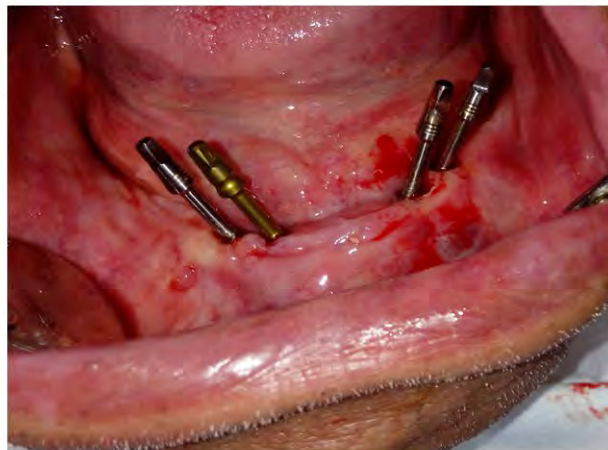
Slide 17



Method 2

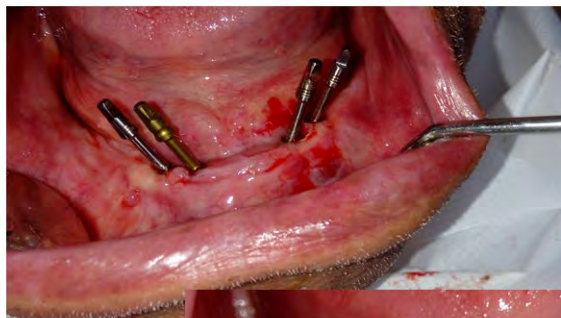
Placement of implants between the mental nerves (in edentulous mandibles), with or without necessity for anchorage in the 2nd (basal) cortical of the mandible. This positioning has 3 advantages:

- Threads are in highly mineralized bone
- Mental nerve can be avoided
- Span to the heads of distal implants is reduced

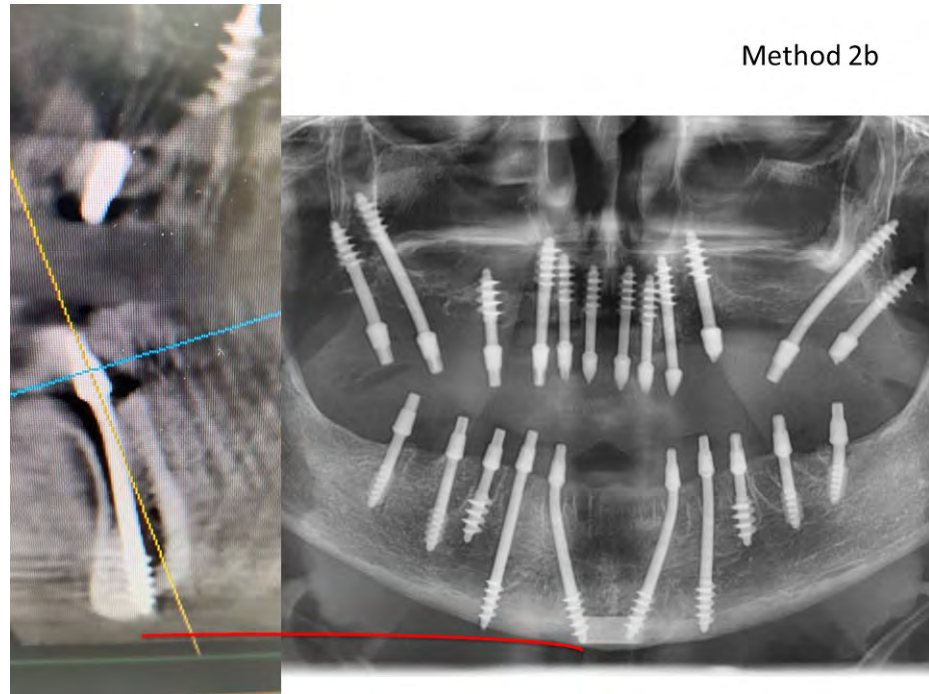


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Method 2

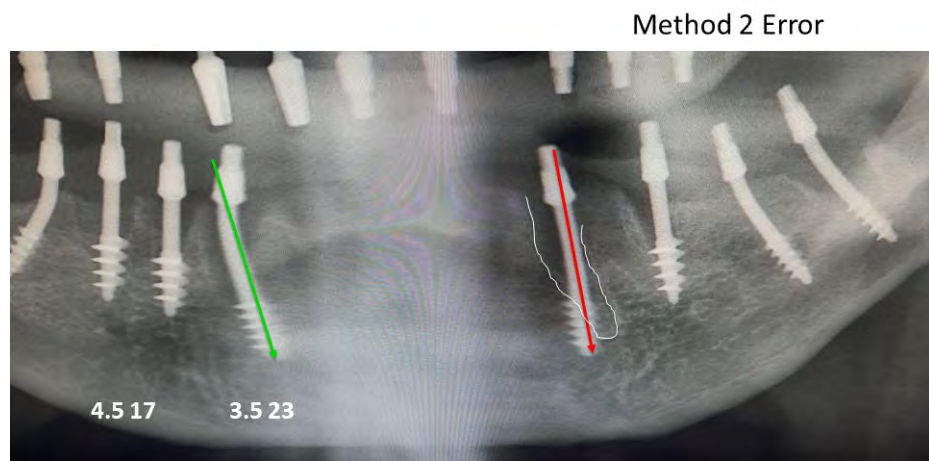


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Method 2b

Slide 20



Method 2 Error

Implant 33 shows distal
 inclination **although it was
 placed correctly mesally out of
 the extraction socket of the
 canine**

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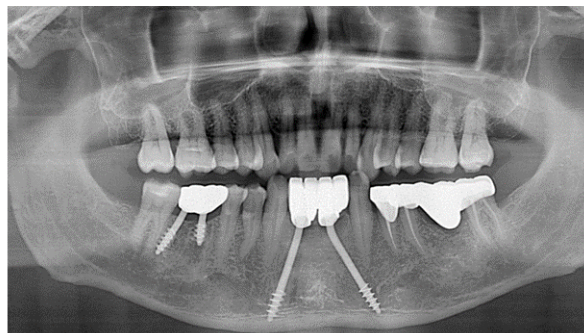
Method 2c



- Implants are placed in distal direction
- Engagement into basal cortical is recommended if the mineralisation of the bone is low
- Indicated for segments 2-2 in lower jaw

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Method 2c



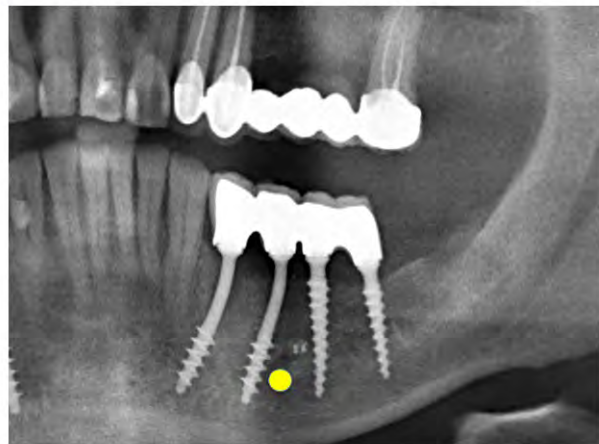
- Implants are placed in distal direction
- Engagement into basal cortical is recommended if the mineralisation of the bone is low
- Indicated for segments 2-2 in lower jaw

Slide 23



Method 3

Anterior anchorage of a segment bridge with two long Strategic Implant[®], placed in the space (slot) between the mental nerve and the root of the lower canine



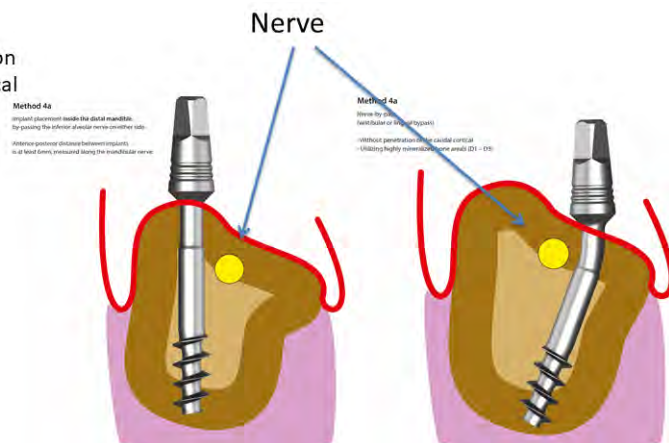
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Method 4 a

Nerve-by-pass
(vestibular or lingual bypass)

- Without penetration of the caudal cortical
- Utilizing highly mineralized bone areas (D1 – D3)



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Method 4 a



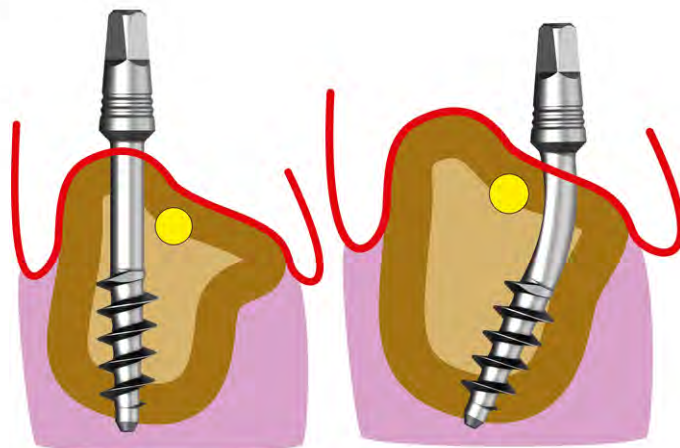
Slide 26



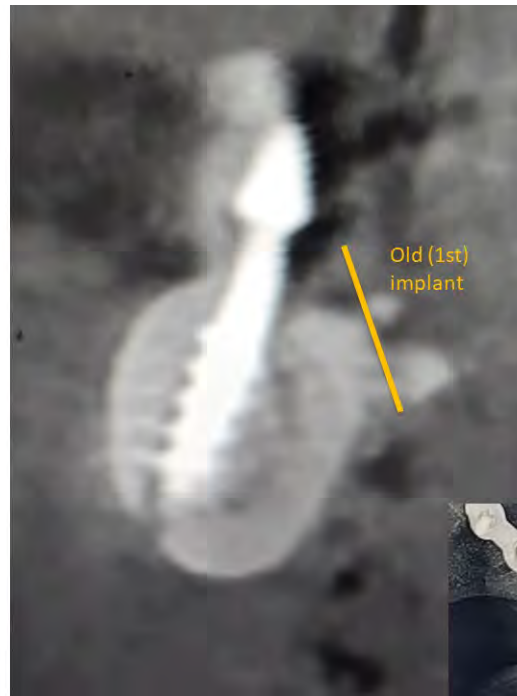
Method 4 b

Nerve-by-pass
(vestibular or lingual
bypass)

- With penetration of the caudal cortical and anchorage in the caudal cortical



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Method 4 b Mistake

After failure of an IFM 5s implant (yellow line) the treatment provider decided to place into the same (1st-cortical) position an IFM 4b implant. In order to do this the treatment provider had to penetrate the 2nd cortical. Mistakenly the treatment provider did not close this hole by anchoring the implant there, but he left this vertical canal open.

