



GUIDELINES FOR CASE REPORTS FOR FELLOW MEMBERSHIP*

General Information

Each Fellow candidate must submit ten cases as specified in the *Requirements for Fellow Membership*. The applicant must have performed both the surgical and prosthetic treatment for each of these ten 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 beginning of the examination period.

The case reports must be submitted in electronic format. Each report must conform to these guidelines.

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 45 days 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

Each Fellow candidate must have completed dental implant treatment of at least fifty (50) arches. From these fifty (50) cases, the candidate will select ten (10) cases on ten (10) different patients for presentation to the examiners. **The candidate must have provided both the surgical and prosthetic treatment for these ten (10) cases.** (For the other forty (40) cases, the following must be listed in the application: patient name, current address and telephone number.)

These ten (10) cases must meet the following criteria:

- **Three (3) complete arch cases on edentulous arches, one (1) of which demonstrates a totally implant-supported (no soft tissue support) prosthesis for a patient with severe atrophy.** [If root-form or plate-form implants are used, the case must include a minimum of four (4) implants. A transosteal implant must have four (4) transmucosal sites to qualify as a full-arch case. The intramucosal insert, endosteal bone pin or augmentation modalities are not acceptable for the edentulous arch case requirement.]
- **One (1) unilateral (Kennedy Class I) or bilateral (Kennedy Class II) edentulous posterior maxilla, replaced with two (2) or more root-form implants without teeth between the implants.**
- **Two (2) cases that show management of bone deficiencies.**
- **The remaining four (4) cases are of the candidate's choice.**

Three (3) of the ten (10) cases must have been completed within twelve (12) to eighteen (18) months of the examination date and two (2) of the ten (10) cases must have been in function for at least five (5) years by the examination date. Cases in which implants of less than 3mm in diameter are used as definitive therapy do not satisfy the requirements of the examination and should not be submitted. All

* Approved by the Admissions and Credentials Board, September 1997; last revision, April 2011.

cases presented for examination must have been in function for at least one year by the beginning of the examination period. **Reports for these ten (10) cases must meet the criteria listed in the following section.**

Case Reports

Fellow candidates must prepare written narrative (prose) reports for three (3) cases and provide radiographic documentation for the other seven (7).

The three (3) written case reports must meet the following criteria:

- One (1) edentulous case with an implant-supported prosthesis (i.e., no tissue support) for a patient with severe atrophy.
- One (1) unilateral (Kennedy Class I) or bilateral (Kennedy Class II) edentulous posterior maxilla, replaced with two (2) or more root-form implants without teeth between the implants.
- One (1) case of the candidate's choice.

The written narrative reports must include all of the pertinent information included in the following outline. In each report, the arch that was treated must be specified; and the teeth must be identified by name, not number. Abbreviations must be explained the first time that they are used in the narrative report. The candidate's name and office name and address must not appear anywhere in the reports *except* on the patient release form, and the patient's address should not appear in the report.

The narrative reports and the cases documented with radiographs must be submitted in electronic format on either a PC formatted CD-ROM or a memory stick (USB flash drive). Each narrative case report must include the following three files: narrative report, photographs and radiographs and labeled as appropriate, e.g., edentulous case with an implant-supported prosthesis for a patient with severe atrophy. **See Appendix 1 for instructions about how to obtain and use the templates for each of these files.**

For each report, complete the Case Report Checklist that is the first page of the written report template.

Place a label on the CD-ROM or memory stick that includes the candidate's examination number only. As noted in the General Information section of these Guidelines, this is the number that candidates receive after their applications are received in the AAID Headquarters Office.

Provide a file for each of the seven cases documented with radiographs and label each as appropriate. Use the template for radiographs to prepare each file.

In addition to the CD-ROM or memory stick that includes the ten (10) reports, provide a print copy of the patient release form for each case report.

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

Case Report Outline

Candidates must develop written narrative (prose) reports for each of the three (3) cases that include the pertinent information listed in the following 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 (Either scan in the health history or provide a print copy with the electronic report. 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** (Either scan in the health history or provide a print copy with the electronic report.)

