



GUIDELINES FOR CASE REPORTS FOR ASSOCIATE FELLOW MEMBERSHIP*

General Information

As specified in the *Requirements for Associate Fellow Membership*, candidates must submit case reports for the oral/case part of the examination. The candidate must have provided surgical and/or restorative treatment for each of the submitted cases. Each case must be on a different patient and must be complete with the final prosthesis in function for at least one year by the examination date.

The case reports may be submitted in either print or electronic format. Irrespective of the format used, each report must conform to these guidelines. For additional information about the preparation of electronic reports, see *Instructions for Electronic Submission of Case Reports*, which is a separate document.

When applications for the examination are received in the Headquarters Office, each candidate is sent a number. Candidates use their number to identify all materials submitted for the examination.

Case reports are due in the Headquarters Office two months before the examination period begins. The applicant is responsible for insuring that the case materials arrive by that date; therefore, use of a delivery process that allows verification of receipt in the Headquarters Office is recommended. **The submitted reports become the property of the American Academy of Implant Dentistry and will not be returned. Applicants will be notified of the specific date and time of their examinations after their case reports are received in the Headquarters office.**

Case Requirements

Associate Fellow candidates must prepare written narrative (prose) reports for three (3) cases on three (3) different patients, which meet the following criteria:

- Single tooth
- Edentulous segment of two (2) or more adjacent teeth with a minimum of two (2) implants
- Edentulous arch [If root-form or plate-form implants are used, the case must include a minimum of four (4) implants, and transosteal implants must have four (4) perimucosal sites. The intramucosal insert and endosteal bone pin modalities are not acceptable for the full-arch case requirement.]

Cases in which implants of less than 3 mm in diameter are used as definitive therapy do not satisfy the requirements of the examination and should not be submitted. Cases presented for examination must have been in function for at least one year by the examination date.

Case Reports

Candidates must develop written narrative (prose) reports for each of their cases that include the pertinent information listed in the following outline. The narrative part of the report must be typed. (For the print format, the report must be double-spaced and printed on 8½" x 11" paper.) Abbreviations must be explained the first time that they are used in the narrative report. The

* Approved by the Admissions and Credentials Board, September 1997; revised to April 2008.

candidate's name, office name and address must not appear anywhere in the reports *except* on the patient release form (do not bind into the folder.) Also, the patient's address should not appear in the report.

Submit each case report prepared in the print format, in a three-ring binder that has two interior pockets. Place the patient release form in the front pocket of the case report binder and the radiographs in the back pocket. For each report, complete a Case Report Checklist and include it as the first page.

Failure to comply with the case report guidelines, including the radiographs, photographs and medical histories, will greatly affect the candidate's case report score.

Place a label on the front cover of each case report as illustrated in Figure 1. The label must include the following information: candidate's examination number, the patient's initials and the case type, i.e., single tooth, edentulous segment of two or more teeth, or edentulous arch.

Figure 1

Candidate: AF 0901 Patient: JLR Case Type: Single Tooth

Case Report Outline

I. Patient Examination

A. History

1. Chief complaint
2. Secondary complaint(s), if applicable
3. Health history when the implant(s) was placed, which has the patient's signature (copy) (If the health history is not in the English language, an English translation must also be submitted.)
4. Laboratory findings (e.g., CBC, SMA, PTT, INR), if applicable
5. Current medications

B. Clinical examination

1. Existing dentition
2. Adjacent soft tissues
3. Periodontal charting, if applicable
4. Lip line
5. Temporomandibular joint function
6. Parafunctional habits
7. Hard and soft tissue anatomy of edentulous areas
8. Other findings

C. Radiographic examination

1. Findings
2. Limitations

D. Preoperative diagnosis

E. Patient Consent form for treatment with the patient's signature (copy)

II. Development of the Treatment Plan

A. Treatment goals

1. Patient desires
2. Functional
3. Esthetic
4. Hygiene
5. Limitations
 - a. Medical conditions
 - b. Physical
 - c. Psychological

- B. Evaluation of existing natural dentition
 - 1. Crown - root ratio
 - 2. Periodontal condition
 - 3. Abutment suitability
 - 4. Alignment
 - 5. Restorative needs
- C. Interarch relationships
 - 1. Occlusion
 - 2. Jaw relation
 - 3. Temporomandibular joint function
- D. Evaluation of edentulous ridge
 - 1. Amount of resorption
 - 2. Soft and hard tissue anatomy
 - a. Deficiencies
 - b. Limitations
 - 3. Suitability for implant(s)
- E. Prosthetic restoration selection
 - 1. Advantages
 - 2. Disadvantages
 - 3. Alternatives
 - 4. Rationale
- F. Hard and soft tissue modifications
 - 1. Grafts
 - 2. Osteoplasties
 - 3. Gingivoplasties
- G. Implant selection rationale
 - 1. Type
 - 2. Number
 - 3. Placement position(s)