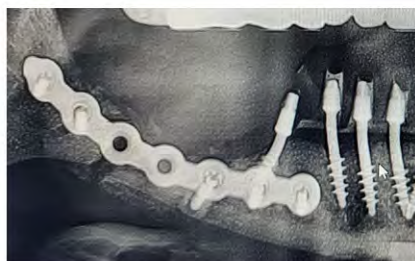
Along the open bone wound the infection wandered south and caused an infection which led to the fracture of the mandible.



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Control 03.06.2025



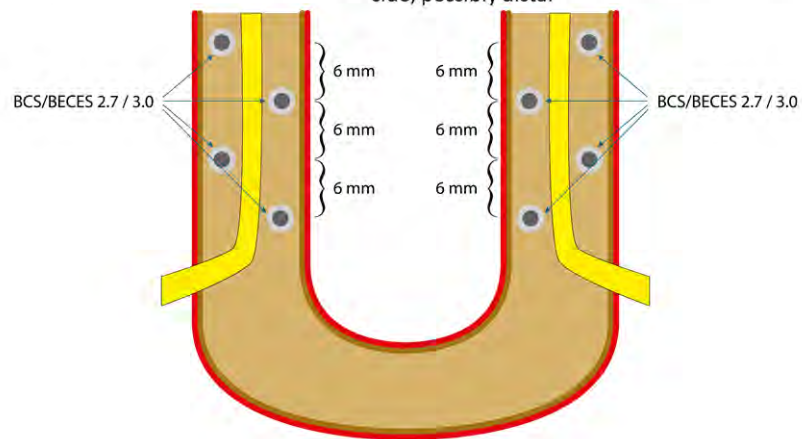
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Method 4 a/b

1. Positioning of implants and distances between implants: min. 6 mm sagittal space
2. At least one 3.5mmd implant on each side, possibly distal



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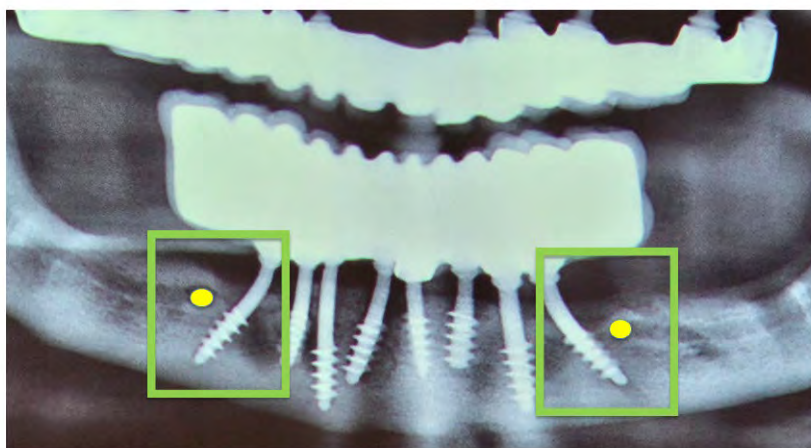


Implant sites where the 2nd cortical was not perforated
are the **Keepers of the Vertical**

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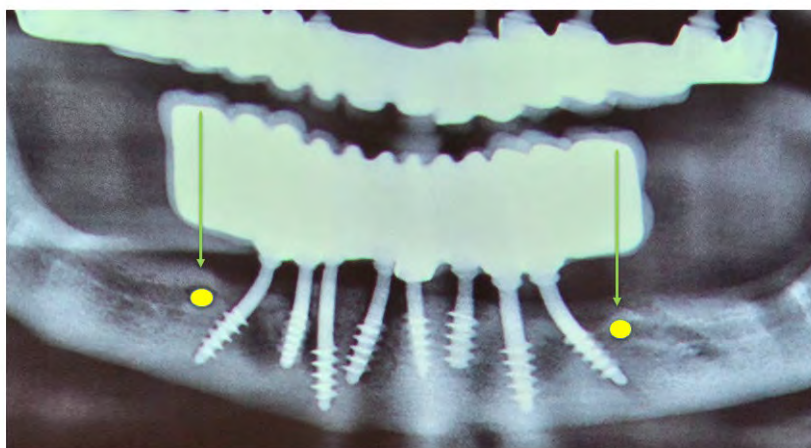
Method 4c
(Lazarov, 2024)



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Method 4c

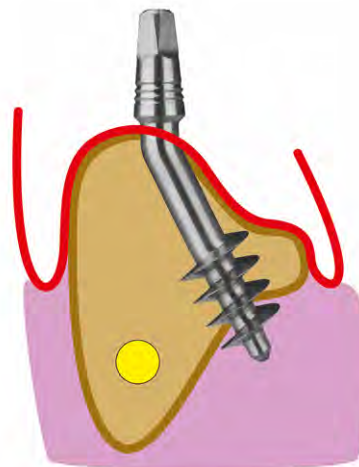


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Method 5a

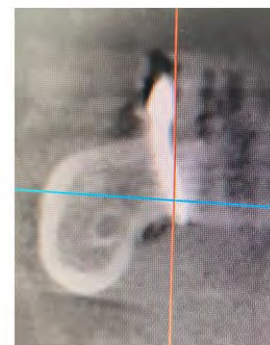
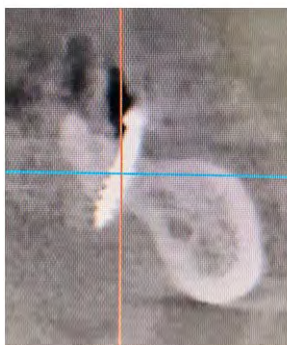
Lingual cortical
engagement in the
distal mandible



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Method 5a



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Method 5a



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Method 5a

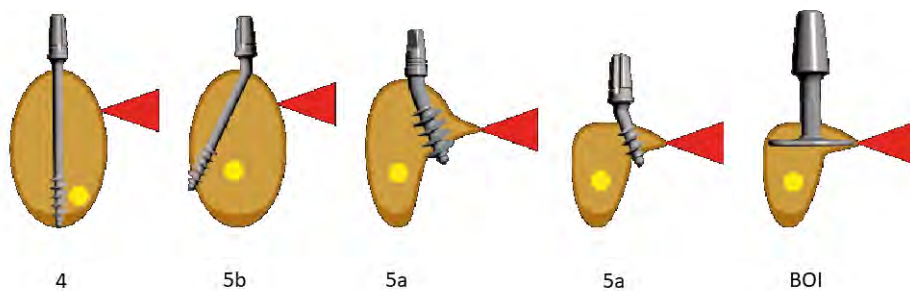
Lingual and vestibular cortical engagement are used for segment constructions in combination.



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Methods 4 & 5
In Overview



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Method 5a
Risks, Mistakes and
Problems to be Solved

Risks & Complications:

- Inoculation of infected bone material through the drill into the submandibular space
- Morphological change of the area of the lingual undercut with subsequent exposing of the thread of the implant (may be shortened or implant must be removed)



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Method 5a. **WRONG/RISKY**

Lingual cortical engagement is not allowed in the inter-foraminal region due to the risk of creating a massive bleeding.