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 of 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 Résumé

- 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 (Provide a print copy.)

Photographs

Post-completion photographs, which are 4" x 6" in size, taken with retraction and clearly show the following views, are required for each case. These photographs must clearly depict the soft tissue relationship to the implant prosthesis. **Do not submit any photographs that are not required.**

- 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, three additional photographs are required:

- An occlusal view of the superstructure without the removable prosthesis in place.
- A frontal view of the superstructure without the removable prosthesis in place.
- A view of the intaglio (tissue side) surface of the removable prosthesis.

Radiographs

Radiographs of the following views must be submitted with each case report. All radiographs must be of diagnostic quality and have minimal distortion, and bone levels must be obvious.

- Presurgical panograph or 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 a panograph or periapical radiographs are acceptable

For each case, a completed case radiographs, taken within 12 months of the 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.

Materials to Bring to the Examination

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.

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.

Appendix 1

INSTRUCTIONS FOR SUBMISSION OF ELECTRONIC CASE REPORTS

General Information

Submit all three written reports on one compact disc (CD), which includes a folder for each case type, labeled as appropriate, e.g., single tooth case. Each electronic case report must include the following three files: written report, photographs and radiographs. A template for each file is posted on the Academy's website (www.aaid.com) in the Credentialing/Associate Fellow/Case Report Resources section. These templates are also available on a CD upon request to the Headquarters Office.

On the CD label, include the candidate's examination number only. As noted in the *Guidelines for Case Reports for Associate Fellow Membership*, the candidate will receive this number after his or her application for the examination is received in the AAID Headquarters Office.

Template for Written Report

Open the written report template using Microsoft Office Word. On page 1, type your examination number and the patient's initials and choose the case type from the pull down screen. On page 2, insert a scanned copy of the medical history, which has the patient's signature, by doing the following: (1) click on the sample history and (2) go to INSERT picture and insert a scanned copy of the patient's medical history. Be sure that the scanned copy is LEGIBLE.

Beginning on page 3, there are headings for each section of the Case Report Outline. The content that must be included in each section is described in the grey shaded area, which is under the section heading. Begin typing the report text in the grey shaded area where your text will write over the content description. To move to the next section of the report, hit TAB. When the written report is completed, label it "Written Report" and save in the appropriate case folder.

Template for Photographs

Use Microsoft PowerPoint to open the photograph template. For each case, type the information specified in the bracketed text. On the first slide, insert the candidate's examination number, the patient's initials, and the case type. All of the photo views required for each case are listed on slide 2, and slide 3 provides the template for each view. In either the slide sorter view or the side bar on the left, click on Slide 3, then edit > copy, edit>paste, and repeat until you have inserted slides for each of the required photos. On slide 3 and subsequent slides, type the view and date that the photo was taken, as appropriate.

To insert a photograph,

- Click on the placeholder that is to be replaced.
- Go to the INSERT menu and click picture and from file, then choose the photograph to be inserted and click insert. Resize the photo to the approximate size of the placeholder.

Save the photographs in the appropriate case folder in a file named Photographs.

Template for Radiographs and CT Scans

Open the template for radiographs in Microsoft PowerPoint. For each case, type the information specified in the bracketed text. On the first slide, insert the candidate's examination number, the patient's initials, and the case type. Slide 2 lists all the radiographs that are required for each case. Slide 3 provides the template for the required radiographs. In the slide sorter view or in the side bar on the left, click on Slide 3, then edit > copy, edit>paste, and repeat until you have inserted slides for each of the required radiographs. On slide 3 and subsequent slides, type the view and date that the radiograph was taken, as appropriate.

To insert a radiograph,

- Click on the placeholder that is to be replaced.
- Go to the INSERT menu and click the following in the following sequence: picture, from file, choose appropriate file and click insert. Resize the photo to be approximately the size of the placeholder.

Save the radiographs in the case folder, as appropriate, in a file named Radiographs.

If a CT scan has been made for a case, a panoramic view and representative slices of the scan may be submitted, using the same procedure. Please note that CT scans are **not** required.

Use the template for radiographs to prepare a file for each of the seven cases documented with radiographs and label each as appropriate.