III. Surgical and Prosthetic Report

- A. Surgical procedures (written, detailed surgical operative report that includes treatment dates)
 - 1. Type and amount of anesthesia
 - 2. Instruments and materials used
 - 3. Suture type and technique
 - 4. Surgical and postoperative complications
- B. Prosthetic procedures (written, detailed operative report, step-by-step, how used and why; include treatment dates)
 - 1. Materials used (as applicable)
 - a. Impression
 - b. Die
 - c. Model
 - d. Transfer
 - e. Abutment
 - f. Restorative
 - g. Cementation
 - 2. Techniques
 - a. Preparation
 - b. Impression
 - c. Bite registration
 - d. Temporization
 - e. Articulation (e.g., hinge, face bow, semi-adjustable)
 - 3. Prosthetic delivery
 - a. Evaluation of fit
 - b. Occlusion/adjustment
 - c. Placement
 - 4. Follow-up

IV. Clinical Resume

- A. Comparison of preoperative and postoperative diagnoses

- B. Type of patient instructions given (e.g., preoperative, postoperative, diet, temporization, prosthetic)
- C. Complications
- D. Patient acceptance and prognosis

V. Release of Information Form, signed by the patient (Place the form in the pocket of the report folder; do not bind into the folder.)

Photographs

Post-completion photographs, which are 4" x 6" in size and show the following views, are required for each case (**slides and additional photographs are not acceptable**):

- Frontal (maxillary and mandibular teeth in occlusion)
- Protrusive
- Occlusal, maxillary
- Occlusal, mandibular
- Lateral view in centric occlusion, left
- Lateral view in centric occlusion, right
- Right working
- Left working

For cases that include a removable prosthesis, two additional photographs are required: (1) a post-completion photograph of the superstructure and (2) a photograph of the implants without the prosthesis in place.

All photographs must comply with applicable patient privacy laws.

Place the photographs in the case report folders in transparent protective covers with two photographs to a page. Place a label under each photograph that includes the following information, as illustrated in Figure 2:

- Candidate examination number
- Patient initials
- Date of the photograph
- View, e.g., frontal

Figure 2

Candidate: AF 0901 Patient: JLR Date: 8/30/08 View: Frontal
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Radiographs

Duplicates of the original radiographs of the following views must be submitted with each case report. Digital radiographs that are printed on either transparency or glossy paper are acceptable; duplicates of digital radiographs are not required. All radiographs must be of diagnostic quality. They must have minimal distortion and bone levels must be obvious.

- Presurgical panograph or a full-mouth radiographic series.
- Post-surgical (within one week of surgery) panograph or a post-surgical periapical radiograph for a single-tooth-implant.
- Post-prosthetic (with prosthesis or bar superstructure in place); either panographic or periapical radiographs are acceptable

For each case, a completed case radiograph, taken within 12 months of the candidate's oral/case examination date, must also be submitted. Either a panograph or a full-mouth radiographic series is acceptable.

If a CT scan has been made for a case, a panoramic view and representative slices of the scan may be submitted but are **not** required.

Label each radiograph with the following information, as illustrated in Figure 3:

- Candidate examination number
- Patient's initial
- Date taken
- Right or left side
- View [e.g., presurgical panographic)

Figure 3

Candidate: AF 0901 Patient: JLR Date: 12/15/08 Side: Right View: Presurgical Panographic
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Place the radiographs in the back pocket of the report folder; do not bind them into the folder.

Candidates must bring the originals of all duplicate radiographs to the examination.

Study Models

During the case presentations, the candidate may use study models, but they are **not** required. Candidates who plan to use study models should bring them to the examination. Do **not** submit study models with the case reports.

Materials to Bring to the Examination

Radiographs: All candidates must bring to the examination the **originals** of all duplicate radiographs submitted in the case reports. (Note: This does not apply to digital radiographs.)

Subperiosteal Cases: Candidates who are presenting a subperiosteal implant case **must bring** the bone model from either the direct bone impression or CT scan to the examination. Do **not** submit these models with the case reports.