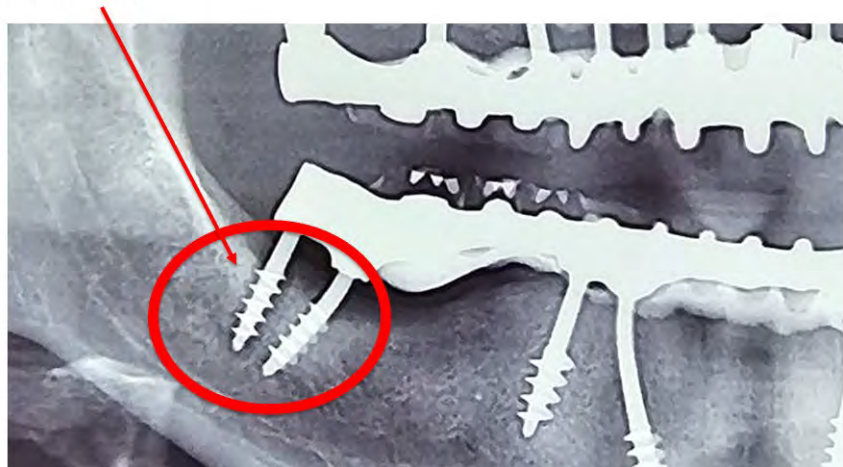


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Method 5a. **WRONG/RISKY**

Distal implant not placed in distal direction

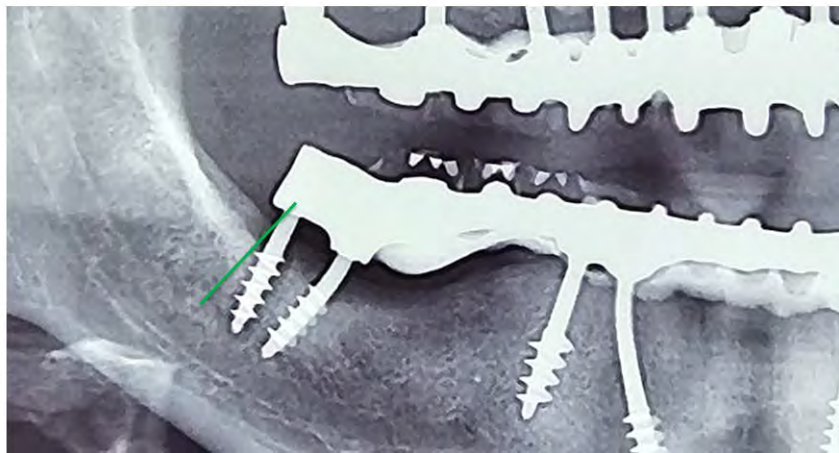


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Method 5a. **WRONG/RISKY**

Distal implant not placed in
distal direction



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Method 5b

Vestibular
cortical
engagement in
the distal
mandible

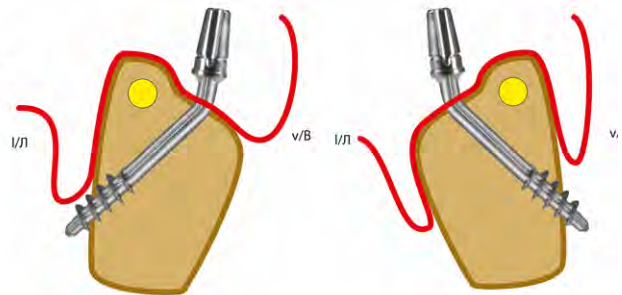


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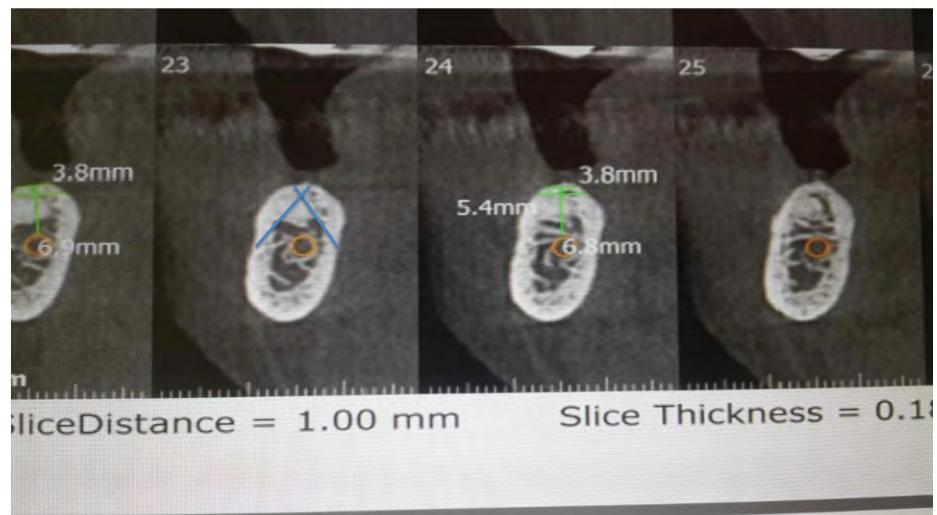
Method 5c

Vestibular or lingual cortical engagement in the distal mandible, with the implant running below the mandibular nerve



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EN4



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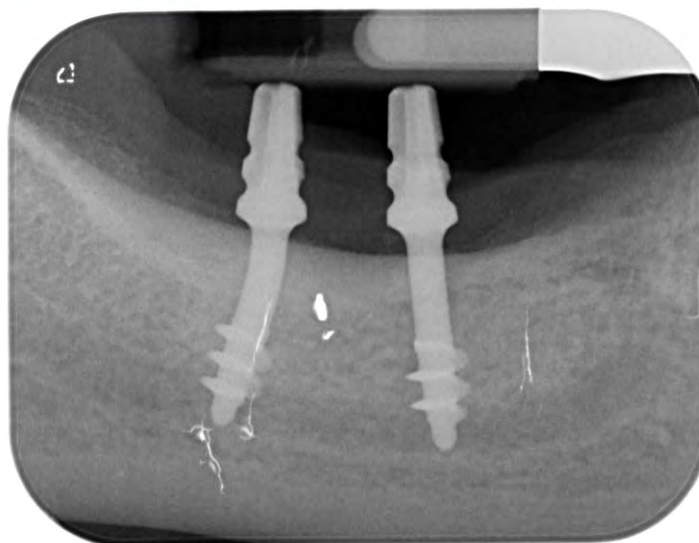
Method 5a



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Method 5a

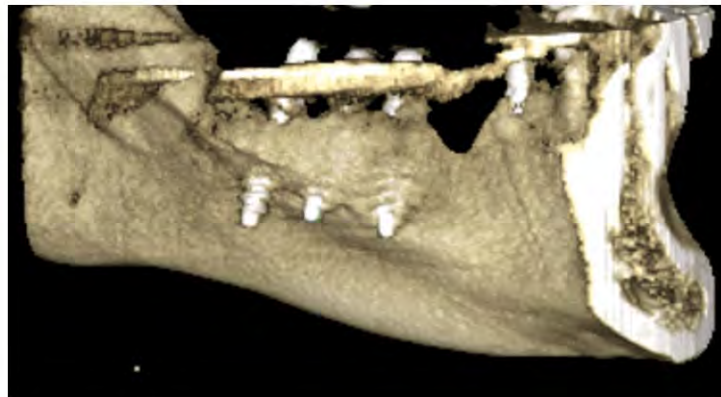


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Method 5a

View from lingual on three implants placed according to IF[®] Method 5a. Correct penetration of the lingual cortical of the mandible.



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Method 6
Horizontal, Bicortical Anchorage

Placement of wide diameter BCS[®] using palatal / lingual and vestibular corticals for anchorage, without using a 2nd cortical in vertical direction

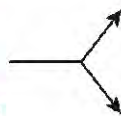
Permanent Corticals



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Methods 6
Horizontal, Bicortical Anchorage
Vs. 2nd Cortical Anchorage



Method 6

Method 2 (b)

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Method 6
Horizontal, Bicortical Anchorage

Placement of wide diameter BCS® using the lingual and vestibular cortical for anchorage, without using a 2nd cortical in vertical direction

[Permanent Corticals](#)

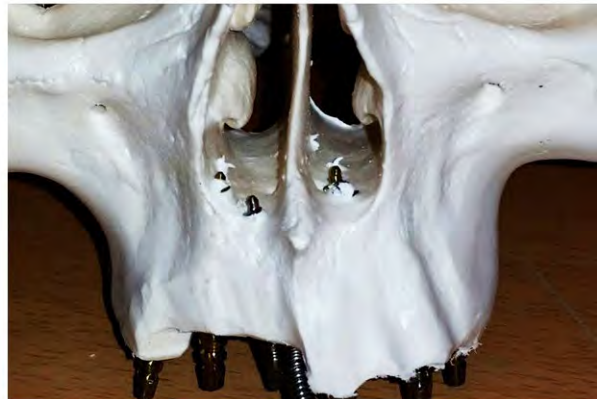


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Method 7 a

Placement of the apical thread of the implants **into the cortical floor** of the nose for anchorage

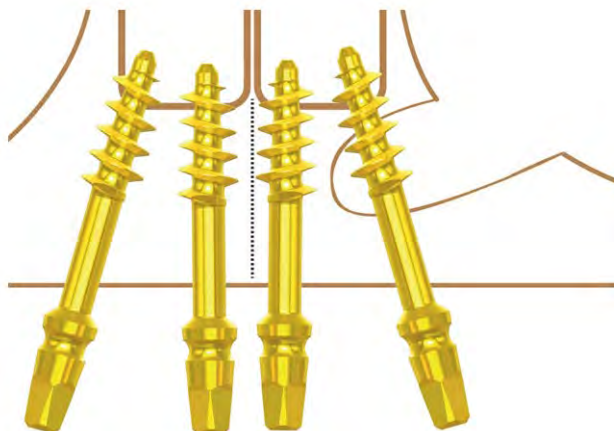


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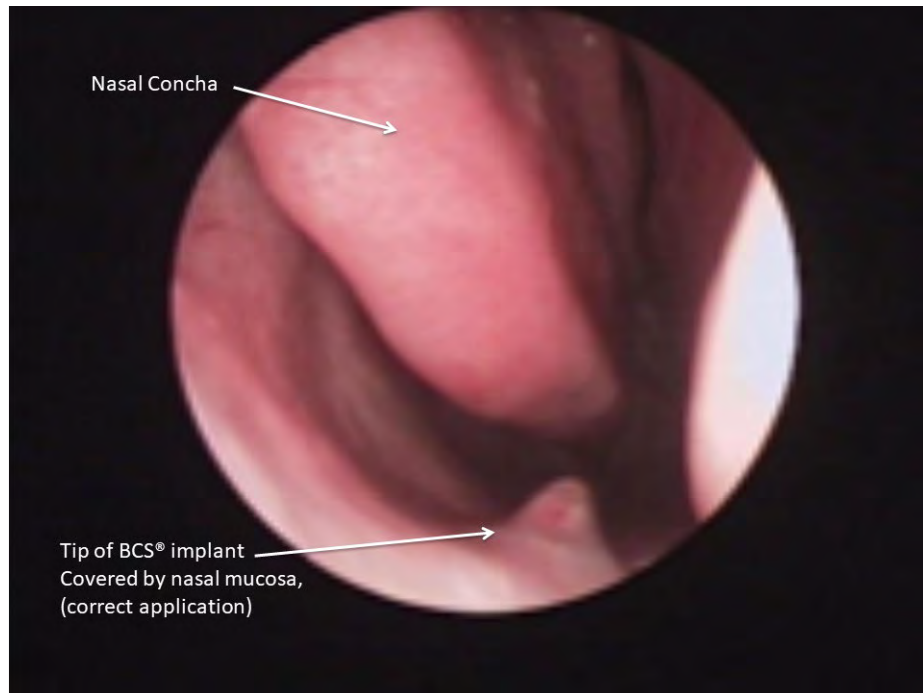


Method 7 a

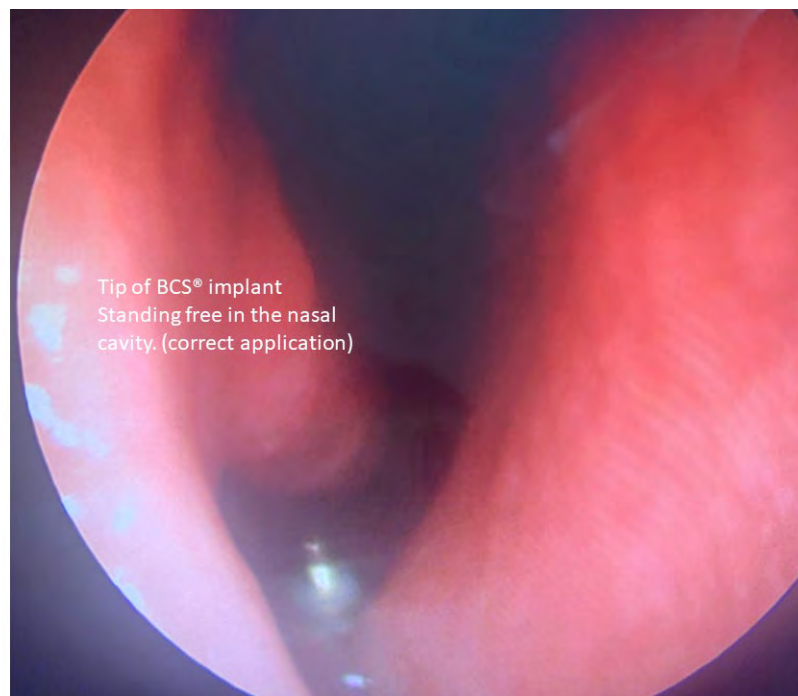
Placement of the apical thread of the implants into the cortical floor of the nose for anchorage



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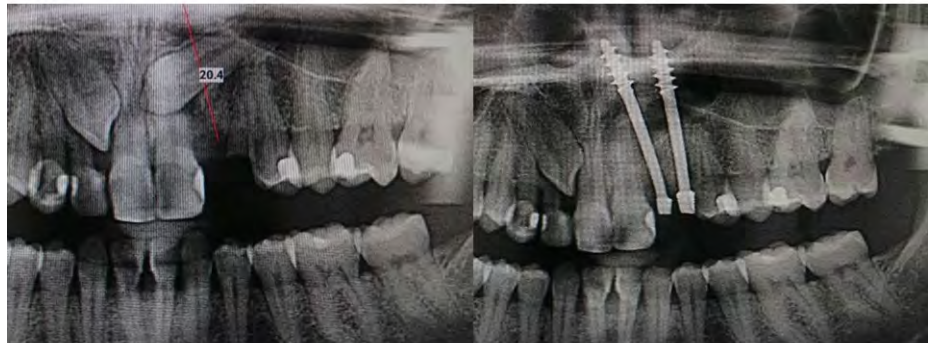


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Method 7 a

Treatment Example:



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Method 7 a

Treatment Example:



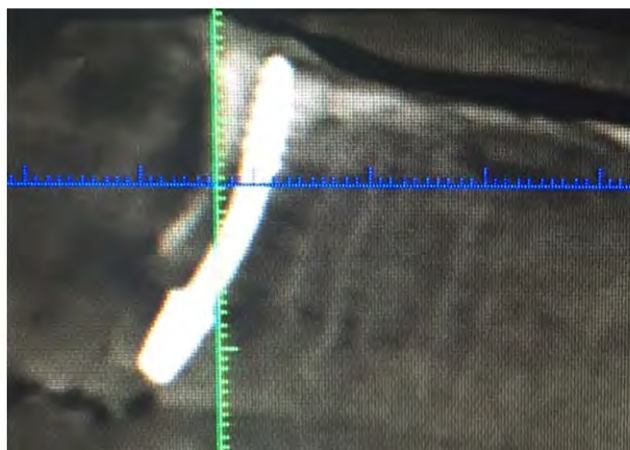
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Method 7b

Palatal insertion of implants, directly into the floor of the nose, by-passing the alveolar bone of the maxilla.

Method 7b and 13 can be used only for polished implants (e.g. BCS®) without any possibility of mechanic retention.



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Method 7b



Bone shows low mineralization however 1st ad 2nd cortical are separated



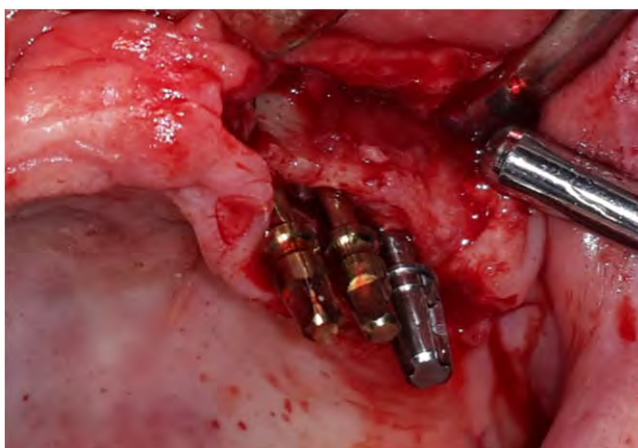
Due to strong atrophy, 1st and 2nd cortical are fused

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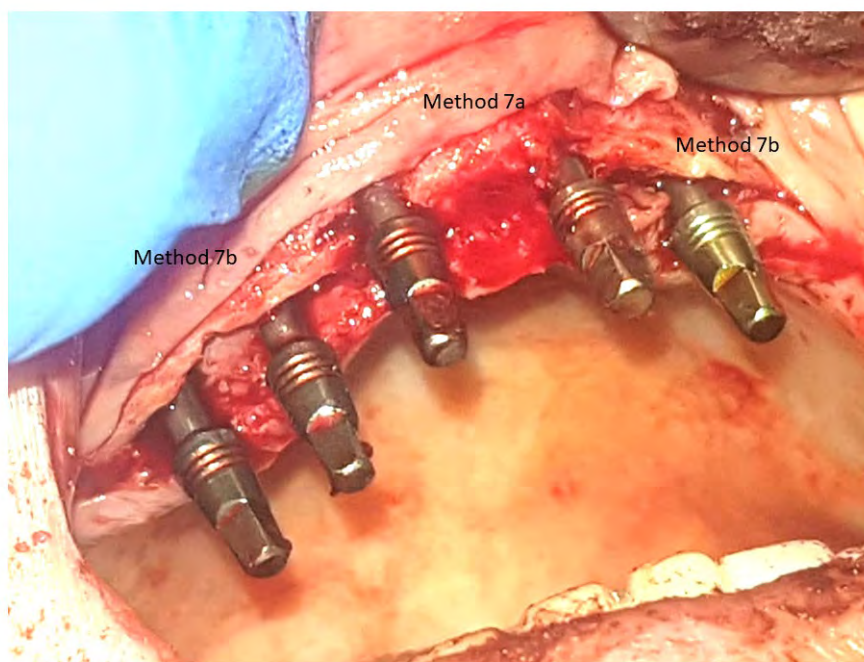


Method 7b

Palatal insertion of implants, directly into the floor of the nose, by-passing the alveolar bone of the maxilla

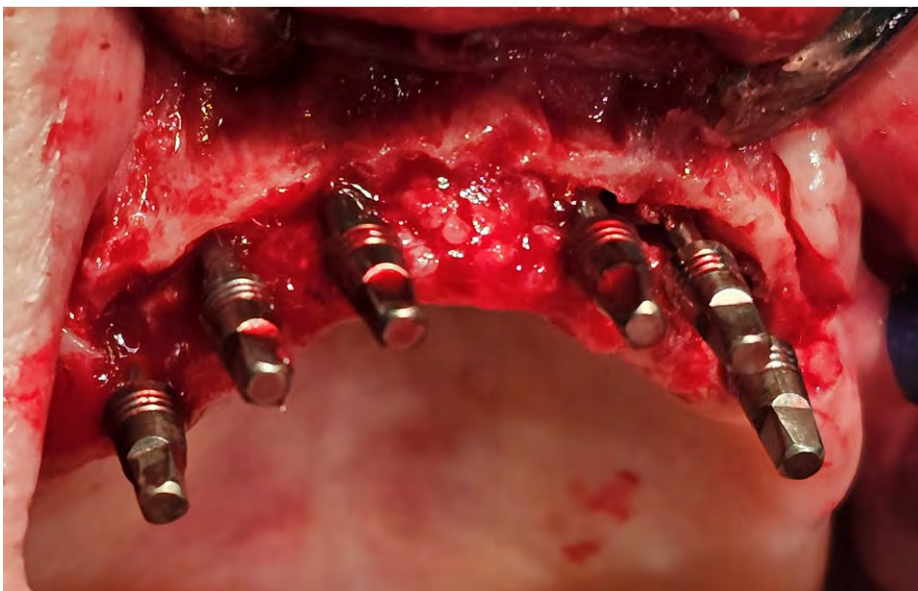


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Method 7b

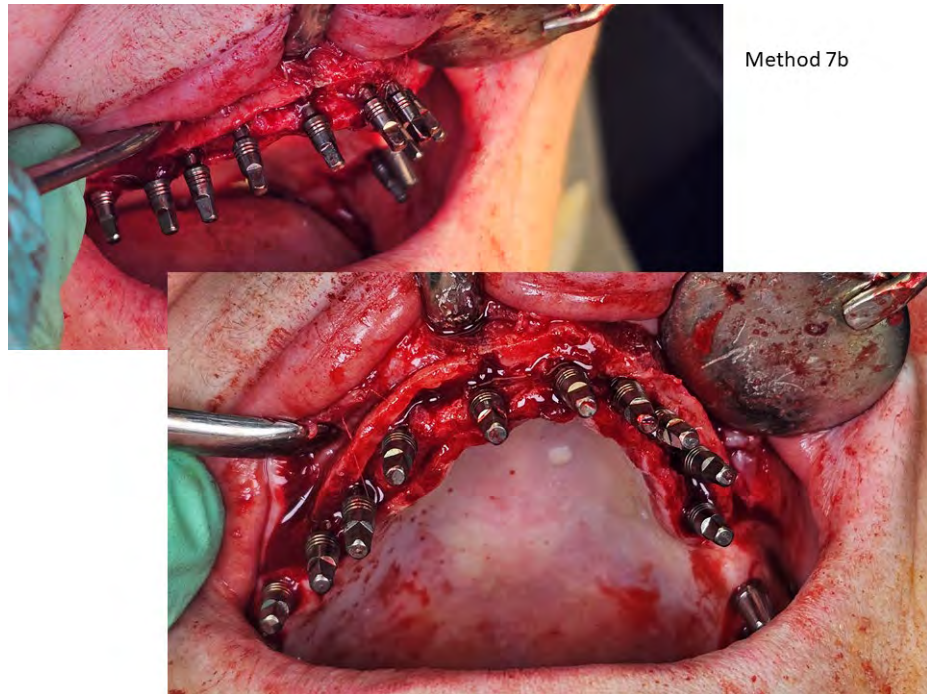


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Method 7b



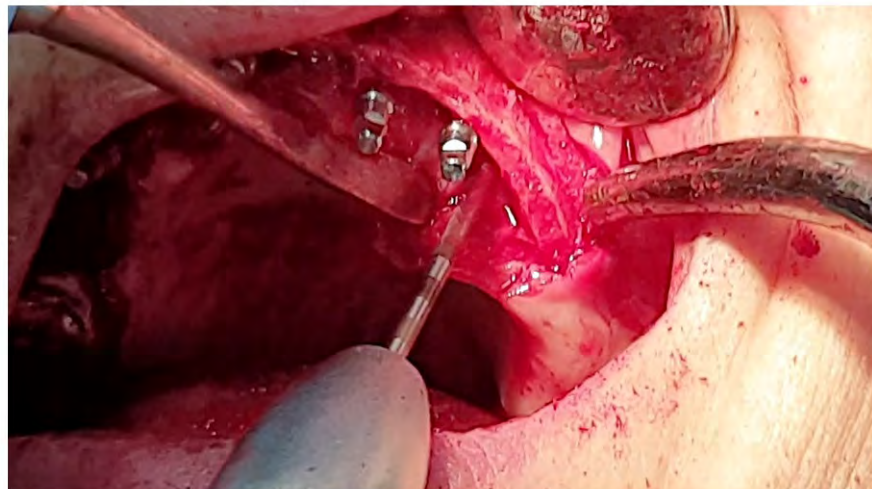
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Method 7b

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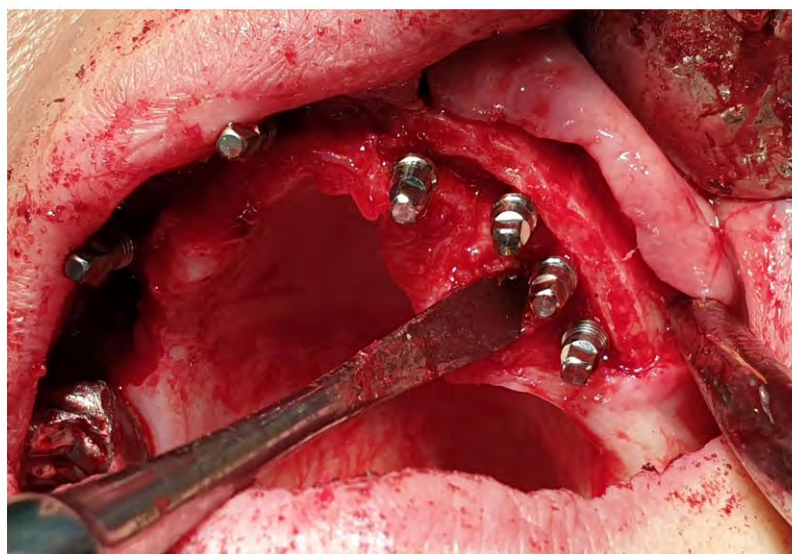
Method 7b



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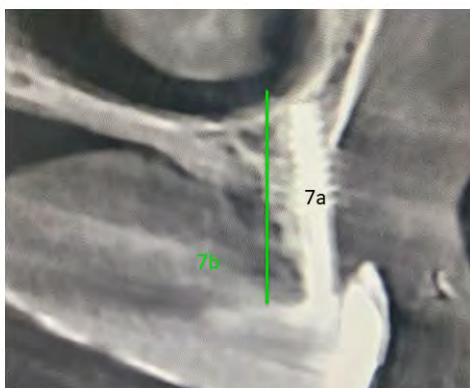
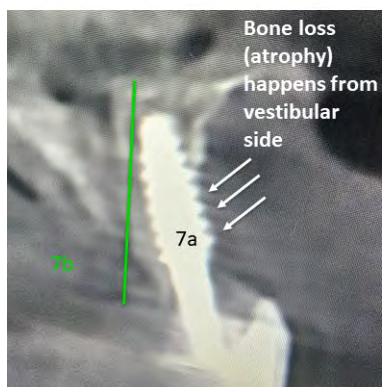
Method 7b



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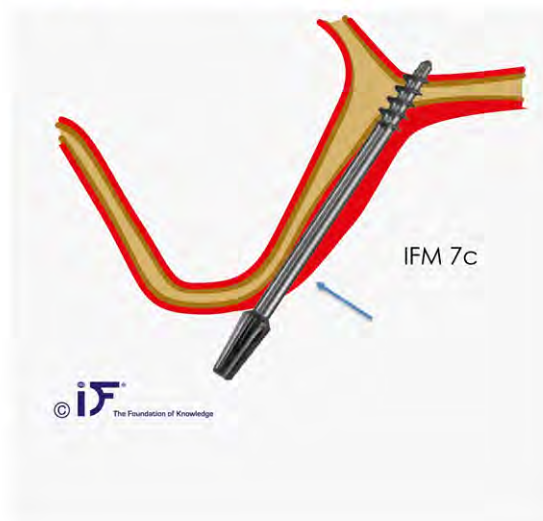
Methods 7a vs. 7b
(If in doubt, use 7b instead of 7a)



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Method 7c

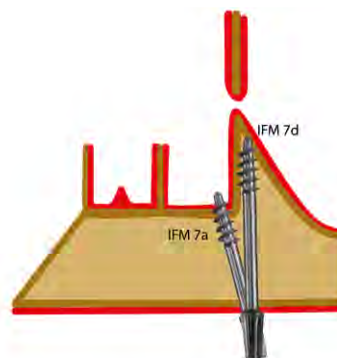


Anchorage in the horizontal part of the palate. The implant is supported by the crestal part of the alveolar crest.

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Method 7d

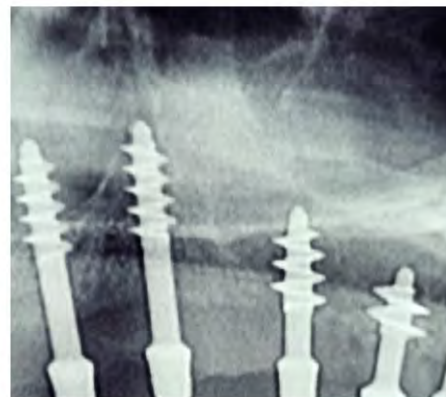
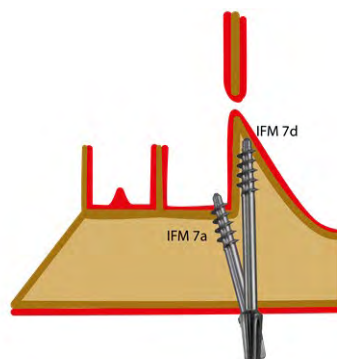


While in Method 7a, the floor of the nose is used for anchorage, in Method 7d, we use the naso-maxillary buttress: the implant is anchored between the lateral wall and the nose and the medial wall of the maxillary sinus. The implant may penetrate into the airway, or the maxillary sinus, or both.

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Method 7d



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Methods 8

Placement of the apical thread of the implants into the **cortical floor of the maxillary sinus** for anchorage

Utilization of **intra-sinusal buttresses** for multi-sided cortical anchorage



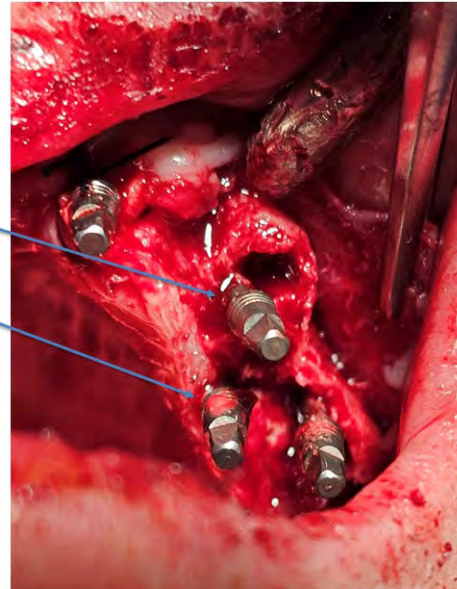
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Method 8a

Implant placed in
Method 7a

Implant placed in
Method 7b



Slide 72



Implant placed in
Method 7a

Implant placed in
Method 7b



Slide 73



If the membrane is perforated by the drill, blood will flow into the maxillary sinus and under the membrane. Subsequently new woven bone formation can be expected inside the maxillary sinus.



Method 8a

2021

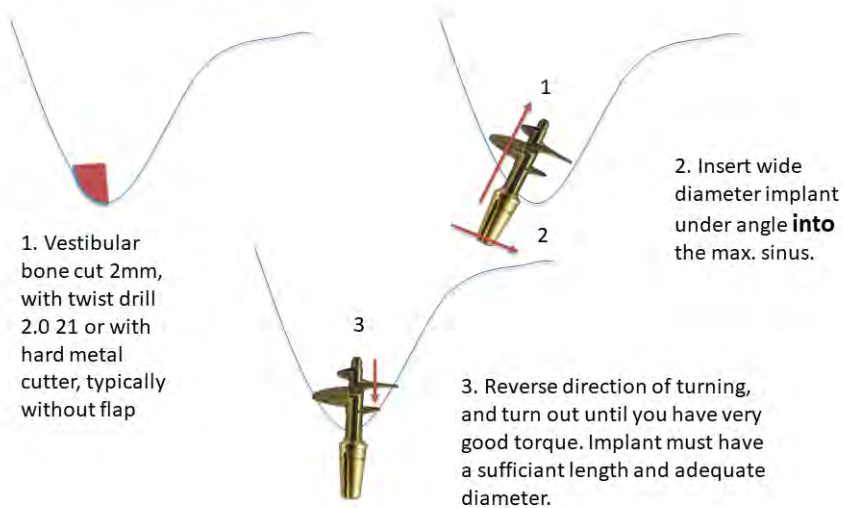
2019

2017

Slide 74



Method 8c



Slide 75



Method 9

Implant anchorage into the floor of the nose, passing through the alveolar bone on the palatal side of the root of the canine



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Method 9

Contraindications for applying Method 9:

- Root canal treated canine
- Frontal group shows caries
- Frontal group shows perio involvement



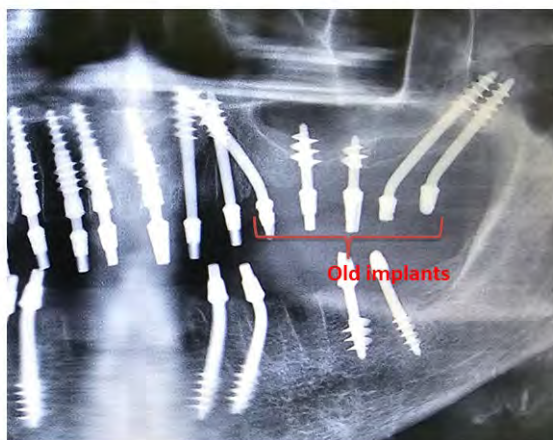
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Method 9

Long-term disadvantage:

- After the canine fails, it is difficult to replace the canine without that the 2 implants are touching each other. The optimum direction of insertion of the canine implant is difficult to determine



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Method 10

Placement of the apical thread of the implants into the cortical bone of the pterygoid plate of the sphenoid bone.



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Method 10



Slide 80

Method 10



Intra-oral view
Double
tuberopterygoid
cortical implant
placement.

Implants are already
bent parallel.

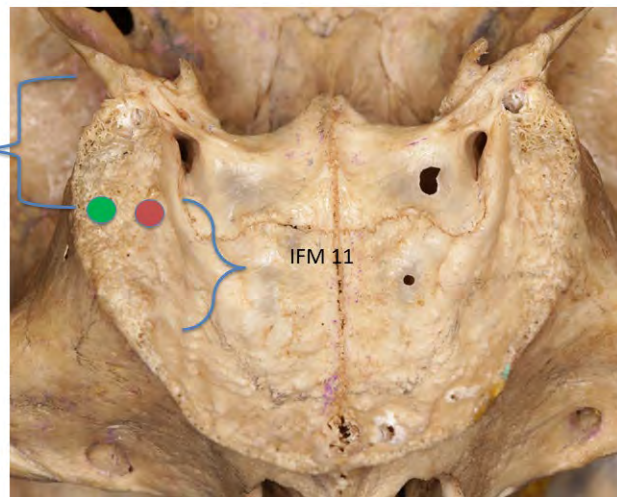


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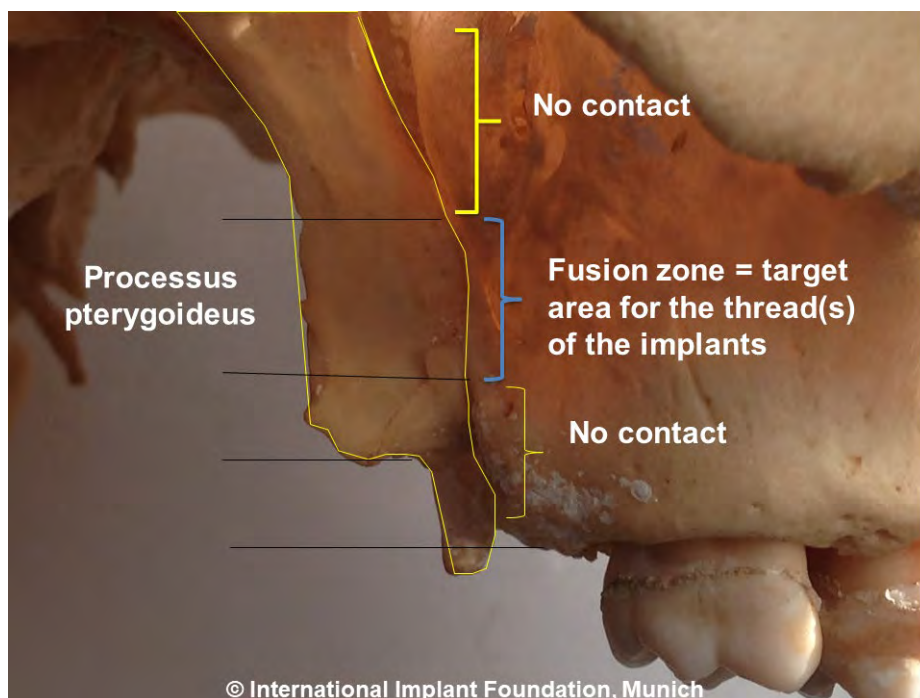


Method 10

Intra-oral view
Double
tuberopterygoid
cortical implants after
parallelization.



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Method 11a

Placement of BCS[®] into the bone palatal to the maxillary sinus

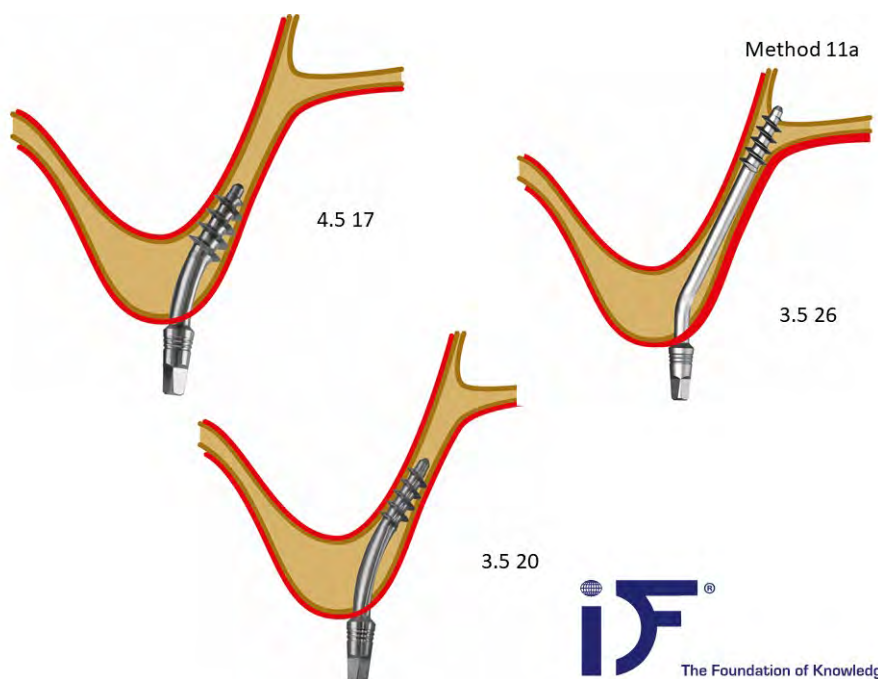
Comprising

11a anchorage in the bone palatally to the maxillary sinus without anchorage in the floor of the nose or the palatal median raphe

11b anchorage in the sutura palatina mediana



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Slide 85



Method 11c

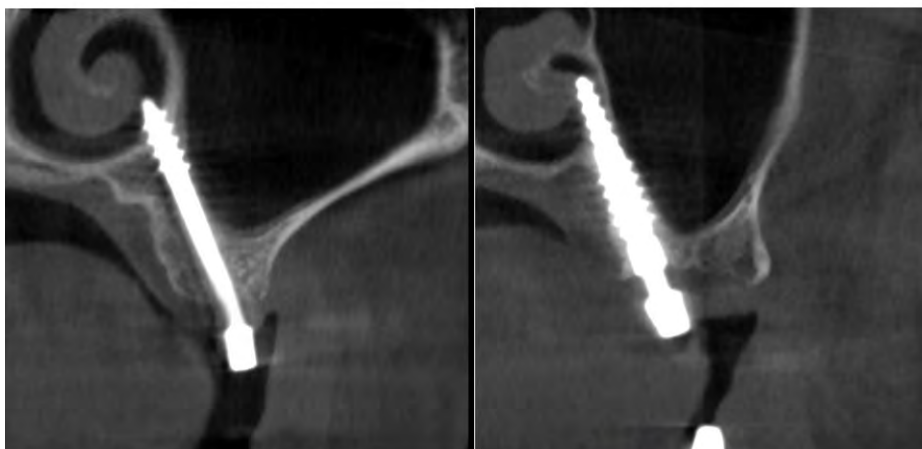


Target cortical:
Anchorage in the floor of the nose

1st cortical:
Alveolar crest

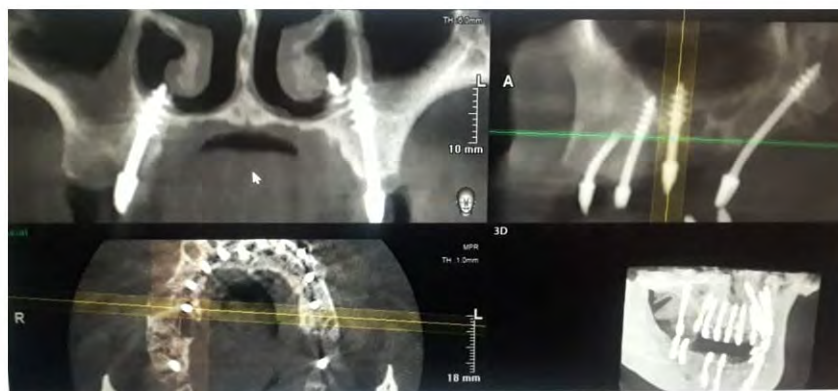
Slide 86

Method 11a



Slide 87

Method 11a



Slide 88

Method 11b

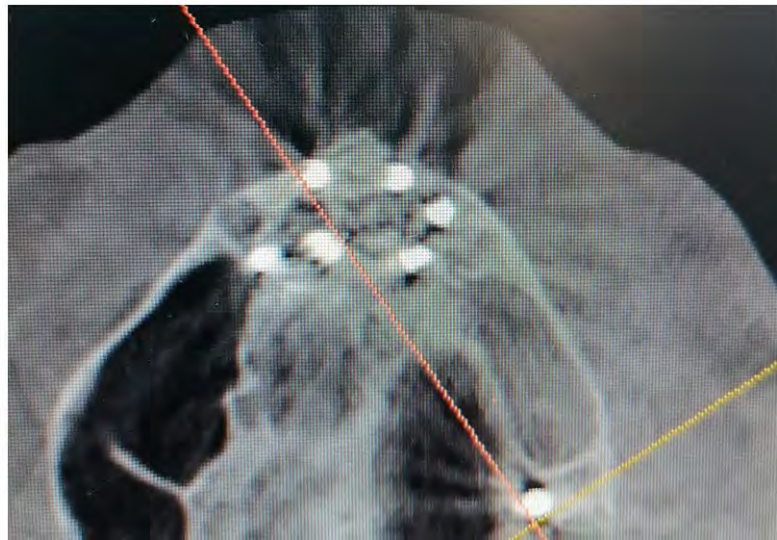


Anchorage in the sutura palatina mediana (sub- / intra-mucosal insertion path)



Slide 89

- Threads of implants are not touching each other
- Threads are placed in 2 rows (correct application)



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The Foundation of Knowledge

Methods 11c / 8a / 10

Anchorage in the sutura palatina mediana (sub- / intra-mucosal insertion path); correct application

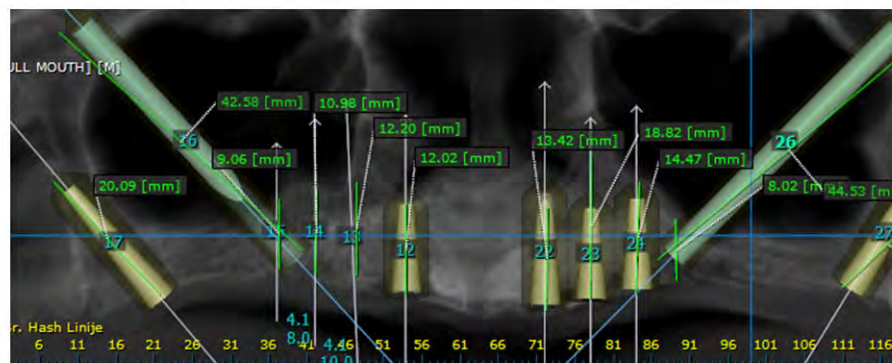


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Method 12

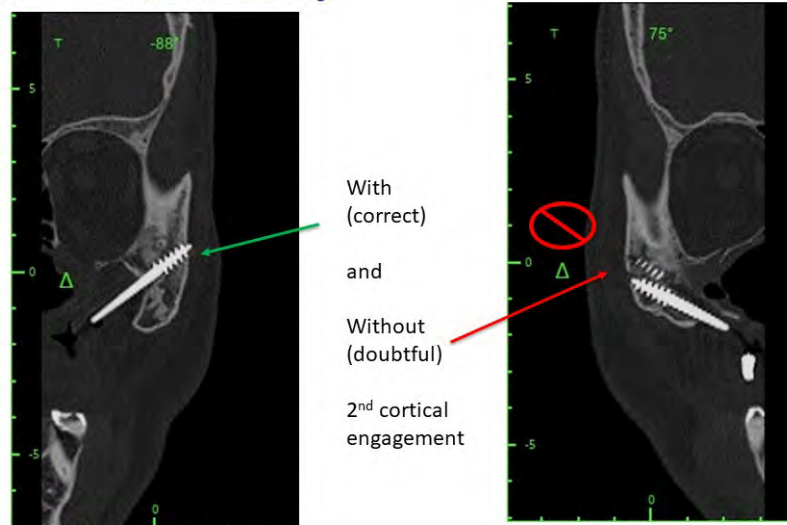
Placement of BCS[®] into the zygomatic bone either directly (vestibular to the alveolar process of the maxilla), or through the maxillary sinus



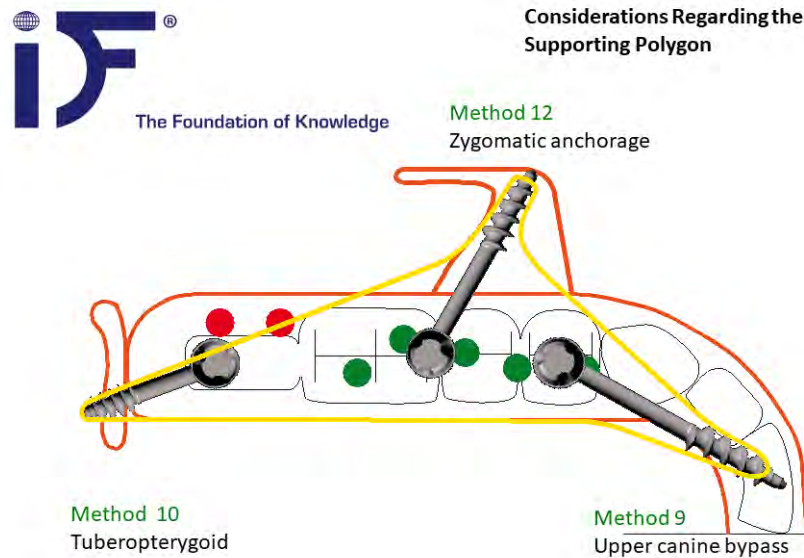
Slide 92



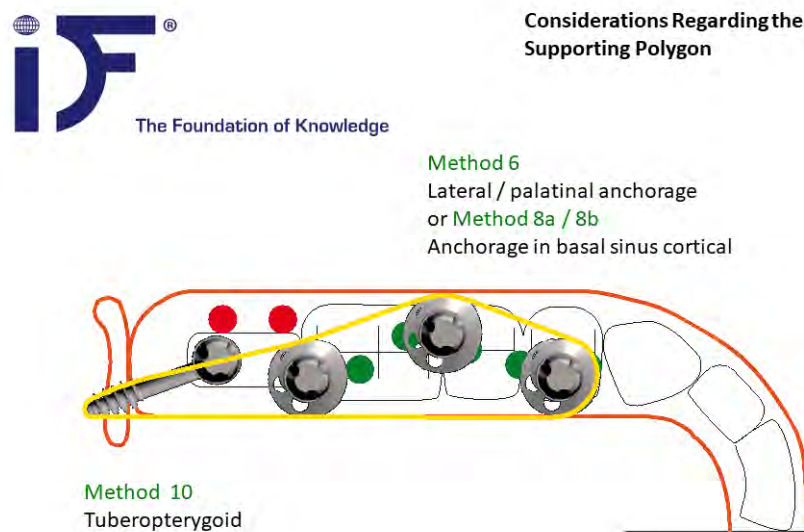
Method 12



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**Considerations Regarding the
Supporting Polygon**



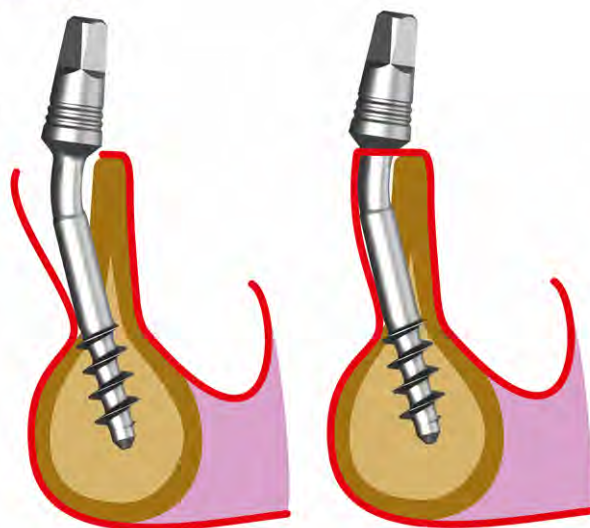
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Method 13

Placement of implants
vestibular to the knife-edge
ridge in the anterior
mandible.

Typical implant diameter is
2.7 mm or 3.0 mm.
Anchorage in the base of
the mandible.

The vertical implant parts
run (at least partially) in a
subperiosteal manner.

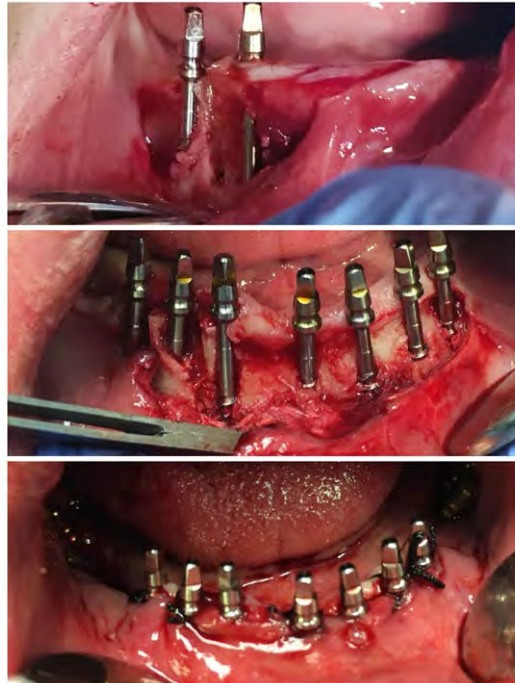


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Don't learn
Implantology
by accident

Methods 7b and 13 can be
used only for polished
implants (e.g. BCS®)
without any possibility of
mechanic retention.



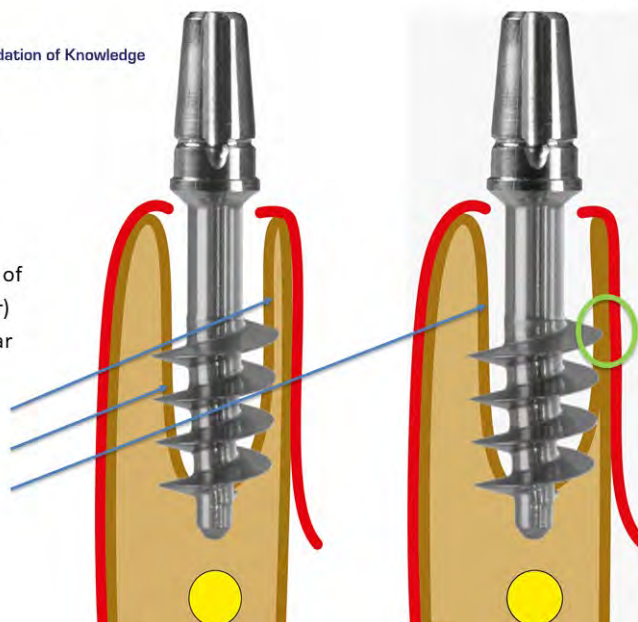
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The Foundation of Knowledge

Anchorage of an
implant with
4.6 mm (or 5.5
mmd) in the
extraction socket of
a lower (or upper)
1st or 2nd premolar

Unstable lamina
Cribrosa
("Cortical")

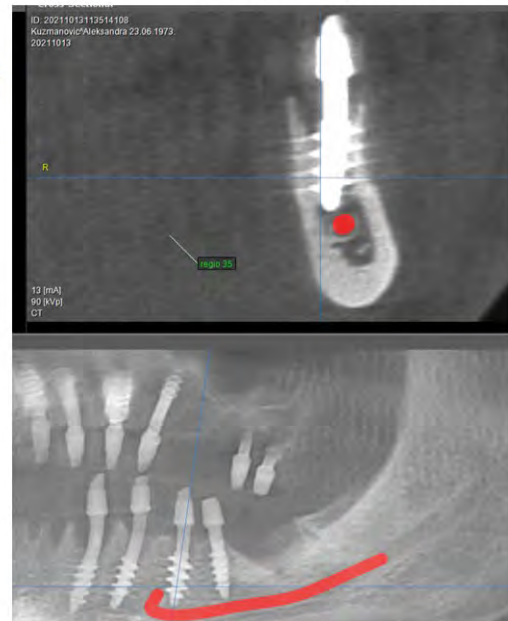


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Anchorage of an
implant with
4.6 mm or 5.5 mm.
in the extraction
socket of a lower
1st or 2nd premolar

Method 14 / Method 6

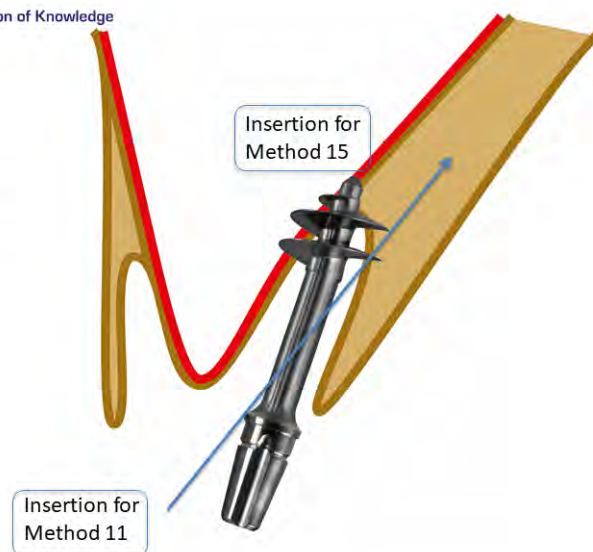


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Placement of a
medium diameter
Strategic Implant[®]
into the palatal
socket of a freshly
extracted upper 1st
or 2nd molar

Method 15



Slide 101



The Foundation of Knowledge

Placement of 2 implants in the area of the 1st upper pre-molar, one of them bypassing the canine, and the other utilizing the socket of the vestibular root of the 1st pre-molar

Canine bypass,
Method 9

Method 16a



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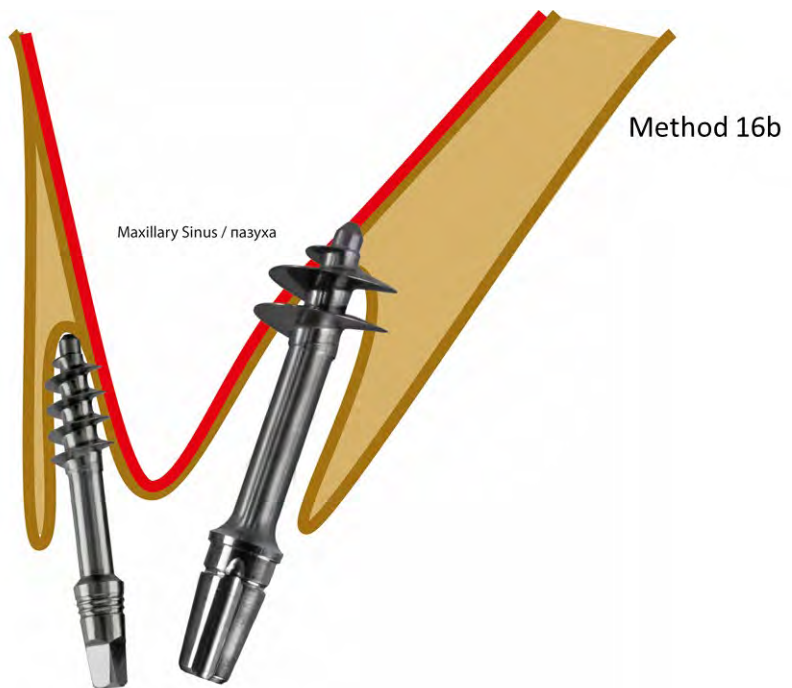
Don't learn
Implantology
by accident

Insertion of 2 implants in the extraction sockets of an upper 1st or 2nd molar, in cases where placement of tubero-ptyergoid is not possible

Method 16b



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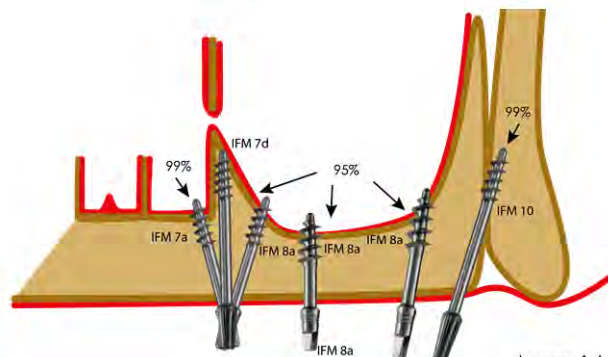


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Method Success Comparison

Which target cortical should be chosen if we have several options?



Lazarov A. Immediate Functional Loading: results for the Concept of the Strategic Implant[®]. Ann. Maxillofac. Surg. 2019;9(1): 78.

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Literature

Lazarov A. Immediate Functional Loading: Results for the concept of the Strategic Implant®. Ann Maxillofac Surg 2019; 9: 78-88.

Dobrinin O., Lazarov A., Konstantinovic V., et al. Immediate-functional loading concept with one-piece implants in the mandible and maxilla – A multi-center retrospective clinical study; J. Evolution Med. Dent. Sci./eISSN- 2278-4802, pISSN- 2278-4748/ Vol. 8/ Issue 05/ Feb. 04, 2019

Ihde et al. New Systematic Terminology of Cortical Bone Areas for Osseo-Fixated Implants in Strategic Oral Implantology. J J Anatomy. 2016, 1(2): 007.

Palka tR, Lazarov A. Immediately loaded bicortical implants inserted in fresh extraction and healed sites in patients with and without a history of periodontal disease. Ann Maxillofac Surg 2019;9:371-8.

Lazarov A. Trans- and Intra-Sinus BCS Implants - Clinical Alternative for Advanced Upper Jaw Atrophy. Statistical analysis of complications associated with maxillary sinus; Dental World, Issue February 1, 2018

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Literature

Lazarov A. Immediate Functional Loading: Results for the concept of the Strategic Implant®. Ann Maxillofac Surg 2019; 9: 78-88.

Dobrinin O., Lazarov A., Konstantinovic V., et al. Immediate-functional loading concept with one-piece implants in the mandible and maxilla – A multi-center retrospective clinical study; J. Evolution Med. Dent. Sci./eISSN- 2278-4802, pISSN- 2278-4748/ Vol. 8/ Issue 05/ Feb. 04, 2019

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Lazarov A. Trans- and Intra-Sinus BCS Implants - Clinical Alternative for Advanced Upper Jaw Atrophy. Statistical analysis of complications associated with maxillary sinus; Dental World, Issue February 1, 2018



Thank you for your attention!

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